



### Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analyzed, and explained where relevant.

<b>Country</b>	Afghanistan
<b>Reporting period</b>	Jan 2015 Year of the last appraisal report – December 2015
<b>Fiscal period</b>	January 2015- December 2015
<b>If the country reporting period deviates from the fiscal period, please provide a short explanation</b>	It is only 10 days difference
<b>Comprehensive Multi-Year Plan (cMYP) duration</b>	2015-2019
<b>National Health Strategic Plan (NHSP) duration</b>	2011-2015 (The development of New strategy 2016-2020 is underway by MOPH, will be available in few months)
<b>National Health Policy</b>	2015-2020

#### 1. REQUEST TO GAVI's HIGH-LEVEL REVIEW PANEL

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – PCV	<i>Renewal</i>	2017	1,499,180	\$997,500	\$14,965,500
NVS – Pentavalent	<i>Renewal</i>	2017	1,499,180	\$1,221,500	\$7,948,000
NVS – IPV	<i>Renewal</i>	2017	1,424,221	US\$	US\$

Indicate interest to introduce new vaccines or HSS with Gavi support*	Program	Expected application year	Expected introduction year
	<i>MR</i>	2016	2017
	<i>Rota vaccine</i>	2017	2018

\*Not applicable for countries in final year of Gavi support

## 2. COUNTRY CONTEXT

### **Context**

In 2015, the total estimated population of Afghanistan is 31.5<sup>1</sup> million with primarily rural population (74%) 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.

Reference to the Afghan Mortality Survey conducted 2010 (AMS) the Infant Mortality Rate (IMR) is 77 deaths per 1000 live births and Under 5 Mortality Rate (U5MR) is 97 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).

Reported national Penta3 coverage is 100% in 2015 while the estimated official coverage is 98%. The reported and estimated PCV3 coverage is 91% and 89% respectively, and 92% coverage has been reported for MCV1 while according to official estimation it is 90%. The dropout rate for PCV is 19% and for the pentavalent vaccine is 11%.

### **Update on political context**

The new unity government came into power in Sept 2014 with new leadership in the MOPH. The new leadership is instrumental in developing a National health policy 2015-20 comprising five key areas - governance, institutional development, public health, health services and human resources. The health policy aims to further strengthen the health system in a challenging context of the country with the ongoing conflict.

In-depth analysis in 2015 using LiST (Life saved tool) reported that 35% of under-five deaths will be averted by the EPI vaccines in Afghanistan between 2015-2020. To address the challenge of averting these deaths the Unity Government is giving high priority to improve EPI outcomes and have appointed a new the national EPI program manager to lead the program.

### **Major contextual challenges faced in 2015**

There were natural disasters as well as the major insecure incidents in 2015. In October 2015, there was an earthquake with an epi center at Badakhshan, Provinces in the north east region where the services were hampered for a temporary period. Anti-Government Elements (AGE) took a control of 30% Nangarhar province. This resulted in the cessation of health services contributing to the outbreak of 10 polio cases in the Nangarhar and Kunar province.

The Taliban attacked Kunduz Province with the destruction of health service infrastructure including MSF provincial hospital, Provincial Health District administrative building MCH plus clinic in a Chaurdara which affected. Some health facilities have yet to be restarted including outreach EPI sessions as well as polio campaigns due to security reasons.

**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 the 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 program. The HSS- SC met 6 times in 2015 and discussed the following topics: EPI performance results, review and approval of the

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<sup>1</sup> Source: UNIDATA

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 the national budget for the EPI program was mainly incurred on payment of government's share under co-financing of GAVI-supported vaccines (Pentavalent, PCV). 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. 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" raise concerns in near future. The national EPI managers plan to compete with other government departments for allocation of additional resources but also to persuade donors 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 3222 vaccinators which only 1005 of them are female (31%). 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.

**Polio situation:**

Afghanistan still an endemic country for polio with Pakistan. The polio transmission is active in the south and southeast provinces of Afghanistan adjoining Pakistan border which is a single epidemiological block involving Pakistan and Afghanistan. National emergency Action Plan has been developed and high-quality eradication efforts are being implemented in the country. Emergency Operation Centers at national and three polio priority regions have been established and are fully functional. Systematic engagement of BPHS implementer NGOs, Executive leadership and coordinator structure of the program has been modified. IPV and OPV SIAs have been conducted in nine districts and is planned for 28 more districts in the first quarter of 2016. Revision of micro plans through GIS is close to completion.

