Joint Appraisal report 2017

Country	Afghanistan
Full Joint Appraisal or Joint Appraisal update	Full Joint Appraisal
Date and location of Joint Appraisal meeting	July 22-27
Participants / affiliation[1]	Annex 1
Reporting period	January 2016-December 2016
Fiscal period[2]	January 2016-December 2016
Comprehensive Multi Year Plan (cMYP) duration	2015-2019

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
Routine	Inactivated Polio Vaccine	2018	2020	1,151,370	US$ 0	US$ 1,423,000
Routine	Pneumococcal	2019	2018	4,020,000	US$ 804,000	US$ 12,797,000
Routine	Pentavalent (DTP-HepB-Hib)	2018	2018	1,242,000	US$ 248,500	US$ 758,500

1.2. New and Underused Vaccines Support (NVS) extension request(s)

Type of Support	Vaccine	Starting year	Ending year
No vaccine extension applicable for Afghanistan			

1.3. Health System Strengthening (HSS) renewal request

Total amount of HSS grant	US$ 39,898,857
Duration of HSS grant (from…to…)	June 2016- May 2020
Year / period for which the HSS renewal (next tranche) is requested	2018
Amount of HSS renewal request (next tranche)	US$ 9,383,942

Total amount of DQIP grant	US$ 2,300,000
Duration of DQIP grant (from…to…)	June 2016- May 2020
Year / period for which the DQIP renewal (next tranche) is requested	2018

[1] If taking too much space, the list of participants may also be provided as an annex.
[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

Amount of DQIP renewal request (next tranche)	US$ 538,441

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Total amount of CCEOP grant	USD 9,366,130	
Duration of CCEOP grant (from October 2018 to December 1021)	The application has been submitted on 06th September	
Year / period for which the CCEOP renewal (next tranche) is requested		
Amount of Gavi CCEOP renewal request	US$	
Country joint investment	**Country resources**	US$
	Partner resources	US$
	Gavi HSS resources[3]	US$

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

Indicative interest to introduce new vaccines or request HSS support from Gavi	**Programme**	**Expected application year**	**Expected introduction year**
	Introduction of ROTA vaccine	2017	2018

Background

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

Context

In 2015 the total estimated population of Afghanistan was 31.5 million *(UNIDATA), of which about 48% are* under 15 years of age. Nearly 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 high proportion of dependents and migrant population increases the vulnerability of poor households to the lack of maternal and child health services.

Reference to the Afghan Mortality Survey conducted in 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 higher 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). Since the Afghanistan Demographic and Health Survey (AfDHS) 2015 data for above three indicators have not been officially endorsed yet, the 2010 AMS figures have been used.

Administrative data shows that national Penta-3 coverage was 84% in 2016, The PCV-3 coverage was 80% and MCV1 coverage 79% (not 75%?), The dropout rate between PCV-1 and PCV-3 was 13% while it is 12% between Penta-1 and Penta-3.

[3] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.
[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

In 2015 administrative coverage of Pentavalent vaccine was 100%, the PCV3 coverage was 91% and MCV1 coverage 92%, and the dropout rate between first and 3rd doses of PCV and Penta vaccines were 19% and 11% respectively.

The administrative data from 2015 and 2016 cannot be compared as changes have been made in efforts to improve the quality of data, including use of Access database and compiling data from HFs, as opposed to previous years' practice of using Excel database and data reported from districts/provinces only. These changes resulted in a decrease in the over reporting and duplication.

Update on political context

The new unity government came into power in September 2014 with the new leadership in MOPH. The new leadership was instrumental in developing a National health policy 2015-2020 that comprises of 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.

Parliamentary elections in 2018: The country will go to elections in 2018, however, new political developments may lead to instability of the current government and this can negatively affect the EPI program. In addition, there may be worsening of security situation in terms of increase in inaccessible areas leading to suboptimal performance of the immunization program.

IDPs and natural disaster: Households in Afghanistan are constantly exposed to conflict and natural disasters, often compelling them to flee their homes abruptly. In 2016, all regions of the country have been affected by the conflict. On average, every day some 1,500 people are forced to leave their homes escaping violence. Over half a million displaced families are scattered across the country, with approximately 20% extremely hard to reach areas not controlled bygovernment. Beside the continuous threat of conflict, more than 70,000 people lost family members, lost their homes or suffered damage and destruction of property due to natural disasters; more than 600,000 Afghans living in Pakistan had their lives uprooted and arrived there with scarce resources and limited community linkages. Once here, they add to the population of internally displaced people, as conflict and lost community networks prevent them from returning to any ostensive place of origin. With no obvious prospects for an improved state of affairs, the year 2017 is likely to see at least 450,000 new IDPs and potentially as many as a million more Afghans returning back from Pakistan.

Active conflict continues to threaten the physical safety and health of Afghans, disproportionately so for the women and children. Indiscriminate attacks against health facilities, patients, medical staff and vehicles continue to disrupt and deprive people of life-saving treatment, half million people live in conflict affected districts with extremely constrained access to health services. (Humanitarian Need Overview (HNO) 2017
http://reliefweb.int/sites/reliefweb.int/files/resources/afg_2017_hno_english.pdf.

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 role 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 405 districts.

Financing of SEHAT (System Enhancing for Health Actions in Transition) activities: The current contracts for SEHAT will come to an end in June 2018. It is being discussed that from June 2018 there will be a funding requirement @ USD 200 million per year for next three years. With the decrease in funding from US, the contribution from USAID will decrease by 35-40%. As of now, there has been commitment of about USD 100 million by major donor agencies/governments (USAID, World Bank, EU and Government of Canada) and, therefore, there is a deficit of USD 100 million per year. SEHAT provides the operational

cost for service delivery of immunization program, thus this deficit may adversely affect the routine immunization. The Government and partners are currently discussing the ways to avert this situation.

The EPI program is managed by the NEPI department at the national level, 7 regional and 27 provincial (totally 34) EPI management teams at the regional and provincial levels respectively. EPI Steering Committee and Health Sector Coordination Committee operate at the national level to give strategic directions for program implementation.

Health and EPI Financing:

Based on the National Health Account 2014, Afghanistan's total Gross Domestic Product (GDP) was about USD 21 billion, which is an increase compared to the previous years, while the GNI is USD 580 per capita.

Total Health Expenditure (THE) in 2014 was about USD 1,992 million, an increase of approximately 32% compared to the last JA; government expenditure on health was around USD 97 million. THE, as a percentage of GDP, was about 9.5%, an increase of 1.5% compared to 2012. While the GNI is USD 580 per capita, the current health expenditure (CHE) as a percentage of GDP was about 9.3%. 2014 NHA used the System of Health Accounts (SHA) 2011; thus separating expenditure on capital from the figure for CHE, which is approximately USD 1,958 million.

Approximately 72% of THE was paid by households out of pocket (OOP); about 5% was financed by the Government of Afghanistan and about 23% by international partners.

The Government of Afghanistan manages some of the funds provided by the donors, estimated at around 12.4% of CHE, whereas the donors themselves managed the balance of donor funding (15.5%). However, individual households managed and expended the amount spent out of pocket.

The national budget expenditures for the EPI program was mainly incurred with payment of Government's share under co-financing of GAVI-supported vaccines (Pentavalent, PCV and IPV). The total financing of the immunization program by Government of Afghanistan has been increasing incrementally e.g. from USD 382,000 in 2009 to USD 1.8 million in 2016. In addition, the major donors to EPI program in Afghanistan are GAVI (ISS, NVS and HSS), WHO, UNICEF, JICA and BPHS donors (World Bank, USAID, European Union).

Polio situation:

Afghanistan remains one of the last polio endemic countries in the world along with Pakistan and Nigeria. The country made significant progress over the past few years, having reduced the number of wild poliovirus (WPV) cases from 20 in 2015 to 13 in 2016 and 5 in 2017 (as of 31 July, 2017). Transmission is currently limited mostly to northern part of Helmand and Kandahar.

Afghanistan demonstrates high level of political commitment to the Polio Eradication Initiative (PEI) with an oversight from H.E the President and H.E the Chief Executive Officer through Polio Steering Committee, Polio High Council and the Office of Presidential Focal Point which deals with line ministries and governorates. Ministry of Public Health (MoPH) plays the lead role and has assigned focal point and senior advisor with full authorities to solicit support to Polio Eradication Initiative (PEI) from all departments of MoPH.

Polio has been declared a national emergency in 2014. Emergency Operation Centers (EOC) were established in 2015 at national level, as well as in the Eastern, Western and Southern priority regions. National Emergency Action Plan (NEAP) was developed for 2015-2016 and later for 2016-17[5]. The program focusses on 47 very high risk districts (VHRDs) that have been responsible for more than 84% of cases over the past seven years. Main NEAP strategies include maintaining program neutrality and gaining access to all children with OPV; implementing alternative strategies, such as Polio Plus interventions and the permanent transit teams (PTT), particularly in inaccessible areas; focusing on

[5]National Emergency Action Plan for Polio Eradication, 2016-2017

identified high-risk provinces and districts and areas where children are persistently missed; ensuring strong household and community engagement; and enhancing accountability of all stakeholders at all levels.
Afghanistan maintains a highly sensitive surveillance system, with key indicators surpassing global targets in all regions (non-polio acute flaccid paralysis/NP AFP rate in 2015-2017 was 14/100 000 children under 15).

National immunization days (NIDs) and Sub-national immunization days (SNIDs) with the use of Oral Polio Vaccine (OPV) are the main types of supplementary immunization activities (SIAs); these are scheduled 4 times a year each. NIDs target over 9.8 million children under the age of 5 in all 34 provinces while SNIDs target over 6.7 million children under five; IPV is also administered simultaneously to the children in VHRDs.

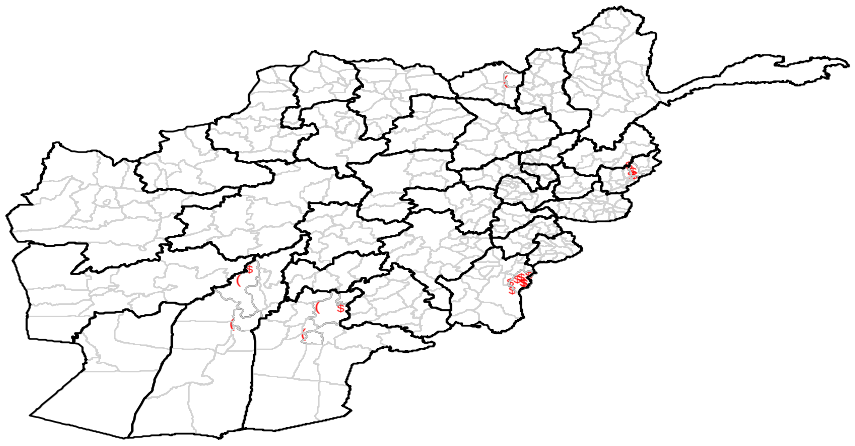


Fig. 1. Confirmed polio cases, 2016 and 2017 (Jan-June).

Regular interaction between the national and regional teams occurs within cross-border coordination with Pakistan through video calls and face-to-face meetings; SIAs schedule for the first half of 2017 between both countries was synchronized. High risk mobile populations are vaccinated by the 378 permanent transit teams; 19 cross-border vaccination points have been established.

Within the polio transition process, a working group comprising MoPH, WHO and UNICEF was established. The initial pilot project on PEI support to strengthening routine immunization services will be implemented in Kandahar, Helmand, Farah, Nangarhar and Kunar provinces. WHO and UNICEF polio programs commit 20% of the field staff time to EPI support: they plan and visit fixed, out-reach and mobile sessions and provide feedback to the respective offices. Main challenges to the polio program in Afghanistan are limited access to some areas due to the insecurity as well as the temporary bans on SIAs, high population mobility and vaccine refusals.

