Annual Progress Report 2009

Submitted by

The Government of

[*Afghanistan*]

Reporting on year: **2009**

Requesting for support year: **2011**

Date of submission: 15th May 2010

Deadline for submission: 15 May 2010

Please send an electronic copy of the Annual Progress Report and attachments to the following
e-mail address: **apr@gavialliance.org**

any hard copy could be sent to :

GAVI Alliance Secrétariat,
Chemin de Mines 2.
CH 1202 Geneva,
Switzerland

Enquiries to: **apr@gavialliance.org** or representatives of a GAVI partner agency.
The documents can be shared with GAVI partners, collaborators and general public.

Note: *Before starting filling out this form get as reference documents the electronic copy of the APR and any new application for GAVI support which were submitted the previous year.*

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES
The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION
The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS
The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION
The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION
The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any

claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY
The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS
The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION
Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.
For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.
The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application..

By filling this APR the country will inform GAVI about :

- *accomplishments using GAVI resources in the past year*
- *important problems that were encountered and how the country has tried to overcome them*
- *Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners*
- *Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released*
- *how GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.*

Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

By signing this page, the Government hereby attest the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in page 2 of this Annual Progress Report (APR).

For the Government of **Afghanistan**

Please note that this APR will not be reviewed or approved by the Independent Review Committee without the signatures of both the Minister of Health & Finance or their delegated authority.

Minister of Health (or delegated authority):	**Minister of Finance (or delegated authority):**
Title: Acting Minister of Public Health	**Title: Minister of Finance**
Signature:……	**Signature:……**
Date: ……	**Date: ……**

This report has been compiled by:

Full name Dr. Abdul Wali Position: Health System Strengthening coordinator and focal point Telephone: 0093 (0) 799 353 178 E-mail: drabwali@yahoo.com	Full name : Dr. Aqa Gul Dost Position: National EPI manager Phone: 0093 (0)799 814 812 E-mail: nationalepi5@yahoo.com
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ICC Signatures Page

If the country is reporting on ISS, INS, NVS support

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

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

Name/Title	Agency/ Organisation	Signature	Date
Dr. Suraya Dalil, Deputy Minister, Policy& Planning	*MOPH*		
Dr. T. Mashal, DG, preventive &PHC	*MOPH*		
Dr. Ahmad Jan Naim, DG, Policy & Plan	*MOPH*		
Dr. Dost, National EPI Manager	*MOPH*		
Mr. S. A. Khan, Focal Point for MOPH	*MoF*		
Dr. Wali, HSS/CSO Focal Point	*MOPH*		
Dr. Faiz Mohammad	*USAID*		
Dr.	*WB*		
Dr.	*EU*		
Dr. Rafiqi, Capacity Building Manager	*TecServe*		
Mr. Peter Jhan Graaff, WR Afghanistan	*WHO*		
Dr. Zahra, Project Officer, EPI	*UNICEF*		
Dr. A. Shakoor, NPO/EPI/GAVI	*WHO*		

ICC may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

Comments from partners:

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Comments from the Regional Working Group:

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HSCC Signatures Page

If the country is reporting on HSS

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), Health System Strengthening Steering Committee *[insert name]* 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.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organisation	Signature	Date
See attached singed list			

HSCC may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

Comments from partners:

This is only the WB comment:
The signature provided above is provided in our capacity solely as an informal member of the ICC & HSCC. It does not represent a contractual commitment or enforceable clause, not is it being provided in the context of any fiduciary responsibility for GAVI Alliance funds or otherwise. This signature should not be viewed as having any legal effect , not should any reliance be placed on any confirmations made above , which are not legally or operationally within the purview of our role or capacity as a committee member.

Comments from the Regional Working Group:

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.....

Signatures Page for GAVI Alliance CSO Support (Type A & B)

This report on the GAVI Alliance CSO Support has been completed by:

Name: Dr. Abdul Wali HSS Also Dr. Tahir Khan, And Dr. Parwez
Post: HSS coordinator, CSO type B support officer and mapping officer, respectively

Organisation: MOPH and WHO

Date: 14th May2010

Signature……

This report has been prepared in consultation with CSO representatives participating in national level coordination mechanisms (HSCC or equivalent and ICC) and those involved in the mapping exercise (for Type A funding), and those receiving support from the GAVI Alliance to help implement the GAVI HSS proposal or cMYP (for Type B funding).

We, the undersigned members of the National Health Sector Coordinating Committee, Health System Steering Committee (subcommittee of Consultative Group for Health and Nutrition) endorse this report on the GAVI Alliance CSO Support.

Name/Title	Agency/Organisation	Signature	Date
See attached list			

Signature of endorsement does not imply any financial (or legal) commitment on the part of the partner agency or individual.

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List of supporting documents attached to this APR

1. *Expand the list as appropriate;*
2. *List the documents in sequential number;*
3. *Copy the document number in the relevant section of the APR*

Document N°	Title	APR Section
	Calculation of [Country's] ISS-NVS support for 2011 (Annex 1)	1.1; 2.4; 3.7
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1. General Programme Management Component

1.1 *Updated baseline and annual targets (fill in Table 1 in Annex1-excell)*

The numbers for 2009 in Table 1 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2009.** The numbers for 2010-15 in Table 1 should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In the space below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

Provide justification for any changes in births: No change
Provide justification for any changes in surviving infants: No change
Provide justification for any changes in Targets by vaccine: No change
Provide justification for any changes in Wastage by vaccine: No change

1.2 *Immunisation achievements in 2009*

Please comment on the achievements of immunization program against targets (as stated in last year's APR), the key major activities conducted and the challenges faced in 2009 and how these were addressed:

1. **Routine Immunization Activities**
- **Micro plans in 180 districts (75%) were updated for 2009). 9 districts are out of any health facility and 51 districts mainly in southern and western regions were not easy accessible).**
- **Outreach services & mobile activities were conducted as planned with (65%) implementation rate for all sessions.**
- **185 districts (56%) of districts achieved 80% or more DPT3 coverage**
- **38 districts (12%) reported Pentavalent coverage less than 50%**
- **Because of measles outbreak and low routine coverage, the 4 rounds of accelerated immunization services with all antigens provided to the population in 28 districts**

2. **Measles and TT SIAs:**
- **The nation-wide, phase-wise follow up measles SIAs conducted in 2009.Around 3 million children vaccinated with one dose of measles vaccine.**
- **Totally, 7800 district coordinators, cluster supervisors, health care workers and PCA monitors were trained for implementation of measles follow up SIAs.**
- **The first phase of TT SIAs conducted in 186 high risk districts**

3. **New vaccine introduction:**
- **Afghanistan introduced Hib vaccine in combined form (Pentavalent) into national Immunization Program in January 2009.**
- **Hib vaccine pre-introduction activities included developing and printing of Hib guideline, conducting of TOT courses for 65 trainers and conducting courses for 2978 immunization health workers, managers,**

and supervisors.

4. **Building Infrastructure:**

- **Maintaining the functionality of the cold chain system at national level (>80%)- self assessment**
- **Increase accessibility through more immunization sites which increased by 48 New fixed sites (total: 1249) and 145 health posts and mobile health teams with conducting at least 4 immunization sessions/year in underserved areas.**

5. **Training:**

- **Refresher training for 469 service providers in provinces (94% of the planned target)**
- **Training of 12 (60% of the planned) District Health Officers on EPI/PEI**
- **Training of 14 (100%) provincial EPI managers on supportive supervision in south of the country**
- **Training of 56 (96% of the planned) EPI managers and supervisors on measles case-base surveillance**
- **Training of 42 (100%) trainers on H1N1disease and vaccine**
- **Training of 103 (85% of the planned) EPI health workers and nurses on safety of injections**
- **Training of 63 (80%) cold chain officers on Vaccine Store & supplies management**
- **Training of 14 vaccinators (100%) on Hepatitis B vaccine (for adults) on storage, administration and reporting**
- **Training of 368 (92%) AFP/Measles/NNT focal points on measles case-base surveillance**
- **Translation of Immunization in Practice (IIP) and printing of 5000 IIP for distribution to all personnel involved in immunization program activities.**
- **Training of 60 (100%) midwives on routine immunization program**

6. Supervision and Monitoring:

- **Planned supervisory visits were conducted (<60%)at all levels**
- **Follow up and monitoring of monthly EPI meetings at provincial level, assessing progress problems at district level with emphases on use of monitoring charts**

7. Quality of recording and reporting system:

- **Printing and distribution of all the recording, reporting and monitoring forms**
- **Follow up on the recoding and reporting system in all provincial levels**

8. Social mobilization:

- **Celebration of all rounds of National Immunization days, measles and TT SIAs at national and provincial levels**
- **Production and dissemination of TV and radio spots on immunization**
- **Preparation and conduction of social mobilization activities for the introduction of the new Pentavalent vaccine**

9. Polio Eradication

- ***Conducting of 4 SNIDs and 6 NIDs rounds each targeting over 7, 5000,000 under five children achieving about 90% coverage in each round***
- ***Detection of 1,378AFP cases with 38 lab confirmed cases of polio mainly from areas with ongoing conflict.***

- *Vitamin A distribution twice for under five children along with the NIDs*

10. Measles case-base surveillance:

- *National Measles lab achieved 100% in the Proficiency test*
- *Continued case-based measles surveillance activities*

11. Rotavirus & Meningitis & Pneumococcal lab-base surveillance

- **Continuation of the above mentioned diseases surveillance**

12. Administrative Performance

- *Bi-weekly EPI task force meeting at national and provincial levels were conducted*
- *Quarterly EPI review workshops were conducted at regional levels as planned*
- *Annual EPI review workshop conducted at national level*

Problems/constraints:

- *Insecurity in south, south-east and western parts of the country*
- *Population displacement and movement*
- *Competing program activities (polio, measles and TT campaigns)*
- *Irregular social mobilization activities for routine immunization*
- *Between 15-25% of population in rural and remote areas remained unvaccinated (around 180,000 children less than one year)*

If targets were not reached, please comment on reasons for not reaching the targets:

The targets set in national immunization policy and cMYP 2006-2010 could not be achieved. There is a slight increase in MCV1 coverage in 2009, but the DPT3 (Penta) coverage has come down (83 % in 2009) comparing with 2008 (85%).

The factors hindering to reach the targeted coverage are:

- **Ongoing conflict in south, south-east, east and part of western parts of the country**
- ***Presidential election***
- ***Renewal of NGOs contracts in major parts of the county which causes reduced coverage during handing over period***
- **Inaccessibility to health-care services including immunization (15-25% of population including nomads, new settlements, and IDPs)**
- **Frequent NIDs/sNIDs; and measles /TT SIAs**
- **High staff turnover because of low salary and absence of motivation of service level staff**
- **Lack of a comprehensive approach to immunization advocacy and communication, to ensure consistency of the strategies and activities.**
- **Poor monitoring and supportive supervision especially of stakeholders (NGOs) immunization performance**
- **Shortage of trained immunization health workers especially in rural and remote areas of the country**
- **Poor implementation of HF/District micro-plans developed based on RED by the stakeholders (NGOs).**
- **Prolonged administrative procedures for releasing fund in both MOPH and MoF**

1.3 *Data assessments*

1.3.1 Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)[1].

Due to the unavailability of competent organization to perform coverage survey, the planned EPI coverage survey in 2009 could not be conducted

1.3.2 Have any assessments of administrative data systems been conducted from 2008 to the present**?** **[NO].** If YES:

Please describe the assessment(s) and when they took place.

1.3.3 Please describe any activities undertaken to improve administrative data systems from 2008 to the present.

To improve immunization administrative data, the MOPH conducted self-DQA in 12 provinces of the country during the 1st quarter, 2009, and *following are the recommendations of SDQA:*

- **The National EPI Program should develop a mechanism to aggregate the reported EPI data from fixed centres at the district level of the country.**
- **The National EPI Program should receive the health facility based EPI and district level aggregated data in addition to current provincial layer.**
- **The program should develop tables to monitor completeness & timeliness of monthly reports from health canters.**
- **Supervision should be on regular basis and supervisory log book should fill-in completely by supervisors during each visit.**
- **Feedback from PEMTs in term of quality of reported data, findings from supervision, and completeness of reports should be provided to EPI fixed canters.**
- **The quality of refresher trainings should verify by internal or third party evaluation to ensure that vaccinator gained the proper knowledge and they have ability to put the gained knowledge in the practice.**
- **The DQS practice should be extended to other fixed centres of the sampled 12 provinces by the trained EPI health workers.**

[1] *Please note that the WHO UNICEF estimates for 2009 will only be available in July 2010 and can have retrospective changes on the time series*

- **Emphasis was made to train provincial EPI health workers of remaining 22 provinces in the country, to use the DQS as strong monitoring tool for enhancement of EPI Program.**
- **The National EPI Program should follow implementation of DQS recommendations through EPI Annual Plan of Action-2009.**
- **The staff from Provincial EPI Management Team appreciated the exercise as a first opportunity to assess their activities in-depth and notice the strength and weakness of the program**
- **The standard stock book for vaccination supply should be available in order to register the amount of vaccine and dry-supply received, utilized and balances of them including additional information such as vaccine batch number, expiration date.**
- **The register for follow up of defaulters should be available and in use with the fixed canter.**
- **Develop the forms to record the timeliness and completeness of monthly reports to the Provincial EPI Management Teams (PEMTs).**
- **The Provincial EPI Management Teams (PEMTs) should provide the written feed-back on the achievements, reports and technical capacity of EPI health workers in the fixed canters.**
- **The address column of register book should have enough information (village, street, house, name of famous mosque, community leader) to easily retrieve the child within community.**
- **Ensure the proper and timely use of standard immunization monitoring chart in all fixed canters.**
- **Enforce the availability of job description for vaccinators which is translated at local language in all fixed centres.**
- **The vaccinators should be fully aware of their job description and this issue should strictly follow during the supervisory visits.**
- **An uniform filing system (i.e; filling by activity in alphabets order) should be establish in all EPI fixed canters, the vaccinators should be trained about and follow-up during supervision should be make that this practice is in place.**

1.3.4 Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

The NEPI has planned to:

- **Conduct SDQA in the remaining 22 provinces**
- **Conduct EPI coverage survey in 2010**
- **Looking for external assessment of immunization program**
- **Strengthen supportive supervision by increase number of supervisors, and conducting regular supportive supervisory visits**
- **Training of all supervisors, data management officers, EPI managers and trainers**
- **Computerization of immunization information system at provincial levels**
- **Monthly district-wise review of immunization data**
- **Strengthen monitoring of NGOs immunization performance and data**
- **Focus on accuracy of recording/reporting, as well as completeness and timeliness of coverage reports**

1.4 *Overall Expenditures and Financing for Immunisation*

The purpose of Table 2 is to guide GAVI understanding of the broad trends in immunization program expenditures and financial flows. Please fill the table using US$.

Table 2: Overall Expenditure and Financing for Immunization from all sources (Government and donors) in US$.

Expenditures by Category	Expenditure Year 2009 ($)	Budgeted Year 2010 ($)	Budgeted Year 2011
Traditional Vaccines	$1,807,393	$1,455,487	**$2,614,944**
New Vaccines	$14,400,000	12,885,992	$12,350,038
Injection supplies with AD syringes	$1,260,000	$1,708,664	$1,119,786
Cold Chain equipment	$559,909	$456,094	$750,576
Operational costs	4,098,321.58	$7,344,958	$2,695,942
Vehicles	0	$7,344,958	$3,672
Personnel	$1,403,040	$5,179,431	$1,528164
Others (campaign operational costs including vaccines)	$16,712,221	$19,800,223	$41,480,669
Total EPI	$38,594,918	$56,175,807	$62,543,791
Total Government Health	$1,152,531	$2,204,122	$1,468,505

Exchange rate used	*$1=49Afs*

Source: NEPI

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 next three years; whether the funding gaps are manageable, challenging, or alarming. If either of the latter two is applicable, please explain the strategies being pursued to address the gaps and indicate the sources/causes of the gaps.

In spite of economic problems, the GoA contributed about 20 % of the routine immunization cost in 2009. With high political commitment to EPI and its inclusion in the Basic Package of Health Services, and Essential Package of Hospital Services, it is expected that Health Sector Partners will continue their contribution. Without sufficient 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.

How many times did the ICC meet in 2009? **Three times**

Please attach the minutes **(Annex Document N° 1)** from all the ICC meetings held in 2009, including those of the meeting endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on items 1.1 through 1.4

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 by promoting integration and maximizing efficiency of immunization and reducing vaccine wastage**

Are any Civil Society Organisations members of the ICC?: **[Yes].** If yes, which ones?

List CSO member organisations:

- **Afghan Health and Development Services (AHDS),**
- **Ibne Sina,**
- **Management Sciences for Health (MSH)-Tech Serve**

Recently after completion of the CSO-Type A project, three CSOs elected by CSOs to be the member of ICC. These new CSOs are STEEP, SAF and BRAC

1.6 *Priority actions in 2010-2011*

What are the country's main objectives and priority actions for its EPI programme for 2010-2011? Are they linked with cMYP?

EPI is a priority program for MOPH of GoA. The main objectives of the EPI program as reflected in the current cMYP are to:

1. Achieve 90% coverage nationally and over 80% coverage with all childhood vaccines in every district, and 80% with TT2+
2. Achieve polio Eradication
3. Strengthen and sustain 90% reduction in measles cases and thus low infant mortality
1. Eliminate Maternal and Neonatal Tetanus
2. Maintain 100% safe injections
3. Maintain "no stock-out" for vaccine and immunization supplies
4. Enhance national capacity to manage EPI service delivery network
5. Link immunization with other maternal and child health interventions
6. Create demand for immunization services
7. Ensure financial sustainability of immunization

The priority activities to be carried out in 2010:

- Conduct national vaccination week focusing on advocacy, education, communication and accelerating immunization activities in low performing districts (DPT3<50%), hard-to-reach areas, (new initiative)
- Strengthening district micro-planning/re-scheduling
- Further improving monitoring and supportive supervision
- Improving quality of immunization data management

• Strengthening vaccine & supply stock management by introducing VSSM • Conducting SDQA • Conducting immunization coverage survey • Strengthening surveillance of vaccine preventable diseases (measles, MNT, Rotavirus, Pneumococcal and meningitis) • Improving IEC The current cMYP is valid up to the end of 2010. The GoA is developing a new cMYP for 2011-2015.	

