**Responses to GAVI IRC requested clarifications to Afghanistan’s application for 2015 Measles Supplementary Immunization Activities (SIAs):**

**ClarificationN01: The strategies to access 95 % of the target population need to be clearly described in light of learning from previous SIAs and the security situation** Plan of Action including timeline of activities and budget, approved by the ICC and GAVI Secretariat is required prior to approval. This is a mandatory document required by GAVI. Please refer to the measles SIA guidelines - ***Plan of Action for 2015 planned measles SIAs will be submitted soon after endorsement of ICC.***

The overall strategy for follow-up measles SIAs remains as a high level political commitment and administrative ownership for successful implementation of measles follow-up campaign. The national, provincial and district Governments, international and national development partners will work together and complement each other's strengths. As measles follow-up campaign is a onetime activity and therefore coverage must be >95% in the target age-group to impact on disease transmission and rapidly build up population immunity. In order to achieve 95% coverage with measles in 2015 SIAs, the potentially measurable strategies and practices from the previous SIAs in Afghanistan will be replicated throughout the country.

The following approaches will be used during preparations, implementations and post-campaign evaluation for measles SIAs in Afghanistan:

* At country level, the National Coordination Committee (NCC) under the chairmanship of General Directorate of Preventive Medicine will provide technical and logistic support to plan, implement, monitor and evaluate the follow up measles SIAs. The NCC will ensure partners’ coordination, vaccine procurement, development and finalizing media plan with timeline, monitor implementation of IEC/Social Mobilization activities at national, provincial and district levels and provide feedback to the Minister/Deputy Minister of Public Health.

***Note: The ToR of NCC with its sub-committees will be updated by the end of April 2015***

*Clarification on the date the ToR of NCC will be completed.*

* At provincial levels, the Provincial Coordination Committee (PCC) under the chairmanship of Provincial Public Health Directorate will be responsible to provide technical and logistic support to the districts to plan, implement, monitor and evaluate the measles SIAs, ensure inter sectoral coordination and full utilization of resources, monitor implementation of IEC/social mobilization activities at the provincial levels, respond appropriately to the media regarding program implementation, progress, safety and AEFI and provide feedback to the General Directorate of Preventive Medicine.

***Note: The ToR of PCC will be updated by the end of May 2015.***

Clarification on the date the ToR of NCC will be completed.

* The Control Rooms (CRs) will be established at national level and in each provincial EPI Management Team to monitor preparedness on a day to day basis especially mobilization of human and other resources like transport, ensure inter-sectoral coordination and full utilization of resources. The CRs will also monitor implementation of the program during the activity. The control room will provide feedback to the PCCs and NCC on progress being made and also on any obstacles being faced. The provincial EPI Manager, Cold Chain Officer, NGO/s, WHO, UNICEF representatives will be stationed in the Control Room.

***Note: Detailed ToR will be developed for CRs* by the end of May 2015**

*Clarification* on the date the ToR for the CR will be completed.

* The PCC will assign the medical officers of the main health facilities as District Coordinators in each district under each PCC jurisdiction to form District Coordination Committees (DCC) for measles SIAs. The DCC will include heads of all health facilities in each district, representatives of district councils, representatives of district government departments and NGO/s.
* The key responsibility of DCC during preparation is to provide support in developing the very accurate district micro-plans. The district micro-plans will be developed in a bottom-up approach from the village/block levels and will be flexible enough to take into account ground realities in different places (urban/rural, secure/insure, IDP camps, illegal settlements, hard-to-reach areas and moving populations (nomads) to ensure that no areas are left out from the micro-plan. The cluster/teams’ supervisors mainly the residents of the same districts will visit each village, area, block in the cities and suburb areas to collect all necessary data/information needed for developing district micro-plans and group villages into clusters.

