Afghanistan

Joint Appraisal report 2018

Country	Afghanistan
Full JA or JA update	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	July 15-20, 2018, Alexandria (Egypt)
Participants / affiliation[1]	Annex 1
Reporting period	January 2017-December 2017
Fiscal period[2]	January 2017-December 2017
Comprehensive Multi Year Plan (cMYP) duration	2015-2019
Gavi transition / co-financing group	

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes ☑	No ☐	N/A ☐
HSS renewal request	Yes ☑	No ☐	N/A ☐
CCEOP renewal request	Yes ☐	No ☐	N/A ☑

Observations on vaccine request

Population	34,989,229				
Birth cohort	1,679,483				
Vaccine	IPV	Penta	PCV13	Rota	…
Population in the target age cohort	1399569	1399569	1399569	1399569	
Target population to be vaccinated (first dose)	1259612	1399569	1399569	1399569	
Target population to be vaccinated (last dose)	NA	1259612	1259612	1259612	
Implied coverage rate	90	90	90	90	
Last available WUENIC coverage rate		65	65	NA	
Last available admin coverage rate	80	81	78	NA	
Wastage rate	20%	20%	10%	5%	
Buffer	25%	25%	25	25%	
Stock reported					

Country team, in coordination with UNICEF colleagues, develops forecasts for vaccine and non-vaccine supplies each year in September for the upcoming year. Forecasting exercise considers available stock, buffer stock, wastage rate and takes UNI data population as the basis for denominators. It includes the shipment schedule for delivery of mentioned items and cold chain equipment to the country. In 2017 Afghanistan did not face any vaccine and/or non-vaccine stock out.

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[3]

[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.
[3] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	NA		

2. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

Context

In 2017, the total estimated population of Afghanistan was 34.65 million (UNFPA and Flow Minder estimates); of them about 48% were under the age of 15 years. Afghanistan Living Condition Survey (ALCS-2017) reported that 54.5% of the country's population lives below the poverty line. The prevalent poverty, high proportion of dependency (101%), large number of returnees and Internally Displaced People (IDPs) increase the vulnerability of the Afghan population and negatively affect their access to health services. During the first seven months of 2018; 486,796 Afghans returned from Iran and Pakistan (465,352 from Iran and 21,444 from Pakistan). In the same period 548,533 Afghans were internally displaced, mainly due to conflict in south and drought in the northwest and western part of the country. Results of the Demographic and Health Survey (DHS) conducted in 2015 showed that the Infant Mortality Rate (IMR) is 45 deaths per 1000 live births and Under 5 Mortality Rate (U5MR) is 55 deaths per 1000 live births. However, UN IFME estimates the IMR and U5MR at 53 and 70 per 1,000 live births respectively. The IMR was higher among rural families, in poorest quintile and at children of illiterate mothers.

Administrative data show that national Penta-3 coverage was 81% in 2017, the PCV-3 coverage was 81% and MCV1 coverage 78%, the dropout rate between PCV-1 and PCV-3 was 13% while it was 12% between Penta-1 and Penta-3.

In 2016 administrative coverage by third dose of Pentavalent vaccine was 84%, the PCV3 coverage was 80% and MCV1 coverage 79%, and the dropout rate between first and 3rd doses of PCV and Penta vaccines were 13% and 12% respectively.

Coverage rate trends from 2015 to 2017 need to be interpreted with caution because:

- Measures to improve the accuracy of numerators, such as training, job aids and induction of provincial data officers, were implemented since 2016;
- The number of doses administered is now reported by health facilities directly (facilitated by the newly introduced MS Access database) as opposed to district level reports in 2015. These efforts have, therefore, resulted in the reporting of a more accurate (albeit lower) overall number of doses administered reported in 2016 as compared to 2015.
- Concurrently, data sources of population estimates were reviewed in 2016, including data reported through the MS Access database, which led to a downward revision of the target population used by the immunization program. Given the relatively low completeness rate of the new MS Access database, upward adjustments were made in 2017 to the target population, bringing the estimate closer to UNIDATA projections.
- Given the revisions made to both the numerator and denominator in 2016 and 2017, it is therefore difficult to interpret the coverage trend from 2015 onwards as the rates were calculated on the basis of different denominators and numerators with varying levels of accuracy.

Update on the political context

The new unity government came into power in September 2014 with the new leadership of 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 environment.

Parliamentary elections: The parliamentary election will take place on 20th October 2018. The election may increase political tension among different parties which could be associated with increased security

incidences. The political developments may lead to instability and negatively affect access to health services and the performance of EPI program.

Insecurity, IDPs and natural disaster: Afghanistan suffers from one of the longest protracted complex emergencies due to conflict, natural disasters and mass population movements. In 2017, the intensity of the conflict expanded to different regions resulting in higher number of internally displaced people and trauma cases. The displacement has resulted in need for additional emergency service support. Between January and September 2017, trauma cases increased by 21 percent compared to those recorded for the same period of time in 2016. Increase in the frequency and intensity of conflict has also resulted in increased violence against health service providers and closure of facilities. In 2018, 69 health facilities were closed in Zabul, Kunar, Nengarhar, Helmand, Kandahar and Badghis provinces. Out of these health facilities only 10 were reopened while 59 still remains close.
Increasing number of internally displaced persons (IDPs), the influx of returnees from Pakistan and Iran, escalating conflict and population movements increase the need for humanitarian health services. However, funding pledges are unpredictable due to extended emergencies in the region, thus reducing the response capacity. In addition, insecurity and limited accessibility to emergency locations in high-risk provinces and damage to health facilities hampers essential emergency health services, capacity building and monitoring activities in conflict affected areas.

Leadership, governance, and program management:

Afghanistan has transformed from a conflict-torn health system to a relatively functional one through an innovative approach of 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 the BPHS and EPHS, the MoPH assumes the stewardship 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 405 districts.

Financing of SEHAT (System Enhancing for Health Actions in Transition) activities: The current contracts for SEHAT will come to an end in December 2018. It is being discussed that from June 2018 there will be a funding requirement of USD 200 million/ year for the next three years. With the decrease of funding from US, the contribution from USAID will decrease by 35-40%. SEHAT provides the operational cost for service delivery of immunization program, therefore, this decrease in funding may adversely affect the routine immunization. A new agreement for the provision of BPHS and EPHS (Sehatmandi) has been signed between the MoF and WB. It's envisioned that new Sehatmandi (June 2018 – June 2021) will be financed by ARTF.

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. At the provincial level program is coordinated through EPI coordination committees.

Health and EPI Financing:

Based on the WB estimates, Afghanistan's total Gross Domestic Product (GDP) was USD 20.815 billion in 2017, which shows a relative increase compared to 2016 (19.469 billion in 2016).

Total Health Expenditure (THE) in 2014 was about USD 1,992 million, an increase by approximately 32% compared to the last NHA; 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.

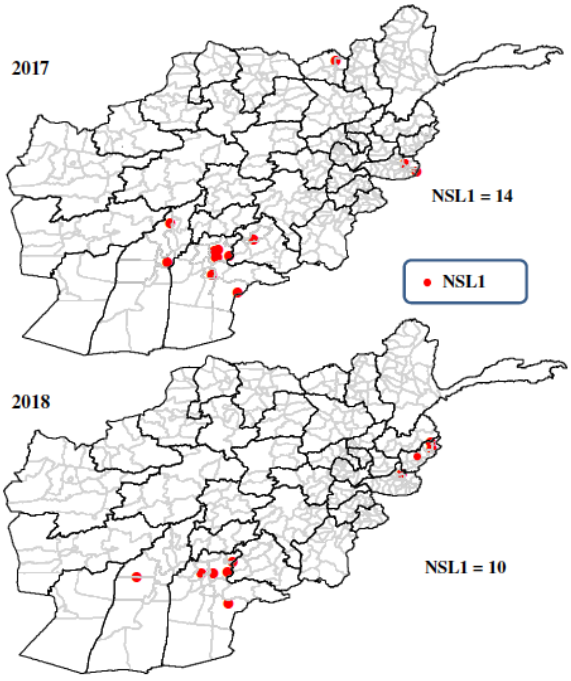
Approximately 72% of THE was paid by households out of pocket (OOP); about 5% was financed by the Government of Afghanistan and about 23% by donors. The Government of Afghanistan manages some of

the funds provided by the donors, estimated at around 12.4% of THE, whereas the donors themselves managed around 15.5% of the THE through direct implementation or contracts with NGOs. The remaining large portion is spent out of pocket and managed by individual households.

The national budget expenditures for the EPI program were mainly incurred with payment of Government's share under co-financing of GAVI-supported vaccines (Pentavalent, PCV, IPV and Rota) in addition to Immunization service delivery by BPHS. The total financing of the immunization program by Government of Afghanistan has had incremental increase, from USD 382,000 in 2009 to USD 1.5 million in 2017. 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 reported 10 Wild Polio Virus (WPV) cases in 2018 (as of July 17, 2018) compared to 14 WPV cases reported in 2017. The polio transmission is limited to the geographic areas in South and East of the country. 6 out of 10 WPV cases in 2018 did not receive any routine or supplemental OPV dose.
Currently Polio Eradication Initiative (PEI) program in Afghanistan is represented by the National Emergency Operation Center (EOC) for polio eradication established two years ago with four regional branches and large WHO and UNICEF Polio programs that provide technical support to the SIAs, AFP surveillance and communication activities.



Supplementary Immunization Activities (SIAs) implemented in the house-to-house fashion are the cornerstone of the polio eradication strategy; 3 National Immunization Days (NIDs) covering entire under five population of the country with OPV (more than 10 million children) and 6 sub-NIDs focusing on the high-risk areas of the country (more than 6 million U5 children) are planned for 2018. More than 60,000 vaccinators, almost 6,000 supervisors and some 7,000 social mobilizers are involved in NIDs. Limited access to children due to insecurity and bans from the different groups are the major impediments to the SIAs quality; most recent May 2018 NIDs witnessed record high number of missed children (close to 1 million) due to the bans on the house-to-house campaigns.

Country needs to increase immunization coverage and improve equity by expanding access to outreach immunization services, particularly in rural and insecure areas. This can be done through improved microplanning and support to the service delivery network. Different VPD surveillance streams need to be streamlined and integrated.

National Emergency Action Plan (NEAP) for Polio Eradication has an objective of providing support to routine immunization using polio assets in high-risk areas of the country.
Following three areas are identified by NEAP 2018:

- Field level engagement of PEI staff in monitoring of routine EPI and taking actions based on findings;
- Engagement of PEI field staff in support of routine EPI as per the PEI/EPI integration plan in all polio priority provinces;
- Development of Joint Accountability Framework for PEI/EPI and NGOS Staff.

Immunization Communication Network	Number
Regional Social Mobilization/M&E officer (Full time)	15
Provincial Communication Officer (Full time)	24
District Communication Officer (Full time)	128
Cluster Communication Officer (Full time)	762
Social Mobilizer (Full time)	4,738
Communication Supervisors (10 days/month)	348
Social Mobilizer (10 days/month)	2,264

PEI to EPI working group under Emergency Operation Center (EOC) developed three checklists:

- Checklist for outreach and mobile sessions
- Checklist for community coverage
- Checklist for fixed center

WHO and UNICEF PEI staff conduct monitoring visits to observe RI activities, fill the checklists and provide monthly reports to the respective offices.

Afghanistan is expected to develop Polio Transition Plan twelve months following the interruption of polio transmission. However, considering large polio human and material resources in Afghanistan, the process of establishing polio transition governing structure and engaging stakeholders should commence at the earliest opportunity. As an initial step a detail Polio Transition Framework for Afghanistan has been drafted, which will be widely discussed with partners in coming months. Attachment 1

The existing ICC/HSS Steering Committee (so called Inter-Agency Coordination Steering Committee/ICSC) could assume the functions of the governing body for the polio transition process. The membership of this committee include General Director of Preventive Medicine, General Director of Policy and Planning, HSS Coordinator and Focal Point, National EPI Manager, head of Grant and Contract Management Unit (GCMU), Health Sector Manager (MoF), CSO representatives, authorized representatives from World Health Organization, UNICEF, World Bank, USAID, European Commission. This will ensure mainstreaming of the polio transition process into the routine EPI and health system strengthening support.

The separate working group will be established under ICSC to provide technical support to the polio transition process as well as implement, monitor and supervise the activities. The working group will consist of the representatives of Emergency Operation Center (EOC) for polio eradication, National EPI, NDSR, GCMU, BPHS NGOs, WHO, UNICEF, USAID, Embassy of Canada.

Polio Assets:
The following tables summarize some of the polio assets. Details inventory/mapping of all assets by district will be done as part of polio transition planning.

a. Human resources Immunization communication network

Surveillance and SIAs

Count of Position	Number of staff
Central Region	67
Country Office	38
Eastern Region	58
Islamabad	1
N. Eastern Region	39
Northern Region	33
S. Eastern Region	48
Southern Region	121
Western Region	58

Grand Total	463

b. Vaccines and cold chain equipment procured in 2017

Vaccine type	**Quantity procured**
Bivalent oral polio vaccines (bOPV)	148 million doses
Mono oral polio vaccines (mOPV1)	5.3 million doses
Inactivated polio vaccine (IPV)	1.5 million doses

Item	**Quantity**
Vaccine carriers	35,732
Cold boxes	4,822
Freezers	116
Ice packs	111,480
Containers	13

- The government of Japan may stop its support for the procurement of traditional vaccines beyond 2019
- The shortage of fund for the implementation of Sehatmandi program (July 2018 – July 2021) may negatively affect provision of immunization services and its coverage
- As part of transition from SEHAT to Sehatmandi there will be changes in health services providers (BPHS and EPHS implementing NGOs), this may temporarily affect health services provision including EPI
- The upcoming parliamentarian election planned for October 2018 might be associated with increased level of violence which will negatively affect the provision of EPI services
- Expecting interruption of the polio virus circulation and polio transition (discontinuation of support to cold chain, supervision and monitoring, microplanning etc.) may increase the workload and expectations from the EPI

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

3.1. Coverage and equity of immunisation

3.1 Immunization coverage

The health system in Afghanistan has shown a steady progress over the last few years, with an increasing coverage of primary health care services throughout the country. However, the immunization status of children in Afghanistan is characterized by a low and stagnating coverage.

As per the latest DHS-2015 survey, Penta-3 coverage at the national level is 57.7%. There is a huge Inter-provincial difference in immunization coverage. The Penta-3 coverage was high in Faryab (81.7%), Badakhshan (80.9%) and Bamyan (78.3%), while it was abysmally low in Nooristan (0.7%), Uruzgan (2.1%) and Kandahar (24.8%). As per the Coverage Evaluation Survey (CES-2013), the proportion of fully vaccinated children was 51% at the national level.

Immunization coverage data from multiple sources are inconsistent. As shown in Fig. 2 below, there is a huge difference in the administrative coverage and DTP-3 coverage as per the survey data.

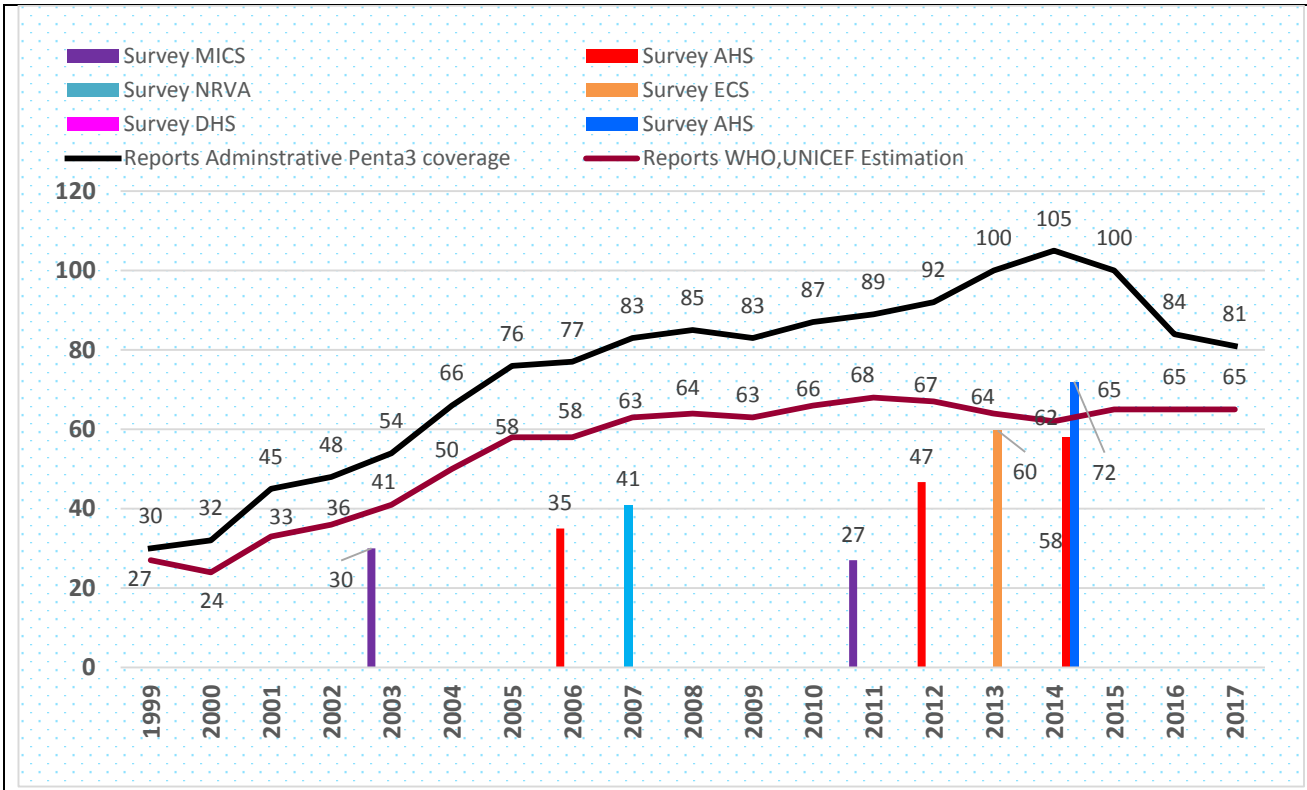


Fig 2: Comparison of administrative and survey coverages in Afghanistan (1999-2017)

Although the reported administrative Penta-3 coverage in percent in 2017 is the same as 2016, but in absolute numbers there is discrepancy between numerators and denominators in 2015, 2016 and 2017 (Fig 3). The 2016 data and JRF needs to be re-checked and resent.

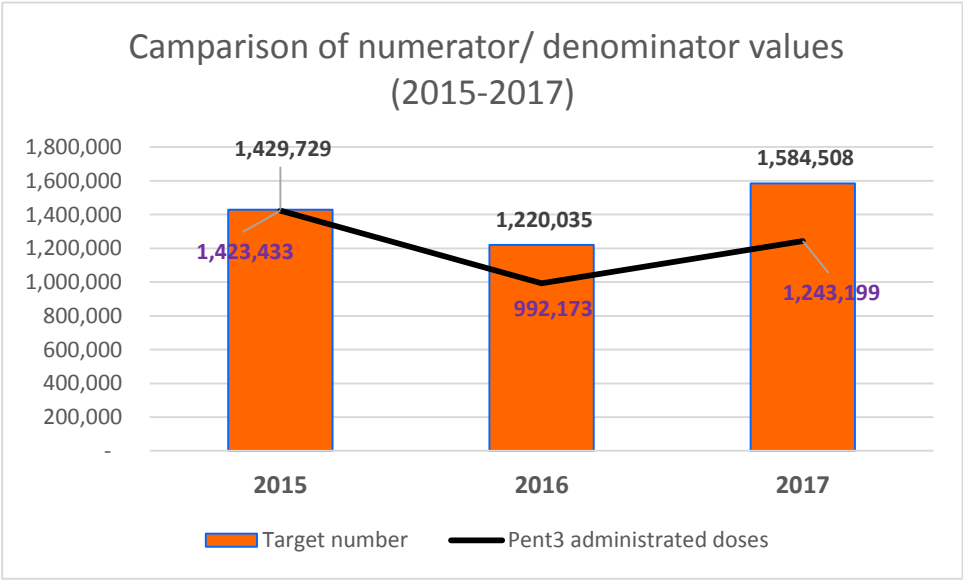


Fig3: Comparison of numerator/ denominator values (2015-2017)

The Fig. 4 shows the antigen-wise administrative coverage by different antigens. The administrative coverage of DTP-3 vaccine has decreased in 2017 as compared to 2016. This can be attributed to the continued efforts for improvement in the quality of data. However, there is a slight increase in coverage of Hep-B birth dose. This could be due to increase in institutional deliveries in the country and improved knowledge, attitude and behavior of parents and caregivers due to consistent Behavior Change Communication (BCC) messages using multiple media (leaflets, posters, banners, Radio and TV spots). However, this needs to be validated.

