Joint appraisal report

Country	Afghanistan
Reporting period	*Jan 2014 Year of the last appraisal report – December 2014 of the current appraisal*
cMYP period	*2010- 2015 revised cMYP 2015-2019*
Fiscal period	*January 2014 to December 2014*
Graduation date	*Only relevant for graduating countries*

1. EXECUTIVE SUMMARY

1.1. Gavi grant portfolio overview

- The National EPI program provides vaccines against 9 preventable diseases namely Tuberculosis, Tetanus, Pneumococcal infection, Hepatitis B, H influenza type B, Pertussis, Diphtheria, Polio and Measles. Of the mentioned vaccines, only Penta and Pneumococcal vaccines are supported by GAVI, and the rest are all supported by Government of Japan funding through UNICEF.
- In 2013 the total financing for the immunization program was estimated at USD 53 million, the total spending on EPI in Afghanistan was shared among the Government of Afghanistan, Govt. Co-Financing of GAVI support, GAVI grants (GAVI-ISS, GAVI-NVS and GAVI-HSS), WHO, UNICEF, JICA and BPHS donors (;World Bank, USAID, European Union).In 2013, GAVI was the largest financer of the EPI which provided 52% of the total resources: GAVI-ISS (12%), GAVI-NVS (26%) and GAVI-HSS (13%).
- Gavi, the Vaccine Alliance has supported the National EPI of Afghanistan since 2001 with immunization system strengthening, cash based support and vaccines with a commitment of $198,430,122 until 2015.
- The national EPI coverage survey conducted in late 2013, revealed the coverage for BCG is 77.9%, Measles is 58.8%, Penta-3 is 59.7%, TT2 is 73.8% and proportion of children receiving all antigens before the age of 2 years is 51%. The full immunization coverage varies from 2.5% in Farah province to 86.8% in Paktia province.
- In 2014 Afghanistan reported Penta 3 coverage was 91 % against the target of 90%. The dropout rate between Penta 1 and Penta 3 was 13%. As per the WUENIC draft estimate for 2014 released recently, the Penta 3 coverage is estimated to be 75%.
- The vaccine wastage rate for the Pentavalant vaccine was 6% and for PCV was 4% as compared to acceptable wastage rate of 25% and 5% respectively during 2014.
- In the EVM report (Dec 2014) overall scores of the assessment for all levels of the supply chain is 77%, while it was 88% in 2011. Three criteria (vaccine arrival, storage capacity and vaccine management practice) exceeds the WHO recommended minimum score of 80%. An improvement plan (IP) has been prepared which will be funded through HSS3.

- The country has a total net cold storage capacity of 234.6 m3 as per the CC inventory undertaken in March 2015 (175 m3 Positive 58.7 m3 negative).The CCE procurement through HSS 2 will expand the storage capacity by additional 182 m3 capacity (109 m3 Positive and 73 m3 of negative) by August 2015, which will be sufficient considering IPV introduction in September 2015.
- The new cMYP for the period from 2015-2019 has been developed and the target population for 2016 is 1,175,682 total births and 1,085,154 as surviving infants.
- Country is preparing for IPV introduction in September 2015 and for tOPV to bOPV switch in April 2016.
- AFP surveillance is in accordance with WHO standards, however Measles surveillance needs improvement and country has requested additional technical assistance for this purpose. AEFI surveillance needs to be improved to ensure the vaccine safety.
- MOPH fully realizes the need of strengthening data quality, it is one of the key components of the cMYP 2015-19. The data collection tools have been updated in January 2015, concerned staff at national level have been provided training, and now all provinces are submitting data to national level using these tools. To further build the data quality MOPH is working with partners to develop a specific DQ improvement plan. CES is planned for 2016 and 2018.
- The ISS grant will close by end of 2015, the NEPI staff both at the central and Provincial received their salaries from ISS grant. The last steering committee approved that the ISS staff salary will be covered from HSS2 saved budget till transfer of first tranche of HSS3 grant. approval requested
- GAVI HSS funded program has contributed to strengthening the health system, produced tangible results through applying innovative approaches to improve access to quality health care services, increasing demand for and utilization of maternal and child health care services including EPI, and strengthening the stewardship functions of the MoPH at different level. HSS2 grant has an estimated 80% of the total budget executed by May 2015 the encumbrance and commitments ensures that the grant will be closed by end of 2015 and the country is in need of new cash support in the first quarter of 2016.
- **Performance on mandatory indicators:** Based on country administrative data Afghanistan had an improving trend on Mandatory Performance Indicators; i.e. there was 4%, 5% and 1.5% increase for penta3, MCV1 and geographic equity (DPT3 coverage) respectively. Increase on Socio-economic equity, drop-out rate and % of fully immunized children will be reported at the end of 2016 by EPI coverage survey.
- **Performance on intermediate indicators:** As intermediate results Afghanistan reported an increase of 10% penta3 coverage in Kuccha children, Proportion of women with skilled birth attendants at delivery has increased to 54% in 2014 where the baseline in 2013 was 47.4%. The Penta3 coverage increased from 38% in 2013 to 83% in 2014 the targeted 6 insecure provinces where CSO type B services are provided through public private partnership approach based on the HMIS data. 85% of HFs were equipped with cold chain which determines an increase of 2% compared to the baseline of 2013. Similarly, an increase of 8% in the monitoring of HFs by PHOs was reported in 2014. Intermediate results are at its highest performance on training of cold chain management staff, vaccinators and CHWs as of 100%, 99.7% and 99% respectively.
- Govt. of Afghanistan paid the required co-financing amount and also earmarked the co-financing fund for the 2015 and don't fore see any problem in co-payment for 2016 as well.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements

- Through the establishment of MHTs, nomadic population has better access to basic health services including EPI. Based on program data the coverage has been increased from 16% to 31% in the target provinces.

- The finding of external evaluation of CSO type B (PPP) support indicates the innovative approach works for the provision of basic health services in insecure and underserved areas, contributing to decrease inequities in health. It contributes to the reduction of child and maternal mortality in those communities. The report recommends the extension and expansion of this model in other insecure and hard to reach areas. The Penta3 coverage increased from 38% to 83% in the targeted provinces based on the HMIS data.
- Coverage and equity has been improved, quality of immunization services has been improved, and governance stewardship of MoPH has been improved for details please refer to section 3.2.
- Full time dedicated managerial and supervisory EPI staff available at regional and provincial levels

Challenges

- There are 2878 villages, constituting 7% of villages in Afghanistan, that lacks out-reach and 449 out of 537 (17%) HSCs do not provide immunization services.
- Female to male ratio of vaccinators is 1:3.
- In adequate monitoring of NGOs performance in insecure provinces.
- Poor awareness and demand for immunization in the community level.
- Strengthening Data quality remains a challenge as target population is not properly estimated, there is limited capacity for data collection, analysis and monitoring.
- The capacity of cold chain equipment and physical infrastructure is inadequate for new vaccines introduction and expansion of routine immunization and vaccine Temperature monitoring system is not in place.

