Health System Strengthening (HSS) Cash Support

Application Package – Proposal Form

COUNTRY NAME: AFGHANISTAN DATE OF APPLICATION: 01 June 2015

This proposal form is for use by applicants seeking to request Health System Strengthening (HSS) cash support from Gavi, the Vaccine Alliance (Gavi). Countries are encouraged to participate in an iterative process with Gavi partners, including civil society organisations (CSOs), in the development of HSS proposals prior to submission of this application for funding.

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As an important supplement to this document, please also see the '*General Guidelines for Expressions of Interest and Applications for All Types of Gavi Support*, available on the Gavi web site:
http://www.gavi.org/support/apply/

The General Guidelines serve as an introduction to the principles, policies and processes that are applicable to all types of Gavi support, both Health Systems Strengthening (HSS) and New and Underused Vaccines Support (NVS).

All applicants are encouraged to read and follow the accompanying '*Supplementary Guidelines for Health System Strengthening Applications in 2014*' in order to correctly fill out this form. Each corresponding section within the Supplementary HSS Guidelines provides more detailed instructions and illustrative instructions on how to fill out the HSS proposal form.

Please note that, if approved, your application for HSS support will be made available on the Gavi website and may be shared at workshops and training sessions. Applications may also be shared with Gavi partners and Gavi's civil society constituency for post-submission assessment, review and evaluation.

Gavi's Key Elements for Health System Strengthening Grants

The following key elements outline Gavi's approach to health system strengthening and should be reflected in an HSS grant. They are presented as being either 'required' for a Gavi HSS Grant or 'recommended' for a Gavi HSS Grant:

Required Elements:

- One of Gavi's strategic goals is to "contribute to strengthening the capacity of integrated health systems to deliver immunisation". The objective of Gavi HSS support is to address system bottlenecks to achieve better immunisation outcomes, including increased vaccination coverage and more equitable access to immunisation. As such, it is necessary for the application to be based on a strong bottleneck and gap analysis, and present a clear results chain demonstrating the link between proposed activities and improved immunisation outcomes.
- Performance based funding (PBF) is a core approach of Gavi HSS support. All applications must align with the Gavi performance based funding approach introduced in 2012. Countries' performance will be measured based on a predefined set of PBF indicators against which additional payments will be made to reward good performance in improving immunisation outcomes. Under the PBF approach for HSS, the programmed portion of HSS grants must be used solely to fund HSS activities. Countries have more flexibility on how they wish to spend their reward payments, as long as they are still spent within the health sector. Neither programmed nor performance payments may be used to purchase vaccines or meet Gavi's requirements to co-finance vaccine purchases, and shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies.
- Gavi's HSS application requires a strong M&E framework, measurement and documentation of results, and an end of grant evaluation. The performance of the HSS grant will be measured through intermediate results as well as immunisation outcomes including diphtheria tetanus pertussis (DTP3) coverage, measles-containing vaccine first dose (MCV1) coverage, fully immunised child coverage, difference in DTP3 coverage between top and bottom wealth quintiles, and percent of districts reporting at least 80% coverage of DTP3. Additionally, so as to systematically measure and document immunisation data quality and data system improvement efforts, independent and recurrent data quality assessments and surveys will be required for all HSS applications.
- Gavi's approach to HSS includes support for strengthening information systems and improving data quality. Strong information systems are of fundamental importance both to countries and to Gavi. Gavi requires that countries have in place routine mechanisms to independently assess the quality of administrative data and track changes in data quality over time. Countries are strongly encouraged to include in their proposals actions to strengthen data systems, and to demonstrate how their grant will be used to help implement recommendations or agreed action items coming from previous data quality assessments. The process of conducting periodic data quality assessments and monitoring trends should be credible and nationally agreed. For example, incorporating an independent element to the assessments could involve national institutions that are external to the programme that collects or oversees the data collection. Comprehensive information on reporting and data quality requirements are provided in the NVS/HSS General Guidelines for 2015. Please refer to section 3 on Monitoring and Reporting and Annex E on Data Quality.
- Gavi recognises the importance of effective and efficient supply chain systems for the management of existing and new vaccines and health commodities. Gavi has therefore developed and approved in June 2014 a supply chain strategy[1]. (For more information about the strategy initiatives, see the factsheet http://www.gavi.org/Library/Publications/*Gavi*-fact-sheets/Gavi-Supply-Chain-Strategy/). The Effective Vaccine Management (EVM) assessment and improvement plan are essential steps in the strategic approach to supply chain improvement in countries.
    - **New Requirement**: As approved by the Gavi Board in June 2014 all future proposals (2015 and beyond) that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure pre-qualified equipment by WHO through the Performance Quality and Safety

[1] See Gavi supply chain strategy section 3.5, http://www.gavi.org/About/Governance/Gavi-Board/Minutes/2014/18-June/Minutes/05---Gavi-Alliance-immunisation-supply-chain-strategy/

(PQS) programme. The purchase of non-PQS pre-qualified equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi.

- Gavi supports the principles of alignment and harmonisation (in keeping with Paris, Accra and Busan declarations and the International Health Partnership, IHP+). The application must demonstrate how Gavi support is aligned with country health plans and processes, complementary to other donor funding, and uses existing country systems, such as for financial management and M&E. The IHP+ Common Monitoring and Evaluation Framework is used as a reference framework in the supplementary HSS guidelines.
- Gavi requests countries to identify and build linkages between HSS support and new vaccines implementation (Gavi NVS) – linkages to routine immunisation strengthening, new vaccine introduction, and campaign planning and implementation must be demonstrated in the application. Countries should demonstrate alignment between HSS grant activities and activities funded through other Gavi cash support, including vaccine introduction grants and operational support for campaigns.
- As part of vaccine introduction, Gavi HSS support should be used during pre-and post-introduction for strengthening the routine immunisation system to increase the coverage e.g. through social mobilisation, training, supply chain management etc. (see grant categories in table 1 of the Supplementary HSS Guidelines) for all the vaccines supported. This should complement other sources of funding including vaccine introduction grants from Gavi.
- Applications must include details on lessons learned from previous HSS grants from Gavi or support from other sources such as previous New and Underused Vaccine Support, the EVM assessment or PIE tools, EPI reviews etc.
- Applications must include information on how sustainability of activities and results will be addressed from a financial and programmatic perspective beyond the period of support from Gavi.
- Applications must include information on how equity (including geographic, socio-economic, and gender equity) will be addressed.
- Applications will need to show the complementarity and added value of Gavi support to reducing bottlenecks and strengthening the health system, relative to support from other partners and funding sources and relative to other funding from Gavi specific to new vaccines and/or campaigns.

Recommended Elements:

- Gavi supports the use of Joint Assessment of National Strategies (JANS). If a country has conducted a JANS assessment the findings can be included in the HSS application. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.
- Gavi's approach to HSS includes support for community mobilisation, demand generation, and communication, including Communication for Immunisation (C4I) approach.
- Gavi supports innovation. Countries are encouraged to think of innovative and catalytic activities for inclusion in their grants to address HSS bottlenecks to improving immunisation outcomes.
- Gavi strongly encourages countries to include funding for CSOs in implementation of Gavi HSS support to improve immunisation outcomes. CSOs can receive Gavi funding through two channels: (i) funding from Gavi to Ministry of Health (MOH) and then transferred to CSO, or (ii) direct from Gavi to CSO. Please refer to Table 1 for potential categories of activities to include in budget for CSOs and Annex 4 of the Supplementary HSS Guidelines for further details of Gavi support to CSOs.
- Recommended: Countries can incorporate new strategy elements in their NVS and HSS proposals that begin to address the three key elements of supply chain management fundamentals (supply chain managers, supply chain performance dashboards, and comprehensive supply chain management plans) and can use existing resources such as:
    - The EVM, EVM improvement plan and the Progress report on the EVM improvement plan which shall be submitted with applications, if available; and, which should contribute to providing evidence on the existing cold chain status and the country plans to address supply chain bottlenecks and

inform the development of a comprehensive supply chain management plan.

- While Gavi's current PBF approach is applied to HSS grants at the national level, Gavi also encourages countries to consider using performance-based funding at sub-national levels. Where appropriate, countries may decide to align with other PBF programmes, such as the World Bank's results-based financing (RBF) programmes, and if so, sufficient information must be included with the Gavi HSS proposal on how funding will be aligned. If aligning to a World Bank RBF programme, please provide the concept note or programme design document. Describe which of the objectives of the grant are for the PBF/RBF programme. Please also attach the results framework and budget for the RBF programme. Please note that more than one immunisation-related indicator is expected to be part of any such PBF/RBF programme, if the Gavi HSS grant is proposed to be aligned with it (please see part IV of the Introduction to the Supplementary HSS Guidelines).
- Applicants are encouraged to identify technical assistance (TA) and capacity building needs for implementation and monitoring of the HSS grants. Applicants are required to include details of short term and long term TA if they are requesting TA as part of the HSS application to ensure strong implementation and effectiveness of Gavi HSS support.

PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION
For further instructions, please refer to the Supplementary Guidelines for HSS Applications

Checklist for a Complete Application

A completed application comprises the following documents. Countries may wish to attach additional national documents as necessary.

HSS Proposal Forms and Mandatory Gavi attachments *→ Please place an 'X' in the box when the attachment is included*		
No.	*Attachment*	***X***
1.	HSS Proposal Form	*X*
2.	Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members	*X*
3.	Minutes of HSCC meeting endorsing Proposal	*X*
4.	Minutes of three most recent HSCC meetings	*X*
5.	HSS Monitoring & Evaluation Framework	*X*
6.	Detailed budget, gap analysis and work plan	*X*
7.	Detailed Procurement Plan (18-month)	*X*

Existing National Documents - Mandatory Attachments Where possible, please attach approved national documents rather than drafts. For a decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents. *→ Please place an 'X' in the box when the attachment is included*		
No.	*Attachment*	***X***
8.	National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions	*X*
9.	National M&E Plan (for the health sector/strategy)	*X*
10.	National Immunisation Plan	*X*
11.	Country Comprehensive Multi-Year Plan for Immunisation (cMYP)	*X*
12.	Effective Vaccine Management (EVM) Assessment report (from an EVM conducted within the preceding 36 months). In addition the related documents must be attached if available. : If this is not available, please indicate when the next EVM is anticipated. ▪ Latest EVM Improvement Plan. In case an EVM Improvement Plan is not provided, the country shall provide a justification and identify a plan for developing the improvement plan. ▪ Latest Progress Report on the EVM Improvement Plan Implementation (no older than 6 months prior to proposal submission). In case a Progress Report on the Improvement Plan Implementation is not provided, the country shall provide a justification.	*X*
13.	Terms of Reference (TOR) of Health Sector Coordinating Committee (HSCC)	*X*

Existing National Documents - Additional Attachments Where possible, please attach approved national documents rather than drafts. For a decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents. *→ Please place an 'X' in the box when the attachment is included*		
No.	*Attachment*	***X***
14.	Joint Assessment of National Health Strategy (JANS) (if available)	*NA*
15.	Response to Joint Assessment of National Health Strategy (if available)	*NA*
16.	If funds transfers are to go directly to a Civil Society Organisation (CSO) or CSO Network, please provide the 3 most recent years of published financial statements of the lead CSO, audited by a qualified independent external auditor	*NA*
17.	Health Supply Chain Strategy and/or national health implementation supply chain plans, please provide latest documents (final or draft). Other key supply chain analysis and/or activities including but not limited to supply chain network design & optimization, human resource assessments, supply chain information systems, etc.	*NA*
18.	Cold chain equipment inventory list and/or cold chain storage capacity analysis (if available)	*X*

19.	Coverage Improvement Plan if available	*NA*
20.	Equity Analysis and Plan if available	*NA*
21.	Evaluation of previous HSS grant	*X*
22.	List of target populations/districts, and criteria for selection	*X*
23.	Post Introduction Evaluation Report	*X*
24.	EPI Review/evaluation Report	*X*
25.	Report from last completed household survey	*X*
26.	Concept note or programme design document (including results framework and budget) of any World Bank Results-Based Financing (RBF) programme, or other PBF/RBF programme document, if the Gavi HSS grant is proposed to be aligning with such programme.	*X*
27.	Study report - PPP evaluation Uruzgan (final version 15 May 2013)	*X*
28.	BPHS Gap analysis Report (focused on immunization)	*X*
29.	EPI Desk Review 2012	*X*
30.	MICS-Report from last completed household survey 2012	*X*
31.	Vaccine storage capacity 2015	*X*
32.	PPP CSO type B External Evaluation 2011	*X*
33.	PPP Guidelines	*X*
34.	Proposal development team	*X*
35.	CTA Country Tailored Approach	*X*
36.	Grant Implementation Manual	*X*
37.	Workshop and meetings	*X*
38.	Other project review	*X*
39.	Gap analysis work shop	*X*
40.	Construction design, Cost estimation and specification for construction	*X*
41.	Procurement guideline	*X*
42.	HSS ToR	*X*
43.	BPHS_2010 (Basic Package of Health Services_2010)	*X*
44.	Afghanistan Health Survey 2006	*X*
45.	Afghanistan Health Survey 2012	*X*
46.	Detailed Sub Activities Summery	*X*
47.	Sustainability Plan	*X*
48.	EPI Strategy 2020	*X*
49.	Supportive Narrative_CCVLM_OBJ_2	*X*
50.	NTA Remuneration policy Final	*X*
51.	EPI Desk Review 2012	*X*
52.	Final EPI KAP Report 9 July 2014	*X*
53.	Afghanistan National Health Work force Plan (2012-2016)	*X*
54.	MoPH (2013) Afghanistan National Health Accounts with sub accounts	*X*
55.	HSS2 Proposal	*X*
56.	GLM proposal and Report	

1. Applicant Information	
Applicant:	***Ministry of Public Health***
Country:	***Afghanistan***
Proposal title:	***HSS GAVI new proposal (HSS3 proposal)***
Proposed start date:	***January 2016***
Duration of support requested:	***Four Years***
Total funding requested from Gavi:	***39.9 million USD***
Contact Details	
Name:	***Dr. Noor Shah Kamawal***
Organisation and title:	***HSS Coordination Unit***
Mailing address:	***HSS unit, MoPH main building, second floor***
Telephone:	***+93778829773***
Fax:	*NA*
E-mail addresses:	***Kamawal.noorshah@gmail.com***

2. The Proposal Development Process

This section will give an overview of the process of proposal development, outlining contributions from key stakeholders.

Address all the items listed below. Indicate if any of these are not applicable and explain why:

- *The main entity which led the proposal development and coordination of inputs. It is possible to have multiple lead implementers, however the country must decide which department will lead the proposal development process.*
- *The roles of HSCC and ICC.*
- *Cooperation between EPI programme and the other departments of MOH involved in the proposal development (including Departments of Planning, Child Health, HMIS, and Central Medical Stores (or related Supply Chain Units), etc.).*
- *Involvement of subnational level (provincial, district, etc.) entities.*
- *The role of CSOs in the proposal development. Applicants must describe whether the HSCC/ICC worked with any CSO platforms/coalitions, or just with individual organisations. Please provide the names of the specific CSOs, with contact details, or of the CSO platforms involved.*
- *The names and roles of other specific development partners/donors.*
- *The role of the private sector, if applicable.*
- *Description of technical assistance received during the proposal development. Include the source of technical assistance and a comment on the quality and usefulness of that technical assistance.*
- *Description of the overall process of proposal development: duration, main steps of the proposal development, analytical work involved in the proposal development, links between the proposal development and national health sector planning/budgeting, links between the proposal development and JANS (if applicable).*
- *Description of the most challenging elements during the proposal development and how they were resolved.*

This proposal has been 5 months in the making as updated comprehensive Multi-year Plan (cMYP) and Effective Vaccine Management (EVM) were pre requisites. It has been developed based on cMYP 2015-2019[2] and National Health and Nutrition policy 2012-2020[3] and approved Gavi Country Tailored Approach (CTA)[4] through a rigorous consultative process involving all stakeholders including relevant MoPH departments and programs, UN organizations, national and international non-governmental organizations (NGOs), private sector representatives, donor agencies, technical partners and provincial MoPH departments. Several assessments were conducted at national and provincial levels to update existing situation analyses, prioritize the health needs of the population, identify gaps, design appropriate program implementation modifications, estimate financial requirements and propose realistic implementation schedules. Multiple consultative meetings and workshops were conducted to review national strategies, plans and drafts of the proposal during the development process as described below, and in the minutes and attendance sheets annexed as referenced.

The HSS Steering Committee (HSS-SC), which has been merged with the ICC and is a sub-group of Health Sector Coordination Committee (HSCC), provided the coordination and oversight of the GAVI-HSS application process by designating a Working Group (WG) called Proposal Development Team,[5] led by HSS and NEPI departments who would develop and draft the application and report regularly to the HSS-SC on its progress.[6] Several representatives from the stakeholders were included in the WG – from NEPI, WHO, UNICEF, NGO, MoPH departments and donor constituencies.

Afghanistan submitted an expression of interest (EOI) in May 2014. In an ongoing country dialogue with GAVI Secretariat, Afghanistan was invited to submit the HSS3 proposal by May 2015. Since then, the cMYP was revised and inventory for cold chain equipment[7] and the EVM assessment[8] were conducted in a participatory approach in collaboration with all the partners (NEPI, Provincial and District Health Departments, WHO, UNICEF and NGOs) and in close coordination with the HSS Department of the MoPH. In January 2015, the HSS Steering Committee appointed a team in the MoPH to conduct gap analysis for immunization system strengthening with the participation of the different departments involved in the implementation of GAVI HSS 2 (NEPI, NHCD, HP Dept., M&E Dept., RH, PR, HEFD and GCMU). [9] Similarly, other projects supported by GF ATM, WB SEHAT, USAID and EU were reviewed to avoid any duplication and to seek areas of significant synergies with HSS-GAVI support in Afghanistan.[10] In addition, in February 2015, MoPH, WHO and UNICEF conducted a desk review of MoPH policy, the latest EPI coverage survey, HSS1 and HSS 2 program implementation , HSS evaluations, BPHS gap analysis, EPI annual review and reports from third parties on the Afghan health system and EPI program. The results were presented and discussed in a national gap analysis workshop, supporting documents annexed[11] and further described below.

On 18 March 2015, the national gap analysis and consultative workshop was opened by the Deputy Minister of MOPH and chaired by the General Director (GD) of Policy and Planning. The workshop set the strategic directions for the HSS3 proposal with the participation of NEPI (Program and Cold Chain Directors), GD of Public Health Institute, GD of Preventive Medicine, GD of Human Resources, GD of Pharmacy, GD of Curative Medicine, GD of Administration as well as members of their respective departments, the HSS department, ten provincial directors and immunization team staff from areas with low routine immunization coverage and high polio cases provinces, Ministry of Finance (MoF), donors, UN agencies (UNICEF and WHO), CSOs/NGOs (HN-TPO, CAF, AKHS, AADA) and technical partners. Procurement, GCMU department, development budget unit, reproductive health directorate, M&E directorate, GIHS Directorate, Provincial Liaison Directorate and Internal audit department also attended the workshop.

[2] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015.
[3] A#8: MoPH Afg. National Health and Nutrition Policy 2012-2020, Sept 2012.
[4] A#35: Gavi Secretariat and MoPH. Afghanistan Country-Tailored Approach (CTA), draft, 19 May 2015, with Annexes A-E.
[5] A#34: Proposal Development team – Official authority designation from MoPH. (Farsi)
[6] A#29: Proposal Development Team Meetings: 2015: 24 Feb, 4 Mar, 17 Mar, 24 Mar, 29 Mar, 1 April, 5 April, 19 April, 5-6 May.
[7] A#18: Number of Functional Cold Chain Equipment (CC inventory Aug 2014)
[8] A#12: EVM Assessment Afghanistan, 8 Dec -25 Dec 2014: Findings and Recommendations of the Assessment.
[9] A#37: Proposal Development Team Meetings with MoPH Depts: 2015: 25 Jan, 25 Jan, 26 Jan, 27 Jan, 10 Mar, 11 Mar, 14 Mar.
[10] A#38: Proposal Development Team Meetings with SEHAT and Global Fund.
[11] A#39: Minutes and Presentations from March 18, 2015, Gap Analysis Workshop.

The priorities identified through the prior desk review along with other necessary and relevant information were presented at the workshop. At the end of presentations, the 65 participants were asked with prioritizing 5 to 10 main gaps and then categorizing these gaps based on their relevance to Gavi HSS support objectives under four categories, namely: (i) Access and coverage, (ii) Cold chain and vaccine logistic system, (iii) Demand generation for immunization, and (iv) Stewardship and governance at sub national level. Eventually, in the second part of the workshop these four objectives and relevant interventions were prioritized as the proposal strategic directions for HSS3 grant application.

After the workshop, three sub groups were appointed by the proposal development team to work collaboratively and develop the general narrative part of the proposal, M&E frame work, budget and work plan. These subcommittees met regularly and were in rigorous communication with experts on service delivery, cold chain, communication, governance etc. to ensure the technical competency of the proposal and interventions. The sub committees presented their sections to Proposal Development Team where again the proposal has undergone an extensive review and the first draft was formulated.

The first draft of the proposal was submitted to partners in the first week of April, and their comments and inputs were incorporated. The second draft of the proposal was presented to the technical group in a workshop organized by WHO country office in second week of April and inputs were included by the Proposal Development Team. The third draft was shared with the high level Health Sector Coordination Committee of Afghanistan which was chaired by Technical Deputy Minister on 19 April 2015. The comments and recommendations of the partners were incorporated by the Proposal Development Team and, finally it was presented for endorsement to HSS Steering Committee which was chaired in person by H.E. the Minister of Public Health on 23 April 2015; supporting documents of HSCC and HSS-SC for approval are annexed. [12], [13]

In addition to TA provided by WHO and UNICEF country offices, the proposal was also reviewed by EMRO region and Gavi relevant officers in Djibouti from 25-29 April, and later it was reviewed by Dr. Mounir Farag on 4-5th May 2015 in Afghanistan, and finally by WHO HQ and Gavi Secretariat during second week of May 2015. All the comments and recommendations were addressed in the proposal.

The process of HSS3 proposal development was extensively consultative and inclusive and all key stakeholders at national and regional level were part of the process, ensuring cooperation between HSS department, EPI program and the other departments of MoPH and partners involved in the proposal implementation including Departments of Budgeting and Planning, MNCH, HMIS, Central Medical Stores, Supply Chain Units of NEPI, CSOs, donors and UN agencies.

Signatures: Government endorsement

Please note that this application will not be reviewed or approved by Gavi without the signatures of both the Ministers of Health & Finance and their delegated authority.

Minister of Health	Minister of Finance
Name: Dr. Ferozudin Feroz	Name: Mr. Eklil Ahmad Hakimi
Signature:	Signature:
Date: 23.04.2015	Date:

[12] A#3: MoPH, Minutes of HSS3 Proposal Endorsement Meeting, April 19, 2015, and signatures of the HSCC.
[13] A#4: MoPH. Minutes HSS-SC meetings, Dec 17, 2014; April 1, 2015; and April 23, 2015.