2. Immunisation Services Support (ISS)

1.1 *Report on the use of ISS funds in 2009*

Funds received during 2009: No fund received
Remaining funds (carry over) from 2008: US$ 5,280,707
Balance carried over to 2010: US$ 3,973,525

Please report on major activities conducted to strengthen immunisation using ISS funds in 2009.

- **Procurement of new cold chain equipment & installation of new equipment**
- **Distribution of social mobilization materials**
- **Distribution of updated immunization cards, tally sheets, reporting forms and registers**
- **Distribution of the updated vaccinator guide that included the information about the introduction of the new vaccine to all the vaccinators in all the provinces**
- ***Routine monitoring activities***
- ***Procurement of vehicles and cold chain equipment***
- ***Increasing outreach and mobile activities***
- ***Surveillance of vaccine preventable diseases***
- ***Training of different categories of EPI staff***

1.2 *Management of ISS Funds*

Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2009 calendar year? **[YES] :** Please complete **Part A** below. **[IF NO] :** please complete **Part B** below.

Part A: briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of ISS funds.

NA

Part B: briefly describe the financial management arrangements and process used for your ISS funds. Indicate whether ISS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of ISS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the ICC in this process.

- Afghanistan received GAVI ISS/Reward fund through the government bank account.
- National EPI develops annual plan of actions with detailed budget based on the program priority activities identified during the provincial and national semi-annual and annual program review.
- The EPI Task Force Committee review the plan and help the NEPI in directing GAVI ISS fund to the areas of national immunization program where the resources are most needed and best utilized.
- The annual plan of action is submitted to ICC for review, approval and final endorsement.
- The required fund is used by MOPH/ NEPI only for the purpose of implementation of the activities planned.
- The endorsed plan is shared with GAVI secretariat, MOPH line Departments and all concerned partners.
- MOPH/NEPI distributes the support to the provinces and down to the districts through the government bank account and according to the activities and planned budget.
- All payments and purchases are done according to the planned activity using standard formats and following MoF rules.
- Copies of the documents (stipend role, receipts, bills and etc) signed by PEMT managers and Provincial Health Directors are sent with budget expenditure summary sheet to national EPI office quarterly for control and disbursement of fund for the next quarter.
- Copies of all such documents are kept at National EPI office and at provincial EPI for the purpose of auditing at least for 3 years.
- The NEPI submit the semi-annual and annual financial reports to ICC indicating the activities carried out and the amount spent against each budget line.
- The work plan may be modified ever six months and is in effect after approval and endorsement of ICC.

- Role of the ICC:
- To review & endorse the EPI annual plan of actions
- To follow-up on the implementation of endorsed plan
- To review progress reports on performance and utilization of fund
- To review & endorse the final settlement of accounts and annual reports

Problems:
The lengthy administrative procedures in both MoPH and MoF usually cause delay in releasing fund for implementation of planned activities.

1.3 ***Detailed expenditure of ISS funds during the 2009 calendar year***

Please attach a detailed financial statement for the use of ISS funds during the 2009 calendar year (Annex Document N°2). *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an **external audit report is available for your ISS programme during your government's most recent fiscal year, this must also be attached (Annex Document N°3).**

1.4 *Request for ISS reward*

In June 2009, the GAVI Board decided to improve the system to monitor performance of immunisation programmes and the related calculation of performance based rewards. Starting from 2008 reporting year, a country is entitled to a reward:

a) if the number of children vaccinated with DTP3 is higher than the previous year's achievement (or the previous high), and

b) if the reported administrative coverage of DTP3 (reported in the JRF) is in line with the WHO/UNICEF coverage estimate for the same year.

If you may be eligible for ISS reward based on DTP3 achievements in 2009 immunisation programme, estimate the $ amount by filling Table 3 in Annex 1.[2]

Comparing to the reported number of children <1 year in 2008 (969149), 7304 additional children < 1 year vaccinated with 3rd dose of DPT3 (Penta) in 2009 (976453). Therefore, the country is entitled for USD 146,080 against the additional number of children vaccinated. But, the coverage achieved in 2009 (83%) is in 2% less than 2008 (85%).

[2] The Monitoring IRC will review the ISS section of the APR after the WHO/UNICEF coverage estimate is made available.

3. New and Under-used Vaccines Support (NVS)

3.1 *Receipt of new & under-used vaccines for 2009 vaccination programme*

Did you receive the approved amount of vaccine doses that GAVI communicated to you in its decision letter (DL)? Fill Table 4.

Table 4: Vaccines received for 2009 vaccinations against approvals for 2009

	[A]		[B]	
Vaccine Type	**Total doses for 2009 in DL**	**Date of DL**	**Total doses received by end 2009 ***	**Total doses of postponed deliveries in 2010**
Penta	**4,359,800**	**9 May, 2008**	**4,447,800**	**0**

** Please also include any deliveries from the previous year received against this DL*

If numbers [A] and [B] are different,

What are the main problems encountered? *(Lower vaccine utilisation than anticipated? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date?...)*	• No problem
What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF SD)	• No problem

3.2 *Introduction of a New Vaccine in 2009*

3.2.1 If you have been approved by GAVI to introduce a new vaccine in 2009, please refer to the vaccine introduction plan in the proposal approved and report on achievements.

Vaccine introduced:	Combined DPT-HepB-Hib (Penta)
Phased introduction [NO]	Date of introduction

Nationwide introduction [YES]	Date of introduction:1st January 2009
The time and scale of introduction was as planned in the proposal? If not, why?	• Yes

3.2.2 Use of new vaccines introduction grant (or lumpsum)

Funds of Vaccines Introduction Grant received:	**US$ 403,975**	**Receipt date:08.09.2008**

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant.

The fund used for :

1. **Training of all categories of immunization staff**
2. **Printing of training materials, printing of all revised immunization recording and reporting materials that meet two years requirement of the program**
3. **Social mobilization activities including radio/TV spots, brochures , billboards**

Please describe any problems encountered in the implementation of the planned activities:

Long Gov admin/procurement procedures, insecurity

Is there a balance of the introduction grant that will be carried forward? [NO]
If YES, how much? US$.....

Please describe the activities that will be undertaken with the balance of funds:

3.2.3 Detailed expenditure of New Vaccines Introduction Grant funds during the 2009 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2009 calendar year **(Annex Document N°3).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

3.3 *Report on country co-financing in 2009 (if applicable)*

Table 5: Four questions on country co-financing in 2009

Q. 1: How have the proposed payment schedules and actual schedules

differed in the reporting year?			
Schedule of Co-Financing Payments	Planned Payment Schedule in 2009	Actual Payments Date in 2009	Proposed Payment Date for 2010
	(month/year)	(day/month)	
1st Awarded Vaccine (specify)	December, 2008	March, 2009	
2nd Awarded Vaccine (specify)			March, 2009
3rd Awarded Vaccine (specify)			March, 2010

Q. 2: Actual co-financed amounts and doses?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (Pentavalent)	US$ 448,000	115,400
2nd Awarded Vaccine (Pentavalent)	US$ 383,500	187,300
3rd Awarded Vaccine (specify)		

Q. 3: Sources of funding for co-financing?
1. Government – co-financing provided from government resource
2. Donor (specify)
3. Other (specify)

Q. 4: What factors have slowed mobilization of resources for vaccine co-financing?
1. **Difference in calendar year caused some confusion in payment co-finance for Pentavalent vaccine for 2009**
2. **Delay in issuing of invoice by UNICEF (UNICEF was in need for advance payment)**
3.
4.

If the country is in default please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy http://www.gavialliance.org/resources/9___Co_Financing_Default_Policy.pdf

GoA has committed to meet its co-financing requirement for Pentavalent vaccine

3.4 *Effective Vaccine Store Management/Vaccine Management Assessment*

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? September, 2007

If conducted in 2008/2009, please attach the report. **(Document N°.....)**
An EVSM/VMA report must be attached from those countries which have introduced a New and Underused Vaccine with GAVI support before 2008.
Was an action plan prepared following the EVSM/VMA? *[YES / NO]*

If yes, please summarise main activities to address the EVSM/VMA recommendations and their implementation status.

EVSM did not conducted in 2008 and 2009

When is the next EVSM/VMA* planned? *[July 2010]*

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

3.5 *Change of vaccine presentation*

If you would prefer during 2011 to receive a vaccine presentation which differs from what you are currently being supplied (for instance, the number of doses per vial; from one form (liquid/lyophilised) to the other; ...), please provide the vaccine specifications and refer to the minutes of the ICC meeting recommending the change of vaccine presentation. If supplied through UNICEF, planning for a switch in presentation should be initiated following the issuance of Decision Letter for next year, taking into account country activities needed in order to switch as well as supply availability. Please specify below the new vaccine presentation:

Depending upon the availability of vaccine in the market and cost affordability, GoA prefers to replace single dose Pentavalent vial/vaccine with 10 dose vial. Though the wastage will be higher, but it allows reserving some cold chain space for the new vaccine/s that the GoA is interested to apply for GAVI support.

Please attach the minutes of the ICC meeting (Document N°Not yet decided) that has endorsed the requested change.

3.6 *Renewal of multi-year vaccines support for those countries whose current support is ending in 2010*

If 2010 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support

starting from 2011 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby request for an extension of GAVI support for Liquid Pentavalent Vaccine for the years 2011-2015. At the same time it commits itself to co-finance the procurement of Liquid Pentavalent Vaccine in accordance with the minimum GAVI co-financing levels as summarised in Annex 1.

The multi-year extension of Liquid Pentavalent Vaccine support is in line with the new cMYP for the years 2011-2015 which is attached to this APR (Annex Document N°4 .Multiyear plan).

The country ICC has endorsed this request for extended support of Liquid Pentavalent Vaccine at the ICC meeting whose minutes are attached to this APR. (Annex Document N°5)

3.7 *Request for continued support for vaccines for 2011 vaccination programme*

In order to request NVS support for 2011 vaccination does the following:

1. **Go to Annex 1 (excel file)**
2. **Select the sheet corresponding to the vaccines requested for GAVI support in 2011 (e.g. Table4.1 HepB & Hib; Table4.2 YF etc)**
3. **Fill in the specifications of those requested vaccines in the first table on the top of the sheet (e.g. Table 4.1.1 Specifications for HepB & Hib; Table 4.2.1 Specifications for YF etc)**
4. **View the support to be provided by GAVI and co-financed by the country which is automatically calculated in the two tables below (e.g. Tables 4.1.2. and 4.1.3. for HepB & Hib; Tables 4.2.2. and 4.2.3. for YF etc)**
5. **Confirm here below that your request for 2011 vaccines support is as per Annex 1:**

[YES, I confirm]

Annex 6 (annexes for c-MYP)

If you don't confirm, please explain:

4. Injection Safety Support (INS)

In this section the country should report about the three-year GAVI support of injection safety material for routine immunisation. In this section the country should not report on the injection safety material that is received bundled with new vaccines funded by GAVI.

4.1 *Receipt of injection safety support in 2009 (for relevant countries)*

Are you receiving Injection Safety support in cash *[NO]* or supplies *[NO]*

If INS supplies are received, please report on receipt of injection safety support provided by the GAVI Alliance during 2009 (add rows as applicable).

Table 7: Received Injection Safety Material in 2009

Injection Safety Material	Quantity	Date received

Please report on any problems encountered:

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

Even if you have not received injection safety support in 2009 please report on progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report what types of syringes are used and the funding sources:

Table 8: Funding sources of Injection Safety material in 2009

Vaccine	Types of syringe used in 2009 routine EPI	Funding sources of 2009
BCG	AD	UNICEF
Measles	AD+ Mixing syringes	UNICEF
TT	AD	UNICEF
DTP-containing vaccine	AD	GAVI

Please report how sharps waste is being disposed of:

- Use safety boxes at all service levels
- Incineration of all sharp waste or burying 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

Does the country have an injection safety policy/plan? [YES]
If YES: Have you encountered any problem during the implementation of the transitional plan for safe injection and sharps waste? (Please report in box below)
IF NO: Are there plans to have one? (Please report in box below)

No problem

4.3 *Statement on use of GAVI Alliance injection safety support in 2009 (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:

Fund from GAVI received in 2009 (US$): NO
Amount spent in 2009 (US$): NO
Balance carried over to 2010 (US$):NO

Table 9: Expenditure for 2009 activities

2009 activities for Injection Safety financed with GAVI support	Expenditure in US$
NA	
Total	

If a balance has been left, list below the activities that will be financed in 2010:

Table 10: Planned activities and budget for 2010

UNICEF provides AD syringes and safety boxes for traditional vaccines	

Total	

Health System Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. This section **only needs to be completed by those countries that have been approved and received funding for their HSS application before or during the last calendar year**. For countries that received HSS funds within the last 3 months of the reported year this section can be used as an inception report to discuss progress achieved and in order to enable release of HSS funds for the following year on time.
2. All countries are expected to report on GAVI HSS on the basis of the January to December calendar year. In instances when countries received funds late in 2009, or experienced other types of delays that limited implementation in 2009, these countries are encouraged to provide interim reporting on HSS implementation during the 1 January to 30 April period. This additional reporting should be provided in Table 13.
3. HSS reports should be received by 15th May 2010.
4. It is very important to fill in this reporting template thoroughly and accurately and to ensure that, **prior to its submission to the GAVI Alliance, this report has been verified by the relevant country coordination mechanisms** (HSCC or equivalent) in terms of its accuracy and validity of facts, figures and sources used. Inaccurate, incomplete or unsubstantiated reporting may lead the Independent Review Committee (IRC) either to send the APR back to the country (and this may cause delays in the release of further HSS funds), or to recommend against the release of further HSS funds or only 50% of next tranche.
5. Please use additional space than that provided in this reporting template, as necessary.
6. Please attach all required supporting documents (see list of supporting documents on page 8 of this APR form).

Background to the 2010 HSS monitoring section

It has been noted by the previous monitoring Independent review committee, 2009 mid-term HSS evaluation and tracking study[3] that the monitoring of HSS investments is one of the weakest parts of the design.

All countries should note that the IRC will have difficulty in approving further trenches of funding for HSS without the following information:

- Completeness of this section and reporting on agreed indicators, as outlined in the approved M&E framework outlined in the proposal and approval letter;
- Demonstrating (with tangible evidence) strong links between activities, output, outcome and impact indicators;
- Evidence of approval and discussion by the in country coordination mechanism;

[3] All available at http://www.gavialliance.org/performance/evaluation/index.php

- Outline technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year
- Annual health sector reviews or Swap reports, where applicable and relevant
- Audit report of account to which the GAVI HSS funds are transferred to
- Financial statement of funds spent during the reporting year (2009)

4.4 *Information relating to this report*

4.4.1 Government fiscal year (cycle) runs from 21st March to 20th March

4.4.2 This GAVI HSS report covers 2009 calendar year from 21th March 2009 to 20th March 2010.

4.4.3 Duration of current National Health Plan is from 2008- End 2013.

4.4.4 Duration of the current immunisation cMYP is from 2006-2010 and the revised one is developed for the years Jan 2011 to Dec 2015

4.4.5 Person(s) responsible for putting together this HSS report who can be contacted by the GAVI secretariat or by the IRC for possible clarifications:

[It is important for the IRC to understand key stages and actors involved in the process of putting the report together. For example: '*This report was prepared by the Planning Directorate of the Ministry of Health. It was then submitted to UNICEF and the WHO country offices for necessary verification of sources and review. Once their feedback had been acted upon the report was finally sent to the Health Sector Coordination Committee (or ICC, or equivalent) for final review and approval. Approval was obtained at the meeting of the HSCC on 10th March 2008. Minutes of the said meeting have been included as annex XX to this report.*']

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any programmatic clarifications:			
Dr. Abdul Wali	MOPH	Wrote the HSS part, Finalized the CSO parts	drabwali@yahoo.com 0093 (0) 799 353 178
Dr. Najla Ahrari	MOPH	Drafted the HSS part	najlaahrari@gmail.com 0093 (0) 799 302 996
Focal point for any accounting of financial management clarifications:			
Eng. Asmatullah Shahban	MOPH	Finalized financial figures	enggasmatullah@gmail.com 0093 (0) 708 816 582
Other partners and contacts who took part in putting this report together:			
Dr. Ahmed Rahman	WHO	Reviewed	elrahmana@who.emro.int.afg 0093 (0) 799 860 061
Dr. Tahir Khan	Dr. Tahir Khan	WHO/MOPH Drafted the CSO type B	Tahir88@gmail.com 0093 (0) 799 308 746
Dr. Parwez	WHO/MOPH	Drafted CSO type A part	cso_maaping@yahoo.com.uk doctor_parwiz@yahoo.com 0093 (0) 799 308 746

4.4.6 Please describe briefly the main sources of information used in this HSS report and how was information verified (validated) at country level prior to its submission to the GAVI Alliance. Were any issues of substance raised in

terms of accuracy or validity of information (especially financial information and indicators values) and, if so, how were these dealt with or resolved?

[This issue should be addressed in each section of the report, as different sections may use different sources. In this section however one might expect to find what the MAIN sources of information were and a mention to any IMPORTANT issues raised in terms of validity, reliability, etcetera of information presented. For example: *The main sources of information used have been the external Annual Health Sector Review undertaken on (such date) and the data from the Ministry of Health Planning Office. WHO questioned some of the service coverage figures used in section XX and these were tallied with WHO´s own data from the YY study. The relevant parts of these documents used for this report have been appended to this report as annexes X, Y and Z.*]

The main sources of information used have been the independent third party evaluation conducted by JHU/IIHMR, HMIS, Routine reports of different involved directorates of MOPH in planning and implementation of Health System Strengthening activities, results conference held March 2010, reports of NGOs involved in implementation of the HSS grant and WHO and UNICEF data and JRF 2009. In addition, figures from National Risk and Vulnerability assessment 2008.

4.4.7 In putting together this report did you experience any difficulties that are worth sharing with the GAVI HSS Secretariat or with the IRC in order to improve future reporting? Please provide any suggestions for improving the HSS section of the APR report? Are there any ways for HSS reporting to be more harmonised with existing country reporting systems in your country?