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

The key areas to improve immunization coverage include

1. Increasing access to Immunization by, proper micro planning and its implementation. Expansion of Delivery centers through sub centers, Innovative approach for Insecure and hard to reach areas/populations, Involving private sector and CSOs'
2. Creating demand generation by engaging the community stake holders through IPC, advocacy and social mobilization etc. based on a comprehensive communication plan
3. Improving program management at every level
4. Addressing Data quality issues by implementing the planned activities outlined in cMYP and DQ improvement plan

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

To continue the support for penta3 and PCV13 vaccines according to the request submitted in APR whereby the 1,420,121 doses of Pentavalant and PCV13 each are requested to achieve the target coverage of 95%.The wastage rate are expected not to exceed the recommended wastage limits.

In order to lessen the huge logistics issues linked with single dose formulation of PCV13, The country would like to switch to multi-dose vial when they are available

1.4. Brief description of joint appraisal process

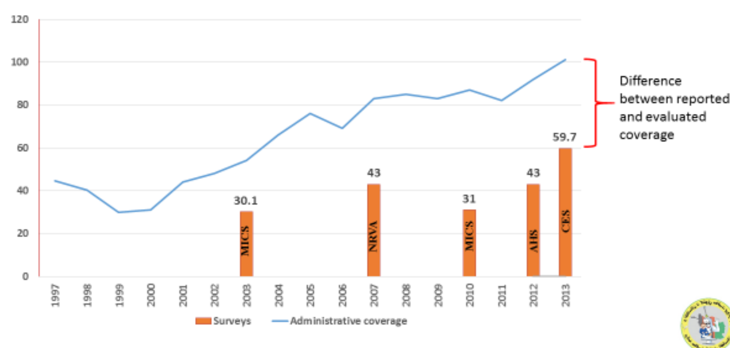
The joint appraisal was co-convened by the Ministry of Public Health (MOPH) and Gavi, and was country-led. It was inclusive of relevant national and international stakeholders, that enabled unbiased, evidence-based discussions, build on existing country processes and results of other reviews.
Though the mission was planned to be held at Kabul Afghanistan 7- 11 June 2015, however because of certain security concerns a remote Joint appraisal mission was held in Cairo from 13-16 June 2015. Representative from the MoPH i.e. Dr Noorshah Kamawal HSS coordinator and Dr Sardar Parwiz EPI Manager, Dr Shakoor WHO Afghanistan and Dr Raveesha Mugali UNICEF Afghanistan joined the appraisal team that was composed of Dr Mounir Farag, WHO/EMRO; Dr Irtaza Chaudhri, WHO/EMRO , Ciara Goldstein and Anne Cronin, Gavi Secretariat.
To facilitate the appraisal mission a preliminary technical report was drafted by MOPH. During the remote appraisal videoconference for was held with the relevant stakeholders from the Ministry of Public Health, members of the Inter-agency Coordinating Committee (ICC) and Health Systems Coordinating Committee (HSCC), including civil society organizations and staff from alliance partner organizations.
The process identified actionable recommendations and the process, findings and recommendations endorsed by the Health System Strengthening Steering Committee (HSS-SC)/ICC on 24 June 2015.
Appreciation is extended to WHO EMRO and WHO CO for convening the remote JA and supporting the process (videoconference facilities, logistics, transport etc.).

2. COUNTRY CONTEXT

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

In 2015, the total estimated population of Afghanistan is 31.5 million with primarily rural population (74%) (UNIDATA), of which 36.5% of the country's population lives below the poverty line; more in rural areas (38%) than in urban areas (29%), and worst among Kuchis (54%), who are the nomads comprising about 6% of the population. The last count of the population of Afghanistan was done in the 1979 Population and Housing census. EPI programme bases its denominator as per the UNI data estimates. The literacy rate is estimated at 17% for females and 45% for males with high discrepancy between rural (25%) and urban areas (54%), and 7.2% for Kuchis.

Regarding health statistics, the Afghan MICS in 2011 measured Infant Mortality Rate (IMR) at 74 deaths per 1000 live births and Under 5 Mortality Rate (U5MR) at 102 deaths per 1000 live births. The IMR was high among rural families (76 versus 63/1000 live births in urban areas), poorest quintile (75 versus 62/1000 in richest quintile) and illiterate mothers (74 versus 55/1000 live births among mothers with secondary education).
According to the National Immunization Coverage Evaluation Survey (CES) Afghanistan 2013, Penta-3 coverage was 59.7%. Significantly, there was a 30 point gap between the survey data and the EPI administrative data which reported Penta-3 coverage as 89%. The findings of CES 2013 also reveal that the proportion of fully immunized children ranged from merely 2.5% in Farah province to 86.8% in Paktia province. In only 4 provinces, proportion of fully immunized children was above 80% whereas 13 provinces were found below that national coverage of 51%. The findings of the survey also reveal that there exists a wide gap (22%) of vaccine coverage between poor and rich households. The proportion of fully vaccinated children in rural areas (49%) was significantly lower when compared to the urban areas (61.8%). 18.3% children never received any vaccination. Similarly, for TT coverage, at the time of delivery of the youngest child, 58.6% of mothers and their newborns were protected against Tetanus, but about 19.5% of women had never received TT vaccination – worse among poorest compared to wealthiest quintile (29.1% vs 13.9%); among non-educated compared to some education (22% vs 8%); and among rural compared to urban mothers (20% vs 14%).
The trend in immunization coverage since 1997 is outlined in the graph below showing a slow improvement in immunization coverage, though there remains significant gap between reported and assessed coverage.



The MOPH is cognizant of the situation and to commits to take it forward with clear commitment which fostered in the CALL TO ACTION held in May 2015.

EPI service delivery: Immunization delivery centers are located in regional, provincial and district hospitals as well as sub centers. Over the last decade the EPI delivery centers and vaccinators have expanded: centers increased from an abysmal 400 in 2004 to 1,575 in 2014 and vaccinators from 800 to 2,906.

Leadership, governance and program management: Afghanistan has transformed from a conflict-torn health system to a relatively functional one through an innovative approach by contracting out Basic Package of Health Services and Essential Package of Health Services at primary and tertiary levels to NGO sector. While NGOs are the implementing public health care providers, the MoPH assumes the stewardship and governance responsible for policy and strategy formulation in addition to regulation, coordination, health financing, monitoring, evaluation and accreditation. The country is administratively divided into 34 provinces and around 399 districts. The EPI program is managed by department of EPI at the national level, 7 regional and 34 provincial EPI management teams. EPI Steering Committee and Health Sector Coordination Committee operate at the national level to give strategic directions to the implementation of the programme. The ICC is integrated to HSS-SC; its membership includes government department, international organizations and CSO. The HSS- SC met 6 times in 2014 and discussed the following topics: EPI performance results, review and approval of the APR, issues related to IPV & measles, HSS3 new application, EVM, Co-financing, CTA, cMYP, IHP+, and support for civil society organizations.

