GAVI Alliance

Annual Progress Report 2013

Submitted by

The Government of

Afghanistan

Reporting on year: **2013**
Requesting for support year: **2015**
Date of submission: **15/05/2014**

Deadline for submission: 02/06/2014

Please submit the APR 2013 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

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 the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) 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 APR, 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 languages of the arbitration will be English or French.

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.

1. Application Specification

Reporting on year: **2013**

Requesting for support year: **2015**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015
Routine New Vaccines Support	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	2015

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2013	Request for Approval of	Eligible For 2013 ISS reward
ISS	Yes	next tranche: N/A	N/A
HSS	Yes	next tranche of HSS Grant N/A	N/A
CSO Type A	Yes	Not applicable	N/A
CSO Type B	Yes	CSO Type B extension per GAVI Board Decision in July 2013: N/A	N/A
HSFP	Yes	Next tranch of HSFP Grant No	N/A
VIG	Yes	Not applicable	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2012 is available here.

2. Signatures

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

By signing this page, the Government of Afghanistan hereby attests 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 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 (IRC) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Dr. Suraya Dalil	**Name**	Dr. Hazrat Omar Zakhelwal
Date		**Date**	
Signature		**Signature**	

<u>This report has been compiled by</u> (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr. Aga Gul Dost	National EPI Manager	0093 799814812	dr_adost@hotmail.com
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Dr. Noorshah Kamawal	HSS Coordinator and Focal Point	0093 778829773	kamawal.noorsha@gmail.com
Dr. Najla Ahrari	HSS Deputy Coordinator	0093 799302996	najlaahrari@gmail.com
Dr. Fazil Ahmad	EPI specialist	0093 798507605	faahmad@unicef.org

2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) 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.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating 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.

Name/Title	Agency/Organization	Signature	Date

Dr. Fazil Ahmad, EPI Specialist	UNICEF		
Dr. Sherin, Chief H&N	UNICEF		
Dr. Arshad Quddus, MoH/PEI	WHO		
Dr. Shakoor, NPO/EPI	WHO		
Representative	JICA		
Representative	MoF		
Representative	EC		
Representative	WB		
Dr. Simpson Diane, CDC health coordinator	CDC Athlanta		
Dr. Roshani, Health Coordinator	USAID		
Dr. Najla Ahrari, HSS Deputy Coordinator	MOPH		
Dr. Noor Shah Kamawal, HSS coordinator	MOPH		
Dr. Dost, NIP Manager	MOPH		

Dr. Mashal, DG of Preventive Medicine	MOPH		
Dr. A. Qadir, DG of Policy & Planning	MOPH		
Dr. Najia Tareq, Deputy Minister Health Service Provision	MOPH		
Dr. Kabir, Health Coordinator, AHDS	NGO		
Dr. Lal Mohammad, BRACK EPI coordinator	NGO		
Dr. Lal Mohmad	BRAK		

ICC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

• National EPI Department should develop annual plan of actions including resources/technical support from all partners<?xml:namespace prefix = "o" />

• NEPI should separately report to ICC the budget planned for 2014 from MOPH, GAVI, WHO, UNICEF and other partners

• DG of Preventive Medicine/NIP should closely work with HSS Unit in planning, implementation, monitoring and evaluation of activities under HDFP proposal

• NIP to update/develop national EPI strategic plan (cMYP 2016-2020) in line with National Health Policy/Strategies 2016-2020

• NEPI/GCMU to further strengthen coordination and collaboration between NIP and NGOs

• NEPI Manager is responsible to strictly follow up transferring pending and 2014 co-finance amount to UNICEF

• National EPI should implement the RI coverage improvement plan 2014-2015 with the support from all partners

• Steps should be taken to use PEI infrastructure for strengthening RI services

• GCMU/HSS/NIP should implement the RI expansion plan through PPT, HFs without RI services and establishment of community based EPI Fixed Centers

• NEPI should continue working with partners to implement the followings before introduction of IPV:

- Conduct EVMA
- Conduct nationwide cold chain/logistic assessment
- Increase CC capacity if there is need

• NEPI manager should work with relevant departments of MOPH to mobilize government funds for RI programs.

• GCMU/NEPI should strengthen joint monitoring and supervision and quarterly report to ICC

ICC is going to closely monitor the NIP planned activities

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), 11/05/2014 , 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/Organization	Signature	Date
Dr. Shakoor Waciqi / NPO	WHO		
Dr. Yasin Rahimyar/ CSO representative	CAF		
Dr. Tawfiq Mashal / General Director of Preventive Medicine	MoPH		
Dr. Fawad Farewar / Advisor to Deputy Minister	MoPH		
Dr. Emal Latif/ Advisor to Minister	MoPH		
Dr. Fawad Farewar / Advisor to Deputy Minister	MoPH		
Dr. Salehi/ Director of HEFD	MoPH		
Dr. Dost / National EPI	MoPH		
Dr. A. Qadeer Qadeer / General Director of Policy and Planning	MoPH		

Dr. Roshani/ Health Specialist	USAID		
Dr. Fazil Ahmad, EPI Specialist	UNICEF		
Dr. Noorshah Kamawal / HSS focal point	MoPH		
Dr. Najla Ahrari / Deputy HSS coordinator	MoPH		
Dr. Malala Ahamd Zai/ HSS TA	MoPH		

HSCC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

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).

2.4.1. CSO report editors

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

Name/Title	Agency/Organization	Signature	Date
Dr. Haseebulah Neiayesh / CSO type B coordinator	WHO		
Dr. Homayoon Helaal / health coordinator	Health Net - TPO		

2.4.2. CSO report endorsement

We, the undersigned members of the National Health Sector Coordinating Committee (or equivallent

committees)- , endorse this report on the GAVI Alliance CSO Support.

Name/Title	Agency/Organization	Signature	Date
Dr. Sefatullah Habib/ program Manager	EU		
Dr. Shakoor Waciqi / NPO	WHO		
Dr. Yasin Rahimyar/ CSO representative	CAF		
Dr. Tawfiq Mashal / General Director of Preventive Medicine	MoPH		
Dr. Fawad Farewar / Advisor to Deputy Minister	MoPH		
Dr. Emal Latif/ Advisor to Minister	MoPH		
Dr. Salehi/ Director of HEFD	MoPH		
Dr. Dost / National EPI	MoPH		
Dr. A. Qadeer Qadeer / General Director of Policy and Planning	MoPH		
Dr. Fazil Ahmad, EPI Specialist	UNICEF		
Dr. Roshani/ Health Specialist	USAID		
Dr. Noorshah Kamawal / HSS focal point	MoPH		

Dr. Najla Ahrari / Deputy HSS coordinator	MoPH		
Dr. Malala Ahamd Zai/ HSS TA	MoPH		

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

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4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Number	Achievements as per JRF		Targets (preferred presentation)			
	2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2013	Current estimation
Total births	1,480,661	1,477,244	1,516,196	1,516,196	1,552,585	1,552,585
Total infants' deaths	191,006	191,006	195,589	195,589	200,283	200,283
Total surviving infants	1289655	1,286,238	1,320,607	1,320,607	1,352,302	1,352,302
Total pregnant women	1,480,661	1,480,661	1,516,196	1,516,196	1,552,585	1,552,585
Number of infants vaccinated (to be vaccinated) with BCG	1,317,788	1,487,437	1,364,576	1,364,576	1,397,326	1,397,326
BCG coverage	89 %	101 %	90 %	90 %	90 %	90 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,147,792	1,302,508	1,188,546	1,188,546	1,217,072	1,217,072
OPV3 coverage	89 %	101 %	90 %	90 %	90 %	90 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,263,861	1,447,307	1,294,194	1,294,194	1,325,255	1,325,255
Number of infants vaccinated (to be vaccinated) with DTP3	1,147,792	1,302,508	1,188,546	1,188,546	1,217,072	1,217,072
DTP3 coverage	89 %	101 %	90 %	90 %	90 %	90 %
Wastage*[1]* rate in base-year and planned thereafter (%) for DTP	0	40	0	40	0	40
Wastage*[1]* factor in base-year and planned thereafter for DTP	1.00	1.67	1.00	1.67	1.00	1.67
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	1,263,861	1,447,307	1,294,194	1,294,194	1,325,255	1,325,255
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	1,263,861	1,302,508	1,294,194	1,188,546	1,217,072	1,217,072
DTP-HepB-Hib coverage	98 %	101 %	98 %	90 %	90 %	90 %
Wastage*[1]* rate in base-year and planned thereafter (%) *[2]*	25	25	25	25	25	25
Wastage*[1]* factor in base-year and planned thereafter (%)	1.33	1.33	1.33	1.33	1.33	1.33
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1 dose of Pneumococcal (PCV13)	1,263,861	0	1,294,194	1,294,194		1,325,255

Number of infants vaccinated (to be vaccinated) with 3 dose of Pneumococcal (PCV13)	1,263,861	0	1,294,194	1,188,546		1,217,072
Pneumococcal (PCV13) coverage	98 %	0 %	98 %	90 %		90 %
Wastage*[1]* rate in base-year and planned thereafter (%)	5	5	5	5		5
Wastage*[1]* factor in base-year and planned thereafter (%)	1.05	1.05	1.05	1.05		1.05
Maximum wastage rate value for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	5 %	5 %	5 %	5 %	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,096,206	1,183,570	1,162,134	1,211,976	1,217,071	1,241,063
Measles coverage	85 %	92 %	88 %	92 %	90 %	92 %
Pregnant women vaccinated with TT+	1,184,528	936,139	1,288,766	1,288,766	1,397,326	1,397,326
TT+ coverage	80 %	63 %	85 %	85 %	90 %	90 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0
Vit A supplement to infants after 6 months	0	0	0	0	0	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	9 %	10 %	8 %	8 %	8 %	8 %

** Number of infants vaccinated out of total surviving infants

*** Indicate total number of children vaccinated with either DTP alone or combined

**** Number of pregnant women vaccinated with TT+ out of total pregnant women

1 The formula to calculate a vaccine wastage rate (in percentage): [(A B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

2 GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2013 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2013.** The numbers for 2014 - 2015 in Table 4 Baseline and Annual Targets 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 fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  As there was no any population census or official recommendation about changes in population figures, therefore no change made in births.

- Justification for any changes in **surviving infants**

  According to Maternal Mortality Survey the infant mortality rate in 2010 is 71/1000LB and it is officially valid, so no change made in surviving infants.

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

  Since the official announcement of coverage evaluation survey is pending, therefore no change made in targets by vaccines.

- Justification for any changes in **wastage by vaccine**

  Wastage for vaccines/injection supplies have been calculated based on GAVI maximum acceptable

5.2. Immunisation achievements in 2013

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2013 and how these were addressed:

Below are the major RI achievements:

A) EPI Planning & Management

- The 2013 administrative coverage for all antigens are: BCG – 101%; Penta1/OPV1-112%; Penta3/OPV3-101%; PCV13 data is not available as it was introduced in December 2013; MCV1-92%, MCV2-57%;TT2+ - 63%. The dropout rate for Pent1-Penta3 is 10%.
- Introduction of Pneumococcal conjugate vaccine in December 2013 & Hepatitis Birth Dose in January 2014
- EPI desk review and development of coverage improvement plan
- EPI coverage evaluation survey
- Improving RI data quality (WHO-CDC Project, funded and implementation started)
- Submission of proposal for nationwide measles SIAs targeting <5 children (developed, submitted and approved by GAVI)
- As part of Global Vaccine Action Plan (GVAP) the country is striving to achieve GVAP goals: the number of confirmed polio cases has reduced to 14 in 2013 compared to 37 and 80 cases in 2012 and 2011 respectively. Most part of the country is polio free and the disease has localized mainly in eastern and southern regions. The reported RI coverage is higher than GVAP goal, but there is a big difference between the reported coverage and the result of coverage evaluation survey. As part of disease elimination/eradication, the measles and TT mop-up campaign conducted in 64 high risk districts in 2013. The country has introduced PCV13 in December 2013 and Hepatitis Birth Dose in January 2014 into RI schedule.
- The health HFs/District micro-plans exercised in 264 districts.
- Revision of National Immunization Strategy
- The NEPI could manage to conduct regular EPI Task force meetings involving all partners.
- 2 NITAG meetings held in 2013 and has recommended to MOPH to introduce IPV into national immunization schedule

and apply for Rotavirus vaccine.

- The National Measles Validation Committee Meeting in its Dec (2013) consultative meeting reviewed routine measles coverage and surveillance data and the status of implementation of recommendations of previous meeting and has advised all concerned to closely follow up the recommendations and start preparation for 2015 nationwide measles SIAs.
- Close coordination with all concerned departments of MOPH and NGOs for improving RI system and coverage.
- Widespread public awareness during world vaccination week.
- The NIP communication strategy was developed and is pending for final recommendation by NITAG
- The annual national and quarterly EPI review workshop conducted during the 2013.
- Development of annual plan of action including coverage improvement plan
-

B) Service Delivery

- Keep on provision of RI services through 1541 EPI static centers with regular performing of outreach and mobile services
- The three rounds of pulse immunization activities implemented in 64 low performing districts with all antigens (children aged 9-59M vaccinated with measles vaccine)

	Measles	Peta1/OPV1	Pnta2/OPV2	Penta3/OPV3	TT2+	BCG*
	9-59M	<1Y	<1Y	<1Y	PW	<1Y
1st round	813,243	149,765	13,849	12,731	243, 761	14,756
2nd round	33,761	17,752	148,376	11,784	21,752	

4791

3rd round

29394

15827

14793

13942

12743

382

Total

876,398

183,344

177,018

38,457

34,495

19,929

•□□□□□□□□Τηε □2 rounds of TT campaign conducted in 92 intermediate and high risk districts in 27 provinces.