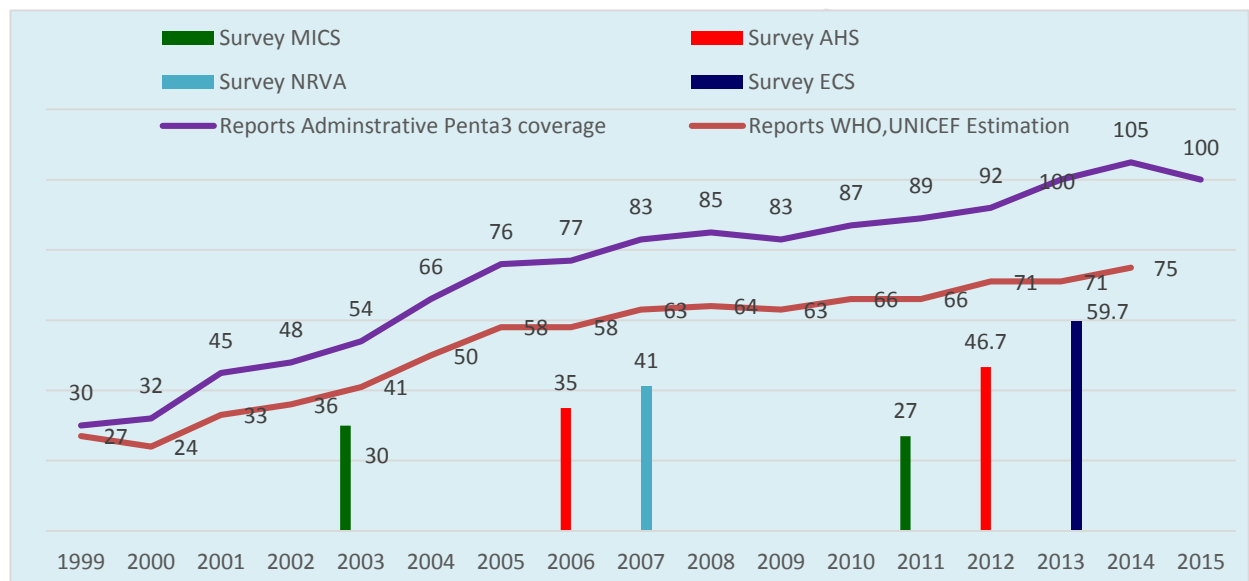
At the top level, there is an oversight from H.E the President and H.E the CEO through National Taskforce and Office of Presidential Focal Point. The Presidential Focal point is dealing with line ministries and governor through coordination with EOC. Ministry of Public Health assigned a focal point and senior advisor with full authorities whose responsibility is to make sure that all departments of MoPH are providing full support to PEI, and to have an oversight on the performance of EOCs. In terms of cross-border coordination with Pakistan, there are regular interaction between the regional teams of both sides through Video Calls and Face-to-Face meetings. Focal persons from both side at a national and regional level were identified. SIAs schedule for the first half of 2016 between both countries are synchronized.

There are also efforts on using polio assets for improving EPI through monitoring the EPI sessions and improving the communication and social mobilization to improve the EPI coverage is being planned to implement in 2016.

**Immunization coverage and equity:** According to the National Immunization Coverage Evaluation Survey (CES) 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 92% in 2013. 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, the 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. 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 administrative reported coverage of Pentavalent vaccine for 2015 is 100% while the official estimate is 98%. The weaknesses in data are well recognized by the country and partners, steps have been intimated to improve the accuracy of the coverage figures



The trend of reported coverage increasing over the period beyond 100 percent raises the concern of the quality of the data which needs to be audited periodically.

### **Strengthening data quality**

The reported coverage is high and may not be representing the true coverage. The country developed the Data quality improvement plan with a budget of 2.3 million. The improvement plan has been approved by the IRC for the period of 2016-19 based on results of strategies identified through national and international DQ workshops held in 2015. In the upcoming HSS3 proposal yearly data quality assessments are planned considering the need of data quality improvement.

In the year 2015, Access based software was developed which enable to capture the data from each health facility.

DQIP aims to achieve.: a) Improvement in the availability of disaggregated immunization data by geographic area by month; b) Reduction in the gap between the estimates of different data sources for immunization coverage; c) Improved data quality monitoring through systematic and robust data audits; d) Improved staff capacity on data recording, reporting; and) Improve systems for data use and feedback leading to informed decision-making

### **Key EPI achievements 2015**

The following important activities and achievements were implemented in 2015;

IPV introduction;

- In 2015, IPV campaigns were conducted in 9 targeted high-risk districts in the Nangahar province (Shinwar district), Farah Province (Bakwa district), Nimroz Province (Khashrood) and

Kandahar province (Boldak, Maywand, Zari, Panjwai, Daman/Shiga and Nish, KDH Dand districts) of the country with a target population of 513,796 children.

- Polio NIDs and SNID (four each),
- The measles SIAs conducted in all 34 provinces with a 94% coverage achieved.
- Accelerated Immunization Activity,
- School and community TT campaign,
- Solar refrigerators temperature monitoring system with 30-day temp monitoring was installed ,
- Access-based reporting system software scaled and rolled out in the whole country.
- 150 Vaccinators received initial training (induction) and 1000 vaccinators received refresher training course.
  
- Provision of computer and mobile to all provinces,
- Cold chain equipment procurement Inventory l) Airport vaccine stores and m) building Kandahar REMT building
- The EPI delivery centers and vaccinators have expanded: centers increased from 400 in 2004 to 1761 in 2015 and vaccinators from 800 to 3222 of which 1005 (31%) are female vaccinators. To date there are 7 provinces with 0-10% of female vaccinators; 14 provinces with female vaccinator between 11-30%, and the percentage of female vaccinators in 13 provinces is between 31-61%.
- Provincial EPI managers, supervisors and provincial BPHS implementer supervisors received training courses on *MLMs, immunization data management, vaccine/supply management, and monitoring and supportive supervision*.
- The WHO manuals of immunization in practice, National EPI guideline, and guideline/tools for monitoring/ supervision /supportive supervision were updated /translated /printed/ distributed.
- All 34 PEMTs/REMTs were equipped with IT equipment and furniture for training rooms.
- The two batches of training courses for 54 cold chain managers and technician's/EPI managers were held
- To improve the quality of routine immunization data at all levels of health system, all immunization recording and reporting materials are updated/printed,
- A new EPI reporting database including coverage, vaccine and injection supplies; AEFI and vaccine preventable diseases was developed, piloted and successfully introduced in RI program and incorporated with HMIS/MOPH.
- Developed successful GAVI-HSS3 proposal
- Data Quality Improvement Plan (DQIP) approved by Gavi,