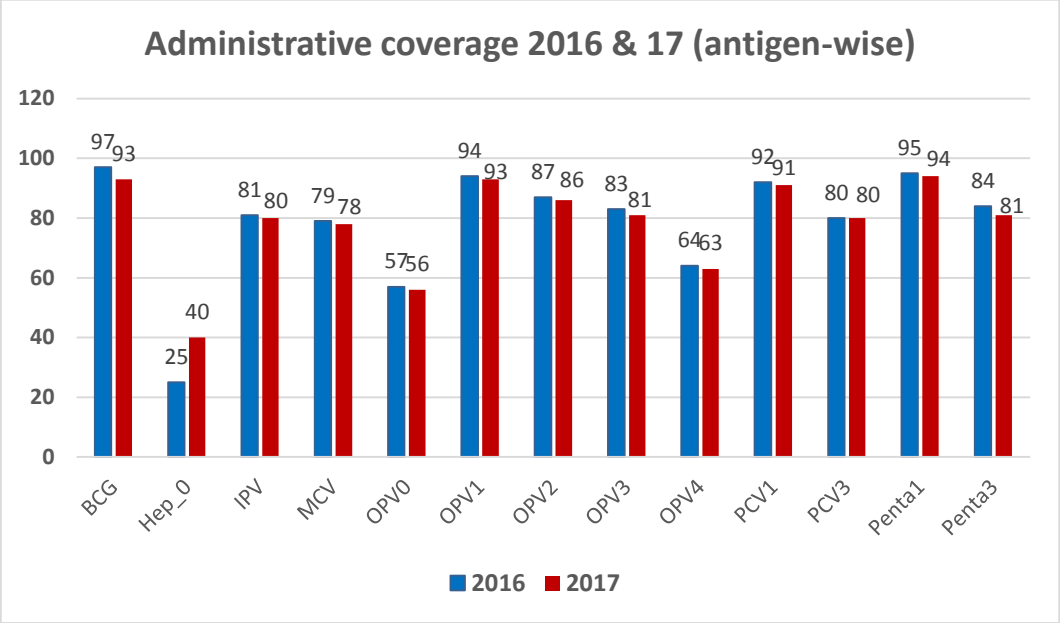


Fig. 4: Administrative coverage by different antigens (2016 and 2017)

At further exploration, the administrative coverage of Penta-3 over a period of one year, in 2017 has been consistent with only a slight variation in different months. As shown in Fig. 5, the administrative coverage of 2017 is consistently lower than that of 2016 in all the months of the year.

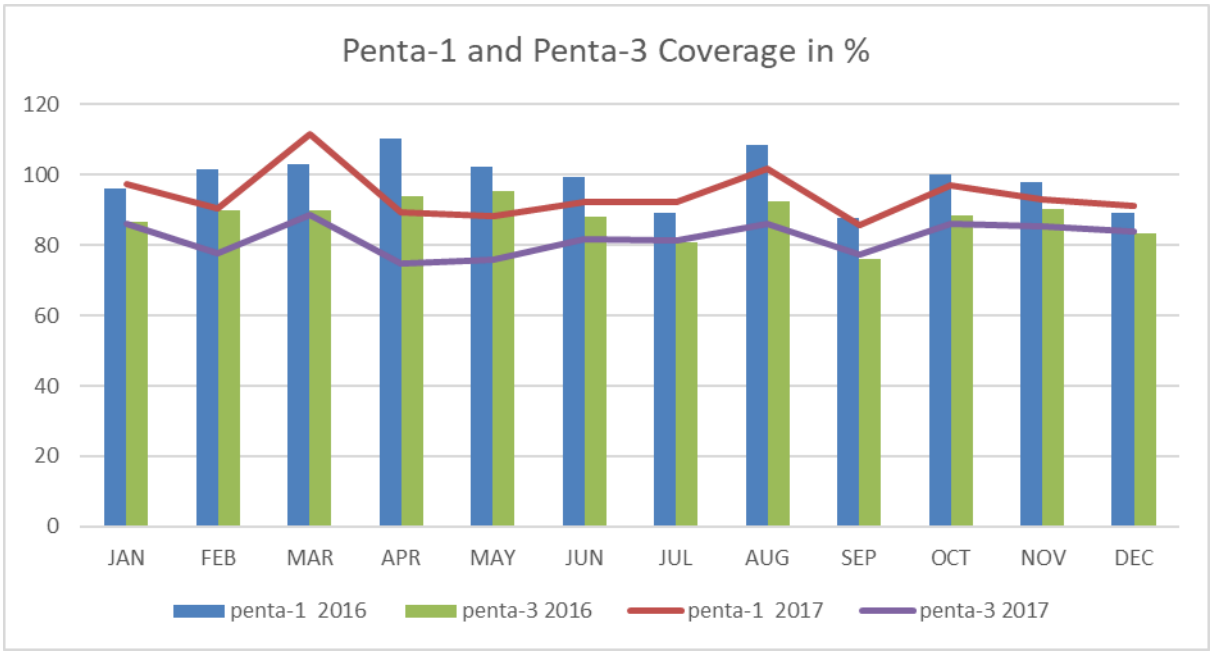


Figure 5: Comparison between Penta-1 and Penta-3 Coverage in 2016 and 2017

There is a disturbing trend of increase in the Penta 1-3 dropout rate among provinces, in 2017, in a range of 2% (Nimroz) to 33% (Urozgan). 38% of provinces felt in category of DOR less than 10%, thirty-five percent of provinces with DOR between 11-15% and twenty-six percent of provinces reported DOR greater than 15%. Fig. 6 shows dropout rate (between provinces) in 2017.

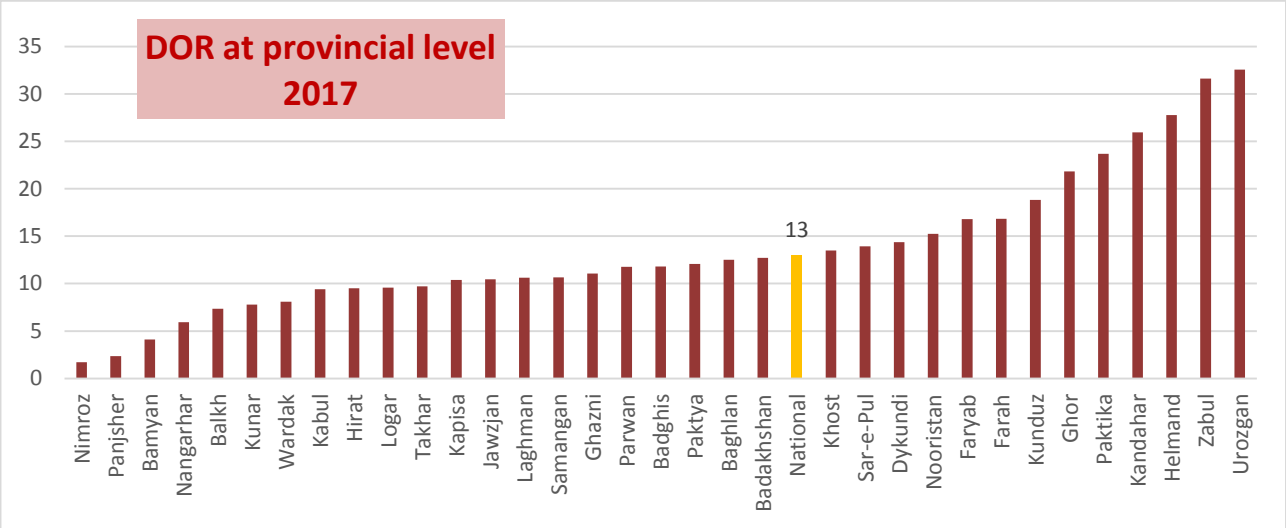


Fig. 6: Comparison of Penta 1-3 dropout rate in 2016 and 2017 (Province-wise)

By comparing coverage of antigens scheduled at the same time, the coverage of mentioned antigens appears more or less the same indicating low chance of missed opportunity.

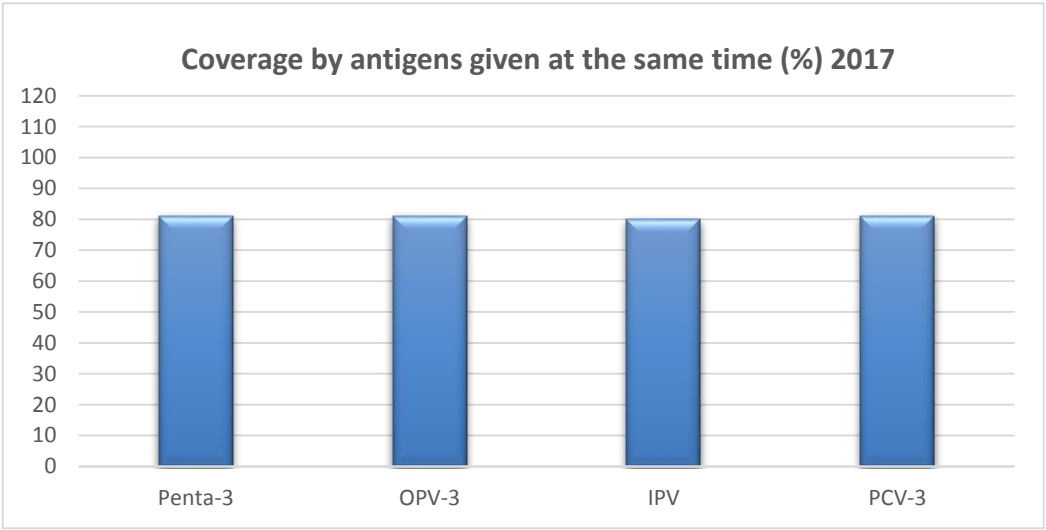


Fig.7: Comparison of antigens given at the same time

In a period of 2000-2017 the measles coverage was slightly lower than Penta-3 coverage

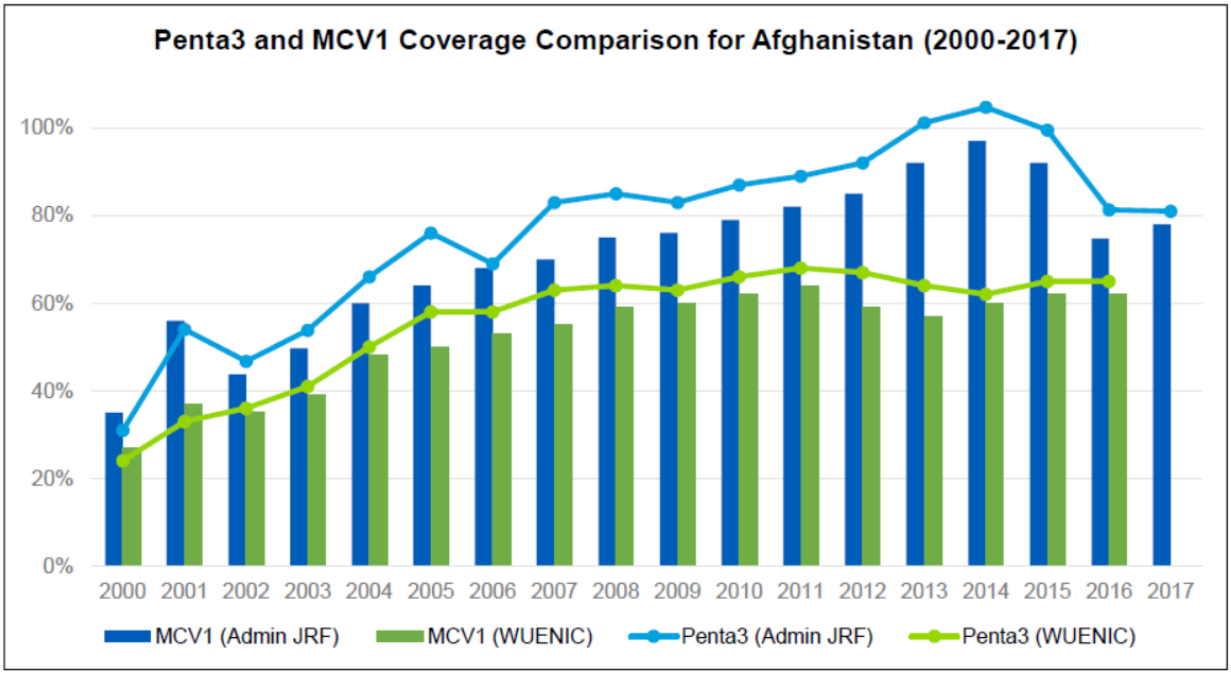


Fig.8: Penta1 and MCV1 coverage 2000-2017

As per the Joint Reporting Form; (JRF), the districts are divided into 5 categories: with coverage >95 %, between 90-94%, 80-89, 50%-79% and <49% respectively. In 2016, 38% districts felt in the first category; however, the percentage decreased to 33.6% in 2017. Second and 3rd categories are almost the same; from 12% in 2016 to 13% and 21% in 2016 and 2017. Percentage of districts in the 4th category also remain the same in 2017 compared to 2016. The percentage of districts with less than 50% Penta-3 coverage has increased from 5% in 2016 to 6% in 2017.

On the other hand, the Fig. 9 below shows that the percentage of district falling in <49-79 and more than 95% categories decreased; while the percentage of districts falling between a range of 80%-94% has increased.

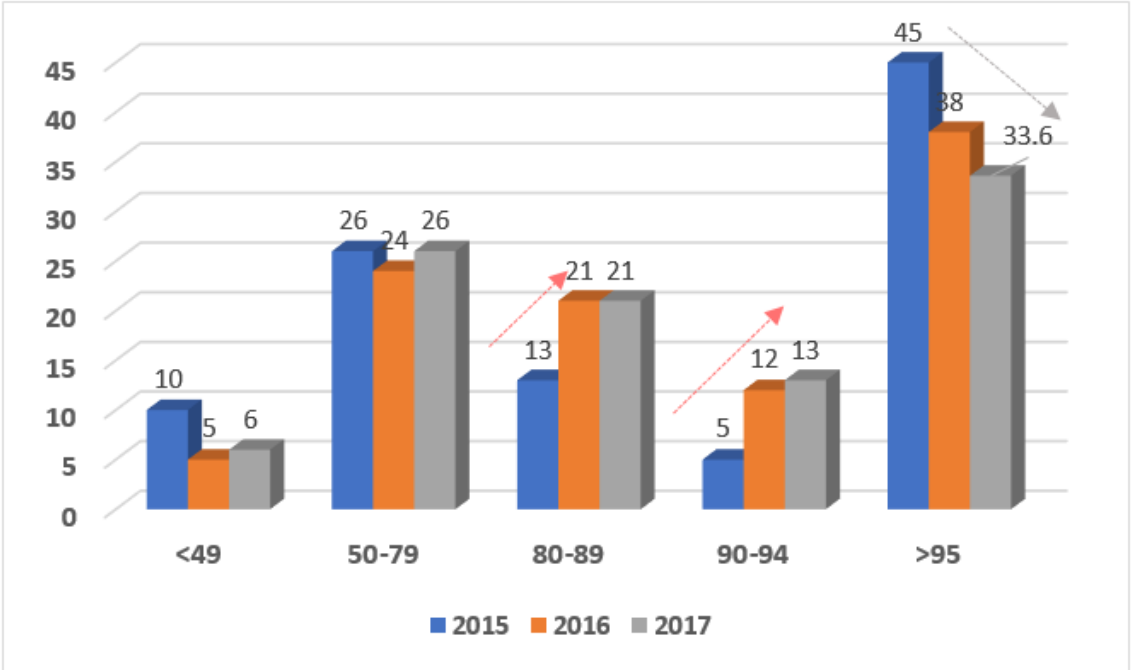


Fig. 9: Comparison of district wise administrative coverage of 2015, 16 and 17

3.1. B: Equity and Coverage

According to Afghanistan Demographic Health Survey (AfDHS), the full immunization coverage at the national level is 46%, and there is huge inter provincial coverage among various districts, as shown in Fig. 10 below:

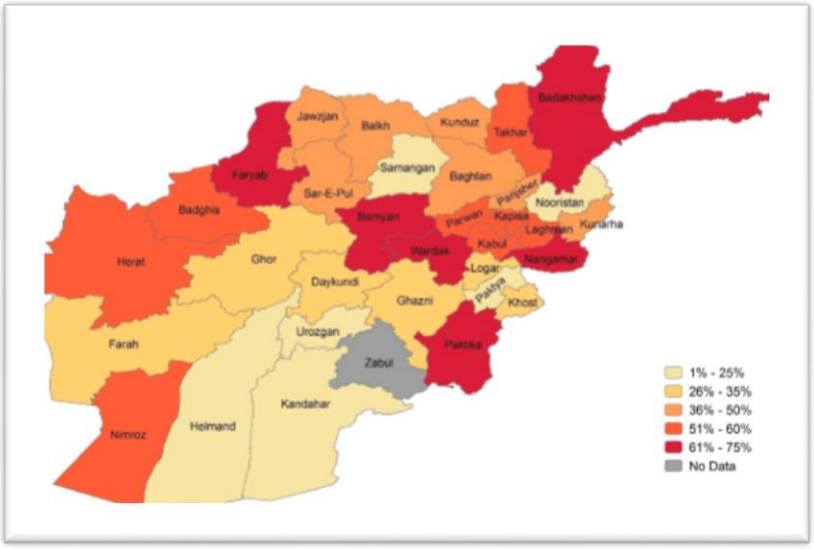


Fig 10: Province wise full immunization coverage in Afghanistan (AfDHS – 15)

The survey also shows that there is a wide variation in immunization coverage rates between the regions and between wealth quintiles, maternal education levels, birth order and areas of residence (Fig. 11) below:

- There is no significant gender difference in the outcome of EPI program. Although the immunization coverage is low, but the services are accessed and utilized equally by the parents and caregivers of boys and girls.

- In addition to the inter-provincial difference in the immunization coverage, there is a variation based upon the residential area. The percentage of full immunization coverage is 09 points higher if the children are residents of urban areas rather than the rural areas.

- The full immunization coverage is also affected by the income of the families. It is higher in wealthiest quintile (55.5%) as compared to the poorest (38%) quintile.

- Education status of parents has been one of the most crucial determinants for achievement of full immunization coverage. The data shows that the full immunization coverage improves significantly with the advancement in educational status of parents and caregivers. There is a 20-point difference between the immunization coverage of children whose parents/caregivers had no education and the children whose parents/caregivers had higher education.

- Considering birth order although the immunization coverage is higher in 1st children of families, but there is no significant deference between 2nd to 6th born and higher.