C) Cold chain & Logistics

•□□□□□□□□ The NIP has received 20 pickups and 50 RCW50EG Refrigerators under GAVI introduction grant through WHO

•□□□□□□□□ UNICEF provided 233 RCW50EG Refrigerators; 400 cold boxes; 10000 vaccine carriers; one walking cold room; 19 generators for provincial cold rooms and cold chain monitoring devices.

D) Capacity building

•□□□□□□□□ The National EPI Guideline was updated/printed/distributed and the WHO MLMs, IIP and RED guidelines/manuals were also translated

into local languages and distributed to all concerned in EPI.

•□□□□□□□□ Training of 120 EPI Managers, trainers and supervisors for 6 days on HF/district micro-planning and developing of annual provincial EPI plan.

•□□□□□□□□ Totally 991 vaccinators have undergone refresher training

* The 3-month training courses for 300 new vaccinators are going on

•□□□□□□□□ Organized skilled technical training on repairing/maintenance of cold chain equipment for 13 national cold chain personnel with the support of UNICEF and WHO

E) Disease Surveillance

•□□□□□□□□ With the technical and financial support of WHO, the NIP continue surveillance of vaccine preventable disease (measles, AFP, NNT, MNT, Rotavirus, Meningitis and Str. Pneumonia)

•□□□□□□□□ Totally, 267 focal points were trained on measles/MNT surveillance

Main challenges and how they are addressed:

- Delivery of immunization services under in security situation: the three rounds of pulse immunization activities with all antigens conducted mainly in unsecured districts using hit and run strategy.
- Expansion of immunization service delivery through establishment of EPI fixed centers in functional health facilities, private health sectors and community-based EPI teams mainly in remote and unsecured areas: plan is in place and the negotiation with MOPH line departments and NGOs is going on.
- Inadequate health facility/district micro-plans: the 120 provincial EPI managers and supervisors underwent training on how to increase immunization coverage at service delivery levels and the micro-planning exercise conducted in 264 districts, shared with

NGOs for implementation of the district micro-plans.

- Insufficient funding for outreach and mobile activities: through the series of meeting and in close coordination with GCMU, NGOs and partners for increasing salaries and benefits for vaccinators, the NGOs in 24 provinces have agreed/started to increase vaccinators' salaries and providing allowance and transportation cost for outreach and mobile services. It is estimated that out of 115,200 outreach and mobile sessions planned for 2013, only 73728 sessions conducted and 41472 (36%) sessions could not be conducted.

- Low BPHS/EPHS coverage (around 60%): plan for expansion of immunization services has been prepared, the new vaccinators are under training and NIP has received > 250 new vaccine refrigerators and the negotiation with HR department of MOPH is going on to recruit the newly vaccinators under the government structure and NGOs for establishment of new EPI fixed centers in functional health facilities without immunization services.

- Weak performance of RED strategy: the initial steps have been taken to use polio infrastructure for improve routine immunization services through implementation of all components of RED approach and in close coordination with provincial public health departments and NGOs.

- Weak monitoring system and using of data for actions: with the support of MOPH/WHO/CDC, the NEPI has started planned activities for improving the quality of immunization recording/reporting and management of RI reporting system and data by developing and introducing of a database. In addition, NEPI has updated guideline and tools for supportive supervision, planned for training of national management staff on MLMs; planned for conducting data quality self-assessment and quarterly review of RI data. The 20 pickups are distributed to the provincial EPI management teams to be used for monitoring/supervision.

- Inadequate funding for 2015 measles SIAs from government sources: application submitted to GAVI for funding support

- Delayed co-financing of new vaccines: Government has approved US$2,050,000 for payment of pending co-finance from 2013 and the whole co-finance for 2014.

High vaccinators' turnover mainly in remote areas: about half of newly selected/to be trained vaccinators are from the remote areas and as agreed will be recruited by NGOs and MOPH after completion of training courses.

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

- Low public health care service coverage (it is estimated that about 35% of population have no access to public health care services including immunization)

- Poor quality of HF/District micro-planning and inadequate implementation of EPI outreach and mobile strategies due to shortage of funds and ineffective management of human resources and funds at service delivery levels

- Insecurity in certain areas of the country that has prohibited access to health care services

Lack of actions for implementation of EPI expansion plan because of funding gap, low level of salaries for vaccinators, health system barriers, shortage of cold chain equipment, poor coordination with non-BPHS NGOs and private sectors

5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **yes, available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls
Administrative data	2013	50.8%	49.2%

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

All EPI recording and reporting materials (vaccination card, registration book and tally sheet) include both boys and girls separately and accordingly reported.

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Yes**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on

http://www.gavialliance.org/about/mission/gender/)

Gender gaps in Afghanistan are widespread in health and as well as in education and employing opportunities. However, during the past 12 years steps have been taken by Government and civil society organizations to empower women to overcome gender barriers to health care including immunization services. There is no significant difference in immunization coverage between girls and boys and they have the same likelihood of being immunized. The ratio of girls to boys vaccinated with routine antigens is 49.2/50.8.

5.4. Data assessments

5.4.1. 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)

The EPI coverage evaluation survey (CES) conducted in 2013. The final report will be announced officially by MOPH.

* Please note that the WHO UNICEF estimates for 2013 will only be available in July 2014 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2012 to the present? **Yes**

If Yes, please describe the assessment(s) and when they took place.

The EPI coverage evaluation survey (30/7 cluster) conducted during the 3rd quarter of 2013

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2011 to the present.

•□□□□□□□□□ Implementation of recommendations of data quality self-assessment

•□□□□□□□□□ Initiation/implementation of WHO/CDC project focusing on improving RI administrative data including development of access-based software for RI reporting.

Training of key EPI staff on improving EPI recording and reporting

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

The WHO/CDC joint project activities are going on to improve RI administrative data/system. The activities includes: Support NIP in improving immunization data management by recruitment of an access programmer for developing access base software, installation, training of staff at different levels and immunization data management; strengthen management and accountability of EPI program by a local expert working exclusively on EPI to plan and manage supervision, develop curriculum, guidelines, standards, tools for supervision and conducting training workshops in each region, conduct quarterly review in each province focusing on districts, equip each province and develop and use dashboard; enhance implementation of emergency EPI plan in 10 provinces by assessing baseline, conducting workshops to assess the needs, and support in implementation of micro-plans .

WHO/MOPH have planned to conduct DQs planned to conduct DQs in June-July 2014. In case if GAVI is interested to support NIP in performing IDQA with the support of external experts, the MOPH may consider it and let GAVI know in due time.

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 56

Enter the rate only; Please do not enter local currency name

Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	**Expenditure Year 2013**	**Source of funding**						
		Country	**GAVI**	**UNICEF**	**WHO**	**USAI**	**WB**	**EC**
Traditional Vaccines*	3,895,113	0	0	3,895,113	0	0	0	0

New and underused Vaccines**	15,462,852	18,700	15,413,779	0	30,373	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	1,191,912	24,133	244,015	923,764	0	0	0	0
Cold Chain equipment	1,023,373	0	0	1,023,373	0	0	0	0
Personnel	8,047,800	298,900	755,420	147,000	69,000	2,745,000	2,240,000	1,792,480
Other routine recurrent costs	2,437,123	897,564	183,580	1,354,979	1,000	0	0	0
Other Capital Costs	1,083,925	0	0	1,083,925	0	0	0	0
Campaigns costs	1,570,260	0	0	1,570,260	0	0	0	0
Capacity building, district micro-planning, guidelines, manuals, tools, pulse immunization activities, EPI KAP study, PCV introduction, VPD surveillance, measles outbreak response and etc		0	0	0	1,276,685	0	0	0
Total Expenditures for Immunisation	34,712,358							
Total Government Health		1,239,297	16,596,794	9,998,414	1,377,058	2,745,000	2,240,000	1,792,480

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2014 and 2015

UNICEF is providing traditional vaccines/injection supplies for Afghanistan's RI programs.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Not selected**

If Yes, briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

Action plan from Aide Mémoire	Implemented?
NEPI hasn't received Aide Memoire	No

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

No, the joint HSS/ISS FMA is planned in 2014.

If none has been implemented, briefly state below why those requirements and conditions were not met.

Almost all GAVI FMA findings and recommendations are generally related to the whole health system and the plan/policy/HSS department addresses.

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2013? **3**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2014 endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.5 Overall Expenditures and Financing for Immunisation

As per administratively reported data for 2103, the target set for almost all antigens are achieved (section 2.2.1). But, due to particular reasons indicated in section 5.2.2, and lack of accurate denominator the reported coverage data may not reflect the actual situation. The last ICC has emphasized on accelerated implementation of RI coverage improvement plan, expansion of RI services through establishing of EPI centers in

functional public health facilities, private health centers and expand community based EPI centers mainly in remote and unsecured areas.

As per annual plan of action, the total amount planned for 2013 was about US$30,000,000 and the implementation rate for 2013 is about 94%.

Are any Civil Society Organisations members of the ICC? **Yes**

If Yes, which ones?

List CSO member organisations:
BRACK, AHDS, AADA

5.8. Priority actions in 2014 to 2015

What are the country's main objectives and priority actions for its EPI programme for 2014 to 2015

The main objective of Afghanistan NIP is to achieve and sustain 90% coverage with all antigens nationally and at least 80% coverage in each district.

The key activities for 2014 include:

- Accelerated implementation of RI coverage improvement plan has already been started with more focus on reaching the unreached population through mobile and pulse immunization activities and within the limited funds available. Some of the activities are pending because of lack of funds.
- Expand RI services by establishment of new EPI centers in functioning public and private health facilities and establishment of community-based EPI centers in remote and unsecured areas. The activity is pending because of lack of funds.
- Enforce implementation of RED approach through re-exercising and re-scheduling health facility/district micro-plans and implementation of outreach activities. Inadequate management of scarce funds and lack of money for outreach activities are the challenges for full implementation of outreach services.
- Improve the quality of RI reporting system and data management under joint MOPH/WHO/CDC project
- Conduct DQs/IDQA
- Conduct EVMA
- Conduct nationwide cold chain/logistic assessment
- Mobilize funds from government sources for RI programs.
- Strengthening monitoring and supervision of RI activities

Conduct selective measles mop-up campaign in high risk districts including flood affected.

- Pilot using of PEI infrastructure for strengthening RI services/system
- Further strengthen vaccine preventable disease surveillance through training and field monitoring

5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2013

Vaccine	Types of syringe used in 2013 routine EPI	Funding sources of 2013
BCG	AD syringe –Medico Inj 0.05ml	UNICEF
Measles	AD syringe –Medico Inj 0.5ml	UNICEF
TT	AD syringe –Medico Inj 0.5ml	UNICEF
DTP-containing vaccine	AD syringe –Medico Inj 0.5ml	GAVI
PCV	AD syringe –Medico Inj 0.5ml	GAVI

Does the country have an injection safety policy/plan? **Yes**

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

If No: When will the country develop the injection safety policy/plan? (Please report in box below)

The 1st injection policy was developed in 2005 and was updated in 2012. The country has reached 100% injection safety using AD syringes, safety boxes and incineration of sharp waste disposal.

Please explain in 2013 how sharps waste is being disposed of, problems encountered, etc.

Depending on availability of waste disposal facilities at health centers, the EPI sharps waste are managed as part of health facility waste management. The common method is incineration. But in health facilities without incinerators, sharps waste managed by burning/ burying.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2013

	Amount US$	Amount local currency
Funds received during 2013 *(A)*	0	0
Remaining funds (carry over) from 2012 *(B)*	2,292,096	128,357,376
Total funds available in 2013 *(C=A+B)*	2,292,096	128,357,376
Total Expenditures in 2013 *(D)*	939,000	52,584,000
Balance carried over to 2014 *(E=C-D)*	1,353,096	75,773,376

6.1.1. 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.

The procedure for ISS fund management and arrangements includes:<?xml:namespace prefix = "o" />

1. Development of annual plan of actions with budget and timeline by MOPH.
2. Review of plan of actions in EPI Task Force Committee and recommendation to ICC.
3. Review, approval and endorsement by ICC.
4. Submission of plan to MoF for releasing of fund to MOPH and provinces through government channel
5. All payments and purchases are done according to the planned activities using standard formats and following MoF rules.
6. 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 MOPH.
7. Copies of all documents are kept at National EPI office and at provincial EPI at least for 3 years.
8. 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.
9. The work plan may be modified every six months and is in effect after approval and endorsement of ICC
10. The ISS fund included into the national health plan.

The government prolonged procedure for releasing of fund at provincial levels cause delay in implementation of planned activities.

