

**Islamic Republic of Afghanistan**

**Ministry of Public Health**

 Dear Sir/Madam, 13 August 2012

Reference is made to the letter from GAVI Alliance Secretariat of 19 June 2012 regarding Afghanistan's application to the GAVI Alliance for Health Systems Funding Platform (HSFP), which was reviewed by IRC in May 2012 and recommended **“approval with clarifications”**

First of all I would like to convey my sincere regards to GAVI board esteemed members and GAVI secretariat.

We are pleased to receive your "Approval with Clarification" and appreciate the trust placed on us to use the funds to improve the health of Afghan children to reach targets set in GAVI Health System Strengthening application for Afghanistan and consequently the MDGs.

In response to the "clarification" requested, the letter has been shared with partners and meetings were held with assigned technical group. The responses have been prepared on a participatory manner and presented to HSS – Steering Committee (equivalent to HSCC) dated 5th August 2012. (Attached minutes) Please find attached clarifications and other modified documents.

The followings are responses to the clarifications received through official letter dated 19 June 2012:

**Clarifications:**

**Clarification 1:**Correct all inconsistencies (describe in detail above) between the program narratives, log frame and performance framework.

**Country response 1:** The consistencies have been made between the program narratives, long frame and performance framework and necessary modifications also have been made accordingly in the relevant document.

**Clarification 2:** Adjust immunization coverage estimates in the target to reflect data as available in the MICS survey and WHO/UNICEF estimates.

**Country response 2:** It has been observed that there is apparently a huge difference on the coverage estimates, estimated through household surveys and Health Management Information System (Administrative coverage) in Afghanistan; however this concern has been raised in many forums such as Monitoring and Evaluation Advisory Board, CGHN and Technical Advisory Groups (TAG) in the MoPH.

In order to tackle this problem, the MoPH has plans to conduct an EPI coverage survey later this year. The preliminary findings on EPI coverage estimates will hopefully be available in October this year. The coverage survey will provide the MoPH and its partner’s with realistic and more reliable estimates of the immunization coverage. Since the EPI Coverage estimates used for the baseline in the HSPF Proposal is based on the administrative coverage for Penta(87%), therefore the proposed target of achieving 92% coverage for EPI seems realistic. However, in case, the coverage estimates that will be produced by the EPI household Survey happens to be significantly different from the current estimates, the MoPH will modify the coverage estimates accordingly.

**Clarification 3:** Provide detailed evidence based information on the programming and financing gap analysis to better understand the added value of this request from a big picture perspective of the Afghanistan health sector.

**Country response 3:** Since Afghanistan is a post conflict country, it is obvious that the health system of Afghanistan is under reforming and restructuring, there is limited information and Afghanistan will need time to have completed information on financial issues.

Currently, the MoPH is busy in conducting Health Financing Performance Assessment using WHO OASIS tool (Institutional and Organizational Assessment for improving and Strengthening Health Financing). Besides, the MoPH intends to produce a National Health Accounts (NHA) report by end of 2012. Furthermore, the MoPH is currently exercising the costing of BPHS, EPHS and national hospital services. As a complementary to the named activities, a comprehensive funding gap analysis for the heath sector in Afghanistan is proposed in the HSFP proposal and should be part of the technical assistance in the first and second years of the support. The gap analysis will highlight the current healthcare financing situation and future needs of the country given the MoPH five-year strategic plan. Moreover, the proposed activity will allow the MoPH to expand the costing exercises to the national health programs such as maternal and child health, immunization, nutrition, mental health, disability, malaria, tuberculosis, HIV/AIDS and HRH. Having a comprehensive set of information on current costs of the sector, availability of resources and futures needs will enable the MoPH to identify the gaps and seek out solution to fill the gaps.”

In addition to responding to IRC requested clarifications, we would like to reflect over some of the IRC observations which were part of the detailed report but not requested as a clarifications which may help to better understand the situation:

***Clarification #1:***

***Annex 6 with the list of 13 participants that endorsed HSFP proposal includes 1 CSO representative.***

Country response:

Referring to Annex 6 with regard to list of participants that endorsed HSFP proposal which includes 1 CSO Representative, representing CSOs in HSS Steering Committee who has been elected through a transparent voting process, where this one representative represents a network of CSOs titled Alliance for Health Organization (AHO)which was established as outcome of first phase CSO type A GAVI support,[Currently AHO represents a network of over 21 Health CSOs in Afghanistan].Since the CSOs representative was part of proposal development team assigned by the Health System Strengthening Committee (equivalent to HSCC) , the different drafts of the proposal was regularly shared through this elected representative with the all member CSOs in the network. Therefore, it reflects the views of all of key CSOs.