The Afghanistan fiscal year starts and ends as the same time with the year calendar (solar calendar 21st March to 20th March). It is even not possible to have the reports exactly for the year from Jan to Dec. we propose that the reporting is considered 2009, which covers 9 months of 2009 and 3 months of 2010. Flexibility should be given.

4.4.8 Health Sector Coordinating Committee (HSCC)

How many times did the HSCC meet in 2009: Six time the meetings were held.
Please attach the minutes **(Annex 1 zip all HSS-SC meetings minutes)** from all the HSCC meetings held in 2009, including those of the meeting which discussed/endorsed this report
Latest Health Sector Review report is also attached **(Annex 2).**

4.5 *Receipt and expenditure of HSS funds in the 2009 calendar year*

Please complete the table 11 below for each year of your government's approved multi-year HSS programme.

	2007	2008	2009	2010	2011
Original annual budgets (per the originally approved HSS proposal)	$ 6,700,000	$ 8,950,000	$ 7,200,000	$ 6,600,000	$ 4,650,000
Revised annual budgets (if revised by	$ 2,500,000	10,091,209	8,157,346	10,634,411	

previous Annual Progress Reviews)					
Total funds received from GAVI during the calendar year	$ 6,699,975	$ 4,594,975	$ 7,318,000	$ 8,157,346[4]	NA
Total expenditure during the calendar year	$ 143,087	$ 5,607,558	$ 9,545 893.29	$10,081,393[5]	$ 8,722,069[6]
Balance carried forward to next calendar year	$ 6,556,888	$ 5,544,305	$ 3,316,411.7	$ 1,392,364.7	0
Amount of funding requested for future calendar year(s)					$ 7,329,704 request for 2011

Please note that figures for funds carried forward from 2008, income received in 2009, expenditure in 2009, and balance to be carried forward to 2010 should match figures presented in the financial statement for HSS that should be attached to this APR.

Please provide comments on any programmatic or financial issues that have arisen from delayed disbursements of GAVI HSS *(For example, has the country had to delay key areas of its health programme due to fund delays or have other budget lines needed to be used whilst waiting for GAVI HSS disbursement)*:

No major problems encountered. In the year 2009 the released disbursement was mistakenly send to another account which was fixed with the support of GAVI secretariat , MOPH and Afghan Ministry of Finance. The approved mount ($ 8,157,346) for the year 2010 has not been to date received by the Afghanistan Bank. GAVI secretariat to kindly support.

[4] The fund is approved but not received by the Afghanistan Bank.
[5] Planned expenditure for the year 2010 out of which, 3,145,791,9 spent from Jan to 20th March 2010 and the remaining are under expenditure. The expenditure reported for the year 2009 covers both from 21st March 2009 to 20th March 2010.
[6] Planned expenditures for the year 2011 including expected carry forward from 2010

4.6 *Report on HSS activities in 2009 reporting year*

Note on Table 12 below: *This section should report according to the original activities featuring in the HSS application. It is very important to be precise about the extent of progress, so please allocate a percentage to each activity line, from 0% to 100% completion. Use the right hand side of the table to provide an explanation about progress achieved as well as to bring to the attention of the reviewers any issues relating to changes that have taken place or that are being proposed in relation to the original activities. It is very important that the country provides details based on the M& E framework in the original application and approval letter.*

Please do mention whenever relevant the **SOURCES** of information used to report on each activity.

Table 12: HSS activities in the 2009 reporting year

Major Activities	Planned Activity for 2009	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Objective 1:	**Improved access to quality health care particularly maternal and child health**	
Activity 1.1: Establishing Sub-Centers in under-served areas Activity 1.2: Deploying mobile health outreach teams	• Monitor the implementation of the projects and make sure that SC and MHT provide quality health services to the communities. Develop a mechanism to measure the effectiveness of MHTs for further decision making. • Provide technical support to the implementers based on SC and MHT concept note. • Review of progress of narrative reports and provide feedback to implementers through official channels or face to face meetings on quarterly bases. • Supply vehicles for MHTs • Make sure availability of EPI equipment in SCs and MHTs.	• Activities carried out as planned. The remaining planned for the year 2008, 20 SCs and one additional needed SC, established. In total 121 SCs and 26 MHTs are active in 25 Provinces. No major changes in the planned activities, only one additional SC has been established. 8 National and 7 international NGOs are implementing the project activities.. In addition, in four provinces activities are being implemented by MOPH. According to the plan, establishment is completed 100% (Annex 3. Map of SC and MHTs in Afghanistan funded by GAVI-HSS funds) • In total 52 monitoring visits form both MHTs and SCs in different provinces conducted by the M&E team during the reporting period. The findings indicate that in most of the cases the HFs are operating smoothly. In few cases especially under staffing (female health workers) and lack of IEC materials has caused some problems. • A technical committee assigned to develop evaluation tools to measure the effectiveness and efficiency of the approach. Anecdotal evidence and available to date HMIS data show that the MHTs are better utilized by communities since they reach very hard to reach areas and focused on preventive measures including immunization. However, the number of deliveries remains very low in MHTs because managing delivery by MHT is difficult. The results of the evaluation will be disseminated by end of Aug this year. • A standard quarterly reporting system established for the project and quality reports are provided by consultant organizations (Contractors).

		Regular feedback is provided to the consultant organizations with follow up schedules by HEFD grant consultants. Face to face, meetings held with organizations and technical support is provided wherever needed. workshops are held with all organizations and challenges are put on discussion (Example cold chain problem in SCs and case by case information are collected to tackle the problem) • The 26 planned zero kilometre Toyota pickups have been purchased and distributed to implementing organizations through amendment of the contracts on 11/July/2009 for use of Mobile Health Teams to provide outreach services to the underserved areas of 25 Provinces. • The overall under coverage population of SCs exceeds the already estimated target population (7000) which increases the need to provide the SCs with their own cold chain system, The existing guideline for equipping SCs with the cold chain equipment recommended by the Sub Centres concept note cannot be applied universally due to geographical distance and some other obstacles . The transportation of the icepacks to the SCs located in far districts of e.g Badakhshan and Nuristan provinces is not feasible and should be equipped with RCW50 (47 SCs equivalent to 39% as first priority). • 79% of fixed and mobile health facilities have been staffed with at least one female health worker. (Highly satisfactory since shortage of female staff in remote areas of Afghanistan is a huge challenge). • During the reporting year in the GAVI-HSS supported HFs, 1,160,988 OPD visits. In total 12,873 DTP3 and 18,182 TT2+ vaccines administered. 3464 deliveries, 33,347 ANC visits and 31,048 FP clients were taken care. The average trend of service utilization has been steadily increasing during the course of the year. (Annex4). Chart of utilization of services from MHTs and SCs-Source : HMIS reports) • All provincial EPI management teams instructed to provide relevant cold chain equipment to SC and MHTs. According to the reports, over 85% of GAVI-HSS financed health facilities are supplied with planned cold chain equipment

Activity 1.3: Expanding integrated management of childhood illness (IMCI) to community level	• Monitor the implementation of the project by conducting visits from training sites, baseline survey and monitor CHWs who received C-IMCI training. • Provide technical assistance to the implementers. • Review of progress of narrative reports on quarterly bases and provide feedback to implementers through MOPH official channels or face to face meetings	• In total 3 monitoring missions at zone level carried out by IMCI central unit. During these visits a total of 13 CIMCI courses for CHWs in 9 provinces and 12 districts were monitored. 15 monitoring visits conducted for the training sites, for baseline survey process and for the CHWs who received C-IMCI training during service delivery by M&E team in coordination with provincial teams. The results indicate that the C-IMCI pictorial job aid training was very effective. Most of CHWs were able to catch the main topic from it and can apply the knowledge. Patients were mostly satisfied with the treatment they received. Just the old age CHWs and the illiterate ones had some difficulties regarding their learning abilities, the consultant organizations performance was good and there was, in general, good coordination between consultant organization and BPHS implementers. • The implementer NGOs received regular TA and guidance based on need according to the observations from quarterly reports and monitoring missions. Face to face, meetings held with the NGOs based on the need. On the spot feedback is provided to health providers during monitoring visits. • The plan was to train 3,075 (30% of 9225 planned for three years) CHWs in the first year while 3463 (37.5% of three year plan) CHWs and CHSs have been trained in both modules by consultant organizations. Implementation % exceeds 112%. Of the total trained, 1830 are females (53%) and 1633 are males(47%). The reason for overcrossing the target was that the consultant organizations were able to have more training sessions in some cases, which is appreciated. • The overall implementation is highly satisfactory. Annual evaluation workshop conducted and showed successful implementation of the activity. (Annex 5. C-IMCI Evaluation workshop report) • Baseline survey conducted in provinces and draft report produced. The report will be finalized soon. Since USAID is planning to fund the in service training program in the provinces where HSS funds were invested and on the other hand, there was need to invest more on C-IMCI, the HSS-Steering Committee decided to transfer the remaining planned funds for in service training activity to C-IMCI activity. In total, around 1,000,000 US$ will be shifted to C-IMCI which will be contracted out throughout the year of 2010. (Please refer to HSS-SC meetings minutes).

Activity 1.4: Develop an in-service training program for BPHS primary healthcare providers	• Monitor the implementation of the project by conducting visits from training sites • Provide technical assistance to the implementers. • Conduct post training evaluation from the health facility staff. Provide feedback to the implementing agency and the targeted NGOs	• Monitoring visits conducted to training sites in Khost, Paktya, Juzjan, Baghlan, and Takhar provinces. Visits were jointly carried out by M&E and APHI training teams. Summary findings indicate that performance has been satisfactory. However, some problems related to coordination, nomination of the candidates have been encountered. The issue of coordination and nomination was fixed through meetings and follow-ups with implementing organizations. TA and guidance have been provided to implementing agencies in response to reports and findings from monitoring visits. • Post training evaluation is under way and final report will be available by end Aug 2010. • Regular feedback has been provided to the implementing agencies. • In total out of planned 1054 health workers for the year 2009, 741 (70.3%) doctors, nurses, midwives, pharmacists, and CHS have been trained in basic and comprehensive Obstetric Care, Continuum of Care, drug management, Nutrition, IMCI, and Family planning. Based on the balance of funds remaining in addition to the training of the remaining 570 individuals, 314 more health facility staff will be trained. This makes a total of 1311 health workers. The reason for this increase in the number of trainings is that the C-EOC (which is comparatively expensive) training will be covered by Health Services Support Project of USAID; therefore, 314 more health workers will be trained in other modules. All such trainings will be completed by the end of August 2010 from GAVI HSS funds. As mentioned above, USAID will cover all the training programs in HSS targeted provinces. The remaining balance of funds (app. 1,000,000 US$) after completion of the trainings from this activity will be shifted to another planned activity in the original HSS proposal, that is the C-IMCI.
Objective 2:	**Increased demand for and utilization of health care services**	
Activity 2.1: Implementing a nationwide Information, Education and	• Identify the winner NGO based on proposal evaluation for conducting KAP survey • Monitor from the KAP survey process in the failed • Conduct IEC campaign based on KAP survey findings	• KAP survey announced and through competitive process contracted with an International academic institution. The project started on 1st of October 2009 and ended by 31st March 2010. The first draft of the report is ready and will be finalized by end June 2010. KAP survey process was monitored in six provinces of Herat, Kabul, Laghman , Bamyan , Paktia and Nengarhar provinces. The objectives of this survey was to measure the knowledge, attitude and practices of the people, the factors associated

Communication (IEC) campaign for immunization and other MCH messages	• Continuation of IEC Key messages broadcasted via media • Monitoring of health facilities to make sure, the presence and use of IEC developed materials. • Conduct IEC/BCC workshops for different health personnel. • Finalize MOPH IEC strategy	with the choice of preferred health service provider , the barriers towards the utilization of the health services and how the utilization of health care services be optimised. (Annex 6. draft KAP survey report). • Communication strategy for the MOPH is under development process. • In total 12,077 minutes IEC messages been broadcasted throughout the year. Out of which 2,988 (24.7%) minutes TV and 9089 (75.3%) minutes radio broadcasting. In total 9 TV and radio channels were contracted for broadcasting. The broadcasting have been related to key IEC messages for maternal and child health including immunization. • MOPH IEC strategy with the full support of HSSP USAID and IEC taskforce finalized. • In total. 171,399 posters and brochures for 24 NGOs in 16 provinces have been distributed to be used at the health facilities. • Islam and health conference conducted where over 320 of Mullas (religious leaders) from 19 province and Kabul districts participated. The focus was maternal and child health. The conference had two objectives: 1: to get support of religious leaders to communicate IEC messages through mosques to communities and 2: to design a book of the relation and importance of the maternal and child health in the context of Islam. The next step would be distribution of the book throughout the country • IEC stock equipped. Fortunately, the GAVI-HSS support has enabled the MOPH to have better stock for IEC materials and timely distribute it to the needy provinces. • Development of 15 more TV and Radio spots are under process.
Activity 2.2: Pilot a model of demand side financing (DSF).	• Assist implementer NGOs in developing baseline survey tool, a transparent mechanism for paying incentive to the family and CHWs. • Monitor the baseline survey and regular monitoring of the project implementation.	• The implementer NGOs with the technical support from MOPH developed the baseline survey tool. The project started with baseline line through conducting a household survey in four provinces and sixteen districts within the project sample size. • Monitoring tools developed to monitor the project progress. • The Ministry of Public Health reviews the report and progress of the project through the project coordination body. Feedback is provided to the implementing agency to support and accelerate the project implementation

Activity 2,3: Piloting a program to provide monetary performance incentives to volunteer Community Health Workers	• Provide technical assistance and direction to the implementer NGOs based on the project TOR	process. • The implementer NGO receiving reimbursements based on the financial and technical reports submitted to the Ministry of Public Health. Due to under spending, the Hope Worldwide received two out of four instalments this year. Further instalments are planned for the year 2010 which is already adjusted. The project will continue till 30th May 2011.
Objective 3:	**Improve the ability of the MOPH at various level to fulfil its stewardship role**	
Activity 3.1: Up-grade the physical, information /communication technology infrastructure and means of transportation[7] of the M&E Department	• Identify winner NGO for Capacity building training on strengthening Monitoring and evaluation system of MOPH • Develop a unified checklist for monitoring of all HSS activities with all implementing departments. • Provision of transport facilities for provincial monitoring • Provision of equipment • Nationwide monitoring of all BPHS implementation and EPHS implementation	• The winner NGO selected through open competition to conduct one year M&E capacity building course, the program started on November 15th 2009, and 6 modules (Report writing, Biostatistics, Health System Research, Applied epidemiology, health survey and HMIS) taught for the relevant 27 staff of MOPH. • Monitoring tools for all HSS activities revised and field tested and the implementation has started. (Annex 7. Revised M&E checklists for HSS activities) • 31 out 34 provinces were planned to have rented vehicles for monitoring. 29 vehicles rented in 29 provinces for strengthening monitoring functions. In the rest of the provinces either the vehicle is available or security at all does not allow monitoring. Regular monitoring visits from BPHS, EPHS and other Health relevant Projects of MoPH in 28 provinces conducted by M&E staff. Monitoring was conducted from Samangan, Laghman, Nangarhar, Kabul, Saripul, Juzjan, Balkh, Baghlan, Takhar, Parwan, Kapisa, Panjsheer, Kunar, Saripul, Faryab, Kunduz, Badakhshan, Bamyan, Ghore, Daikundi, Hirat, Wardak, Logar, Paktya, Kandahar, Badghees, Nemroze, Helmand, and Khost, provinces. 47% of provinces

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

	• Train 10 provinces in NMC and take over the national Monitoring check list data base from Tech Serve (USAID funded project) • Enhance data use at different levels through conducting workshops and follow up visits • Support to implementation of nationwide use of BSC • Renovation of offices and provision of internet	monitored at least once in each quarter. • The National Monitoring Checklist (NMC) data base was taken over from Tech-Serve by M&E directorate and revised based on updated requirements of MOPH. Totally 177 Provincial and district health officers received NMC training. National NMC database and tool which is a national tool is revised vastly with the support of GAVI, a very interesting data base is being developed for NMC tool which is self-explanatory and will not have the need for trainings. This NMC will monitor the BPHS funded by WB, EU, USAID and many other donors including GAVI HSS funds for SCs. As a next step the plan is to do the same for EPHS. • M&E Directorate in coordination with HMIS department conducted (2) workshops to promote routine information system and data use in Herat and Nangarhar provinces. The PPHOs of southeast and eastern provinces participated in the workshop. • M&E team assisted the third party (JHU/IIHMR) in conducting of BSC 2008 result dissemination and using workshops at the central and regional level in (Faryab, Juzjan, Saripul, balkh, Samangan, Baghlan, Kunduz, Takhar and Badakhshan, Hirat, Nangarhar, Kunar Nooristan, Laghman, Khost, Paktya Bamyan and Daikundi) provinces. • MOPH internet was supported during the reporting period • Offices were not renovated because the MOPH may move to a new building
Activity 3.2: Launch a community demographic surveillance system	• To be decided once fund availability and duplications with Ministry of Interior Affairs is thoroughly solved.	This activity was already cancelled and cancellation approval obtained in the APR 2008. The reason was the limited availability of resources. This activity funding is being discussed with the World Bank which will probably fund the activity.
Activity 3.3: Expanding capacity building program for MOPH	• Announcement , procurement and contract of the second round quality public health course for 240 provincial officers	• The quality public health management course for second round was announced as open call for proposal 11/12/2009, but the procurement process has been stopped by procurement committee of MOPH because of a new minister of finance circular. As per this circular all ministries are asked to process procurement of consultancy services with estimation cost of over 200.000$ through ARDS organization established in Ministry of Planning. To get this problem solved, first of all the HSS-Steering