3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

3.1. Coverage and equity of immunisation

Immunization coverage data from multiple sources are inconsistent and therefore it is difficult to comment on trend in the immunization coverage in the recent years.

Administrative coverage data from 2016 for 3 doses of Pentavalent (DTP-HepB-Hib) vaccine was 84% at national level.

In 2016 administrative coverage data decreased compared to previous years across all antigens. This can partially be explained by change in methodology of data collection and consolidation for administered doses as well as with the revision of target population.

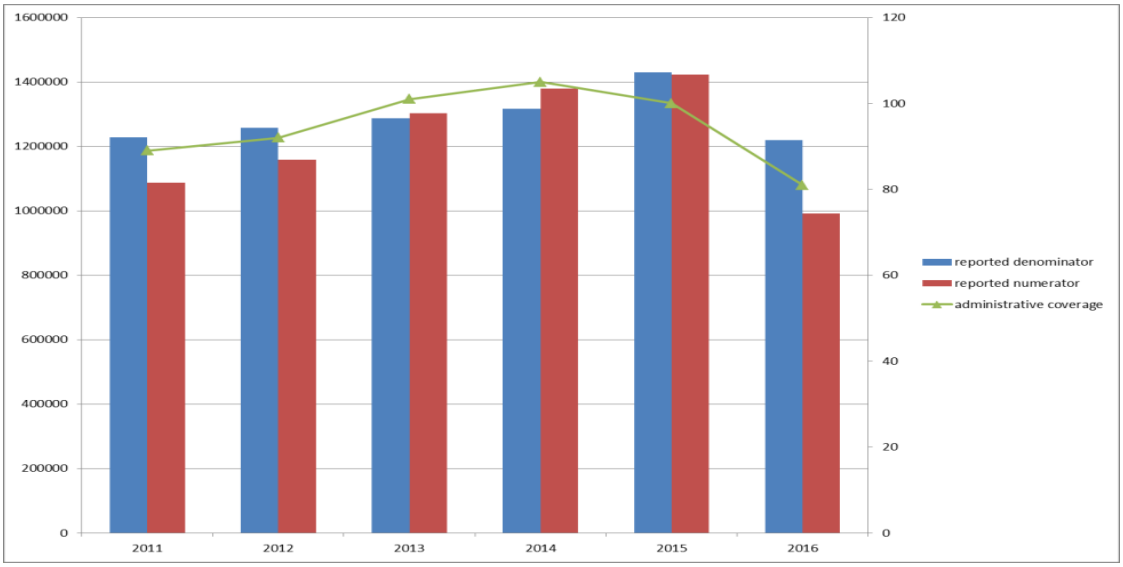


Figure 3: Comparison between administrative coverages in 2015 and 2016

Immunization coverage and equity:

As per the 2016 administrative data, the national coverage for DTP3 was 84% with **71**% of districts reaching 80% or higher among districts achieving over 80% coverage **30**% of districts reported coverage level above 100%.

As per the AfDHS survey, at the provincial level (fig. 2) the distribution of coverage is rather uneven; full immunization coverage was high in Paktika (75%), Badakhshan (72%), and Wardak (71%) and low in Nooristan (1%), Urozgan (2%), Paktya (16%), and Kandahar (16%) provinces.

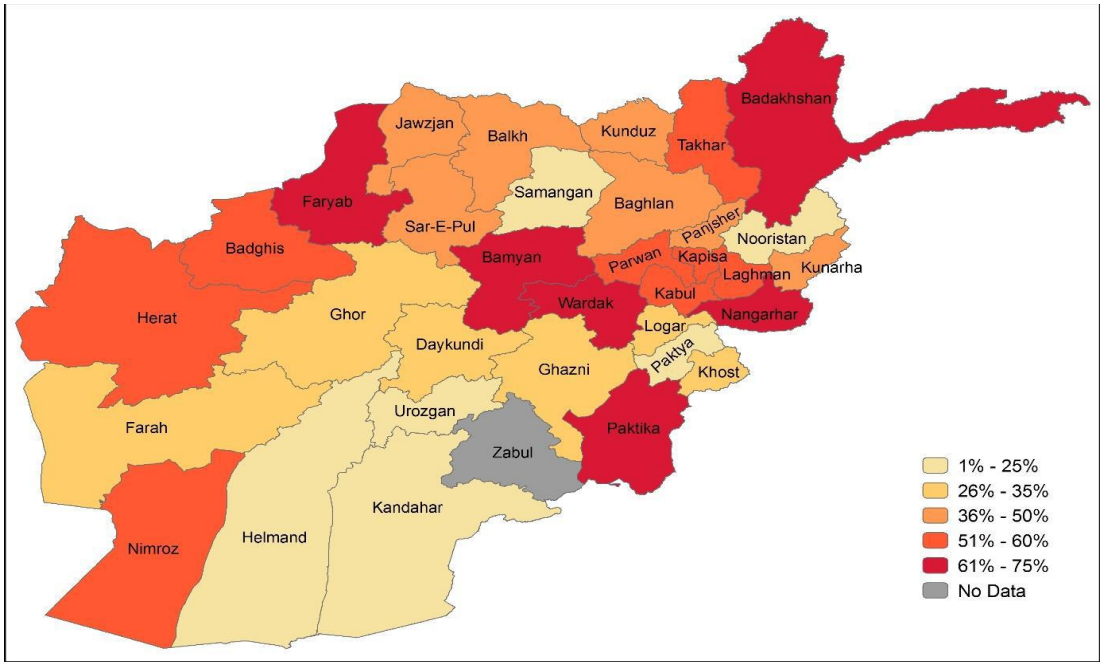
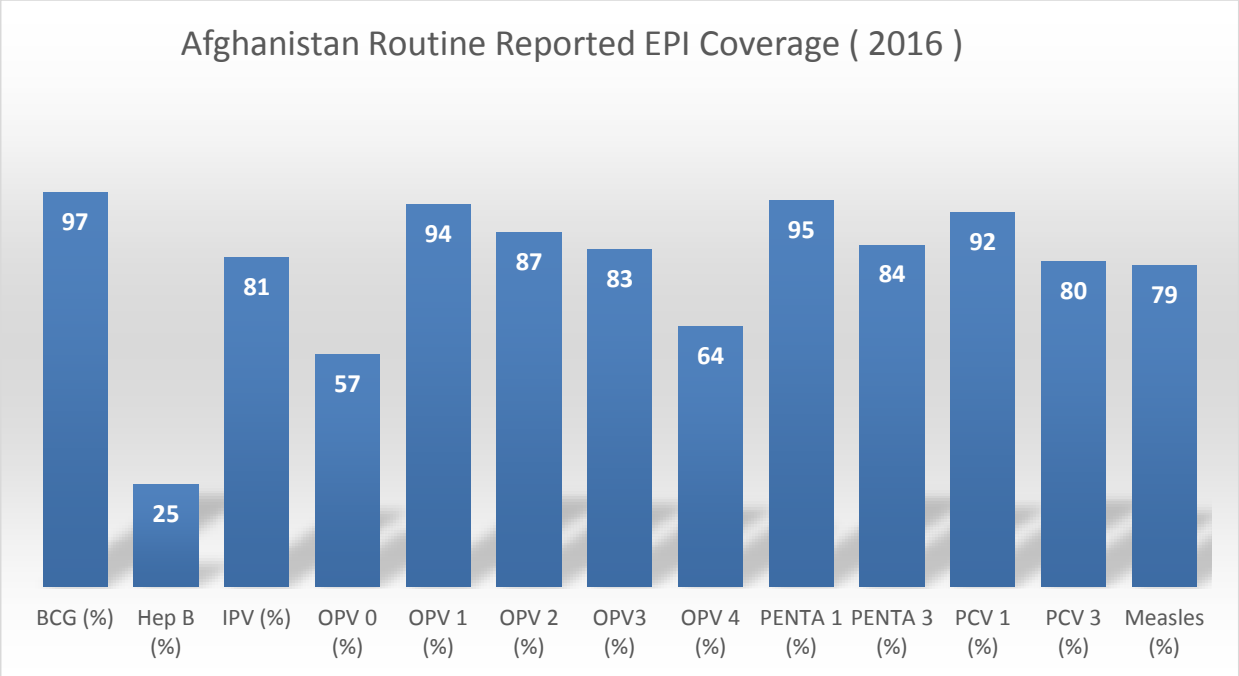


Fig 4: Proportion of fully vaccinated children by province (AfDHS, 2015)

Most recent National Immunization Coverage Evaluation Survey (CES) was conducted in 2013[6]. According to the results of the survey, Penta-3 coverage was 59.7% which was 30-points less than EPI administrative data (reported Penta-3 coverage was 92% in 2013). The proportion of fully immunized children was 51% at national level. Administrative coverage of Penta 3 is 84% for the year 2016 while DHS Penta 3 and WUENIC coverage are 58% and 65% respectively. Below is administrative coverage of all antigens for the year 2016.

Figure 5: Administrative coverage of various vaccines in Afghanistan in 2016



The administrative coverage of Pentavalent vaccine for 2016 is 84% while that the survey results are substantially lower than the official estimate (fig.6).

[6] National Immunization Coverage Evaluation Survey

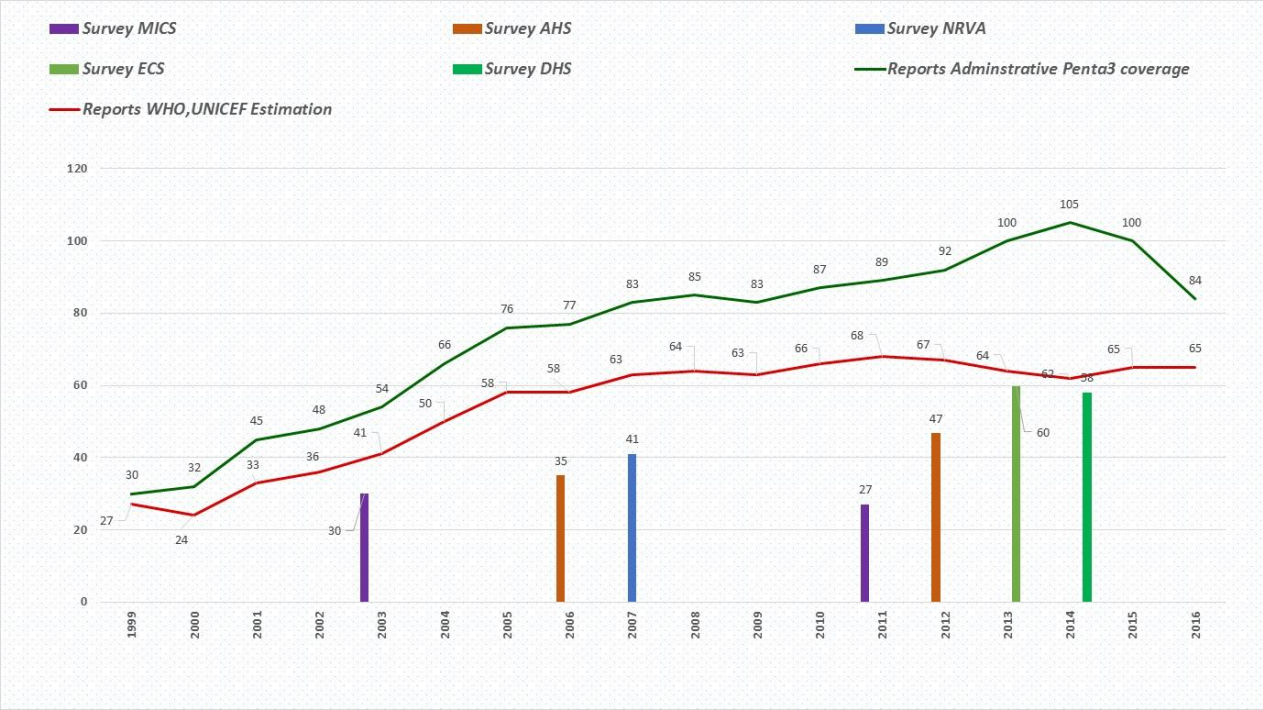


Fig 6: Comparison of the officially reported coverage and survey data in Afghanistan

As per the National Immunization Schedule, Penta-3, PCV-3 and Polio-3 vaccines are administrated at the same time, but, there is a small difference between coverage of these vaccines i.e. 84%, 80% and 83% for Penta-3, PCV-3 and OPV-3 respectively. The exact reasons for differential coverage are not known and need to be explored.