 **Comprehensive Multi Year Plan (cMYP) overview**

cMYP provides a thorough analysis of health care system/context and EPI. In the end of situational analysis section SWOT analysis is presented separately for various system components.

cMYP is aligned with the national health sector plan in terms of definition of challenges Health related challenges: the strategic plan for the Ministry of Public Heath (2011-2015) is built on (and is complementary to) the NHSS. It stated 10 strategic directions. cMYP refers to 5” national health priorities” and 10 goals (targets) to be achieved by the 2015, and links EPI with the revised MDG targets.

Updated cMYP is attached

***Clarification # 2:***

***The objectives 3, particularly component 3.1 is devoted to the strategic of M&E framework in the country that would benefit M&E of the HSS implementation.***

The M&E National plan (2012-2014) describes M&E Directorate’s capacity, data and information collection mechanisms, reporting system and contain M&E framework that actually use instrumental for measure M&E directorate performance (and not the performance of health care system, or progress in health system strengthening as one could expect looking at the tile of the document).

Country response:

A monitoring matrix will be developed to include the key indicators of health system in Afghanistan. The matrix will serve as an M&E framework for the MoPH. The framework will be comprehensive enough to support EPI, maternal and child health care services indicators. The M&E department will provide information on the progress made on the key indicators on quarterly basis to the MoPH. The M&E officers will regularly monitor the services using the checklists and other data collection tools. They will perform joint monitoring visits along with the provincial public health officers. A joint monitoring mechanism at peripheral level will be further strengthened in order to monitor the progress of the health sector priority indicators particularly contributing toward improving quality and coverage of EPI intervention as well as Maternal and Child health indicators.

In non secure areas where it seems challenging for state entities to monitor the HSS interventions, an alternative mechanism will be established and used in order to monitor the process of implementation as well as progress made toward achieving the objectives and targets reflecting in the HSFP. The monitoring mechanism will include establishing passive reporting system (reports provided by implementing NGOs and the contracted private facilities). In addition, people from the communities in the insecure areas will receive training on simple monitoring mechanism and will be provided with appropriate monitoring tools to monitor the interventions particularly those reflected in the HSFP. Regular data review and feedback mechanisms will be strengthened in order to assist program and policy level decision makers to take informed decisions.

***Clarification #3:***

***The HSS proposal performance framework includes 6 outcome indicators. In addition 19 output level indicators are provided with baselines and targets (though for some indicators they are missing).***

County clarification:

The Objective / indicator number 2.7, 2.9, 3.4, 3.5 have been modified accordingly and the revised Performance Framework is attached.

***Clarification 4:***

***The indicators in the performance framework related to the immunization coverage targets appear unrealistic since these are based on administration coverage. The target for 2014 is 92% for Penta even though the MICS survey found the coverage is 66% (administration coverage is 87%).***

Country Response:

It has been observed that there is apparently a huge difference on the coverage estimates, estimated through household surveys and Health Management Information System (Administrative coverage) in Afghanistan; however this concern has been raised in many forums such as Monitoring and Evaluation Advisory Board, CGHN and Technical Advisory Groups (TAG) in the MoPH.

In order to tackle this problem, the MoPH has plans to conduct an EPI coverage survey later this year. The preliminary findings on EPI coverage estimates will hopefully be available in October this year. The coverage survey will provide the MoPH and its partner’s withrealistic and more reliable estimates of the immunization coverage. Since the EPI Coverage estimates used for the baseline in the HSPF Proposal is based on the administrative coverage for Penta(87%), therefore the proposed target of achieving 92% coverage for EPI seems realistic. However, in case, the coverage estimates that will be produced by the EPI household Survey happens to be significantly different from the current estimates, the MoPH will modify the coverage estimates accordingly.

***Clarification # 5:***

***Intervention 2.1 (“to increase DPT3 coverage in kochi children from 16% in 2010 to 30% in 2014’) does not sound feasible as far as it can be considered as a target for objective #1 rather than as an activity (or a group of activities).***

Country Response:

The appropriate modification has been made with this regard in the narrative section of the proposal. The target “To increase DPT3 coverage in kochi children from 16% in 2010 to 30% in 2014”has already been reflected in the list of Impact / outcome indicators.