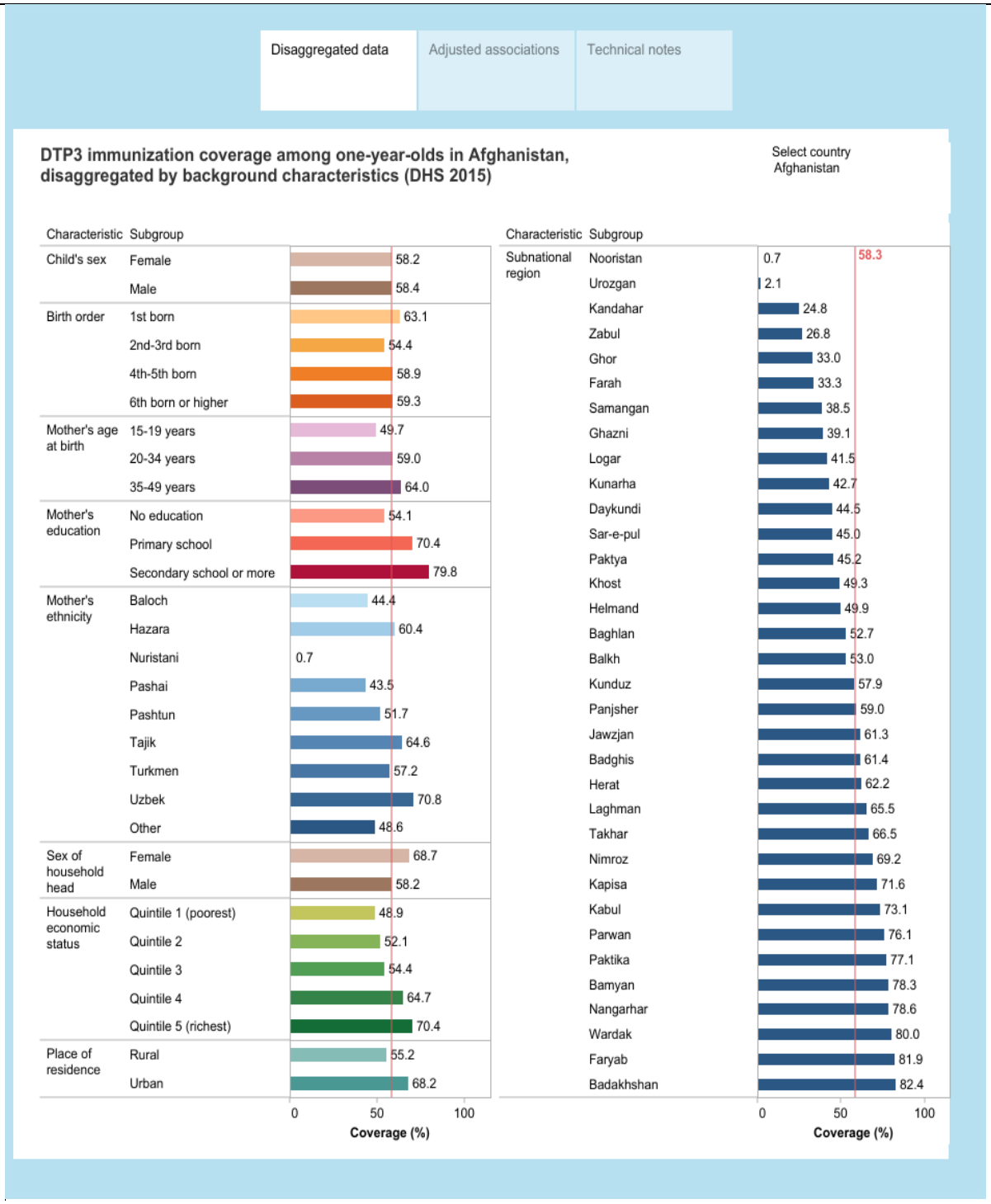


Fig. 11: Penta3 disaggregated coverage by background characteristics (DHS-2015)

As per the 2017 administrative data, the national coverage of Penta 3 is 81% and there is huge variation among the provinces, as shown in the figure below:

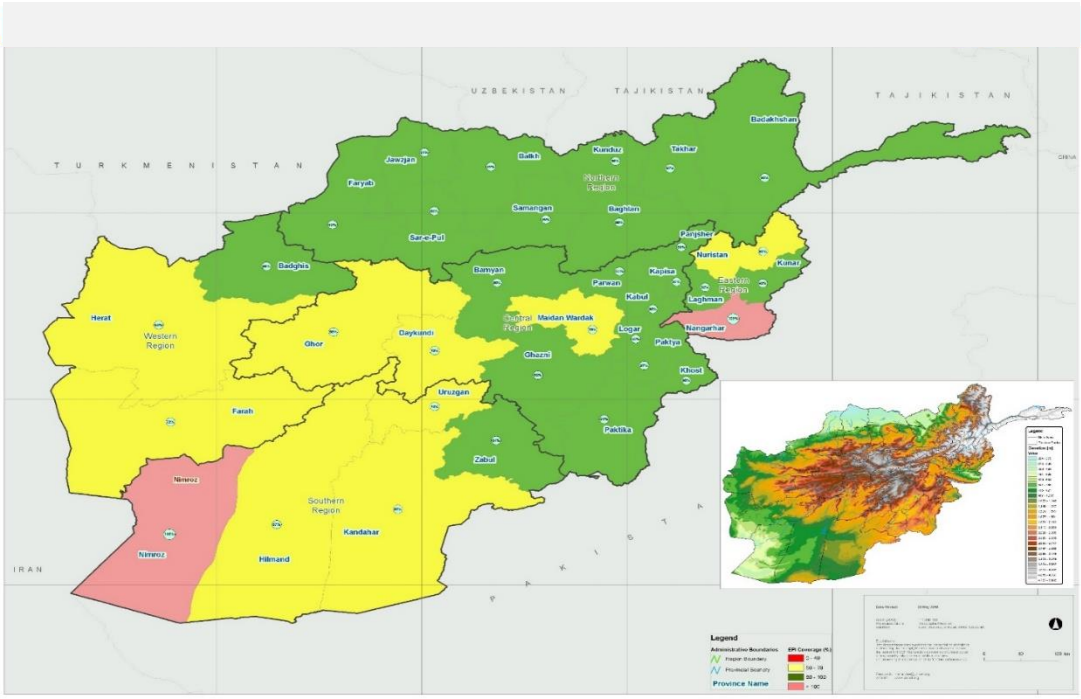


Figure 12: Province wise coverage of Penta-3 (Administrative coverage) in 2017

The Penta3 coverage in 26% of provinces is between 50% -79% and in 48% of provinces between 80%-95%. This figure is between 95%-99% in 21% of provinces while two provinces reported more than 100% penta3 coverage.

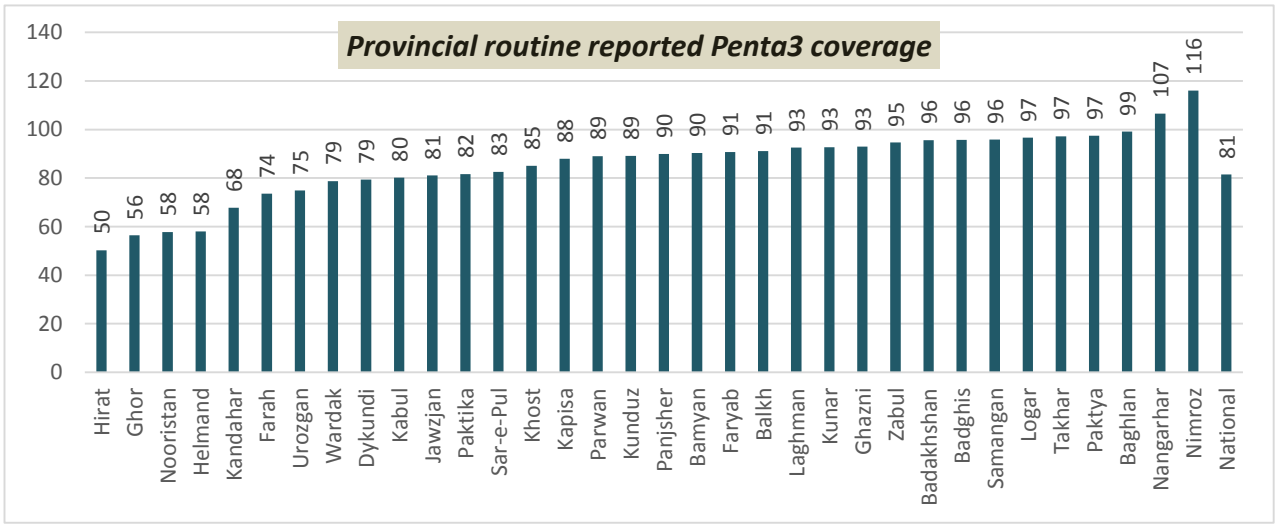


Figure 13: Provincial routine reported Penta3 coverage

At provincial level there are differences between routine penta3 coverage and the DHS result. This difference is huge in some of provinces for example Nooristan (57) and Samangan (58), Urozgan (73) and Logar (55) while this figure for Herat province is (-12). The difference between mentioned sources of data in five provinces (in Wardak, Paktika, Helmand, Kabul and Faryab) is between 1and 10. At national level the difference is 23 points.

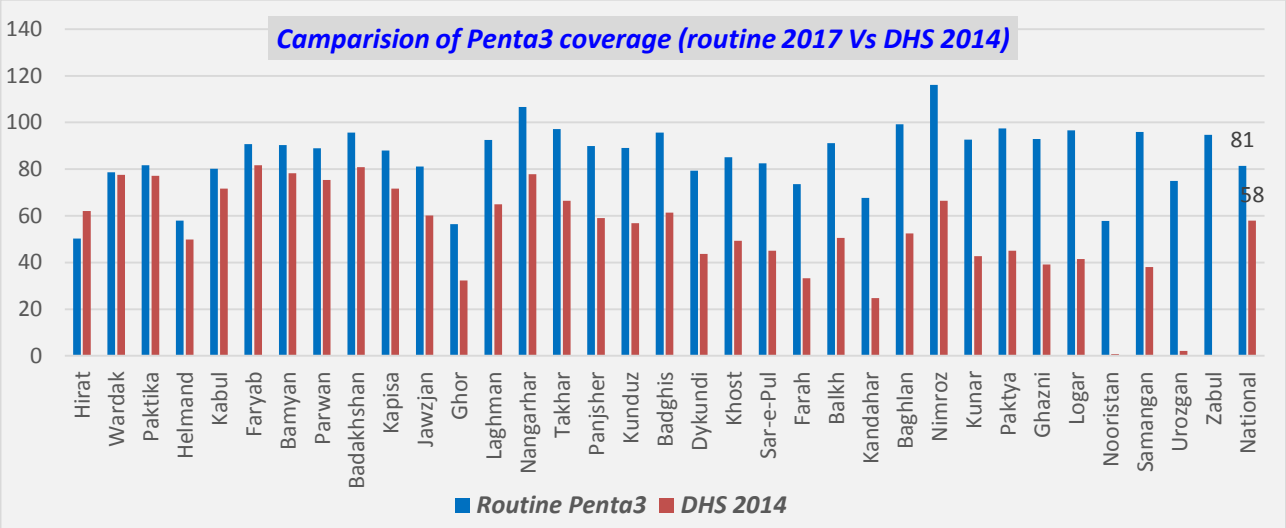


Figure 14: Comparison of provincial Penta3 coverage (routine 2017 Vs DHS 2014).

Key EPI achievements in 2017

- The country decided to include Rota vaccine in its immunization schedule. All the planning including capacity building of program managers and vaccinators, validation of cold chain availability, plan for vaccine logistic management, demand generation and social mobilization were completed in 2017. The vaccine was launched in Afghanistan in January 2018. Till date, the implementation has been smooth and there has not been any stock out of vaccine at any level.
- Four Polio NIDs and six SNIDs were conducted in 2017. In addition, response activities were conducted in many affected areas.
- The proposal for nationwide Measles SIA developed and submitted to Gavi for approval. The proposal included microplanning, capacity building of program managers and vaccinators, vaccine and logistics procurement, demand generation and social mobilization. The plan has been approved by Gavi and the SIAs will be conducted in September (first round) and November (2nd round) 2018.
- EPI dashboard has been developed to synchronize the data from various sources. In addition, android and IOS applications have also been developed to encourage the program managers to use data for action.
- As stated earlier, there are differences in survey data coverage between the provinces. All conducted surveys provide provincial data, not district-wise data. Above graph of EPI coverage also indicates the difference between the reported and survey data which is huge in majority of the provinces. Reported data reveals difference in coverage between the districts which is not included in this report and can be provided separately when required. Afghanistan did not yet conduct any analysis between the urban and rural. The later could be recommended for the future.

3.2. Key drivers of sustainable coverage and equity

Workforce and Human Resources:

- Low coverage due to the lower access to and poor utilization of immunization services could be attributed to 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 280-300 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 3789 vaccinators, 1175 (31%) of which are females, 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 centers and vaccinators has increased from 400 and 800 in 2004 to 1910 and 3700 respectively in 2017, as shown in Figure 14 below:

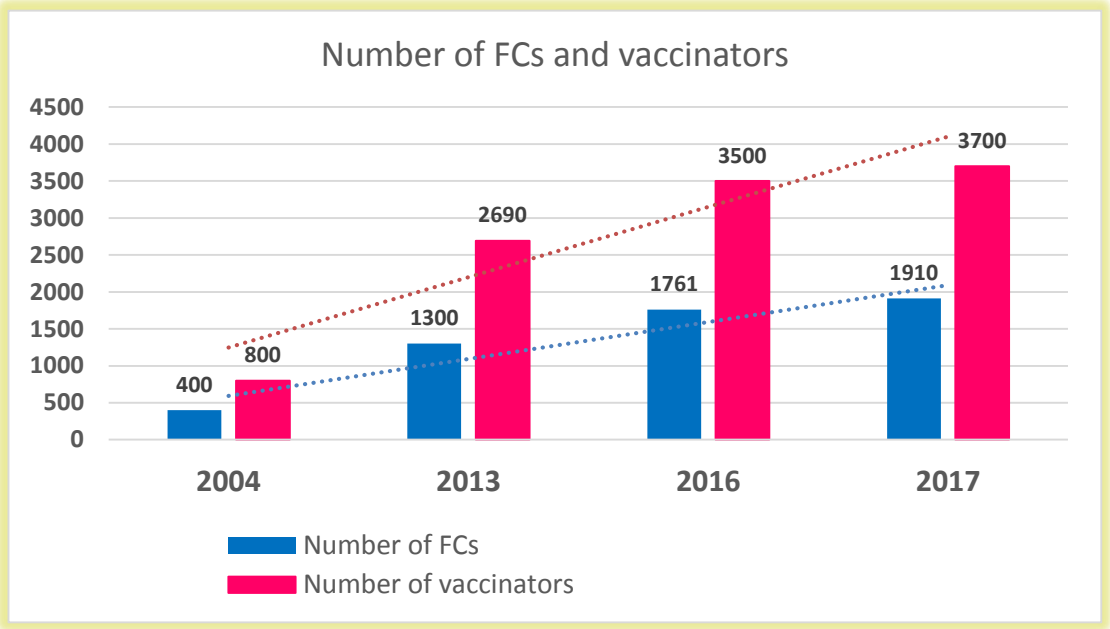


Fig. 15: Number of Fixed centres and vaccinators in Afghanistan

Supply chain: Findings of the recent EVM assessment indicate that the criteria around distribution, storage/space, MIS and maintenance need to be improved. The cold chain related interventions implemented so far are in line with the EVM recommendations. Attachment 2 For example, cold chain inventory has helped to identify the needy health facilities to be equipped with the solar fridges, construction projects will expand the space for storing the vaccine and non-vaccine supplies; development of SOPs, job aids and provision of fridge tag will strengthen the cold chain system, and training will build the capacity of cold chain staff to install and maintain/repair the equipment.

Key achievements in Cold chain and Vaccine logistic management

- A total of 456 Solar Direct Drives (SDDs) have been procured in 2016-17, utilizing Gavi HSS funds. The total number of SDDs procured so far in the country ate 499. The SDD installation trainings were rolled out in 2017 and till date, six regions have been covered. The cold chain staff in one region will be trained by August 2018. A total of 166 SDDs have been installed so far.
- The national cold chain inventory was updated in second half of 2017. The update helped to develop a rational plan for SDD installation.
- A total of 22 cold chain and warehouses will be developed by utilizing HSS funds. Till date, the designs of 21 building have been developed and soil feasibility has been completed. The construction has rolled out. The construction activities are in progress at 10 sites.
- EVM assessment was planned in 2017 and was successfully conducted in 2018. A total of 48 sites were assessed. The sites included national cold chain stores, all seven REMTs, 11 randomly selected PEMTs and HFs corresponding to the selected PEMTs. The assessors included colleagues from National EPI, REMTs, UNICEF and WHO health sections and UNICEF Polio section. Job aids were developed for ensuring optimal use of 30 TDR data loggers. A video film developed for technical facilitation of users. The training sessions planned for Rota vaccine introduction also included one session on the use of data loggers.

- 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 2018.

Demand generation / social mobilization 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 focus largely on service delivery and place insufficient emphasis on demand side issues.

The poor demand generation and social mobilization can be attributed to a multitude of factors including the security issues, gender specific socio-cultural norms or simple lack of awareness.

Beyond any doubt, the area that needs comparatively more attention is the inadequate awareness and demand for and utilization of health services including routine Immunization. Information related to knowledge and practices of caregivers regarding immunization needs to be improved. There has been a lack of adequate and systematic efforts to improve population awareness, household-level beliefs, knowledge of danger signs on various health issues, identification of barriers to routine immunization. The last joint appraisal report emphasized on improvement of demand for immunization and developing of key document to streamline the strategy on demand generation for vaccination. Since last JA, following communication activities have been initiated/completed in the country:

EPI KAP study: *Overall, this study has demonstrated that the knowledge, awareness and types of practices among female care givers towards vaccinations for children under the age of 24 months was mixed. Significant disparity was noted across the population, depending on socio-economic status, level of education, geographic location and overall socio-cultural responsibilities and barriers for women in communities. While attitudes towards vaccination were reported to be relatively high, the extent to which female care givers had the knowledge and ability to vaccinate their child was often a result of situations which were outside of their control – such as access, finance and security.*

Furthermore, female care givers, despite trusting information from health professionals, were often limited in their potential to increase their overall knowledge and awareness of vaccines as preventative measures, as access to such professionals was restricted. As such, female care givers continue to rely on localized methods of treatment, and local sources of information to educate them on appropriate childhood health practices. Further limitations however, were noted in the capacity for female care givers to make independent health related decisions concerning their children. While women are socially identified as the key care giver for children, their autonomy and ability to exercise appropriate practices is dramatically limited due to hierarchies within her household and community. Current interventions focus on increasing the knowledge and attitudes of female care givers, without recognizing the dynamics of household decision making within the Afghan context and overall gender roles, and as such continue to target an audience which has little autonomy to change practices and increase overall vaccination coverage.

***D*evelopment of EPI communication strategy:** To address demand side barriers resulting in stagnating immunization coverage, UNICEF supported NEPI by recruiting an international consultant to develop Immunization Communication strategy and a costed multiyear operational plan. A comprehensive review of quantitative and qualitative data through secondary sources (Progress reports, Research studies, Routine MIS, cMYP and Program related material) was done to assess the system preparedness, human resource mapping and their capacity at different levels for the development and implementation of the action plan. Meetings with government officials, key stakeholders and partners were held to understand the reasons for low immunization coverage, behavior patterns of the community, political ownership and commitment, strengths and weaknesses of the system, level of media engagement and sensitization of the media on different aspects of immunization, mapping of partners and agencies.

EPI communication strategy has been drafted and shared with relevant stakeholders. The strategy is revised accordingly based on the comments received. A draft operational plan was developed based on

the communication strategy. The EPI communication strategy and operational plan will be finalized after the review of and inputs from all relevant stakeholders. The results of KAP study will be incorporated in the communication strategy. Thereafter, a Consensus building workshop will be organized with government officials, partners and stakeholders for agreement on the way forward for implementation of strategy and the operational plan.