### **3. GRANT PERFORMANCE AND CHALLENGES** (maximum 3-4 pages)

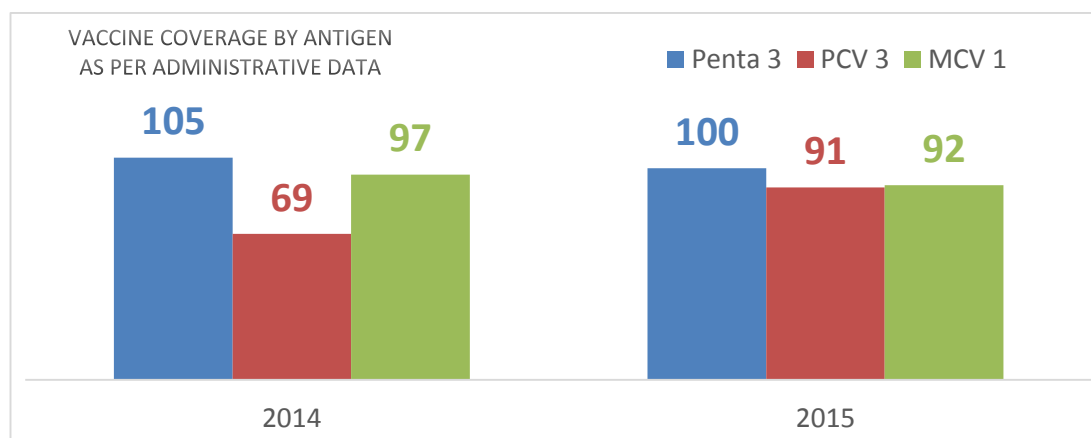
#### **3.1. New and underused vaccine (NVS) support**

##### **3.1.1. Grant performance, lessons, and challenges**

## Programmatic performance and challenges

### Targets, achievements and reasons for any discrepancy

Reported national Penta3 coverage is 100% in 2015 while the estimated official coverage is 98%. The reported and estimated PCV3 coverage is 91% and 89% respectively, and 92% coverage has been reported for MCV1 while according to official estimation it is 90%. The dropout rate for PCV is 19% and for the pentavalent vaccine is 11%.



However, despite the same schedule for PCV and Penta vaccine, the PCV3 coverage is not matching with penta3 coverage. At the national level difference of 8% in the coverage of PCV3 and Penta 3. The PCV3 is lower than Penta 3. Following a review of subnational analysis, this difference is only with eight provinces. These eight provinces need further exploration further through an operational study and reviewing reports from health facility wise data available in access database.

**Equity of coverage:** Because the IPV vaccine has been introduced end of Sep 2015, the coverage will be reflected in the upcoming report, according to JRF the districts are divided into 3 categories, > 80%, between 50%-79% and <50%, in 2014, 68% districts failed in first category while in 2015 decreased to 63%, the 2nd category was 22% in 2014 which increase to 26% in 2015, this is due to improvement in data quality at the HF level. The data on difference in penta3 coverage between the highest and lowest wealth quintiles and children of educated and uneducated mothers will reflect after EPI coverage survey.

The table below reflects findings from the Gavi Performance Framework 2015 highlighting the overall equity gaps in Penta 3 coverage.

Equity in pentavalent 3 coverage	2012	2013	2014	2015
Percentage of districts with Penta3 coverage ≥ 95%	41%	50%	53%	44%
Percentage of districts with Penta3 coverage ≥ 80%	59%	67%	68%	63%
Percentage of districts with Penta3 coverage between ≥ 50% and <80%;	28%	24%	22%	26%
Difference in Penta3 coverage between the highest and lowest wealth quintiles	NA	22%	NA	NA
Penta3 coverage difference between males and females	NA	2%	NA	NA
Penta3 coverage difference between the children of educated and uneducated mothers/care-takers	NA	17%	NA	NA

Source: Administrative data and National EPI Coverage Survey report 2013

### Accelerated immunization activities for RI

In 2015 three rounds of accelerated immunization activities was conducted in 51 districts which were identified on the criteria of low reported coverage and as well as remote areas covering all antigens to

minimize missed children and dropouts. Totally 372,267 doses were given to under one year, 161,886 to children aged one to two years and 119,781 TT doses to Child bearing age women during three rounds of activities.

#### **TT SIA information**

TT campaign was planned in community and girls schools, the first round was conducted in thirteen provinces (Takhar, Badakhshan, Jewzjan, Badghis, Farah, Ghor, Herat, Helmand, Uruzgan, Zabul, Kabul, Paktia, and Logar), while the second round in ten provinces. During two round totally 227,560 doses were given to the target women.

#### **Status of surveillance systems**

The measles case-based surveillance has the capacity to timely detect cases and outbreaks of measles. Hospital-based rotavirus, pneumonia and meningitis surveillance and rubella/CRS and hepatitis B studies (burden of diseases and introduction of new life-saving vaccine/s) are going on and helps MOPH decision makers in evidence-informed based decision for introduction of new vaccines and technologies and assessing the impacts recently introduced vaccines

There was a significant increase in the number of Measles outbreaks and cases in 2015 compared to 2014. During 2015, there were 200 outbreaks compared 131 outbreaks 2014. Total confirmed measles cases in 2014 were 552 this increased to 1191 in 2015.

Total confirmed Rubella cases were 46 in 2014 and 60 in 2015. The rubella surveillance needs strengthening these cases were confirmed from the negative measles samples from the measles surveillance.

#### **AEFI:**

There were two serious AEFI cases happened during the measles SIA due to operational reasons. The AEFI surveillance system needs further strengthening, New EPI monthly immunization report has introduced AEFI module for the institutionalizing AEFI through EPI data quality project.