Health and EPI Financing: The latest report on National Health Accounts (2012-13) indicate that the Total Health Expenditure (THE) per capita is USD 55.59, out of which 73.3% (USD 41) is Out-Of-Pocket (OOP) whereas the central government's contribution is only 5.6% and the remainder is financed by the international community. The expenditure under EPI programme was mainly incurred on payment of government's share under co-financing of GAVI-supported vaccines. The total financing of the immunization program is estimated at USD 2,641,291 million in 2013, the total spending on EPI in Afghanistan was shared among the Government of Afghanistan, Govt. Co-Financing of GAVI support, GAVI grants (GAVI-ISS, GAVI-NVS and GAVI-HSS), WHO, UNICEF, JICA and BPHS donors (;World Bank, USAID, European Union).In 2013, GAVI was the largest financer of the EPI which provided 52% of the total resources: GAVI-ISS (12%), GAVI-NVS (26%) and GAVI-HSS (13%). The pie chart in the annex shows the contribution of partners. The MoPH is well cognizant of the fact that the funding gap for the overall sustainability (programmatic and financial) is not limited to a single component of the immunization system. Therefore, an integrated and holistic approach has been adopted to ensure achieving best value for the money. However, keeping in view the rapidly expanding health sector coverage in Afghanistan, the funding gap structure and severity of shortage related to "Activities and other recurrent costs" raises concerns in near future. The national EPI managers plan to compete with other government departments for allocation of additional resources but also to persuade the donor's for bridging the gaps in resource availability.

Workforce and Human Resources: The critical HR for immunization services include Vaccinators, Provincial and regional EPI management staff. Although there are 2,926 vaccinators there are only 700 female vaccinators. A majority of these female vaccinators are also working in the urban areas. This is an

important barrier as it is unacceptable for women to get vaccinated by male vaccinators. There is also an attrition of these vaccinators due to low salary. Human resource problems such as inappropriate employment of staff by NGOs, high staff turnover, low pay and poor supportive supervision are challenging issues for delivery of immunization services.
High levels of poverty, large size of dependent population, big number of nomads, poor female literacy rates, sensitive cultural practices and widespread insecure areas point towards difficulties and obstacles that the health program managers and implementers have to face in planning, service delivery, demand generation and social mobilization for health service delivery, in general, and immunization, in particular. These gaps are the key areas to be addressed in order to achieve effective and efficient vaccine coverage and outcomes.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and underused vaccine support

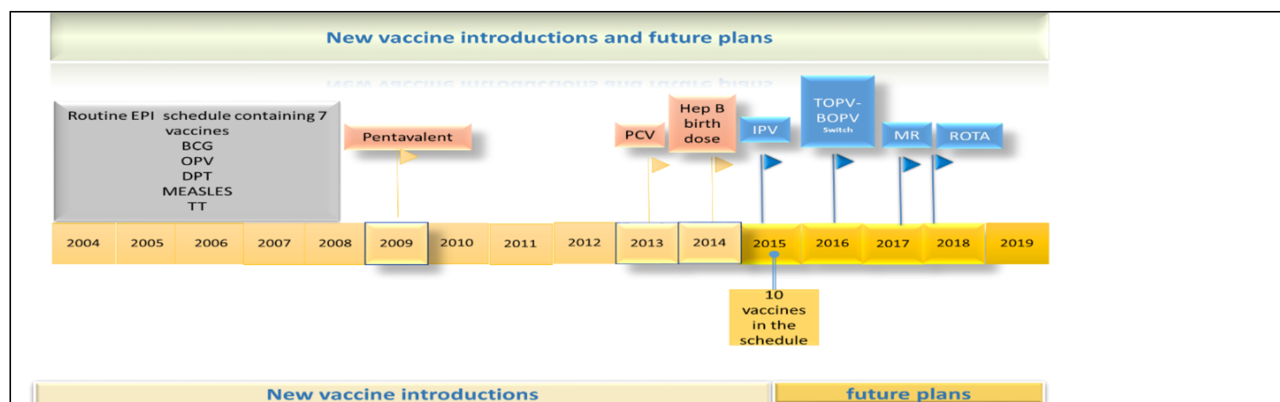
3.1.1. Grant performance and challenges

DTP-HepB-Hib (Penta)

Even though the denominator has increased significantly, the country has overachieved the coverage target for Penta3 as reported in section 4 of the APR. However, it is to be noted that the coverage rate for Penta1 based on the reported number of children immunized stands at 113%. This signifies serious issues related to quality of administrative data. It is to be noted that WUENIC estimate for Penta3 for 2013 was significantly lower (by 28% points) than administrative coverage reported by the country in the APR. DTP1-3 dropout rate: The country has also reported an increase in the dropout rate from 10% in 2013 to 13% in 2014. While this may in part be explained by the increase in the denominator in 2014, the interpretation of drop-out rate should be done with caution

Pneumococcal Vaccine (PCV)

The country has missed the target for Pcv3 by a significant margin of 24% points. Country has achieved a target of 66% compared to the target of 90%. However, the coverage of PCV1 is 113% based on the reported number of children immunized which again raised concerns around quality of administrative data and points to potential inaccuracies in the estimation of surviving infants. The difference between PCV1 and PCV3 also points to a high dropout rate for which country has pointed to severe stock constraints as a reason.
The **vaccine wastage rate** for the Pentavalant vaccine was 6% and for PCV was 4% as compared to acceptable wastage rate of 25% and 5% respectively (JRF 2014). graph in annex.
In the **EVM report** (Dec 2014) overall scores of the assessment for all levels of the supply chain is 77%, while it was 88% in 2011. Three criteria (vaccine arrival, storage capacity and vaccine management practice) exceeds the WHO recommended minimum score of 80%. An improvement plan(IP) has been prepared which will be funded through HSS3.Following key interventions will be implemented though GAVI HSS3 proposal: 1,Real time vaccine logistics stock management system:2, Planned preventive maintenance and supportive supervision system:3,Construction of 21 warehouses, 7 provincial vaccine stores and 1 national vaccine store complex.
Surveillance: AFP surveillance as per standard and Measles surveillance needs improvement other VPD diseases surveillance to be established. There is need of the looking into establishment of integrated VPD surveillance.



As per the Infographic above on NUVI, the Penta and PCV been introduced using GAVI support in 2009 and 2013. In 2015, GAVI supported the introduction of IPV, and as per cMYP there is a plan to introduce MR in 2017 and ROTA in 2018.

The country has a total net **cold storage capacity** of 234.6 m3 as per the CC inventory undertaken in March 2015 (175 m3 Positive 58.7 m3 negative).The CCE procurement through HSS 2 will expand the storage capacity by additional 182 m3 capacity (109 m3 Positive and 73 m3 of negative) by August 2015, which will be sufficient considering IPV introduction in September 2015. Considering the three important interventions during the 2016 to 2019 period, cold storage capacity needs further enhancement of 236 m3. By end of the proposal country will be with Cold storage capacity of 575 m3 (450 Positive and 125 negative) - graph in annex.

Following activities were performed for the NUVI with HSS2 grant;

- Cold chain equipment purchased based on provinces needs which had been identified upon an need assessment conducted by NEPI with the assistance of UNCEF in which the additional equipment were considered for introduction of new vaccine i.e. pneumococcal vaccine similarly in the construction of warehouses the capacity for new vaccines was considered.