***Clarification # 6:***

***It is not clear enough how or why establishing new hospitals or exploration of “the social impact, the cost effectiveness and the capacity of the private sector to run the newly established hospitals’’ is relevant to the objective(#1) of increasing immunization and “other essential health services particularly to the undeserved population”.***

Country Response:

This intervention will not be conducted anymore; and has been removed from the list of proposed interventions in HSFP proposal.

***Clarification #7:***

***Some interventions under objective 1 and 2 look repetitive, especially related to health sub-centers (training of medical staff).The proposal does not explain how mobile phone can deliver important content to illiterate population (if voice calls are not used) in rural areas.***

Country Response:

Under objective 1, the proposed interventions focus on increasing DTP3 coverage among children of nomadic populations through the implementation of cascade of well-defined and prioritized interventions. These interventions include the establishment and operationalization of mobile health team (MHTs) for the nomadic (Kochi) Population, selection and training of community health workers (CHWs) from the nomadic communities for the nomadic population, establishing health shuras among the Kochi population. So far the nomadic (Kochi) population has been considered among the most marginalized groups of population in Afghanistan; they do not have proper access to very primary level of health care services.

The Sub Health Centers (SHC) and Mobile Health Teams (MHT), currently supported by the GAVI/HSS, do not cover the nomadic population. These SHC and MHTs have been established to cover certain pocket of fixed population living in remote and marginalized areas. Since the nomadic (Kochi) population always moves from one geographical place to another, it is important to establish special Mobile Health Teams in order to ensure access to health care services by this marginalized group of people in order to improve their health status. Under the objective 1 of HSFP Proposal, CHWs will be selected from the Kochi people and will receive training on a modified package of health services. Curricula will be pictorially designed as majority of Kochi people are illiterate.

Under the objective 2 of the HSPF Proposal, the proposed interventions will mainly focus on improving the quality and performance of EPI interventions including cold chain system, availability and maintenance of vaccine, training of the vaccinators, monitoring of the EPI interventions and on improving the awareness of the people in order to increase the coverage of the vaccination program among Kochi population.

There are four options proposed on how mobile phone would deliver important content to illiterate population, one or a combination of them will use in the call centers: 1) to deliver text messages to the target audience. 2) To deliver voice messages to the target audience. 3) To make a call through an assigned team in the MOPH to the audience. Upon pressing the received call button the client(s) will hear health relayed messages. 4) To have short code such as 125, that will be announced through media in order to guide the people who would like to collect information on health issues, they will call this number, there will be live agent (professional team) who are responsible to directly talk with the client(s) and will provide them with necessary information, as a results both literate and illiterate clients will benefit from the proposed intervention.

It is deemed that more than 70% of the Afghans who have access to mobile phones can benefit from the proposed intervention. The remaining 30% population will be covered by other means of communications including arrangement of health education sessions in the health facilities, displaying flipcharts, posters and other health education materials. In addition, the broadcast of key health messages via local Radio and TVchannels will be among the vehicles used for awareness rising.

***Clarification # 8:***

***It is not enough clear how health awareness promotions activities under #2.3 differ from 1.1.3” raise awareness among nomadic population” or how much it is possible.***

Country Response:

The activity # 2.3 focuses on awareness raising interventions among the general public at the national level. This will be accomplished by designing and distribution of IEC materials throughout the BPHS health facilities. Key messages will be developed and broadcasted via national and local radios and television channels.

In addition; IEC / BCC and IPCC training will be conducted for the different category of health professionals at the BPHS health facilities.

The activity # 1.1.3 mainly focuses on raising the awareness of nomadic population, it is obvious that the nomadic populations are the most vulnerable and marginalized social groups in Afghanistan still maintaining the world worse health and social indicators.

The literacy rates are extremely low among Kochi population, therefore this group of population requires specially designed health interventions in particular, awareness raising interventions. The IEC and awareness raising materials should be designed to the context, values, social believe and understanding of this group of population.

It is aimed to develop pictorial IEC materials for the Kochi population; CHWs will be selected among the Kochi population and will receive training on health promotion interventions based on a standard health package designed for them.

***Clarification # 9:***

 ***Unit costs tables (for MHT, CHW training, etc) are not uniform and not easy to understand (e.g.25% increase in unit costs between 2 columns (in MHT table)***

Country Response:

The unit cost tables of MHT revised and necessary corrections have been made. The unit cost of training of CHW on C-IMCI table was prepared based on C-IMCI training program which is currently under implementation with the support from the current GAVI –HSS grant. It indicates that the average cost of training one CHW for six days on two modules of Acute Respiratory Infection (ARI) and Control of Diarrheal Diseases (CDD). The Kochi CHW training table shows that the average training cost per CHW who will receive initial training based on standard training package will be developed for Kochi CHWs.