Equity of coverage: Provinces with low Penta-3 coverage are mostly located in the south and west regions.

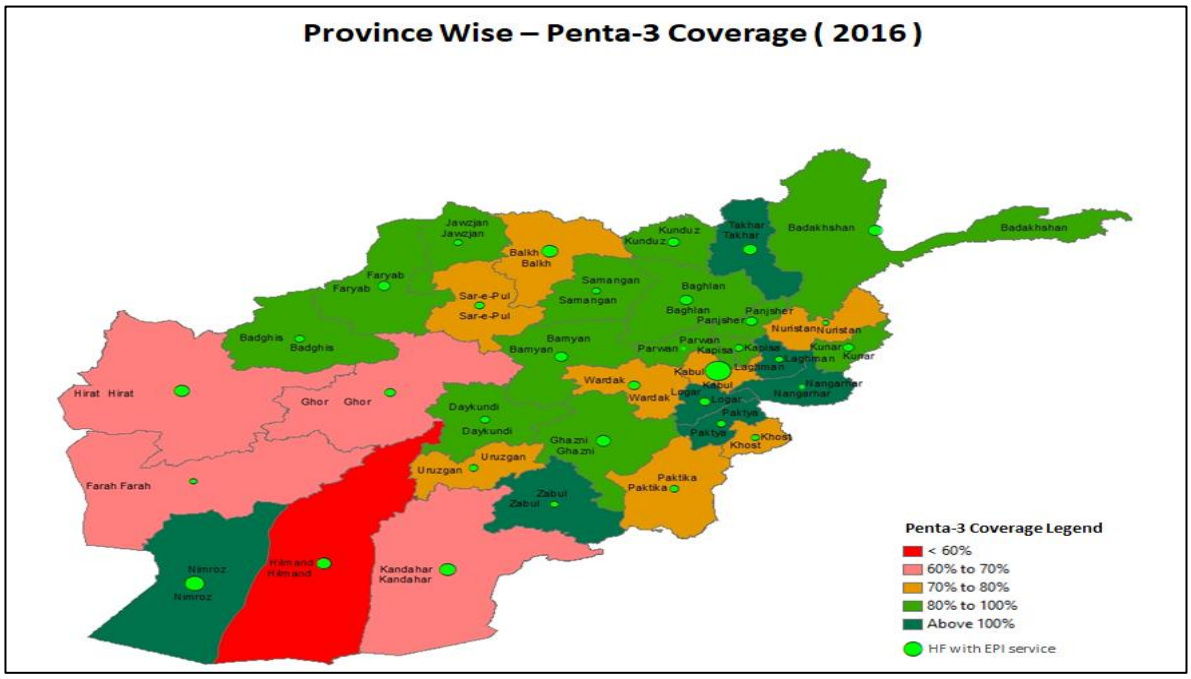


Figure 7: Province wise coverage of Penta-3 (Administrative coverage) in 2016

According to JRF, the districts are divided into 5 categories: with coverage >95 %, between 90-94%, 80-89, 50%-79% and <49% respectively. In 2015, 45% districts felt in the first category; however, the

percentage decreased to 38% in 2016. Second category was 26% in 2015 and decreased to 24% in 2016. Percentage of districts felt in the 3rd and 4th categories is increased in 2016 compare to 2015. The percentage of districts with more than 95% Penta3 coverage has been decreased. The graph 8 below also shows that the proportion of districts with coverage between 80-94% has increased from 18 to 33% which can be attributed to improvement in data quality at the health facility level (figure 8). The new data collection tool enables us to capture the data from each health facility.

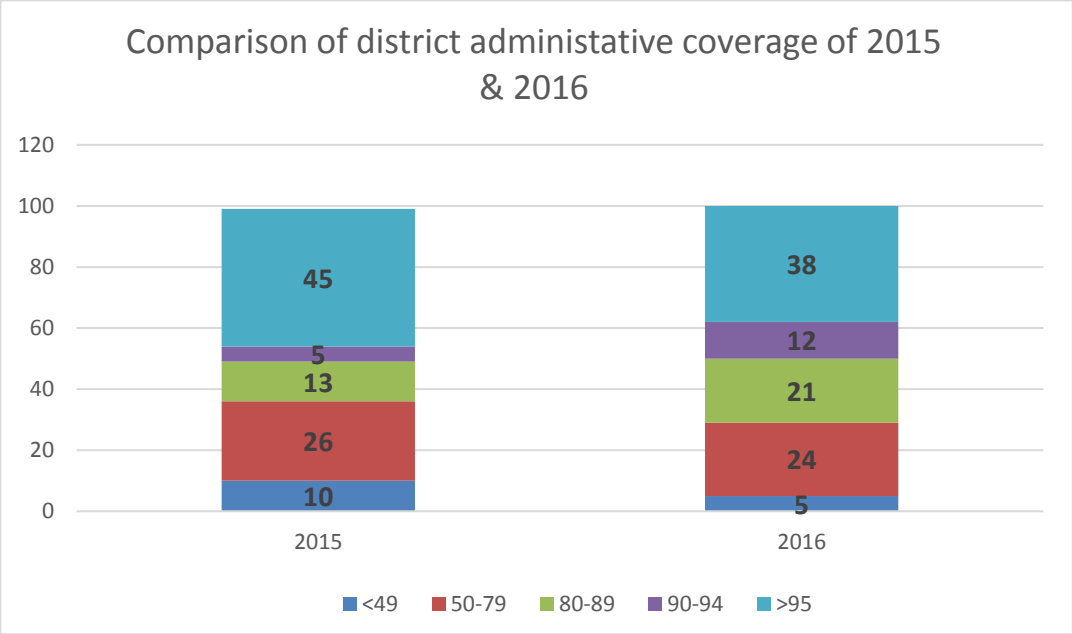


Figure 8: Comparison between district administrative coverage in 2015 and 2016

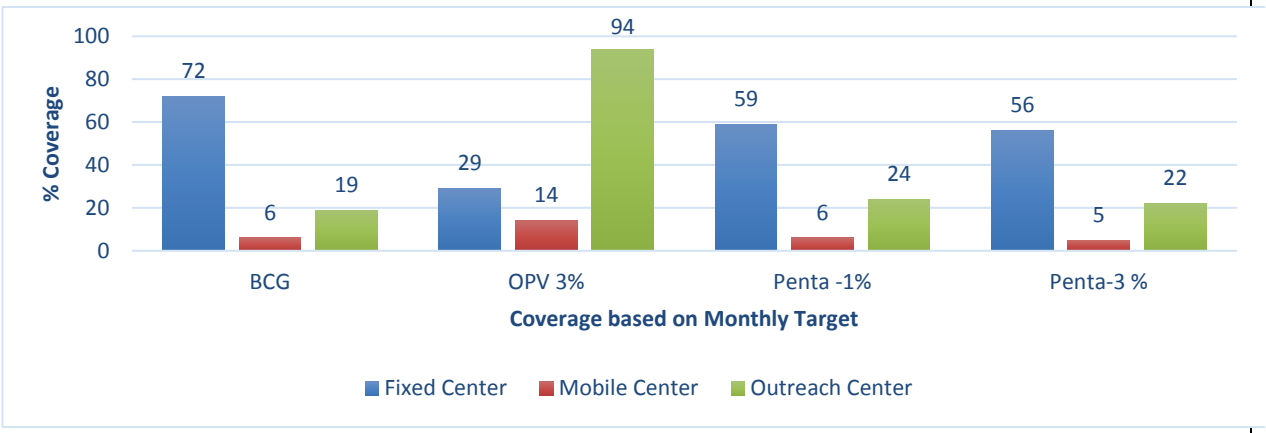


Figure 9: Coverage of antigens, based upon the site of vaccination

The graph 9 shows the proportion of vaccination done at different service delivery platforms. However, the shares of each category do not sum up to 100% indicating the data quality issues.

Key EPI achievements in 2016

- Developed and implemented National Annual Plan of Actions with budget for 2016 and 2017
- Based on the new developments in immunization programs, introduction of new vaccines and technology and in line with Public Health Strategy 2016, updated/revised Immunization cMYP 2015-2019 as key management tool for immunization program,
- Switched from tOPV vaccine to bOPV successfully, no dose of tOPV remained in any of the health facilities providing routine immunization services

- External comprehensive review conducted to systematically review different components of EPI to identify strengths and weaknesses for further strengthening of EPI programme. PIE was integrated in the comprehensive EPI review held in 2017.
- Polio NIDs and SNIDs (four each) conducted
- In 2016, Measles SIAs were planned in 92 low performing/high risk districts (in 24 provinces). However, SIAs were conducted in 82 districts (10 districts with 280,000 targeted children omitted due to the active conflict). Measles SIAs were combined with Polio SIAs; 1,416,964 children 0-59 M received bOPV during measles SIAs. Based on the reported coverage, out of 2,335,647 targeted children of 9 months to 10 years, 2,430,824 (104%) children received measles vaccine. Based on the PCA, conducted in 50% districts three days after the campaign showed that 95% targeted children received a dose of MCV during the campaign. In 2017 selective measles SIAs were planned/conducted in 35 low performing/high risk districts (in 11 provinces) targeting children aged 9-59M during in 2017. Out of 1,085,130 children 5-59M planned, 1,053,452 children (97%) received measles vaccine.
- Substantial improvement of the cold chain and vaccine management practices was achieved in 2016 (details provided in part 3.2)
- Recording and reporting materials for all levels of immunization updated/printed
- The new access based EPI reporting database developed in 2015 including coverage, vaccine and injection supplies; AEFI and vaccine preventable diseases, successfully introduced in RI program and incorporated with HMIS of MOPH.

3.2. Key drivers of low coverage/ equity

Workforce and Human Resources:

Low coverage due to the lower access to and poor utilization of immunization services could be attributed to different factors such as low BPHS coverage, disparity in distribution of health care services between rural and urban areas, unavailability of health care services in certain areas of the country, shortage of immunization service providers, insecurity that hampers operations and access to services; weak management and accountability. A total of 330 officials are employed in REMTs (Regional EPI Management Teams) and PEMTs (Provincial EPI Management Teams) throughout the country. At the central level in NEPI department, National EPI program manager leads a team of more than 20 officials.

About 3500 vaccinators, 1090 (32%) which are female provide vaccination in the field. Majority of female vaccinators work in the urban and secure areas. This is an important barrier as it is unacceptable for women (Tetanus toxoid) to get vaccinated by male vaccinators. There is also an attrition of vaccinators due to low salary. Human resource problems such as high staff turnover, low pay and poor supportive supervision are challenging issues for delivery of immunization services.