6.1.2. 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 ISS fund channeled to the government bank with the following details<?xml:namespace prefix = "o" />

Da Afghanistan Bank Head Office Branch

Da Afghanistan Bank Head Office Branch

MOF-GAVI Project for MOH (792902)

Ministry of Finance

Pashtunistan Avenue

Kabul

Branch Code: 3000

Currency Code: USD

Customer ID: 491

Email: info@mov.gov.af

Account: MOF-NonInt. Bearing Current Account in F

Account N0: 3000208027039

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2013

The major activities carried out under ISS fund are:<?xml:namespace prefix = "o" />

•□□□□□□□□□ Program planning and management

•□□□□□□□□□ Training of immunization health workers

•□□□□□□□□□ RI Immunization service delivery

•□□□□□□□□□ Advocacy, education and communication

•□□□□□□□□□ Program monitoring and supervision

•□□□□□□□□□ Vaccine preventable diseases surveillance

Transportation & maintenance and overheads

6.1.4. Is GAVI's ISS support reported on the national health sector budget? **Yes**

6.2. Detailed expenditure of ISS funds during the 2013 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2013 calendar year (Document Number 7) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **Yes**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number 8).

6.3. Request for ISS reward

Request for ISS reward achievement in Afghanistan is not applicable for 2013

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

7.1. Receipt of new & under-used vaccines for 2013 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2013 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2013 vaccinations against approvals for 2013

	[A]	[B]		
Vaccine type	**Total doses for 2013 in Decision Letter**	**Total doses received by 31 December 2013**	**Total doses of postponed deliveries in 2013**	**Did the country experience any stockouts at any level in 2013?**
DTP-HepB-Hib	5,404,000	7,568,700	0	No
Pneumococcal (PCV13)	831,300	786,600	0	No

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

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  There was no stock –out of Pentavalent vaccine and the vaccine arrived into the country in three shipments and as forecasted.

- 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 Supply Division)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

  Only shipment adjusted.

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

No stock-out of any vaccine

7.2. Introduction of a New Vaccine in 2013

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2013, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Phased introduction	Yes	01/01/2013
Nationwide introduction	Yes	01/01/2013
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	Yes

Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
Phased introduction	Yes	08/12/2013
Nationwide introduction	Yes	08/12/2013
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	No, the 1st shipment of PCV arrived during the 4th quarter of 2013. Initially it was planned to introduce PCV13 in January. Due to the shortage of vaccine in the market the 1st shipment arrived in October 2013 and officially introduced in December 2013.

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **June 2015**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9))

A copy of last PIE is attached.

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFI expert review committee? **Yes**

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **Yes**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

Does your country conduct special studies around:

a. rotavirus diarrhea? **Not selected**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **Yes**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

The surveillance data are shared regularly with NITAG and ICC. The surveillance data are used for making evidence based decisions for RI. As an example, based on surveillance data the NITAG has recommended to MOPH to introduce IPV, and Rotavirus into national immunization schedule and the ICC has agreed on NITAG recommendation.

7.3. New Vaccine Introduction Grant lump sums 2013

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2013 (A)	1,107,477	62,018,712
Remaining funds (carry over) from 2012 (B)	0	0
Total funds available in 2013 (C=A+B)	1,107,477	62,018,712
Total Expenditures in 2013 (D)	966,831	54,142,536
Balance carried over to 2014 (E=C-D)	140,646	7,876,176

Detailed expenditure of New Vaccines Introduction Grant funds during the 2013 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2013 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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 major activities carried out under GAVI new vaccine introduction grants:

•□□□□□□□□□ Revision of national EPI policy and planning for PCV introduction

•□□□□□□□□□ Training of around 2900 EPI personnel

•□□□□□□□□□ Advocacy, education and communication activities

•□□□□□□□□□ Procurement of 50 RCW50EG Refrigerators

•□□□□□□□□□ Procurement of 20 pickups for RI

•□□□□□□□□□ AEFI surveillance and monitoring

Transportation of vaccine/injection supplies

Please describe any problem encountered and solutions in the implementation of the planned activities

Only shortage of PCV vaccine as the quantity of the 1st shipment was small

Please describe the activities that will be undertaken with any remaining balance of funds for 2014 onwards

The remaining balance is planned to procure vehicles and continue surveillance, monitoring and communication/social mobilization activities

7.4. Report on country co-financing in 2013

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2013?	
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	1,081,000	506,000
Awarded Vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	0	0

	Q.2: Which were the amounts of funding for country co-financing in reporting year 2013 from the following sources?
Government	1081000
Donor	0
Other	0

	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	27,830	506,000
Awarded Vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	166,500	45,000

	Q.4: When do you intend to transfer funds for co-financing in 2015 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2015	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	July	Government
Awarded Vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	July	Government

	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing
	There is need for briefing of national and partners staff on changing of GAVI policies. Orientation on developing financial sustainability strategies, mobilizing funding for immunization

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/about/governance/programme-policies/co-financing/

Due to the complex administrative formalities and late transfer of co-finance for 2012 and 2013 to UNICEF, the country is in the list of default. Actions have been taken to get Government approval for US$2,050,000 to disburse/transfer the pending amount and co-finance amount for 2014 soon after receiving invoice from UNICEF Supply division.

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **August 2011**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Are there any changes in the Improvement plan, with reasons? **No**

If yes, provide details

No

When is the next Effective Vaccine Management (EVM) assessment planned? **March 2015**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

Afghanistan does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

Afghanistan does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2014

Renewal of multi-year vaccines support for Afghanistan is not available in 2014

7.9. Request for continued support for vaccines for 2015 vaccination programme

In order to request NVS support for 2015 vaccination do the following

Confirm here below that your request for 2015 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don't confirm, please explain

The request for 2015 is confirmed

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	200,000$		250,000$	
			<=	>	<=	>
DTP-HepB	HEPBHIB	2.00 %				
HPV bivalent	HPV	3.50 %				
HPV quadrivalent	HPV	3.50 %				
Measles second dose	MEASLES	14.00 %				
Meningococcal type A	MENINACONJUGATE	10.20 %				
MR	MR	13.20 %				
Pneumococcal (PCV10)	PNEUMO	3.00 %				
Pneumococcal (PCV13)	PNEUMO	6.00 %				
Rotavirus	ROTA	5.00 %				
Yellow Fever	YF	7.80 %				

Vaccine Antigens	VaccineTypes	500,000$		2,000,000$	
		<=	>	<=	>
DTP-HepB	HEPBHIB				
DTP-HepB-Hib	HEPBHIB	25.50 %	6.40 %		
HPV bivalent	HPV				
HPV quadrivalent	HPV				
Measles second dose	MEASLES				
Meningococcal type A	MENINACONJUGATE				
MR	MR				
Pneumococcal (PCV10)	PNEUMO				
Pneumococcal (PCV13)	PNEUMO				
Rotavirus	ROTA				
Yellow Fever	YF				

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	1,289,655	1,320,607	1,352,302	3,962,564
	Number of children to be vaccinated with the first dose	Table 4	#	1,263,861	1,294,194	1,325,255	3,883,310
	Number of children to be vaccinated with the third dose	Table 4	#	1,263,861	1,294,194	1,217,072	3,775,127
	Immunisation coverage	Table 4	%	98.00 %	98.00 %	90.00 %	

	with the third dose						
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.33	1.33	1.33	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	1,951,420			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	1,951,420			
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	Country co-financing per dose	Co-financing table	$		0.20	0.20	
ca	AD syringe price per unit	Table 7.10.1	$		0.0450	0.0450	
cr	Reconstitution syringe price per unit	Table 7.10.1	$		0	0	
cs	Safety box price per unit	Table 7.10.1	$		0.0050	0.0050	
fv	Freight cost as % of vaccines value	Table 7.10.2	%		6.40 %	6.40 %	
fd	Freight cost as % of devices value	Parameter	%		0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

Stock of Pentavalent doses on 31st December 201 - 1,951,420 and the same amount on 1st January 2014.

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

4

Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group	Low

	2013	2014	2015
Minimum co-financing	0.20	0.20	0.20
Recommended co-financing as per APR 2012			0.20
Your co-financing	0.20	0.20	0.20

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2014	2015
Number of vaccine doses	#	4,696,300	3,754,800

Number of AD syringes	#	4,315,300	3,183,000
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	47,475	35,025
Total value to be co-financed by GAVI	$	9,813,500	7,930,000

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2014	2015
Number of vaccine doses	#	508,300	400,800
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by the Country <i>[1]</i>	$	1,041,000	831,500

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2013	2014		
				Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	9.76 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,263,861	1,294,194	126,374	1,167,820
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,263,861	1,294,194	126,374	1,167,820
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	3,791,583	3,882,582	379,122	3,503,460
E	**Estimated vaccine wastage factor**	*Table 4*	1.33	1.33		
F	**Number of doses needed including wastage**	*D X E*		5,163,835	504,232	4,659,603
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.333) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.333)*		40,343	3,940	36,403
H	**Stock to be deducted**	*H1 - F of previous year x 0.333*				
H1	**Calculated opening stock**	*H2 (2014) + H3 (2014) - F (2014)*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	0	1,951,420		
H3	**Shipment plan**	*UNICEF shipment report*		5,579,400		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		5,204,500	508,203	4,696,297
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*		4,315,218	0	4,315,218
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*		47,468	0	47,468
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		10,018,663	978,290	9,040,373
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		194,185	0	194,185
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		238	0	238
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		641,195	62,611	578,584
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*		10,854,281	1,040,900	9,813,381
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		1,040,900		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*		9.76 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2015		
			Total	Government	GAVI
A	**Country co-finance**	*V*	9.64 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,325,255	127,814	1,197,441
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,217,072	117,380	1,099,692
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	3,823,227	368,729	3,454,498
E	**Estimated vaccine wastage factor**	*Table 4*	1.33		
F	**Number of doses needed including wastage**	*D X E*	5,084,892	490,409	4,594,483
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.333) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.333)*	- 19,785	- 1,908	- 17,877
H	**Stock to be deducted**	*H1 - F of previous year x 0.333*	909,869	87,752	822,117
H1	**Calculated opening stock**	*H2 (2014) + H3 (2014) - F (2014)*	2,565,107	247,390	2,317,717
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*UNICEF shipment report*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	4,155,500	400,775	3,754,725
J	**Number of doses per vial**	*Vaccine Parameter*	10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	3,182,930	0	3,182,930
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*	35,013	0	35,013
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	8,099,070	781,109	7,317,961
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	143,232	0	143,232
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	176	0	176
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	518,341	49,992	468,349
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	8,760,819	831,100	7,929,719
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	831,100		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	9.64 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

Table 7.11.1: Specifications for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	1,289,655	1,320,607	1,352,302	3,962,564
	Number of children to be vaccinated with the first dose	Table 4	#	1,263,861	1,294,194	1,325,255	3,883,310
	Number of children to be vaccinated with the third dose	Table 4	#	1,263,861	1,294,194	1,217,072	3,775,127
	Immunisation coverage with the third dose	Table 4	%	98.00 %	98.00 %	90.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.05	1.05	1.05	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	225,150			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	225,150			
	Number of doses per vial	Parameter	#		1	1	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.00 %	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

See table

Co-financing tables for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

Co-financing group	Low

	2013	2014	2015
Minimum co-financing	0.20	0.20	0.20
Your co-financing	0.20	0.20	0.20

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2014	2015
Number of vaccine doses	#	3,661,500	3,964,300
Number of AD syringes	#	4,049,500	4,400,300
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	44,550	48,425
Total value to be co-financed by GAVI	$	13,343,500	14,359,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2014	2015
Number of vaccine doses	#	215,800	235,200
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by the Country <i>[1]</i>	$	775,500	840,000

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 1)

		Formula	2013	2014		
				Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	5.56 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,263,861	1,294,194	72,011	1,222,183
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B x C*	3,791,583	3,882,582	216,032	3,666,550
E	**Estimated vaccine wastage factor**	*Table 4*	1.05	1.05		
F	**Number of doses needed including wastage**	*D X E*		4,076,712	226,834	3,849,878
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		23,888	1,330	22,558
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	0			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		3,877,200	215,732	3,661,468
J	**Number of doses per vial**	*Vaccine Parameter*		1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*		4,049,453	0	4,049,453
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*		44,544	0	44,544
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		13,147,586	731,548	12,416,038
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		182,226	0	182,226
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		223	0	223
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		788,856	43,893	744,963
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*		14,118,891	775,440	13,343,451
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		775,440		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*		5.56 %		

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 2)

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	5.60 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	1,325,255	74,199	1,251,056
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B x C*	3,975,765	222,595	3,753,170
E	Estimated vaccine wastage factor	*Table 4*	1.05		
F	Number of doses needed including wastage	*D X E*	4,174,554	233,725	3,940,829
G	Vaccines buffer stock	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	24,461	1,370	23,091
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	Reported stock on January 1st	*Table 7.11.1*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	4,199,400	235,116	3,964,284
J	Number of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	4,400,249	0	4,400,249
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	48,403	0	48,403
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	14,151,978	792,340	13,359,638
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	198,012	0	198,012
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	243	0	243
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	849,119	47,541	801,578
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	15,199,352	839,880	14,359,472
U	Total country co-financing	*I x country co-financing per dose (cc)*	839,880		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	5.60 %		

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Please use this APR section (9. Health Systems Strengthening Support) to report on grant implementation of the previous HSS grant which was approved before 2012. In addition, please complete and attach the HSS Reporting Form to report on the implementation of the new HSS grant which was approved in 2012 or 2013.