Equity analysis was done by UNICEF country office (Q2, 2015) using the Tanahashi framework comprising of supply, demand, and enabling environment and the challenges for duty-bearers to reach the rights-holders. As per the equity analysis paper, there are eight provinces with less than 40% full immunization coverage: Farah, Nooristan, Hilmond, Urozgoan, Ghor, Zabul, Kandahar and Badgis. Kandahar, Uruzgon and Zabul had polio cases in 2014. These provinces need support in building and expansion of quality assured EPI delivery system. Key areas of capacity strengthening include human resources, cold chain system and differential micro planning and monitoring. Nuristan Province does not even have a provincial vaccine store, the vaccines are being supplied by two neighboring provinces. There are seven more provinces identified with a high birth cohort and large number of missed children due to growing urbanization, internally displaced population and Kuccha nomadic population settling in these areas. This poses a big threat of outbreaks of VPDs in the urban areas. The district wise analysis of equity with planning and allocation of resources will be addressed through the CTA-DQ proposal in complementarity with UNICEF support. The entry points to families in the Afghanistan context are quite different than other countries hence there is a need of strong communication efforts through multiple channels to reach the parents and families to achieve the behavior change and mobilization.

The **ISS grant** will close by end of 2015, the NEPI staff both at the central and Provincial received their salaries from ISS grant from the beginning of ISS grant. The last steering committee approved that the ISS staff salary will be covered from HSS2 saved budget till transfer of first tranche of HSS3 grant. To prevent financial gaps in Kochi MHT, PPP, M&E, Health Information Call Centre activities till beginning of new grant (HSS3) and the salary of HSS staff who directly involved in the planning, implementation and oversee of the HSS project, will be covered from the HSS2 saved budget.

In the **new cMYP** for the period from 2015-2019 the target population for 2016 is 1,175,682 total births, however as per the UNIDATA estimates which are used as a basis for the EPI programme including vaccine forecast the target of under one children is 1,233,963 There is difference of 58,000 less children (apex 5% of surviving infants cohort) between UNIDATA and estimated in cMYP figures. It was agreed during

the joint appraisal that MOPH in consultation with partners will review these figures to make sure that no underestimation of resources particularly vaccines is made. The joint appraisal team considered to review the cMYP figures considering the implications.
The need of **strengthening Data quality**, it is one of the key components of the Cmyp2015-19 in addition MOPH is working with partners to develop a specific DQ improvement plan. Given the recent results of the coverage survey, the WHO and UNICEF estimates provides overestimated results; which requires a discussion on WHO and UNICEF estimates. The 30% discrepancy between administrative data and coverage survey suggests data quality to be improved which is planned under approved CTA 2015. Following activities are already planned CES survey on 2016 and 2018. DQSS is also planned in 2016. Micro planning and M&E activities are reinforced with innovative mechanisms through HSS3 proposal.

3.1.2. NVS renewal request / Future plans and priorities

Continue support for penta3 and PCV13 vaccines according to the request submitted in APR whereby the 1,420,121 doses of Pentavalant and PCV13 each are required to achieve the target coverage of 95%. The wastage rate are expected not to exceed the recommended wastage limits
In order to lessen the huge logistics issues linked with single dose formulation of PCV13, The country would like to switch to multi-dose vial when they are available
The program plan to apply for Rota vaccine in 2016 following improvement in coverage to be eligible. The Rubella introduction which is planned in 2017, subject to a high quality implementation of MR SIA before introduction of Rubella. The past measles SIA coverage were not satisfactory hence country intends to plan for a High quality Rubella SIA and apply to Gavi for support in 2016.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

Afghanistan performed well in the HSS component through the adoption of two main strategies. The first is the establishment of Mobile health teams (MHTs,) to provide nomadic population has better access to basic health services including EPI. The second strategy is an innovative approach of Public Private partnership (PPP) model that was developed for the provision health delivery system in remote areas (white areas). The finding of external evaluation of GAVI supported HSS1 grant indicates that this innovative approach works for the provision of basic health services in insecure and underserved areas, contributing to decrease inequities in health. The Penta3 coverage in areas supported under HSS 1 increased from 38% to 83% in the targeted provinces based on the HMIS data. The external evaluation report recommends the extension and expansion of this model in other insecure and hard to reach areas. In areas supported under HSS2 the Penta3 coverage has increased from 16% to 51% in the targeted 12 provinces (8% of the total population) based on the program data.
The reported challenges in implementation were security, delays in administrative processes of cold chain equipment and construction, and geographical barriers. Despite the difficulties however, targets were achieved in most areas. Based on country administrative data Afghanistan had an improving trend on **Mandatory Performance Indicators;** i.e. there was 4%, 5% and 1.5% increase for penta3, MCV1 and geographic equity (DPT3 coverage) respectively. Increase on Socio-economic equity, drop-out rate and % of fully immunized children will be reported at the end of 2016 by EPI coverage survey. **As intermediate results** reported an increase of 10% penta3 coverage in Kuccha children, Proportion of women with skilled birth attendants at delivery has increased to 54% in 2014 where the baseline in 2013 was 47.4%. The Penta3 coverage increased from 38% in 2013 to 83% in 2014 the targeted 6 insecure provinces where CSO type B services are provided through public private partnership approach based on the HMIS data. 85% of HFs were equipped with cold chain which determines an increase of 2% compared to the baseline of 2013. Similarly, an increase of 8% in the monitoring of HFs by PHOs was reported in 2014. Intermediate results

are at its highest performance on training of cold chain management staff, vaccinators and CHWs as of 100%, 99.7% and 99% respectively.

In 2014 under HSS 2 support to improve quality, effectiveness and utilization of health care immunization services the program focused on **provision of cold chain equipment and construction of warehouses** in 11 provinces. To date 80% of the requested cold chain equipment has been delivered while the construction of warehouse in 11 out of 34 provinces is in progress which would be completed by end of September 2015 through WHO. Construction of warehouses for the remaining provinces are planned under HSS3 new proposal.

To strengthen the ability of MOPH at various levels to provide **stewardship** responsibilities the Geo Location Monitoring (GLM) initiative was successfully installed. The central M&E officers (31 officers) conducted in total 31 field visits/quarter to 91% provinces and 28% of HFs during 2014.
In response to the **observations made by the FMA** (2012) to streamline procurement processes procurement directorate at MoPH developed 10 procurement guidelines to simplify the procedures. These guidelines will also standardize and increase data accuracy and further improve the procurement planning and transparency in procurement of goods, works and consultancy services.
Training and deployment of 299 out of 300 (1/3 of which was female) new vaccinators resulted in better access to EPI services. HSS- SC oversaw the project and provided active guidance.
The extension of activities in 2015 are to be carried out using the left over/saving funding available from 2014 which has been approved by the HSS- SC in its minutes. These activities include extension of MHTs, PPP project, call center and support of EPI staff and activities as ISS window is closed.

Financial gap analysis (FGA) of health sector was completed where the final report will be submitted by end 2015.

3.2.2. Strategic focus of HSS grant

HSS grants strategic goal is to contribute to reduce maternal and child mortality by addressing health system bottlenecks related to immunization. The objectives aim to strengthen the performance of the health system by addressing key health and immunization system bottlenecks.
The strategic focus of HSS2 grant is to increase the coverage and equity through improving community participation, increasing demand for immunization service, strengthening effective vaccine management capacity, and strengthening management and leadership capacity. Immunization program in Afghanistan is supported within BPHS package which is funded by WB, EC and USAID, where Gavi is providing complementarity support to address system bottleneck and challenges that are not covered by other donors as stated in the cMYP.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

- The HSS3 application has been submitted on 1st June 2015, which will support the country from 2016-2019; which will improve immunization coverage and equity
- The data quality improvement plan to be submitted in October 2015.