Signatures: Health Sector Coordinating Committee endorsement

We the members of the HSCC (HSS-SC), or equivalent committee met on the **23/ 04/2015** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.

Please list all HSCC members	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Deputy Minister for Policy and Planning	H.E Dr. Ahmad Jan Naeem		
Secretary	Aid Coordination	Dr. Noor Mohamad Arezoie		
MOH members	General Director of Policy and Planning	Dr. Abdul Qadir Qadir		
	HSS Coordinator and focal point	Dr. Noor Shah Kamawal		
	Genera Director of Preventive Care	Dr. Taufiq Mashal		
	Director of HEFD	Dr. Ahmadshah Salehi		
	NEPI Manager	Dr. Sardar Mohmad Parwiz		
	General Director of HIS	Dr. Attauallah Saeedzai		
	General Director of HR	Dr. Ihsanullah Shaheer		
	Reproductive Health Director	Dr. Zulikha Anwari		
	Deputy HSS Coordinator	Dr. Najla Ahrari		
	BPHS gap analysis advisor	Dr. Adam Khan Azizi		
Development partners				
UNICEF	Program Manager EU	Dr. Sefatullah Habib		
USAID	USAID HSS Unit head	Andrew Rebeg		
CIDA	DFATD Advisor Canada	Palwasha Anwari		
CSO members	General Director AADA/AHO/CSO deputy	Dr. S. Ashrafuddin Aini		
	AHO/CSO Coordinator	Dr. Masoud		
WHO	Team Leader Health System WHO	Dr. Najeebulah Safi		
UNICEF	Chief Health , UNICEF	Dr. Sherin Varkey		
	EPI specialist	Raveesha Mugali		
	Immunization Specialist UNICEF	Fazil Ahmad		
MoPH	Communication officer NEPI	Dr. Gula Khan		
	National Cold Chai Manager	Mr. Haji Mateen		

Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes ☒ No ☐

Individual members of the HSCC may wish to send informal comments to: gavihss@gavi.org
All comments will be treated confidentially.

PART B – EXECUTIVE SUMMARY

For further instructions, please refer to the Supplementary Guidelines for HSS Applications

3. Executive Summary

Please provide an executive summary of the proposal, of no more than 2 pages, with reference to the items listed below:

- ➔ *The main bottlenecks for achieving immunisation outcomes addressed within this proposal and how proposed objectives in this application will address these bottlenecks and improve immunisation outcomes.*
- ➔ *A summary description of the population to be covered by the intervention (i.e. total population targeted).*
- ➔ *Objectives and the related budget for each objective.*
- ➔ *The proposed implementation arrangements including the role of government departments and civil society organisations. Please include a summary of financial management, procurement and M&E arrangements.*

Afghanistan, which has a total estimated population of 31.5 million (UNIDATA),[14] with 48% under 15 years of age, and 36.5% living below the poverty line,[15] is one of the last two countries in the world with endemic polio disease. The EPI coverage survey conducted in 2013[16] revealed that the national crude immunization coverage for a fully immunized child was 51%, not close to the 90% necessary to stop polio or measles outbreaks. Even more disappointing is the provincial disparity of only 2.5% of children in Farah Province fully immunized, 26% coverage of Penta 3 among the Kuchi nomads (A# 5), a large gap in vaccine coverage between poor and wealthy households, and 18.3% of children who were never vaccinated with any antigen.

In line with the core values of the Health Sector, such as equity, quality, transparency, and community participation, as expressed in the NHNP 2012-2020, this proposal aims to strengthen routine immunization, especially in underserved communities. This grant proposal is for an estimated budget of USD 39.9 million, to be spent over 4 years from 2016 to 2019 based on approved CTA, 2015 and NHNP 2012-2020, and in alignment with, the existing cMYP 2015-2019 which will be **subsumed** in the new health sector strategic plan for 2016-2020. The objectives address key health and immunization system bottlenecks preventing the country from overcoming **socio-economic and geographical inequities** in immunization outcomes and aim to strengthen the performance of the health system related to immunization. It is noted that the problems with data quality will be addressed in a parallel proposal to be submitted to Gavi under CTA, 2015.

The main **bottlenecks** for achieving the high rates of immunization coverage (80-90%) needed to reduce morbidity /mortality from childhood diseases are mentioned below along with the proposed interventions and cost:

Equitable access bottlenecks: Among the reasons given for not immunizing their children, 40% said the health facility (HF) was too far away, 21% said the area was insecure, and 9% said there was no female vaccinator.[16] The analysis of population per EPI delivery centre reveals that there are 449 health sub-centres (HSCs) without immunization services;[17] the male to female ratio of vaccinators is 3:1;[14] and there are 6 insecure provinces (Uruzgan, Farah, Paktia, Kandahar, Helmand and Noristan) with low-performance, where the average penta3 coverage is 34% based on EPI coverage survey. At the same time, sub-populations are missed due to lack of updated detailed micro-plans, and outreach services are not provided due to contractual issues with NGO-BPHS implementers while government departments use drastically different population figures and even numbers of districts.[18]

Objective 1 aims to enhance equitable access and effective coverage of immunization services to a total population of 4.7 million people by training female vaccinators and bringing cold chain equipment to 310 unserved HSCs and training vaccinators for community-based outreach from 2878 villages in "white areas." It also 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 interventions are proven to work in Afghanistan through other Gavi opportunities[15, 19, 20], are cost-effective and sustainable,[21] maintain the gains from previous interventions, integrate BPHS

[14] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015.

[15] A#25: Afg Central Statistics Organization (CSO) and ICON-Institute. National Risk and Vulnerability Assessment (NRVA) 2011-12: Afghanistan Living Conditions Survey. Kabul, 2014.

[16] A#24: UNICEF, CSO, NEPI- MoPH. National Immunization Coverage Survey Afghanistan 2013, also called NEPI Coverage Evaluation Survey (CES) 2013, April 2014.

[17] A#22: List of target districts and population.

[18] A#39: Minutes and Presentations from March 18, 2015, Gap Analysis Workshop

[19] A#28: Apex2Consulting with CDC, Atlanta. Afghanistan BPHS Gap Analysis Survey, Feb-Mar 2015: Routine Immunization (EPI) Service Delivery, Preliminary Report. May 2015.

[20] A# 32: Governance Institute Afghanistan (Gi-A). Mid-Term Evaluation CSO Support Type B Project, Partnership with Private for Profit Health Service Providers (PPHSP) Model in Afghanistan – Uruzgan and Farah Provinces. April 2011.

[21] A#47: Sustainability Plan for Gavi HSS3

and immunization services, build synergies and share costs with BPHS and SEHAT projects, and target the inequities and underserved populations. Please see Section 10 – Lessons Learned for further discussion. (Allocated budget for objective 1, $ 11,155,242.1 = 28% of total budget).

Cold chain and vaccine logistic bottlenecks: According to the cold chain and vaccine management analysis,[22] the introduction of IPV and Rotavirus vaccines (2015-18) is jeopardized by the current inadequate cold chain capacity and storage. Eight provinces do not have sufficient cold rooms and 23 provinces need warehouses for dry supply. Further there are no refrigerated trucks and the vaccine logisticians need further training on vaccine tracking and management (for further details please refer to A# 31).

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. (Allocated budget for objective 2, $ 15,344,385.8 = 38.5% of total budget).

Demand generation bottlenecks: Female literacy is 17%[15] which may explain why parents of unimmunized children say they are not aware of the diseases prevented or why their children should be vaccinated.[16] Latest surveys indicate need for better communication about importance of immunization through evidence based advocacy and more reliance on Inter-personal communication (IPC) with credible health care providers and CHWs as well as elders and religious leaders, depending on the community.

Objective 3 aims to **improve demand for immunization services** by developing IEC materials and conducting seminars at district level to raise awareness about need for immunizations among 14,400 religious leaders to build trust in immunizations and remove misconceptions. This proposal would also enlist broadcast media, support the Health Information Call Center, and build the capacity of frontline health workers and school teachers, as well as supporting CHWs other mobilizers with tools and advocacy materials for interpersonal communication (IPC) in order to increase demand among the disadvantaged population (Allocated budget for objective 3, $ 2,628,572.0 = 6.5% of total budget).

Monitoring and management bottlenecks: The March 2015 Gap Analysis Workshop[18] with the participation of partners, CSOs and Provincial Directors agreed there was sub-optimal coordination between national EPI and CSOs for proper immunization service delivery and weak accountability of NGOs at sub national level along with lack of sufficient capacity at provincial level for monitoring leading to dependency on central level for planning, monitoring and supervisory functions.

Objective 4 aims to train and mobilize PHOs and DHOs for effective M&E using National Monitoring Checklist and an innovative, Geo-Location Monitoring (GLM) software and database at the health facility level. It will also strengthen management capacity for monitoring and oversight of the BPHS implementing NGOs and data flow of administrative and program data will be improved. Funds will also be allocated for strengthening financial management and audit. (Allocated budget for objective 4, $ 8,554,178.5 = 21.4% of total budget). The program support cost is 5.6 % of total grant.

A critical analysis of the budget allocation indicates that 100% of the budgeted program activities are directly **contributing towards reducing socio-economic and geographical inequities** whereas 62% of the total budget will contribute towards **reducing gender-based inequities**. The expected outcomes of the above interventions in the next four years are to increase coverage of Penta-3 from 59.7% to 80%, Measles-1 from 58.8% to 80%, TT2+ from 59% to 80%, fully immunized children from 51% to 80%, decrease dropout rate from 18.6% to 10%, and thus reduce the number of confirmed cases of Poliomyelitis to zero, and to stop outbreaks of measles and pertussis.

The funds are to be managed jointly by three lead implementers – MoPH, UNICEF, and WHO - 45.6%, 30.7% and 23.6% respectively. For further details on implementation arrangement and risk mitigation please refer to Part F and section 10 of this proposal.[23] [24] [25]. Furthermore, details on sustainability of planed interventions and staff under this proposal are given in section 17 and sustainability plan as attached (A# 47).

The indicators and targets within M&E frame work (A#5) and MoPH M&E Plan and other programmatic areas of this grant will be monitored using different methods as mentioned in section 14 of this proposal. The means used for monitoring are the HMIS, programmatic routine reports, field visits using the National Monitoring Checklist, household surveys, an end program evaluation and third party health facility assessments such as Balanced Scorecard.

TWO PAGES MAXIMUM

[22] A#49: Supporting Narrative for Objective 2 of the Gavi Proposal. Cold chain and vaccine logistics management system, Afghanistan, May 2015.

[23] A# 33: MoPH, Afg. Implementation Guideline Package for the PPP Program in Afghanistan. 2014.

[24] A#36: Policy, Planning and International Affairs Directorate, MoPH. Health System Strengthening Grants Implementation Manual, April 2015.

[25] A#41: Procurement Guidelines (folder)

4. Acronyms

➔ *Please detail the full version of all acronyms used in this proposal, including in the HSS M&E Framework (Attachment 3) and in the Budget, Gap Analysis and Workplan Template (Attachment 4).*

A#	Attachment Number
AFMIS	Afghanistan Financial Management Information System
AHO	Afghan Health Organization (CSO Coordinator)
AHS	Afghan Health Survey
ANDS	Afghanistan National Development Strategy
APR	Annual Progress Report
BCC	Behavior Change Communication
BCG	Bacillus Calmette–Guérin (anti-tuberculosis vaccine)
BHC	Basic Health Center
BPET	Budget Preparation and Expenditure Tracking System
BPHS	Basic Package of Health Services
BSC	Balanced Scorecard
C4I	Communication for Immunization
CAAC	Catchment Area Annual Census
CBA	Child Bearing Age women
CBHC	Community Based Heath Care
CC	Cold chain
CDC	Communicable Disease Control
CES	Coverage Evaluation Survey
CHC	Comprehensive Health Center
CHNs	Community Health Nurses
CHSs	Community Health Supervisors
CHWs	Community Health Workers
cMYP	Comprehensive Multi-year Plan
CPHL	Central Public Health Laboratory
CSO	Central Statistics Organization
CSOs	Civil Society Organizations
CTA	Country Tailored Approach
DEWS	Disease Early Warning System
DH	District Hospital
DHOs	District Health Officers
DPT	Diphtheria Tetanus Pertussis vaccine
DQS	Data Quality Self-assessment
EDL	Essential Drug List
EMRO	Eastern Mediterranean Regional Office (WHO)
EOI	Expression of Interest
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
EU	European Union
EVM	Effective Vaccine Management
FM	Financial Management
GAVI	Gavi - The Vaccine Alliance
GCMU	Grants and service Contract Management Unit

GD	General Directorate
GDP	Gross Domestic Product
GF ATM	The Global Fund to Fight AIDS, Tuberculosis & Malaria
GGHE	General Government Health Expenditure
GHE	Government Health Expenditure
GIHS	Ghazanfar Institute of Health Sciences
GLM	Geo-Location Monitoring
GoA	Government of Afghanistan
HDI	Human Development Index
HEFD	Health Economic and Financing Directorate
Hep-B	Hepatitis-B
HFs	Health Facilities
Hib	Haemophilus influenza type b vaccine
HIS	Health Information System
HMIS	Health Management Information System
HP	Health Post
HPD	Health Promotion Department
HR	Human Resources
HSC	Health Sub-Center
HSCC	Health Sector Coordinating Committee, same as HSS-SC
HSFP	Health Systems Funding Platform
HSS	Health Systems Strengthening
HSS-SC	Health Systems Strengthening Steering Committee, same as HSCC
ICC	Inter-agency Coordinating Committee
IEC	Information, Education and Communication
IHP	International Heath Partnership
ILR	Ice-Lined Refrigerator
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
IPV	Inactivated Polio Vaccine
IRC	Independent Review Committee
JANS	Joint Assessment of National Strategies
JAR	Joint Annual Review
JRF	Joint Reporting Form (WHO-UNICEF report on coverage)
KAP	Knowledge, Attitude and Practice
M&E	Monitoring and Evaluation
MCV	Measles Containing Vaccine
MHCs	Mobile Health Clinics
MHTs	Mobile Health Teams
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MNT	Maternal and Neonatal Tetanus
MoF	Ministry of Finance
MoPH	Ministry of Public Health
MR	Measles Rubella
MSH	Management Services for Health
NCCVLMIS	National Cold Chain Vaccine Logistics Management Information System

NEPI	National Expanded Programme on Immunization
NGO	Non-Governmental Organization
NHA	National Health Account
NHNP	National Health & Nutrition Plan
NHP	National Health Plan
NHPS	National Health Policy and Strategy
NHSPA	National Health Service Performance Assessment
NHSS	National Health Sector Strategy
NIP	National Immunization Program
NRVA	National Risk and Vulnerability Assessment
NVS	New and underused Vaccines Support
OOP	Out of Pocket
OPV	Oral Polio Vaccine
PBF	Performance Base Funding
PCV-13	Pneumococcal Conjugate Vaccine – 13 antigens
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
Penta	Pentavalent vaccine (DPT-HepB-Hib)
PHC	Primary Health Care
PHD	Provincial Health Directorate
PHDs	Provincial Health Directors
PHOs	Provincial Health Officer
PIE	Post Introduction Evaluation
PP	Procurement Plan
PPHCC	Provincial Public Health Coordination Committees
PPHDs	Provincial Public Health Directors
PPHOs	Provincial Public Health Officers
PPP	Public Private Partnership
PQS	Performance of Quality and Safety
RBF	Results-based Financing
RDU	Rational Drug Use
REACH	Rural Extension of Afghanistan Community-based Health Program
RED	Reaching Every District (EPI strategy)
REMT	Regional EPI Management Team
RH	Reproductive Health
RI	Routine Immunization
Rota	Rotavirus vaccine
RTMD	Remote Temperature Monitoring Device
SEHAT	System Enhancement for Health Action in Transition (World Bank grant)
SIA	Supplementary Immunization Activity
SM	Strengthening Mechanism ("contracting in")
SOPs	Standard Operating Procedures
SWOT	Strengths, Weaknesses, Opportunities, Threats
TA	Technical Assistance
TAG	Technical Advisory Group
THE	Total Health Expenditure
TPM	Third Party Monitoring
TT	Tetanus Toxoid vaccine
UN	United Nations

UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
USG	United States Government
VLMIS	Vaccine Logistic Management Information System
VPD	Vaccine Preventable Disease
WB	World Bank
WG	Working Group
WHO	World Health Organization

PART C– SITUATION ANALYSIS

For further instructions, please refer to the Supplementary Guidelines for HSS Applications

5. Key Relevant Health and Health System Statistics

- *Please use the tables below to provide information on vaccines currently used by the Immunisation Programme as well as on any vaccines planned for future use.*
- *In the textbox below the tables please provide the most recent statistics for the key health, immunisation, and health system indicators by referring to the most recent EPI Review, Health Sector Review or DHS. Please also attach the source document.*
- *If there is an existing coverage improvement plan / equity analysis and action plan, whether supported by Gavi, please list key findings/recommendations*
- *Where possible, data on the key statistics should be presented showing: rates for early marriage, maternal and infant mortality, vaccine coverage by wealth quintile differences, and coverage disaggregated by sex. Data on vaccine coverage by maternal education should also be included if available.*
- *If available, disaggregated data for the key statistics indicators showing differences by geographic location (region / province) and urban / rural should also be included in the space provided after the table.*
- *If relevant, please include information on the impact on the health system of refugee or internally displaced populations, whether due to natural disaster or conflict.*
- *Please include activities related to addressing equity issues or particular populations such as IDPs in sections 11 (Objectives of the Proposal) and 12 (Description of Activities).*

Vaccines Currently Used by the Immunisation Programme

Vaccine	**Year of introduction**	**Comments** (including planned product switches, wastage etc.)
BCG, Measles, dT and OPV and DPT	*1984*	
Switch dT to TT	*1989*	
Switch DPT to tetra vaccine (DPT-HepB)	*2006*	
Switch Tetra to Penta (DPT-Hep B Hib)	*2009*	
Hep B birth dose	*2013*	
Pneumococcal Vaccine	*2013*	

Vaccines Planned for Future Use by the Immunisation Programme

Note: This section should include any future vaccines currently under consideration by the country and does not represent a commitment by the country to introduce the vaccines listed below.

Vaccine	**Month / Year of Introduction**	**Comments** (including planned product switches, wastage etc.)	**Plan for vaccine introduction taken into account in HSS application? If not, why not?** (Requirements for cold chain, human resources etc)
IPV	*Sep 2015*	*GAVI VIG been granted and preparation has been made..*	
Switch tOPV to bOPV	*March 2016*	*Switch plan has been prepared.*	*Under the HSS3 cold chain and human resources considered.*
Switch from Measles to MR	*2017*	*It is planned as per cMYP*	*Under the HSS3 cold chain and human resources considered.*
Rota	*2018*	*It is planned as per cMYP*	*Under the HSS3 cold chain and human resources considered.*

Please use the space below to provide: Further disaggregation of the data provided in the supporting documentation. This data will be used to illustrate equity differences by geographic location and urban/rural.

In 2015, the total estimated population of Afghanistan is 31.5 million (UNIDATA),[26] of which about 48% are under 15 years of age.[27] Nearly **36.5% of the country's population lives below the poverty line**; more in rural areas (38%) than in urban areas (29%), and **worst among Kuchis (54%), who are the nomads comprising about 6% of the population.[17]** The high proportion of dependents and migrant population increases the vulnerability of poor households to the lack of maternal and child health services. The regional gap is also significant with 51% living below poverty line in Northeast as compared to 28% in the Southwest.[17] A mapping exercise conducted in 2015 by MoPH revealed that there are still 2,878 villages with an estimated population of **2.6 million (8% of the total population) that do not have access to public health facilities.[28]** The security situation remains another challenge affecting access to children and quality of vaccination campaigns, particularly in high risk and insecure provinces. Also Afghan families are very sensitive about privacy and family matters. Generally, men have the right to make decisions that control female behaviour which is done to preserve male prestige and family honour.

The literacy rate is estimated at 17% for females and 45% for males with high discrepancy between rural (25%) and urban areas (54%), and 7.2% for Kuchis.[17] Literacy rates for women differ greatly among the provinces with 31% in Kabul, 19% in Balkh, and merely 1% in Helmand, Kandahar, and Uruzgan.

Regarding health statistics, the Afghan MICS in 2011 measured **Infant Mortality Rate (IMR) at 74 deaths per 1000 live births and Under 5 Mortality Rate (U5MR) at 102 deaths per 1000 live births**.[29] The IMR was high among rural families (76 versus 63/1000 live births in urban areas), poorest quintile (75 versus 62/1000 in richest quintile) and illiterate mothers (74 versus 55/1000 live births among mothers with secondary education).[19] The poor situation of health indicators was also reflected in analysis of vaccination coverages. According to the National Immunization Coverage Survey Afghanistan (CES) 2013**, Penta-3 coverage was 59.7%.[30]** Significantly, there was a 30 point gap between the survey data and the EPI administrative data which reported Penta-3 coverage as 89%. Penta3 coverage among Kuchis was estimated at 22% in 2012 compared to 16% DPT3 coverage in 2008.

The findings of CES 2013 also reveal that the proportion of **fully immunized children ranged from merely 2.5% in Farah province** to 86.8% in Paktia province. In only 4 provinces, proportion of fully immunized children was above 80% whereas 13 provinces were found below that national coverage of 51%.[20] The findings of the survey also reveal that there exists a **wide gap (22%) of vaccine coverage between poor and rich households**. Residence in rural areas increases the chances of not getting vaccinated. The proportion of fully vaccinated children in rural areas (49%) was significantly lower when compared to the urban areas (61.8%). A major area of concern is that 18.3% children never received a vaccination shot. Similarly, for TT coverage, at the time of delivery of the youngest child, 58.6% of mothers and their newborns were protected against Tetanus, but about **19.5% of women had never received TT** vaccination – worse among poorest compared to wealthiest quintile (29.1% vs 13.9%); among non-educated compared to some education (22% vs 8%); and among rural compared to urban mothers (20% vs 14%).

A substantial proportion of children drop out before they become due for next dose of an antigen.[31] On average, **15% children are lost between Penta-1 and Penta-3.** This proportion further increases to 30% before receiving Measles-1, and even further between Measles-1 and Measles-2. The drop-out rate indicates the inability of the EPI to follow-up and protect the cohort of children initially reached. In the "Reach Every District" (RED) strategy, it is used as an indicator of "utilization" of services, related to the demand for services. In this sense, Penta-1 is an indication of "access," while reducing the drop-out rate is an indication of "demand generation."

High levels of poverty, large size of dependent population, big number of nomads, poor female literacy rates, sensitive cultural practices and widespread insecure areas point towards difficulties and obstacles that the health program managers and implementers have to face in planning, service delivery, demand generation and social mobilization for health service delivery, in general, and immunization, in particular. These gaps are the key areas to be addressed in order to achieve effective and efficient vaccine coverage and outcomes.