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2013**. All countries are expected to report on:

   a. Progress achieved in 2013

   b. HSS implementation during January – April 2014 (interim reporting)

   c. Plans for 2015

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2013, or experienced other delays that limited implementation in 2013, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **15th May 2014**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2014, the HSS reports are expected by GAVI Alliance by September 2014.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2013

   b. Minutes of the HSCC meeting in 2014 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2013 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

9.1. Report on the use of HSS funds in 2013 and request of a new tranche

Please provide data sources for all data used in this report.

9.1.1. Report on the use of HSS funds in **2013**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.

9.1.2. Please indicate if you are requesting a new tranche of funding **No**

If yes, please indicate the amount of funding requested: US$

These funds should be sufficient to carry out HSS grant implementation through December 2015.

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	6700000	8950000	7200000	6600000	4650000	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	2500000	10091209	8157346	10634411	11050232	
Total funds received from GAVI during the calendar year (*A*)	6699975	4594975	7318000	7977346	2999975	4149629
Remaining funds (carry over) from previous year (*B*)		6556888	5544305	3316411	5114944	3558848
Total Funds available during the calendar year (*C=A+B*)	6699975	11151863	12862305	11293757	8114919	7712585
Total expenditure during the calendar year (*D*)	143087	5607558	9545893	6178813	4650867	5061451
Balance carried forward to next calendar year (*E=C-D*)	6556888	5544305	3316411	5114944	3558848	2651134
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)	2651134			
Total Funds available during the calendar year (*C=A+B*)	2694099			
Total expenditure during the calendar year (*D*)	2381967			
Balance carried forward to next calendar year (*E=C-D*)	312132			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Table 9.1.3b (Local currency)

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	6700000	462981710	372454560	303049600	224636850	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	125994250	522016223	421977877	488289615	533825657	
Total funds received from GAVI during the calendar year (*A*)	337663330	237697137	356840316	366287818	144925792	216942604
Remaining funds (carry over) from previous year (*B*)		330452074	278071358	169434825	352016266	175451235
Total Funds available during the calendar year (*C=A+B*)	337663330	568149212	634911674	535722644	396942059	402123953
Total expenditure during the calendar year (*D*)	7211255	290377853	465476848	283706377	224678757	263628696
Balance carried forward to next calendar year (*E=C-D*)	330452074	278071358	169434825	252016266	175451235	138495257
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)	138495257			
Total Funds available during the calendar year (*C=A+B*)	148073750			
Total expenditure during the calendar year (*D*)	130918979			
Balance carried forward to next calendar year (*E=C-D*)	17154769			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Report of Exchange Rate Fluctuation

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2008	2009	2010	2011	2012	2013
Opening on 1 January	50.3	51.86	48.76	45.91	48.31	56
Closing on 31 December	51.86	48.76	45.91	48.31	52.085	56

Detailed expenditure of HSS funds during the 2013 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2013 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2014 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

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 HSCC in this process.

The financial management of the HSS funds follows the similar financial procedures as other donors such as World Bank, Global Fund, Government of Afghanistan, and USAID. All developmental budgets currently being channeled through Ministry of Finance. First of all work plans are made at the departmental level and follow the normal procedures for approval. This includes approval from the donors; incase of GAVI-HSS, the approval is being received from the the HSS-SC. Later on allof the departments' plans are shared with The Finance Directorate of The MoPH. According to Chart of Accounts of The Ministry of Finance; the development budget unit of finance directorate categorizes the expenditures and all relevant forms are being completed. At this stage the finance directorate makes requests for allotments of required budget on the basis of approved work-plans received the various departments of the MoPH from The Ministry of Finance. The requests of allotments are signed by the finance director and the leadership of MOPH. Once the allotments are approved the relevant departments are accountable for the implementation of the approved work plans. In order to start the implementation of the work plans by the relevant department, once again the approval obtains from the leadership of MoPH. In case the activities reflected in the work plans are complemented or adjustments are needed to request more funds ,the leadership of MoPH (The Ministers or Deputy Ministers) approve it and forward it to Finance Directorate of MoPH for processing. In order to ensure transparency and , the head of departments are signing accountability the relevant financial documents and once again the signatures of the leadership of MoPH are obtained. The documents are being sent to the teams controllers seconded by the Ministry of Finance to The Ministry of Public Health for further scrutiny in order to make sure that the documents are properly processed in accordance to the defined rules and regulations; Once the relevant documents are being cleared up by the team of controllers , the controllers singed the relevant documents and forward them to Ministry of Finance. At the provincial level, once the financial allotments are received , the provincial health offices liquidate the budgets in line with the approved rule and regulations of Afghan Government under the oversight of Mustufiates, (The Ministry Financial set up at provincial level) the provincial Ministry of Finance structures). It
is worth mentioning that the HSS is theonly 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 tothe provinces.
The 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 theGovernment 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 system is is user friendly at central level. At provincial level, the financial reports are provided by the Ministry of Finance Mustufiates. On one hand, 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 years show that by approaching the new fiscal year which coincides with the 20th of March, The Mustufiates provide mixed reports which puts up the MOPH to a challenge. Clearing up the financial 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 15th of May while clearing up all the relevant accounts with provincial level reaches normally at the end June every year. In some instances, the other donor’s money comes to the account or vice versa which requires more time to fix the problem. It looks that this problem may resolve over the passage of years while the system gets matured enough. 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 play any major role in the management of HSS funds since there is the HSS-Steering Committee involved in the process of approval of HSS plans,allocation of funds, modifications of budget, and
recommendations for procurement decisions and so on. The HSS steering committee consists of USAID,EU, WB, WHO, UNICEF, MOF, CSOs and MOPH representatives. This committee is set of 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 instrumental in implementation of HSS funds to date.

Has an external audit been conducted? Yes

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

9.2. Progress on HSS activities in the 2013 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is

very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2013 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Activity1.1:Establishing Sub-Centers in under-served areas Activity1.2:Deploying mobile health outreach teams •	The establishment of MHT and Sub health center activities completed by end of December 2012, only the last payments of the NGOs remained pending until receiving the NGOs final financial report and the 2012 audit report.	100	Grant and Contract Management Department based on NGOs quarterly reports, HMIS and MHT evaluation report. (100% for SC and MHTs continuation means that they are established and functioning but also need continuation)
Activity 1,3:Expanding integrated management of childhood illness (IMCI) to community level	The second round of CIMCI project ended by February 2013. The last payment of the Implementer NGOs released after submission of final project report and 2012 audit report.	98	IMCI department of Child and adolescent directorate of MoPH reports • NGOs quarterly reports, • Monitoring Reports,
Activity 1,4: Develop an inservice training program for BPHS primary healthcare providers	The project ended by due date		
Activity 2.1: Implementing a nationwide Information, Education and Communicatio n (IEC) campaign for immunization and other MCH messages	The activities related to IEC were completed by end of December 2012. only the payment of some activities released	100	Health Promotion Department reports
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	The project has already completed by June 2011	100	Health Economic and Financing Department reports - End line survey report - Final report of the project
Activity 3.1: Up-grade the physical, information /communication technology infrastructure and means of transportation of the M&E Department	- The payment of the monitoring officers perdium who conducted monitoring visits from the implementation sites for the last two quarter of year 1391. - The HSS program evaluation payment took time due submission of final report. -The last payment of internet fee remained from 1391 fiscal year. All payment released	100	M&E directorate reports Finance section

Activity 3.2: Launch a community demographic surveillance system	This activity canceled at the beginning of the project and the budget was shifted to C-IMCI		
Activity 3.3:Expanding capacity building program for MOPH managers at the Central and Provincial levels	The Project closed by end of 15 June 2012. only the last payment of the NGOs were remained pending due to submission of project final report and 2012 audit report and the last payment of MoPH staff capacity building program released.	100	Afghan National Public Health Institute / Training department reports - NGO quarterly Reports, and monitoring reports - Finance section
Activity 3.4:Developin g a communicatio ns and internal advocacy program to seek increased funding	Planed activities completed by end of December 2012. The payment of some activities which was not paid due to short fiscal year of 2012 , released.	100	Public Relation department Finance section
Activity 3.5: Launching an initial cadre of District Health Officers	All recruited District Officers already absorbed in the MoPH structure	100	
Management cost	The operation cost of HSS unit and relevant departments who are involved for project closing such as Payment of staff salary for the last 3 month of 1391 as well as based on availability fund in the Management part of the GAVI-HSS budget, it has been decided by MoPH leadership to cover salary for the first three month of year 1392 for those staff who directly involved in closing of GAVI - HSS and will be involved in the implementation of HSFP from the current grant + Operation cost, purchasing some new IT equipment's, top up cards, renting vehicles, fuel, stationary and ect......... which all payments have released.	100	HSS unit Finance section

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
Activity1.1:Establishing Sub-Centers in under-serv	The progress toward establishment of MHTs and SHC already reported in 2012 APR. The project officially ended by December 2012. For the sustainability of this important project the MOPH continued its endeavors to coordinate and discuss with donors supporting BPHs to include the GAVI funded SHCs and MHTs run under HSS Grant so far in the BPHS contracts. The 42 sub health centers and MHTs in the BPHS contracts of EU supported provinces included in EU BPHS contracts.

	The MoPH faced with the reluctance of USAID for absorption of remaining 72 health facilities in 13 provinces under USAID funded BPHS contracts. The communications with USAID at different levels failed to reach to a momentous end and MoPH inevitably explored additional alternate options. Finally MoPH could convince the World Bank to fund the remaining HSS funded health facilities through absorbing them in the MoPH run Strengthening Mechanism (SM) project at least for one year ,through which the health care service delivery is funded by WB while MoPH has the responsibility of direct provision of services through provincial public health directorates. In the renewal time of USAID contracts with NGOs, the MoPH succeed to convinced the USAID to include 72 SHCs in the BPHS contracts , which guaranteed the sustainability of the project.
Activity 1,3:Expanding integrated management of ch	The progress and achievements of C-IMCI activity reported in 2012 APR , The second project of C-IMCI were focused on northeast and southeast zones covering 8 provinces of Baghlan, Kundoz, Badakhshan , Takhar , Ghazni, Paktika, Khost and Paktya which started from 1st March 2012 and ended by 28th February 2013. 4869 CHWs and CHSs were planned to be trained in two modules of ARI and Control of Diarrheal Diseases. By the end of project totally 4713 (97%) CHWs and CHSs trained in two CIMCI modules.
Activity 1,4: Develop an inservice training progra	As it was mentioned in the last APRs , the in service training project after one year terminated and the budget shifted to C-IMCI project, after steering committee approval.
Activity 2.1: Implementing a nationwide Informatio	This activity reported in 2012 APR, no technical activities were conducted after December 2012.
Activity 2.2: Pilot a model of demand side financi	The Demand Side Financing pilot project officially ended by end of June 2011 which has been reported in 2012 APR
Activity 3.1: Up-grade the physical, information /	The 2012 M&E activities reported in the 2012 APR and no other activities implemented under GAV_HSS grant.
Activity 3.2:Launch a community demographic survei	This activity canceled at the beginning of the project
Activity 3.3:Expanding capacity building program f	There were no technical activity implemented during year 2013. The progress and achievements under this activity already reported in 2012 APR.
Activity 3.4:Developin g a communicatio ns and int	No activity implemented during 2013
Activity 3.5: Launching an initial cadre of Distri	No activity implemented during 2013

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Since the GAVI –HSS grant closed by end of 2012, and no technical activities were planned for the year 2013 under GAVI-HSS grant, only the last payment of NGOs, and few other payments from other activities the management cost and staff salaries for the first quarter of year 2013 planned to be paid by the year 2013. After receiving the 2012 audit report as well as completion of end project financial and technical reports. The Development Budget Department (DBD) reported that426,875 USD remained unspent form total ceiling of NGOs contracts. There was a proposal from National EPI that some health facilities were facing shortage of cold chain equipment's especially RCW50. The issue was discussed in the HSS steering committee dated 12 June 2013. It was decided by HSS steering committee member to transfer the remaining amount to WHO for purchasing 120 RCW50 using the WHO procurement system due to lengthy process of procurement system through procurement law of Afghanistan. After getting approval from Special procurement Committee (SPC) in MoF, and signing an MOU with WHO the money transferred to WHO to purchase the 120 RCW50. The RCW50 purchased by WHO based on specification given National EPI and ready for distribution to needy health facilities.

After finalization and reconciliation with MoF , NGOs, and final payments of the remained activities, it has been reported by DBD that from of total amount of 34.100.00 USD GAVI-HSS grant 312,132 USD has remained unspent .In order to use this money efficiently based on MoPH needs and priorities, the issue was brought to HSS steering committee dated 20 October 2013 to get their approval for transfer remained money to WHO for purchasing quality medicines for Kochi population 10 MHTs which are supported by MoF,publishing and developing standard IEC materials for Kochi population awareness raising / capacity building and purchase of necessary supplies to promote EPI program in Kochi

population.