managers at the Central and Provincial levels.	• Monitoring the quality public health training course. • Develop and update national training data base for MOPH managers	Committee endorsed procurement by MOPH and secondly MOPH applied for certification of procurement above 200.000 $. In response the MOF assigned a team to assess MOPH capacity. The final decision has yet to be announced. • Two post training follow ups conducted for training from Paktia and Parwan provinces and feedback provided to implementer NGOs in face to face meeting with NGO management. • National training database developed and regularly updated. • In total189 MOPH provincial staff members have been trained in MOPH policies and strategies, supervision/monitoring/evaluation, planning/budgeting and financial management. In addition, 111 DHOs also received above mentioned trainings except financial management • In 11 provinces (Badghis, Samangan, Saripul, Mazar, Farah, Helmand, Wardak, Parwan, Nimroz, Kapisa and Panjshir) computer and English language courses were conducted for provincial heath officers. Duration of each course was 8 months. In total 131 provincial officers trained in aforementioned subjects.
Activity 3.4: Developing a communications and internal advocacy program to seek increased funding	• Arranging press Travels (For Reflecting MoPH Success Stories) • Organizing PR Conferences • Conducting PR Trainings for MoPH Programme Managers • Support MoPH Monthly Publication • Maintain MOPH web site • Establish Media resource center at MOPH • Develop documentary films, video talk shows and audio talk shows	• Press travels did not happen due to insecurity and presidential elections. • Over 140 Press conferences had been arranged in different health events such as International and National Health Days, Contracts & MOUs signing and etc. • 420 Press Releases in Dari, Pashto and English versions developed and distributed to the National and International News Agencies to be broadcasted. • Public Relation Strategy drafted and will be finalized this year. • Media Database developed and regularly updated. • Press Conference guideline is under development process will be finalized this year. . • MOPH Website launched and over 500 news and events were published through MOPH website in both Dari and English versions along with the photos, audios and videos. However, the size is very small and needs expansion and refinement. • 600 Journalists introduced for preparation of the reports and stories from

		the local hospitals and reflection of progress and challenges of health sector through media. • Documentary films were not developed due to insecurity and presidential elections. Developing 4 documentary films about the BPHS, Vaccines, Community Midwifery education and Mobile Health teams are re-scheduled for the year 2010.
Activity 3.5: Launching an initial cadre of District Health Officers	• Complete the PRR process of 50 DPHOs • Start the PRR process for second round (100) DPHO. • Evaluation of DHOs effectiveness through joint venture of MOPH and NGOs • Take initial steps to recruit the last batch of 100 DHOs • Conduct trainings for DHOs • Supervise and monitor the performance of DHOs • Provide support to District Health Coordination committees	• Appraisal of 50 DPHOs completed and steps have been taken to enrol them in Gov structure. • The TOR, evaluation tools and guideline developed by a technical working group consisted of MOPH, WHO, Tech-Serve (MSH), EC. Initial decision was that the evaluation should be done by a joint venture of NGOs and MOPH, due to conflict of interest with these two parities, it has been decided that the evaluation should be done by evaluation agencies through an open bidding process. USAID/Tech serve will fund the evaluation. The HPRO organization is selected to carry out this evaluation which will be completed by 21st July 2010. • Because of the political pressure to reduce the number of employees of the Government, the number of employees for the MOPH has been consistently reduced. MOPH did not succeed to put all of the District Health Officers in the government structure 35 out of 143 are now in the structure and efforts are going on to put all of them in the structure of MOPH till end of the year 2010. • Based on the original HSS proposal, since the DHOs are recruited through competitive process and practically working in the districts, cessation of this program, till all of them are in the Government payroll, might lead to numerous problems.. The initial budget requested was $ 1,200,000 and it will require around$ 750,000 more till end of this year. Since there are no further options left, the SC approved further funding from HSS with the following conditions: MOPH to seriously follow the issue to put the rest of the DHOs in Gov structure by the end of this year. The third batch should not be recruited from GAVI HSS funds and the evaluation should be done by third party and completed as soon as possible. Meanwhile, the MOF will support the MOPH in this regard. • In total, one initial training conducted for (20) newly recruited DPHOs, five batches Refresher Training conducted for 72 DPHOs and two batches Specific training in Basic Management conducted for 36 DPHOs.

		• In total 69 DPHOs supervised in 17 provinces of Kunar, Nangarhar, Laghman, Parwan, Kapisa, Panjshir, Bamyan, Balkh, Samangan, Baghlan, Sari pul, Kunduz, Takhar, Badakhshan, Ghazni, Jawzjan, Logar and Herat jointly with provincial health team. • District Health Coordination committees established and mos of them conducted regular meetings. The District Health officers are chairing the meetings.

4.7 *Support functions*

*This section on **support functions** (management, M&E and Technical Support) is also very important to the GAVI Alliance. Is the management of HSS funds effective, and is action being taken on any salient issues? Have steps been taken to improve M&E of HSS funds, and to what extent is the M&E integrated with country systems (such as, for example, annual sector reviews)? Are there any issues to raise in relation to technical support needs or gaps that might improve the effectiveness of HSS funding?*

4.7.1 Management

Outline how management of GAVI HSS funds has been supported in the reporting year and any changes to management processes in the coming year:

There have been no changes in the management of HSS funds. The overall management is overseen by the deputy Minister of MOPH for policy and planning and GD of Policy and Planning and coordinated by HSS coordinator. Based on the nature of activity, the HSS funds are managed by different relevant departments of MOPH. The finance directorate oversees the financial aspects while the procurement directorate is responsible for procurement.

Overall support is overseen strictly by Health System Strengthening Steering Committee. The Health System Strengthening Steering committee (HSS-SC) with the presence of key CGHN members within the health sector of Afghanistan is actively supporting the health sector for successful implementation of global health initiatives related to HSS especially the GAVI support. The HSS-SC as coordination and monitoring body for HSS program is comprised of three MOPH voting members (key departments), representatives of UNICEF, WHO, World Bank, European Commission, USAID, Civil Society Organization representatives and Ministry of Finance. The bottom up annual plan of action (form 11 MOPH departments) was developed, approved by HSS-SC and accepted by MoF. Each relevant MOPH department has its focal point for HSS and each department plans and implements its relevant activities. The relevant running costs of each department are covered from HSS support and other costs are covered by either the Government of Afghanistan or other donor's support. To date, the HSS support has been very helpful to strengthen the health system; for example, some of the departments severely lacked the capacity of planning, reporting, or following up the issues. Now all of the relevant departments know the concepts of planning, coordination, implementation, and are actively involved in management and implementation of their plans whether it is GAVI or other donors or Government resources.

4.7.2 Monitoring and Evaluation (M&E)

Outline any inputs that were required for supporting M&E activities in the reporting year and also any support that may be required in the coming reporting year to strengthen national capacity to monitor GAVI HSS investments:

M&E of HSS activities fully merged into MOPH M&E plan. Therefore, the budget allocated for the M&E support cost was also re-allocated into that plan. In addition, the Afghanistan original proposal for HSS as approved by GAVI has one specific activity under the name of "upgrading the physical technology infrastructure of the M&E department". Therefore, the M&E department receives its main source of support from GAVI– HSS funds. It includes staff support, equipment, vehicles and TA at both central and provincial levels. In addition, M&E department is actively involved in designing tools and checklists for monitoring the HSS activities and actively involved in monitoring those activities. As the M&E department has myriad of tasks including monitoring of the non-for profit- private sector and for- profit private sector, in order to have more robust monitoring of HSS activities, the HSS-SC decided

to have separate plan for M&E of HSS. This plan should be functionally integrated with MOPH M&E department plan and the approved financial support in this line according to GAVI-HSS proposal to be used.

On the other hand, the National Balance Score card, a national monitoring tool implemented by third party and funded by the World Bank, captures information about some of the HSS indicators. HMIS department actively provides information from routine reports about the outputs of the activities especially the mobile health teams and sub- centers. This year USAID/Tech serve will support evaluation of "launching a new cadre of District Health Officers". In addition, since different technical relevant departments of MOPH implement the HSS activities, staffs of many departments of the MOPH are actively monitoring the HSS activities. Furthermore, inside the design of the most of the planned activities, M&E activities are in-built for example, the C-IMCI implementation has pre-and post-project surveys. For routine monitoring of HSS activities, checks are developed, field-tested, and implemented.

All these cross-linked M&E activities are providing the bases for monitoring the health sector activities including the GAVI-HSS funded activities. However, in such a post conflict setting, M&E needs further strengthening at provincial level which will require continuous efforts of and sustained funding for by of all health sector partners and the Government of Afghanistan.

4.7.3 Technical Support

Outline what technical support needs may be required to support either programmatic implementation or M&E. This should emphasise the use of partners as well as sustainable options for use of national institutes:

TA has been very helpful and effective. The key health sector partners who are member of HSS-SC provide useful guidance for program implementation and take remedial actions when required. MOPH using the approved amounts for TA in the original HSS application, has recruited national consultants to support different activities. In addition, WHO in the years 2008 and 2009 provided TA in form of one advisor from its own resources to support program implementation. This support for the year 2010 will be covered from HSS funds.

All sources of support have been very helpful. Recruitment of the national TA, based on the extensive MOPH experience in Afghanistan looks to be inexpensive and will ensure national level capacity building, contribute to TA sustainability, ability to be better used at field level, easy to communicate and recruit. This fact is actually one of the keys linked to impressive results achieved recently in the health sector of Afghanistan. However, international TA (currently provided by WHO) has its own key benefits to the health sector of Afghanistan. The commitment of health sector partners in Afghanistan especially in the HSS-SC proved to very helpful in terms of both ensuring transparency and accountability and technical guidance for programs implementation.

Note on Table 13: This table should provide up to date information on work taking place during the calendar year during which this report has been submitted (i.e. 2010).

The column on planned expenditure in the coming year should be as per the estimates provided in the APR report of last year (Table 4.6 of last year´s report) or –in the case of first time HSS reporters- as shown in the original HSS application. Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right, documenting when the changes have been endorsed by the HSCC. Any discrepancies between the originally approved application activities / objectives and the planned current implementation plan should also be explained here

Table 13: Planned HSS Activities for 2010

Major Activities	Planned Activity for 2010	Original budget for 2010 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Revised budget for 2010 (proposed)	2010 actual expenditure as at 30 April 2010	Explanation of differences in activities and budgets from originally approved application or previously approved adjustments
Objective 1:	**Improved access to quality health care particularly maternal and child health**				
Activity 1.1: Establishing Sub-Centers in under-served areas Activity 1.2: Deploying mobile health outreach teams	• Monitor the implementation of the project and make sure that SC and MHT provide quality health services to the communities. • Conduct MHT effectiveness evaluation • Provide technical support to the implementers based on SC and MHT concept note. • Provide technical review of progress of narrative reports • Provide feedback to implementers	$ 3,946,566	$ 4,312,637	Based on the calendar of Afghanistan (20th March 2009 to 21st March 2010), all the following figures are reported as 2009 expenditure in the financial statement. All the following figures are estimated expenditure in 2010 but with strong assumption to be true. $ 1,675,778	There has been no difference in the activities. Implementation of the activity will remain the same. The SCs & MHTs payments are made on quarterly basis according to the expenditure and balance as per the payment schedule. Three organizations could not spend more than half of the previously given instalments due to the following reasons: The BPHS implementers who are also responsible to run GAVI-HSS funded health facilities changed in Paktya, Sari Pul and Samangan provinces (funded by the USAID and WB). As per requirement of the contracts, as the BPHS implementer changes through the open competition bidding, the new implementer should take over the GAVI-HSS funded HFs. Therefore, these contracts have been handed over to the new implementing agencies through an amendment made in the contracts. The hand over process is normally time-consuming. Since the time was about the end of the fiscal year, MOPH could not transfer the allocated budget about $ 462,486. However, smooth running of these projects continued with the support of the new organizations own sources. The remaining instalments will be transferred early new fiscal year. MOPH purchased 26 pickups through international bidding

	through official channels or face to face meeting on quarterly bases.				process for mobile health teams (MHTs) organized by the Afghanistan Reconstruction and Development Services (ARDS) and distributed to the NGOs after amendment of their contracts. Based on NGO's contractual obligations the NGOs should handover the vehicles back to MOPH at the end of the project. Payment of 20% cost of 26 vehicles for MHTs which is equal to $189,800 was not transferred to the company due to un clarity about the M7, a formality requested by MOF controllers at the MOPH. The rule is to have the M7 form completed by one of the MOPH officials who have P2 (being on the payroll of MOPH). Since the vehicles will be used by NGOs and it is not possible to have it registered to MOPH employees and on the other hand, provide a government number plate to NGOs it is not possible to fill the M7 form as required by the controllers. Payment of this 20% was due Feb 2010 but not yet paid. This issue has remained as a problem and efforts are going on to solve the issue. Both of these issues have led to minor changes in the approved amount for the year 2010 for this activity and the revised work plan for the year 2010.
Activity 1,3: Expanding integrated management of childhood illness (IMCI) to community level	• Monitor the implementation of the project by conducting visits from training sites, baseline survey and monitor CHWs who received C-IMCI training. • Provide technical assistance to the implementers. • Review of progress	$ 694,531	$ 1,094,103	$ 169,063	The total revised allocation for C-IMCI was around is $ 1,800,000 for five years. Since there was no available further funding three zones with lowest bid prices and more need covering 17 provinces contracted with three NGOs and the cost of training per CHW to receiving C-IMCI training is roughly $ 208. To date the C-IMCI implementation is quite successful. According to the Steering Committee approval, since the C-IMCI is an important area to improve child health and initially planned in the HSS proposal, the remaining funds from the in service training activity to be used for implementation of C-IMCI in two more zones. In total this will cover 5 out of 7 zones. For the remaining zones further fund raising will be required either in future from GAVI or from other donors. The in-service training will be covered by USAID since it

	of narrative reports in quarterly bases and provide feedback to implementers through MOPH official channels or face to face meetings • Start procurement process of two remaining zone of north east and south east from remaining budget from in service training .				has recently started already taking over this activity. Addition of two more zones to train CHWs recently in the plan has increased the amount of funds required for the year 2010 for this activity.
Activity 1,4: Develop an in-service training program for BPHS primary healthcare providers	• Closure report will be compiled as part of overall HSS report	$ 364,578	0	$ 222,411	As mentioned above, at the middle of 1388 (2009), Health Services Support Project (HSSP) received additional funds from USAID for the training of health providers in 13 USAID supported provinces already funded by GAVI-HSS. In addition, USAID provided additional funds recently (1.5% of the total contract price) for the NGOs for this purpose. In order to avoid duplication and fill the critical gaps exist in the originally planned HSS activities, it was proposed to terminate the BRAC contract and the remaining budget to be shifted to C-IMCI activity to cover two more zones. After discussions with USAID, HSSP and Afghan Public Health Institute, the issue was finally approved in the HSS-Steering Committee on 31st March 2010. (please kindly refer to the minutes)
Objective 2:	**Increased Demand for and Utilization of Healthcare**				
Activity 2.1: Implementing a nationwide Information,	• Continuation of IEC Key messages broadcasted via media	$ 357,692	$ 608,279	$ 253,010	Activities remain the same as planned but certain additional key activities are planned. The new planned activities which are approved by HSS-Steering Committee are:

Education and Communication (IEC) campaign for immunization and other MCH messages	• Continue the distribution of IEC materials to the health facilities and health posts at community level • Monitoring of health facilities to make sure, the presence and use of IEC developed materials. • Conduct KAP survey • Develop the communication strategy based on KAP findings. • Conduct IEC campaign based on KAP survey findings • Revised IEC strategy				1: Development of 15 more IEC spots 2: Printing more brochures and poster to be distributed to Health Facilities, and health posts at community level 3: Conducting 2 separate capacity building workshops for 34 provincial health directors and 50 relevant staff of NGOs working in the health sector related to IEC/BCC 4: Work with the Ministry of education to include some IEC messages in the school curricula 5: Start efforts to attract support of mobile phone networks in relation to broadcasting IEC messages In addition, KAP survey finalized but because of the end of fiscal year the payment has not been made. These issues has made changes in the original planned budget and revised work plan of 2010 for this activity.
Activity 2.2: Pilot a model of demand side financing (DSF).	• Monitor the baseline survey and regular monitoring of the project implementation. • Provide technical assistance and direction to the	$ 722,370	$ 463,739	$ 112,288	The planned activity remains the same with no changes. The original cost for the plan was an estimation but once the project contract was signed and actual price was known, some changes in the planned budget were introduced. More important, the actual implementation of the project started in July 2009 and over 6 months spent in the preparation phase of the project. It was planned to release four payments but since the MOPH contracts to date are cost re-imbursement

Activity 2.3: Piloting a program to provide monetary performance incentives to volunteer Community Health Workers	implementer NGOs based on the project TOR for proper project implementation • Provide feedback to implementer NGO based on submitted quarterly technical and financial reports.				contracts, the NGO were not able to utilize initial instalments. That is why the MOPH released two instalments and kept the two instalments for the year 2010. Meanwhile, after discussions with the NGO, regarding the NGO actual spending capacity and feasibility of efficient use of funds, the final planned budget for the year 2010 is $ 463,739. That is $ 258,621 less that approved amount for this activity for the year 2010.
Objective 3:	**Improve the ability of the MOPH, at all levels, to fulfill their Stewardship Responsibilities**				
Activity 3.1: Up-grade the physical, information /communication technology infrastructure and means of transportation[8] of the M&E Department	• Provision of transport facilities for provincial monitoring • Nationwide monitoring of all BPHS implementation and EPHS implementation • Enhance NMC use at provincial level • Support to implementation of nationwide use of BSC • Generate and	$ 700,000	$ 907,160	$ 185,285	The planned activities remain the same. From provision of transportation activity in addition to rental vehicles, two vehicles were planned to be purchased. All the procedures completed but due to end of the fiscal year, payment was not done. In addition, due to presidential elections and insecurity some monitoring missions remained to be done in the year 2010. Internet connection of the MOPH contracted but due payment is not done yet. In addition, for the year 2010, databases of the MOPH will be revised and Geographical Information System (GIS) for better monitoring will be strengthened.