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[26] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015. "Lack of accurate information on the size of the population is a key problem in health planning and management." (p. 6) CSO estimate for January 2013 was 26.01 million while UNIDATA was 30.75 million. NEPI and partners have agreed to use UNIDATA, but it highlights the importance of micro-planning at the service delivery level for accurate estimation of program targets.

[27] A#25: Afg Central Statistics Organization (CSO) and ICON-Institute. National Risk and Vulnerability Assessment (NRVA) 2011-12: Afghanistan Living Conditions Survey. Kabul, 2014.

[28] A#22: Mobile Immunization for White Areas: List of target districts and population.

[29] A#30: Central Statistics Org (CSO) and UNICEF. Afghanistan Multiple Indicator Cluster Survey (MICS) 2010-2011: Final 2012.

[30] A#24: UNICEF, CSO, NEPI- MoPH. National Immunization Coverage Survey Afghanistan 2013, also called NEPI Coverage Evaluation Survey (CES) 2013, April 2014.

[31] Dropout cases refer to the children/women who have initially received at least one dose of any antigen and then failed to receive the next doses to get them fully immunized. (National Immunization Coverage Survey 2013, page 13)

6. Description of the National Health Sector

This section will provide Gavi with the country context which will serve as background information during the review of the HSS proposal.

- ➔ *Please provide a concise overview of the national health sector, covering both the public and private sectors, including CSOs, at national, sub-national and community levels, with reference to NHP or other key documents.*
- ➔ *Please include a copy of the National Health Strategy/Plan as Attachment 5. If the NHP is in draft format please provide details of the process and timeline for finalising it. If there is not an NHP, or if other documents are referenced in this section, please provide these other key relevant documents.*

It is recommended that applicants refer to Gavi's health system strengthening grant categories detailed in the Supplementary Guidelines for HSS Applications (Table 1). Please refer to the list of health sector aspects in the Supplementary HSS Guidelines and if any are not included in your reference documents then please provide a short commentary. In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, and provide reference to the relevant section in the National Health Plan for further detail.

The core values of the Health Sector, such as equity, quality, transparency, and community participation, are expressed in the National Health and Nutrition Policy (NHNP) 2012-2020 and have guided the development of the health sector at least since 2003. The objectives and strategies of the cMYP 2015-2019 are firmly aligned with the NHNP 2012-2020, promoting strategies to increase equitable access to quality health services; enhancing use of data for improvement; strengthening the stewardship role of MoPH and governance in the health sector; and supporting health promotion and community empowerment. This proposal to Gavi is based on, and in alignment with, the existing cMYP 2015-2019 and the NHNP 2012-2020, and will be subsumed in the new health sector strategic plan for 2016-2020. The below subsections provide a summary picture of National Health Sector, referring to major documents, to provide the background and context relevant to our proposal.

Service Delivery in the Afghan Health Sector is characterized by cooperation between the MoPH and not-for-profit Non-Governmental Organizations (NGOs) as well as other Civil Society Organizations (CSOs). Since 2003, the **Basic Package of Health Services (BPHS)** has formed the basis for delivery of primary health care (PHC), focusing on improving equitable access, especially in rural areas, and the **Essential Package of Hospital Services (EPHS)** was added in 2005 to define secondary care at Provincial Hospitals. The BPHS and the EPHS define the services that should be provided by each type of facility and specify the staff, equipment, diagnostics, and medications required to provide those services.[32] Funds from major donors - USAID, World Bank, and EU - support contracting arrangements for BPHS and EPHS implementers who are held accountable for measurable outcomes through independent evaluations by international organizations.

Currently, primary health care services are delivered at 405 Comprehensive Health Centers (CHC), 821 Basic Health Centers (BHC), and 537 Health Sub-Centers (HSC), and secondary health services at 87 District Hospitals (DH), as defined by BPHS, contracted out to NGOs in 31 provinces, and covered in 3 provinces by MoPH, while EPHS-defined secondary health care is delivered at 15 Provincial Hospitals, also contracted out to NGOs. Other public secondary and tertiary hospitals, managed by MoPH, include 13 Provincial Hospitals, not under EPHS, and 6 Regional Hospitals, located in provincial capitals, as well as 26 national and specialist hospitals located in Kabul. All of the above-mentioned facilities are providing immunization services except for HSCs, of which only 88 are currently delivering some level of EPI services.[33]

With GAVI HSS1 support, the MOPH further improved geographic equity of access to services by adding definitions for Health Sub-Centers (HSCs) and Mobile Health Teams (MHTs) to the BPHS and establishing 121 HSCs and 26 MHTs to serve the under-served communities.[34] Since then, other donors have joined GAVI and increased the number of HSCs and MHTs, and most of them are now contracted out within the BPHS grants.

The continuously moving Kuchi (nomad) population present another challenge in providing equitable access to health services. Under HSS2, 15 MHTs were established to serve the Kuchi population in 2013. Insecure areas are a third challenge in providing equitable access to services. In 2011, MoPH successfully piloted

[32] A#43: A Basic Package of Health Services for Afghanistan, 2010/ 1389.

[33] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015. p. 22.

[34] A#21: Governance Institute Afghanistan (GI-A). Evaluation of the Gavi Alliance Funded Health System Strengthening Program, Afghanistan (Dec 2007 – Dec 2012), Survey conducted Aug 11 – Oct 31, 2013. Report published May 04, 2014.

the involvement of the 'for-profit' private sector in providing EPI and other healthcare services in insecure areas under HSS1, expanding with HSS2 support to directly operate in six provinces. In view of lessons learned, MOPH has drafted new and concrete guidelines for supervision, data collection, and monitoring to improve the effectiveness of the PPP arrangements; see PPP Guidelines in annexes.[35]

Outside of the public sector and PPPs, the for-profit private sector provides more than half of health services in the country and consists of physicians, traditional practitioners, private laboratories, drug stores, clinics and hospitals. Improved data collection on the performance and quality of services in the private sector and improved regulation of the private sector are goals of the MOPH.

Workforce and Human Resources: Based on Afghanistan national health workforce plan (2012-2016)[36] Afghanistan has only 7.26 doctors, nurses and midwives (combined) per 10,000 population, falling below the WHO threshold of 23/10,000 necessary to deliver essential maternal and child health services. In addition, the health sector workforce continues to face geographic, gender, and skills-mix imbalances as discussed in cMYP 2015-2019.[37] The BPHS definitions and their contracting arrangements are aiming to improve the number of female health workers and availability of services in rural areas. Furthermore, initiatives by other partners have introduced training programs for community midwives and community nurses, which are gradually improving the gender balance. Although vaccinators are still in male to female ratio of 3:1, other cadres mentioned have also been trained on EPI and this proposal aims to train more female vaccinators to address this issue. *Please see section on Community below for discussion of role of CHWs.*

To maintain quality, the HR Department of MoPH requires certification from a recognized training institution for recruitment against different cadres of staff, but after the time of induction in service, appointments and relocations are often influenced by politicians or exigencies in the field. To counter this trend and to reduce turn-over of trained vaccinators, quarterly monitoring of BPHS facilities includes points for having female staff and trained vaccinators in place. The GCMU has also taken steps to increase support for the cadre of vaccinators and for their outreach services in 2014 in the negotiated contracts with BPHS implementers.[28]

HR quality initiatives have also piloted 'performance-based incentive' systems. Please see Attachment 26[38] for a discussion of two ongoing pilot studies.

Procurement and Supply Chain Management System: The particular procurement procedures through MoPH for this grant are described in the A#41 Procurement Guidelines folder and in A#36 the HSS Implementation Manual.[39] Procurement of vaccines and cold chain are managed by UNICEF under the UN procurement procedures, and cold chain equipment is strictly limited to equipment pre-qualified by WHO through the Performance Quality and Safety (PQS) programme. Information on distribution of vaccines is covered in the Effective Vaccine Management (EVM) assessment.[40] NIP has installed a Vaccine Logistics Management Information System (vLMIS) to track vaccines and equipment and improve MoPH stewardship of vaccine and cold chain supplies; training of cold chain managers and vaccine logisticians is critical. [28]

Non-cold-chain commodities and construction of cold rooms and warehouses are managed by MoPH Procurement Directorate according to the detailed procurement plan and implementation arrangement in line with the Effective Vaccine Management (EVM), Vaccine Storage Capacity analysis, and Cold Chain Inventory attached. [41]

Health Information Systems (HIS): Important components of HIS for the NIP[42] include the Routine EPI Database, collecting immunization records from HFs, entering at district level and transmitting for analysis to provincial and national levels; Health Management Information System (HMIS), which is a passive surveillance system that collects information on monthly or quarterly basis from the HFs throughout the country; the Disease Early Warning System (DEWS), EPI and AFP surveillance systems which are active and passive sentinel site case-based systems, supported by Central Public Health Laboratory (CPHL); the National Monitoring Checklist implemented by MOPH M&E Directorate and PEMT, visiting HFs in each province about four times a year since launching in 2011 with support from HSS1; and Balanced Score Card, which is a National Health Services

[35] A# 33: MoPH, Afg. Implementation Guideline Package for the PPP Program in Afghanistan.
[36] A#53: Afghanistan National Health Workforce Plan (2012-2016)
[37] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015.
[38] A#26: Result-Based Financing Intervention in BPHS Facilities and Hospitals in Afghanistan: Operations Manual, 2009.
[39] A#36: Policy, Planning &IA Directorate, MoPH. Health System Strengthening Grants Implementation Manual, April 2015.
[40] A#12: EVM Assessment Afghanistan, 8 Dec -25 [0]Dec 2014: Findings and Recommendations of the Assessment.
[41] A#31: Cold Chain evaluations and information (folder)
[42] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015.(pp. 54, 91)

Performance Assessment (NHSPA) conducted annually using a stratified random sample of all HFs providing BPHS and EPHS. The MoPH has established a 'common database' through which other departmental databases (M&E database, HMIS, DEWS, EPI database, HR database and procurement database) interact with the core system. Based on the MoPH new leadership, M&E, Surveillance and Research Directorates and HMIS Department will come under one umbrella, the HIS General Directorate, in order to streamline data entry, analysis and use as well as data quality. Please see also the M&E National Plan 2016-2019.[43]

The data quality of the Routine EPI database is poor and has suffered from past lack of monitoring and lack of timely use of data as information for action in the field. New efforts of MoPH to improve data use and data quality and to bring increased M&E visits to the periphery should have an impact on data quality, including this proposal for introducing the Reach Every District (RED) strategy to PHOs, DHOs and HFs. NIP has planned to have immunization coverage measured in a household survey at least every two years, and the quarterly EPI Review and annual NIP program reports will serve to improve coordination, guide implementation, reinforce monitoring and improve stewardship of the program. At the same time, a separate DQ improvement plan will be developed as outlined in the CTA document to address coordination of data sources through HMIS and the several parallel surveillance programs, with funding of about $2.3 million available from HSS2.

Community and Other Local Actors: As mentioned above, NGOs and CSOs play an important role in service delivery through BPHS, EPHS, and in insecure areas through PPP. Also Community Health Workers (CHWs) are volunteers who have a defined role in the BPHS to link HFs to the community and advocate for utilization of health services such as skilled birth attendance and immunization, and they have a role in community level management of childhood illnesses since training provided by HSS1. This proposal aims to improve immunization coverage by enlisting CHW assistance with population assessment and micro-planning.

The Health Promotion Department of MoPH has the lead for all promotional activities of the Ministry, ensuring coordination of the work of the EPI Communication Officer with the IEC for other health programs Traditionally, the MoPH HPD has focused on visuals in posters to convey meaning to the illiterate population and on radio and TV spots for rural and urban populations, respectively. However, recent surveys of the caregivers indicate low awareness of the need for vaccination and preference for interpersonal communication (IPC). HPD intends to develop new materials to be used by religious and other community leaders for demand generation.

Legal, Policy and Regulatory Environments: Based on Article 52 of the Constitution of Afghanistan 2004 stating that 'the state shall provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens in accordance with the provisions the law,' maternal and child health services, including immunization, will always be exempt from payment. While NGOs are the implementing public health care providers, the MoPH assumes the role of stewardship and governance responsible for policy and strategy formulation in addition to regulation, coordination, health financing, monitoring, evaluation and accreditation. To improve stewardship, MoPH has **decentralized** the responsibility of managing EPI activities, so that NGOs are responsible under BPHS (31 provinces), PHDs under MoPH-SM (3 provinces), and CSOs in insecure areas (districts in 6 provinces). Although the monitoring through M&E Department has been centralized, this proposal intends to re-direct funds to provincial and district levels to support M&E travel and increase de-centralized monitoring.

Due to the many stakeholders, tiers, and types of involvement, **coordination** is of vital importance to proper management of NIP. In the cMYP, MoPH is committed to organize quarterly coordination meetings between National EPI, GCMU, BPHS/EPHS NGOs and CSOs, to publish regular NIP progress reports, and to regularize the meetings of PPHCC at provincial level and HSS-SC in national level for coordinated oversight of NIP and HSS. CSO representatives have also participated in the development of the Gavi HSS proposals.

Health and Community Systems Financing: The latest report on National Health Accounts (2012-13)[44] indicates that the Total Health Expenditure (THE) per capita is USD 55.59, out of which 73.3% (USD 41) is Out-Of-Pocket (OOP) whereas the central government's contribution is only 5.6% and the rest of THE is financed by the international community. The expenditure under NIP was mainly incurred on payment of government's share under co-financing of GAVI-supported vaccines. In the health sector, the execution rate for operating budget and development budget were 90% and 74.7%, respectively. The high execution rate was attributable to program management, effective program implementation by CSOs and counterparts, timely access to program funds and M&E systems which were able to assess implementation and respond to constraints as identified.[45]

It is quite evident that the Afghan health system is being operated under a mix of service delivery models in

[43] A#9: M&E Directorate, MoPH, Afg. M & E National Plan, 2012-2020, Updated May 2015.

[44] A#54: MoPH (2013) Afghanistan National Health Accounts with Subaccounts for Reproductive Health 2011–2012

[45] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015. (p. 29)

which the MoPH is responsible for policy making, stewardship, monitoring and supervision, whereas, to a large extent, delivery of basic and hospital-based services is executed through the NGOs. Innovative approaches like Public Private Partnership, increasing involvement of CHWs, improving M&E capacity, and supporting HSCs and MHTs where EPI services can be provided in integrated manner with other primary health care services were pilot tested and will be scaled up in provinces where immunization coverage is very low.
THREE PAGES MAXIMUM

7. National Health Strategy and Joint Assessment of National Health Strategy (JANS)

This section will be used to determine how immunisation is addressed in the national health plan, and what the key findings of an independent JANS of the strategy were. The Independent Review Committee (IRC) will use the findings of a JANS to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.

- ➔ *Please provide a reference to the relevant sections and pages in the NHP which outline immunization policies, objectives, and activities.*
- ➔ *If a JANS has been conducted, please provide the JANS report as an attachment.*
- ➔ *Please provide a summary of how the government and partners have addressed the weaknesses and recommendations identified in the JANS or attach the country's response.*

This proposal is developed based on the National Health and Nutrition Policy (NHNP) 2012-2020, the cMYP 2015-2019, National EPI strategy 2015-2020, and the Country Tailored Approach document which was agreed with in country partners and the GAVI Alliance. The National Health Policy was developed in 2012 by consensus with all health sector partners including donor agencies, relevant UN organizations, technical partners, and private sector representatives as well as designated MoPH departments, programs at central, provincial and district levels and communities through an inclusive process.

The NHNP 2012-2020[46] policy directions highlight immunization as a country level priority. In particular, the NHNP policy direction 3.4.4 focuses on immunization as to "Ensure delivery of safe, effective, reliable and free services of Expanded Program on Immunization (EPI) for all eligible target groups and assure the people of Afghanistan protection from morbidity and mortality due to vaccine preventable diseases".

In addition, the NHNP 2020's Policy Direction 3.3.1 (page 16) emphasizes that the MoPH's highest priority is to strengthen human resource management and development to provide a well-trained and capable workforce to serve all of the nation's population, particularly women and girls in hard-to-reach areas. Additionally, NHNP Policy Direction 3.4.20 (page 21) seeks to "Recognize the role of community-based health care (CBHC) as the foundation of prevention and health promotion, strengthen and expand the CBHC program to ensure community participation and develop partnerships between community and health facility staff, and provide appropriate quality care by community-based providers".

Due to traditional and cultural limitation especially in rural areas, utilization of health services including immunization is low. The areas targeted in this proposal are in line with the NHNP and include emphasis on local recruitment and training of female vaccinators, expansion of immunization services through further involving CSOs at community level, awareness raising utilizing inter-sectoral community resources, and so on.

The NEPI strategy 2015-20[47] is developed based on National Policy Priorities. It emphasizes the critical importance of expanding the quantity, distribution and effectiveness of service delivery points, increasing the number of female peripheral health staff, improving service delivery support and supervision, and upgrading the quality and utilization of relevant data to enable improved program management and evidence-based decision-making, with the aim to achieve and sustain high coverage of childhood immunization of all antigens among children under one-year old and TT2+ among pregnant and child-bearing-age women. In addition, the country is planning to develop a strategic plan for the health sector which will be in line with the NHNP with the special

[46] A#8a: MoPH Afg. National Health and Nutrition Policy 2012-2020, Sept 2012.(pp. 16, 21)
[47] A#48: MoPH, Afg. Expanded Programme on Immunization Strategy, 2015-2020, Jan 2015.

attention to improve immunization. Therefore, the planned strategy will encompass the cMYP and NEPI strategy.

The Country Tailored Approach (CTA)[48] has been developed to address context-specific challenges in Afghanistan. Key interventions outlined in this document have been used to develop this proposal, including expansion of immunization services, improving cold chain, awareness raising, and capacity building. However, some areas of CTA such as improving the data quality will be addressed apart from this HSS proposal through a specific proposal which will be funded under the CTA and some other areas will be addressed by other partners, for instance, development of EPI communication strategy by UNICEF. ***ONE PAGE MAXIMUM***

8. Monitoring and Evaluation Plan for the National Health Plan

This section will provide background information on how the country organises M&E arrangements and whether this proposal is aligned and complementary to national M&E plans.

- ➔ *Please attach a copy of the M&E Plan for the national health plan.*
- ➔ *Please provide a summary of how the National M&E Plan is implemented in practice. In your answer refer to relevant sections of the M&E Plan in the national health plan for further details.*
- ➔ *Please attach a copy of data quality assessment report(s) conducted within the last 5 years and data quality improvement plans.*
- ➔ *Please provide a description of how development partners are involved in the M&E of the national health plan implementation and financing. Is there a Joint Annual Health Sector Review (JAR) and if so how and when are they are conducted? Please outline the extent of Gavi involvement in the JAR process.*
- ➔ *Please explain how immunisation programme reviews are linked to the JAR, and if they are not linked currently, what will be done to establish linkages.*

The NHNP (2012-2020),[49] under Resource Creation 3.3.5., establishes the national policy to "Expand health information systems to the entire breadth of priority health programs in public and private sectors and promote, support, facilitate and participate in health-related information generation." In addition, the section 3.1.2 of NHNP emphasizes on building the institutional capacity of MoPH in different dimensions including monitoring and evaluation.

The NHNP (2012-2020) defines key indicators and sets targets to be achieved by the end of 2020 in the Performance Measurement Framework pp.21. In alignment with NHNP, the MoPH Monitoring and Evaluation Plan (2012-2020)[50] has been developed which provides an annual breakdown of for the set targets with defined data sources and definitions. The Plan has been updated with the recent data for Penta 3 coverage through Immunization Coverage Survey-2013.

The indicators and targets within MoPH M&E Plan and other programmatic areas of the MoPH, will be monitored using several agreed platforms. Based on the national M&E Plan, this monitoring takes place at three levels, central level, provincial level and district levels, pp. 9-10. The means used for monitoring are the HMIS, Disease Early Warning System (DEWS), programmatic routine reports, field visits using the National Monitoring Checklist, third party health facility assessments such as Balanced Scorecard, specific evaluations and research studies, household surveys including Mortality Studies, National Risk and Vulnerability Assessments (NRVAs), Multi Indicator Cluster Surveys (MICS), Health Surveys, and Immunization Coverage Surveys. pp.10-12.

The national HMIS collects standardized monthly information from almost all public sector health facilities, compiles reported data, conducts decision-oriented analyses and disseminates timely feedback. The MoPH has established a 'common database' through which other departmental databases (M&E database, DEWS, EPI database, HR database and procurement database) interact with HMIS. However, the multiple information

[48] A#35: Gavi Secretariat and MoPH. Afghanistan Country-Tailored Approach (CTA), draft, 19 May 2015, with Annexes A-E.
[49] A#8a: MoPH Afg. National Health and Nutrition Policy (NHNP) 2012-2020, Sept 2012.
[50] A#9: M&E Directorate, MoPH, Afg. M & E National Plan, 2012-2020, Updated May 2015.

systems operating as per the reporting requirements of various health programs including EPI are not adequately integrated at the service delivery level and during data transmission.[51] To set the targets at grassroots levels, the Catchment Area Annual Census (CAAC) is implemented nationally by local staff to determine the number of people, by age and gender that require health services within the catchment area of public health facilities.

The MoPH new leadership (2015), as one of the first steps, established a General Directorate called the HIS. The sub departments will be responsible to plan and coordinate all M&E related issues within and outside MoPH with relevant stakeholders. Also there are plans to integrate data collection systems and collaborate with the establishment of a vital registration system.

All the partners are supporting the National M&E plan. For instance, the WB is supporting the Annual Health Facility Assessments and Balanced Scorecard and also some household surveys. USAID, UNICEF, WHO, GAVI, Global Fund are similarly financing and supporting some elements within the plan i.e. HMIS, surveys, evaluations, and so on. In particular, USAID has supported AMS 2010, GAVI has provided TA to M&E department and BPHS gap analysis; and UNICEF and WHO supported the Immunization Coverage Survey. In addition, because of data quality problems, GAVI has pledged $2.3M to improve data quality in the upcoming four years (2016-2019), for which Afghanistan is developing a data quality improvement proposal which will be finalized through a high level panel review in Oct 2015.

Although there have been no Joint Annual Health Sector Reviews (JAR), a committee called Strategic Steering Committee has been established and, since 2013, three meetings have been held with limited scope. The new leadership of MoPH is planning to initiate annual Health Sector Reviews in December each year through an inclusive process with wider scope that encompasses all programmatic areas including immunization.***ONE PAGE MAXIMUM***

9. Health System Bottlenecks to Achieving Immunisation Outcomes

This section will be used to understand the main bottlenecks affecting the health system performance. The analysis here underpins the application, ensuring the proposed activities are designed to address the bottlenecks.