#### **DQ review and data quality assessments (conducted or planned)**

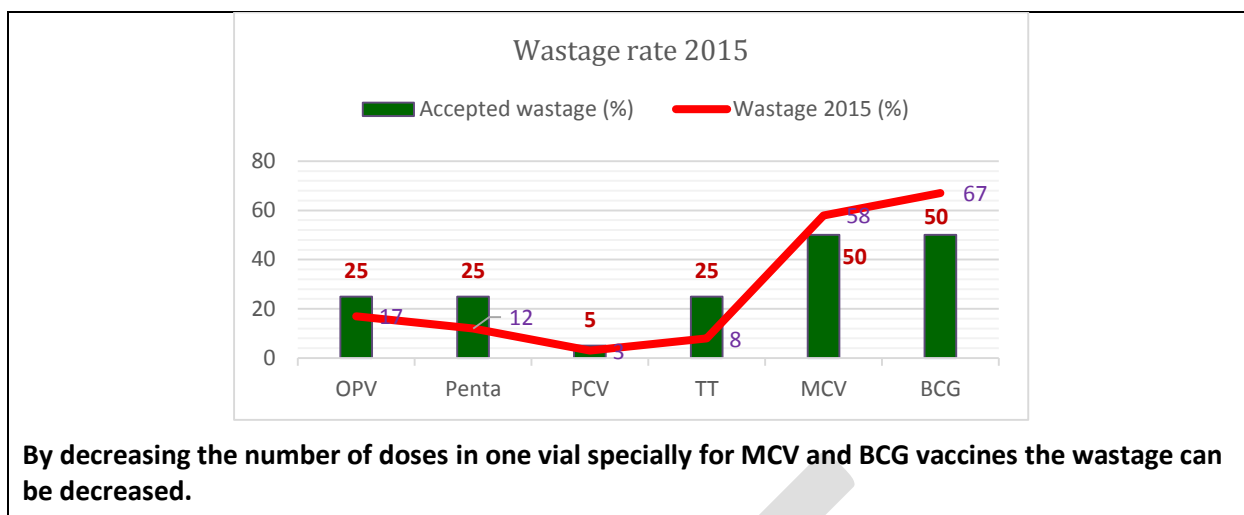
The last DQS assessment conducted in the 2011 showed that among the five domains of quality questionnaire (Demography, Reporting and Recording, Supervision and feedback, Cold Chain and Training), The best domain was Report and Recording (9.02/10) followed by cold Chain (8.99/10) and Supervision and monitoring (8.47/10), while the lowest one was training (5.43/10), followed by demography (7.98/10).

The regular data quality assessments have not been conducted since 2011. The upcoming HSS3 proposal includes yearly data quality assessments considering the need of data quality improvement.

#### **Cold chain maintenance**

In 2015 there were multiple training were conducted for vaccinators cold chain technicians, these include refresher training, additionally the cold chain technicians were given training on the Solar refrigerators installation and maintenance, Newer continuous temperature recording devices (30 DTR, Freeze tags). The refrigerator repair toolkit has been procured by UNICEF and the refresher training on the repair toolkit will be conducted in 2016.

**Vaccine wastage** :The vaccine wastage is directly related to a number of doses added in one vial and implication of WHO multi-dose open vial policy. The wastage of vaccines with multi-dose vials which can be used for subsequent days (even 28 days) are lower than agreed level of wastage such as OPV, Penta, PCV and TT vaccines, while the wastage of vaccines with multi-dose vials which must be discarded after 6 hours of reconstitution is higher than agreed level of wastage like BCG and Measles vaccines.



### 3.1.2. NVS future plans and priorities

Considering the requirement of endgame strategic plan and polio initiative the IPV vaccine has been introduced in routine schedule, in 2015 and one dose administrate along with the 3<sup>rd</sup> dose of penta3 vaccine.

There is a plan to switch tOPV to bOPV starting from April 23rd, 2016. bOPV follows the same immunization schedule as tOPV and recommended to be given at birth, 6, 10, 14 weeks and at 9 months with the first dose of measles vaccine, for routine immunization, so the tally and registration is the same as tOPV.

Continuation of support for penta3 and PCV13 vaccines according to the request submitted in portal whereby the 3.2 million doses of Pentavalent and PCV13 each is required to achieve the target coverage of 95%. The wastage rate is expected not to exceed the recommended wastage. 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 and will request the switch grant in due course.

- Recommendation: Immunization service which are provided by other entities like Kuchi health teams, Mobile health teams, Sub-centres, IMCI needs to be tracked separately so as to generate disaggregated data

#### ***New applications for NVS:***

- **Rubella vaccine introduction**
  - o The Rubella vaccine introduction is planned to be introduced as MR (Measles -Rubella) vaccine, replacing the present measles-only vaccine in 2017.
  - o The application will be submitted in November 2016 subject to meeting application requirements
- **Rotavirus vaccine introduction**
  - o The program plans to apply for Rota vaccine in 2017 and aims to introduce the vaccine in early 2018.

## 3.2. Health systems strengthening (HSS) support

### 3.2.1. Strategic focus of HSS grant and major achievements

The objectives of the HSS2 grant is to strengthen the performance of the health system by addressing key health and immunization system bottlenecks. The strategic focus of the grant is to increase the coverage and equity through improving community participation, increasing demand for immunization services, increase access to immunization services in remote hard to reach areas through public-private partnership



with a focus on insecure areas, strengthening effective vaccine management capacity and strengthening management and leadership capacity.