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

	compile all evidences to date for the effectiveness of HSS interventions • Graduation and certification of students from one year M&E strengthening course.				
Activity 3.2: Launch a community demographic surveillance system	• To be supported by other donors and plans to be decided accordingly	0	0	0	As approved already in the APR of 2008, because of shortage of funds and complexity this activity has been stopped and probably soon will be funded by the World Bank.
Activity 3.3: Expanding capacity building program for MOPH managers at the Central and Provincial levels.	• Finalize the , procurement process of QPHC 2nd round course for 197 provincial officers • Conduct monitoring visit from the quality public health training course session. • Maintain the national training data base for MOPH managers at all levels	$ 526,212	$ 346,528	$ 97,319	No changes in the activities. The procurement process for the second round of QPHC has been started on time but certain restrictions of Ministry of Finance, regarding the procurement of service over 200,000 $ through ARDS, have created a problem for the MOPH. In the year 2004, the MOPH with the support of the WB established the Grants and Contracts Management Unit which is responsible to procure such services with full capacity. It has been assessed several times by different donors and now being supported by almost all of them. As a result of these assessments and positive findings, the USAID channelled last year over 236 Million US$ directly to MOPH. However, there are other Afghan Government organizations that lack such capacity. The circular of MOF is universal and blocks this activity in the entire Government. In order to solve the problems, negotiations are going on between MOPH, MOF, USAID and the HSS-Steering Committee. The final conclusion is to do a

	• Develop MOPH training strategy				systematic evaluation of the capacity of MOPH in this respect to reach an informed final decision. The assessment is ongoing since few months and the final results are yet to be known. Once this is clear the MOPH will act accordingly. That is why the plan for the year 2010 is $ 181,007 lower than the approved amount for this activity.
Activity 3.4:	• Finalize Public Relation strategy • Arranging press Travels (For Reflecting MoPH Success Stories) • Organizing PR Conferences • Conducting PR Trainings for MoPH Programme Managers • Support MoPH Monthly Publication • Develop documentary films, video talk shows and audio talk shows	$ 120,000	$ 184,400	$ 33,132	All the planned activities remain the same. The difference in the revised work plan is some activities pending from 2009 because of presidential elections which lasted several months until the results were clear and the addition of one activity. That is the expansion of the web site of MOPH.
Activity 3.5:	• Complete the PRR process of 143 DPHOs • Conduct trainings for DHOs • Supervise and monitor the performance of	$ 750,000	$ 664,970	$ 166,467	Despite having the approval of further $ 750,000 for the year 2010 by GAVI-IRC 2008 and Health System Strengthening Steering Committee, MOPH tries to keep the cost to the lowest level possible and enrol all the DHOs in the Government payroll by the end of the year 2010.

	DPHOs • Provide support to District Health Coordination committees				
M&E support cost		$ 300,000 (approved in the original each year)	$ 298,980	0	The M&E support cost was initially fully integrated in the MOPH M&E plan. However, in order to have more robust M&E of HSS activities, the HSS-Steering Committee decided to have a separate plan for M&E support cots. This plan includes: 1: Establishment of M&E advisory board 2: Provision of TA related to M&E to all involved departments of MOPH in HSS implementation 3: Data analyzes and target setting for at least two zones (8 provinces) 4: Evaluation of effectiveness of Mobile teams funded by GAVI-HSS 5: Robust monitoring visits to field level and steer involved NGOs in implementation of HSS activities including EPI problems 6: Conducting orientation sessions regarding NMC, checklists of the M&E of HSS activities
Management cost		620,000	1,020,597	$ 591,813	The management cost includes construction of one clinic in Badakhshan province. The activity is not completed and the funds carried forward to the year 2010. Although this is not a management activity, in the last year APR, the budget was added here since this activity will be followed by HSS – coordination team directly. In addition, an extensive external audit of the HSS funds was planned, the procurement is under process, and the planned amounts carry forwarded to the year 2010. This amount also

					includes national TA at national level.
Technical assistance cost		$ 180,000	$ 180,000	0	This is the international TA required from WHO and does not include the national TA as part of each activity. This TA aims to provide programmatic support to HSS planning and implementation. WHO provided continues HSS support since 2007 for application development and implementation follow up. In 2009 MOPH and HSS-SC agreed to allocate this fund to WHO to sustain such HSS support.
TOTAL COSTS		8,801,949*	10,081,393	$ 3,506,567	*The amount 8,801,949 $ included 644,603 $ expected to be remaining from previous year. In a challenging context like Afghanistan, the planned activity budget wise is implemented based on GAVI approvals over 80% this year. However the budget of roughly 20% is carry forwarded to the year 2010 which certainly needs revised work plans.

Table 14: Planned HSS Activities for next year (ie. 2011 FY) *This information will help GAVI's financial planning commitments*

Major Activities	Planned Activity for 2011	Original budget for 2011 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Revised budget for 2011 (proposed)	Explanation of differences in activities and budgets from originally approved application or previously approved adjustments
Objective 1:	**Improved access to quality health care particularly maternal and child health**			
Activity 1.1: Establishing Sub-Centers in under-served areas Activity 1.2: Deploying 80 mobile health outreach teams	• Monitor the implementation of the project and make sure that SC and MHT provide quality health services to the communities. • Provide technical support to the implementers based on SC and MHT concept note. • Provide technical review of progress of narrative reports • Preparation for evaluation and close out the project.	1,700,000	3,512,429	No differences. This year efforts will be paid to hand over this activity to other donors like the EU, USAID and WB. Important: Please note that in past four years, adjustments have been made to the activities and budget based on the actual costs. Only for the year 2011 no adjustment was made and activities will continue as planned and implemented. That is why there will be differences in the original approval in 2007 and actual implementation in 2011. Please note that these costs are in line with the proposed activities in the original HSS application and approved HSS proposal ceiling. These adjustments are because of actual expenditures and more importantly, since the transparent bidding processes is completed, the actual prices are known for each activity. The stewardship role of the MOPH is to contract out most of the activities (please refer to page 66 of this report for role of CSO in HSS implementation).
Activity 1.3: Expanding integrated management of childhood illness (IMCI) to community level	• Monitor the implementation of the project by conducting visits from training sites, baseline survey and monitor CHWs who received C-IMCI	200,000	1,296,103	No differences. Final evaluation will be conducted and results will be disseminated. Efforts will be paid to raise more funding for uncovered 2 zones. The addition of the funds from in-service trainings has increased the amount.

	training. • Provide technical assistance to the implementers. • Review the progress of narrative reports in quarterly bases and provide feedback to implementers through MOPH official channels or face to face meetings • Preparation for evaluation and close out the project.			
Activity 1.4: Develop an in-service training program for BPHS primary healthcare providers	0	$400,000	0	
Objective 2:	**Increased Demand for and Utilization of Healthcare**			
Activity 2.1:Implementing a nationwide Information, Education and Communication (IEC) campaign for immunization and other MCH messages	• Broadcasting of key IEC messages through media • Follow ups with Ministry of Education and other partners related to IEC activities in schools • Conduct IEC workshops • Design IEC materials based on need • Follow ups on changes on KAP • Supply and	200,000	$ 674,320	No differences in planned activities.

	distribution of IEC materials			
Activity 2.2: Pilot a model of demand side financing (DSF). Activity 2.3:Piloting a program to provide monetary performance incentives to volunteer Community Health Workers	• Monitor the implementation of the project. • Provide technical assistance to the implementer. • Review the progress of narrative reports in quarterly bases and provide feedback to implementers through MOPH official channels or face to face meetings • The project will end on 30 of May 2011 the MOPH will assist implementing NGO in conducting end of project survey , data collection , analysis and final report of the project	500,000	$ 538,350	No differences
Objective 3:	**Improve the ability of the MOPH, at all levels, to fulfill their Stewardship Responsibilities**			
Activity 3.1:Up-grade the physical,	• Capacity building	250,000	$ 800,000	M&E of MOPH requires huge amount of support at national and provincial

information /communication technology infrastructure and means of transportation[9] of the M&E Department	strengthening M&E training will be ended by 14/08/2010. Final report will be provided. • Nationwide monitoring of BPHS and EPHS • Further strengthening the use of NMC at provincial level • Generate and compile all evidences for effectiveness of HSS interventions • Provide support to relevant MOPH departments at central and provincial levels.			levels.
Activity 3.2: Launch a community demographic surveillance system	0	200,000	0	Already cancelled and shifted to other activities
Activity 3,3: Expanding capacity building program for MOPH managers at the Central and Provincial levels.	• Monitor the implementation of the project. • Provide technical assistance to the implementer. • Review the progress of narrative reports in quarterly bases and	200,000	$ 350,980	No differences in planned activities

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

	provide feedback to implementers through MOPH official channels or face to face meetings • Explore new initiatives • Evaluation and final report of the project			
Activity 3.4: Developing a communications and internal advocacy program to seek increased funding	• Arranging press travels (For reflecting MoPH success stories) • Organizing PR Conferences • Conducting PR Trainings for MoPH Programme Managers • Support MoPH Monthly Publication • Develop further documentary films, video talk shows and audio talk shows	200,000	$ 180,000	No differences in planned activities
Activity 3.5: Launching an initial cadre of District Health Officers	Provide assistance to DHO system that would be already absorbed in the Government system	100,000	$ 80,000	No differences. Only slight support will be provided to the DHO system based on need in terms of follow up, refinement of the standards or develop further tools or guidelines based on need.
Management cost		100,000	$ 480,000	No differences in planned activities

M&E support cost	• Provision of TA related to M&E to all involved departments of MOPH in HSS implementation • Data analyses and target setting for at least two more zones (9 provinces) • Assessment of the effectiveness of GAVI funded HSS activities • Actively participate in the closure process of the projects • Develop M&E relevant reports • Robust monitoring visits to field level and steer involved NGOs in implementation of HSS activities including EPI problems	300,000	$ 629,887	No differences in planned activities In addition to other activities, one extensive evaluation for HSS support is planned. Also there is need for an household survey to measure the effectiveness of HSS interventions at household level.
Technical Assistance	To be provided by WHO and funds channelled through WHO (Steering Committee date 8 may 2010)	300,000	$ 180,000	
TOTAL COSTS		$ 4,650,000	$8,722,069	

4.8 *Programme implementation for 2009 reporting year*

4.8.1 Please provide a narrative on major accomplishments (especially impacts on health service programs, notably the immunisation program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. Any reprogramming should be highlighted here as well. This should be based on the original proposal that was approved and explain any significant differences – it should also clarify the linkages between activities, output, outcomes and impact indicators.

*This section should act as an executive summary of performance, problems and issues linked to the use of the HSS funds. This is the section where the reporters point the attention of reviewers to **key facts**, what these mean and, if necessary, what can be done to improve future performance of HSS funds.*

The GAVI – HSS funds as envisaged in the GAVI guidelines have been indeed catalytic and instrumental for the health system of Afghanistan.

A. Management

1. Six HSS steering committee meetings were conducted during reporting period. The Health System Strengthening Steering committee (HSS-SC) with the presence of key CGHN members within the health sector of Afghanistan is actively supporting the health sector for successful implementation of global health initiatives related to HSS especially the GAVI support. The HSS-SC as coordination and monitoring body for HSS program is comprised of three MOPH voting members (key departments), representatives of UNICEF, WHO, World Bank, European Commission, USAID, Civil Society Organizations interim representative and Ministry of Finance.
2. The bottom up annual plan of action (form 11 MOPH departments) was developed, approved by HSS-SC and accepted by MoF.
3. GAV I support Type A project completed, GAVI support type B projects are in implementation.
4. HSS components of Global Fund R8 funded projects are in preliminary implantation stage.
5. Timely support has been given to implementing departments of MOPH for planning, implementation and monitoring of the activities
6. Preparations started to include HSS component in GF R10 proposals.

Although very challenging context, with the support of all health sector partners, the MOPH succeeded to a highly satisfactory level implement the planned activities. Through this report, all those who support the health sector of Afghanistan are thanked for their commitment and hard work including but not limited to WHO, UNICEF, WB, EU, USAID, Ministry of Finance, NGOs and other CSOs. This year the MOPH could implement the plan over 80% in total. Over 9,000,000 US$ spent from 20th March 2009 to 21st March 2010.

B. Improved access to quality health care:

B.1: Establishment of sub centres and Mobile Health teams in remote and underserved areas of the country**:**

The SCs & MHT concept notes incorporated and endorsed in to the national policies and BPHS package. Both activities of Improved access to quality health care services through establishment of 120 SCs and deployment of 26 MHT have been contracted out with the total 8 national and 7 international NGOs currently implementing BPHS in the respective provinces with the total cost of 15,314,429 USD for the period of 42 months until February 2012, while 7 SCs and 4 MHTs are run by MOPH itself through MOPH Strengthening Mechanism (SM) in the entire 5 provinces."

Despite the insecurity and fragile situation in most parts of the, country, the presidential election which to some extent deteriorated the overall utilization of health services, significant progress has been made towards the implementation of the establishment of sub centres and deployment of MHTs' project. The health services are being delivered to the most deprived and hard to reach areas by 121 SCs and 26 MHTs (100% Achievement) In addition in spite of serious female health worker shortage in most of the provinces particularly remote areas 79% of GAVI-HSS funded health facilities are staffed with female health workers (Midwives). According to the reports of implementers so far, in total 9,966 children and 13,216 Child Bearing Age Women (CBAW) have received vaccines of DTP, BCG, Measles and TT. Totally 1,000,821 OPD visits

conducted out of which 510,654 children treated for ARI, ENT and Diarrhoea. Meanwhile, 2,725 deliveries, 29,600 New ANC, 26,354 Family Planning services provided by GAVI-HSS funded SCs and MHTs.

HSS thematic programmes are being conceptualized through the BPHS coordination meetings in conjunction with other BPHS Grants including WB, EU and USAID funded projects.
Regular monthly grant administration meetings are held and updates are shared with other grants and other donors supporting BPHS implementation. Problems are identified and shared and come up with and appropriate actions and needed support is provided. The major problem encountered to date is the handing over of mobile teams vehicles to implementers. This problem is being seriously followed up and hopefully will be solved soon.

B.2: Implementation of community based Integrated – Management of Childhood Illnesses:

IMCI department with technical support of MSH / Tech Serve and BASICS designed survey methodology, developed the survey tool and database, surveyors trained and baseline data collected from 2,700 household in three zones. The Survey results entered in designed data base and analysed. The report is under finalization. The plan was to train 3,075 (30% of 9225 planned for three years) CHWs in the first year while 3463 (37.5% of three year plan) CHWs and CHSs have been trained in both modules by consultant organizations. Implementation % exceeds 112%. Of the total trained, 1830 are females (53%) and 1633 are males (47%). The reason for overcrossing the target was that the consultant organizations were able to have more training sessions in some cases, which is appreciated. Since based on the original application of HSS to GAVI, 80% of CHWs planned to be trained on C-IMCI, first of all the number of CHWs increased year by year and secondly because of shortage of funds, only three out of 7 zones were contracted for trainings. Based on the approval of HSS –SC the remaining funds from in service training which will be covered by USAID, will be shifted to C-IMCI to cover two more zones. The project implementation looks highly satisfactory. The impact of these trainings will require further time to be evident. An end project survey is planned inside the planned activity which will clearly show the effectiveness of the trainings. This survey is planned for the year 2011. No major problems encountered in the implementation of this activity.

B.3: To build the capacity of BPHS primary health care provider in 13 provinces:

The implementation of in service training program has been started from 1st February 2009 for three years. The target groups were mainly medical doctors, Nurses midwives and pharmacists. The project implemented by two NGOs (International and National). Based on contract NGO committed to train 3,162 health providers in three years. At the end of first years in total 741 (70.3%) health providers out of 1054 (166 MD, 164 Nurses, 330 midwives and 81 pharmacists) received IMCI, Nutrition, Family Planning, Essential Drug Management (EDM), Continuum of Care (COC), Basic and Advanced Emergency Obstetric Care (EOC) through 57 training courses conducted in 7 regional training centres.
At middle of 1388, Health Services Support Project received additional funds from USAID for the training of health providers in 13 USAID supported provinces; in addition, USAID recently provided funds (1.5% of the total contract price) for the NGOs for this purpose. In order to avoid duplication and fill the critical gaps exist in the originally planned HSS activities, it is proposed to terminate the BRAC contract and allocate the remaining funds to cover the C-IMCI in two more zones. The issue was fully discussed and the HSS-SC approved shifting. USAID representative showed commitment to fill further gaps if any in the area of in service training in USAID funded provinces. The program implementation was satisfactory to date, the remaining health staff will be trained to complete the target. No major problems encountered, however, there were some problems in introducing the trainees which was solved through follow ups with the BPHS and training program implementers. Knowledge score in the balance score card which a nation-wide third party evaluation tool showed improvements for the previous years, while this year the results are not analysed and disseminated.

C. Increases demand for and utilization of health care services

C.1: Implement a nationwide strategic Information, Education and Communication (IEC) initiative:

The IEC/BCC activity in a context like Afghanistan is very vital and critical to improve the health status of people. The planned IEC activities are being implemented on a satisfactory level. The achievements under IEC activity remains high as was in the year 2008.

Knowledge Attitude and Practice (KAP) survey conducted and analyzed which was monitored in four major cities of Herat, Kandahar, Laghman and Ningarhar provinces. In total 12,077 minutes the IEC messages have been broadcasted from 9 TV and Radio channels during reporting year. MOPH IEC/BCC strategy with the full support of HSSP USAID finalized. IEC taskforce is actively involved in advising IEC related activities and initiatives including selection of media channels for broadcasting. IEC stock which was constructed last

year equipped and all IEC materials of MOPH now has appropriate place to stock. In total this year, 171,399 posters and brochures which was published from GAVI funds have been distributed to 24 NGOs in 16 provinces. A national wide conference conducted with the title of "Islam and Health". In Afghanistan religious leaders are key individuals who can influence most of issues at community level. In order to get the support of Mullas to convey IEC messages to people through mosques, over 320 Mullahs were invited from 19 provinces. As an outcome of this conference a book will also be published soon and will be distributed to Mullahs. All the key IEC messages were distributed to Mullahs to be communicated with communities. No major problems encountered in implementation of the activity. The planned activities implemented over 85%.

This year no survey has been conducted to measure the changes in the behaviour of people. However, a maternal mortality survey is planned this year in Afghanistan which will certainly capture IEC indicators. The findings will guide MOPH and its partners to find clues over effectiveness of IEC activities.