Introduction of Rota vaccine: Afghanistan MoPH introduced Rota Vaccine into national EPI program. One of the main components of the plan for introduction was awareness raising about Rota vaccine and its information. UNICEF supported NEPI in developing, finalizing, printing different IEC materials e.g. 12,000 posters, 2,000 banners, 10,000 brochures, 200,000 leaflets and 5,000 folders and four TV and Radio spots as well as distribution of material. A media campaign was also planned and rolled out. The mass media campaign covered broadcasting of the Rota vaccine video and audio clips and message of H.E. the Health Minister through 26 TV and 43 Radio channels at national and provincial levels.

Following communication activities were carried out for Rota Introduction:

- Rota Virus Communication session has been included in Training of Trainers package and subsequently into cascade training. Exclusively Focus has been made toward target audiences and how to reach Rota and Routine EPI messages to audiences in proper manners
- Designed, Printed Out and Dispatched IEC print materials like, Poster, Banner, Leaflet, Brochure and Flag in all 34 provinces.
- Developed four new Radio/TV spots about Rota virus Vaccine that was well integrated in EPI routine scheduled vaccine and aired via Radio/TVs channels mostly in prime time.
- Interview with Azzdi Radio, BBC, Arman FM, Zala, Bano and National TVs like Tolo, Ariana, RTA, Shamshad and Khurshid Carried out.
- Rota Virus Vaccine introduction information and messages have been put in newspapers like Hewad, Anis and Kabul times.
- Round table abut Rota virus introduction and EPI routine scheduled vaccines have been performing and answered questions which public have been raised.
- Vehicle covered by Banners had Rota vaccines and EPI routine scheduled messages and announced via loudspeakers hanged over vehicles.
- As Rota vaccine is part of Routine EPI program so far it was well integrated with EPI routine scheduled vaccines.

Training of religious leaders: The training of religious leaders for improving the awareness and social mobilization for RI has been rolled out in the country. In the first phase, a total of 17 priority provinces have been selected and these are in the Southern, Eastern, Western, Central and northern regions of Afghanistan. Training of Trainers have been conducted in 5 provinces (Kandahar, Helmand, Zabul, Uruzgan and Farah). The training is being conducted at provincial level. NEPI is in process to conduct TOT to eastern four provinces (Nangarhar, Nooristan, Kunar and Laghman) of Afghanistan.

Service Delivery:

Displaced populations and nomads that are on the move are especially difficult to reach. It is strongly believed that immunization coverage is low among population in in-secure and remote areas, nomadic and illegal settlements. Although the rates of urban immunization coverage are usually higher than rural areas, reports show a largest number of unimmunized children live in urban areas, the coverage rate is higher in Kabul city/district (81%) compare to Aqcha district from Jawzjan province (61%) but the number of unvaccinated children is also higher in Kabul (29515) compare to Aqcha (1742).
There is no significant gender related barriers for under one children to be vaccinated but indirectly the mother and female care taker of children are not allowed to go alone or to decide about children vaccination.

3.3. Data

Status of health information systems

Coverage and stock data

The current immunisation information systems track progress on an aggregate basis. Registries and tally sheets are completed at the facility level; these (paper-based) forms are then inputted into a MS Access database at the provincial level. Supportive supervision for data quality occurs at the facility level on a monthly basis to ensure quality information is recorded. The planning of these sessions is informed by analysis conducted at the provincial and national levels.

A dashboard was recently developed which provides automated reports and analytics at the subnational and national levels. Comparison across data sources (namely coverage and stock data) is delayed owing to challenges in rolling out the Real Time Vaccine Stock and Temperature Monitoring System[4].

In parallel, DHIS 2 has been introduced in Afghanistan in 2017 for family planning, tuberculosis, malaria and HIV programmes. Given the available set of analytical tools for immunisation (i.e. MS Access based EPI Management Information System [MIS] and EPI dashboard), the introduction of the immunisation module for DHIS 2 is not currently planned. A demonstration of the DHIS 2 immunisation module was conducted during the Joint Appraisal.

Surveillance data

From 1997-2007, measles surveillance was carried out with Acute Flaccid Paralysis (AFP) surveillance. Since 2007, measles surveillance is accounted for by the Disease Early Warning System (DEWS) – case-based surveillance with serological lab confirmation – as well as the Evaluation and Health Management Information System (EHIS) albeit the latter is passive surveillance. DEWS is supported by WHO while the EHIS is under the leadership of the MoPH. In addition, WHO supports the national lab by providing reagents, supplies, and specimen collection kits as well as recording and reporting materials.

The quality of measles surveillance remains suboptimal owing to the following challenges:

- Duplication and discrepancy in surveillance data owing to parallel systems of AFP/DEWS and EHIS. The discrepancies in data between the parallel systems are striking: for example, DEWS reported 789 suspected measles cases in Q1 2017, of which 548 were confirmed (69%); while the EHIS reported 5,368 suspected cases over the same period of time of which 1,439 were confirmed (27%).

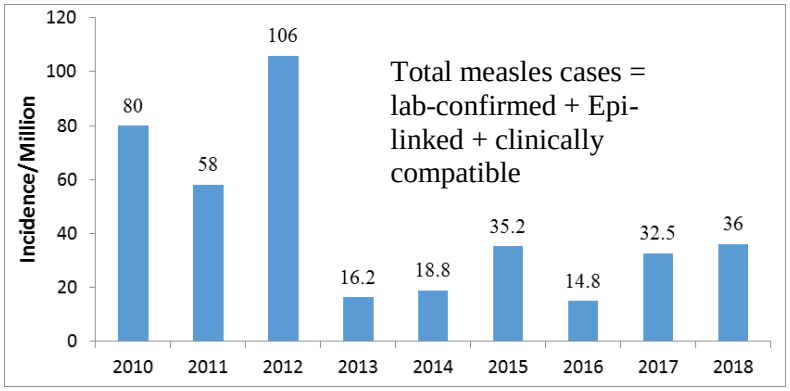


Fig. 16: Incidence of Measles/Million In (Afghanistan), 2010-May 2018 (data source: DEWS)

- Weak involvement of NIP and MOPH and poor coordination and cooperation between stakeholders;
- Limited funding and resulting dependence on external support;
- Frequent staff turnover; as well as
- Inadequate monitoring and use of surveillance data for action.

[4] Please refer to Section 5 for details on delay for rolling out the Real Time Vaccine Stock and Temperature Monitoring Systems.

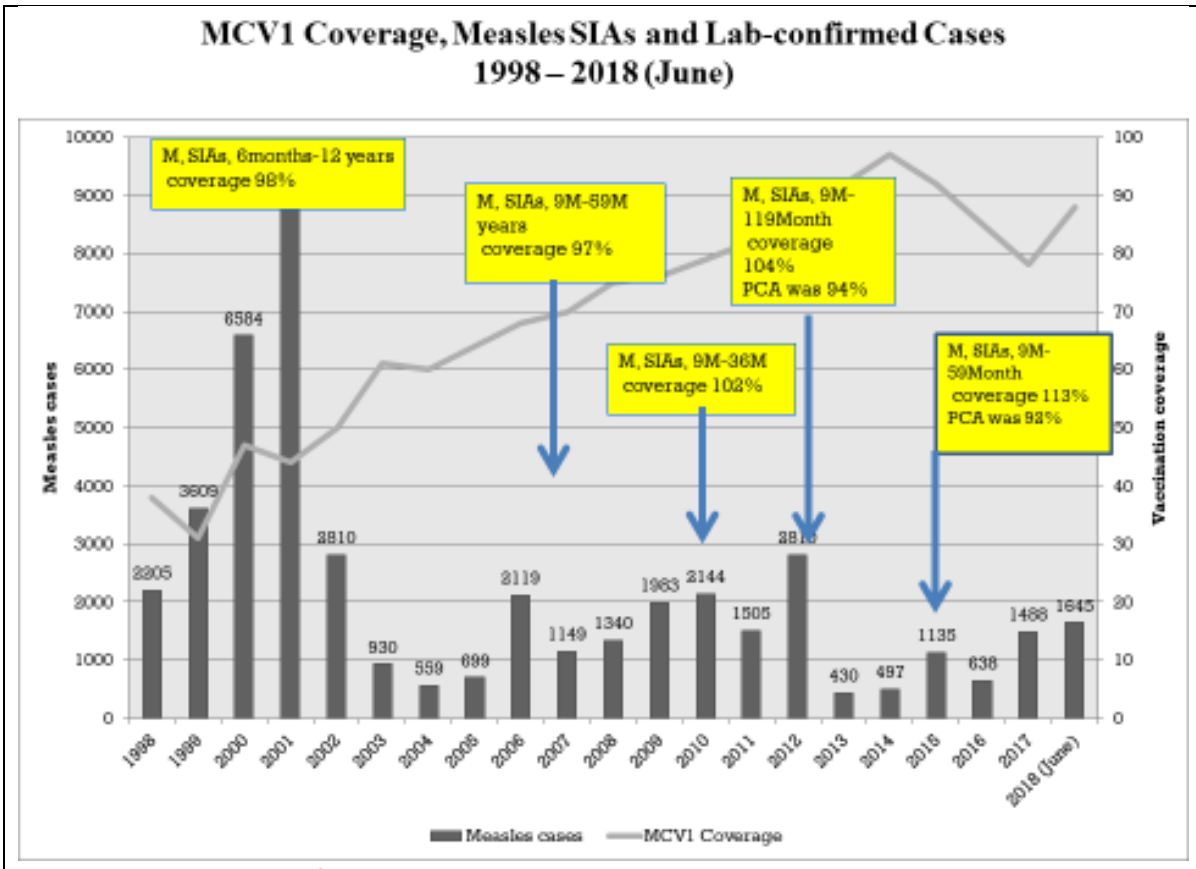


Fig. 17: Measles lab-confirmed cases 1998-med 2018

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 the district level, shortage of skilled labour and insufficient resources for outbreak investigation and documentation at sub-national levels.

Congenital rubella syndrome cases have been detected through the measles surveillance system. As such, CRS surveillance started in Oct 2017 in three national hospitals of Kabul city with the support of CDC/EMPHNET: (1) Indira Gandhi Children's Hospital; (2) Maiwand Teaching Hospital; and (3) French Medical Institute for Children (FMIC).

The selection of hospitals was done based on staff commitment, ability to follow-up on patients, and the incidence of CRS. The objectives of this initiative are (1) to assess the burden of CRS in Afghanistan; (2) to estimate the incidence of CRS in selected hospitals; and (3) to start a regular surveillance system in respected hospitals

Update case detection status (Oct 2017 – May 2018)		
1	Total Tested cases	155
2	Total Not Tested cases	6
3	Total Missed cases	35
4	Total Igg +	94
5	Igg -	31
6	IgM+	3

Denominator related information

Based on UNIDATA estimation, the population for 2018 is 34.65 million inhabitants based on an estimated annual growth rate of 2.4%. This estimate is different from the estimate of Central Statistical Office (CSO) of the Islamic Republic of Afghanistan. Indeed, the CSO-reported population is 35.72 million although it still needs to be approved by the GoA. However, this estimation is only available at national level.

Health services are contracted out to Non-Governmental Organisations (NGOs) in Afghanistan. These NGOs use population estimates published by CSO while the immunisation programme uses UNIDATA population. According previous CSO estimates, the population was lower than UNIDATA estimates. In response to this issue, Afghanistan is planning a data review workshop in Jan / Feb 2019 to come to an agreed time series for numerators and denominators to inform programme planning and reporting.

Key challenges pertaining to data availability, quality and use

A Data Quality Self-Assessment (DQS) was conducted in 2017 in all 34 provinces. Key findings are as follows:

- The Quality Index (QI) is higher at facility than provincial level (84% versus 71% respectively);
- Interestingly, the composite score for "data analysis and use" was higher at the health facility than provincial level. This finding was found inconsistent with current understanding of context;
- The accuracy ratio at provincial and health facility level was 99.7 and 98.9 respectively indicating a slight over reporting at both levels.

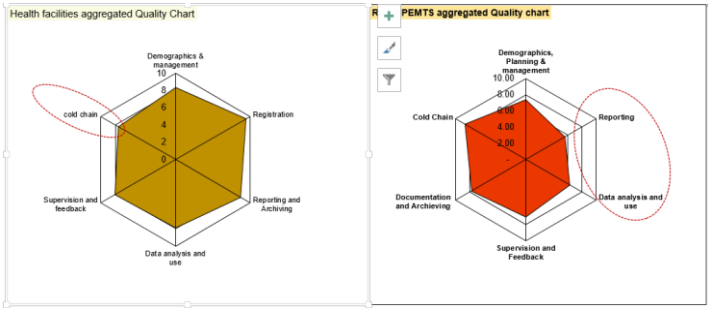


Fig. 18: Comparison of aggregated quality domains for provincial and health levels

- The accuracy ratio is 87.7% signifying that a lower number of children registered in immunisation registers could be accounted for by communities.
- The card retention rate was calculated by number of verified/vaccinated children who showed the vaccination card to DQS teams. It was found to be 86.7%.

Response to the data availability, quality and use challenges: implementation of the Data Improvement Plan (DQIP)

Implemented in 34 provinces, the DIP is designed to improve immunisation data quality and use. Gavi funds were disbursed in October 2016 to the Ministry of Finance (MoF) for the implementation of the DIP. However, activity implementation did not start before mid-2017 for the following reasons:

- MoF released Gavi funds to EPI in March 2017; delay is owing to internal administrative procedures. While Gavi disbursed USD 768K, the MoF released 683K based on the absorptive capacity of the national EPI unit;
- Change of EPI manager in mid-2017; and
- Lack of technical leadership within EPI as the epidemiologist was only hired in February 2018.

As of December 2017, USD 372K were used which represents 18% of the total grant amount. Since 2018, an additional USD 200K have been committed and/or used. Of the 23 activities planned, 5 have been completed and 10 are ongoing. The remainder are planned for 2019-2020.

Fund flow related challenges

The DQIP is the only Gavi grant managed by the national immunisation programme. Two main challenges were experienced in terms of fund flows in 2017: (1) disbursement from the MoF to the MoPH; and (2) availability of funds at the operational (provincial) level.

In response to the first issue, the immunisation team has improved its budget planning. In spite of these efforts, only USD 660K out of the USD 865K for 2018 were approved by MoF. Of note, the MoF transitioned accounting systems in the first quarter of 2018 which resulted in the stalling of disbursements. As a result, Gavi Secretariat approved exceptionally the use of USD 350K from the current HSS grant.

In additional to fund flow challenges at national level, bottlenecks (linked to planning and oversight) at provincial level affected the implementation of fundamental activities such as supportive supervision. To address fund flow challenges at both level, revised financial management arrangements are proposed mirroring how the current Gavi HSS grant is managed. Through this new model, a NGO will be contracted

to facilitate the implementation of activities at the operational level. We expect that this new model will be effective as of Jan / Feb 2019.

Prioritisation of activities and revisions to work plan

In Mar 2018, the DQIP work plan was reviewed and activities were prioritised. The review showed that core fundamental activities such as monitoring and supportive supervisions had not been conducted since the start of the grant. Since Apr 2018, supervision visits were conducted Kandahar, Nangarhar, Balkh, Herat and Kunduz. During these supervisions, on average 4-5 health facilities were visited. A few initial findings are summarised below:

- Vaccinators do not have sufficient time to complete forms; furthermore, by and large, female vaccinators require additional training in data quality;
- Thinking through options for rewarding good performing vaccinators (using non-financial incentives) to promote a culture of accurate reporting;
- Routine immunisation materials should be updated and made available at the health facility level; and
- Regular supporting supervisions from the provincial to the health facility level need to occur on a regular basis.

Compliance with Gavi's survey and data quality requirements

Afghanistan is partially compliant:

- In-depth data quality assessment (i.e. DQS) was conducted in 2017;
- Data improvement plan has been developed and being implemented;
- The annual desk review has not yet been conducted. It is planned for Aug 2018; and
- The Afghanistan Health Survey is ongoing. Results are expected to be released by the end of 2018.

3.4. Immunisation financing

Afghanistan is a donor dependent country; many donors contribute and support the health services in Afghanistan, while 4.3% of government budget is allocated for the ministry of public health. According to International Monetary Fund (IMF), Afghanistan GDP and economic growth is 2% per year. For that reasons, it's impossible to provide the quality health services to the Afghan community without the donors' support.

BPHS (Basic Package of Health Services) is the main component of health System in Afghanistan, which is being supported by the Afghanistan Reconstruction Trust Fund (ARTF), which is coming from the four main donors (USAID, World Bank, European Union, and Canada government) and being managed by the World Bank on behalf of donor agencies. The implementing mechanism is contracting out to the NGOs and Contracting in (Strengthening Mechanism).

The Immunization is also a part of BPHS services and Gavi has supported the Immunization service for many years and still it remains as the main donor of Immunization services in Afghanistan. Currently, the funds are being utilized through MoPH, UNICEF and WHO. Moreover, the Government of Canada, Germany and USAID also contributing to immunization services through off budget projects in Afghanistan.

Polio eradication is one of the critical programs in Afghanistan. Although, the country is one of three endemic countries in the world (along with Pakistan and Nigeria), there is a growing sense of optimism that polio will be the second disease, after smallpox, to ever be eradicated. Number of donors are contributing in polio eradication program in Afghanistan such as Bill & Malinda Gates Foundation, governments of Japan, Canada and Australia, CDC (Communicable Diseases Control), DEFATD (Department of Foreign Affairs Trade and Development) , Estonia, KFW (Kreditanstalt Fur Wiederautbau, A German Government own Bank , NPT, Slim Foundation, UN Foundation, USAID and UNICEF.

For costing the immunization services in Afghanistan, the MoPH need to accomplish the BPHS costing, which immunization is part of it. As well as mapping of available funds through off and on budget. The ministry need support in this regard.

The cMYP costing projections include operational costs of service delivery, costs of the traditional and new vaccines (PCV-13, IPV and Rota), SIAs, monitoring and surveillance as well as shared health system costs.

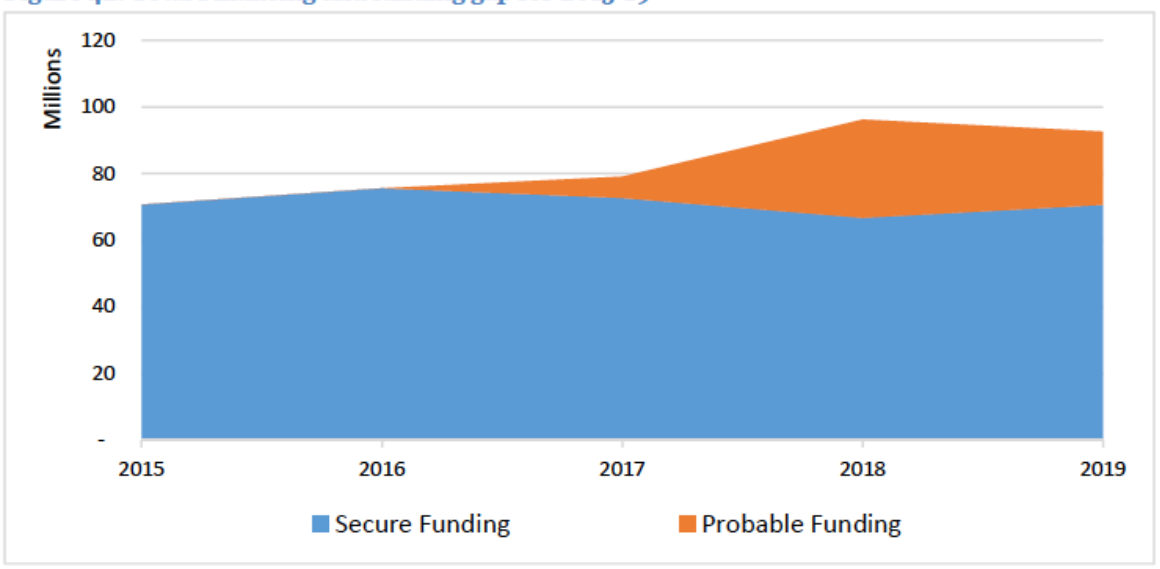


Fig.19: Total financing and funding gap for 2015-19

3.5. Performance of vaccine support

Rota Introduction - EPI

Afghanistan in coordination with technical partners (WHO and UNICEF) decided to include Rota vaccine in its immunization schedule. A detailed proposal was prepared, in coordination with partners (WHO and UNICEF) and was submitted to Gavi, the vaccine alliance for approval. The proposal was approved by the Gavi board and it was decided to introduce Rota vaccine in Afghanistan in 2017-18. All the prerequisites were completed before the introduction of rota vaccine. National EPI constituted various sub-committees and as per the national inventory, the status of availability of cold chain space at different levels (national, regional, and provincial and health facility) was reviewed and necessary actions were taken to address any gaps. WHO supported the capacity building of programme managers and vaccinators across all 34 provinces? UNICEF, in consultation with NEPI and WHO, developed communication materials, media (radio/TV spots, speech by H.E. the Health Minister) roll out plan before the introduction of the vaccine. UNICEF also procure all the vaccines and non-vaccine supplies and supported NEPI to distribute the supplies till the last level i.e. health facilities. The rota vaccine was introduced in Afghanistan on 27th January 2018.