GAVI support has contributed to strengthening the health system and increasing immunization coverage through the application of innovative approaches to improving access to quality health care services especially among underserved. Involvement of the 'for-profit' private sector in EPI and other health services in insecure areas under GAVI Alliance CSO Support Type and it is a continuation in HSS2 contributed to decreased inequities in health and the reduction of child and maternal mortality in six highly insecure provinces. The establishment of 15 MHTs to provide health services including immunization to the neglected 1.7 million nomadic Kuchi population also contributed to addressing immunization coverage and equity challenges

**Major HSS achievements include:**

**Programme Leadership and Management:**

Strengthened leadership, coordination and oversight of program implementation with the integration of HSS-SC and ICC as subgroup of HSCC to provide a formal platform to bring together relevant departments of MoPH, line ministries in Afghanistan, donors and development partners, technical partners and CSOs which facilitated close coordination and succeeded in attracting considerable attention among all stakeholders to focus on strengthening the health system and EPI activities in a more harmonized manner

Based on National M&E plan, 26% of districts (*The target did not meet due security constraints some districts did not monitored*) and 31% of BPHS health facilities were visited by PHOs and DHOs using NMC (national monitoring checklist).

To strengthen the management capacity monitoring and oversight of the BPHS implementing NGOs and improve the data flow of administrative and program data, the Geo-Location Monitoring (GLM) software, and the database was installed which is being piloted in 9 provinces.

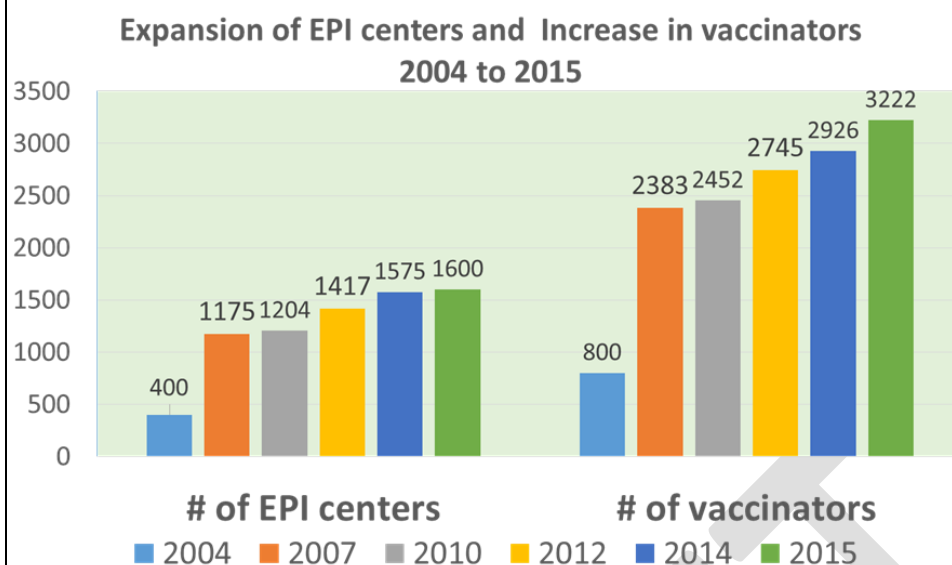
The development of Procurement SOPs to streamline, simplify, standardize and increase data accuracy and further improve the procurement planning and transparency in procurement of goods, works and consultancy services will be modified based on the new changes on the Afghanistan Procurement Law and will be approved by MoPH executive board in coming months.

**Coverage and equity:**

The establishment of Mobile health teams (MHTs) to provide the nomadic population with better access to basic health services including EPI services in 12 provinces for nomads will be continued under HSS3 grant. The CHWs also actively provide basic services to Nomads on a regular basis under the supervision of MHTs staff. In total 150 additional CHWs (male and female) trained under the standard CHW training in four out of five provinces. A third party evaluation of this intervention is in the process and the result will be shared on finalization of the report.

The second intervention is an innovative approach of Public Private Partnership (PPP) model which provide basic reproductive and immunization services in the remote and insecure districts of six provinces where both government and NGOs are not able to provide these services to the people. The Penta3 coverage in the targeted areas increased from 83% in 2014 to 86% based on HMIS data in reporting period. The PPP intervention will be continuing under HSS3 grant and will be scaled up by SEHAT project in other provinces. The PPP external evaluation recommended to increase the number of private health service providers especially female providers in targeted provinces and provide RCW50 refrigerators to those PHSPs where the size of the population is more. Access to nearby BPHS health facilities are difficult for PHSPs to daily commute for receiving the routine vaccine. In addition, 300 new vaccinators received the initial training and providing quality EPI services at the health facility.

Access to immunization services continued to expand from 1575 in 2014 to 1600 in 2015. See table below.



**Advocacy/dialogue/demand creation:**

In 2015 a functional 'Call Centre' was established to support individual concerns on health issues, in total 44,202 phone call were made where citizens got health related information and counseling on health issues mainly reproductive health, nutrition, immunization and first aid during the reporting period.

**Increase the capacity the cold chain system**

The cold chain equipment purchased by WHO was successfully distributed to the relevant provinces and the construction of 10 out of 11 warehouses completed and handed over to relevant provinces, the construction of the final warehouse is about to be completed. 19 warehouse at the provincial level, 5 warehouses at the Regional level and 7 PEMT buildings are planned under HSS3 grant. This construction is undertaken to address reported low score in the EVM especially for stock management and information system functions. Following cold chain equipment have been purchased and distributed: 591 RCW 50 EG (Refrigerator Cooler Working 50, Electric & Gase), 165 Deep Freezers, 531 Cold boxes RCW 25, 1215. Vaccines carriers, 19 Voltage Regulator, 9 WIF Room (Walk-in Freezer), 14 WIC Room (Walk-In Cooler).

***Mandatory Performance indicators;*** there was 3% increase for Penta3, 5% decrease for MCV1 and 5% decrease geographic equity (DPT3 coverage) respectively. Increase on Socioeconomic equity, drop-out rate and of fully immunized children will be reported at the end of 2016 by EPI coverage survey.