C.2: Pilot the effectiveness of a model of demand side financing and Provide monetary performance incentives to Community Health Workers:

Demand Side Financing (DSF) and incentives to CHWs Project is designed to study the effectiveness of incentive paying to the clients and community health workers on utilization of available health care services especially to the mothers and children. The implementation of the project is contracted out to the international non-governmental organization Hope Worldwide based on procurement law and procedures of the Afghanistan's government in four provinces of the country e.g. Badakhshan, Faryab, Kapisa and Maidan Wardak. The project started bydetermining the baseline through conducting a house hold survey in four provinces and sixteen districts within the project sample size. The methodology and findings of the survey is available. For more details refer to house hold survey report. (Annex8)
The project implementation is running smoothly in the selected districts. Except few minor problems, no major problem has been reported. The HMIS data to date since it is in early stages of implementation shows no major differences. The pilot will end on 31st May 2011. An end project evaluation will be conducted. This year the mid-term assessment will be conducted to check the system in different levels which will be completed by end of Aug this year.

D: Improve the ability of the MOPH, at various levels, to fulfill its Stewardship Responsibilities.

D.1: Up-grade the physical, information/communication technology infrastructure and means of transportation10 of the M&E Department:

There are critical changes in the structure of Monitoring dept to improve M&E activities. Capacity building course for 27 MOPH staff in M&E is contracted out to a national NGO. Monitoring tools for HSS activities revised and field tested. (Annex 7) 29 out of 34 provinces were provided rental vehicles. In the rest of province either the vehicles was available or the security does not allow monitoring. Regular monitoring visits conducted from BPHS, EPHS and other health related projected in 28 provinces by M&E staff. out of this 28 provinces , 5 provinces visited once a year. 47% of provinces have been monitored at least once per quarter which was last year 33%. For the first time, with the support of GAVI, MOPH was able to take over the National Monitoring Checklist database from Tech-serve USAID funded project and install it in MOPH monitoring mechanism. Totally 117 provincial and district health officers are trained in use of National Monitoring check list. NMC database is installed in all 34 provinces of the country. M&E team and HMIS department conducted two workshops at zone level to promote routine information system and data use. National Monitoring Checklist (NMC) data base was taken over from Tech-Serve by M&E directorate and revised based on updated requirements of MOPH. Totally 177 Provincial and district health officers received NMC training. National NMC database and tool which is a national tool is revised vastly with the support of GAVI, a very interesting data base is being developed for NMC tool which is self-explanatory and will not have the need for trainings. This NMC will monitor the BPHS funded by WB, EU, USAID and many other donors including GAVI HSS funds for SCs. As a next step the plan is to do the same for EPHS.

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

In addition, the survey of the Balance Score Card which is a national process was assisted by MOPH M&E team was conducted. In addition, the MOPH internet which is an urgent need of MOPH for communication and monitoring was supported.

No major challenges encountered. However, there were some bureaucratic problems especially the development of unrealistic transport rates to the provinces which precluded completion of the M&E missions for around three months. This problem was fixed after intensive follow ups with the support of HSS-SC and Ministry of Transport. The GAVI has contributed significantly to improve M&E especially the routine, however, further intensive support is required to reach to a desired system for M&E.

D.2: Launch a community demographic surveillance system
This activity already cancelled from GAVI funds in 2008.

D.3: Expand capacity building program for MOPH managers at the Central and Provincial levels.

The first round project for the Quality Public Health Management Course is smoothly going on. The quality public health management course for second round is announced and is under procurement process. Two post training follow ups conducted from the training sites in Paktia and Parwan provinces and feedback provided to implementer NGOs. National training data basis developed and updating regularly. In total, 189 MOPH provincial staff have been trained in MOPH policies and strategies, supervision/monitoring/evaluation, planning/budgeting and financial management. In addition, 111 DHOs also received above mentioned trainings except financial management. Furthermore, in 11 provinces of Badghis, Samangan, Saripul, Mazar, Farah, Helmand, Wardak, Parwan, Nimroz, Kapisa and Panjshir, computer and English language courses were conducted for provincial heath officers. Duration of the courses was 8 months. In total the trainings conducted for 131 provincial officers in above subjects. There have been no problems encountered in this activity. Post training evaluation will be conducted this year.

D.4: Develop a communications and internal advocacy program to seek increased funding:

In the reporting year, the implementation of this activity has been to certain extent satisfactory. Over 140 Press conferences had been arranged in different health events such as International and National Health Days, Contracts & MOUs signing and etc. 420 Press Releases in Dari, Pashto and English versions developed and distributed to the National and International News Agencies to be broadcasted, Public Relation Strategy drafted and will be finalized this year, Media Database developed and regularly updated, Press Conference guideline was created and provided , MOPH Website Launched and over 500 news and events were published under MOPH website in both Dari and English versions along with their photos, audios and videos, 600 Journalists introduced for the preparation of the reports and stories from the local hospitals and reflection of progress and challenges of health sector through media.

However, some of the key activities were not carried out. Documentary films were not developed and no press travel conducted due to insecurity and presidential elections. Developing 4 documentary films about the BPHS, Vaccines, Community Midwifery education and Mobile Health teams are re-planned for the year 2010.

D.5: Launch an initial cadre of District Health Officers

Appraisal of 50 DPHOs completed and steps have been taken to enrol them in Gov structure. The TOR, evaluation tool and guidelines developed by a technical working group consist of MOPH, WHO, Tech-Serve (MSH), EC. Initial decision was that the evaluation should be done by a joint venture of NGOs and MOPH. Due to conflict of interest of these two parities, it has been decided that the evaluation should be done by evaluation agencies through an open bidding process. USAID/Tech serve will fund the evaluation. Because of the political pressure to reduce the number of employees of the Government, the number of employees for the MOPH has been consistently reduced. MOPH did not succeed to put all of the District Health officers in the organogram. 35 out of 143 are now enrolled into the structure and efforts are going on to enrol the rest of them in the structure of MOPH by the end of the year 2010. Since the DHOs are recruited through competitive process and practically working in the districts, cessation of this program might lead to myriad of problems. The initial budget requested was 1,200,000 $ and there will a need for around $ 750,000 (already approved in the APR 2008) till end of this year. Since there are no further options left, the SC approved spending of the approved funds from HSS with the conditions to put them in the Gov payroll by the end of

2010 and do not recruit further batches. In total, one initial Training conducted for (20) newly recruited DPHOs, five batches Refresher Training conducted for 72 DPHOs and two batches Specific training in Basic Management conducted for 36 DPHOs. In total 69 DPHOs supervised in 17 provinces of Kunar,Nangarhar,Laghman,Parwan,Kapisa,Panjshir,Bamyan,Balkh,Samangan,Baghlan,Saripul,kunduz,Takhar,Badakhshan,Ghazni,Jawzjan,Logar,Herat jointly with provincial health team. District Health Coordination committees established and mostly conduct regular meetings. The District Health officers are chairing the meetings.

With the support of GAVI for the first time, the MOPH succeeded to have representative at the district level and could establish District level Health Coordination Committees that mostly have the monthly meetings. As discussed above the effectiveness will be studied soon, which will provide bases for making further decision. The plans this year implemented over 75%. No major problems encountered. However, there have been some delays reported in the transfer of funds and reaching the DHOs. The issue has been follow up with MOF but still this looks to have more time required until provincial reforms are implemented at both MOPH and MOF levels.

Almost most of the targets set in the proposal are being achieved. DTP3 coverage has decreased by 2% this year. (Please refer to table 4.8)

Additional notes: Some of the funds remaining unspent with the NGOs as stated in the financial statement, these amounts will be spent in the first quarter of the year 1389. In the first quarter of each fiscal year it takes 2 to 3 months to clear all the accounts within the Government system so in this time period the MOPH is not able to issue instalments for the NGOs.

Problems:

- **Insecurity** in some parts of the country: to solve this problem what the MOPH could do was to pilot a partnership project with for profit private sector in insecure areas under CSO type B.
- **Long administrative procedures inside and outside of the MOHP:** reforms are going on. The pay and grading system is being implemented for the staff. Efforts are going on to systematize operations
- **Poor commitment and capacity of MOPH provincial level to monitor the implementing NGOs and provide them support**
- **Lack of qualified health workers especially female in remote areas of the country.** Efforts are going on to address the problem. This problem is being addressed by different donors including GAVI
- **Geographical constraints**, long winter in certain parts of the country, and bad road conditions.
- **Procurement: The procurement of consultancy services been stopped because of a new minister of finance circular. As per this circular all ministries are asked to process procurement with estimation cost of over 200.000$ through ARDS organization established in Ministry of Planning.** Negotiations are going on with MOF and a committee assigned to the assessment. The assessment completed and the final decision has yet to be announced.

4.8.2 Are any Civil Society Organisations involved in the implementation of the HSS proposal? If so, describe their participation? For those pilot countries that have received CSO funding there is a separate questionnaire focusing exclusively on the CSO support after this HSS section.

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. Form HSS support, over 70% of activities is being implemented by NGOs.

The CSO type B is being implemented by the six national and International NGOs. Four Community Midwifery Education (CME) programs are being implemented in four provinces of Ghazni, Nimroz, Kunar and Zabul and two pilot public-private for profit partnership projects are running in the two insecure provinces of Uruzgan and Farah.

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

4.9 *Management of HSS funds*

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year? ***NO*** **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: further describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of HSS funds.

NA

Part B: briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the ICC in this process.

The financial management of the HSS funds is the same like other funding agencies such as World Bank, Global Fund, Government of Afghanistan, USAID, and all development budget coming through Ministry of Finance. Work plans are made at departmental level and passes normal steps and stages for approval. Then all of the plans are shared with the finance directorate of MOPH. According to Chart of Accounts, the finance directorate development budget unit categorizes the expenditures and relevant forms are completed. At this stage the finance directorate makes requests for allotments from Ministry of Finance. The allotment requests are signed by head of relevant department, finance team and director and the leadership of MOPH. Some of these allocations are for central level and some are for provincial level.

Once the allotments are approved, at central level, the department responsible for the implementation of the planned activity according to its approved work plan initiates the activity implementation and normally gets again approval of leadership. Once the task is completed or advance funds are required after approval of relevant authorities, usually the MOPH minister and deputies, the document is sent to finance directorate

where payment form is made. In order to be assured and have a transparent process, gets the signature of the relevant department head again as well in the payment form and is finally signed by the leadership of the MOPH. Once the form is signed, it is sent to the controllers of Ministry of Finance sitting in MOPH. They further check all background documentation and make sure that the process is completed according to the law. If no concerns, then they sign and the MOPH then sends the payment form to MOF.

At provincial level, once the allotment is received the provincial health offices, in conformity to the Afghan law, implements the budget under the guidance of the Mustufiates (the provincial Ministry of Finance structures). But one thing to mention that the HSS is the only source which transfers the funds to all 34 provinces. The rest of MOPH development budget is either sent through a parallel structure, or not sent to the provinces.

HSS funds are fully reflected in the national health plan according to the agreed framework of HSS proposal. The accounts where the HSS funds are kept, are the Government current accounts and no commercial bank account is used, therefore, no interests are generated. This is the case for all health sector donors in Afghanistan who uses Government channels.

Financial reporting is easy at central level. Form provincial level, the financial reports are provided by the Ministry of Finance Mustufiates. From one side there is limited capacity in most of MOPH provincial offices and on the other hand, the same is with most of Mutufiates. Experiences in the past two years show that by the closure of the fiscal year which is 20th of March, Mustufiates provide mixed reports which puts up the MOPH to a challenge. Clearing the accounts takes two to three more months at provincial level and this can cause slight changes in the financial statements provided because the statements are provided by May 15 while clearing all the accounts with provincial level reaches normally end June. In some instances, the other donor's money comes to the account or vice versa which requires more time to fix the problem.

For fixing the problem extensive discussions, meetings and even once a special committee assigned to work but problems are difficult to solve rapidly. It looks that this problem may be fixed over time. Although there were some suggestions appreciated by MOPH to transfer the funds through a commercial bank and a letter was provided by GAVI to support this suggestion. But after consultation and thoroughly studying the issue, it was found that it might create room for corruption because the Government procedures although very complicated and bureaucratic, are good to prevent corruption. That is why MOPH never used this mechanism for HSS funds.

The ICC does not have any role as there is the HSS-Steering Committee involved in the approval of HSS plans, allocation of funds, modifications of budget, and recommendations for procurement decisions and so on. This committee as fully discussed above, consists of USAID, EU, WB, WHO, UNICEF, MOF, CSOs and MOPH representatives. This committee is the key partners of the Consultative Group for Health and Nutrition which is the high level health sector coordination forum. The support of this committee has been tremendously important and vital in implementation of HSS funds to date.

4.10 *Detailed expenditure of HSS funds during the 2009 calendar year*

Please attach a detailed financial statement for the use of HSS funds during the 2009 calendar year **(Annex 9).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

If any expenditures for the January – April 2010 period are reported above in Table 16, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Reproted as part of financial statement for the year 2009. Document N°.....)**.

The Government of Afghanistan Fiscal year end of March 21st March no expenditures taken place in the month of April (time to clear the accounts). In addition, the statement that is provided covers till 21st March 2010 as overall.

External audit reports for HSS, ISS and CSO-b programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your HSS programme during your government's most recent fiscal year, this should also be attached **(Document N°)**. **Six month is not completed after the completion of the fiscal year. Audit will be completed by end Sep 2010 and reports will be shared.**

4.11 *General overview of targets achieved*

The indicators and objectives reported here should be exactly the same as the ones outlined in the original approved application and decision letter. There should be clear links to give an overview of the indicators used to measure outputs, outcomes and impact:

Table 15: Indicators listed in original application approved

Name of Objective or Indicator *(Insert as many rows as necessary)*	**Numerator**	**Denominator**	**Data Source**	**Baseline Value and date**	**Baseline Source**	**2009 Target**
1: Outcome:						
1.1 To increase National DTP3 coverage for the children under age one (% of children under age one received DPT3 vaccine)	Total number children received DPT3 vaccine	Total number of surviving new born	JRF	85% 2008[11]	JRF	90% 2012[12]
1.2 To increase the number/ percent of districts achieving >80% DPT3 coverage under age one (% of districts achieving DPT3 coverage >80%)	Number of districts achieved > 80% coverage	Total number of districts	JRF	58% (191 out of 329) 2008	JRF	100%/2012
1.3 To reduce under five mortality rate from 210/1000 live births in 2006 to 168/1000 live births by 2012.	Number of children under age 5 died	Total number of children under age 5	NRVA (household survey)	161/1000 live births 2008	NRVA 2008	153 up to 2012
1.4 To increase National Measles coverage (% of children received at least one dose of Measles vaccine)	Total number children received Measles vaccine	Total number of surviving new born	JRF	75%	JRF	90%/2012

[11] The NRVA survey conducted in the year 2007 but the results released late 2008 shows a DTP3 coverage of 43%,and measles 56%. This report is not yet reviewed by M&E advisory board and other partners to review the technical aspects related to validity of data. (Annex 12)

[12] The HSS application targets are set until 2012. No annual targets are set. Most of the HSS indicators are measured through surveys that are difficult to measure annually.

1.5 To increase skill birth attendance (% of deliveries attended by skill birth attendants)	Total number of deliveries attended by skilled health workers	Total number of pregnant women	HHS /HMIS	19% 2006 HHS, 30% HMIS 2008, 24% NRVA survey 2008	HHS/HMIS	40%/2012
1.6 To increase treatment of diarrhoea and ARI at community level (% of children treated for ARI and diarrhoea at community level)	Number of children treated for ARI and diarrhoea at community level	Total number of surviving children	HMIS	30% 2008	HMIS	30% from baseline/2012
Output indicators:						
2.1 To increase contacts per person per year with the health care system (Number of contacts per persons/year)	# of OPD visits	Total estimated population	HMIS	1.06/2008	HMIS	1/2012 achieved
2.2 To increase average number of persons referred by CHWs per quarter (Avg # of persons referred by CHWs/ quarter)	HMIS reported "Referrals In"/ quarter	Total # of CHWs working in that quarter	HMIS	24/quarter/2008	HMIS	20/quarter 2012 Achieved
2.3 Provider knowledge score	#of providers interviewed showing satisfactory score	Total # of providers interviewed during BSC survey	Balanced Scorecard	82.7%/2008	Balanced Scorecard	90% / 2012
2.4 To increase the % of mothers in rural communities knowledgeable about prioritized heath messages (% of mothers in rural communities knowledgeable about prioritized heath messages)	# of mothers responding correctly to questions during survey	Total # of mothers interviewed	HH surveys	TBD	HH surveys	40% from baseline/2012
2.5 To increase % of CHWs trained in community IMCI from 2% in 2006 to 80% in 2012 (% of CHWs trained in community IMCI)	# of CHWs trained	Total # of targeted CHWs	Trainings report/HMIS	28% 2008	Trainings report/HMIS	80%/2012
2.6 To increase the % of provinces receiving monitoring visits using national monitoring checklist per quarter from 25% in 2006	#of provinces visited by M&E team in a	Total # of provinces accessible during that	M&E department monitoring reports	33% 2008	M&E department monitoring	100%/2012

to 100% in 2012.	quarter	quarter			reports	

In the space below, please provide justification and reasons for those indicators that in this APR are different from the original approved application:

Provide justification for any changes in the **definition of the indicators:**

Provide justification for any changes in **the denominator:**

Provide justification for any changes in **data source: Indicator 1.5 and 1.6: the intention was to report based on surveys. Since no Household Surveys been conducted recently to provide information about these two indicators, only the, HMIS figures are being reported. Once Household survey figures are available, will be reported. For measuring indicator 2.4, we struggle to find the data and this year a Maternal Mortality Survey will be conducted and hopefully will capture information from Household Sources for all the three indicators.**

Table 16: Trend of values achieved

Name of Indicator *(insert indicators as listed in above table, with one row dedicated to each indicator)*	**2007**	**2008**	**2009**	**Explanation of any reasons for non achievement of targets**
1 To increase National DTP3 coverage for the children under age one (% of children under age one received DPT3 vaccine)	77%	85%	83%	In security , renewal of the contracts with the NGOs in USAID and WB funded provinces (24 out of 34 provinces), lack of robust supervision and monitoring, presidential elections. Renewal of the contracts affects because of the handing over process between the NGOs and short-term extensions of the contracts until the procurement is completed. In security was the most huge challenge: several provinces which were secure, became insecure in 2009 year. Ghazni security deteriorated. Baghlan, Kunduz, Faryab are the examples of highly populated provinces which were secure but became insecure in the year 2009. If security problems continue, will affect certainly further the health services delivery.
.2 To increase the number/percent of districts achieving >80% DPT3 coverage under age one (% of districts achieving DPT3 coverage >80%)	49%	58%	56%	The same above reasons
3 To reduce under five mortality rate from 210/1000 live births in 2006 to 168/1000 live births by 2012.	191/1000 live births	191/1000 live births	161/1000 live births	It has been great achievement because in the year 2005 this figure was 257/1000 live births.
4 To increase National Measles coverage (% of children received at least one dose of Measles vaccine)	68%	75%	76%	
5 To increase skill birth attendance (% of deliveries attended by skill birth attendants)	19%	30%	32%	
6 To increase treatment of diarrhoea and ARI at community level (% of children treated for ARI and diarrhoea at	30%	30%	32%	2010 household survey is planned and hopefully will provide updated information. For this indicator in addition

community level)				to HMIS, Household level figures are also required.
7 To increase contacts per person per year with the health care system (Number of contacts per persons/year)	0.6	1.06	1.16	
8 To increase average number of persons referred by CHWs per quarter (Avg # of persons referred by CHWs/ quarter)	14.8	24	20	More CHWs are trained, the changes is significant. The more new trained CHWs has changed the denominator
9 Provider knowledge score	67.8	82.7	TBD	Survey is in implementation. The report will be available by end Sep 2010
10 To increase the % of mothers in rural communities knowledgeable about prioritized heath messages (% of mothers in rural communities knowledgeable about prioritized heath messages)	TBD	TBD	TBD	No information. A Maternal Mortality survey planned for the year 2010 which will capture related information. Agency selected
11 To increase % of CHWs trained in community IMCI from 2% in 2006 to 80% in 2012 (% of CHWs trained in community IMCI)	2%	28%	20.3	The number of CHWs is increasing nationwide. Initially it was planned to train 80% of around 16000 CHWs and now the denominator has become bigger (currently there are 21227 CHWs). However, probably around 15,000 of them will be trained in C-IMCI which would be slightly ahead of the target reflected in the original HSS proposal.
12 To increase the % of provinces receiving monitoring visits using national monitoring checklist per quarter from 25% in 2006 to 100% in 2012.	29%	33%	47.1%	

Explain any weaknesses in links between indicators for inputs, outputs and outcomes:

The outcome and out-put indicators reflected above are linked to each other e.x. improved out-puts (indictor 7-12), improves the outcomes stated above (indicators 1-6). Only the indicator number 10, which looks to be an outcome indicator, has been reflected as an out-put indicator. However, this is linked with the activity of Strengthening IEC and some other activities including programs at community level.