The number of fixed centres and vaccinators has increased by more than four times from 2004 to 2016, as shown below:

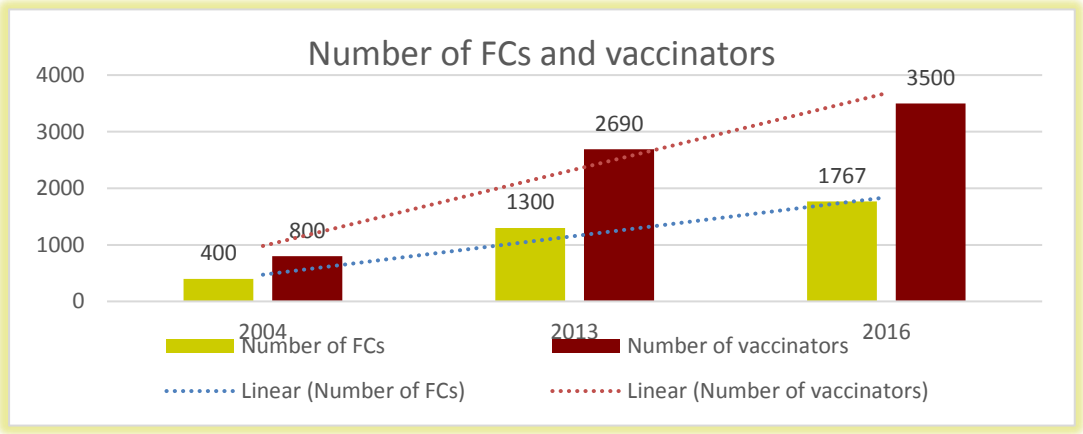


Fig 10: Increase in the number of fixed centers (FC) and vaccinators, 2004-2016

Supply chain:

Key achievements of the EVM IP Implementation

- National cold chain and vaccine management committee formed and working with a concrete Terms of reference
- Availability of revised and standardized formats for immunization supply chain like temperature monitoring formats, stock registers, distribution formats and ledgers across all the supply chain levels
- Total of 11 dry stores are constructed at Regional and Provincial level
- Total of 103 cold chain technicians and 129 EPI supervisors trained in repair/ maintenance and vaccine management respectively
- Total of 18 tool kits are supplied at all the National and regional vaccine stores
- Revised and updated Standard operating procedures for cold chain and vaccine management made available across all the supply chain levels
- Cold chain inventory updated by adopting the WHO CCEI tool
- About 30 TDR data loggers deployed at provincial and health facilities Online ICE 3 extra data loggers are installed at national and Regional level.

The gap analysis, based on the national cold chain inventory, identified needs in the new cold chain equipment which will be required to replace the old equipment, enhance capacity (expansion) and extend new health facilities. Afghanistan qualifies for the CCEOP platform request and MoPH with technical support of UNICEF will submit the CCEOP application in September 2017.

Demand generation / demand for vaccination:

Demand generation is an area of work that is traditionally under-resourced. The key policy documents like comprehensive Multi Year Plan (cMYP) 2015-2019, National Health Policy, Demographic Health Survey (DHS) 2015 and even last joint appraisal report focus largely on service delivery and place insufficient emphasis on demand side issues.

The AfDHS 2015 shows that less than half of the children (43.7 percent) are fully immunized with wide variations across and within districts. The dropout rates for Penta-1 &3 is 21% and 24 percent for Polio-1&3 pointing out the poor utilization of the immunization services. Low coverage, low facility utilization and high dropout rates cannot be exclusively attributed to demand side issues in the absence of evidence. This can be related to security issues, gender specific socio-cultural norms or simple lack of awareness.
For Afghanistan, there is no solid evidence to demonstrate whether demand is an issue for Routine immunization. Polio Knowledge Attitude Practice (KAP) survey (2015) carried out in Polio high risk districts did not explore RI related demand side barriers yet can be used as a proxy measurement it. In the absence of evidence for RI related demand side barriers MoPH planned for a national KAP survey and national communication strategy for RI with the technical assistance of UNICEF Afghanistan under Gavi HSS III with

support from UNICEF's own resources. The activities were expected to start in 2016, however, lack of willingness of selected organization and consultants to come to Afghanistan due to security situation led to substantial delay in the initiation and completion of activities. UNICEF is in the process of contracting out the survey and it is expected to start by mid August 2017. Both these activities are part of end of year milestones due to be reported in November 2017. While waiting for the completion of KAP survey for RI and communication strategy, there are several entry points for increasing demand for RI. Workforce of 6600 social mobilizers and supervisors across 47 districts within Immunization Communication Network (ICN) is available during Polio campaigns and has access marginalized and hard to reach communities. This opportunity can be used to track due and defaulters for RI and convey RI messages rather than only focusing on Polio. These social mobilizers can potentially build trust in RI vaccines and address misconceptions related to RI in addition to Polio.

Furthermore, around 28,000 Community health workers (both male and female) and more than 6500 Family Health Action Group (FHA Group) members are available in all 34 provinces of Afghanistan. The CHWs can play important role to support outreach and mobile activities as well as generating demand and referral for immunization. The member of family Health Action Group who are mainly mothers with young children can cover around 8-12 households with average 10 households at village level. This means that if we use them for generating demand, around 65000 households can be covered by FHAG members. There are around 16000 community councils at village level too, that can be used for community mobilization activities and support of outreach and mobile program. BPHS working through NGOs can play important role in using such resources for demand generation. In addition to the above-mentioned structures existing within the health network, there are sufficient number of Community Development Council (CDCs) will be used for the purpose. Though the latter community-based institution is managed by Ministry of Rural and Rehabilitation and Development (MRRD), it will be linked to health networks for increasing the awareness on importance of health-related services particularly the RI.
RI KAP survey shall be used to qualify whether demand generation is really an issue in the context of Afghanistan and findings/recommendations will be used accordingly to develop strategies and interventions for addressing the identified issues.

In addition to the above mentioned points, it is also needed to focus on structure and system building on communication for immunization at provincial level and national level. This will provide the opportunity for sustaining the demand generation efforts at field level.

- **Gender-related barriers:** These barriers (inadequate number of female vaccinators, low level of female literacy, distance to health facilities) are obstacles both for access and use of health services and these are related to social and cultural norms about men's and women's roles. Women tend to be the primary caretakers of children, but sometimes lack the decision-making power and access to resources or use of available health services.
- AfDHS 2015 did not find any significant gender difference in coverage of children by basic vaccines with 45.0% of males and 46.4% of females having all basic vaccinations

Leadership, management and coordination:

Despite improvements in the health outcome indicators over the past decade, the health system still faces a number of challenges in achieving the high immunization coverage rates (80-90%) to reduce morbidity /mortality from childhood diseases. These includean unequitable access, shortfalls in cold chain and vaccine logistics, demand generation and monitoring capacity at sub-national level.

Within the broader health system, immunization-specific bottlenecks based on cMYP 2015-19 highlighted some cross-cutting issues that affectall six-building blocks of the immunization system. These include multiple oversight structures with overlapping roles and responsibilities, unregular EPI progress reviews, inconsistencies in use of population statistics and number of districts in National EPI and other health programs.

The key bottlenecks are:

- political leadership mainly focused on Polio eradication activities

- low remuneration of vaccination staff
- low proportion of female vaccinators with cultural and traditional barriers in recruiting female vaccinators
- weak monitoring and supervisory processes including prolonged and cumbersome administrative procedure for releasing of funds for EPI supervisory staff
- inadequate cold chain and vaccine logistics capacity
- scattered population in rural areas and large nomadic population; entire population not covered under BPHS
- social and cultural barriers against immunization including misconception against vaccination and low female literacy.

Public financial management:

From July 2016- February 2017 MoPH, UNICEF and WHO received timely installments from HSS3 grant, PEF- TCA and DQIP grants.
Quick book software has been installed and is being used by HSS finance team. Steps have been taken to ensure that the proper filling system is in place and archives established for grant fund to respond timely to the frequent inquiries and follow payment schedules and timelines set in the work-plans and contracts.

Other critical aspects:

NIP needs to strengthen further the government ownership within overall health system strengthening, monitor implementation of annual plan of actions, expand RI services to reach the unreached population, implement annual coverage improvement plan, strengthen health facility/district micro-planning as a key component of RED approach, implement well country-tailored approach to improve RI data quality at all administrative levels; conduct systematic Data Quality Self-assessment (DQs) and use data for actions and closely monitor NGOs performance.

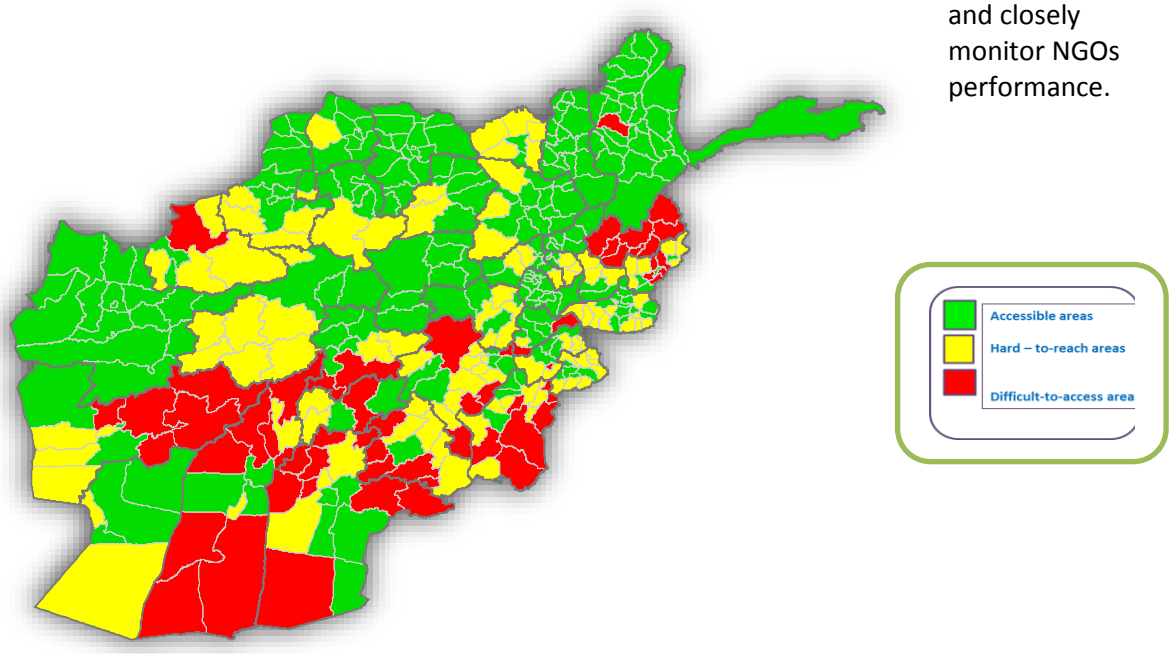


Figure 11: Accessibility status of provinces in Afghanistan

3.3. Data

According to cMYP, lack of accurate estimate of the population size in Afghanistan represents a key problem in health planning and management. The Central Statistics Organization (CSO), Government of Afghanistan, projects annual population estimates of settled population from the baseline of 1979 with a constant population growth rate of 2.03 percent; as of January 2013 country's population was 26.01

million. However, this projection differs from the estimates of National EPI based on UNIDATA. These estimates are based on a study conducted in 1991 with support of UNDP with applied population growth rate of 2.4%. UNIDATA estimates a population size of 30.75 million as of January 2013 (Baseline year for cMYP). There is a concern that MoPH had used CSO data for setting target under Basic Package of Health Services (BPHS) project which is nearly 4 million less than the UNIDATA projections.
HMIS compiles information from all the health facilities working under BPHS and EPHS and forwards it to provincial and national levels. HMIS data quality, completeness, timeliness and accuracy is validated by a third party (KIT) through the assessment of health facilities and balanced score card; accuracy is over 90%. However, HMIS is limited to priority indicators that are used to monitor the progress under BPHS and EPHS. Major limitation of HMIS is reduction of population denominator by 25% based on assumption that only 75% of the population has access to health services, which may lead to over- or underreporting of the services and morbidity/ mortality. Contrary to that, the targets of EPI are calculated without any reduction in population denominator.