***Intermediate results indicators:*** reported an increase of 14% penta3 coverage in Kuchi children. The Penta3 coverage increased from 38% in 2013 to 86% in 2014 the targeted 6 insecure provinces where CSO type B services are provided through public-private partnership approach based on the HMIS data. 100 % of HFs were equipped with a 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 2015. Intermediate results are at its highest performance on the training of cold chain management staff, vaccinators, and CHWs as of 100%, 99.7%, and 99% respectively.

The other successful intervention resulted in increasing the Penta3 coverage among Kuchi population from 16% to 51% in 2014 and to 65% in 2015 in program specific areas. Table below highlights the relevant

### changes in indicators from the Performance framework in 2016.

Intermediate results indicators	Baseline	2013	2014	2015	2016
<b>Reaching Kochi populations</b>					
Pentavalent 3 coverage in Kochi children	16%	NA	51%	65%	
Proportion of Kochi CHWs trained on standard CHW training and providing services according to their TORs.	0%	0%	103%	75%	
<b>Improving supervision and strengthening cold chain</b>					
Proportion of HFs monitored by Public Health Officer using National Monitoring Checklist in a year	20%	23%	28%	31%	
Proportion of cold chain staff trained and providing routine service (refresher)	0%	100%	100%	100%	
Proportion of HFs equipped with cold chain equipment and are functionally providing EPI services	73%	83%	85%	90%	
<b>Public private partnership</b>					
Penta3 coverage in the provinces covered by PPP	36%	NA	82%	86%	
Allocation of HSS annual budget	NA	42%	58%	0%	
Utilisation of HSS budget	NA	15%	25%	48%	12%
<b>Procurement</b>					
Average time (in months) of procurement process of consultancy services, Goods and works at MOPH.	15	15	12	6	

### 3.2.2. Grant performance and challenges

#### Challenges:

1. Continued insecurity in many provinces/districts remain a major challenge facing program, planning, and implementation & monitoring activities.
2. Limited access (geographical, cultural, financial & infrastructure) to basic health services
3. Shortage of skilled health workers in the private sector, especially female HW
4. Limited social participation in planning & evaluation of program
5. Inadequate and unreliable data & information for planning, monitoring & evaluation
6. Weak reporting system from field through provincial to National level

#### Lessons learnt from HSS2: -

- **Costing warehouses:** it was planned to construct warehouses in all provinces for dry supply. However, later on, it was realized that the budget requirement, estimated well before designing and costing, was inadequate to cover all 34 provinces. Consequently, only 11 provincial warehouses could be constructed
- **Target age group for the introduction of NVS:** An abstract from the critical analysis presented in cMYP highlights the importance of understanding local communities when aiming for demand generation. *“For example, pneumonia is a well-recognized life-threatening disease in Afghanistan. Introduction of PCV-13 as prevention from pneumonia among children was highly appreciated by the local communities and a very large percentage of the population, even above the recommended age group, insisted for PCV-13 vaccination. As a result, many of the health care facilities were forced to send urgent demands for PCV-13”*. These findings were similar to the Penta Post-Introduction Evaluation Report 2011 which showed that even though health facility staff received sensitization materials, there was limited “launching” of dissemination of information, and mothers knew only that the vaccine is important but their knowledge regarding the diseases that Pentavalent vaccine prevents from was very limited.
- HSS1 funds were used to train a National M&E Team comprising 35 people on the use of the National Monitoring Checklist. While this team had the potential to train the periphery, the initiative failed because there was no budget allocation for monitoring by DHOs and PHOs and because there was no system for submission of monitoring checklists from one level to another. This limitation will be overcome in future by developing the Geolocation Monitoring

System (GLM) under GAVI HSS2 support. Under the current proposal, GLM system will be more effectively used and also, the PHOs and DHOs will be provided necessary support for transport and per diems. Strengthening of the M&E system at the subnational levels is expected to bring more feasibility because under the prevalent security threats it is difficult for the teams from the central level to travel to far flung areas. In addition, it will make M&E more cost-effective by reducing the costs being incurred on traveling and security.

The HSS3 four years' proposal which is developed based on updated comprehensive Multi-year Plan (cMYP) 2015-2019 and Effective Vaccine Management (EVM), National Health and Nutrition policy 2012-2020 was developed through a rigorous consultative process involving all stakeholders including relevant MoPH departments and programs, UN organizations, national and international non-governmental organizations (NGOs), private sector representatives, donor agencies, technical partners and provincial MoPH departments. The proposal was approved by IRC in June 2015.

**Upcoming challenges:**

Meeting the targets set for 2016 may be challenging due to transition from HSS2 to HSS3

Although steps have been taken to start the procurement processes of consultancy services and construction before signing the HSS3 financial agreement, still there are a five months' gap will occur for the provision of health services by NGOs who are implementing the Kochi MHTs, activities under PPP in the insecure districts of six targeted provinces and Call Center services.

Since the HSS3 grant will start four months later from the beginning fiscal year and the other hand the lengthy process of procurement consultancy services, the execution rate will be a low comparison with the approved budget in the HSS3 proposal.

Construction of warehouses under Afghanistan Procurement Law with low capacity of MoPH construction unit is another challenging area which will be further discussed during the Programme Capacity Assessment (PCA) process to find the plausible solution considering the other options.

**3.2.3. Describe any changes to HSS funding and plans for future HSS applications**

*[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]*

The HSS2 grant planned to be closed by the end of April 2015 based on original HSS2 application. A no cost extension was provided by Gavi secretariat to prevent the gaps between HSS2 and HSS3 grants till the end of April 2016.

The IRC recommended approval of the HSS3 application which will support the country from 2016-2019.

A data quality improvement grant was recommended for approval by the IRC in March 2016. The data quality improvement plan is funded under the country-tailored approach strategy that allows access to the funds allocated for PBF under HSS2, which Afghanistan has been allowed to access as part of the Country Tailored Approach to strengthen data quality to in future access the PBF reward for HSS3.