4.12 *Other sources of funding in pooled mechanism for HSS*

If other donors are contributing to the achievement of objectives outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 17: Sources of HSS funds in a pooled mechanism

Donor	Amount in US$	Duration of support	Contributing to which objective of GAVI HSS proposal
Donor	**Amount in US$ 2008**	**Duration of support**	**Contributing to which objective of GAVI HSS proposal**
World Bank	12.1 M	2013	1.1, 1.2, 1.3 , 1.5, 1.6-2.1, 2.2 , 2.3 , 2.4
USAID	25.823	2014	1.1, 1.2, 1.3 , 1.5, 1.6-2.1, 2.2 , 2.3 , 2.4
EU	over 20 M Euro	2011	1.1, 1.2, 1.3 , 1.5, 1.6-2.1, 2.2 , 2.3 , 2.4
GF	No in 2008, it will start in 2010	5 year	For areas not supported by GAVI

5. Strengthened Involvement of Civil Society Organisations (CSOs)

5.1 *TYPE A: Support to strengthen coordination and representation of CSOs*

This section is to be completed by countries that have received GAVI TYPE A CSO support[13]

Please fill text directly into the boxes below, which can be expanded to accommodate the text.

Please list any abbreviations and acronyms that are used in this report below:

ACBAR	Agency Coordination Body for Afghan Relief
ANCB	Afghanistan NGO Coordinating Bureau
ANDS	Afghan National Development Strategy
APR	Annual Progress Report
AWN	Afghan Women Network
BPHS	Basic Package of Health Services
CGHN	Consultative Group on Health and Nutrition
CHW	Community Heath Worker
cMYP	comprehensive Multi-Year Plan
CSO	Civil Society Organization
DH	District Hospital
EC	European Commission
EMRO	Eastern Mediterranean Regional Office (of the World Health Organization)
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
GAVI	The GAVI Alliance (formally known as the Global Alliance for Vaccines and Immunizations)
GCMU	Grants and Contracts Management Unit
HSS	Heath System Strengthening
ICC	Interagency Immunization Coordination Committee
IEC	Information Education and Communication
IMC	International Medical Corps
JHU	Johns Hopkins University
MICS	Multi-Indicator Cluster Survey (UNICEF and Afghan Central Statistics Office)
MoF	Ministry of Finance
MoPH	Ministry of Public Health
MRDR	Ministry of Rural Development and Rehabilitation
NGO	Non-Governmental Organization
NNGO	National Non-Governmental Organization
NTCC	National Technical Coordination Committee
PHCC	Provincial Health Coordination Committee
PHD	Provincial Health Directorate at MoPH

[13] Type A GAVI Alliance CSO support is available to all GAVI eligible countries.

TAG	Technical Advisory Group
UNICEF	United Nations Children's Fund
USAID	United Sates Assistance for International Development
WHO	World Health Organization

5.1.1 Mapping exercise

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation. Please describe the mapping exercise, the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed (Annexes 10 and 11).

As a global need, the Global Alliance for vaccine and immunization released a grant to all member countries to map the Civil Society Organizations (CSO) in order to further improve health services delivery and save the lives of mothers and children. Civil Society organizations may be non-governmental organizations, community-based groups / or partnerships, professional associations, academic and technical institutions. A questionnaire was developed and the data was collected through PHCC meetings at the provincial level and direct interview was applied at the central level. The aim of this project was to map and make an inventory of CSOs that are involved in health system strengthening in order to further improve coordination among CSOs and other health sector partners in the country.

The mapping mainly focused on the following three domains:

i. CSO profile.
ii. CSO program contents
iii. CSO conducted any research or survey

The specific objectives of the mapping include the following:

- To map civil society organizations in the country and develop a database of the CSOs to MoPH and its partners using questionnaires including recommendations for maintaining the system.
- To analyze and record the CSOs level of experience and degree of involvements in maternal and child health and immunization.
- To nominate CSOs representatives in the high level health sector coordination committees including but not limited to ICC through active participation of CSOs.

According to the findings of this study, big number of CSOs is registered with government of Afghanistan. There are two ministries responsible for the CSOs registration. One is Ministry of Economy responsible for the NGOs registration and there are 1700 of them registered out of those 1399 national and 301 international NGOs. The second one is Ministry of Justice responsible for the Technical Institutions, Professional Associations and Political Organizations. There are 1710 CSOs registered, that most of them are political organizations. However, many of them are not functional due to unavailability of funds. All the registered CSOs working in health sector have to sign an MoU with MoPH. So, 188 CSOs signed MoU with the MoPH but not all of them are functional.

In addition to NGOs, it is recognized that academic institutions, professional association, technical institutions and other civil society organizations at central and provincial levels play important roles in the health sector with contribution to the implementation of strategic interventions to achieve the public health goals such as improved immunization coverage. So, at the time of mapping there were 57 NGOs active out of which 33 were national and 24 were international. Likewise, there were 45 health related professional associations and 16 health and non-health related Technical Institutions.

In order to have a comprehensive information regarding CSOs, in addition to mapping exercise a qualitative research on current status and role of CSOs in health sector of Afghanistan was conducted. The report is attached.
This project was started on 15 March 2009 and it will be ended on 15 March of 2010.

Please describe any hurdles or difficulties encountered with the proposed methodology for identifying the most appropriate in-country CSOs involved or contributing to immunisation, child health and/or health systems strengthening. Please describe how these problems were overcome, and include any other information relating to this exercise that you think it would be useful for the GAVI Alliance secretariat or Independent Review Committee to know about.

In some provinces the security was not good so we invite the representatives of each provincial health directorate to Kabul and trained them regarding target group of the study and data collection process of the questionnaire. Then the data collection was started at the provincial level. The data collection was successfully completed.

5.1.2 Nomination process

Please describe progress with processes for nominating CSO representatives to the HSCC (or equivalent) and ICC, and any selection criteria that have been developed. Please indicate the initial number of CSOs represented in the HSCC (or equivalent) and ICC, the current number and the final target. Please state how often CSO representatives attend meetings (% meetings attended).

It has been noted that the CSO members were selected for CGHN and ICC about 7 years ago and reflect their involvement at that time while the evolving health sector reconstruction and implementation of BPHS by contracted out NGOs meant that dramatic changes have taken place since then.

In addition to NGOs, it is recognized that academic institutions, professional association, technical institutions and other civil society organizations at central and provincial levels play important roles in the health sector and have a contribution to the implementation of the strategic interventions to achieve the public health goals such as improved

immunization coverage.

After the successful data collection of the provinces, the MoPH Policy and Planning General Directorate invited all CSOs representatives in a two days Civil Society Organization Mapping workshop to nominate the CSOs representative in the high level health sector coordination committees in Kabul. The workshop was scheduled on January 17 and 18, 2010. (see annex 1)

Selection of CSOs representatives to key health sector coordination forums was an important part of this workshop. So, the list of CSOs including type of organization area of expertise was developed by CSOs representatives. And election was conducted after one week on 25 January 2010.

Following the reviewing of each coordination mechanism ToR and established forums in the MoPH, the following mechanisms were proposed to the CSOs representatives to select one of the following mechanism or any other criteria if they agreed upon during the workshop.

I. Using list of existing CSOs: The list of all CSOs distributed to participant Where each individual (representing one organization) to mark his favorite CSO for nomination ranking 1 to 10.
II. Proposing candidates by MOPH and voting by CSOs
III. Proposing candidates by CSOs and voting by CSOs
IV. Any other mechanisms agreed by CSOs

Following the presenting the above four mechanisms it was agreed that for each forum volunteer CSOs will candidate themselves for voting.

The following result was the outcomes:

- Inter Ministerial Coordination (IMC), five CSOs were nominated (BRAC, AADA, ACTD, CAF and NAC) and NAC was selected.
- CGHN, 19 CSOs were nominated (AMI, HSSP, SC-US, CAF, BRAC, ACTD, URC, AKU, IbnSina, IMC, SAF, MERLIN, SDO, AADA, LEPCO, MRCA, HADAF, MOVE and CHA) three of them were selected for CGHN coordination forum SC-US, CAF and AADA.
- HSS-SC, the three member of CGHN that have selected CAF.
- ICC, 12 CSO were nominated (STEEP, AADA, LEPCO, MERLIN, SAF, IMC, SC-US, BDN, BRAC, AHDS, ACTD, SHDP) and STEEP, SAF and BRAC were selected for ICC.

Please provide Terms of Reference for the CSOs (if developed), or describe their expected roles below. State if there are guidelines/policies governing this. Outline the election process and how the CSO community will be/have been involved in the process, and any problems that have arisen.

In all health forums the CSOs representatives were selected through a transparent voting system by CSOs and these CSOs representatives will be responsible for liaising between government and CSOs through National Technical Coordination Committees (NTCC). Similarly, the CSOs representatives for each forum are responsible for sending the agenda of each meeting to all CSOs and take their inputs. And also they are responsible for sharing the minutes to all CSOs. CSOs are trying to set a sustainable coordination forum among them which will require support from any source.

Please state whether participation by CSOs in national level coordination mechanisms (HSCC or equivalent and ICC) has resulted in a change in the way that CSOs interact with the Ministry of Health. Is there now a specific team in the Ministry of Health responsible for linking with CSOs? Please also indicate whether there has been any impact on how CSOs interact with each other.

MoPH has performed well in the coordination of health related issues with all stakeholders. Establishment of BPHS coordination meetings, donor coordination meetings, CGHN, ICC and NTCC as well as PHCC at the provincial level are good examples. CSOs are member of these coordination mechanisms. They participate regularly; their ideas and inputs are dealt with positively because of their valuable field experience which provides practical inputs into the discussions.

There is no any specific team in the Ministry of Public Health for linking with CSOs.

There are three coordination bodies in Afghanistan such as ACBAR, ANCB and AWN most of the CSOs are the member of these coordination bodies and they have regular meetings.

5.1.3 Receipt and expenditure of CSO Type A funds

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type A funds for the 2009 year.

Funds received during 2009: US$ 100,000.....
Remaining funds (carried over) from 2008: US$.0.....
Balance to be carried over to 2010: US$..32,000.....

5.2 *TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP*

This section is to be completed by countries that have received GAVI TYPE B CSO support[14]

Please fill in text directly into the boxes below, which can be expanded to accommodate the text.

Please list any abbreviations and acronyms that are used in this report below:

BCC	Behaviour Change Communication
BDN	Bakhtar Development Network (NGO)
BPHS	Basic Package of Health Services
BRAC	Building Resources Across the Community
CGHN	Consultative Group on Health and Nutrition (HSCC equivalent)
CH	Child Health
CHA	Coordination of Humanitarian Assistance (NGO)
CME	Community Midwifery Education
CMW	Community Midwife
cMYP	Comprehensive Multi-Year Plan for National EPI
CSO	Civil Society Organisation
CSO	Civil Society Organization
EPI	Expanded Program on Immunization
FMA	Financial Management Agency
GAVI	The Global Allaince for Vaccing and Immunization
GDPP	General Director of Policy and Planning
HMIS	Health Management Information Systems
HN TPO	Health Net International Transcultural and Psychosocial Organization
CHA	Coordination of Humanitarian Assistance (NGO)
HNI-TPO	Health Net-International Transcultural and Psychosocial Organization
HSCC	Health Sector Coordination Committee
HSS-CU	Health System Strengthening Coordination Unit
IBNSINA	IBNSINA Public Health Programme for Afghanistan (NGO)
IEC	Information, Education, Communication
INGO	International Non-Governmental Organization
LOA	Letter of Agreement
MOPH	Ministry of Public Health
NAC	Norwegian Afghanistan Committee (INGO
NGO	Non-Governmental Organization
NMEAB	National Midwifery Education and Accreditation Board
PHP	Private Health Practitioner
PPP	Private Public Partnership
RH	Reproductive Health
SC	Steering Committee
TOR	Terms of Reference
WHO	World Health Organization

[14] Type B GAVI Alliance CSO Support is available to 10 pilot GAVI eligible countries only: Afghanistan, Burundi, Bolivia, DR Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan.

5.2.1 Programme implementation

Briefly describe progress with the implementation of the planned activities. Please specify how they have supported the implementation of the GAVI HSS proposal or cMYP (refer to your proposal). State the key successes that have been achieved in this period of GAVI Alliance support to CSOs.

The project contracts with CSOs are singed on August 13, 2009. The first and second quarter instalments have been transferred to CSO accounts after signing of the contracts. The implementation of the project started on the same date as following:

- *Four community midwifery schools established in fours insecure provinces of Kunar, Ghazni, Zabul and Nimroz.*
    - *23 students selected according to national criterion and policies in Kunar Province. The implementation is contracted out to, an international CSO, Norwegian Afghanistan Committee (NAC). The training started on 1st September 2009.*
    - *25 Students selected according to national criterion and policies in Ghazni Province. The implementation is contracted out to, a national CSO, Bakhtar Development Network (BDN). The training started in October 2009.*
    - *21 Students selected according to national criterion and policies in Zabul Province. The implementation is contracted out to, a national CSO, IBNSINA Public Health Programme for Afghanistan (IBNSINA). The training started in October 2009.*
    - *21 Students selected according to national criterion and policies in Nimroz Province. The implementation is contracted out to, an international CSO, BRAC. The training started in October 2009.*

  It is worth mentionable that two students have been selected from each district in each province. The students will return back to their districts after completion of the training and deployed in the HFs of relevant district as community midwives (CME). Due unavailability of candidates, students are not selected from one district in Kunar and one in Ghazni provinces. Instead, students from neighbouring districts are selected and will be deployed in districts without candidates after completion of the training.
- *Two pilot models of partnerships with private health service providers commenced in two insecure and underserved provinces of Uruzgan and Farah Provinces on 13th August 2009. The private health service providers are providing immunisation and basic reproductive and child health services in return for incentives. The private health service providers are trained for providing immunisation and basic reproductive and child health services.*
    - *Contracts signed with 30 private health service providers in four districts of Uruzgan province. The project is contracted out to an international CSO, Health Net TPO (HN-TPO).*
    - *Contracts signed with 25 private health services providers in three districts (Gulistan, Purchaman and Bakwa) of Farah province. The project is contracted out to a national CSO, Coordination of Humanitarian Assistance (CHA).*
- *An office has been established within MOPH for grant and contracts management and monitoring and evaluation of the project. A Technical Officer is recruited for carrying out mentioned activities. Meanwhile, a Finance Officer is recruited within WHO for managing*

financial issues of the project.

All of the above activties will contribute significantly to achieve health sector goals and target stated in the HSS proposal. Lack of female staff especially in remote areas of the country has remained a challenge especially on attracting female to attend the HFs who are primary care givers of children. Insecurity is another huge challenge especially in south and southwest parts of the country. In those parts, neither the NGOs nor the MOPH is able to provide services but the private for profit practitioners are present in those areas. If the pilot to use the private sector to provide basic health services including immunization is proved to be successful, this will be as national level solution replicated to other insecure parts to improve the coverage of key services especially the immunization.

Please indicate any major problems (including delays in implementation), and how these have been overcome. Please also identify the lead organisation responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

The project started on August 13, 2009 later than what anticipated (May 2009). The main reason for late commencement of the project is delay in transfer of funds from GAVI to WHO HQ and subsequently to WHO/EMRO and WHO country office. Insecurity is another major problem which hampers the project activities. This problem is addressed through close cooperation with community. Community health councils are established per each Private Health Practitioner (PHP) outlet. Commitment of private practitioner for providing quality services is a challenge. Providing trainings, timely incentives, community health council and regular supportive supervision and monitoring will be among the strategies to motivate private practitioners to deliver quality immunisation and basic RH and CH services.