3.3. Graduation plan implementation *(if relevant)*

3.4. Financial management of all cash grants

GAVI had performed an FMA in 2012 however the MOU was not signed. The Government acknowledged that their financial management processes are slow and as HSS2 had only a 2 year implementation the Government of Afghanistan had requested that HSS funds are sent to partners. Consequently, the HSS funds disbursed in 2014, have been sent to WHO . For HSS 3 it is planned to channel a portion of the

funds through the Government subject to completion of a satisfactory FMA scheduled to take place Q3 2015.

The closing balances of $ 31,725 and $ 11,474 for CSO Type A and B respectively will be refunded to Gavi Secretariat.

Till now GAVI support has been approved for US$ 15,521,149 including four rewards of US$ 8,527,700 based on 2003, 2004, 2005 and 2006 achievements. For the last time $ 1,410,000 came on 28th March 2010 for routine EPI strengthening .National EPI routine program is still running with remaining fund .Current balance for GAVI/ISS fund till due date is US$ 143,213 and is enough up 20 September 2015 which is equal with the end of 6th month local country year calendar.

In 2015 all the ISS incumbrancers will all ISS funds of$ 632, 853.05 will be spent to support the EPI program There is a remaining ISS balance of $169,400 in the Secretariat. This will be transferred to the MoPH following FMA.

During reporting period actual expenditure for HSS2 are (USD 9,757,187) and encumbrance are (UDS 4,271,335) which total expenditure with in process are (USD 14,028,522), the remaining amount is planned for HSS and ISS expenses till end of 2015; and the country need disbursement of HSS3 grant in first quarter of 2016.

There are some small variances in original and planned HSS2 expenditures across some activities/objectives. The reasons for the budget changes are either there were some savings, for example, an estimated 400, 000 USD was saved as the Kits for training of CHWs were contributed by CSO, or there were overestimation of unit cost for some of the activities. All changes are controlled within 15% (actually less than 10%), which ensures that by the end of the project, Afghanistan will be able to efficiently accomplish the objectives of the HSS2 grant and implement all the activities

3.5. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organizations, other partners, Gavi Secretariat)	**Timeline**	**Potential financial resources needed and source(s) of funding**
Preparations for HSS3, i.e. FMA in Q3	GAVI secretariat, MoPH	Q3, 2015	GAVI secretariat
To ensure timely implementation of the HSS3 (Procurement ,Internal Audit and Finance, HR systems)	MOPH	Q4, 2015 and 2016	HSS2, GAVI Secretariat/PEF
Data Quality Plan (CTA) Roll out of Performance Framework	GAVI secretariat MOPH/ UNICEF/ WHO/	Q3, 2015	GAVI Secretariat: Outcome and impact dept.
Support the development of the quality micro planning	MOPH/WHO/UNICEF/CSO'S	2015	UNICEF, WHO,PEF
To enhance distribution of cold chain equipment and construction of 11 warehouses planned under HSS2.	MoPH, WHO	2015-Ongoing	WHO, HSS 2 and UNICEF
Accelerating implementation of the EVM IP	MOPH/UNICEF/WHO	2015	UNICEF -PEF
To establish supportive supervision and decentralizing the Monitoring	MOPH/WHO/UNICEF	2015-Ongoing	WHO, HSS 2, HSS3
Improvement of demand generation activities through Communication, social mobilization and advocacy	MOPH/UNICEF	2015	UNICEF,PEF
Strengthening measles Surveillance	MOPH /WHO	2015	WHO,CDC,MRI,PEF
Follow up for the introduction of Rota and MR vaccines in EPI programme.	MOPH/UNICEF/WHO/GAVI secretariat	2015	UNICEF, WHO, PEF
JANS, IHP+	MOPH& WHO	Q4 2015	IHP+ WHO &WB compact grant and GAVI/ HSS

WHO and UNICEF to discuss the 30% discrepancy between administrative data and coverage survey and the implications on data quality.	EPI, WHO and UNICEF	2015	EPI, WHO, UNICEF

4. TECHNICAL ASSISTANCE

(MAXIMUM 1 PAGE)

4.1 Current areas of activities and agency responsibilities

WHO and UNICEF both national and regional technical assistance were used to facilitate timely implementation of planned HSS2 activities. Current HSS2 grant is being channelled through WHO, which both MoPH and WHO technical and admin staff working together for smooth implementation of HSFP project.
CDC-WHO supported the EPI reporting pilot project, survey and capacity building. Disease burden studies on Hepatitis B and CRS.

Technical Assistance received both from UNCEF and WHO for development of HSS3 proposal.

Developing data quality improvement plan, conducting JANS and development of county compact for IHP+ will require TA for proper.

Also TA support of WHO and UNICEF is needed for HSS3 grant implementation

Planned by UNICEF with RO and HQ support in 2015
-SOPs for vaccine management.
-Wastage study.
-Temp monitoring / mapping for cold rooms.

WHO RO and CO providing support for
software for vaccine stock management,
EVM, IP development,
Preparation of SOPs, capacity building etc.
Development of quality micro plans

Roll out of performance framework MOH GAVI

4.2 Future needs

Prioritization of technical assistance needs

TA need	Justification / Actions	Intended outcome	Modalities	Possible provider	Included in cMYP / HSS3
Short term TA to support strengthening the capacity of the MOH in management of the GAVI HSS 3 grant, specific areas include (Procurement, Internal Audit, HR, Finance systems)	Procurement Redefine policy and procedures and guidelines - short term, capacity assessment of these departments Background: Procurement: HSS2 developed procurement guidelines IA: Dept need more support, to make functional / operational to audit all development budget of MOPH channelled through MOF; guidelines are not optimal, should be applied to development budgets; desk review need to ID gaps, then apply learnings; manual on financial reporting; Different auditing firms by Gavi / GFATM HR systems strengthening: No capacity to audit all development projects (56 projects) only have 2-3 staff Ensure sustain of dept. within government Database - collection of data from private sector Assessment in gaps of health workers Appraisal of EPI staff through HR department	Ensure timely implementation of the HSS3 Transparency / Accountability / On time implementation of grant Efficient utilisation of funds Prevention of misuse	I year technical assistance Consultancy to provide review of processes and training	Opportunity to collaborate with GFATM or WHO	No
Short term consultancy Support to improve EPI coverage through strengthening the planning and management with a focus on the development of and implementation quality micro planning	Micro planning in HSS3 - but implementation and management of micro planning are not included. Implement in a small area with new technology Change reporting system from hard to soft copy. Analysis of what are micro planning bottlenecks - prototype in 2015 would be ideal.	Strengthened micro plans and plans of EPI program leading to improved coverage	1 year technical assistance	WHO	yes