Program Capacity Assessment (PCA) completed by 19, March 2016 and the final report will be ready by April 11-13.

Upon agreement on the recommendation given by PCA team and signing the financial agreement the first tranche of HSS3 budget will likely to reach the county in May 2016.

Any changes to the HSS3 management will be in line with the recommendations of PCA (the grant management requirement will be shared with HLRP)

**HSS2 grant closure**

- A grant closure report will be prepared by MOPH with support of WHO by beginning of quarter 3 (July 2016)

- It is to be ensured that the planned activities implemented during the extended period (end of April 2016) to be reflected in the grant closure report along with any significant achievements along with other requirements e.g. financial management performance.
- Performance framework update:
  - The current performance framework will be updated with HSS3 tailored indicators along with targets and report timelines (by the end of April 2016)
  - Indicators to track the implementation and performance of Data Quality Improvement plan will also be added to the performance framework as part of the update (by the end of May 2016).
  - Operational research on Implementation of the data quality improvement plan has been planned and the possibility of it to be captured in the performance framework will be explored.

### 3.3. Transition planning (if relevant)

Not relevant for Afghanistan

### 3.4. Financial management of all cash grants (e.g. HSS, VIG, campaign operational cost grant, transition grant)

During the HSS2 proposal development the MoPH acknowledged that the procurement process of consultancy services, goods and construction processes are lengthy and complicated which was challenging for the country to implement all activities in two years. In order to use the easy procurement system, WHO was requested to do the financial management of HSS2 grant.

#### HSS1:

The remaining balance of \$312,132 which was carried over to the year 2015, transferred to WHO based on a MoU signed by WHO and MoF and utilized for training of additional 150 Kochi CHWs in five provinces, the HSS1 grant closed successfully.

The closing balance of \$ 11,473 from CSO-B has already refunded to Gavi secretariat, and \$ \$31,725 from CSO-A is in the process of being refunded by Health Net –TPO to Gavi secretariat.

#### HSS2:

The remaining balance of 3,196,116 USD and 1,801,719 USD Carried over to 2015 and 2016 respectively which has been utilized based on approved work plan for management cost of HSS NEPI and NGOs payments after the amendment of their contracts based on NCE approval given to the country until the end of December 2015 and April 2016 respectively from Gavi secretariat. During the reporting period, actual expenditure for HSS2 are 14,321,270 USD and firm committed encumbrance are 1,497,568 USD which the total expenditure within the process are 15,360,292 USD. The remaining amount of estimated 95,641 USD will refund Gavi secretariat.

#### HSS3:

It is proposed that the HSS3 grant will be managed by three principle recipients namely MOPH, UNICEF and WHO based on each recipient's specific responsibility and expertise to proceed quality and timely implementation of the proposed activities under their organizational financial management system.

WHO: From the total allocated budget of 2,969,324 USD Measles SIA, 1,969,384 USD has been utilized and the remaining 999,940 USD will be used on mop-up campaign in 2016. Regarding the IPV budget of 769,156 USD, 581,465 USD has been utilized and the remaining 187,694 USD will be used to conduct a post-introduction evaluation study and the strengthening of RI.

UNICEF: To date UNICEF country office received only a grant 396,823 USD from Gavi to support Measles Catch Up Campaign specifically to implement communication and logistics activities for the Measles campaign in 2015. UNICEF supported the implementation successfully. Around 40,000 USD have remained from this grant. In consultation of MOPH, the remaining fund is planned to be utilized for the

Mop Up Measles Campaign planned in 2016 for the districts with low measles SIA coverage, low RI coverage and more measles outbreaks.

The program Capacity Assessment (PCA) is completed on 19, March 2016 and draft report will be shared with MoPH and Gavi secretariat on 7, April 2016 and the final report will be ready on April 11-13 2016.

#### 4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

*[Status of top 5 prioritized strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]*

Prioritized strategic actions from previous joint appraisal / HLRP process	Current status
1. Preparations for HSS3, i.e. FMA in Q3	<p><b>HSS 3 proposal was submitted and approved in 2015 of cash support of 39,898,858 million USD over a four-year period. May 2016 to April 2020.</b></p> <p>The Program Capacity Assessment in the country review was started from 27 February – 19 March, 2016 and the initial debriefing session was conducted on 22 March 2016. The PCA draft report will share with Gavi on April 7, upon receiving feedback of the final draft of the PCA report. The PCA report will share with MoPH through Gavi secretariat. The Grant Management Requirements will be shared prior to disbursement of funds to the GoA.</p>
2. Implementation Framework for GAVI assisted support to Afghanistan 2016-19	<p>GAVI assisted support to Afghanistan 2016-19</p> <ul style="list-style-type: none"> <li>• To improve program effectiveness and efficiency through strengthening program governance and planning processes</li> <li>• To enhance immunization coverage through improving access, equity and utilization</li> <li>• To improve immunization financing and ensure financial sustainability</li> <li>• To support recruitment of sufficient number of motivated and qualified immunization workers across the country</li> <li>• To further strengthen cold chain systems to ensure timely availability of quality vaccines</li> <li>• To enhance evidence-based decision making through strengthening the monitoring and evaluation and data management systems</li> </ul> <p>In addition, Data quality improvement plan has been submitted to GAVI on Feb 2016. Hopefully, it will be approved by IRC soon and start to implementation.</p> <p>The CTA framework is added as annex 1</p>
3. To enhance distribution of cold chain equipment and construction of 11 warehouses planned under HSS2.	<p>Following cold chain equipment have been purchased and distributed: 591 RCW 50 EG, 165 Deep Freezers, 531 Cold boxes RCW 25, 1215. Vaccines carriers, 19 Voltage Regulator, 9 WIF Room, 14 WIC Room.</p> <p>Construction of one out of 11 warehouses planned under HSS2 is under process while 10 warehouses already handed over to the beneficiary (provincial EPI management team).</p>
4. Strengthen measles Surveillance	<p>The key strategies for strengthening measles surveillance were adopted:</p> <ul style="list-style-type: none"> <li>• Conducting high-quality case-based measles surveillance</li> </ul>