MOPH/GD PP is responsible for coordination, grant management, contract administration and monitoring and evaluation of the projects implemented by CSOs. The HSS Steering Committee revises and endorses all work plans, budgets, reports and amendments. It also provides technical support to the CSO type B project. Meanwhile, as PPP is a new intervention, a separate steering committee is planned to provide technical support and review progress of the two projects of PPP. The NMEAB, an independent body provides technical support to CME schools and carry out regular accreditation of the CME schools.

WHO serves as FMA for the CSO type B support. WHO releases funds to CSOs as quarterly instalments, review financial reports of CSOs and financial audit at the end of the project.

The CSO type B support project is directly implemented by six different CSOs and consortiums in some occasions. The CSOs submit quarterly technical and financial reports to MOPH and WHO.

Please state whether the GAVI Alliance Type B support to CSOs has resulted in a change in the way that CSOs interact with the Ministry of Health, and or / how CSOs interact with each other.

The CSOs submits regular technical and financial reports to MOPH/GD PP. Meanwhile, they participate in MOPH/PPP taskforce, NMEAB meetings and workshops. A PPP coordination committee is established to coordinate technical issues between the two CSOs implementing PPP projects. The CSOs also participate in PPHCC meetings at provincial level contributing to the planning and coordination at provincial levels.

Please outline whether the support has led to a change in the level and type of involvement by CSOs in immunisation and health systems strengthening (give the current number of CSOs involved, and the initial number).

The implementation of BPHS is contracted out to CSOs. Child health and immunisation is the second priority layer of the BPHS. The CSOs are already implementing BPHS in many provinces of Afghanistan.

CSO support type B project is implemented by six different CSOs and consortiums in some occasions. Under CSO type B support, four community midwifery schools are established where 90 students are under training. The students, after graduation, will be deployed in BPHS HFs as midwives. They will be involved in increasing demand for vaccination through IEC and BCC.

Under the two PPP projects, contracts are signed with 55 private health practitioners for providing immunisation and basic reproductive and child health services in return for incentives. They are provided trainings, vaccines, equipments and other necessary supplies

Please outline any impact of the delayed disbursement of funds may have had on implementation and the need for any other support.

The project started later. This caused some budgetary problems for CSOs due to annual inflations. But the CSOs agreed that they will adjust the differences caused by inflation within their current budget limitations.

Please give the names of the CSOs that have been supported so far with GAVI Alliance Type B CSO support and the type of organisation. Please state if were previously involved in immunisation and / or health systems strengthening activities, and their relationship with the Ministry of Health.

For each CSO, please indicate the major activities that have been undertaken, and the outcomes that have been achieved as a result. Please refer to the expected outcomes listed in the proposal.

Table 18: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2009	Outcomes achieved
Norwegian Afghanistan Committee, NAC (international)	Implemented BPHS in Ghazni province	23 students enrolled in CME training in Kunar Province	Training continues
Bakhtar Development Network, BDN	Implemented BPHS in Balkh, Daikundi and Baghlan provinces	25 students enrolled in CME training in Ghazni province	Training continues
IBNSINA Public Health Programme for Afghanistan, IBNSINA (National)	Implemented BPHS in Laghman, Zabul, Paktya and Helmand provinces	21 students enrolled in CME training in Zabul province	Training continues
BRAC Bangladesh (International)	Implemented BPHS in Balkh, Nimroz, Kabul and Badghis provinces	21 students enrolled in CME training in Nimroz province	Training continues
Health Net TPO (International)	Implemented BPHS in Nangarhar, Paktya and Khost provinces.	Contracts signed with 30 private health practitioners for providing immunisation and basic reproductive and child health care	Private practitioners continue delivering immunisation and basic RH and CH services

Coordination of Humanitarian Assistance, CHA (National)	Implemented BPHS in Farah and Herat provinces	Contracts signed with 25 private health practitioners for providing immunisation and basic reproductive and child health care	Private practitioners continue delivering immunisation and basic RH and CH services
Norwegian Afghanistan Committee, NAC (international)	Implemented BPHS in Ghazni province	23 students enrolled in CME training in Kunar Province	Training continues
Bakhtar Development Network, BDN	Implemented BPHS in Balkh, Daikundi and Baghlan provinces	25 students enrolled in CME training in Ghazni province	Training continues
IBNSINA Public Health Programme for Afghanistan, IBNSINA (National)	Implemented BPHS in Laghman, Zabul, Paktya and Helmand provinces	21 students enrolled in CME training in Zabul province	Training continues
BRAC Bangladesh (International)	Implemented BPHS in Balkh, Nimroz, Kabul and Badghis provinces	21 students enrolled in CME training in Nimroz province	Training continues
Norwegian Afghanistan Committee, NAC (international)	Implemented BPHS in Ghazni province	23 students enrolled in CME training in Kunar Province	Training continues

Please list the CSOs that have not yet been funded, but are due to receive support in 2010/2011, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

Please also indicate the new activities to be undertaken by those CSOs already supported.

Table 19: Planned activities and expected outcomes for 2010/2011

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2010 / 2011	Expected outcomes
Norwegian Afghanistan Committee, NAC (international)	Implemented BPHS in Ghazni province	• 23 students continues receiving training • The school is accredited by NMEAB	• 23 students completed their CME training • 23 CME deployed in BPHS HFs in their relevant districts

Bakhtar Development Network, BDN	Implemented BPHS in Balkh, Daikundi and Baghlan provinces	• 25 students continues receiving training • The school is accredited by NMEAB	• 25 students completed their CME training • 25 CME deployed in BPHS HFs in their relevant districts
IBNSINA Public Health Programme for Afghanistan, IBNSINA (National)	Implemented BPHS in Laghman, Zabul, Paktya and Helmand provinces	• 23 students continues receiving training • The school is accredited by NMEAB	• 21 students completed their CME training • 21 CME deployed in BPHS HFs in their relevant districts
BRAC Bangladesh (International)	Implemented BPHS in Balkh, Nimroz, Kabul and Badghis provinces	• 23 students continues receiving training • The school is accredited by NMEAB	• 21 students graduated • 21 CME deployed in BPHS HFs in their relevant districts
Health Net TPO (International)	Implemented BPHS in Nangarhar, Paktya and Khost provinces.	• 30 private practitioners continues providing immunisation and basic RH and CH services	• PENTA 3 coverage increased to >80% • A replicable model of partnership with private service providers to provide access to EPI and basic RH services to about 450,000 population living in insecure and under-served areas of Uruzgan Province.
Coordination of Humanitarian Assistance, CHA (National)	Implemented BPHS in Farah and Herat provinces	• 25 private practitioners continues providing immunisation and basic RH and CH services	• PENTA 3 coverage increased to >80% • A replicable model of partnership with private service providers to provide access to EPI and basic RH services to about 121,000 population living in three insecure and underserved districts of Farah: Bakwa, Gulistan and Purchaman.-
Norwegian Afghanistan Committee, NAC (international)	Implemented BPHS in Ghazni province	• 23 students continues receiving training • The school is accredited by NMEAB	• 23 students completed their CME training • 23 CME deployed in BPHS HFs in their relevant districts

Bakhtar Development Network, BDN	Implemented BPHS in Balkh, Daikundi and Baghlan provinces	• 25 students continues receiving training • The school is accredited by NMEAB	• 25 students completed their CME training • 25 CME deployed in BPHS HFs in their relevant districts
IBNSINA Public Health Programme for Afghanistan, IBNSINA (National)	Implemented BPHS in Laghman, Zabul, Paktya and Helmand provinces	• 23 students continues receiving training • The school is accredited by NMEAB	• 21 students completed their CME training • 21 CME deployed in BPHS HFs in their relevant districts
BRAC Bangladesh (International)	Implemented BPHS in Balkh, Nimroz, Kabul and Badghis provinces	• 23 students continues receiving training • The school is accredited by NMEAB	• 21 students graduated • 21 CME deployed in BPHS HFs in their relevant districts

5.2.2 Receipt and expenditure of CSO Type B funds

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type B funds for the 2009 year.

Funds received during 2009: US$ 1,018,169

Remaining funds (carried over) from 2008: US$ NA
Balance to be carried over to 2010: US$ NA

5.2.3 Management of GAVI CSO Type B funds

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year ? **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: further describe progress against requirements and conditions for the management of CSO Type B funds which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of CSO Type B funds.

Part B: briefly describe the financial management arrangements and process used for your CSO Type B funds. Indicate whether CSO Type B funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of CSO Type B funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the HSCC in this process.

World Health Organisation (WHO) serves as the FMA of the CSO Type B project. Funds are transferred from GAVI to WHO. WHO releases funds to CSOs as quarterly instalments, review financial reports of CSOs and financial audit at the end of the project. The CSOs submits financial reports on quarterly basis to WHO. A standard financial reporting format is developed for this purpose. Financial information is collected from the field by CSOs and sent to CSO country office. The CSO country office aggregates and compiles the information and prepares the quarterly report. The quarterly financial reports are reviewed by MOPH/WHO and approved. The quarterly instalments to CSOs are subject to successful submission of quarterly technical and financial reports.

The CSOs prepares detailed budget for running the projects and the budgets are approved by MOPH/WHO.

The CSO Type B funds are not included in the national health sector budget. The funds are channelled to CSOs through WHO.

As mentioned, there was delay in transfer of funds from donor to WHO HQ and subsequently to WHO Country office and to CSOs. As a result the project started later.

The FMA and CSOs are using commercial bank accounts.

5.2.4 Detailed expenditure of CSO Type B funds during the 2009 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2009 calendar year **(Annex Document N° 14).** *(Terms of reference for this financial statement are attached in Annex 4).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

External audit reports for CSO Type B, ISS, HSS programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your CSO Type B programme during your government's most recent fiscal year, this should also be attached **(Not yet audited. The funds are channelled through WHO. Certainly will be audited as per WHO schedule)**

5.2.5 Monitoring and Evaluation

Please give details of the indicators that are being used to monitor performance; outline progress in the last year (baseline value and current status), and the targets (with dates for achievement).

These indicators will be in the CSO application and reflect the cMYP and / or GAVI HSS proposal.

Table 20: Progress of CSOs project implementation

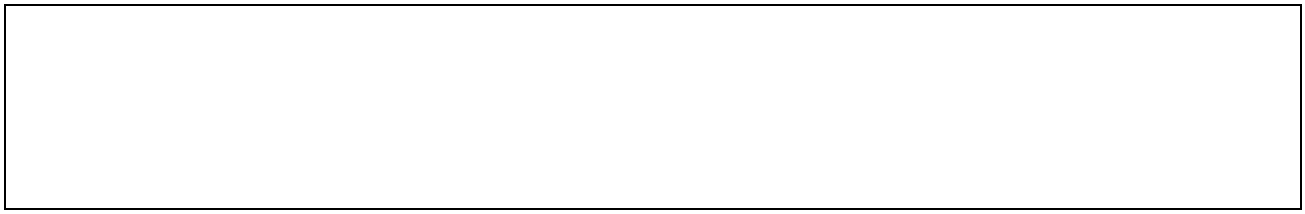
Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target
Four CME training programmes in Kunar, Ghazni, Zabul and Nimroz established	Percentage of BPHS health facilities with at least one female health worker in Kunar, Nimroz, Zabul and Ghazni	HMIS	56% End 2007			80%	June 2011
	No. of new CME programs in Kunar, Nimroz, Zabul and Ghazni accredited by the NMEAB	NMEAB accreditation report	NA	4	Dec 2009	4	First quarter of 2010
	No. of skilled CMWs graduated from the four CME programs in Kunar, Nimroz, Zabul and Ghazni	CSOs CME completion report	NA	NA	NA	90	June 2011
	No. of graduated CMWs deployed in the BPHS health facilities of Kunar, Nimroz, Zabul and Ghazni provinces	CSOs and BPHS joint report on deployment of newly trained CME graduates	NA	NA	NA	90	June 2011
Two pilot models of partnerships with private health service providers in Uruzgan and Farah provinces	PENTA 3 coverage in targeted districts of Uruzgan and Farah provinces	Monthly EPI coverage reports	70% farah 30% Uruzgan End 2007	80 % Farah 65 % in Uruzgan	January 2010	>80%	August 2011
	No. of private sector service providers from Farah and Uruzgan provinces	CSO activity report/monitoring visits report	0	55	Feb 2010	55	August 2011

	trained						
	No. of private sector service provision outlets of Farah and Uruzgan provinces upgraded	Baseline assessment report of the CSO/ monitoring visits report	0	0	0	10	August 2011
	No. of private sector service provision outlets of Farah and Uruzgan provinces delivering immunization and basic RH service	CSO activity report/monitoring visits report/end project assessment	0	55	Feb 2010	55	August 2011
Four CME training programmes in Kunar, Ghazni, Zabul and Nimroz established	Percentage of BPHS health facilities with at least one female health worker in Kunar, Nimroz, Zabul and Ghazni	HMIS	56% End 2007			80%	June 2011

Finally, please give details of the mechanisms that are being used to monitor these indicators, including the role of beneficiaries in monitoring the progress of activities, and how often this occurs. Indicate any problems experienced in measuring the indicators, and any changes proposed.

The above indicators are measured by obtaining data from national HMIS system and quarterly reports of CSOs. The indicators are reviewed both at provincial level and central level. At provincial level, the implementing NGO, provincial MOPH and representative of private sector union are reviewing the indicators and giving feedback to individual private health facility. At central level, the steering committee for public private partnership project is reviewing the indicators, measuring progress and giving feedback to provincial MOPH and implementing NGO.

Community or the beneficiaries are actively involved in implementation of the project activities. There is one community health council per PHP outlet established. The TOR of the health council is oversight and monitoring the activities of private practitioners and coordination with related stakeholders. The community health councils meet once per month. Meanwhile, associations of the private practitioners are established in Uruzgan and Farah provinces.



6. Checklist

Table 21: Checklist of a completed APR form

Fill the blank cells according to the areas of support reported in the APR. Within each blank cell, please type: Y=Submitted or N=Not submitted.

	MANDATORY REQUIREMENTS (if one is missing the APR is NOT FOR IRC REVIEW)	ISS	NVS	HSS	CSO
1	Signature of Minister of Health (or delegated authority) of APR				
2	Signature of Minister of Finance (or delegated authority) of APR				
3	Signatures of members of ICC/HSCC in APR Form				
4	Provision of Minutes of ICC/HSCC meeting endorsing APR				
5	Provision of complete excel sheet for each vaccine request				
6	Provision of Financial Statements of GAVI support in cash				
7	Consistency in targets for each vaccines (tables and excel)				
8	Justification of new targets if different from previous approval (section 1.1)				
9	Correct co-financing level per dose of vaccine				
10	Report on targets achieved (tables 15,16, 20)				
11	Provision of cMYP for re-applying				

	OTHER REQUIREMENTS	ISS	NVS	HSS	CSO
12	Anticipated balance in stock as at 1 January 2010 in Annex 1				
13	Consistency between targets, coverage data and survey data				
14	Latest external audit reports (Fiscal year 2009)				
15	Provide information on procedure for management of cash				
16	Health Sector Review Report				
17	Provision of new Banking details				
18	Attach VMA if the country introduced a New and Underused Vaccine before 2008 with GAVI support				
19	Attach the CSO Mapping report (Type A)				

7. Comments

Comments from ICC/HSCC Chairs:

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

~ End ~

GAVI ANNUAL PROGRESS REPORT ANNEX 2
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR IMMUNISATION SERVICES SUPPORT (ISS) AND NEW VACCINE INTRODUCTION GRANTS

I. All countries that have received ISS /new vaccine introduction grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 2 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2009 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local Currency (CFA)	Value in USD[7]
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[8] – GAVI ISS						
	Budget in CFA	Budget in USD	Actual in CFA	Actual in USD	Variance in CFA	Variance in USD
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditure						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2009	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

[7] An average rate of CFA 479.11 = USD 1 applied.
[8] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own system for economic classification.

GAVI ANNUAL PROGRESS REPORT ANNEX 3
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR HEALTH SYSTEMS STRENGTHENING (HSS)

I. All countries that have received HSS grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2009 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR HSS FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local Currency (CFA)	Value in USD[9]
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[10] – GAVI HSS						
	Budget in CFA	Budget in USD	Actual in CFA	Actual in USD	Variance in CFA	Variance in USD
HSS PROPOSAL OBJECTIVE 1: EXPAND ACCESS TO PRIORITY DISTRICTS						
ACTIVITY 1.1: TRAINING OF HEALTH WORKERS						
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
TOTAL FOR ACTIVITY 1.1	**24,000,000**	**50,093**	**18,800,000**	**39,239**	**5,200,000**	**10,854**

[9] An average rate of CFA 479.11 = USD 1 applied.
[10] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own HSS proposal objectives/activities and system for economic classification.

ACTIVITY 1.2: REHABILITATION OF HEALTH CENTRES						
Non-salary expenditure						
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditure						
Equipment	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Capital works	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR ACTIVITY 1.2	**18,000,000**	**37,570**	**11,792,132**	**24,613**	**6,207,868**	**12,957**
TOTALS FOR OBJECTIVE 1	**42,000,000**	**87,663**	**30,592,132**	**63,852**	**11,407,868**	**23,811**

GAVI ANNUAL PROGRESS REPORT ANNEX 4
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR CIVIL SOCIETY ORGANISATION (CSO) TYPE B

I. All countries that have received CSO 'Type B' grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2009 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR CSO 'Type B' FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO 'Type B'		
	Local Currency (CFA)	Value in USD[11]
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[12] – GAVI CSO 'Type B'						
	Budget in CFA	Budget in USD	Actual in CFA	Actual in USD	Variance in CFA	Variance in USD
CSO 1: CARITAS						
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
TOTAL FOR CSO 1: CARITAS	**24,000,000**	**50,093**	**18,800,000**	**39,239**	**5,200,000**	**10,854**
CSO 2: SAVE THE CHILDREN						
Salary expenditure						
Per-diem payments	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131

[11] An average rate of CFA 479.11 = USD 1 applied.

[12] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own CSO 'Type B' proposal and system for economic classification.

Non-salary expenditure						
Training	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Other expenditure						
Capital works	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR CSO 2: SAVE THE CHILDREN	**18,000,000**	**37,570**	**11,792,132**	**24,613**	**6,207,868**	**12,957**
TOTALS FOR ALL CSOs	**42,000,000**	**87,663**	**30,592,132**	**63,852**	**11,407,868**	**23,811**