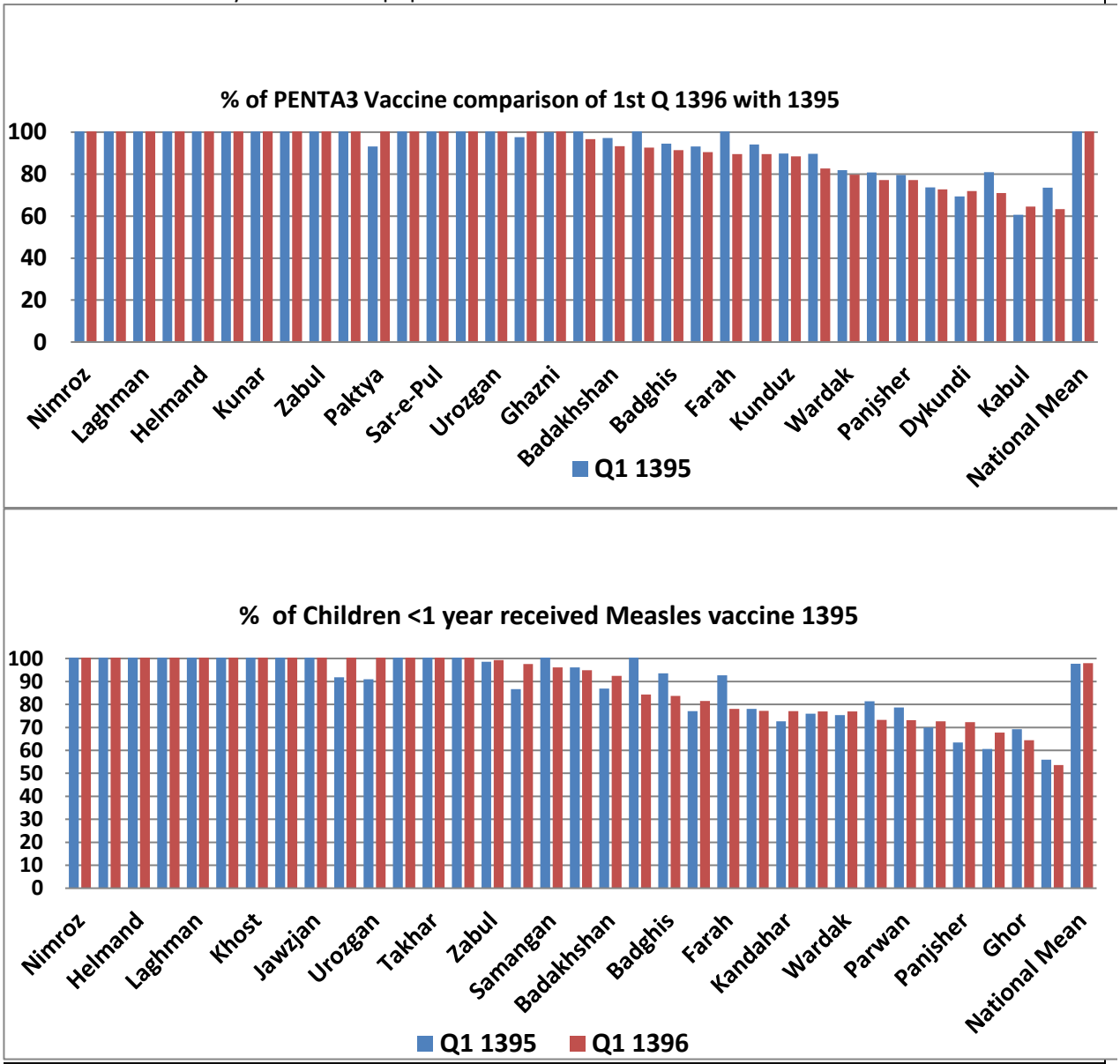


Figure 12 &13 timeliness and completeness

Strengthening data quality

To address the reporting of high coverage that may not have represented a true coverage, country developed data quality improvement plan (DQIP) for the period of 2016-19 with a budget of 2.3 million

support by Gavi. In the year 2015, Access based software was developed to enable capturing the data from health facility.

DQIP objectives

- Improvement in the availability of disaggregated immunization data by geographic area by month
- Reduction in the gap between the estimates of different data sources for immunization coverage
- Improvement in data quality monitoring through systematic and robust data audits
- Improvement in staff capacity on data recording and reporting
- Improvement in use of data for informed decision-making.

DQ review and data quality assessments (conducted or planned)

The last DQS assessment was conducted in 2011 and it showed that among the five domains of quality questionnaire (Demography, Reporting and Recording, Supervision and feedback, Cold Chain and Training), the best domain was Reporting 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 HSS3 proposal includes yearly data quality assessments considering the need of data quality improvement. Due to late transfer of funds, DQS has started in 2017 and the final report is expected to come out by the end of November 2017.

Status of surveillance systems

Measles/rubella surveillance: Measles surveillance in Afghanistan is carried out with the surveillance for Acute Flaccid Paralysis (AFP) from 1997, Disease Early Warning System (DEWS) from 2007 and passively reporting HMIS. Measles case based surveillance with serological lab confirmation was established in 2007 but it depends on the AFP surveillance and DEWS infrastructure. WHO supports national lab with reagents, supplies, specimen collection kits, recording and reporting materials. The quality of measles surveillance remains suboptimal almost all over the country due to the absence of a unified surveillance system, parallel system of AFP/DEWS/HMIS, duplication, discrepancy in surveillance data, poor coordination and cooperation between stakeholders, limited funding, dependence on external support, frequent staff turnover, inadequate monitoring and use of surveillance data for actions. The Measles SIAs or outbreak responses are planned based on surveillance data. Measles case-based surveillance has the capacity to detect cases and outbreaks of measles, but samples are not collected from all suspected cases. The system also suffers from inadequate completeness of reporting at district level, shortage of skilled manpower and insufficient resources for outbreak investigation and documentation at sub-national levels. The discrepancies in data between the parallel systems are striking; e.g. WHO supported surveillance system reported 789 suspected measles cases in Q1 2017; 548 of them were confirmed while the Evaluation and Health Management Information System (EHIS)[7] reported 5,368 suspected cases of measles over the same period of time; 1439 of them were confirmed. EHIS has also reported 80 measles outbreaks in Q1 2017. WHO supported measles surveillance data for 1990-2016 are reflected the number of total measles cases for 2011- 2017 (Q1) disaggregated by confirmed and epi-linked cases. The burden of rubella in the country is not established; rubella is not notifiable disease and the number of rubella cases in table 2 reflects the confirmed cases from the measles suspected cases that were negative for Measles IgM. Congenital Rubella Syndrome (CRS) surveillance is not established yet.

There is a plan to undertake measles surveillance review with support of WHO in September 2017

[7] Evaluation and Health Management Information System (EHIS) First Quarter Report (2017).

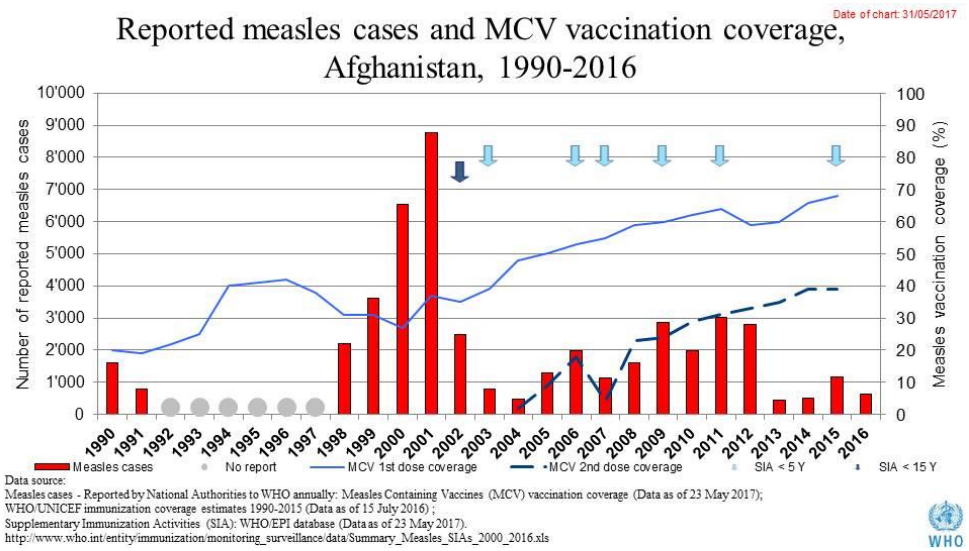


Fig 14: Reported measles cases and MCV vaccination coverage, 1990-2016

Table 2: Measles/rubella cases in Afghanistan, 2011-2017 (Q1)

Cases	2011	2012	2013	2014	2015	2016	2017 (Q1)
Measles							
Lab confirmed	1373	2639	413	491	1154	638	548
Epi-linked		161	17	60	37	0	0
Total		2800	430	551	1191	638	548
Rubella							
	103	94	20	46	60	39	20

Source: WHO Afghanistan

Polio Surveillance: Afghanistan maintains a highly sensitive surveillance system, with key indicators surpassing global targets in all regions (non-polio acute flaccid paralysis/NP AFP rate in 2015-2017 was 14/100 000 children under 15). The number of reported WPV cases in 2017 to date is 5 compared to the 13 cases reported in 2016. AFP surveillance network consists of more than 16,000 reporting and referral sites and volunteers, these include basic health centers, comprehensive health centers, community health workers, pharmacies, faith healers, shrines, mullahs, quacks, GPs. AFP suspected cases are referred to the district focal points, who forward the case reports to the provincial, regional and national levels. Environmental surveillance (ES) samples are collected in 18 sites located in 7 provinces. An external surveillance review conducted in June 2016 concluded that circulation of WPV/cVDPV is unlikely to be missed in Afghanistan; the extent of the existing surveillance network is sufficient; the reporting network needs to include some new private health facilities; practice of active surveillance is generally good.

Rotavirus hospital-based surveillance: The surveillance of Rotavirus gastroenteritis was established in 2008 in two main children hospitals to estimate the burden of disease, morbidity and mortality, and inform NITAG and high level policy-decision makers with regard to introduction of rotavirus vaccine into national immunization program. Diagnostic kits, recording/reporting materials, regular monitoring, on the job training and reporting were provided and carried during the reporting period. The surveillance data shared with all partners including Gavi. The data has been used for NITAG recommendation for introduction of Rotavirus vaccine and subsequent Gavi preproposal, including a study on cost

effectiveness. To evaluate the impact of the vaccine after introduction, NIP – is considering to expand rotavirus surveillance and establish AEFI intussusception surveillance in at least 8 well equipped hospitals with pediatric surgery services. This will help to identify and evaluate any additional risk that might be attributable to the vaccine. Hospital-based invasive bacterial VPD surveillance is going on and specimens are sent to global lab for quality control.

Passive AEFI surveillance is implemented as key component of routine immunization, particularly for newly introduced vaccines into national immunization schedule vaccines. Majority of EPI staff were trained on AEFI, guidelines and tools are updated and available at almost all health facilities providing routine immunization services. Only severe AEFI cases are reported with one serious AEFI case reported in 2017; investigation did not identify any association with vaccine. Serious cases of AEFI with deaths were reported during measles SIAs in 2015 and in 2017. Seven cases of severe AEFI were reported from Gezab districts of Uruzgan provinces with 4 deaths in 2017 during measles SIAs. Based on the finding of the investigation team, the deaths were most likely due to programmatic errors and were clustered in one village; The AEFI surveillance system needs further strengthening. New EPI monthly immunization reporting system has included AEFI for the institutionalizing AEFI through EPI data quality project

3.4. Role and engagement of different stakeholders in the immunisation system

The HSS-ICC as sub group of HSCC provided a formal platform to bring together ICC, relevant departments of MoPH, line ministries, donors and development partners, technical partners and CSO. It facilitated close coordination and succeeded in attracting considerable attention among all stakeholders to focus on strengthening the health system in a more harmonized manner, in contrast to the past where ICC and HSS-SC were working separately with minimal effective linkages. Establishment of this governance and coordination mechanism contributed significantly to strengthen the immunization system.