There was shortage of Rota vaccine in 2018 the at national cold room and one of regions (East/Nangarhar), the main reason was the shipment issues "delayed the shipment" at supply division level as it was supposed to be arrived at 10th may 2018 then delayed to 28th may and then again delayed to June 3rd and then again delayed to 10th June and also not arrived on 10th but finally arrived 13th June while two shipments gathered and arrived around 59,4000 doses.it is worth to mention the shortage did not happen in other PEMTs and HF level all over the country.

Measles:

Measles SIAs in Afghanistan targeting children 9 month – 10 years of age with one dose of measles vaccine irrespective of vaccination status or disease history will be conducted in two phases: 1-10 September and 17-26 November, 2018 (17 provinces each). The most recent readiness assessment at the national level indicates 88% of readiness. Measles vaccine and dry supplies have been delivered to the national level. Training of trainers has been conducted in two batches – 15-16 and 17-18 July, respectively. Issue of limited qualified workforce was addressed by extending the campaign dates and splitting the activities in two phases. Campaign will be facility based (health facilities, mosques, schools); more than 12 thousand vaccination teams consisting of vaccinator,

registrar and social mobilizer will be established. International consultant was recruited by WHO and NEPI staff was assigned to respective provinces for supervision.
Polio program field staff will be fully engaged into preparation and implementation of campaign. Supervision will be arranged at all levels with cluster supervisors providing oversight to four teams each, followed by district, province and national supervisors. SIAs will contribute to strengthening routine immunization by training of vaccinators and creating demand for immunization. Post-campaign coverage survey will be conducted by the WHO Polio Program.
Main potential risks for the campaign: (other risks and planned mitigation strategies have been described above)

- inaccessibility and deteriorated security situation (currently some 70 districts out of 400 are not accessible; around 1 mil children under five were not accessible during May Polio NIDs);
- Potential fatal AEFI from measles vaccine that have occurred in previous campaigns.

Risk mitigation:

- access negotiation with Anti-Government Elements (AGE) and DAESH;
- using any opportunity to target inaccessible communities even outside campaign dates;
- thorough training of vaccinators;
- risk communication activities, appointment and training of spokespersons at provincial and national levels.

Next steps on the measles and rubella control activities

- Coverage achieved during the Measles SIAs and related decrease in measles virus transmission will guide follow-up steps on implementation of the national measles and rubella action plan:
- Strengthening of nation-wide laboratory supported case-based surveillance for measles;
- Consensus building on the introduction of the rubella vaccine into the national immunization schedule. Major impediments for the introduction at the moment are low routine immunization coverage for MCV1 and DTP3 and inability of the government of Afghanistan to co-finance rubella vaccine (the required amount $ 1,363,000 is almost equal to the total government contribution towards all new vaccines – $1.5 mil).

Switch of PCV

The switch from 1 dose vial presentation to 4 dose vial presentation of PCV vaccine was implemented in 2017. This has helped sparing the net capacity of cold chain. NEPI with support of WHO has conducted a one-day orientation for all vaccinators in second quarter of 2017 across the country aimed that the vaccinators must know the importance of this switch.

Other vaccines:

Currently Afghanistan introduced 13 vaccines against vaccine preventable diseases (VPDs) in the expanded program on immunization (EPI), which procured by UNICEF with financially support of Japan government (only traditional vaccines*) and GAVI alliance (New vaccines**) these vaccines are all WHO prequalified. The administrative coverage of all antigens are shown in table below:

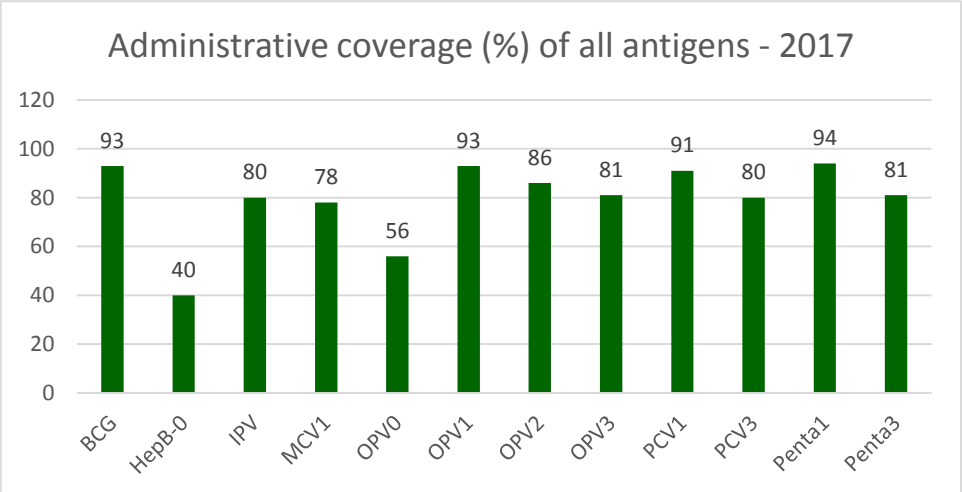


Fig 20: Administrative coverage of different antigens-2017

In general, the DOR between 1st and last dose of deferent antigens as well as Penta1 and Measeles1 was high in 2017. The DOR between two doses of measles administrated in 2017 is high (34%), the possible reason is that the vaccinator does not properly pass the message about need/importance of 2nd dose to parents, in addition to that the long interval between two doses of MCV (9months) and no enough awareness activities on RI specially vaccination after first year of life might be other reasons.

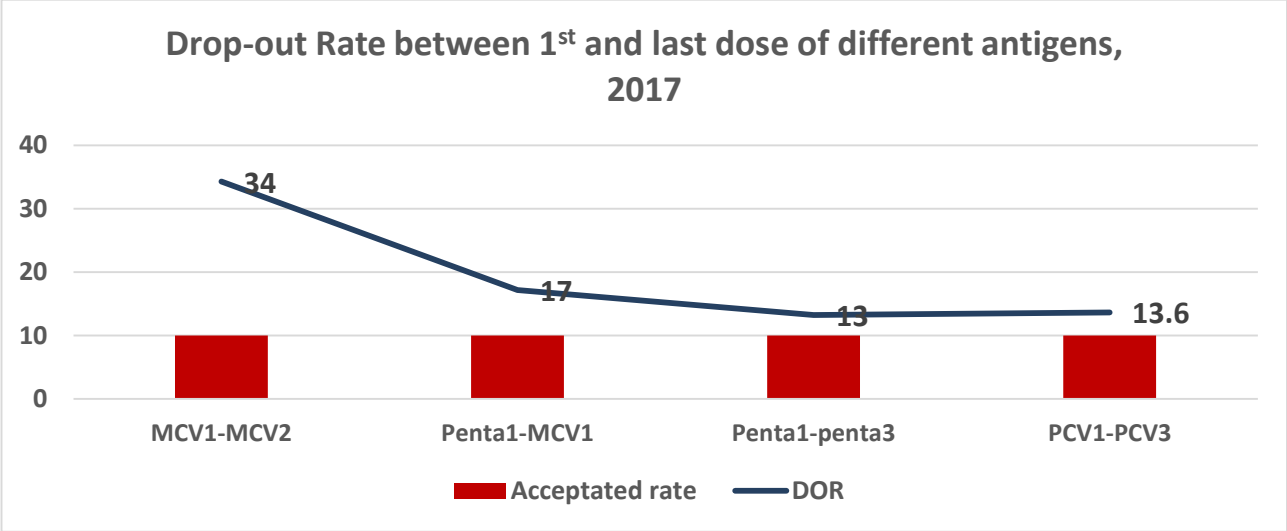


Fig 21: The drop-out rate at national level in 2017

The wastage of BCG and MCV vaccines are also high in 2017 owing to presentation of vaccine vial (10 and 20 doses/ vial) which must not be used after 6 hours of reconstitution. The wastage rate of other antigens is not high. Fig.22

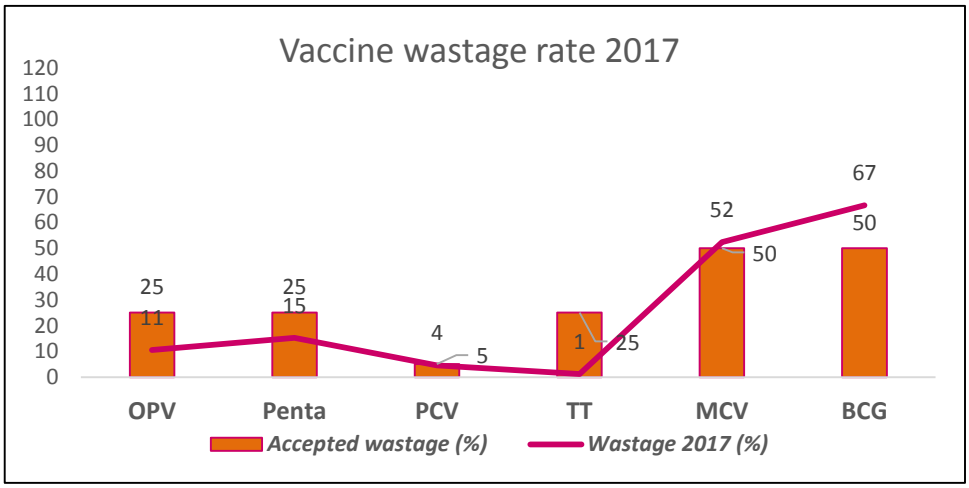


Fig 22: wastage rates of vaccines at national level, 2017

It is worth to mention there was no stock out of routine vaccines and logistics at HF level during 2017.

- ***Overall implementation progress***
  The overall implementation has been satisfactory. The country introduced rota vaccine in the year 2018. There has not been any vaccine/logistic stock out in 2017. To facilitate vaccine stock management, NEPI with technical support of UNICEF is using the software named ViVa (Visibility for Vaccines). Earlier, it was being implemented at the National level only, but, in 2017, it has been scaled up at the regional level also. The REMT (Regional EPI Management Team) colleagues were trained in Kabul for making use of ViVa for better vaccine stock management.
- ***Campaigns:***
  During 2017, no campaign was organized in Afghanistan. A country wide Measles SIA covering children of 09 months to 10 years' age group will be conducted in all 34 provinces of Afghanistan. The proposal was

developed in 2017 and submitted to Gavi. After approval, the planning was initiated, with support from partners.

- ***Update of the situation analysis for measles and rubella***

Measles surveillance in Afghanistan is carried out along with Acute Flaccid Paralysis (AFP) surveillance since 1997, Disease Early Warning System (DEWS) since 2007 and by passively reporting Health Management Information System (HMIS). Measles case-based surveillance with serological lab confirmation was established in 2007, however, it relies on the AFP surveillance and DEWS infrastructure. WHO is supporting national laboratory with reagents, supplies, specimen collection kits, recording and reporting materials. Quality of measles surveillance is suboptimal due to the absence of a unified surveillance system, parallel systems of AFP/DEWS/HMIS, duplication, discrepancy in surveillance data, poor coordination and cooperation between stakeholders, limited funding, dependence on external support, frequent staff turnover, insufficient use of surveillance data for actions.
The country is having endemic measles transmission that is not being reflected accurately by the surveillance system. The measles cycles appear to occur every 2 to 3 years. Laboratory confirmation rate is low and the capacity of surveillance system to detect, investigate, collect samples and undertake the case response measures is suboptimal.

The burden of rubella in the country is not established; rubella is not notifiable disease and the number of rubella cases in table below reflects the confirmed cases from the measles suspected cases that were negative for Measles IgM. Congenital Rubella Syndrome (CRS) surveillance is not established yet.

Measles and Rubella, Serological Tests and final classification

Classification	2016	2017	2018 (June)
Total No. of suspected measles cases	1692	2918	2497
Total No. of suspected measles sample collected	**1090**	**2304**	**2326**
Total No. of blood specimen tested in CPHL	1090	2304	2326
Total No. of Measles IgM+ve (lab confirmed)	**618**	**1488**	**1645**
Total No. of Rubella IgM+ve (lab confirmed)	42	52	30
Total No. of discarded for Measles	430	816	681
Total No. of discarded cases for Rubella	388	764	651

- ***Describe key actions related to Gavi vaccine support in the coming year***

In the year 2018-19, Government of Japan will support the traditional vaccines viz. BCG, Hepatitis B (birth dose), TT, Measles and OPV. Gavi needs to support IPV, Pentavalent and PC vaccines. In 2018, Afghanistan will implement Measles SIA in 34 provinces, in two phases. The target group for this campaign will be 09 months to 10 years of age. As per UNDATA, the target group is around 14 million, however, it may change after the micro plans for SIA are finalized.

Afghanistan is not eligible to introduce the MR vaccine in the routine program because as recommended, the country doesn't have DTP3 coverage ≥70% and also doesn't meet one of the following two criteria:

- Routine MCV1 coverage ≥ 80% for the last three consecutive years (as determined by WUENIC released July 2016)

OR

- Measles SIA coverage ≥ 80% (by a reliable coverage survey) in the most recent nationwide measles campaign.

3.6. Performance of Gavi HSS support (if country is receiving Gavi HSS support)

HSS 3 grant

The third Health System Strengthening (HSS3) program commenced in June 2016 following a Program Capacity Assessment (PCA) held in March/April 2016. Based on revised budget work plan, the Allocation of activities under the Health System Strengthening 3 project is as follows: MOH $17.2m (47%), WHO $1.5m (4.3%), UNICEF $19.1m (52%).

Despite major delays related to the lengthy contracting of NGOs and construction companies, conducting PCA for selected NGOS, selection of construction providers and overall security challenges, the country succeed to sign 24 contracts with the NGOs which all of them went to PCA process and the PCA recommendation included in NGOs contracts, contracts with 10 construction companies have been signed and the construction is going on. The planned cold chain equipment purchased and distributed to the provinces and health facilities.

In order to further strengthened leadership, coordination and oversight of program implementation with the integration of ICC/HSS-SC to more focus on strengthening the health system and EPI activities in a more harmonized manner, the Acasus consultancy firm which has been assigned to work with ICC/HSS committee member.

Objective 1:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**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 211 existing health sub-centers (HSCs) to EPI service delivery points.* *Activity 1.2: Establishing community-based outreach by vaccinators to cover 2878 villages.* *Activity 1.3: To continue the 15 MHTs for nomadic (Kuchi) population which are established under HSS.* *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.* *Activity 1.5: Supporting micro-planning through RED strategy using CHWs and BASIC tools to improve the immunization services.*
Priority geographies / population groups or constraints to C&E addressed by the objective	**By implementing the Objective 1, equitable and effective immunization services are being provided** to a total population of **3.8** million people, through training female vaccinators , bringing cold chain equipment to **211** unserved HSCs ,establishing **117** community-based outreach vaccinators covering 2754 villages in "white areas" which targets an additional **4.2** million people covered by continuing service delivery through PPPs (CSO type B) and continuing Kuchi Mobile Health Teams (MHTs) supported by 1200 CHWs. These four interventions are cost-effective, sustainable and integrated with BPHS and immunization services to build synergies and share costs with BPHS and SEHAT projects, and target the inequities and underserved populations and boost the immunization coverage throughout the country. Equity in health care provision is one of the prime priorities of MoPH, and the BPHS has been designed to be pro-rural and pro-poor, defining the level of HFs by geographical distance as well as the size of catchment population. However, despite significant expansion in BPHS, the access to primary health care remain limited. On average, only **57%** population have access to a health facility within one-hour walking distance. Besides physical accessibility, the health services utilization by females is low due to affordability and acceptability of services because they are

	dependent upon a male member to accompany them to any health facility, and they often need to have a female health care provider. The interventions under objective1 are the service delivery component of the EPI program which address the mentioned gaps particularly the routine availability of service to remote rural population and increase the coverage and access to the immunization services such as, the upgraded sub-health centers to EPI fixed centers and established community outreach vaccinators interventions are being implemented in **17** provinces and covering **2,131,425** populations. The PPP intervention is covering 43 districts and **841,321** populations in the **six** insecure provinces. The Kochi MHTs is being implemented in **12** provinces and covering the total Kochi population of **766,665**. As a result, the above-mentioned activities will have profound impact on immunization throughout the country for example; upgraded sub-health centers to EPI fixed centers and established community outreach vaccinators by increasing the number of EPI delivery points addresses geographic inequities which is one of the main reason why many caregivers do not take their children for immunizations. Furthermore, training the female vaccinators, helps to address the gender inequities due to cultural constraints that discourage women from seeking health services from male health providers as well as improve vaccination coverage by reducing geographical, gender-based, social and cultural inaccessibility. The Kochi MHTs staff also receive refresher training on BPHS components to improve the quality and equitable access of nomads to BPHS and other RMNCH services and also to contribute in polio eradication and measles elimination, 1200 volunteer Kuchi CHWs who have already been trained will continue to coordinate immunization services at the community level. In addition to that, the required cold chain equipment has also been provided to health facilities which ensures continues access to immunization services.
% activities conducted / budget utilisation	**Activities 1& 2:** In total 211 out of 310 (68%) planned sub-health centers' upgraded to EPI fixed center and 170 out of 316 (54%) community outreach vaccinator teams have been established. The NGOs received the 100 % of planned budget based on the payment schedule and 71.2% of the received budget was utilized by the implementing NGOs. **Activity 3:** 15 MHTs for Kochi population have been established and more than 90% of its staff recruited to provide the primary health care services including immunization, maternal, child and neonatal services to Kochi population. The implementer NGO received the 100%of planned budget, and the utilization rate by NGO is 51,2%. **Activity 4:** 233 out of 236 (99%) PHPs established in six targeted provinces and 100% of planned budget transferred to NGOs and utilization rate by the NGOs is 47%. **Activity 5:** The micro-planning process has been started in polio high risk provinces of Kandahar, Helmand, Nengarhar, Kunar and urban slums and return camps in Kabul province.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	***Activity 1&2: Upgrading SHCs to EPI fixed centers and establishing Community Outreach Vaccinator*:** **At the Ministry level:** • A technical committee comprising members from UNICEF, NEPI, HSS Coordination Unit, Development Budget Unit and GCMU was formed to develop the criteria and scope of work for upgrading Sub Health Centers with EPI cold chain and deploying Community Based Outreach Vaccinators. • Criteria, formats were sent out to all provinces to list all SHCs with no cold chain and identify the white and underserved areas for CBO. • Information collected from the provinces and interpreted by the technical committee. • Based on the set criteria, the eligible SHCs for upgrading with EPI cold chain listed and selected by implementing NGOs, provincial health directorates and approved by the Provincial Public Health Coordination Committee (PPHCC) • The provinces were later on ranked by the assigned technical committee based on the lowest FIC coverages. • The procurement documents were developed and RFP sent to the BPHS implementers. Proposals were reviewed, by the assigned technical team and successful negotiation meetings held with NGOs to discuss the cost and the technical issues of the proposals. Afterword the

identified NGOs went through the PCA process and the PCA recommendations were added to their contracts to improve the areas which were identified by the PCA.