***Note: ToR of DCC will be updated by the end of May 2015***

*Clarification of the date that the ToR of the DCC will be completed.*

* The DCC will identify in-accessible villages/districts in security-compromised areas and through district councils, religious leaders, village elders, ICRC, ARCS and NGOs will communicate with opposition leaders to allow supervisors to those districts for preparing district micro-plans. Such mediators as are accepted by them will be approached to participate in the development and implementation of appropriate strategies aimed at reaching their hard-to-reach population.
* District micro-plans will include the provision of additional financial and technical support to address social mobilization, logistics and security needs for reaching the groups of hard-to-reach populations.
* Each team will consist of three persons including one community mobilizers.2-3 days before the actual implementation of SIAs, the community mobilizers will visit each household to identify eligible children, mark the number of children on the households’ doors, record total number of children and inform the parents/caretakers about the place, date and time of vaccination sessions in the nearest mosques or other public places of the village/block. The mobilizers will meet with village leaders and religious leaders informing them about the importance of measles vaccination and requesting them to mobilize communities for vaccinating their children.
* During the day of implementation, community mobilizers will visit all households for referring eligible children to the vaccination session sites. By the end of immunization sessions, supervisors/community mobilizers will compare the number of children vaccinated by each team with the actual number of children eligible for measles vaccination in the same village where the session conducted.
* Supervisors/intra campaign impendent monitors will monitor villages/ areas immediately on completion of activity and check at least 20 target age-group children. If according to supervisors’ or independent monitors’ observations 4 or more children are found ‘missed, visit will be made to this area to motivate and mobilize missed children to the nearest campaign or routine immunization session site.
* Intra campaign independent monitors will be trained to engage them in conducting rapid convenience assessment for the quality of activity in an area. They will use standardized monitoring tool to uncover pockets of un-immunized children to take corrective actions like repeating the activity in an area where significant number of unimmunized children are found after completion of activity.
* During the campaign period, immunization activities for the campaign will be conducted on average for 6 working days without disturbing the routine immunization. The flexibility of maximum 12 days will be considered especially for remote areas with less number of trained health workers. The fixed, outreach and mobile strategies will be used to reach the objective of measles SIAs. To ensure safety, all children will be immunized at fixed posts (session sites) only.
* One village or an urban area will be covered in 1 day by a team(s). If the size of the village or urban area is large, multiple teams will be deployed so as to cover it in one day. But no vaccination team will conduct activities at two session sites in any one day. Several such vaccination teams will work simultaneously in a block or an urban municipality to complete the immunization activities in the shortest possible time without compromising on quality and safety of vaccination.
* A session will start as soon as in the morning and will end when all children have been immunized. An outreach site will operate from 8 AM to 3pm or until the last child has been vaccinated. The teams will stay for one more hour in that village/block/area for that day after 3pm to vaccinate missed children. *The ToR of vaccination teams will be updated*. Clarification on the date the ToR of vaccination teams will be completed.
* ***Note: ToR of vaccination team will be revised by the end of June 2011***
* All health facilities at PHC level and above will function as session sites throughout the campaign duration to immunize any children in the target age group coming to the health facility, for which measles vaccine is indicated. Outreach/mobile teams will be used for covering hard to reach areas, mobile populations, illegal and temporary settlements.
* To ensure that all staff involved in Measles SIA understand their roles in the SIA, the micro-plans at the clusters/HF/District level are completed, and all vaccinators have appropriate knowledge and skills to conduct the SIA at each of their catchment areas, all key players and staff for measles including cold chain and data handlers will be adequately trained.
* Logistics will be well planned in advance to ensure e advance order of vaccine/injection supplies, timely distribution from HF to session sites, assignment of responsible person at each post, specific timing supply distribution and return, return of unused vaccines in reverse cold chain, return of injection wastes from vaccination posts and their disposal, particular attention to logistics needs for hard to reach and under-served areas, ensuring vaccine and diluents from the same manufacturer, AD syringes, reconstitution syringes and injection safety equipments are distributed together in matching quantities.
* Appropriate communication and social mobilization interventions will be planned and used to mobilize the community for the campaign/inform people about the campaign, create momentum for immunization and will address existing social norms and barriers to immunization.
* Following the measles SIAs, review meetings will take place at district, province and national levels to identify the strengths and weaknesses of the activities. Supervision and monitoring tools used during the campaign will be collected and analyzed in order to provide quantitative information related to the process of implementing the activity. All key players and staff involved in the planning and service delivery aspects of the activity will participate in the review process to document best practices and lessons learned to ensure the highest quality of campaigns in the future.
* The outcome of the measles campaign will be measured by the proportion of the target population (children 9-59M) who were vaccinated during the SIAs. Two approaches will be used to estimate measles campaign vaccination coverage – administratively, based on campaign field reports and conventional household surveys using cluster sampling methodologies or LQA. The first approach can be problematic because information about the target population (denominator) is not correct and the second approach will be used to validate administrative coverage during measles SIAs.
* Once all the administrative coverage data and post – campaign assessment data completed, the decision to do mop-up vaccination campaign will be based upon the finding of sub-optimal coverage (<95%).The districts with low coverage will be addressed immediately after SIAs.

**ClarificationN02: Exemption letter of MoH from taxes and duties on import of vaccines needs to be shared.**

* This important issue is one of the top agendas of the Ministry of Public Health of Afghanistan to negotiate with finance ministry to exempt not only measles vaccine but all EPI related vaccines, supplies and equipment. The MOPH will get exemption certificate from highest government authority through MoF in the next future and will be shared with GAVI. It should be noted that Afghanistan has been receiving EPI vaccines, supplies and equipment as donation and GAVI supported vaccines/injection supplies through UNICEF and that are exempted from taxes.

***Note: MOPH will submit exemption letter for vaccine/injection supplies latest by June 2015.***

The date that GAVI will receive the exemption letter is requested.

**ClarificationN03. The derivation of unit costs in the budget is opaque and needs to be clarified for each item in greater detail.**

* We have revised/adjusted estimated fund requested for 2015 measles SIAs with costing per activity (Attached excel sheet and table 6.3b of the application). The exact/detailed cost per activity will come out after completion of district micro-plans at national level.