- ➔ *Please describe key health and immunisation system bottlenecks at national, sub-national and community levels preventing your country from improving immunisation outcomes. Consider constraints to providing services to specific population groups, such as the hard to reach, marginalised or otherwise disadvantaged populations.*
- ➔ *In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, providing a reference to the relevant section in the National Health Plan for further detail.*
- ➔ *Please describe any gender and equity related bottlenecks to access to immunisation.*
- ➔ *Please reference the analytical work that led to identification of the bottlenecks.*
- ➔ *Describe the bottlenecks identified in any new and underused vaccine proposals submitted to Gavi, the National Health Plan, and any recent health sector assessments such as the Effective Vaccine Management (EVM) assessment or Post Introduction Evaluation (PIE).*
- ➔ *Which of the above specified bottlenecks will be addressed by the current proposal? Which bottlenecks are addressed by other national or externally supported programmes? Please refer to section 13 on the results chain to highlight linkages between bottlenecks identified and objectives and immunisation outcomes.*

In order to keep this section concise, please summarise the key bottlenecks and provide references to the relevant sections in existing bottleneck analyses. Please ensure the referenced analyses are provided as attachments.

Despite improvements in the health outcome indicators over the past decade, the health system still faces a number of challenges. The NHNP 2012-20[52] clearly recognizes these challenges that include: centralization of powers at MoPH with limited attention to the provincial level, weak coordination across the board, political influences, high out of pocket expenditures, low availability of skilled health workforce especially female HWs (especially Vaccinators), disintegrated information systems, limited used of data in planning and decision making, limited access to primary health care, poor security conditions, high levels of poverty, challenges in addressing gender and health equity issues, high burden of preventable MNCH morbidity and mortality, inadequate sanitation facilities and food hygiene practices, low female literacy and a significant proportion of constantly

[51] MoPH (2009) Afghanistan Comprehensive Health Information System Strategic Plan 2009-2013
http://moph.gov.af/Content/Media/Documents/StrategicPlan2009-20136122014103345971553325325.pdf
52 A#8: MoPH Afg. National Health and Nutrition Policy 2012-2020, Sept 2012. (pp. 7-11)

migrant population.

Within the broader health system, immunization-specific bottlenecks were identified more precisely in the SWOT analysis of cMYP 2015-19[53] which highlighted a list of bottlenecks that are cross-cutting in nature and are affecting all six-building blocks of the immunization system. They include multiple oversight structures with overlapping roles and responsibilities, irregular EPI progress reviews, inconsistencies in use of population statistics and number of districts between National EPI and other health programs, weak planning and monitoring processes, political leadership mainly focused on Polio eradication activities, low remuneration of vaccination staff, low proportion of female vaccinators with cultural and traditional barriers in recruiting female vaccinators, prolonged and cumbersome administrative procedure for releasing of funds for EPI supervisory staff, distribution of vaccines through non-refrigerated vehicles, inadequate storage capacity for new vaccines and other logistics in future, aging cold chain equipment, incomplete inventory and stocktaking, no use of innovative technologies for improving temperature and supply system monitoring and supervision, geographical landscape not suitable for maintaining a single warehouse for vaccine storage, entire population not covered under BPHS, low utilization of health sub-centres and mobile health clinics, large nomadic population, scattered population in rural areas, absence of feedback mechanism from national and provincial levels, data quality self-assessment not practiced, social and cultural barriers against immunization, misconception against vaccination and low female literacy.

In order to prioritize the key areas that can be addressed through an HSS focus, the SWOT analysis of cMYP was again critically reviewed and analysed during the National Gap Analysis Workshop[54] specifically organized for developing this proposal. Below mentioned are the issues which were prioritized for consideration under GAVI HSS3 support.

1. Low access to and coverage of immunization services

Equity in provision of care 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 can access a health facility within one hour walking distance.[55] Besides physical accessibility, female utilization of health services is inequitable due to issues of 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. Illustrating the challenges of access for the female population, the NRVA Survey 2011-12 revealed that coverage of one antenatal care visit is 78% among urban women, 46% among rural women, and 23% among Kuchi women.[56]

Findings of the EPI Coverage Survey[57] recorded the reasons why mothers do not take their children for vaccination, including: health facility was too far away (40%), security concerns (21%), absence of vaccinators (10%) and non-availability of a female vaccinators (9%). Due to the nature of the terrain in Afghanistan, where scattered populations live along narrow inaccessible valleys, MoPH has realized the need to expand BPHS with increased number of Health Sub-Centers and Mobile Health Teams, which were initiated within HSS1 in 2008. The cMYP 2015-2019 indicates that only 88 of the 547 HSCs provide immunization services, and, in the HSCs surveyed for the BPHS Gap Analysis[58] there were no female vaccinators. A mapping assessment of MoPH (2015) indicated that there are still uncovered 'white' areas comprised of 2,878 villages with an estimated population of 2.5 million (8% of total population).[59] Responding to the critical need to raise immunization coverage in these areas and to provide equitable services, this proposal will provide initial training to 400 existing vaccinators and refresher training to 626 additional vaccinators, **two-thirds of which is female**, and upgrade 310 HSCs with

[53] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015 (pp. 48-51)

[54] A#39: Minutes and Presentations, March 18, 2015, Gap Analysis Workshop

[55] A#8a: MoPH Afg. National Health and Nutrition Policy 2012-2020, Sept 2012.

56 A#25: Afg Central Statistics Organization (CSO) and ICON-Institute. National Risk and Vulnerability Assessment (NRVA) 2011-12: Afghanistan Living Conditions Survey. Kabul, 2014.(p. 91)

57 A#24: UNICEF, CSO, NEPI- MoPH. National Immunization Coverage Survey Afghanistan 2013, also called NEPI Coverage Evaluation Survey (CES) 2013, April 2014.

58 A#28: Apex2Consulting with CDC, Atlanta. Afghanistan BPHS Gap Analysis Survey, Feb-Mar 2015: Routine Immunization (EPI) Service Delivery, Preliminary Report. May 2015.

[59] A#22: List of target districts and population.

equipment and resources to provide immunization services.

The hostile security situation is widespread and is a major constraint facing health care delivery as it poses substantial risk to the public health workers and limits the movements of the beneficiaries, in particular women and children. Public Private Partnerships is one of the channels already tested in the previous GAVI grants to provide health services for insecure populations and is also planned to be continued in HSS3. *Please see Section 10.* Similarly, the continuously moving Kuchi (nomad) population of about 1.7 million[60] present another challenge in providing equitable access to health services, as they are one of the most disadvantaged populations in Afghanistan with highest rates of poverty and lowest rates of literacy and access to services. Under HSS2, 15 MHTs were established to provide basic healthcare along with immunizations to the Kuchi population in 2013[61], and it is proposed to continue this support under HSS3 until they are integrated into BPHS by the end of 2018. *Please see Section 10 for lessons learned.*

Discrepancy in data reporting and population statistics has remained a major problem in Afghanistan health sector. In order to improve immunization coverage, it is important to know the target population and the coverage achieved. Lack of accurate population figures has proved to be a chronic problem because the last census was conducted back in 1978 and a big confusion remains over the estimates and proxy figures used for estimation of population-based targets. Population benchmarks used by National EPI and BPHS implementers differ from each other and often result in confusion on reported coverages. In addition, the EPI Desk Review[62] has identified the absence of district level planning/micro-planning as a barrier to efficient use of resources and provision of effective immunization services in the country.

Some of the provinces and districts have overcome this problem for routine EPI after introducing the Reach Every District (RED) strategy in 2007, so the HSS3 grant proposes an evaluation of district-level strategies to introduce RED where it has not been implemented so far. Micro-planning is a critical component of RED Strategy that will help in setting a unified denominator for district planning. In addition to micro-planning, training on the RED strategy will re-invigorate outreach services, improve supportive supervision, and improve data management and accountability, thus helping to improve the provision of service and enhance the stewardship function of the MoPH.

2. Inadequate physical capacity, cold chain and vaccine logistics management system

A functional immunization program requires: 1) Uninterrupted supply of vaccines 2) Proper maintenance of cold chain and availability of other logistics, 3) Adequate cold space to accommodate the newer vaccine introductions and 4) Real time supply chain information system. In Afghanistan, the cold chain and transportation and storage of vaccines is continuously threatened by problems of difficult terrain, extreme weather conditions, poor security, and poor availability of power supply, especially in remote and hard to reach areas.[63] Furthermore, the current vaccine storage capacity cannot meet the demands for expansion of immunization service delivery centres under HSS3, aging of cold chain equipment requiring replacement, and introduction of newer vaccines including: Inactivated Polio Vaccine (IPV) in September 2015, Measles-Rubella (MR) in 2017 and Rotavirus (Rota) in 2018. Currently, to manage the supply, the central level has to distribute to provinces twice per quarter to have space to receive new supply, which is outside the standard distribution efficiency of three times per year. Eight provinces[64] do not have cold rooms as per standard protocols. Also under HSS2, construction was completed for only 11 out of 34 provincial warehouses needed for dry vaccine-related supplies. *Please see Section 10 for Lessons Learned*.

In the EVM report[65] overall scores of the assessment for all levels of the supply chain is 77% which demonstrates a need for improvement of the vaccine and supply management system and deterioration from the last assessment score (88% in 2011). In only three criteria (vaccine arrival, storage capacity and vaccine management

[60] NRVA 2011-2012 stated Kuchis were 1.459 million out of total population of 26.955. Adjusted to UNIDATA total population estimate of 31.5 million, used by cMYP, the estimate for Kuchis would be 1.7 million.

[61] Provinces where MHTs are functioning among Kuchi populations: Balkh, Faryab, Jawzjan, Ghazni, Samangan, Herat, Kabul, Kunduz, Nangarhar, Badakhshan, Kandahar, and Logar.

[62] A#51. WHO-EMRO, CDC-Atlanta. EPI Review Afghanistan, Aug 26- Sept 5, 2012.

[63] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015. (pp. 40-41)

[64] A#18: Number of Functional Cold Chain Equipment (CC inventory Aug 2014): Provinces lacking CC: Kabul, Logar, Zabul, Nooristan, Takhar, Baghlan, Jawzjan and Ghazni

[65] A#12: EVM Assessment Afghanistan, 8 Dec -25 Dec 2014: Findings and Recommendations of the Assessment.

practice) NIP reached or exceeded the WHO recommended minimum score of 80%. Performance levels of other criteria - vaccine storage temperature, building-equipment-transportation and distribution - were slightly less than 80%. However, stock management, maintenance and repair, and information system -supportive management functions were notably very weak with performance in each category less than 70%.

At present, the vaccines logistic management system is using traditional methods, primarily paper-based, for reporting and monitoring stocks and temperature levels, causing delays in timely reporting and accuracy of the data. This proposal aims to build the capacity of vaccine logisticians and cold chain management staff throughout the country to track vaccine supplies from national level to HF level using the latest technology and MIS, a 'real time' vaccine logistics stock management system; A# 31, 41 and 49 provides further details.

3. Lack of awareness and low demand for immunization

Lack of awareness and low demand for immunization remains a longstanding problem in Afghanistan. There are multiple factors on the demand side that are contributing to low immunization coverage in the country. The National Health & Nutrition Communication Strategy 2008-13[66] has previously identified the important underlying causes that are essential to be addressed for improving immunization coverage and decreasing morbidity and mortality due to vaccine preventable diseases: low awareness about importance of vaccination including TT and AFP symptoms, high drop out because side effects of vaccination are not explained, and misconception about injection, side effects and vaccines.

The findings of the National Immunization Coverage Survey 2013[67] revealed that 18.3% children never received any vaccine. The top five reasons for caretakers not vaccinating their children are place for vaccination being too far (40%), no faith in immunization (34%), unaware of the need for vaccination (33%), concerns about security (21%), and not being allowed to go to clinic without a male family member (Mahram) (21%). Other reasons highlighted were: fear of side effects (18%) and too busy to take the child for vaccination (12%).

. In order to generate demand for immunization, the MoPH Health Promotion Department will take into consideration the high illiteracy rate, especially in rural areas, which .decreases the effectiveness of many communication tools used to propagate health messages. The KAP survey conducted in 2013[68] showed the top three sources of information about child immunization for Afghan families were television, the health practitioner and the radio. The HPD, while ensuring coordination of IEC for NIP and other health programs, plans to use multiple communication channels with an emphasis on interpersonal communication (IPC) to educate the general population about benefits of immunization for women and children. In this proposal with support of UNICEF, IEC will involve religious leaders in order to build trust among people and remove the religious misconceptions regarding immunization and also educate the political leadership on importance of immunization.

Another channel of communication will use the innovative MOPH initiative called the Health Information Centre, located in Kabul hospital. Six health professionals including three females are available on the toll free number (166) to receive and respond to 300-350 mobile phone calls per day in two national languages during working hours- five week days. As one of the HSS3 activities, MoPH has planned the Mobile Alliance for Maternal Action (MAMA) project where it is planned to use the Centre to make active phone calls and provide timely information and reminders to mothers via mobile phones, including reminders for vaccination doses and key vaccination messages. This project has been implemented in over 70 countries with great results. HPD will also improve materials and pilot test them for IEC via radio and television. *Please see also Section 10, Lessons Learned.*

4. Weak governance and program management at national and sub-national levels

Being aware of the challenges of ethnic diversity, scattered population and nomads, insecurity, instability and mountainous areas at the periphery which can only be addressed through locally tailored solutions by capable provincial management structures, the MoPH is aiming to de-centralize monitoring and supervision to improve

[66] MoPH Afg. Strategic Plan for the Ministry of Public Health (2011-2015), May 2011.

[67] A#24: UNICEF, CSO, NEPI- MoPH. National Immunization Coverage Survey Afghanistan 2013, also called NEPI Coverage Evaluation Survey (CES) 2013, April 2014.

[68] A#52: MoPH, WHO, UNICEF, 2014. "Assessment of Knowledge, Attitudes and Practices of the communities regarding routine immunization in Afghanistan"

governance through effective M&E, which would further provide guidance and support for health care delivery all over the country. The Gap Analysis Workshop[69] recommended further de-centralization to the district level and suggested introducing the notion of "health district" around a DH, as a planning, management and monitoring unit. This proposal would introduce the RED strategy to build the capacity and participation of the PHOs and DHOs in planning and monitoring improvements in immunization coverage. Such de-centralization would make M&E more effective and sustainable by reducing travel costs incurred from the country's capital. Building district and provincial capacity would also address the findings from the Gap Analysis Workshop that insufficient capacity at the provincial level has led to dependence on the central ministry to perform governance, monitoring and supervisory functions.

In addition to de-centralization of M&E, this proposal would contribute to improving data use and evidence-based decision making, thus linking with the data quality improvement plan supported separately under the CTA.

The level of **data and evidence** used across the health sector by the MoPH has improved in some areas such as establishing a common HMIS database, but poor data quality in NIP has been clearly demonstrated by the large discrepancies between sources of coverage data. For example, the Immunization Coverage Survey 2013 reports Penta-3 coverage of 59.7%, which is substantially lower than the WHO/UNICEF estimate of 71 % and the administrative data reporting of 90% (2013). The discrepancy rate of more than 10% between the national coverage survey and WHO-UNICEF estimates validates the concerns about data quality issues which was also noted in the Comprehensive EPI Review (2012).[70]

This proposal aims to improve the estimation of target population by RED approach to micro-planning and monitoring by using data directly at the HF and district level. At the national level this proposal supports annual data quality self-assessment (DQS) and two rounds of EPI Coverage Survey to track the real improvements in EPI coverage as well as the quality of data. The improvement of health information management system and harmonization among BPHS and EPI baseline and reports with a micro-planning and country tailored approach are the key interventions to address these essential tasks. At the same time, a separate DQ improvement plan will be developed as outlined in the CTA document to address coordination of data sources through HMIS and the several parallel surveillance programs, with funding of about $2.3 million available from HSS2.

FOUR PAGES MAXIMUM

10. Lessons Learned and Past Experience

This description will highlight to Gavi how lesson-learning has been incorporated into the design of the activities. It will provide the evidence base that demonstrates that the proposed activities will be effective, and that implementing them will achieve the desired intermediate results and immunisation outcomes.

- ➔ *Please use the table in the proposal form to summarise the evidence base and/or lessons learned related to each of the objectives in the proposal. Applicants are asked to detail the lessons learned from relevant interventions specific to their country that were successful.*
- ➔ *In addition, please illustrate the challenges to successful implementation.*

**Where possible, please provide evidence of this learning by providing a reference or a web-link to a published document related to the specific interventions.*

[69] A#39: Minutes and Presentations from March 18, 2015, Gap Analysis Workshop
[70] A#51. WHO-EMRO, CDC-Atlanta. EPI Review Afghanistan, Aug 26- Sept 5, 2012.

Objective	Lessons learned, highlighting both successes and challenges; include any lessons learned from grant implementation
Objective 1: Enhance 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.	GAVI support has contributed to strengthening the health system and increasing immunization coverage through application of innovative approaches for improving access to quality health care services especially among underserved. The development of the current application is guided by the lessons learned from the implementation of ISS, NVS, HSS1, HSS2 and CSO support (Evaluations conducted are attached.[71],[72],[73],[74],[75]) In 2011, MoPH successfully piloted the involvement of the 'for-profit' private sector in EPI and other health services in insecure areas under 'GAVI Alliance CSO Support'.[65] This initiative was scaled up in 2013 under 'HSFP'[64] and private health providers (PHPs) were contracted through an open bidding process to increase the coverage of health services in six highly insecure provinces.[76] While this innovative approach contributed to decreased inequities in health and the reduction of child and maternal mortality in the communities, regular monitoring, reporting systems and supervisory processes were inadequate. This proposal aims to monitor health services in insecure areas by forming a community-based monitoring accountability system through closer involvement of CHWs, Community Health Supervisors (CHS), elders and religious leaders. The gaps in supervision and data reporting will be further addressed by clarifying the working definitions, forms and guidelines and improving training methodology for 180 PHPs.[66] Another important and innovative intervention under HSS2 support was to provide health services including immunization to the neglected 1.7 million nomadic Kuchi population by establishing 15 MHTs. Based on HMIS data this successful intervention resulted in increasing the Penta3 coverage among Kuchi population from 16% to 26% in program specific areas. To sustain the existing gains and further increase coverage, the current HSS3 application plans to continue this service delivery channel till June 2018 after which these MHTs will be absorbed by the MoPH as part of BPHS.
Objective 2: Strengthen 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	In the Post-Introduction Evaluation (2001) of Pentavalent vaccine,[63] the following gaps were identified: vaccine requirement is not forecasted by many of the health facilities, requisitions for vaccine supply are based on previous supplies rather than need-based, stock level of vaccines at health care facility level are not tracked, actions are not supported by data, and there is insufficient dry storage capacity at different levels. In this context, low scores were also reported in the EVM Report especially for stock management and information system functions. Therefore, under HSS3 the MoPH is proposing to establish the cold chain and vaccine logistics management dashboard and build capacity of the cold chain managers and logisticians to allow the 'real time' assessment of key supply chain indicators. Under, HSS2 support, it was planned to construct warehouses in all provinces for dry supply. However, later on, it was realized that the budget requirement, estimated well before designing and costing, was inadequate to cover all 34 provinces. Consequently,

[71] A#21: Governance Institute Afghanistan (Gi-A). Evaluation of the Gavi Alliance Funded Health System Strengthening Program, Afghanistan (Dec 2007 – Dec 2012), Survey conducted Aug 11 – Oct 31, 2013. Report published May 04, 2014.
[72] A#: 23. MoPH, Afg. Post-Introduction Evaluation of the Pentavalent Vaccine (2009) in Afghanistan**,** Nov 12-21, 2011.
[73] A# 27: HealthNet-TPO. Study Report: Evaluation Study (March 2013) Public- Private Partnership Program Uruzgan, final version, May 10, 2013.
[74] A# 32: Governance Institute Afghanistan (Gi-A). Mid-Term Evaluation CSO Support Type B Project, Partnership with Private for Profit Health Service Providers (PPHSP) Model in Afghanistan – Uruzgan and Farah Provinces. April 2011.
[75] A# 33: MoPH, Afg. Implementation Guideline Package for the PPP Program in Afghanistan. 2014.
[76] Insecure provinces where PPP is functioning: Uruzgan, Paktya, Kandahar, Nuristan, Farah and Hilmand.

	only 11 provincial warehouses could be constructed. After learning from this experience, with a proper design, unit cost, and accurate calculation of budget by WHO (A# 40), HSS3 support will cover the construction of the remaining 23 provincial warehouses for dry supply and 8 provincial vaccine stores. [77]
Objective 3: Improve demand for immunization services by implementing context specific communication interventions to cover the disadvantaged population	An abstract from the critical analysis presented in cMYP[78] highlights the importance of understanding local communities when aiming for demand generation. "*For example, pneumonia is a well-recognized life threatening disease in Afghanistan. Introduction of PCV-13 as prevention from pneumonia among children was highly appreciated by the local communities and a very large percentage of population, even above the recommended age group, insisted for PCV-13 vaccination. As a result, many of the health care facilities were forced to send urgent demands for PCV-13*". These findings were similar to the Penta Post-Introduction Evaluation Report 2011 which showed that even though health facility staff received sensitization materials, there was limited "launching" of dissemination of information, and mothers knew only that the vaccine is important but their knowledge regarding the diseases that Pentavalent vaccine prevents from was very limited.[79] Learning from these lessons, HSS3 application proposes to improve evidence-based IEC for the promotion of immunizations.
Objective 4: Strengthen management and leadership capacity of the decentralized health system at peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services	Under GAVI HSS2 support, institutionalizing the HSS-SC as sub group of HSCC provided a formal platform to bring together ICC, relevant departments of MoPH, line ministries in Afghanistan, donors and development partners, technical partners and CSOs.[80] It facilitated close coordination and succeeded in attracting considerable attention among all stakeholders to focus on strengthening the health system in a more harmonized manner, in contrast to the past where ICC and HSS-SC were working separately with minimal effective linkages. Establishment of this governance and coordination mechanism contributed significantly to strengthen the immunization system.[81] The GAVI HSS1 funds were utilized to strengthen the stewardship function of MoPH at district level through recruitment of District Health Officers (DHOs). Out of 250 DHOs recruited by MOPH, 153 were recruited with support from GAVI HSS1 funding. Once HSS1 was completed, they were absorbed within the formal organizational structure of MoPH with a role to monitor and supervise health care facilities. In addition, HSS1 funds were also used to train a National M&E Team comprising 35 people on the use of the National Monitoring Checklist. While this team had the potential to train the periphery, the initiative failed because there was no budget allocation for monitoring by DHOs and PHOs and because there was no system for submission of monitoring checklists from one level to another.[82] This limitation was overcome, an innovative approach, by developing the Geolocation Monitoring System (GLM) under GAVI HSS2 support.[83] Under the current proposal, GLM system (A# 56) will be more effectively used and also, the PHOs and DHOs will be provided necessary support for transport and perdiems. Strengthening of the M&E system at the subnational levels is expected to bring more feasibility because under the prevalent security threats it is difficult for the teams from central level to travel to far flung areas. In addition, it will make M&E more cost-effective by reducing the costs being incurred

[77] A#40: Construction Designs, Cost estimation, Specifications for Construction (folder)

[78] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015. (p. 48)

[79] A#: 23. MoPH, Afg. Post-Introduction Evaluation of the Pentavalent Vaccine (2009) in Afghanistan**,** Nov 12-21, 2011.

[80] A#13: Health System Strengthening - Steering Committee TOR, since 2007.