At the implementation level:

1) All local vaccinators were identified, trained and deployed by the NGOs in targeted SHCs and villages through support of national EPI trainers.
2) Each vaccinator received three weeks training (two weeks in class and one-week practical work in the clinics)
3) All the underserved and white villages were mapped and divided into 8-12 Service Delivery Points (SDP) and community outreach teams were provided with necessary items to provide immunization service to white areas.
4) Eligible SHCs are staffed with one-two vaccinators. SHCs with over 15000 populations in the catchment area are staffed with two vaccinators (one for fixed and one for outreach) and SHC with 4000-15000 are staffed with one vaccinators. The outreach vaccinators perform community mobilization, vaccination defaulter's check as well as the outreach vaccination session

As result of the implementation of these interventions through Gavi support in four quarters of 2017 some improvement made such as, vaccination of 15.6% of targeted children and 3% improvement in Pent3 coverage at national level.

The following table illustrates the vaccination data of four quarters of 2017 for the ten provinces which were contracted in the first round and one quarter of 8 provinces which were contracted in the second round.

No of injections	567,829
No of women covered	196,390
No of children covered	371,439
Total population	2,97,24,323
No of children age 2	2,377,946
% of children age 2 covered by new EPI centers and community based outreach	15.6%
No of Penta-3 Doses given	71,702
% of Penta-3 Doses given	3.0%

Note: It is worth mentioning, that the contract of implementing NGO in Urozgan province was terminated due to high security threats in the targeted districts.

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

At the Ministry level:

- The project ToR reviewed and revised by a technical team and officially sent to GCMU for procurement.
- The procurement documents were developed and RFP sent to the BPHS implementers. Proposals were reviewed, by the assigned technical team and successful negotiation meetings held with NGOs to discuss the cost and the technical issues of the proposals. Afterword the identified NGOs went through the PCA process and the PCA recommendations were added to their contracts to improve the areas which were identified by the PCA.

At the implementation level:

- The service delivery points' (SDPs) list reviewed and revised in close consultation with the provincial nomads' directorate and PPHDs.
- All 15 MHTs established and are functional in 12 targeted provinces
- In total 52 MHT staff received clinical trainings on IMCI, Basic Emergency Obstetric Care, HMIS, RUD, and EPI

- The NHCD/MoPH staff received training on Supervision/Monitoring & Evaluation, and Financial Management.
- Regular monitoring from the MHTs services conducted by M&E central and provincial staff.
- In total 431 (191 females and 240 male) Kochi CHWs received refresher training according to CBHC/CHWs training manual
- Awareness raising of nomad population on health key messages in particular vaccination and MCH is going on

Coverage data:

#	Indicator	Target	Achievement	% of coverage data
1	OPD Consultation (New Cases)	169,802	138,291	81.4
2	Number of <5 OPD children treated by mobile health team (Included in the total OPD consultations)	52,602	47,139	89.6
3	Number of deliveries assisted/referred	462	335	72.5
4	Number of home deliveries by mobile health team	725	528	72.8
5	Number of 1st ANC visit by mobile health team	6,056	4,361	72.0
6	Number of <1 PENTA vaccinations performed	13,462	5,085	37.8
7	Number of TT2 vaccination performed	13,462	5,709	42.4
8	Number of FP consultation performed	5,385	5,324	98.9
9	Number of suspected TB cases identified and referred out	11,708	1,406	12.0

The above table shows the 7 months of 2017

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

At the Ministry level:

- A technical committee comprising members from MoPH departments including RMNCH, NEPI, HSS Coordination Unit, Development Budget Unit and GCMU was formed to develop the terms of reference, set criteria and scope of work for the project. The previous ToR for CSO type B was thoroughly reviewed and necessary adjustments made particularly in setting the criteria for PHPs selection and its scope of services
- The list of existing PHPs was reviewed in all six provinces and the planned number of PHPs were determined based on the selection criteria and the project was announced as open tendering under four lots.
- After the completion of procurement processes for the three lots (1,2,3) of first round the MoPH signed the contract with the winner NGOs upon receiving the National Procurement Authority's (NPA) approval.
- The fourth Lot was re-announced because of the very limited number of applicants on the first round and the second round announcement ended up successfully by signing contract with the winner after NPA approval.

At the implementation level:

- All PHPs were mapped and selected by NGOs based on the selection criteria and MoUs signed with each PHP for the types of services they should provide.
- Assessment of coverage indicators conducted to set baseline and targets for targeted services
- PHPs are still receiving trainings on EPI, RMNCH, Health promotion…..etc
- PHPs are being supplied with the required medical and non-medical supplies including cold chain and vaccines (for PHPs agree/ able to provide EPI services).
- Connecting PHPs with the CHWs and nearby health facilities in the catchment area for referral.
- An incentive scheme launched by the NGOs for PHPs
- Routine supervision by NGOs and monitoring visits by M&E staff are continuously being carried out from the respective project sites and PHPs.

Coverage indicators:

#	Indicator	Annual target	Progress
1	Number of ANC 4th	16,013	38,529
2	Number of PNC	12,946	7,370
3	Number of Deliveries	5,360	4,876
4	Number Children under 2 received Penta 3	972	4,096
5	Number Children under 1 received Measles	1,021	6,814

Note: Budget consumption by NGOs was low because of delays in mapping the PHPs mainly because of the security challenges which imposed difficulties in timely conducting the assessments of the project's indicators for setting baselines, targets and finalizing the incentive scheme as agreed in the contracts.

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

- The micro-planning will be conducted in 5 polio high risk provinces of Kandahar, Helmand, Nengarhar, Kunar and urban slums and return camps in Kabul.
- Two days' workshop in each province on the methodology of health facility and district level micro-planning conducted in each province.
- The micro-plans will be available for implementation by the end of October 2018.
- 9 districts of Helmand and 6 districts of Kandahar provinces is planned to be covered by Core Group Polio Project (CGPP) project.

Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]

Activity 1&2:

The SEHAT contracts for implementation of BPHS and EPHS extended for a period of 6 months effective from July-Dec 2018. This extension will not cover takeover of activities such as upgraded SHCs through HSS3 fund and will solely be a continuation as bridge fund for next round of SEHATMNADI project.

Since this activity under HSS3 fund was designed to supplement the BPHS and to improve the EPI coverage in more remote and rural areas, therefore the signed contracts are required to be extended for the same period as SEHAT contracts.

The planned activities for the upcoming period are as bellow:

1) Amending of upgraded sub-centers and CBO contracts
2) Revising the TOR of upgrading SHCs and CBO using the lessons learnt
3) Developing a concept note and costing for scale up of CBO
4) Initiating the procurement processes of CBO
5) Monitoring the implementation of CBO activities

Activity 1.3

1. Continuing services provision to the nomadic population in 12 provinces.
2. Continuing clinical training of MHTs staff based on plan
3. Establishing Community Monitoring System
4. Conducting the Catchment Area Annual Census (CAAC) survey
5. Continuing CHWs refresher trainings

Activity 1.4

1. Continuing the support of PHPs throughout the life of the project.
2. Reviewing the incentive scheme of implementation i.e. data verification and technical assistance if required
3. Completing the planned trainings for PHPs by NGOs

A technical grant officer needs to be hired in HSS team in GCMU for managing new contracts, and formative design assessment of CBO

Objective 2:

Objective of the HSS grant (as per the HSS proposals or PSR)

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.

	Activity 2. 2: Capacity building of the cold chain and vaccine logistics managers and initial training for 300 female and 100 male vaccinators. *Activity 2. 3: Construction of vaccine and non-vaccine storage facilities.*
Priority geographies / population groups or constraints to C&E addressed by the objective	**Objective 2** aims 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. The cold chain related activities are implemented in all the 34 provinces. The construction activities will take place in 22 sites, based upon the need of cold chain stores and warehouses
% activities conducted / budget utilisation	***Activity 2.1:*** 100% of planned cold chain equipment procured and distributed to the provinces and budget utilization is 124%. ***Activity 2. 2:*** *71% of* SDD trainings have been completed in five regions and 166 SDDs (39%) have been installed and 57% of allocated budget has been utilized. ***Activity 2. 3:*** *45% of planned structures has been under construction and only 4% of budget transferred to construction companies.*
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	***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 for 2016-17 has almost been completed. The status of procurement of CCE is attached in Annex 2: ***Activity 2. 2: Capacity building of the cold chain and vaccine logistics managers and initial training for 300 female vaccinators and 100 male vaccinators*** The trainings for installation of Solar Direct Drives (SDDs) have been completed in five regions (Mazar, Kunduz, Nangarhar, Herat and Kandahar) and two regions (Kabul and Gardez) will be covered in the second half of June. A total of 84 cold chain persons have been trained at regional and provincial levels and till date, 166 SDDs have been installed. UNICEF has identified the agency for facilitating initial training of vaccinators. The training module has been developed and finalized. The ToT has been completed and the training has started at two locations viz. Kabul and Herat. ***Activity 2. 3: Construction of vaccine and non-vaccine storage facilities*** With the support of HSS funds, UNICEF will support following vaccines and non-vaccine storage facilities: • National EPI 1 • Regional warehouses 04 • Provincial warehouses 10 • Regional cold stores 01 • Provincial cold stores 06 The status of construction of these warehouses is attached in Annex 3: The need of construction of cold store rooms and warehouses has further been established by the recently concluded EVM assessment that shows that there is shortage of cold chain space. EVM was conducted in April 2018, and data cleaning is completed. Preliminary findings were shared with partners during JA meeting. Final report is under virtual review and will be released by end of July 2018. Brief presentation is attached to JA report as annex.
Major activities planned for	***Activity 2.1:*** Expansion of existing cold chain capacity for the introduction of new vaccines and opening of new service delivery facilities, the cold chain procurement will be completed. The SDD trainings in one region i.e Kabul will be completed by end August. At least 75% SDDs will be

upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	installed by end of the year. Once the approval from urban ministry is received, the construction activities will be started in all 22 sites in the year 2018. Additional funds are required for Regional cold chain store Balkh and National EPI building in Kabul. The request for additional funds, from the saving of HSS, has been approved by ICC. ***Activity 3.2:*** • Developing and getting approval of Learning Resource Packages (LRPs) for both school teachers and frontline health workers training. • Conducting ToT for the facilitators and co-facilitators of school teachers and frontline health workers training. • Establishing regional and provincial training setup. • Developing monitoring and supportive supervision tools: • Conducting 60% of trainings to school teachers and frontline health workers on immunization communication through IPCC and BCC at first 18 months. • TA support might be needed for system design cold chain and logistics distribution system Implementation of RVSTMS
Objective 3:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**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.* *Activity 3.2: Implementation of BCC activities through mass media, ICT and IPC.* *Activity 3.3: Evidence and Knowledge Generation (KAP Survey).*
Priority geographies / population groups or constraints to C&E addressed by the objective	The demand generation activities are implemented in all 34 provinces. The KAP survey was done in 84 districts of 21 randomly selected provinces which will 420 villages, the religious leaders training will be done in 17 provinces, the school teacher and frontline health workers training will be conducted in 20 provinces and the HIC counsellors provide counselling to the general public health queries throughout the country via 166 toll free number for promoting health programs esp. immunization by using mobile phone technology
% activities conducted / budget utilisation	***Activity 3.1:*** The religious leaders' TOT trainings completed in 5 provinces (29.4%) and total budget utilization is 55%. The IPCC and BCC training for school teachers and front line health workers has been contracted out to HNT-PO, it is in the inception phase and the NGO received only 10% of inception instalment. ***Activity 3.2:*** In total 2010 minutes of radio spots have been broadcasted through local radio on 34 provinces focusing on immunization. ***Activity 3.3:*** KAP survey has been completed and the results will be received from June 2018 onwards.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	***Activity 3.1: Increasing awareness and promoting immunization through the mobilization of religious leaders.*** The religious leaders training is being conducted by NEPI with support of UNICEF. The religious leaders of seventeen provinces with low immunization coverage of the Southern, Eastern, Western, Central and Northern region are targeted to receive training. Training of Trainers (TOT) in 5 provinces of Kandahar, Helmand, Zabul, Uruzgan and Farah are already completed and it's in process to be conducted in the four provinces Nangarhar, Nooristan, Kunar and Laghman too. ***Activity 3.2: Implementation of BCC activities through mass media, ICT and IPC.*** The IPCC and BCC training for school teachers and frontline health workers has been contracted out to an NGO, the inception activities such as recruiting the project key staff, developing the detailed implementation plan, hiring a short term consultant for developing Learning Resource Packages (LRPs) and developing training database have been completed. Moreover, for the

	smooth implementation of the project at national and subnational level an MoU has been signed between partners. The HIC revised TOR submitted to GCMU by 21 May 2017 for re-announcement. After completion of procurement process the winner organization was determined on 1st October 2017 and introduced to Gavi for PCA on 28th October, 2017 and the PCA report received on 25th January 2018. Due to destruction of the Health Information Center (which was located in Jamhuriat hospital) in a bomb blast on 27th January 2018, the negotiation was delayed for four months. Upon allocating new site for HIC, the negotiation resumed and finalized with the winner and the procurement documents were sent to National Procurement Authority (NPA) by 18th March 2018. Unfortunately, the documents are remained pending for NPA approval since that time. ***Activity 3.3: Evidence and Knowledge Generation (KAP Survey).*** UNICEF identified a research company, by undertaking a competitive process to facilitate the KAP survey. The agency, in consultation with NEPI and partners (WHO and UNICEF), developed the study framework, focused literature review, data collection tools for both quantitative and qualitative components, field work planning, methodology as well as documents for the IRB submission. A national review committee was established to review the tools and methodology for KAP assessment. The study employed a mixed method approach including quantitative KAP survey, focus group discussions (FGDs/ Social Consensus Groups), key informant interviews (KII) with experts, in-depth interviews (IDI) with program beneficiaries and desk reviews. the assessment has been completed and the first draft of results is available and is being reviewed by UNICEF. The revised draft will be shared with all stakeholders.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[5]	***3.1.1: Increasing awareness and promoting immunization through the mobilization of religious leaders.*** The following activities are planned for upcoming period; • The school teachers and frontline health workers training will be continuing by the implementer NGOs, monitoring and supportive supervision tools will be developed and regular monitoring from the training site will be conducting by M&E and health promotion team. • Upon approval of HIC by NPA, the contract will be signed and the implementation will start. • Airing 3400 minutes of radio spots will be broadcasted through local radio on 34 provinces. • The health promotion IEC materials stock will be renovated ***Activity 3.2: Implementation of BCC activities through mass media, ICT and IPC.*** • Social and behavior change communication (SBCC) training planned for 241 hospitals staff at the national and subnational levels. ***Activity 3.3: Evidence and Knowledge Generation (KAP Survey).*** The results of KAP survey will be included in the EPI communication strategy. Additional funds are required for training of religious leaders in 17 remaining provinces. The request for $371,820 additional funds, from the saving of HSS, has been approved. Based on need TA support will be requested for designing of BCC module and mass media, messages based on the communication strategy.
Objective 4:	

[5] Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

Objective of the HSS grant (as per the HSS proposals or PSR)	**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* *Activity 4.2: Conduct Periodic evaluations to ensure accountability for equity at district and provincial level.* *Activity 4.3: Improving the data flow system and improvement of HR accountability at national and sub national level* *Activity 4.4: Internal Audit system strengthening, procurement and finance system strengthening based on FMA 2012 findings to ensure the accountability of NGOs performance.*
Priority geographies / population groups or constraints to C&E addressed by the objective	The objective 4 aims to strengthen the health system management through decentralization of planning and monitoring to peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services. The M&E of grant implementation and NGOs performance at national level is the responsibility of the M&E directorate and at sub-national level it is the responsibility of Provincial Health Directorates. In addition, 250 District Health Officers (DHOs), who were introduced in the health system of Afghanistan with Gavi HSS1/other donors and are now supported by the Government of Afghanistan under the provincial structure, contribute to the monitoring of insecure districts where this grant is being implemented. The expected intermediate result is an increase in proportion of provinces in where 80% of existing BPHS and EPHS HFs are monitored by PPHOs quarterly. Other activities under this objective include improving the data flow system and improvement of HR accountability at national and sub- national level, Internal Audit system for strengthening the procurement and finance system to ensure the accountability of NGOs performance.
% activities conducted / budget utilisation	***Activity 4.1:*** 29% of districts and 34% health facilities monitored by PHOs and DHOs and 121% provincial staff received M&E decentralized system training. ***Activity 4.2:*** *Data Quality Self-Assessment completed and monitoring from AHS data collection conducted by MoPH team.* ***Activity 4.3****:* 40% of databases for residency specialization program and students essay research of internship program have been completed and 54% of allocated budget utilized. ***Activity 4.4:*** Annual internal auditing of Gavi – HSS3 grant has been completed by MoPH internal audit team and the Internal Audit Policy and Strategy and Anti-Corruption mechanism has been drafted. 48.5% planned budget utilized by relevant departments.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	**Activity 4.1 M&E:** 29% of districts and 34% health facilities monitored by PHOs and DHOs during the reporting period and 56 % of all provinces monitored by central M&E team. In total 256 PPHOs, DPHOs, EPI supervisors and M&E officers and supervisors of implementer NGOs received training on strengthening the M&E decentralized system at the provincial level. In total 530 health facilities in 9 piloted provinces monitored by PHOs and DHOs using GLM technology and the data has been synchronized in M&E data base. In-security in some of the provinces hindered appropriate and effective monitoring visits of some health facilities; lack of female staff within the monitoring structure makes it difficult for male monitors to monitor some services that are gender sensitive namely those provided for pregnant women in labor and health services delivery in the OPD and delivery room respectively. 72% planned budget has been utilized during the reporting period. **Activity 4.2: conducting periodic evaluations:** The data quality self-assessment conducted in 34 provinces and the report finalized. Attachment 3 Since the EPI coverage survey merged with AHS 2018, $ 93,000 amount of the budget has been re-allocated for Procurement of reagents, equipment and supplies for vaccine preventable diseases surveillance and monitoring of AHS. The HSS3 end of project evaluation is planned for year 2020. **Activity 4.3: HR strengthening:** 40% of databases for residency specialization program and students essay research of internship program have been completed and 54% of allocated budget utilized.

	Activity 4.4: Internal Audit: Annual internal auditing of Gavi – HSS3 grant has been completed by internal audit team and the report will be finalized soon, TOR for the training (capacity building) has been finalized and procurement process has been started. The Internal Audit Policy and Strategy and Anti-Corruption mechanism has been drafted. 48.5% planned budget utilized by relevant departments.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[6]	***Activity 4.1: Improving supportive supervision and monitoring of BPHS HFs at different levels with more focus on decentralization*** • *20 monitoring visits from BPHS, EPHS and HSS relevant projects in each quarter* • *Strengthening and continuing GLM project in 9 piloted provinces* • *Evaluating the GLM piloted project* • *Conducting decentralization training for PPHOs, DHOs and M&E officer/ NGOs supervisors* *Activity 4.2: Conduct Periodic evaluations to ensure accountability for equity at district and provincial level.* • *DQSA will be conducted* *Activity 4.3: Improving the data flow system and improvement of HR accountability at national and sub national level* • *The HR data bases will be completed* *Activity 4.4: Internal Audit system strengthening, procurement and finance system strengthening based on FMA 2012 findings to ensure the accountability of NGOs performance.* • *Internal audit staff will receive a training on the internal audit principals* • *The internal Audit Policy, Strategy and Anti-Corruption mechanism documents will be finalized*

3.7. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)

If your country is receiving CCEOP support from Gavi, provide a brief update on the following:

- ***Performance** of CCEOP indicators – achievement against agreed targets as specific in the grant performance framework (GPF);*
- ***Implementation status** (number of equipment installed / waiting installation, user feedback on preventive maintenance training, refrigerator performance, etc.), including any challenges / lessons learned;*
- ***Contribution** of CCEOP to immunisation performance;*
- ***Future needs for technical assistance** in implementing CCEOP support.[11]*

Note: an updated CCE inventory must be submitted together with the CCEOP renewal request.