Within the context of Afghanistan's health system, regulation, financing, resource allocation, and provision of services are illustrated as key functions that shape its health system. The MOPH as regulating body, development partners as financing agencies, and CSOs, mainly NGOs, as healthcare service providers are the key actors recognized in the health system.

NGOs currently implementing BPHS under SEHAT model have had an important role during the past decade in strengthening the health system in Afghanistan. The HSS3 interventions increase the role of the current NGOs/CSOs in the implementation of EPI services through sub-centres, Mobile Immunization Teams, the Public Private Partnerships in insecure areas and establishment of mobile teams for Kuchi population. The proposed interventions contracted out to the BPHS Implementers in respective provinces, CSOs implementing the BPHS are linked with the community through CHWs and religious leaders in their role on health education, communication of health activities, and community mobilization. The dialogue with and engagement of local community and religious leaders is an effective bridge and link between HFs and community. The HFs can inform the community through their religious leaders and CHWs and then receive reports from them as well, such as the case of children missed for immunization.

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

Health System Strengthening (HSS) support

In line with the core values of the Health Sector, such as equity, quality, transparency, and community participation, as expressed in the NHNP 2012-2020, the HSS3 grant is aimed to strengthen routine immunization, especially in underserved communities. The HSS3 grant is for an estimated budget of USD 39.9 million, to be spent over 4 years from 2016 to 2020 in alignment with the existing cMYP 2015-2019 The objectives address key health and immunization system bottlenecks preventing the country from overcoming

socio-economic and geographical inequities in immunization outcomes and aim to strengthen the performance of the health system related to immunization.
The strategic focus of the HSS3 support is to enhance equitable access and effective coverage of immunization services strategies including training female vaccinators and bringing cold chain equipment to unserved HSCs and training vaccinators for community-based outreach in white areas underserved villages, delivery of basic health service through PPPs (CSO type B) and continuing Mobile Health Teams (MHTs) for Kuchi population. Gavi support has contributed to strengthen the cold chain and vaccine logistics management system by increasing the physical capacity with cold rooms and warehouses and improving the human resource capacity for vaccine management to effectively and efficiently track vaccine supplies with new enabling technology, minimizing delays and wastage. Generation of demand to receive immunization services by developing IEC materials and conducting seminars at district level to raise awareness about need for immunizations among religious leaders to build trust in immunizations and remove misconceptions, enlist broadcast media, support the Health Information Call Center, and build the capacity of frontline health workers and school teachers are the area which is covering by Gavi support. Through strengthening the management capacity for monitoring and oversight of the BPHS implementing NGOs, data flow of administrative and program data, the PHOs and DHOs for effective M&E using National Monitoring Checklist and an innovative, Geo-Location Monitoring (GLM) software and database at the health facility level will be trained and mobilized

Major HSS achievement include:

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.
During Joint Appraisal the performance framework jointly reviewed by country and Gavi secretariat team and necessary changes in the baseline, source of data, targets and number of indicators agreed.

Objective 1: Enhancement of equitable access and effective coverage of immunization services through integrated public health care system, private health sector-PPPs, and community participation with more focus on underserved population

Activity 1.1: Upgrading the 310 existing health sub-centers (HSCs) to EPI service delivery points
Activity 1.2: Establishing community-based outreach by vaccinators to cover 2878 villages

- The project TOR developed by a technical team comprised of representatives from UNICEF, GCMU, EPI and HSS departments of MoPH
- After completion of procurement and NGOs CPA, 11 contracts signed with BPHS implementing NGOs for upgrading 96 SHCs and deploying 117 vaccinators to provide mobile immunization at the community level of the white areas of 8 provinces on 1st March 2017
- Implementation started soon after contract signed

Upgrading sub health centers to EPI fixed centers				
	Year-1 (First six months of 2017)	**Year-2 (2017-2018)**	**Year-3(2018-2019)**	**Total**
Planned under HSS3	20	145	114	310
Established HSS3	96 (Has been fully covered by HSS3 including training, equipment, salaries	100 (Will be fully covered by HSS3 including training, equipment, salaries	This # is subjected to number of eligible SHCs determined by the technical committee and the amount of fund remained after all	

	of vaccinators and operation).	of vaccinators and operation).	contracts signed for the target centers set for the first two years.	
Planned by SEHAT	154	268	268	690
Established by SEHAT	154 SHCs has already been upgraded. Salaries and operation are covered by SEHAT. Initial training and cold chain will be provided by HSS3.	Ongoing. This includes upgrading existing SHCs and new health facilities also that require cold chain. Salaries and operation are covered by SEHAT. Initial training and cold chain will be provided by HSS3.	This includes upgrading existing SHCs and new health facilities that require cold chain. Salaries and operation are covered by SEHAT. Initial training and cold chain will be provided by HSS3.	

	Establishment of mobile immunization units in the white areas			
	Year-1 (First six months of 2017)	**Year-2 (2017-2018)**	**Year-3(2018-2019)**	Total
Planned	48	110	120	316
Established	117	79	It will be adjusted based on the need	

Activity 1.3: To continue the 15 MHTs for nomadic (Kuchi) population which are established under HSS2:

- The project's terms of reference finalized and upon completion of procurement process the winner NGO went through PCA
- The contract signed with the winner NGO on 24th April 2017 and the first installment disbursed to NGOs upon submission of inception report

Activity 1.4: To continue, scale up and revise the PPP (CSO type B) project focused on the delivery of EPI and other essential maternal and child health services in remote and insecure areas.

The innovative approach of public Private Partnership (PPP) model which provides 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 Project TOR revised and finalized in consultation with the representative of GCMU, health economic and financing directorate (HEFD), HSS and RMNCH.
- Upon completion of three lots' procurement processes, the contracts signed with the winner NGOs on 6th June 2017
- The remaining one lot (lot 4) was re-announced and it's in final stage of procurement

Activity 1.5: Supporting micro-planning through RED strategy using CHWs and BASIC tools to improve the immunization services,

It is planned to be undertaken in the coming months ***in 2017.***

Objective 2: Strengthening of cold chain and vaccine logistics management system by increasing the physical capacity, maintenance and effective vaccine management (EVM) with provision of adequate infrastructure throughout the country.

Activity 2.1: Expansion of existing cold chain capacity for the intro of new vaccines and opening of new service delivery facilities

The procurement of cold chain equipment has been initiated and a substantial proportion of planned procurement has been completed. The procurement process for the remaining supplies will be completed in the Q3 and Q4 of 2017. As a prerequisite for development of CCEOP proposal, National Cold Chain Inventory was finalized. Based on its findings, the number and type of equipment to be procured under HSS-3 may change. After approval by ICC HSS Steering Committee, the changed plan will be forwarded to Gavi. The status of procurement of CCE is as below:

Equipment	2016	2017	Total procurement planned in 2016-17	Procured	Percentage
Two mode battery solar refrigerator	330	126	456	220	48.2%
Spare part for Solar refrigerator	33	12	45	22	49.4%
Vaccine carriers	1232	428	1660	1332	80.2%
Icepacks,0.3 L	8000	14000	22000	10288	46.8%
Cold boxes	495	235	730	495	67.8%
Electronic refrigerator logger,30 days	395	85	480	390	81.3%
Irreversible Freeze Indicators	860	240	1099	860	78.2%
Water packs freezers	5	5	10	10	100.0%

Activity 2. 2: Capacity building of the cold chain and vaccine logistics managers and initial training for 300 female and 100 male vaccinators

TOR for Initial training of 400 vaccinators (300 females and 100 male) reviewed in consultation with the MoPH (NEPI and GCMU) in order to identify the needs. After thorough review it has been revealed that the central and western regions are in dire need of initial training. The ToR for initial training has been finalized, and there is a plan to cover training of 200 vaccinators in 2017. The management in UNICEF ACO is reviewing whether to contract it through open public bidding, or through cooperation agreement (internally called PCA) with one of the qualified institutions. Once it is finalized, the process of roll out of trainings will be initiated.

Activity 2. 3: Construction of vaccine and non-vaccine storage facilities

The bidding process for the identification of the agency for designing and site feasibility of vaccine and non-vaccine storage facilities has been completed and the contract has been awarded.

Objective 3: Improvement of demand for immunization services by implementing context specific communication interventions to cover the disadvantaged population.

Activity 3.1: Increasing awareness and promoting immunization through the mobilization of religious leaders.

- Training manuals and facilitator's guidelines developed, reviewed and finalized.

Activity 3.2: Implementation of BCC activities through mass media, ICT and IPC

- The procurement process with the announcement of Expression of Interest (EOI) for the school teachers and front line health workers started in June 2017.
- The health information center (HIC) which is the continuation of the same activity under HSS2 grant.

Activity 3.3: Evidence and Knowledge Generation (KAP Survey).

The process of hiring of agency for KAP survey has been completed. A multi-stakeholder group comprising of representatives from NEPI, MoPH and development partners, will be formed to finalize and approve the tools and methodology of the KAP survey in August. The KAP survey will be rolled out from September 2017 onwards.

Objective 4: Strengthening of management and leadership capacity of the decentralized health system at peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services:

Activity 4.1: Improving supportive supervision and monitoring of BPHS HFs at different levels with more focus on decentralization

- Based on National M&E plan, 24% of districts and 25% of BPHS health facilities were visited by PHOs and DHOs using NMC (national monitoring checklist)
- On the job training were provided to the total of 73 PPHOs and DPHOs in 27 provinces with more focus on decentralization
- 57 PPHOs and 29 DPHOs in the 9 piloted provinces received on the job training of Geo Location Monitoring system
- 364 BPHS Health facilities monitored by PPHOs and DPHOs in the 9 piloted provinces through GLM system
- 67 people from MoPH technical departments trained on the revised NMC and its database

Activity 4.2: Conduct Periodic evaluations to ensure accountability for equity at district and provincial level.

Data quality Self-Assessment (DQSA):

- The 1st phase covers 8 provinces conducted and included 32 data collectors from MOPH, NGOs and partners who were trained at national level for three days including one-day practical field work.
- The 2nd and 3rd phases of DQSA training stared on 23rd July 2017. The results will be available by November.

The EPI coverage: WHO

Preparation for conducting immunization coverage cluster survey involving national technical committee (MOPH, WHO, UNICEF and CSO) was almost complete. Technical documents such as coverage survey protocol, tools and MOU with costing were already reviewed by technical committee. Based on government mandate, CSO is responsible for implementation of coverage survey and a contract was expected to be made between WHO and an organization who would have been responsible for the management of funds as well as for the provision of additional technical support to CSO. The survey was expected to start soon after receiving the ICC and GAVI approval. However, ICC in its meeting of 27 July, based on an earlier decisions taken at partners meeting, decided to use the planned Afghanistan Health Survey (AHS) 2017/2018 to address EPI survey requirements to maximum possible effect. EPI would provide technical inputs with support from WHO for incorporating the EPI component in the AHS. The AHS report would be ready by June 2018.

Activity 4.3: Improving the data flow system and improvement of HR accountability at national and sub national level

The study to explore factors for attracting and retaining female health workers in rural areas was planned under HSS3 proposal, meanwhile Health System Resiliency(HSR) funded by USAID project also planned to conduct this study in a large scale covering both retention of female and male health workers in rural area therefore in order to avoid duplication, upon getting ICC/HSS steering committee approval the budget re-allocated, to strengthening the HR databases by establishing databases for residency specialization program and students Essay research of internship program in general directorate of Human Resource as well as IT department staff capacity building based on PCA recommendations ,a data base developer recruited to complete the development of above mentioned databases and train the HS staff for the maintenance of the databases.