	<ul style="list-style-type: none"> <li>Strengthening the quality of epidemiological and laboratory surveillance systems for measles.</li> <li>Include private sector in measles surveillance</li> <li>Ensuring high-quality laboratory contribution to surveillance through laboratories accredited to conduct timely and accurate testing of samples to confirm or discard suspected cases and detect measles virus for genotyping and molecular analysis.</li> </ul> <p>Indicators of surveillance performance described above include:</p> <ul style="list-style-type: none"> <li>National and subnational reporting rates of at least two non-measles cases per 100 000 population</li> <li>Adequate investigation of at least 80% of suspected cases</li> <li>Adequate specimen collection from at least 80% of suspected cases (excluding epidemiologically-linked cases)</li> </ul> <p><b>Adequate specimens for virus detection from at least 80% of laboratory-confirmed chains of transmission</b></p>
5. Follow up with the introduction of Rota and MR vaccines in EPI program	The switch of tOPV to bOPV will be conducted in April 2016, as well as there is a plan to introduce the MR vaccine in 2017 and Rota vaccine in 2018. The preparation for the introduction of MR vaccine will be started after the switch.

## 5. PRIORITISED COUNTRY NEEDS

*[Summarize the highest priority country needs and strategic actions that could significantly improve coverage, equity, and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]*

Please be noted that while preparing a Targeted Country Approach-Partners engagement framework (TCA-PEF) extensive consultations were held and finalized the TA needs for Afghanistan as presented in annex 2.

The JA mission was held in early April 2016 to align behind country financial year and plans. The CTA support for 2015/2016 had not commenced as the partners WHO/UNICEF just received the funds. Furthermore, the PCA was not finalized and there are 5 national TA positions funded under CTA to support the recommendations from the PCA. Before outlining additional requirements for 2016/2017 the support of 2015/2016 need to commence. The program plans to undertake a comprehensive EPI review in August/September 2016. The findings of the comprehensive EPI review will be availed of to align the CTA for 2017.

Prioritized needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?* (yes/no) If yes, indicate type of assistance needed
<p>Improving equity and coverage:</p> <p>Establishment of 310 EPI delivery centers through sub-health centers by identifying appropriate areas in the provinces</p> <p>Immunization services in white areas (areas with no health service) using community teams</p>	2017	To revise the equity analysis.
TCA Improve the quality of routine EPI data through		Yes

<ol style="list-style-type: none"> <li>1. Supporting micro-planning through RED strategy using CHWs and BASIC tools to improve the immunization services</li> <li>2. Improving supportive supervision and monitoring of BPHS HFs at different levels with more focus on decentralization</li> <li>3. Conducting Periodic evaluations to ensure accountability for equity at district and provincial level</li> <li>4. Capacity building of the health staff to produce higher quality data and support data use</li> <li>5. Developing a system of accountability at Provincial as well as National level for EPI data review, feedback and use data for programmatic decisions.</li> </ol>	<p>Mid 2016</p> <p>Q3 2016</p> <p>Once per year</p> <p>Mid 2016</p> <p>2016</p>	<p>External consultant to define target population at the national, Regional and provincial level</p>
<p>Demand Generation through</p> <ul style="list-style-type: none"> <li>• Developing communication strategy</li> <li>• Community involvement for interpersonal communication</li> <li>• Religious leaders, community health workers</li> </ul>	<p>2016</p>	<p>Communication for Immunization/ Appreciative inquiry lead facilitator</p>
<p>Increase access</p>	<p>Gradually start from mid-2016</p>	<p>No</p>

*\*Technical assistance not applicable for countries in final year of Gavi support*

## 6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS



*This section does not need to be completed for joint appraisal update in interim years, instead, the EPI manager is expected to endorse the joint appraisal report.*

<p><b>Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism</b></p>	<p>The ICC/HSS steering committee meeting called on April 6<sup>th</sup>, 2016 and the Joint Appraisal draft report jointly presented by NEPI and HSS representatives. The draft Joint Appraisal report approved by Steering committee member. Committee minute is attached.</p>
<p><b>Issues raised during debriefing of joint appraisal findings to national coordination mechanism</b></p>	
<p><b>Any additional comments from:</b></p> <ul style="list-style-type: none"> <li>• Ministry of Health</li> <li>• Gavi Alliance partners</li> <li>• Gavi Senior Country Manager</li> </ul>	

## 7. ANNEXES



*This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary*

**Annex A. 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 29<sup>th</sup> February 2016 in which the task distribution was done. The member divided the task into two activities i.e.



*financial and technical as well as a review of existing documents. Each member of the team provided a report which was compiled by HSS focal point and it was circulated for comments on 9<sup>th</sup> March 2016. The comments were addressed in the first draft of the report and finally it was jointly reviewed on 15<sup>th</sup> March 2016.*

- *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 the joint appraisal*
  - *Review of the HSS and NEPI staff job descriptions and staff annual appraisal*
  - *Review and revise of HSS2 performance framework*
  - *Short interview with finance, HR, and Admin regarding 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*
  - *Checking of all financial, Admin and HR documents*
  - *Closing meeting regarding documents checked by joint appraisal team with NGO*
  - *Presentation of the joint appraisal report to ICC/HSS steering committee for their approval.*