TA need	Justification / Actions	Intended outcome	Modalities	Possible provider	Included in cMYP / HSS3
To enhance the Acceleration and implementation of the EVM IP	EVM 2011 88% /// EVM 2014 77%. **Covered in HSS3** -Cold chain technician training / refresher on maintenance and repair at national and regional level. -Incentives for CCL staff. -New technologies (solar fridges) - service delivery level - installation / monitoring. -Refrigerator vehicle needed - national / regional level. -Equipment procurement. -National and regional level training workshop. **Is planned by UNICEF with RO and HQ support** -SOPs for vaccine management. -Wastage study. -Temp monitoring / mapping for cold rooms.	Improved EVM score Appropriate storage / transport / monitoring of vaccines	Short term TA 1-3 months	UNICEF CO/RO/HQ	yes
Improvement of demand generation activities through communication, social mobilization and advocacy	-Develop communication strategy -Move from classic interventions such as TV, radio, religious leaders - to "back yard" e.g. train females in community and they directly go to household to train mothers to generate demand -KAP survey (HSS3) to follow up on one in 2013	Stronger community outreach leading to decreases in vaccine hesitancy	Short term TA 1-3 months UNICEF	UNICEF	yes

TA need	Justification / Actions	Intended outcome	Modalities	Possible provider	Included in cMYP / HSS3
Follow up for the introduction of new vaccines in EPI programme	-Joint annual HSS / EPI desk review --> should feed into JA -Development of annual EPI Action Plan - review CMYP, integrated with polio last one was 2012-Planning for introduction of NVS (programmatic readiness assessment) - checklist; pre-introduction evaluation, cold chain evaluation; (remote assess)- -Equity in immunization (2016) activities implementation (some of them are covered through BPHS and HSS3) -Update CMYP 2015-2019 (despite recent update needs for data verification; train 2 nationals in 1 week) - AEFI training revision funded by WHO and UNICEF - NVS preparation e.g. essential staff time of WHO EMRO (WHO) -PIE PCV 13 (BP 2015) (WHO) -PIE IPV (2016) (WHO) -pre-introduction evaluation / readiness assessment IPV (2015) (WHO) -MR feasibility study and burden of disease; retrospective and prospective study on CRS (CDC) -MR campaign / rota introduction: proposal development support (WHO) -Rota surveillance network (WHO)	Adequate preparations for introduction and monitoring of new vaccines, leading to increased coverage	1 year technical assistance Remote study Workshop / extensive country visit Remote assessment Training Assessment Training	WHO / UNICEF	Yes
Accelerating MNT elimination	MNT risk assessment (2016)	Risk assessment done and plan for validation exercise plan prepared	Short term TA 1-3 months	UNICEF	yes
IPV switch	*****Alliance partners to CONFIRM***** -Inventory assessment and disposal training -Communications -Readiness assessment -Cold chain preparedness		Short term TA 1-3 months Training Workshop Communication	WHO / UNICEF	No
Comprehensive EPI review	Review current status of implementation of the EPI program, Identification of weaknesses and strategies for improvement.	Improvement in management and implementation od EPI program	Short term TA 1-3 months	WHO/UNICEF	

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

(MAX. 1 PAGE)

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism:
Issues raised during debrief of joint appraisal findings to national coordination mechanism:
Any additional comments from • Ministry of Health: • Partners: • Gavi Senior Country Manager:

6. ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)
- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Implement better vaccine management particularly in remote and distant areas	Coverage Improvement plan developed in implementation by EPI
Identify a strategy to address the high dropout.	Coordination of vaccinators in fixed centers and outreach has been initiated.
Strengthen data quality by applying DQS and other mechanisms	Annual DQS has been planned under HSS3
The country to consider how to strengthen its AEFI and surveillance systems.	The data quality proposal has considered strengthening the AEFI and Surveillance system.
Improve routine immunization coverage through improved coordination with the MOPH's contracts management UNIT for better oversight and monitoring of BPHS performance related to immunization	BPHS gap analysis conducted, Under HSS3 sub health centers will be upgraded to provide immunization services, monitoring is decentralized to monitor BPHS performance as under HSS2 digital system geo-location monitoring is developed, using mobile phones and an application, to submit checklists from field to database.

- **Annex C. Description of joint appraisal process** (e.g. team composition, how information was gathered, how discussions were held)

- *A team who represents HSS, NEPI, WHO, UNICEF, CSOs and other stockholders was assigned to proceed the process of joint appraisal. The team was led by HSS unit of MOPH that firstly conducted a meeting on 5th May 2015 in which the task distribution was done. The member divided the task into two activities i.e. financial and technical as well as review of existing documents. Each member of team provided a report which were compiled by HSS focal point and it was circulated for comments on 2nd June 2015. The comments were addressed in the first draft of report and finally it was jointly reviewed on 7th June 2015.*
- *The assigned team used the below methodology for data collection and analysis:*
    - *Review of annual progressive reports*
    - *Review of EPI brief reports*
    - *Review of comprehensive multi-years plan for national immunization program*
    - *Review of financial documents of HSS grant implementers*
    - *Discussion with relevant departments of MoPH on technical issues*
    - *Briefing of NGO regarding to our appraisal*
    - *Request from finance department to print of each project ledger sheet*
    - *Request from Admin department to print of each project fixed asset sheet*
    - *Request from HR department to print the list of employees for each project*
    - *Short interview with finance, HR and Admin regarding to policies and manuals*
    - *Random selection of transaction for each project from ledger sheet and ask from Finance department to bring the selected transaction Vouchers*
    - *Random selection of fixed asset for each project from Fixed asset sheet and ask from admin and finance departments to bring the selected items documents*
    - *Random selection from HR list for each project and ask from HR department to bring the selected employees documents*
    - *Checking of all financial, Admin and HR documents*
    - *Closing meeting regarding to documents checked by joint appraisal team with NGO*

2. With GAVI, WHO and UNICEF and other partners at Cairo and remote Video conferencing with relevant stakeholders in the country

- **Annex D. HSS1 grant overview**

	General information on the HSS1 grant							
1.1	HSS1 grant approval date			**HSS1 Approved on August 08, 2007**				
1.2	Date of reprogramming approved by IRC, if any			clarification requested which was provided by 14 July 2007				
1.3	Total grant amount (US$)			34,100,000 USD				
1.4	Grant duration			Originally five year (2007 -2012) later on NCE requested and continued till 2015.				
1.5	Implementation year			Oct-07				
(US$ in million)	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
1.11 Grant approved as per Decision Letter	Yes, dated 8 August 2007	6,700,000	8,950,000	7,200,000	6,600,000	4,650,000	0	0
1.12 Disbursement of tranches	6,700,000	7,318,000	8,157,346	7,329,704	4,594,950	0	0	0
1.13 Annual expenditure	97,069	5,607,558	9,623,628	6,179,420	4,847,239	5,068,808	2,363,950	312,328

1.14	1.15 Delays in implementation (yes/no), with reasons	YES
1.16	1.17 Previous HSS grants (duration and amount approved)	
1.18	1.19 List HSS1 grant objectives 1- Objective one: Improve access to quality healthcare particularly mother and child health. 2- Objective two: Increase demand for and utilization of maternal and child healthcare. 3- Objective three: Improve ability of the MOPH, at various levels, to fulfil the stewardship responsibilities	
1.20	1.21 Amount and scope of reprogramming (if relevant)	