The Special Procurement Committee approval has been gotten and a MoU signed with WHO for transfer of fund to WHO and will be added to HSFP budget. After consultation with GAVI secretariat, WHO requested MoPH to get official approval from GAVI secretariat. Upon receiving GAVI approval the MoU between GAVI and WHO for which has been signed for the financial management of HSFP project,needs to be amended. An official letter has been sent to GAVI secretariat through Deputy Minister of Policy and Planning email account to get GAVI secretariat approval.

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

Efforts are made to deny payment of irrelevant to HSS staff of MoPH. In Afghanistan,all other donors and technical partners in a way contribute to payment of someMoPH essential staff. These include but not limited to USAID, EU, WB, WHO,UNICEF, UNFPA, Global Fund and so on. From GAVI funds, one procurement officer,two HR advisors, one legal advisor, and few staff of MoPH minister have beenpaid. The procurement has been challenge the people paid works for all donors and Gov funds, the HR advisors work for MoPH and are leading the reform process which will significantly impact the all MoPH programs, legal advisor checks allthe contracts and MoUs signed with NGOs including GAVI funded contracts withNGOs. It is worth mentioning that the payments to this entire group are ceased and efforts are made to pay the HR advisors from WB which is already communicated (WB already pays 4 HR advisor).

Although three month before of official closing of GAVI-HSS grant, the above mentioned staff was given notice for the end of their contracts, based on their contribution directly and indirectly for the implementation of previous HSS grant and in the HSFP , the MoPH leadership approved the contract extension ofthe following people; the senior advisor in the Provincial Liaison Directorate who will follow up and facilitate HSS activities at the provinces, the HR consultant will facilitate the HSS recruitments, the M & E director , the legal advisor, the internal audit consultant ,the secretary for the deputy minister of policy and planning, the stock keeper who is looking after of all asset purchased from HSS grants, the MoPH a Gate Guard and the Public Relation department team salary will be paid from HSFP based on HSS steering committee meeting approval (SC minute April 16 / 2013)

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2012 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2013 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2009	2010	2011	2012	2013		
1.1: To increase National DTP3 coverage for the children under age one (% of children under age one received DPT3 vaccine)	77%	JFR/EPI/2007	90% (2012)		83%	87%	89%	87%		EPI	• Insecurity in most parts of the country that prevented vaccinators to go for mobile and outreach activities • Vaccinators' turn over in most part of the country is another main challenge which has contributed to this problem • Remuneration policy for vaccinators is very controversial because MoPH

											has pledged to pay their counterparts such as doctors, nurses and midwives the hardships at the rate of 50, 150 and 200% while it is not applicable for vaccinators in the respective places. This is also a discouraging factor in achieving vaccinators target in their facilities.
1.2: To increase the number/percent of districts achieving >80% DPT3 coverage under age one (% of districts achieving DPT3 coverage >80%)	49%	J FR 2007	100% (2012)		56%	58%	57%	61%		EPI	The same as above
1.3 To reduce under five mortality rate from 210/1000 live births in 2006 to 168/1000 live births by 2012.	210/1000	AHS 2006	153/1000 (2012)		191/1000	161/1000	161/1000	97/1000		AMS 2010	The target for 2012 was 153 but now it reached to 97
1.4 To increase National Measles coverage (% of children received at least one dose of Measles vaccine)	68%	JFR 2007	90% (2012)		76%	79%	82%	81%		JFR/EPI	
1.5 To increase skill birth attendance (% of deliveries attended by skill birth attendants)	19%	AHS/HHS	40%		35%	35%	45%	46%		AHS 2012	
1.6 To increase treatment of diarrhea and ARI at community level (% of children treated for ARI and diarrhea at community level)	30%	HMIS/IMCI	30% (2012)		32%	34%	73%	57%		HMIS	
2.1: To increase contacts per person per year with the health care system (Number of contacts per persons/year)	0.6%	HMIS	1 (2012)		1.16	1.30	1.5	1.8		HMIS	
2.2: To increase average number of persons referred by	14.8	HMIS	20/Quarter		20	22	23.3	34.4		HMIS	

CHWs per quarter (Avg # of persons referred by CHWs/ quarter)											
2.3: Provider knowledge score	67.8	BSC	90% (2012)		NOT MEASURED	70.6%	64.6	69.5%		BSC	
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)	?	HMIS/AHS	40% (2012)								The data for Indicator 9: Proportion of mothers in rural communities knowledgeable about prioritized health does not exist in AHS 2012. The indicator was proposed in 2008 to be included in household survey but was later changed by MoPH leadership and technical committee. The indicator is switched with following indicators: Proportion of mothers having “appropriate” knowledge about introducing complementary food; Proportion of children whose parents are able to name danger signs of diarrhea and ARI and the appropriate response; and Proportion of women (12-49 years) knowledgeable about at least one modern contraceptive method
2.5: To increase % of CHWs trained in community IMCI from 2% in 2006 to 80% in 2012 (% of CHWs trained in community IMCI)	2%	IMCI/HMIS	80% (2012)		20.30%	34.30%	56%	62%		IMCI	CHWs dropout • Harvesting time and winter was a challenge in some areas. During the harvesting time male CHW was not available to attend the training
2.6: To increase the % of provinces receiving monitoring visits using national monitoring	29%	M&E Dep	100% (2012)		47.10%	56.50%	47%	85%		M&E	• Insecurity in some provinces such as Nooristan, Zabul, Orozgan, Helmand and Farah

checklist per quarter from 25% in 2006 to 100% in 2012											• Harsh weather conditions in central and northern provinces such as Bamyan, Daikundi and Badghis and Badakhshan • Shortage of enough personnel to cover all country for monitoring missions

9.4. Programme implementation in 2013

9.4.1. Please provide a narrative on major accomplishments in 2013, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

A. Management

1. Five 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 GAVIsupport. The HSS-SC as coordination and monitoring body for HSS program is comprised of three MOPH voting members (key departments), representatives ofUNICEF, WHO, World Bank, European Commission, USAID, Civil Society Organizations interim representative and Ministry of Finance.

The GAVI-HSS technical activities implementation stopped by end of December 2012, only the payment of last installment of some NGOs and other activities payments carried out during year 2013.

The external evaluation of GAVI/HSS program conducted in 2012- 2013 in order to measure the HSS implementation, the effectiveness of its intervention sand its contribution to the improvement of health and in relation to immunization coverage and to draw the necessary lessons to influence the future policy and implementation of HSS interventions. The evaluation covered the period of GAVI financing 2007-2012 which was conducted by Governance Institute-Afghanistan (G-IA). It has been found that the implementation of GAVI funded HSS Program in Afghanistan started in 2008. This was a significant development and led to major important outcomes far exceeding the planned objectives. The HSS program introduced and implemented a number of innovative initiatives to promote the coverage and performance of, in particular, EPI and basic MCH services. The training of community midwives in remote provinces through partnership with NGOs and the use of the private sector capacity in security compromised areas proved successful innovation in the health system of Afghanistan. In 2007, the DPT coverage was 77% and jumped to 87% in 2010_ which is an example of great achievement.

GAVI-HSS funds have empowered theMOPH to fill gaps in improving access to quality healthcare services,increasingdemand for and utilization of maternal and child health care services, andimproving the ability of the MoPH at various levels to fulfill its stewardshipfunctions.

Despite impressive gains, there arestill myriad of challenges. There are, therefore, two important conclusionsabout the health sector in Afghanistan: first, it has made impressive progresssince the fall of the Taliban; and second, there is still along way to go untilAfghanistan has acceptable health outcomes and an adequate health care system. (HSS Evaluation Report attached)

The Development Budget Department(DBD)of MoPH in close coordination with MoPH different departments, NGOs , MoFand other relevant departments reviewed and verified the NGOs final reports ,collected the inventory lists , invoices and based on all required documents ,their last installments released.

B.1: Establishment of sub centers and Mobile Health teams in remote and under served areas of the country:

The progress toward establishmentof MHTs and SHC already reported in 2012 APR. The project officially ended byDecember 2012.

For the sustainability of thisimportant project the MOPH continued its endeavors to coordinate and discusswith donors

supporting BPHS to include the GAVI funded SHCs and MHTs run underHSS Grant so far in the BPHS contracts.

The 42 sub health centers and MHTsin the BPHS contracts of EU supported provinces included in EU BPHScontracts.

The MoPH faced with the reluctanceof USAID for absorption of remaining 72 health facilities in 13 provinces underUSAID funded BPHS contracts.

The communications with USAIDat different levels failed to reach to a momentous end and MoPH inevitablyexplored additional alternate options. Finally MoPH could convince the WorldBank to fund the remaining HSS funded health facilities through absorbing themin the MoPH run Strengthening Mechanism (SM) project at least for one year,through which the health care service delivery is funded by WB while MoPH hasthe responsibility of direct provision of services through provincial publichealth directorates.

In the renewal time of USAIDcontracts with NGOs, the MoPH succeed to convince the USAID to include 72 SHCsin the BPHS contracts, which guaranteed the sustainability of the project.

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

The progress and achievements of C-IMCI activity reported in 2012 APR , The second project of C-IMCI were focused on northeast and southeast zones covering 8 provinces of Baghlan, Kundoz, Badakhshan, Takhar , Ghazni, Paktika, Khost and Paktya which started from 1st March 2012 and ended by 28th February 2013. 4869 CHWs and CHSs were planned to be trained in two modules of ARI and Control of Diarrheal Diseases. By the end of project totally 4713 (97%) CHWs and CHSs trained in two CIMCI modules.

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

As it was mentioned in the last APRs, the in service training project after one year terminated and the budget shifted to C-IMCI project, after steering committee approval.

C.1.Increases demand for and utilization of health care services

This activity reported in 2012 APR,no technical activities were conducted after December 2012.

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

The Demand Side Financing pilot project officially ended by end of June 2011 which has been reported in 2012APR

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 transportation of the M&E Department:

The 2012 M&E activities reported in the 2012 APR and no other activities implemented under GAV_HSS grant.

D.2: Launch a community demographic surveillance system

This activity canceled at the beginning of the project

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

There was no technical activity implemented during year 2013. The progress and achievements under this activity already reported in 2012 APR.

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

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

No activity implemented during 2013

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

- **Insecurity** insome parts of the country: to cope with insecurity problem the MOPH has pilotedthe partnership with for profit health service provider to provide reproductivehealth, child health and immunization services in insecure and unde rservedareas under CSO type B Project.
- **Long andtedious administrative procedures** inside andoutside of the MOPH: reforming is under way. However, the proposed reforms arenot effective to the extent where pragmatic changes take place.

- **Sub optimalcapacity and commitment of** MOPH authorities at provincial levelto fulfill the stewardship act of MoPH and effectively monitor NGOsimplementing health related interventions.
- **Lack ofqualified health workers** particularly female health workersin remote and under served areas. Various initiatives are underway to train andrecruit more female health workers in insecure and under served areas.
- **Geographicalconstraints**, prolonged and harsh winter in certain parts of the country, andbad road conditions.

The new HSFPapplication will contribute to ease some of these challenges especially theadministrative process related to procurement which is next to the insecuritychallenge. In addition, volunteer health workers will be trained mostly femalein Kochi population through HSFP which will produce evidence based results andfurther ensure equity.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

HSS has beenproviding support to improve the capacity of M and E Directorate thorough assigning national consultant and M&E officer as well as providing regular backstopping and training to M and E set up in MoPH.. Therefore, the budgetallocated to support M and E activities was reallocated to the M & E work plan..In addition, the Afghanistan the current GAVI/HSS proposal has a specificactivity called "upgrading the physical technology infrastructure of theM&E department". Therefore, the M&E department receives its primesource of support from GAVI– HSS funds. It includes supporting salaries of M &E Directorate staff,provision of equipment, vehicles and technical assistance and backstopping a the central and provincial levels. In addition, M&E directorate is assisted toexpand their role in the process of designing M&E tools and checklists formonitoring the HSS supported initiatives.

In addition, theBalanced Score Card, a national evaluation tool aiming at evaluating the MoPHstrategies on an annual basis implemented by The Third Party Evaluation (TheJohns Hopkins University) funded by the World Bank, has also captures importantinformation for some of the GAVI/HSS Program indicators. HMIS department ofMoPH has been collecting information from the BPHS health facilities on aquarterly basis where information from MHT and SHC are also collected , processedand analyzed to assist program and policy people to take evidence based policydecisions During the year 2011 USAID/Tech serve supported the evaluation of"launching a new cadre of District Health Officers". UNICEF has supportedthe MHT initiatives.

In addition,the different departments of MoPH are involved in implementing differentactivities and their staff receives support from GAVI/HSS Program is involvedin monitoring of HSS supported activities. HSS initiative has promoted inincorporation of in-built monitoring mechanism with the projects/interventionsbeing supported by GAVI fund, for instance, C-IMCI project has a baseline andfollow up evaluation in built within the scope of C-IMCI Project.

The Midterm evaluation of GAVI/HSS supported interventions have been conducted and recommendation has been provided to take remedial actions.