Activity 4.4: Internal Audit system strengthening, procurement and finance system strengthening based on FMA 2012 findings

- Based on PCA recommendations, it was planned to develop the electronic financial management System. Ministry of Finance has an existing system and, to avoid duplication it was decided to strengthen this existing system. There are no specific funds available for this activity. A director for the management of development budget in the general directorate of administrative and finance recruited.

Achievements and Progress of DQIP:

The DQIP planned to be implemented in 2016 but due to delay in the fund transfer from GAVI to the Government of Afghanistan the activities were postponed to 2017. During the JA, the DQIP implementation plan was revised (attached as Annex 2). The finding of baseline assessment conducted by KIT, will be discussed in EPI Coordination Meeting in September and the DQIP implementation plan will be modified accordingly.

NEPI with technical support of its international partners developed Standard Operation Procedures (SOPs) and training guidelines. The master training and one-day orientation workshop for NGO in Kabul is to be conducted by end of July 2017 followed by the training of front-line health workers at provincial level. Dashboard is developed and will be launched in near future. Three national staff under PEF (partner's engagement framework) and one international staff by UNICEF was hired. One national staff and one international staff dedicated most of their time to DQI and recently data cell at NEPI was established by hiring data and IT managers while the epidemiologist will to be recruited

Progress of DQIP

Human Resources

Initially it was planned to recruit Data Officers at regional level only, however, after a thorough review it was found that serious problems exist at provincial level also and, therefore, it was decided to recruit 34 Data Quality Improvement Officers in 26 provinces. The changes were submitted to ICC and were approved. A total of 34 Data Quality Improvement Officers hired. The training material for Master training developed and will be translated in Dari and Pashto. Master training will be conducted in August.

Establishment of Data Cell

The hiring process for data cell has been completed. The procurement of technical equipment including server and computers is under progress and will be completed by October 2017

Data tools and guidelines

SOPs for data quality improvement have been developed. Revision of data collection tools including drop outs and due/defaulter list completed. EPIMIS software updated and its integration with HMIS completed and 1780 EPI centres have been registered in the EPMIS software.

Development of Management Information System for RI Data & creation of EPI online Dashboard

It is in process and the first version of EPI dashboard will be available by the end of October 2017. The main objectives of the dash board are:

1. Depict the status of different components of services delivered under the EPI for provinces, districts, EPI centers, using standard methodology and a color coding scheme in maps.
2. Using a composite index, comparison between performance of various districts and provinces
3. Highlight inequities across districts for better focus on marginalized areas
4. Facilitate use of EPI database and HMIS databased for taking appropriate actions
5. Improve the data quality of HMIS by integrating the EPI database with the HMIS and high visualization of data
6. Development of Feedback and accountability mechanism

Implementation of Access software for routine data collection has increased the timeliness of the reports in routine immunization from 40% to 73% and completeness of the reporting from 65% in 2015 to 94% in 2017.

EPI review findings

Following challenges were identified during the National EPI Review in 2017:

- Inadequate political commitment for EPI program vis a vis PEI
- Poor microplanning for RI services
- No strategic plan for advocacy, communication and social mobilization
- Donor dependence for routine vaccines (BCG, Measles, OPV and TT)
- Donor dependence for custom clearance of vaccines
- Inadequate biomedical waste management
- Health facilities don't cover all catchment areas adequately
- Inadequate Completeness, timeliness and accuracy of RI data
- Poor supportive supervision and monitoring mechanisms
- Inadequate surveillance of vaccine preventable diseases

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

The HSS3 grant covers a period of 4 years from June 2016 to May 2020. An estimated budget of USD 39.9 million is required for implementation of GAVI HSS3 jointly by three lead implementers. The MoPH will manage 51 % of the grant (USD 20.35 million), UNICEF will manage 44.2 % of the total grant (USD 17.64 million) and WHO will manage 4.7 % (USD 1.9 million) Out of 10,779,646 USD received by the country (MoPH, UNICEF and WHO) the burn rate is 36.8% (3,966,492 USD) as of end of June 2017.

HSS3 Grant												
	MoPH*				UNICEF				WHO			
	2016	2017	Total	carry forward	2016	2017	Total	carryforward	2016	2017	Total	carryforward
Received fund	$2,177,681	$1,274,547	$3,452,228	$1,234,409	$4,277,874	$2,171,667	$6,449,541	$4,836,528	$877,877	$0	$920,060	$742,217
Expenditure	$858,834	$1,358,985	$2,217,819		$63,010	$1,550,003	$1,613,013		$1,35,660	0	$135,660	
Remarks	**The external audit conducted for the period of May – December 2016.**											

DQIP				
	MoPH			
	2016	2017	Total	carry forward
Received fund	$768,257	0	$768,257	$567,703
Expenditure	0	$200,554	$200,554	

PEF-TCA										
			UNICEF				WHO			
			2016	2017	Total	carryforward	2016	2017	Total	carryforwards
	Received fund		$716,810	$654,804	$1,371,614	$446,540	$154,702	$91,297	$245,999	$91,297
	Expenditure		$716,810	208,264	$925,074		$154,702	0	$154,702	

**Funds received by the MoPH reflect a slight difference to Gavi disbursed funds. We assume it is due to banking fees for the transaction*

4.3. Sustainability and (if applicable) transition planning

- ***Financing of the immunisation programme***:

Afghanistan financially supports EPI activities indirectly by providing housing facilities and funds vaccinators, while directly funds vaccine procurement under co-finance of GAVI-supported vaccines (Pentavalent, PCV). Starting from amount of USD 382,000 in 2009 and gradually increased to USD 1.8 million in 2016, which was shared by the Government of Afghanistan.

The Government of Japan will continue to support the procurement of traditional vaccines in 2018. However, no commitment from Govt. of Japan exists beyond 2018. The Ministry of Public Health is exploring different options including the support from SEHAT for sustainable vaccine procurement beyond 2018.

- **Polio transition planning:**

Polio transition group is established at the National EOC with participation of WHO and UNICEF. Being endemic country, Afghanistan is expected to develop polio transition plan 12 months after the detection of the last polio case. However, documentation of polio assets, human resources and lessons learned has been started

4.4. Technical Assistance (TA)

UINCEF: During the reporting period 80% of PEF activities were on track, the equity analysis on immunization was completed in 2015 and finalized at the beginning of 2016 and it is under comprehensive review and will be updated December 2017.

Based on immunization strategy, the equity analysis helped to design identification of uncovered areas. Multi antigen interventions have been implemented in the identified areas at the beginning of 2016 (carried over from 2015). The plan is based on the need/coverage which will contribute in reducing the VPD cases particularly Measles. Measles campaign was implemented in 91 high risk districts in 2016 with 97% coverage. A total of 94 sub-centers were upgraded to EPI centers and 94 vaccinators (one vaccinator per sub-center) were trained, and the partners are now supplying these centers with cold chain equipment. In addition, a total of 117 community-based outreach teams identified who will be equipped with vaccinators and cold chain very soon. 154 new EPI centers which were identified to be funded by HS3 grant, included in BPHS contracts under SEHAT.

WHO: key technical assistance included updating/revision of immunization strategic plan (cMYP2015-2019), developing annual plan of actions based on cMYP, conducting comprehensive immunization programs review, providing an epidemiological evidence on burden of Rotavirus and developing application and plan of action for Rotavirus introduction; developing proposal, operational plan, training guideline and tools for training, monitoring and verification of switch from tOPV to bOPV and final verification report; developing protocol, tools and other needed documents for planned coverage evaluation survey; provision of guideline, tools and database for data quality self-assessment; updating guideline/tools and developing plan of actions for training, implementation, monitoring, conducting PCA, data collection/analysis of data for selective measles SIAs and reporting; updating AEFI surveillance guideline/tool, and training of 47 EPI trainers on AEFI; Updating of national measles/Rubella surveillance guideline; training of 18 lab staff on quality lab performance; strengthening program management capacity by training of 842 national staff on MLMs, RED approach, data management, data quality improvement, supportive supervision, VPD surveillance and PEI convergence to EPI during 2016 -2017.

EPI Coverage Evaluation Survey will be merged with AHS 2017; NEPI, Development Partners and EHIS Department will ensure adequate representation of variables related to EPI Program in AHS.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Improving equity and coverage: • Establishment of 310 EPI delivery centres through sub-health centers by identifying appropriate areas in the provinces • Immunization services in white areas (areas with no health service) using community teams	• Out of 310 sub-centers planned under HSS3, 94 sub-centers upgraded to EPI fixed centers and 117 Mobile Immunization units established in the white area of 11 provinces by Gavi- HSS3 grant and 154 sub-centers are being upgraded under SEHAT contracts and the implementation will start from August 2017 onward and eligibility assessment for the remaining 60 sub-health centers is going on and will be completed by end of July 2017.
2. TCA Improve the quality of routine EPI data through:	
• Supporting micro-planning through RED strategy using CHWs and BASIC tools to improve the immunization services	• Guideline, tools and database for monitoring/supportive supervision were developed, field tested, updated, printed and distributed. • In total 82 people at the provincial level trained • The micro-planning will start soon after approval of guideline and tools by August 2017
• Improving supportive supervision and monitoring of BPHS HFs at different levels with more focus on decentralization	• On the job training were provided to the total of 73 PPHOs and DPHOs in 27 provinces with more focus on decentralization, the monitoring mission reports disseminated and 81 F2F meeting with PPHDs implementer NGOs and MoPH related departments held and NGOs reminded for improvement plan.
• Conducting Periodic evaluations to ensure accountability for equity at district and provincial level	• Preparation for conducting immunization coverage cluster survey involving national technical committee (MOPH, WHO, UNICEF and CSO) is going on and the technical documents such as coverage survey protocol, tools and MOU with costing are reviewed by technical committee and is expecting to be finalized by 15th July. Based on government mandate, CSO is responsible for

	implementation of coverage survey and a contract will be made between WHO and organization to be responsible for management of fund and provide additional technical support to CSO. The survey will be started soon after receiving the ICC and GAVI approval.
• Capacity building of the health staff to produce higher quality data and support data use	• The DQS training has already been started in all 34 provinces within three back to back phases. The first phase covering eight provinces has been completed and includes 32 data collectors from MOPH, NGOs and partners who were trained at national level for three days including one-day practical field work. the second and third phases started on 23rd July 2017 and the final report is expected to come out by the end of September 2017. • The findings and recommendations of DQS will help NIP to improve the accuracy and quality of RI data and can be aligned/adjusted the DQS recommendations with data quality improvement project activities.
• Developing a system of accountability at Provincial and National level for EPI data review, feedback and use data for programmatic decisions.	• Standard Operation Procedures (SOPs) and training guidelines developed and will be used for training. There is plan to conduct the master training and orientation workshop for NGOs. Job aids for 1700 fixed EPI centers are under design and will be distributed to all EPI fix centers. Dashboard development is almost completed and will be launched in near future. The recruitment of Data cell staff has been completed. 34 data officers have been hired to manage the data at provincial level and facilitate the data usage
3. Demand Generation through • Developing communication strategy	• Three consultants identified by UNICEF-ACO in collaboration with UNICEF regional office through desk review of CVs. • The consultants were contacted but due to the competing priorities, none of the consultants was available. The hiring process will be initiated again. • A communication package, consisting of pamphlet, posters and banners has been

• Community involvement for interpersonal communication (Religious leaders, teachers and community health workers)	developed for improving demand generation for EPI program. In addition, the existing radio and TV spots were also utilized for conducting a mass media campaign. The work on revising the TV spots has been initiated • The operational plan for training of religious leaders is in place, once the results of KAP survey are available, the trainings will be rolled out.