CCEOP application update

Gavi has announced that the date for next round of CCEOP submission is 10th Sep 2018. All partners agreed to re-submit this application. NEPI is leading the process with technical and financial assistance of UNICEF. UNICEF has already identified a consultant who will incorporate into the application the comments received from Gavi.

3.8. Financial management performance

[6] Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

HSS3: The HSS3 grant covers a period of 4 years from June 2016 to May 2020. An estimated budget of USD 39.9 million is approved for implementation of GAVI HSS3 jointly by three lead implementers MoPH, UNICEF and WHO. The financial performance of HSS3 support is showing in the below graph.

Compliance with Financial reporting requirements and audit:

For HSS 3, the 2017 audit has been conducted and was submitted to Gavi. The audit has included all expenditure incurred at the level of MoPH but also the 19 NGOs' contracts (with 11 NGOs) that were managed by the MoPH. For the MoPH and the 11 NGOs, the auditor has expressed an unqualified audit opinion.

For HSS 3, UNICEF and WHO 2017 financial statements were also submitted by their respective HQ to Gavi.

For DQIP support, the audit work has not started yet as the selection process for an auditor is still ongoing and close to be finalized. 2017 annual financial report has been submitted and 2018 six monthly financial report has also been submitted for DQIP.

For PCV support, the Country has submitted a financial report up to end of June 2018.

The only other active grant during 2017 was ISS for which no financial report has been submitted.

For Rota VIG, the implementation has been fully implemented in 2018 according to the feedback received from WHO but no Financial report has been submitted yet (Not yet due).

For Measles, implementation has just started during 2018 and financial reports are not due yet. Annex 4

Financial performance of the portfolio:

HSS 3 Performance:

By end of June 2018, the utilization rate for the HSS3 is 57% (Total Expenditure/Total approval for the period July 2016 to June 2018).

MoPH, UNICEF and WHO have respectively a burn rate (Total expenditure/Total budget) of 46%, 68% and 76% by end of June 2018.

This shows a good improvement compared to the burn rate by end of 2017 that was only 35%.

However, the current financial performance is still sub-optimal. This is mainly due to delays at different levels and mainly with regards to finalizing NGOs assessment and contracting and process related to infrastructure activities.

It is now expected that the implementation pace would be accelerated as the issues encountered at the start of the implementation are alleviated. Despite this, the Country will come-up with an acceleration plan to catch-up on the delays.

Please see below, a chart summarizing the financial performance of the HSS support overall and by partner.

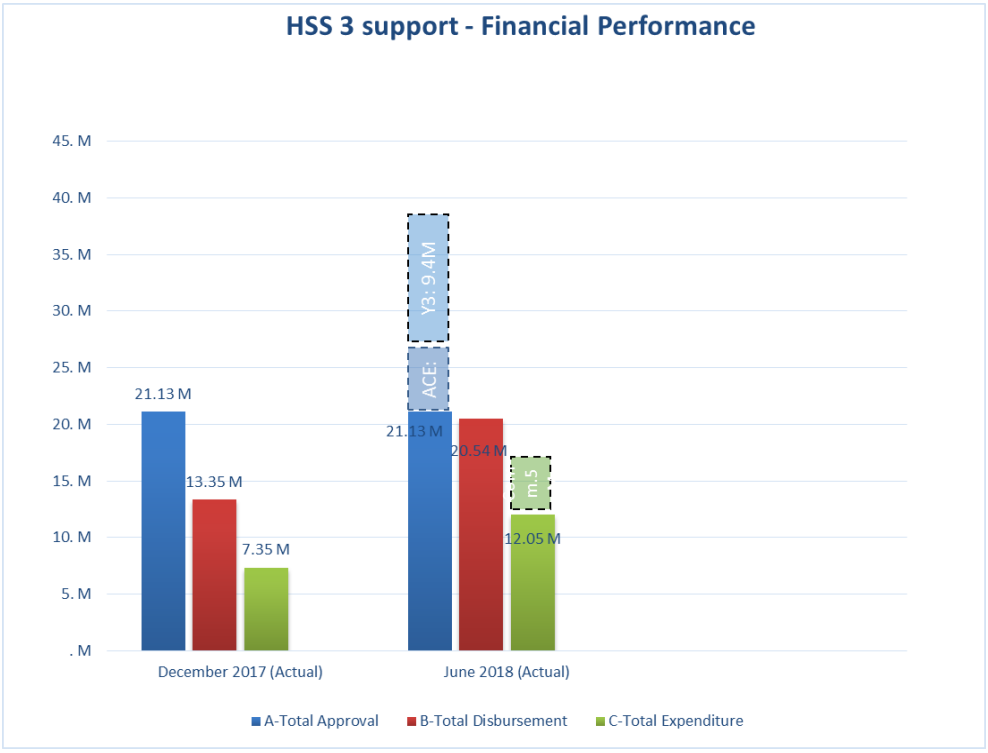


Fig. 22: HSS3 support financing performance

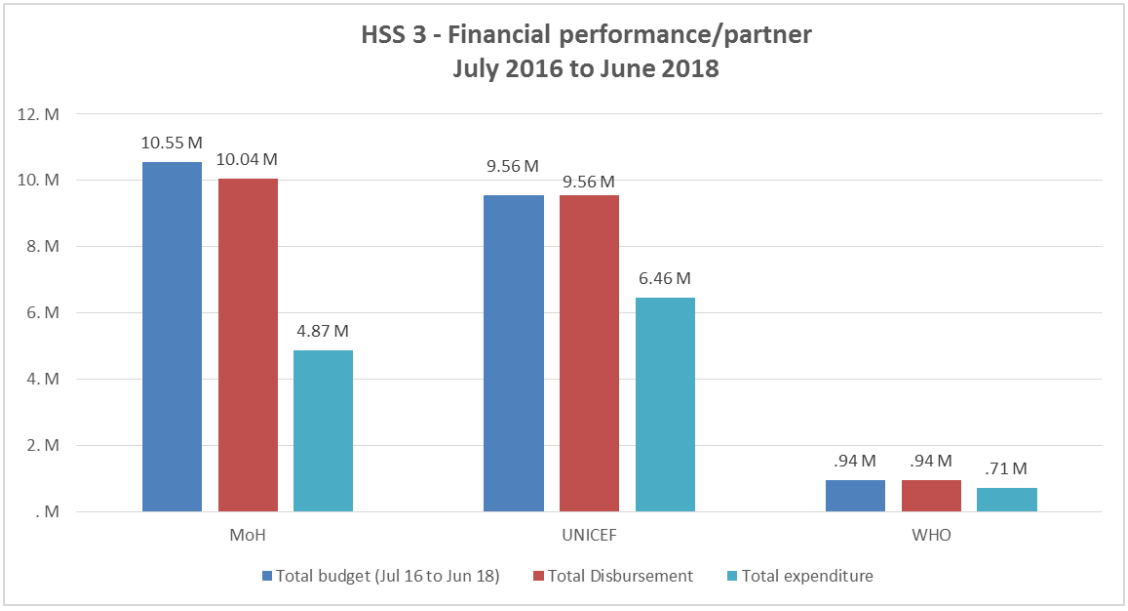


Fig. 2: HSS3 support financing performance by partner

DQIP Performance:

By end of June 2018, the utilization rate for the DQIP support is 28% (Total Expenditure/Total approval). Total expenditure represents 74% of total disbursed amount.

The implementation has suffered severe delays mainly due to Ministry of Finance funding flow mechanism. The country is proposing a change in the implementation arrangement (to align with the HSS implementation arrangement) to overcome this issue. This new model though will not be in place before beginning of 2019.

Please see below, a chart summarizing the financial performance of the DQIP support.

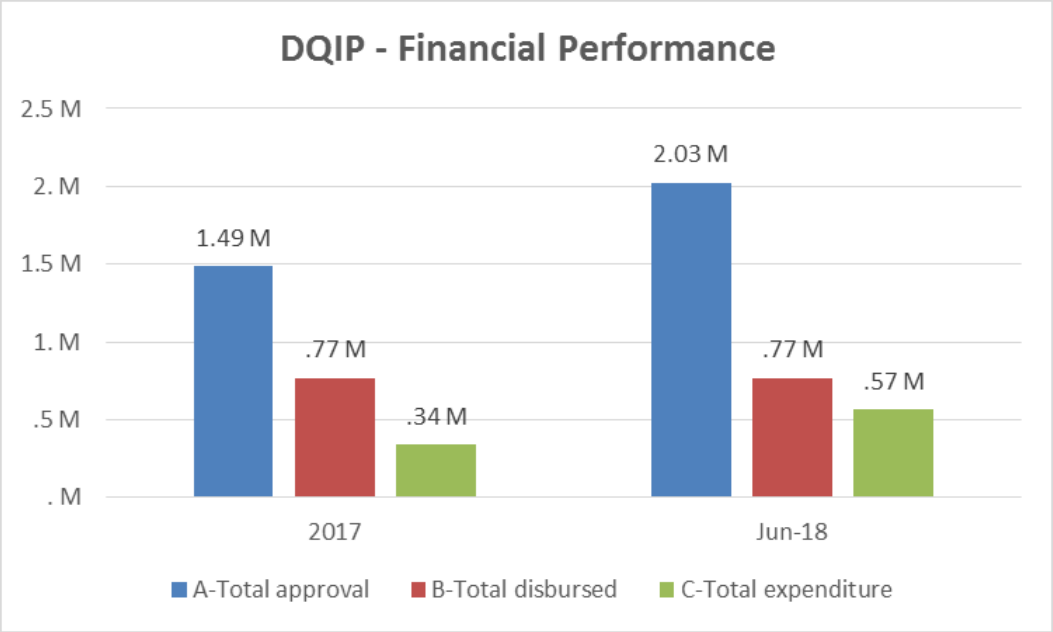


Fig 23: DQIP Financing performance

Other cash supports:

ISS support is still active but no financial report has been submitted yet.

Based on preliminary report from WHO (not based on financial statement), the Rota VIG support has been fully absorbed during 2018.

NO	Activity	Expenditures USD
1	Monitoring	36,884
2	National TOT on introduction of Rotavirus vaccine	36,034
3	Post introduction evaluation for Rotavirus vaccine	31,267
4	Provincial cascade training on introduction of Rotavirus vaccine	369,557
5	Surveillance of Rotavirus	13,600
6	Training of AFP focal points on introduction of Rotavirus vaccine	93,451
Total USD		580,794

3.9. Transition planning (if applicable, e.g. country is in accelerated transition phase)

If your country is transitioning out of Gavi support, specify whether the country has a transition plan in place. If no transition plan exists, please describe plans to develop one and other actions to prepare for transition.

- *If a transition plan is in place, please provide a brief overview on the following:*
  - *Implementation progress of planned activities;*
  - *Implementation bottlenecks and corrective actions;*
  - *Adherence to deadlines: are activities on time or delayed and, if delayed, the revised expected timeline for completion;*
  - *Transition grant: specify and explain any significant changes proposed to activities funded by Gavi through the transition grant (e.g., dropping an activity, adding a new activity or changing the content/budget of an activity);*
  - *If any changes are requested, please submit a consolidated revised version of the transition plan.*

Not Applicable

3.10. Technical Assistance (TA)

UNICEF:

For UNICEF, all PEF related milestones are completed. EVM, KAP and Communication Strategy for RI are the three tasks for which the draft reports are available and now under review. They will be shared with Gavi and other partners soon after their finalization. Though the country has challenging context, extra efforts have been made to ensure smooth implementation of PEF-related tasks. Country partners strongly believe that this contribution to be continued. Detailed report was uploaded in due time onto the Gavi portal.

WHO:

Technical assistance has been provided to develop training materials for PEI staff, revise immunization strategy and cMYP. In addition, TA has been provided for micro planning and acceleration immunization activities in four polio high risk provinces (Kandahar, Helmand, Nangarhar and Kunar) as well as Kabul (urban slums, IDPs, new settlements, returnee's camps and insecure districts).
For the Afghanistan health survey, the data collection has been completed, the report will be available by September 2018. WHO provided support to the National EPI for monitoring data collection.
The sentinel site for CRS surveillance has been established in the Indira Gandhi Children Hospital; WHO provided test kits for detection of IgM and IgG antibodies to rubella.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Provide the status of the prioritised strategic actions identified in the previous Joint Appraisal[7] and any additional significant Independent Review Committee (IRC) or High Level Review Panel (HLRP) recommendations (if applicable).

Prioritised actions from previous Joint Appraisal	Current status
1. Strong leadership, management, coordination and commitment for EPI	
a) Engagement of SEHAT partners and GCMU	The Aid Coordination Directorate was established to better coordinate the relevant projects activities among partners and ensure that the funds are being utilized in an efficient and coordinated way. As part of the activities of this directorate the Health Sector Oversight Committee which is a high level committee in the health system of Afghanistan was established to coordinate among partners and donors and also make mutual decisions regarding health related issues. It should be added that the SEHAT/ SEHATMANDI and On and Off budget are the fixed agendas which is regularly being discussed and updates are being provided in each monthly meeting of this committee. Moreover, the off budget mapping practice has also been conducted recently to find out the contribution of donors in the Health system as well as to avoid the duplication and implement activities in line with the strategic goals of the MoPH.
b) Implementation of HSS3 and DQIP	- Implementation of DQIP has been delayed due to challenges related to fund flow to subnational level and overall HR capacity. A new focal point has been recruited and he is following DQIP implementation and progress strictly. Regular review is done during EPI weekly coordination meetings organized by National EPI (EPI). The DQIP budget has been revised in line with updated

[7] Refer to the section "Prioritised Country Needs" in last year's Joint Appraisal report

	implementation timelines and one-day orientation workshop was conducted for head of BPHS implementers, at Kabul province. - Major delays related to the lengthy contracting of NGOs, conduct of PCA for selected NGOS, selection of construction providers and overall security challenges. However, by the end of 2017 the procurement of the selected NGOs was completed, and planned activities in line with revised budget are on track. The proposal for the allocation of additional $7.6m has been developed and currently being finalized.
c) Financing of routine vaccines beyond 2018	Financing of traditional vaccines is secured until end of 2019 - JICA may stop the financing from the end of 2019. Advocacy with MoF will be started for mobilization of domestic resources and advocacy with JICA for a phased withdrawal of support.
d) Planning and coordination among different departments at the national and sub-national level and stakeholders	Steps have been taken for planning and coordination among partners, National Level: Weekly coordination meetings with Technical partners (WHO and UNICEF) Weekly meetings with deferent departments of MOPH under leadership of preventive medicine Reviews Sub national Level: - PHCCs - Provincial data cell monthly meetings
e) Coordination and complementarity between PEI and EPI	The module for EPI training of PEI colleagues finalized. This module is an abridged version of the module developed by national EPI for vaccinators. The training of PEI colleagues (DPOs, ICN, etc) is part of PEF TCA 2018 and these will be rolled out from mid-July 2018 onwards WHO Polio staff engaged to provide support in improving RI including accelerated and supplementary immunization activities such as provision of technical support to provincial EPI management teams in developing health facility / district micro-plans, monitoring implementation of micro-plans. NEPI with support of WHO will conduct a training for 100 WHO PEI staff at least for 6 days on the fundamentals of routine immunization soon**.**
2. Immunization supply chain (cold chain capacity and maintenance)/Vaccine and logistics management at different level	
a) Submission of CCEOP proposal	As per consultations with NEPI and Gavi, the CCEOP proposal will be submitted on 10th September 2018. The consultant has been identified, and his contract will be signed soon through UNICEF.
b) Effective Vaccine Management (EVM)	The EVM assessment has been completed in April-May. A five-day training was organized and was attended by NEPI, REMT, PEMT officials, WHO and UNICEF colleagues (both EPI and PEI). Thereafter, teams were constituted and a total of 48 sites were assessed (National stores, all regional stores, randomly selected provincial stores and health facilities). The data cleaning and analysis has been completed. The Improvement Plan (IP) meeting will be conducted in July. Final report is under virtual review.
c) Solarization of cold chain points in Afghanistan	The SDD installation trainings have been completed in 6 regions and the remaining one regions (Kabul) will be covered after Eid holidays. To date, a total of 166 SDDs have been installed and rigorous follow up mechanisms developed for expediting the installation of SDDs.
d) Roll out of Real Time Vaccine Stock and Temperature Monitoring System (RTVSTMS)	The RTVSMS development was outsourced to an external agency (Afghanistan based). Despite continuous handholding support, the agency could not develop the desired product. The agency lacked technical and professional expertise. The contract was cancelled. Currently, the negotiations are going on with the supply section to find out the way forward.
3. **Service Delivery**	

a)	To coordinate between partners (GCMU, BPHS, three donors, UNICEF, WHO) to ensure implementation of mobile/outreach activities	Coordination among partners was initiated from development of the Term of Reference (ToR) of mobile/outreach. The implantation mechanism has been agreed by all partners (NEPI, UNICEF, WHO). In the pre-proposal stage all NGOs were oriented on the implementation mechanism. In addition to that the sustainability of mobile/outreach was discussed with the World Bank to be integrated along with the upgraded sub-centers in the SEHATMANDI project. Since this intervention is not included in the BPHS, it has been decided to continue outreach immunization intervention from Gavi – HSS3 grant.
b)	To focus on areas with low coverage e.g. Nuristan and some parts of southern provinces	30 Private Health Providers (PHP) under PPP project established to accelerate immunization program in Nooristan province. In addition, ICNs (Immunization Communication Network) has been assigned to improve routine coverage in Nooristan province
c)	To improve Convergence between polio and RI	Explained at 1.(e) above
d)	To strengthen role of the heads of health facilities in improving immunization coverage	The head of HFs attend to monthly meeting where EPI is one of agenda in the PHCC meeting at the provincial level. NEPI plan to conduct one-day orientation on EPI for Head of HFs focusing on data quality, AEFI, strategies etc.by support of BPHS implementers and WHO and UNICEF
4.	**Lack of use of data for evidence based decision making, in-consistent national coverage targets across strategic documents and delayed implementation of DQIP**	
a)	Fast tracking implementation of DQIP	• DQIP focal point new has been hired to manage and strictly follow up the overall project • DQIP plan, budget assumptions and budget plan were revised and the new activities have also been included in objective 3 of DQIP proposal. • For better coordination strictly follow up of DQIP related activities, all PHDs are officially assigned by HE minister to follow up the planned activities and budget utilization of DQIP and update the HE minister of public health on the progress regularly. • The DQIP monitoring and supervision tools were developed in both national languages is developed. • To address to low budget utilization of DQIP, the DQIP focal point and NEPI financial team visited the four regions, and the main aim was to find out the reasons behind low expenditures in 2017.
b)	Regular data analyses including the annual desk review of the immunisation data as defined in the SOPs	• Immunization data are being collected on monthly basis from the provinces, quarterly analysis take place and regular feedback is provided to provinces, and health facilities. • The findings (fact sheets) are being shared with immunizations staff and partners (WHO, UNICEF, CDC) etc. • Annual desk review has been planned in July 2018.
5.	**Fragmented Surveillance System**	
a)	Alignment of surveillance data sources and mechanisms	Manual for case-based surveillance for measles rubella and CRS has been developed by WHO. Initial discussions were held between WHO Polio surveillance and NEPI surveillance unit to start negotiations with NDSR on establishing integrated VPD surveillance.
b)	Review and standardize case	New WHO guidelines will be released in 2018; national guidelines will be aligned to include updated international case definition for all VPDs.

	definitions across surveillance system	
c)	Strengthen laboratory based surveillance	NEPI/directorate of surveillance have proposed to establish at least four regional labs for VPD surveillance. Need assessment is being conducted to identify the required equipment/supplies, staff, and space in four regional labs and three hospitals in Kabul. National measles/rubella lab was accredited in Dec 2017.
d)	Leverage polio surveillance system to improve VPD surveillance	AFP surveillance system collects and reports clinical cases of measles from sentinel sites.
6.	**Demand Generation**	
a)	Complete national KAP survey to understand the demand related issues for immunization	The data collection The preliminary results will be available by second week of August
b)	Impart TA in the development of national communication strategy for RI	The communication strategy has been developed. The results of KAP survey and recommendations will be assimilated in the strategy and it will be finalized.
c)	Conduct training of the religious leaders on the importance of RI	Seventeen priority provinces have been selected which are in the Southern, Eastern, Western, Central and northern regions of Afghanistan, TOTs have been conducted in 5 provinces and the training of religious leader completed in 42 districts .
d)	Advocate with national EPI to assign focal points for communication and demand generation and provincial level	The National EPI that EPI supervisors will be assigned as a provincial focal points for communication related activities.
e)	Establish mechanism for collaboration and coordination between PEMTs and CBHC and BPHS implementers at provincial level	Meetings are being conducted on monthly and the CBHC, BPHS and PEMT are member of mentioned meeting.
f)	Advocacy to establish accountability and M& E mechanism between national and provincial level on demand generation and communication	A pilot study on Demand Creation/Generation Study/Project (DCP) for vaccination was conducted and the result is expected to be out by late July 2018, Upon successful result there is a plan to first expand the study from 20 districts in 5 High risk provinces (Kandahar, Helmand, Nangarhar, Kunar and Laghman) to 75 districts and in the second step is expansion of activities on demand generation and communication at national level, Currently there is a coordinator at national level as well as provincial level supervisors, who regularly follow up the planned activities (communication and demand generation) and sharing the updates/reports with National EPI team.