[81] A#21: Governance Institute Afghanistan (Gi-A). Evaluation of the Gavi Alliance Funded Health System Strengthening Program, Afghanistan (Dec 2007 – Dec 2012), Survey conducted Aug 11 – Oct 31, 2013. Report published May 04, 2014.

[82] A#21: Governance Institute Afghanistan (Gi-A). Evaluation of the Gavi Alliance Funded Health System Strengthening Program, Afghanistan (Dec 2007 – Dec 2012), Survey conducted Aug 11 – Oct 31, 2013. Report published May 04, 2014.

[83] A#56: Zwak Media Services. Proposal for Geo Location Monitoring System Development, March 2014.

	on travelling and security.
TWO PAGES MAXIMUM	

PART D - PROPOSAL DETAILS

For further instructions, please refer to the Supplementary Guidelines for HSS Applications

11. Objectives of the Proposal

This section will be used to assess whether the proposed objectives are relevant, appropriate and aligned with the National Health Plan and cMYP, and contribute to improving immunisation outcomes. It will also ensure alignment with the bottleneck analysis above.

➔ *Please succinctly describe the immunisation and HSS objectives to be addressed in this proposal and explain how they relate to, and contribute to, reducing HSS and immunisation bottlenecks (identified in section C.9 above) and strengthening of the health system. Please describe how these objectives are aligned with those in the national health plan.*

The objectives need to be aligned to and numbered in the same way in the HSS M&E Framework (Attachment 5) and also in the detailed Budget, Gap Analysis and Workplan Template (Attachment 6).

➔ *For each objective, please describe:*

a) Which immunisation outcomes will be improved by implementing the activities, and how will the activities contribute to their improvement? Please focus on the key activities related to each objective rather than every single activity. Please demonstrate this link in the next section on the results chain.

b) Whether and how the proposed objectives relate to the equity and gender related barriers to access as identified in the bottleneck analysis, and how the objectives will result in narrowing the equity gap in immunisation coverage and contribute to reaching the under reached, underserved and marginalised populations. Countries are requested to consider gender related and geographic barriers to access of immunisation and other health services.

➔ *Please list and describe all of the proposed activities in the Budget, Gap Analysis and Workplan Template. Please organise the activities accordingly by objective. If Gavi funding is requested to go into pooled funds, please attach the Annual Work Plan and Budget for the pooled fund and related TORs.*

➔ *If this Gavi HSS grant (either a portion or all of it) is proposed to be aligned with the World Bank's RBF programme or any other existing PBF programme in the country, then please attach the concept note or programme design document. Describe in this section which of the objectives of the grant are for the PBF/RBF programme and how the grant will be aligned.*

In line with the core values of the Health Sector, such as equity, quality, transparency, and community participation, as expressed in the NHNP 2012-2020, this proposal aims to strengthen routine immunization by scaling up service delivery, especially in underserved communities, through different strategies recommended in the cMYP to improve EPI coverage in children and women of child-bearing age. This proposal is based on, and in alignment with, the existing cMYP 2015-2019 and the NHNP 2012-2020, and will be **subsumed** in the new health sector strategic plan for 2016-2020. The objectives address key health and immunization system bottlenecks preventing the country from overcoming inequities and the plateau in immunization outcomes and aim to strengthen the performance of the health system. It is noted that the problems with data quality will be addressed in a parallel proposal under CTA.

Afghan health indicators show that populations with less access to health services are often those in rural or insecure areas, nomadic, and those in certain areas with rough mountainous terrain. Female access to services is also affected by their low literacy rates and the cultural constraints which may require attendance by female health care provider. This proposal supports HSCs and MHTs to increase access of the underserved. To ensure functioning of these and other HFs, regular monitoring with feedback and a secure cold chain are also vital components addressed in this proposal. Equitable female access is addressed by training more vaccinators and other female healthcare workers on vaccination as well as female-friendly IEC channels for demand generation. HFs will also be monitored for retention of female staff and trained vaccinators.

The six targeted immunization outcomes are DTP3 coverage, Measles coverage, Geographic equity of DTP3

coverage, Reduction of difference in DTP3 coverage between lowest and highest wealth quintile, Reduction of Drop-out rate between DTP1 and DTP3 coverage, and Coverage of fully immunised child.

Objective 1: Enhance the 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: The proposed comprehensive approach to increasing the number of EPI delivery points; improved micro-planning exercises; aggressive mobile outreach to isolated communities and nomadic populations; and provision of services through private health providers in insecure areas increases access of the population, especially the underserved, and should have a direct effect on immunization outcomes for both total coverage and equitable coverage of underserved groups. Continuing the interventions under HSS2 which provide health services to 4.2 million (1.7 million Kuchis (nomads) and about 2.5 million people living in insecure areas), it is here proposed to upgrade 310 HSCs to provide EPI services so that an additional 4.7 million (2.2 million by HSCs and 2.5 million by community-based outreach; A# 22) people would be covered, making a total of 8.9 million of the total population of Afghanistan. The expansion of health services, outreach, and improved planning will also support greater effectiveness of supplementary campaigns, including polio eradication, and a successful transition to new vaccine introductions.

Objective 2: Strengthen cold chain and vaccine logistics management system by increasing the physical capacity, maintenance, and effective vaccine management with the provision of adequate infrastructure and capacity building of staff involved in cold chain throughout the country to achieve sustainable access to quality supply. Without proper cold chain, there can be no successful immunization services, so it is important for all immunization outcomes. Achieving this objective will ensure an uninterrupted supply of vaccine and related logistics; proper maintenance of cold chain and adequate cold space to accommodate the newer vaccine introductions; and real time supply chain information as envisaged in the 3+1 Approach of interventions[84]. Expanded cold chain and dry storage space will support new vaccine introductions, including IPV in 2015, tOPV-to-bOPV switch in 2016, MR vaccine in 2017 and Rota vaccine in 2018. Increasing cold chain capacity and strengthening the Cold Chain Vaccine Logistics Management System (CCVLMS) is also necessary to support the expansion of immunization delivery points in objective 1 and will be a boost to the smooth implementation of supplemental immunization activities for measles elimination and polio eradication.

Objective 3: Improve demand for immunization services by implementing context specific communication interventions to cover the disadvantaged population. Appropriate and effective demand generation improves utilization of services that are already available and has a positive effect reducing the Drop-out Rate between Penta1 and Penta3 as well as increasing the number of children fully immunized. Activities under this objective will address the mistrust, misinformation and plain lack of information about the national immunization program. Evidence-based materials will be drafted and pilot tested and health personnel and frontline workers at all levels will be trained using the Appreciative Enquiry approach to develop and implement evidence-based communication plans that will increase awareness about the consequences of not immunizing children; build confidence in caregivers and service providers; and engage communities through interpersonal communication of community and religious leaders, CHWs and polio mobilization network.

Objective 4: Strengthen management and leadership capacity of the decentralized health system at peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services. This year marks the start of a newly elected Government, new Minister of Public Health, and a new EPI Program Manager. Support to the leadership and administration will pay off in a smooth transition and new opportunities to break old molds. The new Minister is keen on de-centralization which is a key for better supportive supervision and finding answers to stagnation in the improvement of immunization coverage and the outcomes specified above. It is envisaged that decentralized planning and monitoring through PHDs and strengthening their ability to monitor health services and establishing structured feedback will enhance the program management. Introducing the notion of "health district", as a planning, management and monitoring unit will help to improve the performance, the quality and the effectiveness of immunizations as well as the other access indicators for health care. It will enable the provincial and district health teams to re-program on a quarterly basis to achieve the planned targets. They will be able to identify the specific package components or geographical areas where performance is weak and explore the most appropriate solutions and provide the NGO- BPHS implementing agency with the right support to address the problems and challenges, including the introduction of standard procedures for planning, accounting and monitoring.

Data quality poses an added challenge to the program and is complicated by inadequate vital statistics,

[84] http://www.gavi.org/Library/Publications/GAVI-fact-sheets/Gavi-Supply-Chain-Strategy/

necessary integration of private sector data, large burden of disease, and weak links between data generation and utilization in decision-making. This proposal focuses on immunization-specific use of data and links with a separate parallel proposal developed in line with the CTA to address data quality and HR capacity of health management information strengthening.

This objective also includes advocacy for resource mobilization which will help establish financial sustainability of the immunization program by informing political and technical leadership about the importance of addressing the funding gap to improve morbidity and mortality due to vaccine preventable diseases and increasing the co-funding for EPI-specific costs under regular government budget.

TWO PAGES MAXIMUM

12. Description of Activities

This description will be used to assess if the proposed key activities will be sufficient to achieve the identified immunisation outcomes.

→ Please present a description of key activities organised according to the above specified objectives in the table below. Clearly explain how the proposed activity is linked to improving immunisation outcomes. Please ensure that activities described here are aligned with activities that are included in the Budget, Gap Analysis and Workplan Template.

→ Countries should demonstrate alignment between HSS grant activities and activities funded through other Gavi cash support, including vaccine introduction grants and operational support for campaigns.

Objective / Activity	**Explanation of link to improving immunisation outcomes**
Objective 1: Enhance equitable access and effective coverage of immunization services through integrated public health care system, private health sector-PPPs, and community participation with more focus on underserved population.	
Activity 1.1: Upgrading the 310 existing health sub-centres (HSCs) to EPI service delivery points.	This activity recruiting, refresher training and motivating 310 male and female vaccinators, preferable local residents, to work in newly established EPI fixed centres in HSCs, and also provide outreach services, thus adding EPI to the basic health services provided at the HSCs. [85] 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 because they consider "*EPI centre is too far away*". Furthermore, training female vaccinators, helps to address the gender inequities due to cultural constraints that discourage women from seeking health services from male health providers. Necessary cold chain equipment will be provided and, where other power options are unavailable, solar powered refrigerators will be installed. These HSCs will be sustained after integration within the next BPHS contracts at the end of 2018.
Activity 1.2: Establishing community-based outreach by vaccinators to 2878 villages.	This activity involves recruitment, refresher training, and motivating 158 EPI Teams (each comprising one male and one female vaccinators) from the local communities. These teams will organize and support outreach activities of RMNCH services from existing health care facilities to rural communities in 2878 villages that do not have access to immunization services (Attachment #22 lists the villages and criteria for inclusion).[86] These community-based EPI Team HSCs will be integrated within the next BPHS contracts at the end of 2018. This activity will improve vaccination coverage by reducing geographical, gender-based, social and cultural inaccessibility.
Activity 1.3: Continuing the 15 MHTs for nomadic (Kuchi) population which are established under HSS2.	This activity will continue support to 15 MHTs established in 12 targeted provinces under HSS2 and about 1200 volunteer Kuchi CHWs who have already been trained and will continue to coordinate immunization services with the MHTs designated for an estimated 1.7 million Kuchi population. The health providers on the MHTs will also have refresher training on BPHS to improve the quality and equitable access of nomads to other RMNCH services and contribute to polio eradication and measles elimination as well.
Activity 1.4: Continuing, scaling up and revising the PPP (CSO type B) project focused on the delivery of EPI and other	As mentioned in Lessons Learned, PPPs will be continued in six insecure provinces[87] with careful attention to supervision and reporting and an initiative for better monitoring through community-based monitoring accountability system with closer involvement of CHWs, CHSs, elders and religious leaders.[88] About 180 PPP health workers would be trained to improve the quality of the PPP provision of health services along with EPI. Existing private practitioners are

[85] Basic health services at HSCs include Integrated Management of Childhood Illnesses (IMCI), Essential Obstetric Care (EOC), mental health, HMIS, Rational Drug Use (RDU), and family planning.

[86] A#22: Mobile Immunization for White Areas: List of target districts and population.

[87] Insecure provinces where PPP is functioning: Uruzgan, Paktya, Kandahar, Nuristan, Farah and Hilmand Provinces.

[88] A# 33: MoPH, Afg. Implementation Guideline Package for the PPP Program in Afghanistan. 2014.

essential maternal and child health services in remote and insecure areas. .	leveraged to increase the equitable access and coverage of basic public health services in the insecure provinces, while the trust and influence of the private practitioners in the local community contributes to behaviour change and improved demand and utilization of services. Integrated delivery of RMNCH with EPI services is cost-efficient and benefits both maternal and child health outcomes. Each private facility would be linked to the nearest public health facility to provide supervisory support and the regular health and immunization supplies.
Activity 1.5: Supporting micro-planning through RED strategy using CHWs and BASIC tools to improve the immunization services.	This activity builds capacity of public health providers, DHOs, and PHOs towards the universal implementation of the Reach Every District (RED) strategy to strengthen immunization service and planning at district level, including detailed mapping, population assessment and micro-planning with the assistance of CHWs, defaulter tracing, data management, supportive supervision, and accountability. Micro-planning and defaulter tracing are imperative to reduce the drop-out rate and to improve the quality of coverage data.
Objective 2: Strengthen cold chain and vaccine logistics management system by increasing the physical capacity, maintenance and effective vaccine management with provision of adequate infrastructure throughout the country.	
Activity 2.1: Expansion of existing cold chain capacity for the intro of new vaccines and opening of new service delivery facilities	The expansion of total net cold storage capacity of EPI, from 245.5m³ to 575 m^3, by procurement and installation of cold rooms, ice-lined refrigerators, and deep freezers, as well as installation of solar refrigerators (in health facilities without other feasible power supply), is vital for the successful expansion in number of EPI delivery centres and introduction of newer vaccines and to meet criteria of standard efficient schedule of delivery of vaccines. Refrigerated vehicles will be procured to improve vaccine supply management system.
Activity 2. 2: Building capacity of the cold chain and vaccine logistics managers and establishing ppm and supportive supervision system	Training cold chain and vaccine logistics managers on the NCCVL-MIS and establishing the supply chain dashboard will improve timely evidence-based decisions on vaccine logistics to minimize the wastage of vaccines and distribute them where needed. Establishing a planned preventive maintenance system and supportive supervision visits for cold chain equipment minimizes the sickness rate of the equipment and improves sustainability of the program.
Activity 2. 3: Constructing vaccine and non-vaccine storage facilities	This activity is for construction of facilities to house the cold stores mentioned in Activity 2.1 and 23 warehouses needed to store dry immunization supplies at provincial and regional levels and for furnishing/ equipping the associated offices of EPI managers and logisticians.
Objective 3: Improve 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	It includes development of IEC materials and conducting seminars at district level to raise awareness about need for immunizations among 14,400 religious leaders. They are encouraged to disseminate these messages to disseminate to their communities with objectives of building trust in immunizations, removing misconceptions and improving demand for immunizations. They possess a key role in Afghani society and their position of great respect will help in creating demand for vaccination.
Activity 3.2: Implementing BCC activities through mass media, ICT and IPC.	It include enlisting broadcast media, supporting the Health Information Call Center, and building the capacity of frontline health workers and school teachers, as well as supporting CHWs other mobilizers with tools and advocacy materials for interpersonal communication (IPC).
Activity 3.3: Generating Evidence and Knowledge	Baseline, midline and end-line studies will ground the strategy in evidence and data and generate critical feedback and lessons learned for program improvement at different stages of implementation.
Objective 4: Strengthen 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.	Training and supporting PHOs, DHOs, and EPI supervisors to conduct supportive supervision based on the National Monitoring Checklist will keep the HFs under BPHS-implementing-NGOs on track in their coverage interventions and improving services. Piloting Geo-Location Monitoring System.
Activity 4.2 Conducting Periodic evaluations to ensure accountability for equity at district and provincial level.	The proposal will improve data quality by conducting a Data Quality Self-Assessment (DQS) each year, EPI coverage survey every two years, BPHS gap analysis every three years, and HSS grant end program evaluation. Involving the academia and third party expert agencies for conducting assessment and evaluations will yield the unbiased results to make evidence-based decisions for the improvement of the program.
Activity 4.3 Improving the data flow system and	Harmonization of EPI with SEHAT and HMIS data systems is a must to avoid inconsistencies of data, simplify M&E and ultimately allowing use of data for decision making. Re-

improvement of HR accountability at national and sub national level.	activating the HR data base and data flow system is important to track the effort to increase female health workers, make BPHS-implementing-NGOs accountable to their contracts, and improve gender equity.
Activity 4.4 Internal Audit system strengthening, procurement and finance system strengthening based on FMA 2012 findings to ensure the accountability of NGOs performance. ***TWO Pages***	Decentralized monitoring system will use National Monitoring Checklist to monitor service delivery at health facilities on quarterly basis and provide timely feedback to NGOs at national and provincial level. The EPI coverage survey, conducted every two years by a third party, will be used to evaluate the performance of the NGOs across Afghanistan, and to inform MoPH to take corrective measures about the performance of NGOs. Twenty percent of the total budget of NGOs implementing GAVI grant contracts will be contingent on satisfactory performance on selected indicators. Note: for details of implementer, management entity and list of sub activities please refer to detailed sub activities summery (A# 46)

13. Results Chain

This description will detail to Gavi how the proposed activities will result in improved immunisation outcomes.

➔ *Please present a Results Chain using the template provided below for each objective. This diagram should demonstrate how activities contribute to achieving intermediate results and how intermediate results contribute to achieving immunisation outcomes. The intermediate results should link directly to the HSS bottlenecks identified in Section 9 and should address or contribute to addressing the selected bottlenecks for the Gavi HSS proposal.*

(Please only include the key 4-5 activities for each objective that are central to delivery of intermediate results and immunisation outcomes. It is not necessary to list all activities for each objective as these are listed in Section 12 Description of Activities and in Section 15 Detailed Budget and Workplan Narrative.)

➔ *The Results Chain should be consistent with the HSS M&E Framework. For every activity and intermediate result listed in the Results Chain there should be corresponding indicators to measure achievement detailed in the box below. Immunisation outcomes indicators do not have to be related to any specific objective, they are related to the programme as a whole so are not included in this results chain. Indicators should align to those detailed in the HSS M&E Framework.*

➔ *Please note that a Gavi HSS proposal must include an independent and systematic data quality assessment and an improvement plan described in the Supplementary HSS Guidelines Key Terms Section. Applicants must identify specific data quality problem areas where funds will be used.*

Objective 1: Enhance 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.

Key Activities:	**Intermediate Results:**	**Immunisation Outcomes:**
• *Upgrading the 310 existing health sub-centres (HSCs) to EPI service delivery points.* • *Establishing community-based outreach by vaccinators to 2878 villages.* • *Continuing the 15 MHTs for nomadic (Kuchi) population which are established under HSS2.* • *Continuing, scaling up and revising 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.* • *Supporting micro-planning through RED strategy using CHWs and BASIC tools to improve the immunization services.*	*- 90% of districts have completed the micro planning through RED strategy*	▪ *Pentavalent3 coverage increased from 59.7% in 2014 to 80% in 2019.* ▪ *Measles coverage increased from 58.8% in 2014 to 80% in 2019.* ▪ *Socio-economic equity of DTP 3 coverage immunisation coverage – No more than 10 percentage points difference in DTP3 coverage between lowest and highest wealth quintile* ▪ *Penta3 coverage in Kochi Children increased from 26% to 42%* ▪ *Geographic equity of DTP 3 coverage – 67% increased to 78% of districts have at or above 80% Penta3 coverage*
Related Key Activities Indicators: • *% of targeted sub-centres (HSCs) upgraded to EPI fixed centres* • *% of female vaccinators received initial training and deployed* • *% of Penta3 coverage in Kochi Children*	**Related Intermediate Results Indicators:** ▪ *% of districts that have completed the micro planning through RED strategy*	

• *% of Penta3 coverage in targeted provinces where public-private partnership models for vaccine delivery have been implemented*		

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

Key Activities: • *Expansion of existing cold chain capacity for the intro of new vaccines and opening of new service delivery facilities* • *Building capacity of the cold chain and vaccine logistics managers* • *Constructing vaccine and non-vaccine storage facilities*	**Intermediate Results:** - *95% of BPHS/EPHS HFs equipped with appropriate, functioning cold chain and providing EPI services*	**Immunisation Outcomes:** ▪ *Pentavalent3 coverage increased from 59.7% in 2014 to 80% in 2019.* ▪ *Socio-economic equity of DTP 3 coverage immunisation coverage – No more than 10 percentage points difference in DTP3 coverage between lowest and highest wealth quintile* ▪ *Geographic equity of DTP 3 coverage – 67% increased to 78% of districts have at or above 80% Penta3 coverage*
Related Key Activities Indicators: ▪ *% of cold chain technicians trained in CCVLM to use supply chain dashboard* ▪ *Number of newly constructed warehouses used for dry supply*	**Related Intermediate Results Indicators:** ▪ *% of BPHS/EPHS HFs equipped with appropriate, functioning cold chain and providing EPI services*	

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

Key Activities: • Increasing awareness and promoting immunization through the mobilization of religious leaders • Implementing BCC activities through mass media, ICT and IPC. • Generating Evidence and Knowledge (KAP study)	**Intermediate Results:** - *Increase from 5% to 25% of children whose mothers attended to vaccinate children*	**Immunisation Outcomes:** ▪ *Drop-out rate - 18.6 percentage point difference between Penta1 and Penta3 coverage reduced to 10 point difference* ▪ *Proportion of children fully immunised increased from 51% to 75% of children aged 12-23 months who receive all basic vaccinations in a country's routine immunisation schedule*
Related Key Activities Indicators: ▪ *No of districts where CHW orientations held (4 districts per province)* ▪ *Number of districts where religious leaders orientations held (4 districts per province)* ▪ *% of children whose mothers attended to vaccinate children*	**Related Intermediate Results Indicators:** • *% of children whose mothers attended to vaccinate children*	

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

Key activities: • *Improving supportive supervision and monitoring of BPHS*	**Intermediate Results:** - *Increase from 30% to 50% the proportion of*	**Immunisation Outcomes:** ▪ *Increase from 59% to 70% of pregnant*

	HFs at different levels with more focus on decentralization. • *Conducting Periodic evaluations to ensure accountability for equity at district and provincial level.* • *Improving the data flow system and improvement of HR accountability at national and sub national level.* • *Internal Audit system strengthening, procurement, public relation and finance system strengthening based on FMA 2012 findings to ensure the accountability of NGOs performance.*	*provinces in which 80% of its existing BPHS, EPHS health facilities are monitored quarterly by PPHOs*	*women received TT2+ at HF* ▪ *Increase from 47% to 59% the proportion of women having skilled birth attendance at delivery*
	Related Key Activities Indicators: • *EPI Coverage Survey conducted* • *Execution rate for GAVI project*	**Related Intermediate Results Indicators:** • *Proportion of provinces in which 80% of its existing BPHS, EPHS health facilities are monitored quarterly by PPHOs*	

IMPACT: ***Please provide an impact statement and indicator(s)***

- *Reduction of the mortality ratio of children under age 5years from 102 deaths/ 1000 live births to 70/1000.*

ASSUMPTIONS:

- *Government stability ensuring fund flow and functioning infrastructure.*
- *Successful recruitment of local female candidates willing to become vaccinators.*
- *No major emergencies or catastrophes.*

FOUR PAGES MAXIMUM

For further instructions, please refer to the Supplementary Guidelines for HSS Applications

14. Monitoring and Evaluation

This description will enable Gavi to assess how programme performance will be monitored, and to ensure alignment with National M&E arrangements. The proposed M&E framework for the HSS grant should link to the proposed Results Chain. While the Results Chain provides the rationale for how the proposed activities will result in improved immunisation outcomes, this section provides details of how the monitoring and evaluation will be undertaken.