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

Key finding 1	**Strong leadership, management, coordination and commitment for EPI** 1. Need of advocacy for engagement of SEHAT partners (EU,WB and USAID,GAC) for prioritizing EPI activities in the new package of services for SEHAT to be rolled out in June 2018; need for better engagement of GCMU 2. Delays in implementation of HSS3 and DQIP 3. Concern on the financing of the routine vaccines beyond 2018 4. Inadequate planning and coordination between the different departments at national level and different stakeholders at the provincial level 5. Inadequate coordination, support and complementarity between PEI and EPI
Agreed country actions	<u>Engagement of SEHAT partners and GCMU</u> 1. The new SEHAT strategy to have EPI as prioritized intervention and include the clear accountability framework for implementing partners in new SEHAT strategy document; 2. Establish a mechanism to strengthen the coordination among EPI, GCMU, BPHS implementing NGOs and technical partners; <u>Implementation of HSS3 and DQIP</u> 3. (a) Review the performance, develop and implement acceleration plan to catch up with the delayed and planned activities. (b) Establish with GAVI secretariat team 3 monthly video conference review on HSS-3 and DQIP work plan to identify bottlenecks and actions to accelerate implementation of DQIP and HSS-3. <u>Financing of the routine vaccines beyond 2018</u> 4. Advocacy with donors, Ministry of Finance and Parliament for ensuring sustainable funding for routine vaccines and continued co-financing; <u>Planning and coordination</u> 5. Strengthening management capacity for national EPI team; 6. Strengthening **national** and **provincial EPI task force;** 7. Strengthening NITAG; 8. Support development of the annual operational EPI plan at **national** and **provincial levels;** <u>Coordination, complementarity between PEI and EPI</u> 1. Develop a plan for leveraging polio programme support to EPI and implement it to increase the coverage and equity for routine vaccines 2. Support the development of Polio transition plan.

Associated timeline	**By end June 2018**
Technical assistance needs	TA through WHO for actions 1-4 External assistance for NITAG and EPI
Key finding 2	**Immunization supply chain (cold chain capacity and maintenance)/Vaccine and logistics management at different level**
Agreed country actions	• Submission of CCEOP proposal • Effective Vaccine management • Solarisation of cold chain points in Afghanistan • Roll out of Real Time Vaccine Stock and Temperature Monitoring System (RTVSTMS)
Associated timeline	By December 2018
Technical assistance needs	• Existing capacity by UNICEF and WHO is sufficient
Key finding 3	**Service Delivery**
Agreed country actions	• To coordinate between partners (GCMU, BPHS, three donors, UNICEF, WHO) to ensure implementation of mobile/outreach activities • To focus on areas with low coverage e.g. Nuristan and some parts of southern provinces • To improve Convergence between polio and RI • To train more female vaccinators • To strengthen role of the heads of health facilities in improving immunization coverage
Associated timeline	By end of 2017
Technical assistance needs	Existed capacity will be sufficient.
Key finding 4	**Lack of use of data for evidence based decision making, in-consistent national coverage targets across strategic documents and delayed implementation of DQIP.**
Agreed country actions	1. Fast track implementation of DQIP • To conduct the expert led workshop planned in the DQIP to agree on a consistent source of data for denominators and endorsed by the Ministry. In order to achieve the objective of the workshop a preparatory analyses of the current population data from various available sources should be conducted. Consistent time series of denominator from the same source to be able to interpret trends. • Re-enforce the capacity building of users of EPI dashboard at all levels to be able to translate information to decisions. The plan already includes a guideline to be developed as part of the DQIP (annex to be provided by UNICEF) 2. Regular data analyses including the annual desk review of the immunisation data as defined in the SOPs

	• The EPI task force to review all the currently available documents with national level coverage targets and present the recommendations for harmonizing coverage targets to ICC
Associated timeline	Action 1: by December 2017 Action 2: by December 2017 and ongoing Action 3: by Q1 2018
Technical assistance needs	• For the expert led workshop on denominators, technical assistance may be needed for preparatory analyses of the current population data from various available sources should be conducted. Consistent time series of denominator from the same source to be able to interpret trends. • Technical assistance to follow up on the recommendations of the expert led workshop on denominators • Technical assistance for the project management of the DQIP implementation
Key finding 5	**Fragmented surveillance systems**
Agreed country actions	• Alignment of surveillance data sources and mechanisms • Review and standardize case definitions across surveillance system • Strengthen laboratory based surveillance • Leverage polio surveillance system to improve VPD surveillance
Associated timeline	Action 1: by July 2018 Action 2: by December 2017 Action 3: by July 2018 and ongoing Action 4: by July 2018
Technical assistance needs	1. VPD surveillance review in 2018 2. Support surveillance activities by WHO
Key finding 6	**Demand Generation**
Agreed country actions	• Complete national KAP survey to understand the demand related issues for immunization. • Impart TA in the development of national communication strategy for RI • Conduct training of the religious leaders on the importance of RI. • Advocate with national EPI to assign focal points for communication and demand generation and provincial level • Establish mechanism for collaboration and coordination between PEMTs and CBHC and BPHS implementers at provincial level • Advocacy to establish accountability and M& E mechanism between national and provincial level on demand generation and communication
Associated timeline	Jan 2018 to June 2019

Technical assistance needs	TA required for the development of guidelines and training material on demand for immunization

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

A team consisting the representatives from HSS, NEPI, WHO UNICEF and CSOs and other stakeholders was assigned to proceed the process of joint appraisal. The team was led by HSS unit of MoPH and the preliminary meeting held to review the JA guideline and distribute tasks among assigned team on 12th June 2017. The members divided the task into two activities, technical and financial as well as review of existing documents. The zero draft of JA prepared by 4rd July and reviewed jointly by JA team. Comments were addressed on the first draft and reviewed by 16th July. Each member of the team provided report which was compiled by deputy HSS coordinator and it was circulated for final comments on 18th July 2017 to Gavi secretariat and partners. The draft was jointly reviewed with Gavi team from 23-26th July 2017 and latest draft presented to ICC/HSS steering committee on 27th July 2017 for the endorsement. The ICC/ HSS steering committee minute endorsed the JA is attached.

8. ANNEX 1:

Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	√		
Financial Reports			
Periodic financial reports	√		
Annual financial statement	√		
Annual financial audit report	√		
End of year stock level report	√		
Campaign reports	√	√	
Immunisation financing and expenditure information	√		
Data quality and survey reporting			NA
Annual desk review	√		
Data quality improvement plan (DQIP)	√		
If yes to DQIP, reporting on progress against it	√		
In-depth data assessment (conducted in the last five years)		√	NA
Nationally representative coverage survey (conducted in the last five years)	√		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	√		
Post Introduction Evaluation (PIE)	√		
Measles-rubella 5 year plan			NA
Operational plan for the immunisation program	√		
HSS end of grant evaluation report			NA
HPV specific reports			
Transition Plan			NA

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.

ANNEX 2: Plan of Action for Accelerating Procurement/Implementation HSS-3 and DQIP

#	Delayed Activity	Lead Department		Reasons for delay in implementation/procurement	Mitigation measures	Plan of action	Any lessons for the future procurement process
2	Supporting micro-planning through RED strategy using CHWs and BASIC tools to improve the immunization services.	WHO	NEPI	- Late transfer of fund to BC - NEPI has requested to postpone until receiving geo-population survey data from USAID - Time constraints (other priority activities) -Reluctance of former NEPI manager to strengthen RED/REC strategy and proposing household registration of children and women which is not within the NEPI/NGOS/WHO capacity and small amount of fund.	WHO has been working with NEPI to update /simplify RED guideline/tools and shift from RED to REC strategy, documents are updated and need to be reviewed by Task Force and finalize.	Based on latest EPI partners meeting decision, the plan is to print document (REC guideline) and /tools enough for all EPI staff at all levels and conduct training courses with field practices for all EPI management staff including NGOs to further train immunization health workers on correct developing of HF/district micro-plans. The total fund allocated is about $400,000 and the award is valid up to end of June 2018. The activity starts in October 2017.	Shortening of admin/fin beaurocracy both by WHO RO/HQ and GAVI
3	Capacity building of the cold chain and vaccine logistics managers and initial training for 400 male and female vaccinators	UNICEF	NEPI	The initial training of vaccinators is a three-month residential training. As it involves substantial logistics arrangement, there was a discussion for identifying the best possible mechanism for supporting this training e.g. the choice between an NGO, contractor	It is good to develop in-house capacity to manage such trainings at the MoPH level e.g. some components like identification of trainers, training sites etc. are managed by NEPI and the	The ToR will be finalized by second week of September and the bidding process will be initiated in September. The training will be rolled out in the last quarter of 2017	NA

				agency and/or professional body etc. It has been decided that the training will be outsourced to a contractor agency.	logistics are managed by the agency		
4	Construction of vaccine and non-vaccine storage facilities	UNICEF	NEPI	Time taken for finalization of sites and identification of the agency for designing, site feasibility and supervision.		The hiring process has been completed and contract awarded to the agency	
5	Increasing awareness and promoting immunization through the mobilization of religious leaders	UNICEF	HPD	Coupling of religious leaders training with KAP study and delay in one led to delay in the other activity.	Post JA discussion, the two activities have been delinked	The operational plan has been developed and subsequent to inputs by NEPI, it will be rolled out	Coupling of religious leaders training with KAP study and delay in one led to delay in the other activity.
6	Establishment of Health Information Call Center (HIC) and school teacher training	MoPH	HPD	At the negotiation stage the company refused to implement the HIC due wrong budget calculation and the project has been re-announced and currently the technical proposal evaluated. ToR of trainings of school teachers and front line health workers project under procurement process.	UNICEF is requested to support HIC till the end of procurement process.	After evaluation of financial proposals of the shortlisted NGOs, contract will be signed with the winner consulting organization by October 2017. Upon completion of proposal evaluation contract will be signed with the winner NGO by October 2017)	
7	Evidence and Knowledge Generation (KAP survey)	UNICEF	HPD	The selection process was completed in 2016 but the identified agency declined the offer.	NA	The hiring process has been completed and the contract has been awarded. An action plan will be developed shortly to complete the	

						study by first quarter of 2018	
8	Conduct Periodic evaluations to ensure accountability for equity at district and provincial level EPI coverage survey BPHS gap analysis	WHO	NEPI, HSS, GCMU	-late transfer of fund -emphasis by partners on DHS and AHS results -planned AHS by MOPH in 2018 and HE Ministers' instruction of combining CES with AHS survey.	WHO/MOPH has been working with CSO to conduct coverage survey and all the needed documents were ready to start CES including an NGO to manage fund and provide technical support. But, because of HE Instruction, CES will one of the important component of AHS planned in 2018.	Based on new CES methodology, all indicators including the needed components of CES report required for EPI CES are included into AHS and it is upon MOPH to determine the timing for implementation of AHS. WHO CO, RO and HQ will provide technical support to MOPH in AHS	
9	Economic evaluation of Medicine and Ready to Use Therapeutic Food (RUTF) local production vs. importation in Afghanistan	MoPH	HEFD	The comments and suggestions of procurement unit was considered and sent back to procurement unit. We followed up several times, but the procurement unit were busy.		Waiting for procurement response.	A comprehensive procurement plan for all the projects should be developed in advance with coordination all stakeholder units considering the time and resources.
10	Data Quality Improvement Plan	MoPH	UNICEF	SOPs and training guidelines were developed and translated on time. Master Training: Due to holy month of Ramadhan the		The second phase of master training will be conducted in Mid-September	All the activities need to be planned in close coordination with the

				master training did not happen on June 2017. The first phase of the master training was conducted in last week of August 2016. Orientation workshop for NGOs completed in last week of August 2017 Frontline Health workers training was delayed to due delay of master training. Job Aids for Health Facilities are under design and will be completed till end of 2017 Tracking Bags delayed due to delay on design of immunization cards.		The frontline health workers training will be conducted after completion of second phase of master training at the end of September 2017 Will be completed until the end of the year We work closely with communication department to print immunization card and the tracking bags will be ready until the end of this year in health facilities.	International Partners and field staff