	General information on the HSS2 grant				
1.1	HSS2 grant approval date			**HSS2 Approved on April, 2013**	
1.2	Date of reprogramming approved by IRC, if any			N/A	
1.3	Total grant amount (US$)			15,914,478 USD	
1.4	Grant duration			Originally two year (2013/2014 - 2014/2015) later on NCE requested to end of December, 2015.	
1.5	Implementation year			April, 2013	
(US$ in million)				**2013/2014**	**2014/2015**
1.11	Grant approved as per Decision Letter			6,775,520	9,138,959
1.12	Disbursement of tranches			6,775,520	9,138,959
1.13	Annual expenditure			2,961,176.27	9,757,187
1.14	1.15 Delays in implementation (yes/no), with reasons			YES	
1.16	1.17 Previous HSS grants (duration and amount approved)			From 2007 to 2012 and amount is 34,100,000 USD	
1.18	1.19 List HSS2 grant objectives **Objective 1: To improve access and increase the coverage of immunization and other essential health services particularly for the underserved population** Activity 1.1 To increase DTP3 coverage in Kochi children To establish Mobile Health teams & train CHW for nomadic population Activity 1.1.2: To establish partnership with for-profit private sector Activity 1.1.3:To implement (CIMCI) program in the remaining 5 out of 34 provinces **Objective 2: To improve quality, effectiveness and utilization of health care and immunization services.** Activity 2.1.4:Initial Training of 300 new vaccinators Activity 2.2: To do critical analyses of the implementation of BPHS at different levels. • The study conducted by third party. Activity 2.3 :To promote health through awareness raising initiatives/ Establishing Health Information Call Centre **Objective 3: To improve the ability of MOPH to fulfil its stewardship responsibilities at all levels with a more focus on peripheral level** Activity 3.1: Improving M&E processes at different levels with a more focus on peripheral levels				
1.20	1.21 Amount and scope of reprogramming (if relevant)				

Annex E. Best practices (HSS newsletters attached)