**Where possible, Gavi asks for both country administrative data as well as data from 'other' sources. 'Other' recommended data sources are DHS/ Multiple Indicator Cluster Survey (MICS) or recent coverage estimates from WHO/UNICEF..*

- *Please provide an HSS grant Monitoring & Evaluation Framework as Attachment 3 (please complete the Gavi template).*
- *Please provide a description of how the monitoring and evaluation will be carried out for the grant, indicating how M&E is aligned with the national health plan results framework.*
- *Which sources of data will be used? Please provide an explanation of any disparities between administrative statistics and 'other' statistics and details of any plans to improve data quality to address these disparities. Please detail whether these plans are being implemented or if their resourcing and implementation are to be covered in the current HSS application.*
- *How much budget will be allocated to monitoring and evaluation, which will include M&E for this grant as well as for national M&E systems strengthening?*
- *Please describe the M&E system strengthening activities to be funded through this proposal.*
- *Please identify one or more immunisation outcomes for each objective.*
- *Please identify a number of intermediate results indicators related to each objective of the grant that shall be used for tracking the overall progress of the grant implementation (these will be used for PBF – please refer to the Introduction in the Supplementary HSS Guidelines). These are the same intermediate results indicators that are included in the Monitoring & Evaluation Framework, and will be used to measure the outputs / intermediate results that are included in the results chain in Section D.13.*
- *If this Gavi HSS grant (either a portion or all of it) is proposed to be aligned with the World Bank's RBF programme or any other existing PBF programme in the country, then please also attach the results framework for that programme. Please describe in this section how that results framework is relevant for Gavi's programme objectives. Please note that more than one immunisation-related indicator is expected to be part of any such PBF/RBF programme, if the Gavi HSS grant is proposed to be aligned with it.*
- *Gavi requires an end-of-grant evaluation by an independent third party to be planned and budgeted for as part of the grant design and funding request. If countries propose to use an existing evaluation for this purpose, they should provide appropriate justification. Gavi also strongly recommends a mid-term evaluation to help inform possible improvements to the implementation of the grant. Please provide details about the planned evaluation of the HSS grant.*

The Monitoring and Evaluation (M&E) Framework for HSS3 grant is attached as annex #5.[89] Monitoring and evaluation of grant implementation and NGOs performance at national level is basically the responsibility of the M&E Directorate and at sub-national level it is the responsibility of Provincial Health Directorates. In addition, the total of 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, could contribute to the monitoring of insecure districts where this grant is implemented. However, due lack of transport and on-job training for Provincial Health Officers (PHOs) and DHOs, the planned quarterly monitoring of health facilities (HFs) using the National Monitoring Checklist (NMC) only reached 28% in 2015.[90]

Objective 4 of this proposal focuses on capacity building of PHOs for proper monitoring, quality of data and decentralization of monitoring, according to the decentralization plan of NHNP 2012-2020, the cMYP 2015-2019, National EPI strategy 2015-2020 and the Country Tailored Approach (CTA). Under this HSS3 proposal, the monitoring and evaluation improvement activities will be supported through WHO, which will provide Technical Assistance (TA) support and also facilitation of provincial financial management to support PHO and DHO training and travel for monitoring. The six national TAs (One based in WHO and 5 based at MoPH) will provide on-job training to PHOs and DHOs and conduct joint monitoring with them using the NMC to monitor the progress at HFs on set indicators of the M&E National Plan[91] and the performance of each NGO based on their contractual obligations and performance indicators.

[89] A#5: HSS3 Monitoring & Evaluation Framework

[90] A#39: Minutes and Presentations from March 18, 2015, Gap Analysis Workshop.

[91] A#9: M&E Directorate, MoPH, Afg. M & E National Plan, 2012-2020, Updated May 2015.

In order to track the progress on mandatory outcome indicators and programmatic intermediate result indicators, an EPI coverage survey will be conducted in both 2016 and 2018 to follow progress from the baseline values recorded in the National EPI Coverage Evaluation Survey 2013.[92] The results of this Survey highlighted a difference of 30 percentage points between program data and survey data, pointing to a clear need to improve data quality and capacities in the immunization program, which will be specifically addressed in a parallel proposal which is under development and will be approved by high level review committee/ GAVI Secretariat in October 2015. In addition, GFATM (2015) plans to support the essential HMIS activities, comprised of providing provincial HMIS Assistant salaries, program operational costs, supporting regular field visits, and training costs, which will complement M&E in this proposal.

A total of 5% of the budget under this HSS3 proposal is allocated for monitoring and evaluation: 4% budget for M&E of this grant, and 1% budget allocated for decentralization of the national M&E system during the grant implementation period which will improve accountability of NGOs with the below four strategies:

1. Continuous de-centralized monitoring with NMC will check each HF once in a quarter, and timely feedback will be provided to NGOs at national and provincial level as step 1: feedback; step 2: warning; step 3: termination of contract. This is both for GAVI grant implementers and all other BPHS implementing NGOs.
2. MoPH leadership will handle NGO contracts based on the results of the latest EPI coverage survey and BPHS gap analysis planned under this proposal and conducted by a third party.
3. GAVI grant implementing NGO contracts will include at least one out come-immunization indicator to track performance, and 20% of the total budget will be conditional to the performance.
4. Payment schedule will be included in the contracts of each NGOs; the payment will not be processed until the relevant MoPH/ grant program approves the performance of the NGO.

In addition to the EPI Coverage Survey and BPHS gap analysis, annual Balanced Scorecard assessment of HFs and end-of-grant evaluation studies are planned. EPI Program Supervisors and PHOs/ DHOs will jointly develop monitoring plans and report on their implementation to MoPH. Under HSS2 many areas have already been improved to facilitate decentralized M&E; for example, PHOs received initial training on revised NMC and Geo-Location Monitoring (GLM) software and database which was developed with the Gavi HSS2 support. GLM (A# 56) is an innovative approach for conducting monitoring by PHOs who submit data through smartphones, which reduces the cost of monitoring and improves the verification as it is based on geo coordinates.[93]

As described in Section 12, this proposal has four major objectives and 16 key activities to achieve nine immunization and basic health outcomes.

Objective-1: aims to enhance the equitable access and effective coverage of immunization. The major outcomes will be increased coverage of Penta3 and Measles MCV1 and improved socio-economic equity and geographic equity, as measured through EPI Coverage Survey. The Penta3 coverage among Kuchi population is set as an important EPI equity outcome that will be monitored through EPI coverage survey and program data. The overarching intermediate result of this objective will be the proportion of districts having completed micro-planning using RED Strategy. **Activities:** The planned activities under this objective include: initiation of EPI services in HSCs, training and mobilizing outreach vaccinators from HFs to the nearby uncovered areas, supporting designated MHTs for Kuchis, and expanding the PPPs providing basic health services including EPI to insecure areas. These activities will be monitored by using activity-specific indicators through EPI and BPHS program.

Objective 2: aims to strengthen the cold chain and the vaccine logistics management system which, along with objective 1, contributes to increased coverage of Penta3 and MCV1 as well as socio-economic equity and geographic equity by ensuring that the cold chain is available for the rural areas and other underserved populations. The overarching intermediate result is the proportion of BPHS/EPHS health facilities equipped with appropriate, functioning cold chain and providing EPI services. **Activities:** The key activities are increasing the

[92] A#24: UNICEF, CSO, NEPI- MoPH. National Immunization Coverage Survey Afghanistan 2013, also called NEPI Coverage Evaluation Survey (CES) 2013, April 2014.

[93] A#56: Zwak Media Services. Proposal for Geo Location Monitoring System Development, March 2014.

number of cold rooms and dry storage warehouses of vaccine supply, and training vaccine logisticians and cold chain managers, which will be monitored by using activity-specific indicators through EPI and BPHS program.

Objective 3: aims to improve demand for immunization services which is particularly targeting a reduction in the drop-out rate of Penta1 to Penta3 coverage and an increase in the proportion of children fully immunized, which would also reflect on improved OPV3 coverage, as measured by the EPI coverage survey. The overarching intermediate result will be an increase in the proportion of children whose mothers visited a health facility for vaccination of their children. **Activities:** The planned activities for generation of demand include mobilizing different sectors at community level – religious leaders, teachers, community shuras, and the media as well as CHWs and health professionals – with the goal of increasing interest and participation of families, especially mothers, in the immunization of their children. This would be backed by improved IEC materials based on different surveys and workshops conducted by the Health Promotion Directorate to provide evidence for improving the BCC strategies and monitored by using activity-specific indicators through administrative data.

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. Since this effort for decentralization for health system strengthening applies to all BPHS and EPHS facilities, this objective potentially affects broader maternal and child health outcomes such as increasing the proportion of women having skilled birth attendance at delivery as well as increasing the percent of pregnant women receiving TT2+ at HF, as measured by household surveys. The expected intermediate result is an increase in proportion of provinces in which 80% of its existing BPHS and EPHS HFs are monitored quarterly by PPHOs. **Activities:** The key activities under this objective include: institutionalization of provincial- and district-based monitoring of HFs, including PPP HFs, on a quarterly basis using the NMC. The training of PHOs and DHOs on NMC and GLM is planned under SEHAT project while this HSS3 grant will be used for procuring mobile phones, computers, internet facilities as needed for the GLM aspect as well as providing the travel costs for the regular joint missions of central, provincial and district levels for monitoring the HFs. An annual result conference will be held in MoPH to discuss the health information collected and processed over the year.

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. In this manner, the HSS3 proposal aims to monitor CSOs/NGOs performance both technically and financially to strengthen the stewardship function of MoPH and improve the public health services availability and quality for the Afghan population, especially for women and children, rural and underserved populations. ***TWO PAGES MAXIMUM***

PART E – BUDGET, GAP ANALYSIS AND WORKPLAN

15. Detailed Budget and Workplan Narrative

This description will be used to assess if the proposed budget shows sufficient justification for the proposed activities and activity costs within the HSS grant.

- ➔ *Please provide a detailed budget and workplan as Attachment 6 to this proposal. Please refer to the Supplementary HSS Guidelines for the list of items required from the budget and workplan. It is highly recommended that applicants use the Gavi HSS Budget, Gap Analysis and Workplan template as Attachment 6. However, countries can also provide this information in the format of an existing national Annual Operational Plan or equivalent document.*
- ➔ *Please provide a summary of the amount budgeted by year in the table below.*
- ➔ *Please include additional information on the assumptions within the budget and justification of unit costs to demonstrate that they are reasonable and supported by in-country planning. These assumptions and unit cost justifications may be inserted here or attached as separate documentation.*
- ➔ *Please provide a detailed Procurement Plan (PP) for the acquisition of goods, works and consultant's services covering the first 18 months of programme implementation. This should be submitted as Attachment 7 together with the workplan and budget (Attachment 6). This PP shall be reviewed and approved together with the workplan and budget by*

the HSCC/ ICC of the country.

➔ *If this Gavi HSS grant (either a portion or all of it) is proposed to be aligned with the World Bank's RBF programme or any other existing PBF programme in the country, then please also attach the budget for that programme. Please describe in this section what portion of the Gavi HSS grant budget is proposed to be aligned with that programme and how. Also describe what budget portion is supported by the World Bank and any other funding sources for the RBF/PBF programme. Please complete the Gavi HSS Excel budget and workplan template accordingly to reflect the budget and workplan related to the RBF/PBF programme.*

Year	***Total Amount Budgeted (USD)***
2016	***11,749,734***
2017	***9,383,942***
2018	***9,382,792***
2019	***9,382,389***

Budget Assumptions

HSS3 interventions and the budget plan have been developed based on experiences and lessons learned from HSS1 and HSS2 to efficiently develop the assumptions within the budget and justification of unit costs.[94] This strategy has also allowed the setting reasonable timelines for the implementation of this grant.

The salary rates and per-diems of the public servants are based on National Technical Assistance (NTA) Remuneration Policy 2013. The rates for cold chain equipment and related supplies are inclusive of freight charges. This information is provided by UNICEF as per the suppliers specifications. The costs for vehicles are estimated as per the prevalent markets rates. The National EPI Office provided the information on vehicle-specific average transportation costs according to the government policy and standard rates for different types of trainings. The costs of operational activities are calculated on the basis of historical data. Costs of buildings and warehouses are calculated in line with the WHO's standard BoQ for buildings and warehouses. The resource requirement for every Objective-specific activity (including the related sub-activities) was populated on separate Excel spreadsheets and which were consolidated afterwards for the prescribed GAVI HSS budget templates as attachments (All budget assumption are included in A#6)

It is pertinent to mention that the future requirements for immunization program under Budget Gap Analysis are estimated by using both actual data from the government/ donors' documents and the financial projections generated under cMYP; however, shared health system costs were not accounted for.

Budget Description

This grant proposal covers a period of 4 years from 2016 to 2019. An estimated budget of USD 39.9 million is required for implementation of GAVI HSS3 jointly by three lead implementers. The MoPH will manage 45.6 % of the grant (USD 18.2 million), UNICEF will manage 30.7 % of the total grant (USD 12.3 million) and WHO will manage 23.6 % (USD 9.4 million). Twenty-nine percent of the total budget will be spent in 2016 (first year of implementation) followed by nearly 24% every year during 2017-19.

Although all four HSS3 objectives are highly interlinked and cannot be achieved in isolation, analysis of objective-wise budget distribution shows that (Please refer to detailed budget, gap analysis and work plan A# 6):

- 28% budget is allocated for 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 (USD 11.2 million)
- 38.5% budget is allocated for strengthening of cold chain and vaccine logistics management system by increasing the physical capacity, maintenance and effective vaccine management with provision of adequate infrastructure throughout the country (USD 15.3 million)
- 6.5% budget is allocated for improvement of demand for immunization services by implementing context specific communication interventions to cover the disadvantaged population (USD 2.6 million)
- 21.4% budget is allocated for strengthening of management and leadership capacity of the decentralized

[94] A#6: HSS3 Detailed budget, gap analysis and work plan

health system at peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services (USD 8.6 million)

- 5.6% budget is allocated for MoPH, UNICEF and WHO management cost (USD 2.2 million)

The HSS3 objectives are cross-cutting in nature and are in line with the government policies of reducing inequities. A critical analysis of the budget allocation indicates that 100% of the budgeted program activities are directly contributing towards reducing socio-economic and geographical equities whereas 63.4% of the total budget will contribute towards reducing gender-based inequities.

The table given below presents GAVI HSS Category-wise allocation of the proposed budget. Procurement of cold chain equipment and supply chain management is the major cost driver requiring 36.6% of the total resource requirement.

GAVI HSS Category	USD in Millions	
Procurement & supply chain management	**14.6**	36.6%
Service Delivery	**11.7**	29.4%
Health information systems	**6.2**	15.4%
Workforce and human resources	**3.5**	8.8%
Community and other local actors	**1.7**	4.2%
Program management	**2.2**	5.6%
Total	**39.9**	100%

It is pertinent to highlight that the total funding basket from GAVI HSS3 is USD 47.5 million. However, 7.6 million of this grant is placed under Performance Based Financing (PBF). If Afghanistan successfully achieves its targets and is considered eligible for the PBF portion, this money will be utilized as an incentive for improving the performance of vaccinators through a Pay for Performance (P4P) scheme.

Considering the overall nature and condition of GAVI proposal guidelines, all the incentives, benefits, contracts and payments are performance based and will be managed through a clear and properly defined set of performance indicators explained in the implementation manual in their action plans and contracts.

Workplan Narrative

The HSS3 work plan is a logical extension of objectives into activities and related sub-activities. Budget planning is directly linked to sequencing and scheduling of activities under the work plan because every activity has been costed separately and then consolidated for developing the detailed budget. This will also allow tracking the pace of program activities by using Monitoring and Evaluation framework.

The detailed 18-month procurement plan (Annex #7)[95] provides the details of activity-specific costs and their schedule for implementation. Majority of the activities will continue through the duration of program implementation with some variation in quantity and duration. Key features of the work plan are as follows:

- Recruitment and training of staff for establishing EPI-centres in 310 HSCs will commence in second half of 2016 whereas formal initiation of EPI activities will start in January 2017. A budget amounting to USD 51,682 has been allocated for this purpose. The main reason for keeping this lag period of almost one year is to provide ample time to UNICEF for procuring and supplying the required cold chain equipment and supplies. Once all the HSCs are established the total budget requirement for their operationalization will be USD 1.5 million for 2017 and 2018. The MoPH plans to absorb these centres in BPHS; therefore, no budget is allocated for 2019.
- Community-based MHTs, supported for 3 years under this program, will be absorbed in BPHS by 2019.
- Micro-planning with RED Strategy approach will be completed in the first year of implementation.
- EPI service delivery in six insecure provinces will be supported throughout the program duration.
- Procurement of cold chain and activities for strengthening supply chain management are planned through the program duration. In the first year, priority will be given to improving cold storage and warehousing capacity followed by replacement of outdated cold chain equipment in 2017 to 2019.

[95] A#7: Detailed Procurement Plan (18-month) for Consultancy Services and for Cold Chain

- Capacity building and skill development through trainings and refresher courses is a regular feature of program activities. Trainings on introduction of new vaccines will be conducted accordingly.
- Activities pertaining to demand generation and communication have been planned throughout the four years.
- Periodic evaluations and coverage surveys are planned for 2016, 2018 and 2019. ***TWO PAGES MAXIMUM***

16. Gap Analysis and Complementarity

This description will ensure Gavi is aware of support provided by other donors, thereby avoiding overlap or duplication, and highlighting the value-added of the requested Gavi support.

- ➔ *Please complete the gap analysis tab in the Gavi HSS Budget, Gap Analysis and Workplan Template. This gap analysis should be related to each of the proposal objectives to show the total resource requirements for health system strengthening related to that objective, and the different resources for HSS financing already in place, as available in National Health Sector Strategy/Plan, cMYP, or other gap analysis conducted.*
- ➔ *For each of the objectives, applicants should list different resources for HSS financing already in place that contribute to the proposal objective, including government and external donor contributions, the project name if applicable (or indicate budget support), duration of support, funding amount provided (in US$), and geographic location covered by the support. The Supplementary HSS Guidelines provide more detail on the key required elements of the gap analysis.*
- ➔ *In the box below, please provide a narrative description of other efforts by the Government or development partners that focus on the bottlenecks that are addressed by the proposal objectives, including the timeframe and the geographic location of this support, thereby highlighting the value-added of Gavi support and how the current proposal complements those efforts.*

Gavi encourages the use of data from existing gap analyses, rather than undertaking a new gap analysis.

Improving immunization coverage through health system strengthening in Afghanistan is heavily dependent upon foreign assistance from donors and development partners. Findings from the cMYP 2015-19 highlight that during 2013, Government of Afghanistan contributed only 5% towards the total expenditure on EPI which was mainly spent for payment against Government's share for co-financing for GAVI vaccines. Therefore, the funding gaps for HSS interventions are likely to be bridged through foreign assistance. This section presents funding gap analyses for all four objectives separately.

Objective 1:

The HSS activities to enhance the equitable access and effective coverage of immunization services require a total funding of USD 58.2 million. Although a substantial amount of funding (USD 41.1 million) is being financed by the World Bank, European Union and USAID under SEHAT 1 & 2 projects, the Government of Afghanistan is still facing an overall funding gap of USD 17.1 million. Keeping in view the limited resource availability, the interventions under Objective-1 are planned in such a manner that maximum benefits can be delivered to those population segments who have limited access to the available immunization services on account of geographical and socio-economic inaccessibility. The funding proposed under GAVI HSS3 (USD 11.2 million) fulfils 67% of the funding gap for Objective-1. It is important to highlight that the targeted investment through phase-wise implementation of five activities under Objective-1, gradually decreases the Government's dependence on GAVI HSS3 resources. Newly establish HSCs, Mobile Health Teams and Community-based EPI Teams will be gradually absorbed under BPHS. By year 4, GAVI HSS will be contributing only 20% of the planned expenditure for activities under Objective-1. The Government recognizes that even after successfully securing GAVI HSS3 Grant, immunization system in Afghanistan will be facing a funding gap of USD 5.6 million in relation with increasing coverage of immunization system. It will require enhancing efficiency of the immunization system to minimize wastage of resources with a specific focus on freeing up additional resources for health system strengthening.

Objective 2:

The estimation of funding requirement for activities under Objective-2 is based on cMYP 2014-19 and EVM Improvement Plan.[96] The Government of Afghanistan plans to use GAVI HSS3 to comprehensively strengthen the

[96] A#12b: Effective Vaccine Management (EVM) Improvement Plan

cold chain supply, storage and maintenance services because no secure funding is available from any other source. The BPHS donors provide overheads and operating costs for cold chain at the health facility level, but supply of new equipment, replacement of outdated equipment, repair and maintenance, and capacity building of cold chain staff remains a responsibility of the National EPI Office with support from UNICEF. UNICEF will provide USD 0.3 million for procuring IT equipment for remote temperature monitoring system. As this funding is available, the current HSS3 proposal contains budgetary requirement for the operational cost of the remote temperature monitoring system. The overall funding gap under Objective-2 is estimated at USD 15.3 million. GAVI HSS3 provides a novel opportunity to completely bridge this funding gap.

Objective 3:

Health promotion activities include: increasing awareness and promoting immunization through the mobilization of key stakeholders (political and technical leadership, religious leadership, target communities and healthcare providers); implementing behaviour change communication activities through mass media, local media, ICT and Interpersonal Communication and Counselling (IPCC); and generating evidence and knowledge. It is estimated that EPI requires USD 7.5 million for implementation of a comprehensive demand generation, communication and advocacy campaign. The existing support from UNICEF and BPHS partners will provide USD 3.2 million which constitutes 43% of the total required resources. In this scenario, the Government still faces a funding gap of USD 4.3 million. The proposed budget under GAVI HSS will provide 64% of the total funding gap for strengthening demand generation activities.

Objective 4:

In order to strengthen management and leadership capacity of the decentralized health system at peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services, the Government of Afghanistan needs USD 34.7 million. Financial projections from cMYP 2015-19 and current commitments from Global Fund indicate that nearly 55% of this requirement is available from three sources: Government budget allocation, Global Fund and BPHS partners (World Bank, European Union and USAID). This funding amounting to USD 19.1 million will be primarily spent on providing transportation and per-diems to provincial health teams and vaccination staff at sub-district levels. In addition, USD 2.3 million is available from HSS2 with special permission from GAVI under the Country Tailored Approach (CTA). This amount has been specially allocated for data quality improvement. A separate Data Quality Plan will be developed as outlined in the CTA document. This plan will be complementary to the HSS3 objectives and activities.