***Clarification # 10:***

***Some weaknesses were identified in the proposal. These include a budget start date that does not correspond to HSS program start date (2012 vs.2013); and poorly described approaches to sustainability as this in only mentioned only in the executive summary.***

Country Response:

1. The starting date for the implementation of HSFP is considered to be on 1stApril 2013
2. More details on sustainability:

The Ministry of Public Health and the donor community supporting the health system of Afghanistan have already took over the support of several initiatives launched through the HSS Grant, for instance, the Mobile Health Teams and the Sub Health Centers., In addition, some of interventions supported through HSS in the past were fully integrated into the health system and being supported through the fund allocated by the government. An example for that is the District Health Officers (DHOs) Scheme .The HSS Grant supported a cascade of interventions that are counted among priority health interventions. So far there has been no resistance to maintain these interventions either by MoPH or the donors supporting the health system of Afghanistan.

In addition, the Health System Strengthening Program has focused on improving efficiency, accountability, transparency and in building the capacity of managers and health professional in the various components of health system. That is instrumental in building stronger and more responsive health system able to deliver, to face the challenges and to produce more health with the available funds.

In addition, HSS program has significantly contributed to the ability of MoPH to assume effective oversight, stewardship and resource allocation as well as better coordination at different levels including strengthening of private sector and building partnership with for profit health service providers through continuation and expansion of CSO type B that enables the MoPH to promote health equity and to enhance population health outcomes.

Providing health services in the insecure areas of Afghanistan will scale up the visibility of government of Afghanistan and will contribute toward improving stability and peace building.

Institutional development, capacity building of health professionals and making the health system responsive to the needs of most vulnerable and marginalized population is the core function and contribution of Health System Strengthening program.

All health system building blocks that include health work force, service delivery, governance and leadership, informatics, resource creation (health system financing) and access to essential drugs are strengthened through the support provide by GAVI fund.

The growing role of national NGOs in the delivery of healthcare services is leading to an increased indigenous ability to provide health care. This process is actively facilitated by many actors in the healthcare sector through a broad process of transfer of technology and capability from internationals to national. The involvement of the for profit private sector, being the major care provider in the country, further increase the coverage and access of health care and extends the HS M&E instruments to ensure quality of care.

This proposal will enhance the role of the existing cadre of Community Health Workers. The proposal plans to establish or strengthen communication between the CHWs and the larger health system in addition to the various training activities proposed. The proposal plans to further strengthen coordination and collaboration at different level of MoPH. Decentralized decision making by empowering provincial health set up will be promoted.

The proposed budget structure can be considered as a factor contributing to sustainability. Though the proposal would have benefited if it demonstrating how the procured assets will be maintained and some other recurrent costs (for example mobile phone user fees) are covered.

***Clarification # 11:***

***The description of current HSS efforts carried out by different development partners is not helpful enough to outline areas where GAVI HSS support can add value to ongoing or anticipating interventions.***

Country Response:

 The current HSS efforts carried out by different development partners are definitely added value to the health system of Afghanistan, the HSS unit has planned to conduct an end of program evaluation that will measure the added values of GAVI/HSS contributed to the Health System of Afghanistan. The District Public Health Officers (DPHO) evaluation conducted by third party which the results of this evaluation recommended that this was an excellent initiative supported by GAVI funded should be expanded to other district. Meanwhile the results of mobile health team evaluation presented a wonderful picture of service delivery in the remote areas of the country. The evidences during the evaluation showed that the interventions have proved to be very effective. Therefore it has been recommended to continue this intervention with the support through the funds received from other donors and government of Afghanistan.