The external evaluation of GAVI/HSS program conducted in 2012- 2013in order to measure the HSS implementation, the effectiveness of its interventionsand its contribution to the improvement of health and in relation to immunizationcoverage and to draw the necessary lessons to influence the future policy andimplementation of HSS interventions. The evaluation covered the period of GAVIfinancing 2007-2012 which was conducted by Governance Institute-Afghanistan (G-IA). It has been found that theimplementation of GAVI funded HSS Program in Afghanistan started in 2008. Thiswas a significant development and led to major important outcomes far exceedingthe planned objectives. The HSS program introduced and implemented a number of innovative initiatives to promote the coverage and performance of, in particular, EPI and basic MCH services.

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

GAVI/HSS availthe opportunity to integrate the M&E activities with the country system;HSS provide technical support to conduct annual health sector review so calledresults conference and health sector retreat where the progress in the healthsector has been reviewed and the gap analysis exercise has been conducted andpolicy and program recommendations proposed. HSS support the M and Edirectorate to collect information on GAVI/HSS indicators as well as healthsector indicators and review those indicators on regular basis; in future, GAVIHSS support will be used to strengthen the reporting and stewardship act of MoPHat Provincial level as well. GAVI/HSS supported initiative is the sole addedinitiative to assist MoPH to integrate and support M and E activities on aregular basis in Afghanistan.

Health servicedelivery is monitored by M&E officers using a structured checklist known asNational Monitoring Checklist (NMC) all over Afghanistan. GAVI fund supportedMoPH to build the capacity of provincial officers to use NMC and report it tocentral M&E department. NMC is approved checklist that is also used byGrants and Contracts Management unit to monitor health service delivery inmonitoring visits jointly with M&E officers. The evaluation of healthservices is conducted by a third party annually. The Evaluation directorate ofM&E department is closely working with the third party in

devising,revising, executing and analyzing the evaluation data. Given the circumstances,the M&E is going to prepare a strategic plan to transfer the knowledge,tools and skills required for annual evaluation to M&E department so thatthe M&E officers will be able to conduct health facility assessments innext three years.

Monitoring andevaluation reports are widely shared with the MoPH leadership and other policymakers.

However, inorder to build consensus around most of the findings; and set up a platform forsecondary analysis and timely action, GAVI/HSS is supporting two importantnational events, a result conference and a health sector retreat workshop.

As a result ofthe GAVI/HSS technical support to M&E and HMIS departments, M&Eadvocated for establishing an umbrella department known as Health InformationSystem (HIS) where the data of departments including HMIS, M&E, Researchand Disease Early Warning System (DEWS) etc can be properly channeled, analyzedand disseminated. This will also help to standardized the process of datacollection and avoid duplication by other departments.

As explainedearlier, HMIS and M&E departments collect mostly input and process datawhile the third party is responsible for output and outcome data. As a part ofthe health system strengthening efforts, the majority of indicators that MoPHreported were input and process with very few outcomes. In the meantime, some indicatorsas part of HSS were collected from vertical departments such as IMCI and CommunityBased Health Care department. In order to organize the HSS funding, effortsshould be made to select and report on already established input, process,output and outcome indicators in the HMIS and M&E departments. In addition,efforts should be made to incorporate indicators pertaining vertical programsinto the national HMIS and M&E data.

The proposedM&E intervention in the HSFP proposal aims to build up on early gains andto streamline M&E activities at different levels. Current monitoring toolsat central level will be revised. Regular joint central and provincial jointmonitoring missions to the districts will be organized in at least 82% of theprovinces. The M&E department of MoPH will be equipped with necessarycommunication and transportation facilities and provided strong technicalassistance. The newly established unit of private sector monitoring will be strengthened.The existing MoPH database will upgrade to accommodate revised PHC and hospitalM&E/NMC. Guidelines for monitoring at the provincial level addressingrelated issues, coordination, reporting, advocacy, monitoring lists, quality ofdata etc., will be developed. 37 central and 34 provincial staff members willbe trained in M&E to be able to use the revised tools and the new guidelines.An annual result conference will be held in MoPH to discuss the healthinformation collected and processed over the year.

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

At theoversight level, the HSS-SC provides a significant level of support to GAVI HSSsupported initiatives in the process of design and implementation. Otherstakeholders such as the World Bank, USAID, WHO, UNICEF, and EU play animportant role in the process of oversight and provision of technical input andbackstopping of GAVI HSS supported activities. The MOPH Afghanistan and itspartners believe that the use of Civil Society Organizations (CSOs) will help thehealth sector of Afghanistan to timely and efficiently achieve its national and,consequently the international, health targets. Therefore, the MOPH Afghanistanhas adopted the stewardship role and contracted out most health service deliveryto NGOs. Form HSS support, over 65% of activities is being implemented by NGOs.

The CSO type Binitial phase was implemented by the six national and International NGOs. Four CommunityMidwifery Education (CME) programs were implemented in four provinces ofGhazni,Nimroz, Kunar and Zabul provinces and completed last year. Two pilot public-privatefor profit partnership projects are running in the two insecure provinces ofUruzgan and Farah and two more are added in CSO bridging in Nooristan andPaktya provinces and two additional provinces of Helamand and Kandahaar addedfrom HSFP fund .

Theachievements so far in Afghanistan can be attributed to the significant involvementof CSOs in the health sector. In 31 out of 34 provinces NGOs are implementing aBasic Package of Health Services (BPHS) in Basic Health Centers, ComprehensiveHealth Centers, and District Hospitals. NGOs are also involved in the implementationof Essential Package of Hospital Services (EPHS). Other CSOs are involved intraining programs and in monitoring and evaluation.

The majority ofHSFP activities have already contracted to the NGOs through open Biddingprocess according WHO procurement rule and regulation.

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

The majority ofthe HSS activities are being implemented by the National and International NGOssince beginning of the HSS program, some projects being implement by one NGOand some of the in consortium with one or two NGOs.

The Sub centersand MHT implemented by 7 International NGOs like Swedish Committee forAfghanistan (SCA), Aid Medical International (AMI) , BRAC , HNTPO, Aga Khan HealthSystem (AKHS), Merlin and MARCA and 7 National

NGOs like Bakhter DevelopmentNetwork(BDN), Care of Afghan Families (CAF), Ibnsina, STEP Health anddevelopment Organization (STEP), Solidarity for Afghan Family (SAF), HumanitarianAssistance Development of Afghanistan (HADAF) and Coordination for HumanitarianAssistant throughout the country.

The C-IMCIprojects are also running by two International of Save children / US, HNTO andAgency for Assistance and Development of Afghanistan (AADA) a National NGOcovering 25 provinces.

The QualityPublic Health Management courses for the capacity building of health managersat the central and provincial level also implementing with a consortium by HADAFand IIHMR (both National and International NGOs) throughout the country.

M&E diplomacourse for training of 27 M&E officers conducted by Ibnsina , meanwhile theKAP survey conducted under health promotion activity conducted by IIHMR.

TheDemand Side Financing project was implemented by Hope World Wide anInternational organization

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

As stated inseveral parts of the report, the GAVIHSS support has been very instrumental toaddress the challenges and bottlenecks of existed in the health system ofAfghanistan.. There have been no changes in the management of HSS funds. Theoverall management is overseen by General Directorate of Policy and Planningand Deputy Minister Policy and Planning and coordinated by HSS Unit, beingimplemented by different departments of MoPH as well as CSOs and NGOs. Giventhe nature of activity, the HSS funds are managed by different departments ofMOPH. The finance directorate development budget unite is responsible for thefinancial management, M&E for monitoring and evaluation and the procurementdirectorate is responsible for procurement.

The GAVI HSSProgram oversight by Health System Strengthening Steering Committee. The HealthSystem Strengthening Steering committee (HSS-SC) consists of representativefrom the WB, USAID, EU, Ministry of Finance, WHO, UNICEF and CSOs as well aspresence of key CGHN members within the health sector of Afghanistan isactively supporting the implementation of GAVI HSS supported initiatives andpromote the implementation of global health initiatives related to GAVI/HSS TheHSS-SC as coordinating and monitoring body for HSS program is comprised ofthree MOPH voting members (key departments), representatives of UNICEF, WHO,World Bank, European Commission, USAID, Civil Society Organizationrepresentatives and Ministry of Finance. The bottom up annual plan of action(form 11 MOPH departments) are developed, approved by HSS-SC and MoPH Ministerand accepted by MoF. Each relevant MOPH department has at least one designatedstaff for HSS and each department plans and implements its relevant activities.The relevant running costs of each department are covered from HSS support andother costs are covered by either the Government of Afghanistan or otherdonor's support. To date, the HSS support has been very helpful to strengthenthe health system for example; some of the departments severely lacked thecapacity of planning, reporting, or following up the issues. Now all of therelevant departments know the concepts of planning, coordination,implementation, and are actively involved in management and implementation oftheir plans whether it is GAVI or other donors or Government resources.

9.5. Planned HSS activities for 2014

Please use **Table 9.5** to provide information on progress on activities in 2014. If you are proposing changes to your activities and budget in 2014 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2014 actual expenditure** (as at April 2014)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
To increase DTP3 coverage in Kochi children	To purchase quality medicine for Kochi populaition	120000	0		After finalization and reconciliation with MoF , NGOs, and final payments of the remained activities, it has been reported by	

					DBD that from of total amount of 34.100.00 USD GAVI-HSS grant 312,132 USD has remained unspent .In order to use this money efficiently based on MoPH needs and priorities, the issue was brought to HSS steering committee dated 20 October 2013 to get their approval for transfer remained money to WHO for purchasing quality medicines for Kochi population 10 MHTs which are supported by MoF ,publishing and developing standard IEC materials for Kochi population awareness raising and purchase of necessary supplies to promote EPI program. The MoF Special Procurement Committee approval has been gotten and the MoU signed with WHO for transfer of $312,132 to WHO using WHO procurement system. need more explanation	
	To publish standard IEC materials for Kochi population awareness raising	70282	0			
	To purchase necessary supplies to promote EPI program	100000	0			
WHO program support cost		21850	0			
		312132	0			0

9.6. Planned HSS activities for 2015

Please use **Table 9.6** to outline planned activities for 2015. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 9.6: Planned HSS Activities for 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
		0			

9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

9.8. Other sources of funding for HSS

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

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
Global Fund -HSS / SSF consolidated grant	15700000	2 year (1st Nov. 2012- 20 Dec. 2014)	There are many other sources of funding by WB , USAID, WB and other donors/partners providing Grants for the implementation of BPHS in 34 provinces. This table only outlines the funds that are labeled HSS and provided by the GAVI and GFATM. Improve the coverage and quality of health services delivered to and within communities by critical assessments and improving the recruitment and supervision of CHW (training of 250 female CHS and training of 525 community nurses) Strengthen the quality of peripheral laboratory performance through the creation of a regional reference laboratory system (establishment 3 reference laboratory at regions and providing equipment in given hospitals and health facilities; 13 provinces, 20 districts, 160 CHC/BHC). Improvement of health management information system, Strengthening the performance and services of laboratory through establishment lab services at BHC levels Strengthening the community health services through establishment of community nursing education program (training of 525 community nurses)

9.8.1. Is GAVI's HSS support reported on the national health sector budget? **Yes**

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Afghanistan Mortality Survey 2010	A huge nationwide survey	
HMIS 2013	Routine checks by HMIS department	
JRF 2012	EPI department , WHO, UNICEF	

National Monitoring Data base	Routine checks by M&E department	
NRVA 2010-2012	Central Statistics office records	

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

The attachment port is not accepting a folder, only one word document accepted , for example the minute of HSS steering committees should be scanned other wise the minutes will be missed to be attached. the portal should have space for comments and additional information , which the current portal dose not have space for this purpose.

since Afghanistan GAVI- HSS 1 started on 2007 , but the table 9.1.3a , 9.1.3b and 9.1.3c in the portal are started from 2008 , please consider the hard copy of these tables with the financial statement in the attachment part.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2013?5

Please attach:

1. The minutes from the HSCC meetings in 2014 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

10.1. 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 *1*

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

CSO initial Type A support was already completed and in due time reported to GAVI.

Since there in no place to download the CSO Type A support 2, please find the complete technical, financial and audit report in the attachment list number 23 and the soft copy of the technical report is attached in the others.

10.1.1. **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 exercises, 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 **(Document number 23)**

Already completed and the report is submitted

If there is still remaining balance of CSO type A funds in country, please describe how the funds will be utilised and contribute to immunisation objectives and outcomes as indicated in the original proposal.

No

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.

NO

10.1.2. **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 is already reported

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.

It is already provided

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.

Although already reported, but we are getting more systematic inputs from CSOs. We see positive changes around working with CSOs as well within CSOs interactions. CSOs participation in service delivery, policy development , coordination , Technical assistance, Evaluation ect............