After completion of GAVI ISS and GAVI HSS2, the Government is facing difficulty in providing remuneration to the EPI management staff both at national and provincial levels. In addition, no budget is available to continue the HSS Unit in MoPH. Besides, remunerations of the management staff, the immunization program also requires resources for strengthening its management processes, improving data quality and conducting formative and analytical research studies. In total, the funding gap for Objective-4 amounts to USD 15.6 million. The funding from GAVI HSS3 will provide USD 15.6 million for achieving outcomes of Objective-4 that will reduce the overall funding gap by 62%.

It is very important to highlight that the ISS flexible funding was used mostly for management and operation costs of EPI program but unfortunately Afghanistan lost the ISS rewards of over USD 5 million for three consecutive years (2010-2012) because of data discrepancy. Funding gap in the delivery of immunization services emerging from the 4th quarter of 2015 and delays in accessing HSS3 funding will have damaging consequences for the immunization program. Successful implementation of the parallel data quality proposal under CTA is also vital to the program.

TWO PAGES MAXIMUM

17. Sustainability

This description will enable Gavi to assess whether issues of sustainability have been adequately addressed.

➔ *Please describe how the Government is going to ensure sustainability of the results achieved by the Gavi grant after its completion. This should encompass sustainability of financing for immunisation services and health system strengthening,*

as well as programmatic sustainability of results.

➔ *If there are other recurrent costs included in this proposal please describe how the country will cover these costs after the funding finishes.*

Financial sustainability of the immunization program is the primary responsibility of the MoPH, and the NHNP 2012-2020 includes "sustainability" among its core values and principles, defined as "creation of a health system that can be supported and wholly 'owned' by Afghanistan, both technically and financially in a timely manner."[97] However, macroeconomic and sustainability indicators show that the immunization system is highly dependent upon external funding in Afghanistan, both direct financing of EPI and indirect financing of immunization services as part of BPHS, which is critical for the attainment of immunization outcomes. It is important to be realistic in assessing financial sustainability in Afghanistan and to use an appropriate time horizon. Given the depth of poverty and a limited ability to collect taxes, the Government will not be able to finance a reasonable level of health services within the next 10 years. In the long-term, the prospects could be better in view of the growing economy and presuming security and stability. However, the financial projections show that the cost per Penta-3 child (all costs included) is estimated to significantly increase from USD 64.1 in 2013 to USD 84.3 in 2019, and the planned continued expansion of the coverage of health services will make a steeply increasing curve of costs.

The MoPH is applying for GAVI HSS support to fill the gaps in the funding of its plans. While MoPH is continuously working toward increased financial efficiency and sustainability of the immunization program and taking steps to reduce the funding gap between financial resources mobilized and planned expenditures, in case of unresolved funding gap, the coverage targets would need to be revised/ adjusted according to the availability of funding. Based on cMYP 2015-2019,[98] considering only the secure funds, there is a substantial funding gap of USD 204 million (52%) for the period of 5 years, but when accounting for probable funding, the funding gap is reduced to 20% (USD 96 million). According to the current financial projections, the funding gap may be covered as the Government projects almost tripling its own investments in the immunization system during the next five years, from USD 2.2 million in 2013 to USD 6.4 million per year during 2015-19. As mentioned, if funds necessary to finance planned strategies and activities could not be mobilized, then financial sustainability would be restored by postponing the planned interventions pending availability of funds.

Programmatic sustainability

- The proposed interventions are aligned with the national health policy and strategies and are based on a thorough review of the health system, its performance, achievements and challenges.
- The proposed activities are all in line with the national health policy and strategies of MoPH. The activities build on existing structures and complement on-going activities where gaps or weaknesses were identified. The interventions and activities of this proposal builds on and benefit from the structures of MoPH, the large network of CSOs working in BPHS and the public health infrastructures. Implementing CSOs are selected through a bidding process that observes the technical as well as the financial aspects of the bidding proposals.
- The interventions build on and benefit from existing health system structures and activities and rely, wherever possible, on existing human and financial resources to carry out new activities. Building the capacity of available human resources is vital to technical sustainability. In addition, building capacity at the provincial level increases effectiveness of management, decreases dependence on the centre, promotes ownership and consequently support by the beneficiaries in addition to reducing the management costs.
- The proposal focuses on activities (such as immunization and awareness raising) that are regarded as highly cost-effective and maximize the community support to the health sector.
- The Government plans to gradually integrate the program activities with the existing public health structure so that the immunization activities proposed under objective 1 through HSCs and MHTs will be taken over by BPHS implementers at the end of 2018 when the WB- SEHAT project is revised.
- There is well established evidence that the MoPH gradually absorbs the workforce into its organizational structure. The number of MoPH staff paid by GAVI/ISS was 288 in 2008 and more than 310 in 2010 but was reduced to 110 in 2014, most of them absorbed and paid by the Government. This number is

[97] A#8a: MoPH Afg. National Health and Nutrition Policy 2012-2020, Sept 2012, p. 13.

[98] A#11: NIP, MoPH, Afg. Comprehensive Multi-Year Plan (cMYP) for Immunization, 2015-2019. Jan 2015.

projected to continue to decrease in coming years as more staff are included in the Government structure; please refer to A# 47.

- Expansion in cold chain and warehousing facilities will be sufficient to meet programmatic demands for at least next 10 years.

Financial Sustainability

- MoPH policies and strategy, revised cMYP analysis and financial gap analysis conducted under HSS2 are used for the allocating budget to each objective. All the interventions and costing process have undergone through participatory and consultative group works composed of CSO, MoF, MoPH related departments, UNICEF, WHO, and all other technical and financial stakeholders and partners of both EPI and health system strengthening departments of MoPH.
- While the availability of vaccines, injection supplies, cold chain, and other logistics will depend on one-time foreign assistance, many of the recurrent costs such as salaries; per diem/ travel costs for monitoring; power supply or fuel for the cold chain, vehicles, and heating/ cooling of buildings; and maintenance and repair of cold chain equipment, machines, and vehicles would be absorbed by the Government, while those directly related to services at the health care facilities would be borne by the BPHS implementer.
- Generally, there are no outlier expenditures in any line items.
- The proposal fits within the strategies and activities laid out by the cMYP to increase financial efficiency and sustainability of the immunization program by strengthening the existing EPI management structures and business processes, as follows:

  Strategy 1: Enhance efficient utilization of human resources by developing synergies with other health initiatives. Activities: Train EPI program managers on program management and developing mechanisms for financial efficiency; Increase number of skilled immunization staff through integration of EPI with other PHC programs being implemented under BPHS; Develop synergies with PEI through the project on 'Afghanistan PEI Networks Support to EPI through use of PEI Assets'

  Strategy 2: Minimize wastage of resources under immunization program. Activities: Rationalize use of POL for monitoring and supervision by management staff at national, regional, provincial and district level; Develop and introduce need-based supply of vaccines, syringes and other materials; Minimize vaccine wastages, practice of invalid vaccine doses and drop-out rates for different antigens.

  Strategy 3: Advocacy for resource mobilization for ensuring financial sustainability of immunization program. Activities: Utilize cMYP as the foundation document for developing program proposals and grant application for the Government and donor community. Inform political and technical leadership about the importance of funding gap in terms of burden of morbidity and mortality due to vaccine preventable diseases. Mobilize political and technical leadership for increasing share for EPI-specific costs under regular Government budget; Develop financial projections for mobilizing donors and development partners on yearly basis.

TWO PAGES MAXIMUM

PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

For further instructions, please refer to the Supplementary Guidelines for HSS Applications

18. Implementation Arrangements

This section will be used to determine if the necessary arrangements and responsibilities for management, coordination, and technical assistance inputs of the implementing parties have been put in place to ensure that programme activities will be implemented. Please describe:

- ➔ *How the grant implementation will be managed. Identify key implementing entities and their responsibilities.*
- ➔ *Please describe governance and oversight arrangements.*
- ➔ *Mechanisms which will ensure coordination among the implementing entities.*
- ➔ *Financial resources from the grant proceeds that will be allocated to grant management and implementation.*
- ➔ *The role of development partners in supporting the country in grant implementation.*

The Ministry of Public Health (MoPH) in its stewardship role of health sector is responsible for formulating health policies, coordination, regulation and overseeing the implementation of health related grants and activities in the country. MoPH, UNICEF, and WHO will be the key recipients of this grant. In order to effectively implement the GAVI grant in the country, multiple and relevant technical departments of MoPH will support and coordinate the implementation of health service provision through NGOs/ CSOs[99]. UNICEF will proceed procurement of pre-qualified equipment by WHO through the Performance Quality and Safety (PQS) programme and will hand over the equipment to the National EPI; as well as , UNICEF will manage training of religious leader and KAP survey for knowledge generation. WHO will manage PPP (SCO type B), RED strategy and micro-planning at district level, periodic evaluations and decentralized M&E components of the proposal.

The HSS Coordination Unit of the MOPH will be the core department responsible for coordinating the activities with various departments, oversight of the grant and to communicate with technical partners and GAVI secretariat. This department will organize monthly task force committee meetings and quarterly HSS steering committee (HSS-SC is a sub-committee of HSCC mechanism and the ICC is integrated to it, TOR of HSS-SC is attached)[100] meetings to review the grant implementation and progress jointly with implementing departments and partners including UN Agencies and CSOs to ensure implementation is in line with the approved work plan & budget.

National EPI in consultation with HSS department will be the responsible department to upgrade the fixed centres with cold chain and vaccinators within the BPHS and to identify suitable candidates for enrolments into the vaccinators training. The NEPI will also take the lead role in designing and implementation of Micro-planning component in close coordination and technical assistance with WHO, UNICEF and PEMTs and REMTs. National EPI will be given an active participation role in the process of developing the TORs and in the evaluation of the proposals submitted to MOPH by CSOs against request for submission of proposals. National EPI will be the core department receiving, repairing and managing cold chain system over all the country as well as jointly overseeing the construction process for cold rooms.

The GCMU of the MOPH will be the responsible department for contracting out health service delivery activities. This department is with transparent interface between International Development Partners and the MoPH in capturing and managing the public health funds, especially related to the country wide provision of the BPHS, EPHS and previous HSS activities. This unit has been certified by the World Bank, EC and USAID, Ministry of Economy and Ministry of Finance and awarded certificate of authority to proceed 'National' and 'International' service procurement with unlimited threshold of authority. The Terms of References, procurement planning and other activities related to the pre-tendering stages will be worked out by this office jointly with the technical departments following the 'National Procurement law' and 'Rules of Procedures'. Development Budget Department (DBD) will be responsible for management of financial affairs of HSS related activities. This department is currently managing the financial expenditure of the development budget of the health sector financed by MOPH's main donors including BPHS and HSS related grants supported by WB, EU, USAID, GF and

[99] This proposal uses the term Civil Society Organizations (CSOs) as encompassing 'not-for-profit' Non-Governmental Organizations (NGOs) as well as other entities such as private educational institutions and media and public-private partnerships (PPPs).

[100] A#13: Health System Strengthening - Steering Committee TOR, since 2007.

GAVI. Based on the FMA conducted in 2012, guidelines under HSS2 were developed to improve transparency in the procurement process for GAVI grant; the guidelines are attached annex #41.[101]

The Finance Section within the development budget department of MoPH will be in close coordination with the HSS Unit and technical departments to carry out financial management activities including but not limited to forecasting annual departmental budgets, obtaining budget allocations and payments to the vendors, contractors and staff salaries, monitoring budget expenditures of the implementing CSO Partners, and annual reconciliation and producing annual financial progress reports. This department will be in close contact with HSS Coordination Unit and HSS-SC for timely and necessary adjustments and approvals required for entire activities. The Monitoring and Evaluation (M&E) Department of the MOPH and Provincial Public Health Officers (PPHOs) will be having the key role of monitoring the technical progress of interventions using the GLM software and National Monitoring Checklists (NMCs).

The M&E staff at central MOPH will provide on-job training to the PHOs and DHOs on use of the NMCs, EPI checklist and GLM to conduct supportive supervision and monitoring visits. M&E staff will also jointly prepare an annual monitoring action plan with the technical departments, PHOs and DHOs to carry out joint monitoring missions. The joint monitoring will provide the opportunities to verify progress on milestones and proposed work plan of the implementing NGOs/CSOs by multiple sources and take more appropriate and comprehensive actions. Moreover, this will validate the findings, increasing their legitimacy, and engage the provincial health teams and technical departments on the action required for improvement. The MOPH will also assess the possibility for inclusion of targets set for activities under this proposal, e.g. immunization newly fixed at HSCs and mobile immunization benchmarks, into the 'Third Party' evaluation using the Balanced Scored Card, depending on the feasibility and negotiation with existing contract holder, so the outcomes would be correlated to the payments to the contractors or taking disciplinary measures in terms of holding the NGOs/ CSOs accountable.

To ensure effective utilization of the grant and that set principles and regulations are applied, the Government Internal Audit and the Control and Audit Offices will carry out periodic internal auditing of the financial statements and accounting transactions of the GAVI grant. To ensure transactions and expenditures are more fairly utilized, the grant's fund including 'financial' and 'internal control' mechanisms of the contracted out CSOs will be externally audited by reputed audit firms on an annual basis and their report will be shared with GAVI Secretariat. The accountability mechanism for CSO performance is described in section 19 of this proposal.

Development partners, including MOPH's main donors supporting the BPHS and other components of health sector, have been playing an important role for over a decade and continue to build up and enhance the system not only through financing and implementing the health service provision, they also support the MoPH in developing core operational and national strategies, enhancing fiduciary and sub-national systems and providing technical assistance to health information system and health economics initiatives such as establishing National Health Accounts to enable MOPH to become more responsive and move towards a more sustainable health system. Development partners' technical expertise including their National and International TAs will actively contribute to the process of implementation and their management resources and facilities at the provincial level will be extended to successfully implementing the HSS Grant.

In addition to UNICEF and WHO support, MOPH will not proceed management of the GAVI grant as an standalone project through a single unit or management team within the Ministry; rather the grant will be implemented through different technical departments of MoPH under the rules of Government as described in the implementation manual.[102] The program management is estimated to cost USD 2.2 million that is about 5.6 % of the HSS proposal's total budget (Please see Section 15, page 44 of this proposal.)

TWO PAGES MAXIMUM

[101] A#41: Procurement Guidelines (folder)

[102] A#36: Policy, Planning and International Affairs Directorate, MoPH. Health System Strengthening Grants Implementation Manual, April 2015.

19. Involvement of CSOs

This description will be used to assess the involvement of CSOs in implementation of the proposed activities. CSOs can receive Gavi funding through Gavi HSS grants going to the MoH and then transferred to the CSO[103].

- ➔ *Please describe how CSOs will be involved in the implementation of the grant activities, indicating the approximate budget allocated to CSOs.*
- ➔ *If CSOs will not be involved in implementation please provide an explanation of why they are not involved and what steps will be taken to facilitate future involvement of CSOs in Gavi HSS activities.*
- ➔ *Please detail the role of CSOs in reaching equity groups, e.g. uneducated mothers, remote areas, poorest quintiles, conflict affected populations.*
- ➔ *Please ensure that any CSO implementation details are reflected within the detailed budget and workplan.*

Within the context of Afghanistan's health system, regulation, financing, resource allocation, and provision of services are illustrated as key functions that shape its health system. The MOPH as regulating body, development partners as financing agencies, and CSOs, mainly NGOs,[104] as healthcare service providers are the key actors recognized in the health system, and the way these functions and actors are involved and related shapes an effective and efficient health system. The MoPH has separated purchaser and providers through the allocation of financial resources into two mechanisms of "contracting-out" and "contracting-in". This decision was taken in view of the fact that the Government structures were poorly regulated and the system lacked efficient human resources to manage the required duties at the implementation and management levels. On the other hand, the Ministry realized that the PPHOs and the provincial treasury and budget departments are not able to provide health service and at the same time be coordinating it and managing it at standards to meet the donor's requirements. Therefore, MoPH involved NGOs, CSOs and private sector to meet its organizational goals.

Health service delivery is 'contracted out' to NGOs in 31 out of 34 provinces and 'contracted in' through MoPH Strengthening Mechanism in three provinces. The key service delivery strategies of the MoPH are the Basic Package of Health Services (BPHS), which is a pro-rural primary health care package, and the Essential Package of Hospital Services (EPHS), mainly defining services at hospitals in provincial capitals. The key funders of BPHS include but are not limited to USAID, World Bank and European Union. The role for CSOs as implementing partners of MoPH is endorsed in the Afghanistan National Development Strategy (ANDS, 2008), and the MoPH is devoted to continue working with NGOs/ CSOs and to develop their capacity.

The components for the BPHS include Maternal and New-born Health, Child Health and Immunization, Communicable Disease Control, Essential Medicines, Nutrition, Mental Health and Disability.[105] The NGOs-BPHS implementers are contracted to deliver these key components to the entire population of the district or province. In the HSS3 proposal supported by GAVI the same BPHS implementing NGOs/CSOs are contracted to address the gaps linked to access to immunization services in underserved populations that are so far uncovered by BPHS. This approach will reduce the management cost while the existing physical and non-physical opportunities will be used at their maximum.

CSOs such as NGOs currently implementing BPHS under SEHAT model have had an important role during the past decade in strengthening the health system in Afghanistan. This proposal increases the role of the current NGOs/CSOs in the implementation of EPI services through sub-centres, Mobile Immunization Teams, and the Public Private Partnerships in insecure areas. These activities will be contracted out to the current BPHS Implementers in respective provinces under sole source selection method. The current BPHS implementers have already been assessed on their past experiences, performance and qualification through a competitive international bidding process with oversight by the World Bank and the National Procurement Commission.

Contracting the current BPHS-implementing NGOs will improve feasibility of implementation and provide cost-saving opportunities, as they are contracted on a provincial basis and have active presence and operational

[103] In special circumstances grant funds can go directly from Gavi to a CSO, please refer to the Supplementary HSS Guidelines for further information.

[104] This proposal uses the term Civil Society Organizations (CSOs) as encompassing 'not-for-profit' Non-Governmental Organizations (NGOs) as well as other entities such as private educational institutions and media and public-private partnerships (PPPs).

[105] A#43: A Basic Package of Health Services for Afghanistan, 2010/ 1389.

facilities for managing the primary healthcare service provision in the provinces, which prevents unnecessary operational expenses such as rent of field offices and their operational cost for implementation of the proposed activities. In this manner, contracting BPHS Implementers also avoids duplication, improves coordination, and provides synergies between all MoPH programs managed within the provincial BPHS catchment areas and health facilities, including MCH and curative components.

The MOPH has also experienced that cost-effective interventions, with aim to tackle the burden of diseases, can be best achieved if public health and curative services are provided through an integrated package including immunization services. The lesson learnt and achievements were mainly in result of partnerships built with National and International CSOs for provision of BPHS and EPHS packages where they were selected through competitive bidding process on the basis of performance and quality proposals. As a result of these partnerships, the MoPH has achieved tremendous progress over the last 10 years. The number of clinics and hospitals vastly increased from 400 in 2002 to over 2300 by 2014 (HMIS, 2014) and health indicators from multiple surveys show remarkable improvement in the health status by reduction of infant and child mortality from 165 and 257 in the year of 2002 to 77 and 97 respectively in 2012 per 1000 live births (AMS, 2010).[106] Furthermore, CSOs in Afghanistan are supporting other areas of the health system such as HR development through training and deployment of 'community midwives, and 'female nurses' and 'female vaccinators', monitoring and evaluation, information and participation in the development of policies and strategies, representation in national coordination forums and meetings i.e. BPHS/EPHS, HSS-SC and TAG. Moreover, some CSOs involved in advocacy and research and evaluation organizations, while not providing immunizations services, play an important advocacy role for immunization, particularly for campaigns and National Immunization Days.

CSOs implementing the BPHS are linked with the community through CHWs and religious leaders in their role on health education, communication of health activities, and community mobilization. The dialogue with and engagement of local community and religious leaders is an effective bridge and link between HFs and community. The HFs can inform the community through their religious leaders and CHWs and then receive reports from them as well, such as the case of children missed for immunization.

Mobile teams and private providers enrolled on the PPP approach will be managed and supervised by the CSOs implementing BPHS in in the relevant districts or provinces. Mobile teams and PPP will report to the HF CSOs and the information will be channelled through the HMIS. These interventions through CSOs thus not only aim to reach the underserved population but also their reports will make an excellent source of data coming directly from the community. Detailed budget and work plan provides further details on this in Annex #6.[107]

Under this proposal, CSOs will be implementing the key activities under objective 1 and 3 to reach the underserved population and cover 'white areas' and insecure provinces. Under objective 2 construction companies through a transparent bidding process of MoPH will be recruited, and they will be using the designs and specification and BoQ developed by WHO under HSS2 and attached as annex #40.[108] The program will be regularly monitored by the technical team of the respective implementer organization and MoPH at national and sub national level.

In addition to the implementation, CSOs have been actively involved in the planning and development process of this proposal, as their coordinating body AHO convened two consecutive meetings on 8th April and 15th April 2015. The budget allocated to be spent on the activities by CSOs will be about USD 10 M for service delivery to underserved population, and the accountability mechanisms have been covered above in Section 14 on M & E.
TWO PAGES MAXIMUM

[106] A#39: Minutes and Presentations from March 18, 2015, Gap Analysis Workshop
[107] A#6: HSS3 Detailed budget, gap analysis and work plan
[108] A#40: Construction Designs, Cost estimation, Specifications for Construction (folder)

20. Technical Assistance

This description will outline to Gavi how technical assistance and National Institutions will support implementation of the proposed activities.

- ➔ *Please describe technical assistance (consultancy services) included in the grant activities. Please describe how this technical assistance will improve the way health systems and the immunisation programme function.*
- ➔ *Please outline how technical assistance will improve institutional capacities of Government agencies and CSOs and contribute to sustainability.*
- ➔ *Please explain the role that any National Institutions will be given. This could be for a research or training institution with expertise in data quality assessments and monitoring.*
- ➔ *If no technical assistance is planned to support implementation of this HSS grant please provide an explanation of why it is not planned.*

Most of the activities depend on the developed national capacities, based on lessons learnt and previous experiences and expertise attained especially in procurement of health service provision and contract management and grant closeout. The MOPH emphasizes continually enhancing the capacity of existing country national staff to enable them to work more efficiently and effectively. Therefore the proposal allocates 0.5% of the budget for training and upgrading skills of MOPH's national staff which help improving capacity of staff at national and sub-national levels as well as local CSOs relevant staff, to provide high quality services.

Although a 'Training Needs Assessment' will be conducted at the start of the grant execution to identify specific gaps, the MOPH can foresee training needs in certain thematic areas such as Good Governance, Accountability and Leadership, M&E Training specifically for NMC and GLM, Procurement and Contract Management, Complaint & Conflict management, Gender mainstreaming and women's leadership, financial management and audit, fraud prevention, , Cost Effectiveness Analysis and Resource Allocation Policies, and Result-Based Monitoring and Evaluation that are interlinked with HSS visionary subjects and successful management of grant. In addition to this, for decentralization of M&E, WHO will provide six national TA consultants, one of them based in WHO and five of them based at MoPH while UNICEF will provide four national TA consultant for cold chain equipment procurement, distribution and installation one based at UNICEF and three at NEPI; as well as, five national TA for HP and NEPI (2 based at health promotion department and 3 at NEPI) Annex #6.[109] The WHO consultant TA engineers used in HSS2 will be deployed again at MoPH for construction as they have experience with the project implementation and monitoring. Technical support for conducting surveys and studies will be by utilizing the local expertise where possible and through the WHO and UNICEF experts available in country office. Evaluations of grant activities will proceed separately by third part engagement.