Additional significant IRC / HLRP recommendations (if applicable)	Current status

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 6 below).

7. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

In addition to prioritized activities under HSS section, following areas are prioritized.

1. The following interventions 1) establishment of additional community based outreach vaccination (CBOV) 2) improving immunization service delivery in urban setting 3) Construction of additional Regional/Provincial Cold chain stores and Provincial warehouses 4) Strengthening of EPI services in 29 polio high risk districts of Southern and Eastern have been proposed through separate concept notes to be covered from the additional 7.6 m USD.
2. The DQIP financial flow for the remaining activities in the next two years will be implemented by the NGOs which will be selected through open bidding by GCMU.
3. Streamlining and strengthening measles surveillance (review of existing parallel surveillance streams and development of the measles surveillance guidelines); provision of the test kits for detection of IgM/IgG to measles and rubella viruses; assessment of the capacity /needs of regional labs to establish the regional laboratories. Establishment of the sentinel rotavirus post-marketing surveillance for identification of intestinal intussusception cases.
4. SEHAT project was closed on 30th June 2018. However, the contracts of NGOs for the provision of BPHS and EPHS have been extended for 6 months from the Sehatmandi grant. The request for proposal for the new contracts has been finalized and advertised. It is expected that the procurement process will be completed by December 2018 and new contractors/NGOs will start service delivery from 1st January 2019. The contract of KIT, the third party monitor, is also amended/extended for 6 months (the same timeline with BPHS/EPHS contracts). Under Sehatmandi, there will be two contracts for third party undertaking Afghanistan Health Survey and Balanced Score Card/HMIS verification.

Key finding / Action 1	**Uncertain availability of financing for traditional vaccines from beyond 2019. JICA has announced to stop funding by end of 2019.**
Current response	JICA has agreed to support the traditional vaccines till November 2019
Agreed country actions	• Explore alternatives to financing of traditional vaccines following withdrawal of JICA funding beyond 2019. i.e. Mobilization of domestic resources, advocacy with MoF, Advocacy with JICA for a phased withdrawal of support.
Expected outputs / results	• Alternate modalities/areas for funding of traditional vaccines identified
Associated timeline	• Immediate (the discussions with the different stakeholders will be initiated at the earliest possible after the JA meeting)

Required resources / support	• No funding support from Gavi is required for this action , however, strong advocacy needs to be done for different stakeholders to find a long term solution to ensure availability of traditional vaccines in the country
Key finding / Action 1	**High dropout rate (13% for 2016 &2017) Penta 1 – Penta 3**
Current response	Provision of 1000 tracking bags for defaulter tracking Creating linkages between health facilities within the province to review vaccination records and reconcile doses received by individual children at multiple facilities
Agreed country actions	• Identify provinces with dropout rate >10 • 1,000 tracking bags were already distributed to selected health facilities; distribution of 2,200 tracking bags is planned to cover all the needs. The second copy of the routine immunization card will be printed for entire birth cohort of 1.5 million children for use in the tracking bags; the costs required are $27, 000. • Utilize the opportunity of supervisory visits to 1) ensure proper use of tracking bags and availability of copies of vaccination cards for the bags, 2) review vaccination registers for defaulters 3) focus on interpersonal communication messages to care givers to complete primary vaccination series • Social mobilization and demand generation to return for additional doses, including utilization of CHW to find defaulters • Reduce missed opportunities during non-vaccination health center visits
Expected outputs / results	• Decrease drop-out rate to <10%
Associated timeline	• Identify provinces by October 2018 • Other activities November 2018- Dec 2019
Required resources / support	• Advocacy with BPHS teams • Utilization of DQIP resources
Key finding / Action 2	**Inconsistent data particularly JRF 2016-2017**
Current response	To conduct a data time series analysis with the help of WHO and UNICEF
Agreed country actions	• A workshop for time series analysis planned at Kabul for Jan/Feb 2019
Expected outputs / results	• The data both denominators and numerators to be re adjusted through triangulation of data from various sources WHO/UNICEF to be estimates to be updated
Associated timeline	1st Quarter, 2019
Required resources / support	• Technical support from WHO/UNICEF Financial support for the workshop participation local around USD5000 and international WHO/UNICEF USD 5000-10000
Key finding / Action 3	**Inconsistent administrative data reported for 2016 and 2017 reported to the JRF**
Current response	To conduct a desk review of existing data sources (i.e. administrative, surveys, polio and surveillance) to revise the time series for numerators, denominators and rates
Agreed country actions	▪ Conducting the annual data quality desk review for 2018 ▪ An analytical workshop for reviewing and revising current time series planned in Kabul (with support from technical partners). *This exercise is similar to what was conducted in Pakistan in 2018.*
Expected outputs / results	Revised time series for numerators, denominators, coverage rates that will inform Afghanistan's official coverage estimates
Associated timeline	First quarter of 2019 (Jan or Feb)
Required resources / support	• Technical support from WHO and UNICEF for both the annual data quality desk review for 2018 and the analytical workshop

	• Financial support for hosting the workshop (overall cost is approximately USD 15,000 which includes USD 5,000 for local participants and USD 10,000 for international technical partners)
Key finding / Action 4	**Delayed implementation of Afghanistan's Data Improvement Plan (DIP) owing to challenges relating to fund flow from national to provincial levels**
Current response	• Following the hiring of the epidemiologist within the EPI Team, work plan has been revised to accelerate pace of implementation. While this has resulted in some activities (e.g. supportive supervision) being implemented, owing to fund flow related challenges, implementation rate has been slower than expected.
Agreed country actions	▪ To modify the financial management arrangements of the DIP, mirroring the approach currently used for Gavi's HSS investments (i.e. MoPH contracting a non-governmental organisation [NGO]) • To review the findings of supportive supervision reports in Nov/Dec 2018 in order to see if improvements in data collection and analysis practices have been observed. DQIP activities can be fine-tuned accordingly
Expected outputs / results	▪ Funds being available at provincial for the implementation of fundamental activities at the operational level (i.e. independent monitoring, data quality review and check, etc.) • DIP work plan is reviewed and/or revised in light of the findings from supportive supervision
Associated timeline	• Jan / Feb 2019; process for contracting a NGO takes approximately 6-7 months
Required resources / support	▪ Gavi Secretariat to review and approve the terms of reference for the bid • Gavi Secretariat to review proposed revisions, if any, to the DIP work plan
Key finding / Action 5	**National and subnational immunisation staff responsible for data management and analysis have limited capacity in data use**
Current response	▪ The DIP includes basic training for vaccinators on basic immunisation as well as monitoring and evaluation training for national staff
Agreed country actions	▪ To develop a training plan for staff at all levels to improve data use capacity, which would include (1) a training for subnational staff on basic analyses (using Excel) to check quality of data; and (2) inclusion of national staff to WHO AFRO's next data quality workshops
Expected outputs / results	▪ Analytical tool for facilitating data analysis and use at the operational level is available ▪ National and subnational staff are exposed to best practices relating to data strengthening
Associated timeline	▪ By next Joint Appraisal (i.e. mid-2019)
Required resources / support	▪ Technical support for developing new and/or adapting existing analytical tool for facilitating data analysis ▪ Financial support for organising/participating in learning opportunities
Key finding / Action 6	**Fragmentation of surveillance data systems; for example, two parallel systems exist for measles surveillance**
Current response	▪ Data from both measles surveillance systems are analysed and compared; no consensus reached yet for the way forward
Agreed country actions	▪ Conduct a review of current surveillance systems for all vaccine-preventable diseases (surveillance for polio, measles/rubella, CRS, Invasive Bacterial Disease, Rotavirus, neonatal tetanus)
Expected outputs / results	▪ A roadmap is developed for integrated disease surveillance systems based on recently published WHO guidelines
Associated timeline	▪ By the next Joint Appraisal (i.e. mid-2019)
Required resources / support	Technical assistance to conduct the review and develop the roadmap ▪ Financial support for conducting the review as well as implementing recommendations resulting from this exercise

Key finding / Action 7	**No reporting for adverse event following immunisation (AEFI) is happening at the facility level.** ***This is because vaccinators link the occurrence of AEFIs with their individual performance.***
Current response	A supervision checklist has been rolled out recently that looks at reporting done at the facility level
Agreed country actions	Use the upcoming measles campaign to reinforce vaccinators' knowledge and capacity relating to AEFI reporting
Expected outputs / results	▪ Vaccinators understand the importance of reporting AEFI resulting an improved reporting rate ▪ Based on AEFI reported, additional training needs will be identified and addressed
Associated timeline	By the next Joint Appraisal (i.e. mid-2019)
Required resources / support	Technical assistance to prepare training materials on AEFI reporting
Key finding / Action 8	**Polio resource support for RI**
Current response	As per the recommendation by Polio TAG (Technical Advisory Group), PEI network is committing 20% of its time on EPI services. Currently, the main domain of support of monitoring of immunization sessions.
Agreed country actions	Capacity building of PEI staff by EPI teams (NEPI, WHO and UNICEF) on basic principles of routine immunization Congruence of PEI and EPI micro plans in four polio high risk provinces (Kunar, Nangarhar, Kandahar and Helmand) Monitoring of immunization sessions Monitoring of Measles SIA Following proposal of HSS ICC to be the governing body of the Polio transition process, country to take it forward.
Expected outputs / results	PEI staff in the field is well conversant with the basic principles of routine immunization programme PEI colleagues do quality monitoring of immunization sessions and provide hands-on support EPI micro plans, congruent with PEI micro plans, prepared in four provinces Quality monitoring of Measles SIA is done by PEI colleagues
Associated timeline	Capacity building of PEI staff by end September Formulation of EPI micro plans prepared in four provinces by end October Monitoring of immunization sessions is an ongoing activity and will continue for the whole year Measles monitoring will be done in Phase 1 (September 1-10) and Phase-2 (November 1-10), depending on the field presence of polio colleagues
Required resources / support	Funds for training of PEI colleagues are available under PEF TCA Funds for microplanning are available under HSS-3 No additional funds are required
Key finding / Action 9	**Country plan for Measles SIAs 2018**
Current response	Measles SIAs in Afghanistan targeting children 9 month – 10 years of age with one dose of measles vaccine irrespective of vaccination status or disease history will be conducted in two phases: 1-10 September and 17-26 November, 2018 (17 provinces each). The most recent readiness assessment at the national level indicates 88% of readiness. Measles vaccine and dry supplies have been delivered to the national level.
Agreed country actions	- Thorough preparation for quality Measles SIAs is under way, in particular: - Ensure thorough training of vaccinators building strong knowledge on the vaccine management and administration; - Using any opportunity to target inaccessible communities even outside campaign dates;

	- Risk communication activities, appointment and training of spokespersons at provincial and national levels. - Access negotiation with Anti-Government Elements (AGE) and DAESH; - Undertake Post Coverage Assessment.
Expected outputs / results	To achieve high coverage (≥95%) during both phases of campaign verified by the independent coverage survey.
Associated timeline	July 2018 – March 2019
Required resources / support	Funds for the planned SIA are available. TA for measles surveillance system review
Key finding / Action	**Shortage of funds under the SEHATMANDI project on EPI**
Current response	- Based on past expenditures of BPHS and EPHS we would need 600 Million USD only for BPHS and EPHS services for three years. Due to shortage of fund, currently only 570 Million USD for BPHS and EPHS service are available, 20 Million USD for 3rd party monitoring and MOPH management cost and only 10 Million USD for community engagement and health promotion campaign. - Due to this shortage, HSS activities dropped out, except waste management and extra activities will not be supported as well. Further to that, following issues might happen with this shortage of fund; - Problem on sustaining the same level of BPHS and EPHS services (with 30 Million USD shortage) - Limitation on expansion of primary health care - No any health system strengthening program at the Central and provincial level and - Shortage of local technical staff for MoPH programs
Agreed country actions	- For smooth and quality of immunization services, capable health system should be in place. - Priority uncovered areas for immunization services such as Community Based Outreach in white areas, should be covered through GAVI fund. - Complementary activities to improve immunization services needs to be identified and will be included under HSS additional funding opportunity. - Identify potential immunisation gaps due to SEHATMANDI shortage of funds and submit proposal within the +50%HSS financing for Gavi consideration
Expected outputs / results	- Uncovered white areas will be covered and consequently coverage and equity will be increased particularly for deprived population in remote areas. - Supporting Health system strengthening activities will help smooth implementation of immunization services in the country.
Associated timeline	January 2019 – December 2021
Required resources / support	Not applicable. Proposal will be submitted to Gavi after MOPH and partners discussion on gap analysis and immunisation.

8. 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 8th May 2018. The members divided the task into two activities, technical and financial as well as review of existing documents. The report has been prepared based on the desk review, program reports and field reports provided by the NGOs (which have been verified by PHDs). The second JA meeting held on 6th June 2018 to discuss the JA agenda point for Alexandria meeting. The zero draft of JA prepared by 25th June and reviewed jointly by JA team. Comments were addressed on the first draft and reviewed by 23th June. Each member of the team provided report which was compiled by deputy HSS coordinator and it

was circulated for final comments on 30th June 2018 to Gavi secretariat and partners. The draft was jointly reviewed with Gavi team from 15-20th July 2018 and the latest draft presented to ICC/HSS steering committee on 4th September 2018 for the endorsement. The ICC/ HSS steering committee minute which endorsed the 2017 JA is attached.

9. ANNEX: Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal. ***It is important to note that in the case that key reporting requirements (marked with *) are not complied with, Gavi support will not be reviewed for renewal.***

	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 (which is normally provided by 15 May as part of the vaccine renewal request) *	√		
Campaign reports *			
Supplementary Immunization Activity technical report			√
Campaign coverage survey report			√
Immunisation financing and expenditure information			
Data quality and survey reporting			
Annual data quality desk review			√
Data improvement plan (DIP)	√		
Progress report on data improvement plan implementation	√		
In-depth data assessment (conducted in the last five years)			√
Nationally representative coverage survey (conducted in the last five years)	√		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	√		
CCEOP: updated CCE inventory			√
Post Introduction Evaluation (PIE)			√
Measles & rubella situation analysis and 5 year plan	√		
Operational plan for the immunisation programme	2017√		
HSS end of grant evaluation report			√
HPV specific reports			√
Reporting by partners on TCA and PEF functions			

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: Status of Cold Chain Equipment Procurement

No	Items	Planned for 2016-17	Procurement done/initiated	% achievement	Remarks
1	SDDs	456	456	100	
2	Spare part for Solar refrigerator	45	46	102	
3	Vaccine carrier, storage capacity 1.5-3L	1660	2062	124	
4	Icepack 0.6-liter capacity	21980	22280	101.4	
5	Cold box, RCW 25	580	585	100.1	
6	Cold box Long Term Storage	150	50	33.3	Changed in consultation with NEPI
7	Electronic refrigerator logger,30 days	292	1195	409	Changed in consultation with NEPI
8	Irreversible Freeze Indicator	1100	1860	169	
9	Freezer room,20 m³	-	2	200	
10	Water packs freezer TFW 800/Dometic Group SARL	10	10	100	
11	Freezer, Vest frost MF 314, PQS E003/023	66	0	0	Due to space constraint in PEMTs, NEPI to deferred to buy these equipment.
12	Refrigerator Vest frost MK 304, PQS E3/007	265	0	0	
13	Cold room, walk-in type,30 m³	6	0	0	
14	Remote Temperature Monitoring Device (RTMD) 16 sensors	1	0	0	The system was replaced with new technology
15	Remote Temperature Monitoring Device (RTMD) 08 sensors	2	0	0	
16	Real time logistic stock and temperature monitoring system	-	0	0	
17	Spare parts Cooling Unit for WIC/WIF	26	26	100	
18	Refrigerated vehicle	1	1	100	

No	Items	Planned for 2016-17	Procurement done/initiated	% achievement	Remarks
19	Refrigerated pickup	7	7	100	
20	Voltage regulators Single Phase 1KVA	60	200	333	As per consultation with NEPI
21	Forklift	0	1	100	
22	Generators 27KV	0	4	400	
23	IT equipment for cold chain	30	9	30	

Annex. 3: Status of construction activities

S. No	Province	Type of Construction	Contract Status	Construction Status
1	**Balkh**	Regional warehouse	Contract signed	Construction is in progress
2	**Paktya**	Regional warehouse	Contract Signed	Construction is in progress
3	**Kunduz**	Regional warehouse	Contract Signed	Construction is in progress
4	**Herat**	Regional warehouse	On hold	Contractor selected. But due to land issue (non-availability of land papers), agreement is on hold. Department of Public Health has promised to send the documents in the week of 10th June.
5	**Logar**	Provincial cold room	Contract Signed	Construction started but land issue
6	**Ghazni**	Provincial cold room	Contract Signed	Construction is in progress
7	**Takhar**	Provincial cold room	Contract Signed	Construction is in progress
8	**Baghlan**	Provincial cold room	Contract Signed	Construction is in progress (DoPH stopped the construction)
9	**Zabul**	Provincial cold room	Contract Signed	Construction is in progress
10	**Balkh**	Regional cold room	Tender Activity not yet started	Design, drawing and specification were submitted in March 2018 to Urban Ministry and waiting for their approval to initiate tender process*
11	**Parwan**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
12	**Bamyan**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
13	**Paktika**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
14	**Badakhshan**	Provincial cold room	Tender Activity not yet started	Approval from UM awaited

S. No	Province	Type of Construction	Contract Status	Construction Status
15	**Sari Pul**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
16	**Faryab**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
17	**Ghor**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
18	**Badghis**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
19	**Kapisa**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
20	**Wardak**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
21	**Samangan**	Provincial warehouse	Tender Activity not yet started	Approval received from UM; tender in process
22	**Kabul**	National Cold Room	In design status	NEPI approved the layout; design is in progress

Annex 4:

Type of support	Approvals 2001-2022 (US$) (22 Aug 2018)	Commitments 2001-2022 (US$) (22 Aug 2018)	Disbursements 2000-2018 (US$) (22 Aug 2018)	% Disbursed (22 Aug 2018)	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Measles SIA (NVS)	$2,163,903	$2,163,903	$2,163,903	100%															■				
Measles SIA - Operational costs (OPC)	$3,574,000	$3,574,000	$3,574,000	100%															■				
Measles-Follow-up campaign (NVS)	$4,307,000	$4,307,000	$4,856,288	113%																	■		
Measles-Follow-up campaign op.costs (OPC)	$8,702,377	$8,702,377	$8,702,377	100%																	■		