Annex to Joint Appraisal document

Figure 1: Cold space expansion Plan 2016-19

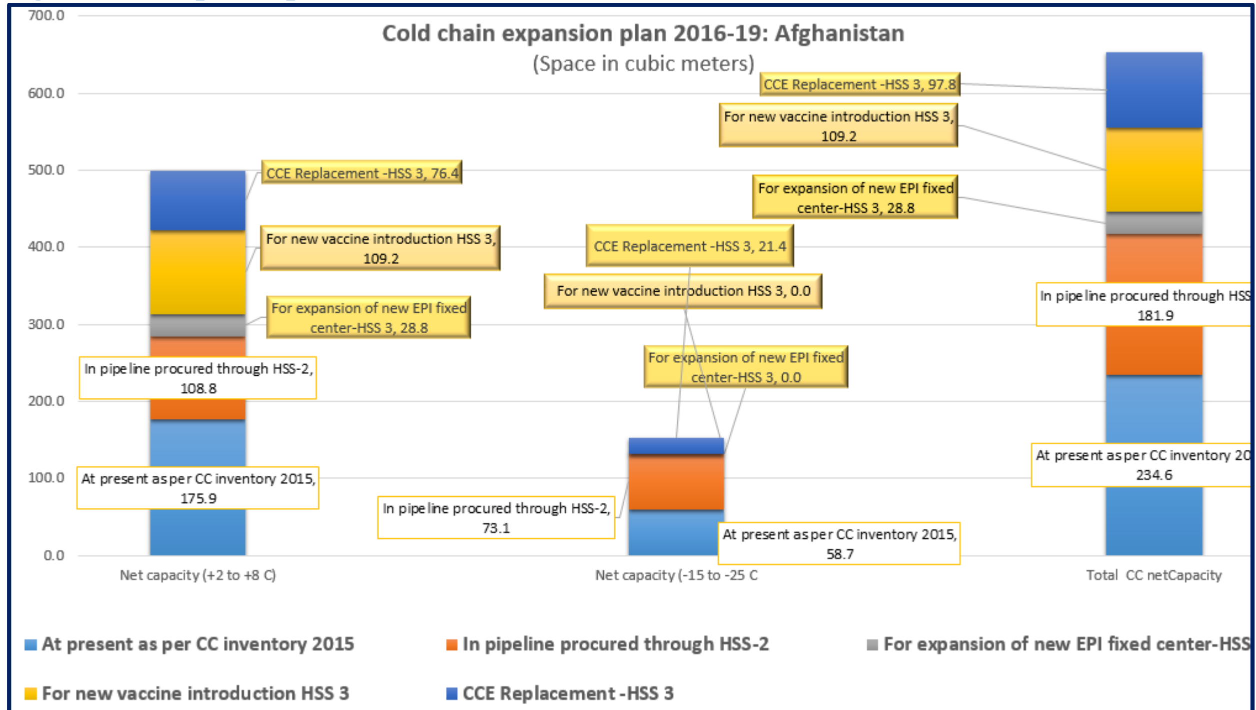


Figure 2: NUVI Plan Afghanistan

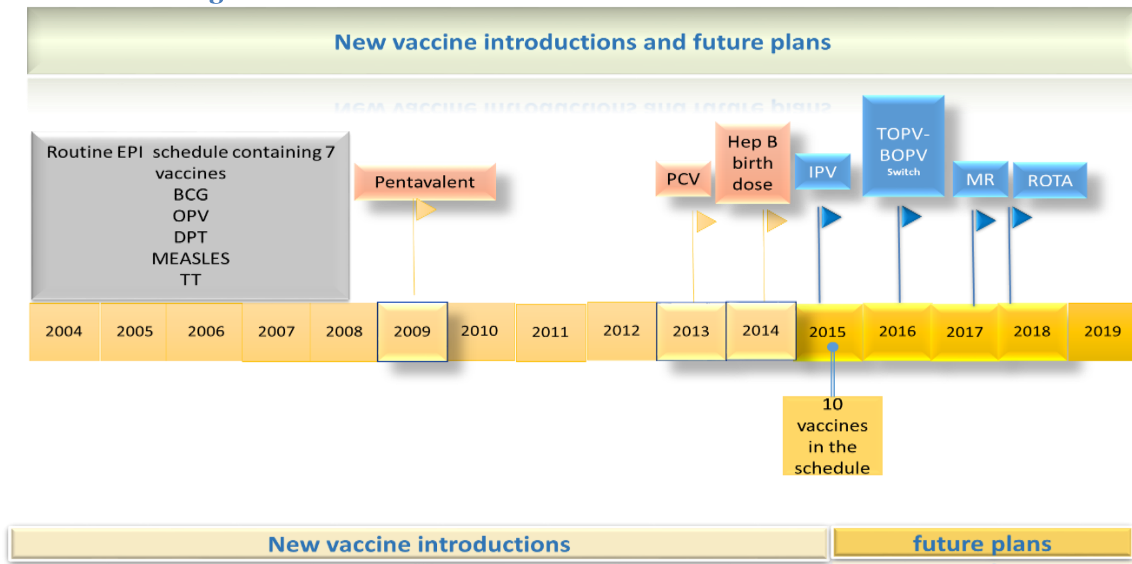


Figure 3: Baseline Financing Profile in 2013

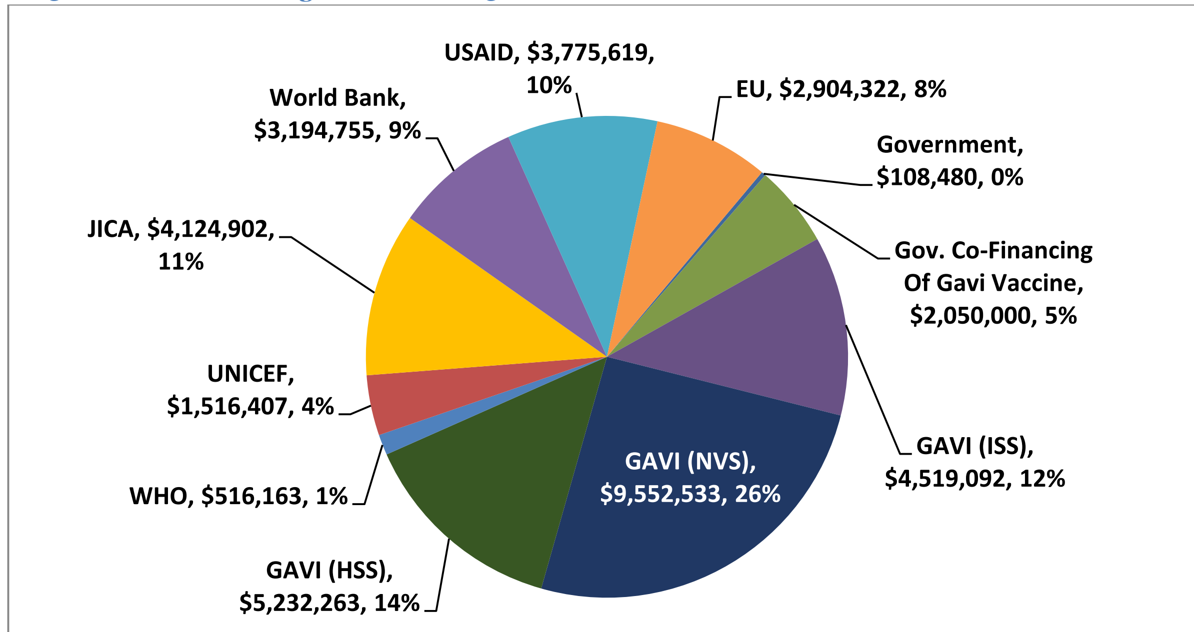


Figure 4: EPI bottleneck Analysis

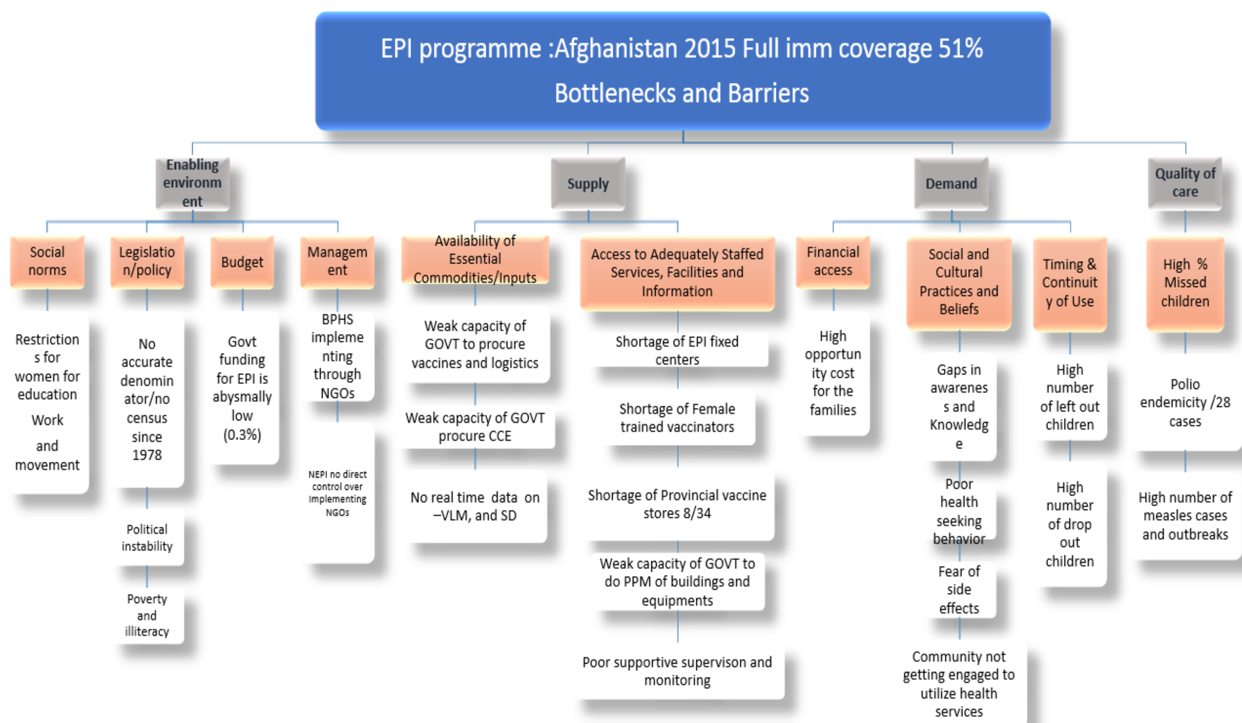


Figure 5: Support Areas of EPI partners to EPI programme Afghanistan.

	EPI program components	Sub areas	Partners working			
1			WHO	UNICEF	GAVI	CDC

	Program management	*Planning, policy and strategy*	Yes	Yes		
		Advocacy		Yes		
		Coordination	Yes	yes		
		Newer vaccines and innovations	Yes	Yes		
		Management capacity	yes	yes	YES	YES
2	**Capacity Building**	*Training*	yes	Yes	Yes	yes
3	**Vaccine, equipment, supplies & logistics**					
		Vaccine procurement for RI		Yes	yes	
		Vaccine procurement for SIA		Yes	yes	
		Non-vaccine procurement		yes		
		Cold chain equipment		yes	yes	
		Distribution		yes		
		Operation and maintenance		yes		
		Cold chain infrastructure		yes		
4	**Service delivery**	*EPI micro-planning*	Yes	Yes		
		Routine vaccine delivery	yes	yes		
		SIAs	yes	yes		
		Equity		yes	yes	
		Outbreak response		yes		
		Accelerated IA		yes		
		Humanitarian Emergencies		yes		
5	**Monitoring & Evaluation**	*Supportive supervision*	yes	yes	yes	yes
		Routine monitoring	yes	yes	yes	yes
		Monitoring SIA	yes	yes		
		Immunization safety	Yes			
6	**Surveillance**	*AFP surveillance*	Yes	yes		
		Measles & MNT surveillance	Yes			
		VPD surveillance	Yes			
		AEFI surveillance	Yes			
7	**Communication & Mobilization**					
		IEC, BCC and Social Mobilization		yes		
		Advocacy for RI		yes	yes	
		Advocacy for SIA	Yes	yes		
8	**Survey & Research**		Yes	Yes		
9	**Construction & Renovation**			Yes	Yes	

Islamic Republic of Afghanistan
Ministry of Public Health
Deputy Minister for Policy and Plannig
Health System Strengthening Coordination

جمهوری اسلامی افغانستان
وزارت صحت عامه
ریاست عمومی پالیسی و پلان
آمریت تقویت سیستم صحي

Date: 24/ June / 2015

Afghanistan Joint Appriasal Report Endorsment

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