**ClarificationN04. The rationale for the high operational costs of child vaccinated in this proposal needs to be explained particularly with potential savings from cost sharing with Polio Plus.**

* The operation cost per child vaccinated in 2012 SIAs was around U$1 including vaccine/injection supplies. The cost per child in this proposal for 2015 measles SIAs is based on ground realities such as high and increasing cost of fuel/transport, cost implication for extended duration of preparation (training of staff on district micro-planning, preparation of district micro-plans), longer duration for training of staff and actual implementation of measles SIAs, increased number of staff to reach the expected coverage, post-campaign evaluation and possibly conducting measles mop-up campaign where the coverage will be less than 95%. The exact cost for the planned SIAs will come out after completion of district micro-plans at national level. The unspent balance (if will be remained) will be shared with GAVI and if agreed will be used for strengthening routine immunization.

The operational cost and plan of action approved by the ICC and GAVI Secretariat is required prior to approval (see point N 01)

***Note: ICC has already endorsed the application with estimated cost. The revised cost estimation with plan of actions will be put forward in the agenda of next ICC meeting for approval and will be shared soon after ICC meeting.***

* Based on the past experiences and as negotiated, polio fund will be used to cover the incentives of additional staff for administration of polio vaccine only.

Will any of polio funds be used to cover integrated campaigns activities, or are measles SIA funds being used to cover polio activities? Are there other activities that overlap and are to be shared between measles SIA and polio and by whom?

***As mentioned, polio fund will be used to cover the cost for incentive of staff that will be engaged in administration of OPV only. The logistic cost of vaccine (OPV), monitoring/supervision and evaluation will be covered by measles fund***.

**ClarificationN05.** **The high cost of transportation needs explanation, along with reassurances that no capital expenditures will be incurred and budget be used only for rentals.**

* The total revised fund estimated for transportation is US$796,180 (annex2 and Table 6.3b of application). The cost estimated for transportation is based on the past SIAs, NIDs and SNIDs and supposed cost of fuel/transportation in 2015. The higher cost estimated for transportation is based on increased number of vehicles for all the planned activities for SIAs and efforts made to estimate it realistically. ***The estimated fund is planned for covering the transportation cost of SIAs operations only and no capital expenditure is considered.***

This response has not addressed the issue raised. It has not clarified that no capital expenditure will occur.

**ClarificationN06. The conditional offer of government contribution to funding of this SIA requires firming up.**

* The issue of government co-financing was raised in the last ICC meeting and in several technical meetings including last national measles validation committee meeting. The government is fully committed to contribute and the deputy minister has advised the concerned departments in MOPH to follow up this issue. Since the government budget is annual and the procedure is prolonged to get the fund for co-financing, for the time being UNICEF has committed to contribute U$300,000 to partially cover the cost of vaccine for 2015 measles SIAs (UNICEF message attached). The government contribution (if approved) will be communicated in due time.

The operational budget of $4,179,042 will have to be resubmitted with a clear breakdown of the GAVI contribution of no greater than $3,575,000, as the GAVI policy is to contribute $ 0.65 cents per child. The revised budget needs to clearly identify how GAVI’s contribution will be allocated versus other partner’s contribution.

The Measles SIA Action plan will also need to be approved by the ICC and submitted to the Secretariat for approval prior to the disbursement of the first tranche of funds.

***As per your advice, the estimated operation cost is revised (attached excel sheet and Tabl 6 of application).But based on our past experiences, we are expecting shortage of fund for covering the whole operation cost of measles SIAs.***

**ClarificationN07. Mitigation steps in light of the report of gender-based discrimination in some small communities.**

In Afghanistan, there is no significant difference in immunization coverage between girls and boys and they have the same likelihood of being immunized. There are very small communities that culturally favoring boys over girls. But if the communities have access to health care services and immunization both girls and boys are treated likewise and the parents are using health care services and immunization equally. However, to reach all eligible children of both sexes with measles vaccination during 2015 SIAs, the following actions will be taken to address this issue:

* The communication materials will be designed and addressed culturally-appropriate messages to promote immunization coverage in the communities. Information and messages will be adapted to acknowledge local health beliefs and views so that the messages are understandable and acceptable to the people. Information and communication campaign that will be started at least one month before the SIAs will try to implicate mothers, fathers, families and communities in improving childhood immunization.

* The community mobilizers and supervisors will work face to face in the communities with fathers, families, religious leaders and community elders to explore reasons for gender based barriers (if exist) and define with communities appropriate solutions to increase access to vaccination coverage.
* Since women are mainly decision- makers over child vaccination and at the same time are facing time and resource limitations in getting their children vaccinated, changes in immunization service organization and extended service hours will be considered to facilitate utilization of immunization services.
* Attention will be given to involving men in the immunization of their children so that gender disparity to immunization and that will help to slowly change gender difference if that exist the communities.
* The national and local women organizations and civil society organizations will be engaged in all steps of measles SIAs to identify problems with gender disparity ( if any) and find innovative solutions.
* Communication activities will mainly focus on individuals and communities to understand the value of vaccines and increase demand for measles immunization and all the other routine vaccinations.