The purpose of the TAs mentioned above will be:

- To contribute to the process of implementation more effectively and efficiently for the proposed activities mainly EPI Components. TAs will be mainly responsible for building capacity for decentralized M&E and the installation and maintenance of cold chain equipment, especially solar fridge.
- To demonstrate and transfer the knowledge for cold chain management and quality assurance from inception to utilization at the EPI facility level.
- To build capacity through continuous coaching and mentoring to the cold chain technicians, assist the NEPI for better and quality management of direct EPI related activities, mainly to provide inputs and assistance into implementation of RED strategy, micro-planning and improving data quality. Building capacity will contribute to sustainability of the programme. For example, by conducting training on installation of solar fridge, cold chain technicians will gain first-hand knowledge on solar installation method, and the knowledge will remain among local partners.
- To provide technical assistance on conducting EPI coverage evaluation survey every two years, KAP studies for communication activities (baseline, mid and end studies), and mid- and end-term evaluation of PPP. In the past, such studies either in small and or large scale, had been contracted with international organizations. Recently, the experience from EPI CES clearly showed that national capacities are now available to perform some studies if provided proper guidance and support. Their involvement will further

[109] A#6: (Budget Assumption 1-15)

improve the capacities within the country to support not only EPI-related studies but other health sectors.

- To provide technical assistance to NEPI in overall EPI system strengthening and to technically coach and assist the established coordination forums and committee not only to sustain institutional and maintain gained capacities as well as to envisage and provide them with future vision for sustainability and assess possible graduation.
- To carry out quality design, bid preparation and bid evaluation for construction works for cold rooms and warehouses, and to transfer the knowledge of procurement and construction management to the MOPH Works and construction department through providing coaching and on-job training during whole procurement cycle and enable them to carry quality work independently.
- To conduct regular supervision and monitoring of construction in all target provinces and identify defects and produce report for payments and ensure construction materials are according to specification and best met EPI Needs. ***ONE PAGE MAXIMUM***

21. Risks and Mitigation Measures			
This information reflects the risk of a country not being able to implement the proposed activities within this grant proposal and/or spend the funds as approved by Gavi. It is expected that the Lead Implementer will be responsible for assessing and ensuring that risk mitigation measures are actually implemented. ➔ *If the country has existing health sector risk analysis, please attach these assessments and provide a brief reference to the relevant sections.* ➔ *If the country does not have existing health sector risk analysis, please complete the table below for each of the proposed objectives. Please refer to the Supplementary Guidelines for HSS Applications for a description of the various types of risk. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.*			
Description of risk	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	Mitigation Measures
Objective 1: Enhancement of equitable access and effective coverage of immunization services through integrated public health care system, private health sector-PPPs, and community participation with more focus on underserved population.			
Institutional Risks: • Complicated financial system at the provincial level to use the funds. • Sub-optimal level of coordination at national level. • Potential insecurity and threats	• Medium • Low • Medium	• Medium • Low • Medium	• Contracting-out process will be initiated after the approval of this proposal before the grants disbarment. • ICC merged to HSS Steering Committee. • PPPs and CHWs engaged for health services with a monitoring mechanism by PHOs and DHOs.
Fiduciary Risks: Possibility of PPP to make excessive profit by over reporting.	• Low	• Low	New implementation standards and community-based monitoring mechanism to regularly monitor the progress and verify the reports.
Operational Risks: • Centralized M&E system while PHOs/ DHOs are not supported in monitoring • Women reluctant to serve as vaccinators in outreach or MHT due to culture barriers.	• Medium • Medium	• Medium • Medium	• Decentralized M&E system will provide technical and financial support to provinces. • Recruitment of couple vaccinators for outreach in identified 2878 villages.
Programmatic and Performance Risks: • Low capacity at the provincial and district level to monitor the implementation. • Shortage of female vaccinators in the rural area.	• Medium • Medium	• Low • Medium	• Training of PHOs and DHOs by national experts and conducting joint monitoring visits. • Plan for training female vaccinators
Overall Risk Rating for Objective 1	Low to Medium	Low to Medium	
Objective 2: Strengthening of cold chain and vaccine logistics management system by increasing the physical capacity, maintenance and effective vaccine management (EVM) with provision of adequate infrastructure throughout the country.			
Institutional Risks: • Prolonged procurement system. • Cold chain capacity inadequate for New Vaccine	• Medium • Medium	• Medium • Medium	• Necessary Internal Procurement Guidelines developed for procurement of services and goods. • Selection of UNCEF for purchasing CC equipment and support from ARDS and TA for construction.
Fiduciary Risks: Lack of capacity for storage of cold chain equipment and dry supplies.	• Medium	• Medium	• Warehouse constructed under HSS2 and uncovered provinces will be covered.

Operational Risks: • Miscalculation of costing of required equipment. • Delay in designing of construction of warehouses	• Low • Medium	• Low • Medium	• UNICEF did calculations for cold chain equipment based on international costs. • WHO designs/ specifications which were developed under HSS2 will be used.
Programmatic and Performance Risks: • Security problem for shipment of equipment to provinces.	• Medium	• Medium	Local shipping companies will be recruited.
Overall Risk Rating for Objective 2	Medium	Medium	
Objective 3: Improvement of demand for immunization services by implementing context specific communication interventions to cover the disadvantaged population.			
Institutional Risks: • Poor coordination at provincial level. • Low awareness on and high sensitivity against vaccine in southern regions.	• Low • Medium	• Low • Medium	Task force committees will be established with a clear TOR at provincial level and regular meetings. CHWs, school teachers and religious leaders engaged in awareness to reduce the sensitivity.
Fiduciary Risks: Lack of expert on assessing the effect of messages for social mobilization	• Medium	• Medium	Support from experienced technical partners i.e UNICEF will be sought
Operational Risks: • Adversary social norms / traditions could present an accessibility barrier decrease the unitization of services. Low demand and thus low utilization	• Medium	• Medium	Use the health professionals, CHWs and CHSs from the same communities.
Programmatic and performance risk. • Provision of on time cold chain equipment	• Low	• Low	UNICEF has done the preliminary work i.e procurement planning and distribution planning.
Overall Risk Rating for Objective 3	Low to Medium	Low to Medium	
Objective 4: Strengthening of management and leadership capacity of the decentralized health system at peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services.			
Institutional Risks: Suboptimal coordination among PEMT, REMT, BPHS implementers NEPI and other stakeholders.	• Low	• Low	Establishing EPI task force committee with clear TOR. Active engagement of NEPI in proposal evaluation process and participation of NEPI in quarterly BPHS/EPHS Coordination Workshops
Fiduciary Risks: • Accountability of implementer NGOs	• Medium	• Medium	• Decentralized monitoring system is initiated based on which NGOs will get feedback, warning and termination of contract. • Contracts will include the PBF conditions (20% conditional amount) against the indicators set in M&E framework.
Operational risks: Possibility for duplication among development projects supported by different donors.	• Low	• Low	All donors and technical partners were engaged in development of this proposal and all other projects were reviewed. General Directorate of the Policy and Planning and HSS Coordination Unit oversee other support in HSS-SC
Programmatic and performance risk: Internal audit and HR system	• Medium	• Medium	TA has been planned for improvement of internal audit and HR system.
Overall Risk Rating for Objective 4	Low to medium	Low to medium	TWO PAGES MAXIMUM

22. Financial Management and Procurement Arrangements

In this section applicants are requested to describe:

- ➔ *a) The proposed financial management mechanism for this proposal*
- ➔ *b) Financial Management Arrangements Data Sheet: The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for oversight, planning and budgeting, budget execution (incl. treasury management and funds flow), procurement, accounting and financial reporting (incl. fixed asset management), internal control and internal audit, and external audit. CSOs can receive Gavi funding through two channels: (i) funding from Gavi to MOH and then transferred to CSO, or (ii) direct from Gavi to CSO. Please refer to Annex 4 of the Supplementary HSS Guidelines for further details*
- ➔ *c) The main constraints in the (health sector's) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance needs in order to fulfil the above functions.*

4 pages (more pages necessary if more than one lead implementer)

Question (a): applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one. A rationale for this choice should be provided.	The grant fund under this proposal will be managed by three principle recipients namely MOPH, UNICEF and WHO. The decision on the mechanism was established by the fact that each recipient has the specific responsibility and expertise to proceed quality and timely implementation of the proposed activities under their organizational financial management system. The MOPH will use a portion of the grant fund which shall be transferred by GAVI to Government account directly in Da-Afghanistan Bank. The financial management system of the Ministry is being managed using AFMIS, a national financial management software developed by the Ministry of Finance. This system works under charter of account codes for specific activities and generates report on the expenditures as well as used for internal control for the purpose of tracking the disbursement status. This financial management arrangement is being used for other development projects such as BPHS and EPHS, financed under SEHAT Grants. There will be a Financial Management Team located in the Development Budget Department (DBD); the team will work under the supervision of the head of DBD and work in close coordination and be in regular contacts with the HSS department. Payments will be made in accordance with the Government procedures and approved work plans and annual budget for suppliers, CSOs, contractors, and staff salaries using bank transfer system. Vendors and day-to-day operation costs will be managed using cash-based disbursement for small invoices such as travel and perdiem costs. The World Health Organization will manage a portion of the grant fund which shall be disbursed directly by the GAVI to WHO in Geneva which subsequently links the fund to WHO Afghanistan country program. WHO uses the 'GSM' system as an 'Enterprise Resource Planning' and management system that integrates data and processes into a unified planning, budgeting and monitoring system as well as provides easy access for WHO's country office. Staff salaries, suppliers and vendors will be transferred through bank account system. UNICEF will manage a portion of grant fund which shall be transferred by GAVI to UNICEF's headquarters in USA which then interlinks the fund to Afghanistan office. UNICEF uses ProMS, a computerized information system that integrates and streamlines its programming and work plan, including budget and financial data. Funds to suppliers and vendors will be transferred through bank account system and field implementation will be provided cash as per the jointly developed work plans approved by MOPH.

Question (b): Financial Management Arrangements Data Sheet	
Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).	
1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	Mr. Hafizullah Saadat, MoPH finance director Email add: hafiz_saadat@yahoo.com Mobile #: 0783368829
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	Yes, MOPH has experience managing grant funds financed by the WB, USAID, EU, GAVI, GFATM and UN agencies from 2003 up to the present. (12 years of experience managing funds with the WB, 6 years with USAID, about 10 years with GAVI and more than 12 years with UN agencies).
3. **If YES** • Please state the name of the grant, years and grant amount. • **For completed or closed Grants of Gavi and other Development Partners:** Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • **For on-going Grants of Gavi and other Development Partners:** Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	**Experience with the WB:** **Project** **Grant #** **Duration** **Grant amount** HESRDP H043, H206 H384 7 years 100 million SHARP H581 & TF96362 4 years 154 million SEHAT H829 & TF015005 5 years 407 million **Experience with the USAID**: **Project** **Grant #** **Duration** **Grant amount** PCH 6 years 240 million GAVI-HSS1 370321 5 years 34 million GFATM(GFR5-10) Multiple 8 years 80 million MOPH has no ineligible expenditure record - neither verified, nor qualified external audit opinion issued. No misuse of the grant fund or overdue or delayed audit report exists.
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	The HSS- SC is the body responsible for in-country oversight of the program. The committee members are comprised of: the HSS Coordinator, representatives from the some key departments of MoPH, elected representatives of CSOs, WHO, UNICEF and members from the main donors including USAID, EU, WB. The committee is chaired by the Deputy Minister of Policy and Planning. The committee provides review and support to the pre and post implementation aspect of the grant implementation and operations mainly reviewing work plans, annual budget as well as mentoring and monitoring the progress and performance, approving HSS related operations norms and decision is taken by 'consensus development' among the members. The committee meetings organized twice a quarter and on ad hoc based upon call by MOPH. Agenda and minutes are consistently documented and shared with the members and results are disseminated to technical departments implementing the grant fund and activities. In order to enhance the oversight and governance, members of the committee will plan to conduct field visits to monitor implementation, achievements and the challenges faced in the field. o
5. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	The main responsible is the Deputy Minister, and then General Director of Policy and Planning.
6. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and	Annual planning and budgeting process is initially to be developed by each technical department utilizing the grant budget and its work plan as mother documents. Annual budgeting and planning are then collected by HSS Coordination unit prior to being reviewed and approved by HSS-SC. The work plan including its budget will be reviewed by the HSS-SC which endorses

budget?	necessary changes as required or issues approval with or without condition. Afterward, the annual plan including its departmental budgets is presented to MOPH Authorities for approval as rules are set by the Government before implementation commences. The Ministry of Finance is responsible for the organization of the execution of the appropriations of the State Budget and enforcement of the financial management requirements as established by the Public Financial and Expenditure Management Law and annual budget procedures as adopted by the Parliament.
7. Will the Gavi HSS program be reflected in the budget of the MoPH submitted every year to the Parliament for approval?	YES, MOPH Portion only, since it has to be first included into the national budget before the fund is authorized for disbursement. WHO's and UNICEF's portions do not require Parliament approval.
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	**For MOPH Fund Portion:** • The suggested banking arrangement will be Budget Support USD Account under a GAVI specific Bank Account in Da-Afghanistan Bank. • The authorized signatory for MOPH Portion will be the Minister of Finance of Government of Afghanistan. **For WHO Fund Portion:** • WHO banking arrangement will be on **USD** bank name **UBS AG, 1211 Geneva 2** swift code **UBSWCHZH12A** • Authorized signatory is **Dr Richard Peeperkorn, WHO Representative** **For UNICEF Fund Portion:** • UNICEF banking arrangement will be on **USD** bank name **JP Morgan Chase Bank International Agencies Banking, 277 Park Avenue 23rd Floor New York, NY 10172-0003** swift code **CHASUS33** • Authorized signatory is **Ms. Nalinee Nippita – Senior Adviser UNICEF New York**
9. Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	**For MOPH Fund Portion:** • The GAVI Fund will be transferred to from GAVI to Da-Afghanistan Bank under a GAVI specific Bank Account for MOPH. **WHO bank account details:** Currency : USD Account number: **240-C01169920.3** IBN: **CH31 0024 0240 C016 9920 3** **UNICEF bank account details:** Currency : USD Account number: **014-1-076224**
10. Would this bank account hold only Gavi funds or also funds from other sources (Government and/or donors- "pooled account")?	The Bank Account will hold only GAVI funds.
11. Within the HSS programme, are funds planned to be transferred from central to decentralised levels (provinces, districts etc.)? **If YES**, please describe how fund transfers will be executed and controlled.	**For MOPH Fund Portion:** No

Procurement	
12. What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	UNICEF and WHO will be following their standard procurement and financial system for the proportion of the grant for which they are the recipient. At MoPH, the procurement of goods and health services will be processed under the Procurement Law and Rules of Procedure for Public Procurement of Government of Afghanistan. The law and procedure applies the level of supervision and oversight and establishes thresholds of authority for different levels. The first level to review the procurement process is the independent 'Procurement Committee' within the MoPH. This committee reviews and provides comments and verification or rejects the procurement documents with reasons in five stages. The second level is the 'Office of Control and Visa. This office reviews the complete set of procurement documents including sample of contracts. The third level is the 'National Procurement Commission' comprised of a member from the Ministry of Economy, Minister of Justice, and Minister of Finance, with direct oversight by the President of Afghanistan. The procurement of services is managed by the Procurement Department of the Procurement Directorate called 'Grants and service Contract Management Unit (GCMU). The unit has the capacity to carry out national and international procurement of services for all the programs in the MoPH and manage the service provision through 'contracted out' mechanism for the health services contracts (i.e. BPHS and EPHS and other programs including prior GAVI- and GF-ATM-financed HSS Grants) within the country. This unit of the Procurement Directorate has been certified and awarded certificate by Ministry of Economy and Ministry of Finance for preceding procurement of services with unlimited thresholds. Moreover, GCMU has been assessed and certified by the World Bank, USAID, EC as a contract management and procurement entity for consultancy services with transparent interface between international development partners and the MoPH in capturing and managing the public health funds, especially related to the country-wide provision of the Basic Package of Health Services and the expansion of the Essential Package of Hospital Services, in coordination with other MoPH departments, and stakeholders. The Department of Goods is established under the Procurement Directorate of MoPH for managing procurement of goods for ordinary and development budget under the same law and procedure, using the standard bidding documents issued and oversight by the same bodies.
13. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Under MoPH activities all items will be purchased according to Afghanistan Procurement Law, except procurement of cold chain equipment and some interventions that are appointed to UNICEF and WHO.
14. What is the staffing arrangement of the organisation in procurement?	• Under the oversight of Procurement Directorate, the procurement of health services will be managed by the HSS procurement staff placed at the GCMU Office. A team of two procurement staff and a manager are planned for this program to develop the procurement plans, initiate the procurement process including developing TORs, announcing and short listing, review of proposals, negotiations, and preparing contracts. The team will also take management duty of some contracts till closure.

	• Procurement of goods will be handled by the three procurement officers based in the Department of Goods. Moreover, these staff will be engaged in developing bills of quantity for acquisition of required supplies and procurement proceedings through support of ARDS. • Procurement of works will be proceeded by staff of Works Department of the Procurement Directorate with technical assistance by civil engineers from the WHO side from inception to completion of all construction of planned warehouses and cold rooms during planned year and take over.
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES: The procedure for physical inspection and quality control for goods will follow the instructions and guidance given by the Rules of the Procedure for Public Procurement. Technical inspection details, i.e. time, place, either during manufacturing or before shipment, or upon delivery or completion before final acceptance, will be stated in the contracts. The inspection procedure will also have set observation, testing on quality by internal inspection committees, or external, committed depending on the nature of goods. A committee comprising representatives of the Procurement Office, storekeeper or staff responsible for management of goods and supplies, and a representative of the end user, where goods are being procured for a particular department, will be formed to verify and ensure the correct quantity and completeness of the order delivered by the contractors.
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES: The Procurement Law and Rules of Procedure of the Government of Afghanistan provides the opportunities for complaint to any bidder that has suffered damage due to the violation of the Law and are entitled to seek review by submitting a written application for review identifying the specific decision, act, or failure to act alleged to violate the procurement legislation/law. Upon successful negotiation and getting closer to the contract award stage, the procurement offices for goods and services issue 'Notice of Award' to all bidders and the notice will be open for 14 working days for any complaint. In case of complaints supported with valid reasons, the complaint will be reported to MOPH Authority and seek their approval for re-review by MOPH or independent review committee established at the Ministry of Finance.
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES: Any dispute between the Parties as to matters arising pursuant to contracts signed that cannot be settled amicably within thirty (30) working days after receipt by one party of the other party's request for such amicable settlement may be submitted by either party for settlement in accordance with the provisions specified in the contract form. If, in a dispute subject to special clauses set in the contract, one party fails to appoint its arbitrator within thirty (30) working days after the other party has appointed its arbitrator, the party which has named an arbitrator may apply to the Secretary General of the Permanent Court of Arbitration, The Hague to appoint a sole arbitrator for the matter in dispute, and the arbitrator appointed pursuant to such application shall be the sole arbitrator for that dispute. Arbitration proceedings shall be conducted in accordance with the rules of procedure for arbitration of the United Nations Commission on International Trade Law (UNCITRAL) as in force on the date of signed contract.
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	There will be a finance team for the grants working in DBD of MoPH who will be responsible for the project accounting and reporting with oversight by the head of DBD. UNICEF and WHO will use existing staff of their finance departments.
19. What accounting system is used or will be used for the Gavi HSS Programme? (i.e. Is it a specific accounting software or a	MoPH uses financial database called 'Budget Preparation and Expenditure Tracking System' (BPET) for its accounting and reporting purposes. WHO will use GSM and UNICEF will use

	manual accounting system?)	ProMS as program management systems.
20.	How often does the implementing entity produce interim financial reports and to whom are those submitted?	Financial reports are produced on quarterly basis and reports are analysed by finance staff submitted to the Deputy Minister for Finance and Administration.
	Internal control and internal audit	
21.	Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	Yes, MoPH has a financial management manual that captures the required procedures and internal control system.
22.	Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	Yes, MoPH has an internal audit and control department that reviews each financial requisition to ensure they comply with approved budget and work plan and contract payment schedules as well as to be in line with Governmental accounting procedures.
23.	Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	No, each project management staff including delegated finance officers will follow up the implementation of internal audit recommendations under the supervision of head of programs reporting to Deputy Minister for Finance and Administration Affairs and MOPH leadership.
	External audit	
24.	Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[110]	YES. Annual External Audit has been budgeted and will be conducted by an External Audit Firm. The firm(s) will be selected through competitive process using Request For Proposal. The auditing will cover overall expenditures and financial affairs of the HSS3 Unit at the Ministry and the contractors with main objectives 1) To discover the reliability of the accounting system and ensure proper accounting system is in place and followed up by MoPH in central level and 2) To identify risk and opportunities of the internal control system for improvement and making the appropriate recommendations for management actions, and to identify risks and propose risk mitigating solutions. The audit firm will mainly assess the adequacy of operational and internal control systems established for HSS3 based on the overall organization arrangements, staffing, finance, human resources, procurement, asset & cash management and necessary internal controls including the different levels of delegated authority for different operational functions and appropriate segregation of duties in general to minimize risks.
25.	Who is responsible for the implementation of audit recommendations?	The Development Budget Department in coordination with HSS unit and the relevant departments implement the recommendations. Audit recommendations are strictly followed up by the HSS Grant team. Observation(s) related to the financial management of MOPH Finance section and the contractors will be jointly implemented by HSS Coordination Unit, Development Budget Unit and Technical Departments. Observation(s) will also be reported and presented to MOPH's Authority for review and to seek advice as matter of rule.
THREE PAGES MAXIMUM PER DATA SHEET		

[110] If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.

Question (c): Please indicate the main constraints in the (health sector's) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance needs in order to fulfil the above functions
The major constraint in the financial management system is existence of inadequate number of finance staff who are overloaded due to high volume of work in Development Budget section. Moreover, the finance staff are frequently overwhelmed with multiple internal auditor groups visiting the Ministry on irregular and ad-hoc basis with no prior scheduled time for inspection. This hinders normal working schedules that may lead to delay in timely review of financial expenditure reports and consequently affects and pushes back timely transactions and financial reporting for project management. The MOPH will ensure sufficient staff are allocated to manage the finance affairs for the grant. The finance team in DBD will also ensure the data-base is kept active and the proper filling system and archives established for grant fund to respond timely to the frequent inquiries and follow payment schedules and timelines as set forth in the work-plans and contracts. ***HALF PAGE MAXIMUM***