The Demand Site Finance (DSF) project was piloted in sixteen districts of four provinces from December 2008 to May 2011.The aim of the project was to assess the impact of providing incentive(S) to improve utilization of maternal and child health and immunization services. It was a quasi-experimental study with four arms; 1): providing Incentive to families to utilize maternal health and vaccination; families were given $6 for each delivery that has been conducted at a public health facility and $3 for bringing a child to the health facility to receive DPT3 vaccination. 2): Providing incentive to community health workers; $3 for the referral of a pregnant woman in order to promote institutional delivery at the public health facilities as well as referral of a child to receive DPT3 vaccination. 3): In the combined arm, both household and CHWs were provided with incentive and 4): in the control arm, no incentive was provided to families and clients. According to the end of project survey the findings suggested that the payment of incentive is proved to be an effective mechanism to increase demand. *“The findings suggested that more can be done to reach women who have never delivered at a health facility and to communicate the program to the disadvantaged women .Cash incentives – when provided to both community health workers and households, are associated with an increase in institutional delivery and DPT3 vaccination”.*

1. The Kochi package of care will promote equity and enhance universal coverage of health care in the country.
2. Implementation of the proposed plan will have significant positive impact on the EPI coverage. Reaching out for the Kochi population will solve one of the major challenges facing the efforts to increase that coverage.
3. The CSO Type B experience to work with the private sector proved very successful. This proposal aims at building on previous gains to maintain and expand health coverage in security compromised areas*.*

***Clarification #12:***

***With country failing to provide a clear financing analysis, it is challenging to see how this application adds value to on-going HSS efforts.***

Country Response:

Since Afghanistan is a post conflict country, it is obvious that the health system of Afghanistan is under reforming and restructuring, there is limited information and Afghanistan will need time to have completed information on financial issues. Currently, the MoPH is busy in conducting Health Financing Performance Assessment using WHO OASIS tool (Institutional and Organizational Assessment for improving and Strengthening Health Financing). Besides, the MoPH intends to produce a National Health Accounts (NHA) report by end of 2012. Furthermore, the MoPH is currently exercising the costing of BPHS, EPHS and national hospital services. As a complementary to the named activities, a comprehensive funding gap analysis for the heath sector in Afghanistan is proposed in the HSFP proposal and should be part of the technical assistance in the first and second years of the support. The gap analysis will highlight the current healthcare financing situation and future needs of the country given the MoPH five-year strategic plan. Moreover, the proposed activity will allow the MoPH to expand the costing exercises to the national health programs such as maternal and child health, immunization, nutrition, mental health, disability, malaria, tuberculosis, HIV/AIDS and HRH. Having a comprehensive set of information on current costs of the sector, availability of resources and futures needs will enable the MoPH to identify the gaps and seek out solution to fill the gaps.”

The following weaknesses were identified related to consistency across proposal documents:

* The same issues are repeated several times (particularly problems) within the same document that makes difficult to map prioritized problems with intervention addressing them.
* Budget timeframe not consistent with proposal timeframe: e.g. starting in Q1 of Y1, but in reality starting in Q2 of Y 1 (April 2013 on p 1 of proposal, performing framework), and the end date needs to be changed accordingly (Q1 of 2015 & not Q4 of 2014)
* Activity grouped by service delivery areas and objectives in the log frame (excel file) and the proposal form do not match.
* Lack of corresponding budget in work plan for activity 1.2.1.2, 1.3.1 & 1.3.4 although timing has been indicated.

***Clarification #13:***

***The lack of harmony and inconsistencies between proposal and critical components (programmatic narrative, log frame and performance framework) makes it challenging to understand the clear linkages.***

Country Response:

* The starting date for the implementation of HSFP proposal is considered to be Q2 of Y1 and the proposed end date is Q1 of Year 2015, which has been modified in the budget timeframe , at the same time the budget from Q1 of Year 1 shifted accordingly to Q1 of year 2015 with few changes in the budget, such as National TA cost missed to be budgeted in the original budget time frame and work plan, the WHO international TA cost increased , due to adding the comprehensive financial gap analysis cost which was missed in the original budget work plan as well , with the new changes in the cost above mentioned activities, the total ceiling shows only $ 390 decreases from the original ceiling ( The proposed original ceiling was $18,199,607 and new proposed ceiling calculated $ 18,199,217) .
* The revised log frame is attached
* The activity 1.2.1.2 in the work plan shows only the process of technical part , the budget of the two new province has already been included under 1.2.1.1, along with the four previous provinces,
* Activity 1.3.1 has cancelled during the resubmission of the HSFP proposal. The proposed timeline for the 1.3.1 has also been removed from the budget work plan.
* Activity #1.3.4. Since the feasibility study of the hospital is planned to be conducted by one of the USAID funded project, therefore HSS will make the follow up during the process as well as follow up of the recommendations of the study, in order to improve the performance of hospital sector.

Please feel free to request any further necessary information.

 Thanks in advance for your kind consideration.

 With best regards,

Dr. Ahmad Jan Naeem

Deputy Minister for Policy and Planning