Please provide the list of CSOs, name of the representatives to HSCC or ICC and their contact information

Full name	Position	Telephone	Email

Dr.Yasin Rahimyar / CSOs representative	Country Director of CAF	0093(0)700709317	yasinrahimyar@gmail.com

10.1.3. **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 2013

	Amount US$	Amount local currency
Funds received during 2013 *(A)*	0	0
Remaining funds (carry over) from 2012 *(B)*	119,296	5,861,047
Total funds available in 2013 *(C=A+B)*	119,296	5,861,047
Total Expenditures in 2013 *(D)*	87,571	4,203,117
Balance carried over to 2014 *(E=C-D)*	31,725	1,657,930

Is GAVI’s CSO Type A support reported on the national health sector budget? **No**

10.2. 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 ***1***

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

CSO support type Project have been continued to provide lifesaving EPI, maternal and child health services, treatment of common diseases and referral of pregnancy and pregnancy complicated cases as well asseverely ill patient to BPHS health facilities in 4 insecure provinces of Afghanistan. Given the successful implementation of CSO support type B project in 6 insecure provinces, the end of project evaluation not only recommend the extension of CSO support type B project , but also the expansion ofCSO support type B project in other hard to reach and insecure provinces of Afghanistan. Therefore, CSO support type B project has been expanded within Nuristan and Paktia provinces. Thus CSO support type B has been operating in four insecure provinces of Afghanistan from Jan 2012 to June 2013 through the generous support of GAVI bridge fund. CSO received their quarterly instalments given the successful implementation, submission and review of technical andfinancial reports. CSO support Type B received no cost extension1st Jan2013 through 30 June 2013 from GAVI headquarter. WHO was responsible for thecontract management of CSO support type B project from Jan2012 to June 2013.CSO support type B considers the sole means of providing EPI, Basic Reproductive Health services, treating common diseases, promoting health through health education and awareness raising interventions and referral services in insecure districts of Urozgan, Nuristan, Paktia and Farah Provinces.

Intotal there are 114 private for profit health service providers operate under CSO support type B project. The private for profit health service providers operatein insecure areas of Urozgan, Farah, Paktia and Nuristan provinces are the only means to provide life-saving maternal and child health services.

10.2.1. **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.

Urozgan Province

30 privatefor profithealth service providers contracted through BPHS impmementing partner NGO have been operating in 4 districts (12 private for profit healthservice providers inChora District, 8 private for profit health service providers in Trinkot district,4 private for profithealth service providers inKhas-Urozgan District and 6private for profit health service providers in CharchinyDistrict) of UrozganProvince during theyears 2012-2013. The CSO support type BProject contractedout to Health NetTPO, an international NGO. The privatepractitioners havereceived initial and refresher trainings on immunization, C-IMCI, basic reproductive health services, Health Management Information System(HMIS)reporting and basic management andInfection prevention. The PHF sreceived regular supplies of required medicines, equipment and supplies. The PHFs were also renovated for provision of required services. The project facilitated establishment of Private Medical Association (PMA) in UruzganProvince.The PHM has been registered with the Ministry of Justice. The PMArepresentative haveactively participated in Provincial Public Health Coordination Committee(PPHCC), the PHCC is considered the coordinating as wellas decision making body at the provincial level on the issues related to thehealthsector. The privatepractitioners have actively participated in NIDs and assisted to expand thevaccination interventions insecure districts whereitwas impossible tovaccinate. 17 out 30 PHFs provide vaccinationservices,outpatient services, referraland health education, 6 PHFs provide Reproductive health, outpatient services,referral and health education and 7PHFs provide outpatient services (treatment of common diseases), referral and Healtheducation services.In total 2 doctor (1male and 1 female), 5 midwives,10 nurses, 1 pharmacist, 1 laboratory technicianand 11 mid- level- private forprofit health workers operate in UrozganProvince.

Farah Province

24 private for profit health service providers have beenoperatingin 3 districts of Farah Province;(9 private for profit health serviceprovidersin Purchaman District, 7 private for profit health service providersin Gulistan District, 8 private for profit health service providers in BakwaDistrict).Theproject is contracted out to Coordination of HumanitarianAssistance (CHA), anational NGO. 24 private for profit health facilities haverenovated in FaraProvince. The private practitioners receive initial andrefresher trainings onimmunization- IMCI, basic reproductive health services,Health ManagementInformation System (HMIS) reporting and basic management,Infection Preventionand First Aid. The PHFs received regular supplies ofrequired medicines,equipment and commodities. The project facilitatedestablishment of PrivateMedical Association (PMA) in Farah province. The PMArepresentative regularlyparticipated in Provincial Public Health CoordinationCommittee (PPHCC)meetings on quarterly basis. The private practitionersactively participated inNIDs and through their assistance some uncovered areaswere covered with NIDs.16 out 24 PHFs are providing vaccination services,reproductive health,outpatient, referral and health education services and theremaining 8 PHFs areproviding reproductive health services, outpatient,referral and healtheducation services. It is planned that the implementing NGOwill increase thenumber of PHFs providing direct vaccination.

Intotal there are 6 female private for profit health serviceproviders and 18male private for profit health service providers operating in 3insecuredistricts of Farah Province.

Nuristan Province

20 private for profit health serviceproviders have been operatingin 6 Districtsof Nuristan Province;(3PPHSPs inParoon2 PPHSPs in Wama, 5 PPHSPsin Noorgram, 3 PPHSPs in Doaba , 5 PPHSPs inWant-waygal and 2 PPHSPs inKamdish District).10 out for 20 PHFs provideservices; 1 PHF providereproductive health services, outpatient services,referral and health educationservices, and 9out of 20 PHFs provide reproductivehealth, outpatient servicesand referral services. The project is outsourced toHumanitarian Assistance andDevelopment Organization for Afghanistan, a nationalNGOs.20 Private for profithealth facilities have been renovated; 20 private forprofit health serviceproviders have received initial and refresher trainings onHMIS reporting anddata use, reproductive health ,treatment of common diseaseEPI. Intotal there are 1 female private for profit health providers(midwife) and 19male private for profit health service providers operating in 6insecuredistricts of Nuristan Province.

Paktica Province

40 private for profithealth service providers have been operatingin 4 districtsof Paktia Province (8PPHSPs in Dandi-Patan, 10 PPHSPs in Ahmadkhil,8 PPHSPsin Jajaryob, 9 PPHSPs inWazizadran and 5 PPHSPs in Gardiz District).23 out of40 PHFs provide EPIservices, 8 PHFs provide reproductive health,outpatientand referral servicesand health education; and 9 PHFs provideoutpatientservices, health educationand referral services. The CSO supporttype BProject contracted out to HealthNet TPO, an international NGO. 40 PHFshavebeen renovated in Paktia Province;all private for profit healthserviceproviders have received training on HMISreporting and data use, C-IMCI,EPI, and Infection prevention procedures.40 PHFshave been regularly suppliedwithmedicine, incentives, equipment andcommodities.

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).

Insecurity is a majorchallenge which hampers the project activities. This problem is addressedthrough close cooperation with community. Community health councils areestablished per each PHF. Commitment of private practitioner for providingquality services is a challenge .Providing training, timelyincentives,community health council and regular supportive supervision andmonitoring will be among the strategies to motivate private practitioners todeliver quality immunization and basic RH services. In addition private forprofit health service providers (PPHSPs) have been involved in the process ofnegotiation while there have been any impediments posed during the projectimplementation.Some of districts happened to be extremely insecure it wasdifficult of Provincial Health Directorate staff and NOGs to travel , in orderto monitor, conduct supportive supervision, and training , therefore DistrictFocal Points have been recruited to carry out monitoring, supportivesupervision and on job training. WHO is responsible for coordination, grantmanagement, contract administration and monitoring and evaluation of theprojects implemented by CSOs.

The HSS SteeringCommittee revises and endorses all work plans, budgets, reports andamendments.It also provides technical support to the CSO type B project.Meanwhile, as PPHSP is a new intervention, a separate steering committee isestablished to provide technical support and review progress of the fourprojects of PPHSP. WHO serves as Management Agency for the CSO type B support.WHO releases funds to CSOs as quarterly installments, review financial reportsof CSOs and financial audit at the end of the project. Also Grant Managementand Contract Management are the tasks of WHO. WHO is responsible forcoordination, and monitoring and evaluation of the projects implemented byCSOs. The HSS Steering Committee revises and endorses all workplans, budgets,reports and amendments. It also provides technical support tothe CSO type Bproject.

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 submit regular technicaland financial reports to WHO. Meanwhile, they participate in MOPH/PPP taskforceand Workshops. A PPP coordination committee is established to coordinatetechnical issues between the CSOs implementing PPP projects. The CSOs alsoparticipate in PPHCC meetings at provincial level contributing to

the provincial planning andcoordination. CSOs have introduced by free elections a representative to HSS SteeringCommittee. Recently, a coordination body has been established among CSOsworking in health sector.

The steering committee has beenestablished representing CSOs, WHO and Ministry of Public Health staff in orderinteract with each other's, in order to coordinate the issues relevant to theproject, exchange technical views and lesson learned and review the progressand challenges encountered during the project implementation and constructive recommendationshave been provided.

Data relevant to the projectregularly reviewed and efforts are made to improve the culture of data among CSOs, private providers and different departments of MoPH.

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 and names of CSOs involved, and the initial number and names of CSOs).

The implementation of BPHS iscontracted out to CSOs. Child health and immunization is the second prioritylayer of the BPHS. The

CSOs are already implementing BPHS in many provinces ofAfghanistan.

CSO support type B project isimplementing by 4 different CSOs and consortium in some occasions. Under CSO typeB support, and bridge fund under the four PPHSP projects, contracts are signedwith 144 private health practitioners for providing immunization and basicreproductive and child health services in return for incentives. They areprovided training, vaccines, equipment and other necessary supplies.

There has been a large network ofCSOs has been established representing wide range of CSOs in Afghanistan by thename of Alliance of Health Organization (AHO) to response to the need forstrengthening the CSOs in health and nutrition sector and maximize use of themand improve coordination of health system delivery in Afghanistan. The AHO isan independent alliance of Afghan and international health NGOs that exists toserve and facilitate the work of its member in order to address efficiently andeffectively health of Afghans. 26 health NGOs (CSOs) closely coordinate and cooperateunder AHO in order to maximize the role of CSOs in the health sector of Afghanistan.

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

There have been some delays to start the CSO support type B intervention in some Provinces. Given the fact that CSOs operate in the most insecure provinces, the process of negotiation with communities, CSOs and through CSOs and communities with anti-government elements took more time to convince them and practically start the CSO support type B project interventions.

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 10.2.1a: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2013	Outcomes achieved
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	25 Private practitioners continue delivering immunisation and basic RH and CH services
Health Net TPO (International)	Implemented BPHS in Paktya and Khost provinces.	Contracts signed with 30 private health practitioners for providing immunisation and basic reproductive and child health care	30 Private practitioners continue delivering immunisation and basic RH and CH services
Health Net TPO (International)	Implemented BPHS in, Paktya and Khost provinces.	Contracts signed with 40 private health practitioners for providing immunisation and basic reproductive and child health care	40 Private practitioners continue delivering immunisation and basic RH and CH services
Humanitarian Assistance and Development Organization for Afghanistan(HADAF)	Implemented BPHS in Nooristan province	Contracts signed with 20 private health practitioners for providing immunisation and basic reproductive and child health care	20 Private practitioners continue delivering immunisation and basic RH and CH services

Please list the CSOs that have not yet been funded, but are due to receive support in 2013/2014, 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 10.2.1b: Planned activities and expected outcomes for 2013/2014

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2013/2014	Expected outcomes
ACTD	Implementing BPHS in Helmand and Ghur	provide lifesaving EPI, maternal and child health services, treatment of commondiseases and referral of pregnancy and pregnancy complicated cases as well as severely ill patient to BPHS health facilities	40 Private practitioners continue delivering immunisation and basic RH and CH services
Afghan Health and Development Service (AHDS) a national NGO	AHDS (a national NGO) currently implements the	provide lifesaving EPI, maternal and child health services	15 Private practitioners continue delivering

	BPHS in Kandahar and Urozgan Provinces,	treatment of commondiseases and referral of pregnancy and pregnancy complicated cases as well asseverely ill patient to BPHS health facilities	immunisation and basic RH and CH services
Coordination of Humanitarian Assistance, CHA (National)	Implemented BPHS in Farah and Herat provinces	provide lifesaving EPI, maternal and child health services, treatment of commondiseases and referral of pregnancy and pregnancy complicated cases as well as severely ill patient to BPHS health facilities	25 Private practitioners continue delivering immunisation and basic RH and CH services
Health Net TPO (International)	Implemented BPHS in Paktya and Khost provinces.	provide lifesaving EPI, maternal and child health services, treatment of commondiseases and referral of pregnancy and pregnancy complicated cases as well as severely ill patient to BPHS health facilities	40 Private practitioners continue delivering immunisation and basic RH and CH services
Health Net TPO (International)	Implemented BPHS in, Paktya and Khost provinces.	provide lifesaving EPI, maternal and child health services, treatment of commondiseases and referral of pregnancy and pregnancy complicated cases as well as severely ill patient to BPHS health facilities	20 Private practitioners continue delivering immunisation and basic RH and CH services

10.2.2. **Future of CSO involvement to health systems, health sector planning and immunisation**

Please describe CSO involvement to future health systems planning and implementation as well as CSO involvement to immunisation related activities. Provide rationale and summary of plans of CSO engagement to such processes including funding options and figures if available.

If the country is planning for HSFP, please describe CSO engagement to the process.

The implementation of the GAVI funded CSO Type B project in two securitycompromised provinces was very successful in providing the populations therewith EPI and basic reproductive and child health services and in building aneffective public private partnership. The experiences gained and lessons learntencourage the MoPH to repeat the same approach in two more provinces in CSOtype B bridge funding opportunity. This intervention will ensure continuationof CSO support when the bridge funding for CSO support is completed whilefurther expanding the support to six more provinces.

In addition, there are several buildingsconstructed by various donor's support to establish new HFs mainly hospitals. TheMOPH and the donors are not in the position to fund operationalization of thesehospitals. However, the HFs will be able to cover significant number of populationand ensure delivery of care including EPI and other maternal and childessential services. At this stage, this is very critical for the health sectorin Afghanistan to explore partnership opportunities with for profit National orInternational partners for operationalization of these hospitals.

The training of the privatepractitioners will focus on EPI, basic reproductive and child health services.Each private facility will be linked to the nearest public health facilitywhich provides the supervisory support and the regular EPI and other supplies.

In addition to the provinces of Uruzgan,Farah, Paktia and Nooristan, two more provinces added to the PPP. The main criterion to select those provinceswas the EPI performance measured by DPT coverage compared to the nationalcoverage (87%). The new provinces are Helmand and Kandahar

The HSFP has been developed widelywith the CGHN sub group for all HSS initiatives is HSS steering committee whichis consists of the members from WB, USAID, EU, WHO , UNICEF , Ministryof Finance, NGOS elected representative.

The CGHN (HSS-SC) discussed in severalmeetings the joint health system funding platform for both GAVI and GF. Alsothe platform was explained by GAVI mission with HSS-SC key members and CivilSociety Organizations through separate meetings. After release of theguidelines, the HSS-SC assigned a team of technical experts to coordinate anddraft the proposal.

10.2.3. Please provide names, representatives and contact information of the CSOs involved to the implementation.

Dr.Ismail Hail HADAAF General Director hadaaf_2005af@yahoo.com, 0093(0) 773333606
Dr.A.Majeed Sediqi HNTPO Head of Mission majeed@healthnettpoaf.org 0093(0)700294627 , the HNTPO is the implementer in two provinces of Paktia and Urozgan.
Eng. Yahya Abasi Country director of CHA abbasy@cha-net.org 0093(0)799446055
Dr. Fareed Asmand , Chief Excecutive Director, fareed@ahds.org , 0700282475
Dr. Abudurahman Shahab, General Director , actd.hq@gmail.com, 0786611325

10.2.4. **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 2013 year

	Amount US$	Amount local currency
Funds received during 2013 *(A)*	0	0
Remaining funds (carry over) from 2012 *(B)*	336,904	21,898,760
Total funds available in 2013 *(C=A+B)*	336,904	21,898,760
Total Expenditures in 2013 *(D)*	325,430	21,156,950
Balance carried over to 2014 *(E=C-D)*	11,474	741,810

Is GAVI's CSO Type B support reported on the national health sector budget? **No**

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 Organization (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 installments, 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 reportingformat 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. Thequarterly installments to CSOs are subject to successful submission ofquarterly technical and financial reports.
The CSOs prepares detailed budget for running the projects and the budgets are approved by MOPH/WHO.

Detailed expenditure of CSO Type B funds during the 2013 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2013 calendar year **(Document Number)**. Financial statements should be signed by the principal officer in charge of the management of CSO type B funds.

Has an external audit been conducted? No

External audit reports for CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number).

10.2.5. **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 10.2.5: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target
Coverage of DPT3 among children< I years of age in	Proportion of children receive vaccination in Uro	EPI Monthly Report	78%	91%	EPI Monthly Report	91	01/07/2013
Coverage of DPT3 among children< I years of age in	Proportion of children receive vaccination in Fara	EPI Monthly Report	83%	90%	EPI Monthly Report	90	01/07/2013
Coverage of DPT3 among	Proportion of children	EPI Monthly Report	56%	82%	EPI Monthly Report	82	01/07/2013

children< I years of age in	receive vaccination in Pakt						
Coverage of DPT3 among children< I years of age in	Proportion of children receive vaccination inNoori	EPI Monthly Report	41%	54%	EPI Monthly Report	54	01/07/2013
Establish Public – Private Partnership Model in Ins	No of PHP contracted in insecure areas of Urozgan	CSO Support Type B, Quarterly Report	0	30	CSO Support Type B Project Monthly Report	100	01/07/2013
Establish Public – Private Partnership Model in Ins	No of PHP contracted in insecure areas of Farah	CSO Support Type B, Quarterly Report	0	23	CSO Support Type B Project Monthly Report	96	01/07/2013
Establish Public – Private Partnership Model in Ins	No of PHP contracted in insecure areas of Paktia	CSO Support Type B, Quarterly Report	0	40	CSO Support Type B Project Monthly Report	100	01/07/2013
Establish Public – Private Partnership Model in Ins	No of PHP contracted in insecure areas of Noorista	CSO Support Type B, Quarterly Report	0	20	CSO Support Type B Project Monthly Report	100	01/07/2013
private for profit health facilityin four insecure	Number of Private for Profit Health Facilities Upg	Quarterly Activity Report	45%	114	Activity Report/Monotoring Report	100	01/07/2013
Private for Profit Health Service Providers in fou	Number of Private for Profit Health Facilities Pro	Quarterly Activity Report	54%	114	Activity Report/Monotoring Report	100	01/07/2013

Planned activities :

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.

CSO support type B,partnership with private for profit health service providers will be continued in, Urozgan, Farah, Paktia and Nuristan Provinces. Two CSOs will be expandedwithin two other insecure provinces of Qandahar and Helmand Provinces in Some of the districts are extremely insecure, in Nuristan, Farah, Urozgan and Paktia Province. Therefore it is required to strengthen community based monitoring system. Currently there are multiple level of monitoring are in place to monitor the implementation of the CSOs; CSOs are being monitored by WHO and Cetral MoPH staff, however it is challenging WHO and MoPH staff to go to someof the insecure provinces. Certain monitoring tools and system are in place to monitor the CSOs. HMIS format have been developed, CSO have received training on HMIS and reporting system; the format are exited in health private health facilities; private health facilities are filling the Health Information System Forms; PPHSPs sent the HMIS form on quarterly basis; the reports have been reviewed by WHO/NGO and feedback provided to PPHSPs.
In addition;Implementing NGOs staff, and District Officers are monitoring the CSO support type B project implementation on regular basis; NGOs staff monitor the implementation of CSO project, on the job training, regular and refresher training are being provided to PPHSPs.
The major challenge in the process of monitoring is prevailing insecurity; there are some districts that active fighting and artillery shelling in going on, e.g some district in Nuristan;It make it difficult to monitor; however , the District Officers are recruited from the same districts and they are living there, therefore it make it possible to monitor the CSOs implementation; In addition we may need to training community elders in monitoring (simple but robust), that they could also monitor the CSO support Type B project.

11. 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

12. Annexes

12.1. Annex 1 – Terms of reference ISS

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 2013 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2013, 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 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2013 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2013, 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 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

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 ***
Balance brought forward from 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2013 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✔	Cover sheet of Annual Progress Report0001.pdf **File desc:** **Date/time :** 13/05/2014 06:50:37 **Size:** 371 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	✔	Minister of Finance Signature.pdf **File desc:** **Date/time :** 14/05/2014 02:37:03 **Size:** 510 KB
3	Signatures of members of ICC	2.2	✔	ICC List of Participants May 2014.docx **File desc:** **Date/time :** 15/05/2014 03:30:30 **Size:** 376 KB
4	Minutes of ICC meeting in 2014 endorsing the APR 2013	5.7	✔	ICC Meeting Minute 14 May 2014.docx **File desc:** **Date/time :** 15/05/2014 03:32:46 **Size:** 66 KB
5	Signatures of members of HSCC	2.3	✔	HSCC Signatures0001.pdf **File desc:** **Date/time :** 13/05/2014 06:55:49 **Size:** 1 MB
6	Minutes of HSCC meeting in 2014 endorsing the APR 2013	9.9.3	✔	All Steering Comitee Meeting Minutes.pdf **File desc:** **Date/time :** 14/05/2014 02:47:58 **Size:** 11 MB
7	Financial statement for ISS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✔	Financial Documents.docx **File desc:** **Date/time :** 15/05/2014 03:35:07 **Size:** 476 KB
8	External audit report for ISS grant (Fiscal Year 2013)	6.2.3	✔	External Audit not conducted in 2013.docx **File desc:** **Date/time :** 08/05/2014 02:46:30 **Size:** 12 KB

9	Post Introduction Evaluation Report	7.2.2	✔	ReportPieAfghanistanNov2011.docx **File desc:** **Date/time :** 08/05/2014 02:49:29 **Size:** 277 KB
10	Financial statement for NVS introduction grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✔	ISS_NVS_Exp_13.docx **File desc:** **Date/time :** 08/05/2014 02:50:58 **Size:** 24 KB
11	External audit report for NVS introduction grant (Fiscal year 2013) if total expenditures in 2013 is greater than US$ 250,000	7.3.1	✔	External Audit not conducted in 2013.docx **File desc:** **Date/time :** 08/05/2014 02:54:42 **Size:** 12 KB
12	Latest EVSM/VMA/EVM report	7.5	✔	AFG EVM_report_Final.doc **File desc:** **Date/time :** 08/05/2014 03:51:23 **Size:** 2 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✔	EVMA 2011-2012.pdf **File desc:** **Date/time :** 08/05/2014 03:05:30 **Size:** 1 MB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✔	EVM-Improvement-Plan for national level.xls **File desc:** **Date/time :** 08/05/2014 03:52:40 **Size:** 195 KB
16	Valid cMYP if requesting extension of support	7.8	✘	AFG_cMYP_11_15.docx **File desc:** **Date/time :** 08/05/2014 04:10:41 **Size:** 2 MB
17	Valid cMYP costing tool if requesting extension of support	7.8	✘	AFG cMYP_Costing_PneumoRota (19 Apr 11) F.xls **File desc:** cMYP costing tool **Date/time :** 08/05/2014 03:11:38 **Size:** 3 MB
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✘	ICC_March_14.doc **File desc:** ICC minute requested extension of vaccine support **Date/time :** 08/05/2014 03:43:18 **Size:** 398 KB

19	Financial statement for HSS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✓	Financial Statement for the year 20130001.pdf **File desc:** **Date/time :** 14/05/2014 06:25:30 **Size:** 6 MB
20	Financial statement for HSS grant for January-April 2014 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✓	Since there was no expenditures occurred in the first quarter of year 2014.docx **File desc:** **Date/time :** 14/05/2014 06:32:56 **Size:** 10 KB
21	External audit report for HSS grant (Fiscal Year 2013)	9.1.3	✓	Final Report Section II.pdf **File desc:** **Date/time :** 04/05/2014 12:37:02 **Size:** 6 MB
22	HSS Health Sector review report	9.9.3	✓	MoPH Health Results Conference Report April 2013.pdf **File desc:** **Date/time :** 04/05/2014 12:05:32 **Size:** 957 KB
23	Report for Mapping Exercise CSO Type A	10.1.1	✓	Project Final Report CSO Type A.pdf **File desc:** **Date/time :** 06/05/2014 07:17:33 **Size:** 12 MB
24	Financial statement for CSO Type B grant (Fiscal year 2013)	10.2.4	✓	Financial Report on CSO support type B.pdf **File desc:** **Date/time :** 03/05/2014 11:56:50 **Size:** 932 KB
25	External audit report for CSO Type B (Fiscal Year 2013)	10.2.4	✓	The CSO type B bridge fund audit will be done by WHO internal audit system.docx **File desc:** **Date/time :** 14/05/2014 06:29:14 **Size:** 9 KB
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2013 on (i) 1st January 2013 and (ii) 31st December 2013	0	✓	27227.pdf **File desc:** **Date/time :** 06/05/2014 01:38:55 **Size:** 648 KB

27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	×	Not applicable.docx **File desc:** **Date/time :** 08/05/2014 03:45:24 **Size:** 12 KB
	Other		×	5. Finincial Report.pdf **File desc:** **Date/time :** 02/06/2014 09:22:13 **Size:** 2 MB
				APR 2013 for submission 2.docx **File desc:** **Date/time :** 02/06/2014 09:22:36 **Size:** 340 KB
				APR 2013 for submission 2.pdf **File desc:** **Date/time :** 02/06/2014 09:22:24 **Size:** 1 MB
				Final Audit Report for Assignment0001.pdf **File desc:** **Date/time :** 04/05/2014 12:40:37 **Size:** 542 KB
				Final Report of AHO AF194GA Revised-13-4-2014.doc **File desc:** **Date/time :** 05/05/2014 11:53:32 **Size:** 155 KB
				Final Report Section II.pdf **File desc:** **Date/time :** 04/05/2014 12:51:13 **Size:** 6 MB
				GAVI Alience CSO A&B Signatures0001.pdf **File desc:** **Date/time :** 15/05/2014 03:40:02 **Size:** 1 MB