GAVI Alliance

Annual Progress Report 2012

Submitted by

The Government of

Afghanistan

Reporting on year: **2012**
Requesting for support year: **2014**
Date of submission: **5/15/2013 8:11:51 AM**

Deadline for submission: 9/24/2013

Please submit the APR 2012 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

Important problems that were encountered and how the country has tried to overcome them

Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners

Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released

How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.

1. Application Specification

Reporting on year: **2012**

Requesting for support year: **2014**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015
INS			

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2012	Request for Approval of	Eligible For 2012 ISS reward
VIG	No	No	N/A
COS	No	No	N/A
ISS	Yes	next tranche: N/A	Yes
HSS	Yes	next tranche of HSS Grant N/A	N/A
CSO Type A	Yes	Not applicable N/A	N/A
CSO Type B	Yes	CSO Type B extension per GAVI Board Decision in July 2012: N/A	N/A
HSFP	No	Yes	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2011 is available here.

2. Signatures

2.1. Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

By signing this page, the Government of Afghanistan hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of Afghanistan

Please note that this APR will not be reviewed or approved by the Independent Review Committee (IRC) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Dr. Suraya Dalil	**Name**	Dr. Hazrat Omar Zakhelwal
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr. Aga Gul Dost	EPI National Manager	0093(0)799814812	nationalepi@gmail.com
Dr. Noorshah Kamawal	Health System Strengthening Coordinator and Focal Point	0093(0)778829773	kamawal.noorshah@gmail.com
Dr.Najla Ahrari	Health System Strengthening Deputy Coordinator	0093(0)799302996	najlaahrari@gmail.com
Dr.Haseebullah Neyaish	CSO Type B Coordinator	0093(0)776912180	dr.niayesh@gmail.com
Dr.Saifurrahman"Ibrahimkhail	EPHS Technical Advisor HealthNet TPO Afghanistan	0093(0)700638370	saif_ibrahimkhail@yahoo.com
Dr.Shakoor Waciqi	WHO EPI Officer	0093(0) 700025888	abdulghafoora@afg.emro.who.int
Eng. Asmatullah Sahban	Finance Consultant	0093(0) 708816582	enggasmatullah@gmail.com

2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Name/Title	Agency/Organization	Signature	Date

Dr. Najia Tareq, Deputy Minister	MOPH		
Dr. A. Qadir, DG of Policy & Planning	MOPH		
Dr. Mashal, DG of Preventive Medicine	MOPH		
Representative of MoF	MoF		
Dr. Dost, NIP Manager	MOPH		
Dr. Najla Ahrari, HSS Deputy Coordinator	MOPH		
Dr.Noor Shah Kamawal, HSS coordinator	MOPH		
Dr. Roshani, Health Coordinator	USAID		
Representative	WB		
Dr. Shakoor, NPO/EPI/VPD	WHO		
Representative	EC		
Dr. Kabir NGO Representative	NGO		
Dr. Moazzem, Chief of H & N	UNICEF		

Dr. Fazil, EPI specialist	UNICEF		
Dr. Arshad Quddus, PEI Medical Officer	WHO		
Representative	JICA		
NGO Representative	BRAC		
Dr. Rafiqi, NITAG Chairperson	Independent		

ICC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

- □□□□□□□□□ Close coordination between MOPH, donors and partners
- □□□□□□□□□ NIP to develop national annual EPI plan of actions including inputs from all concerned
- □□□□□□□□□ Monitor the progress of annual plan of actions and report to ICC
- □□□□□□□□□ Strengthen joint monitoring and supervision
- □□□□□□□□□ Speed up the process for implementation of EPI coverage evaluation survey
- □□□□□□□□□ Substitute measles vaccine with MCV (MR) in 2014 with the support of UNICEF and JICA
- □□□□□□□□□ Introduce Hepatitis B birth dose with the support of UNICEF
- □□□□□□□□□ To develop plan of actions based on the recommendations of EPI-Review
- □□□□□□□□□ To coordinate with partners, donors and stakeholders to implement the plan of actions
- □□□□□□□□□ To carry out assessment of cold chain system all levels for adequate storage of PCV and other vaccines
- □□□□□□□□□ To coordinate with GAVI and partners to introduce PCV vaccine latest by August 2013
- □□□□□□□□□ To continue activities towards measles and MNT elimination
- □□□□□□□□□ To build up capacity of national staff in preparing HF/district micro-plans
- □□□□□□□□□ To develop HF/district micro-plans, share with all partners and monitor the process of implementation
- □□□□□□□□□ To update cMYP based on new National Health Policy 2013-2020

To expand delivery of immunization service to reach the unreached population using all windows of opportunity including GAVI HSS fund

Comments from the Regional Working Group:

- □□□□□□□□ Complete the information and secure the required signatures as appropriate: Government Signatures page for all GAVI support, List the members of the ICC, ICC Signatures page, HSCC signatures page & Signatures page for GAVI Alliance CSO support if relevant.
- □□□□□□□□ Please make sure that the data reported in the APR 2012 are in line with other data sources like the cMYP, or the JRF 2012
- □□□□□□□□ Mention the meeting which will be held for final endorsement of the GAVI APR 2012and attach the minutes
- □□□□□□□□ Countries may use MICS survey if applicable to respond to some of the gender questions formulated in the GAVI APR 2012 form
- □□□□□□□□ Please refer to Section 13 of the GAVI APR 2012 where all mandatory requirements for GAVI APR submission are stated and attach as appropriate. The list could be visualized online. Please note that it has been customized on a country by country basis so no need to attach those that are not mandatory.
- □□□□□□□□ Please ensure that all clarifications requested in the 2011 Independent Review Committee (IRC) report sent to you have been addressed. For this purpose, you may wish to consult the relevant IRC report by clicking on the link that appears at the end of section 1 of the GAVI APR labeled Application Specification
- □□□□□□□□ Countries should ensure in the GAVI APR 2012 all activities which took place and highlight clearly any new request for new vaccine or need for reprogramming

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), Steering committee , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organization	Signature	Date
Dr. Gulakhan Ayub	MoPH/ National EPI		
Mashal. MD. PHD	General Directorate of Prevention Care		
Dr. SM. Moazzem Husain	UNICEF		
Dr. Haseebullah Niayesh	WHO		

Dr. yasin Rahimyar	CSO Representative		
M. Khalid	Ministry of Finance		
Dr. Sefatullah Habib	E.C representative		
Dr. Ahmad Shah Salehi	HEFD		
Dr. Noor Sha Kamawal	HSS		
Dr. Najla Ahrari	HSS		
De. Emal Latif	GAVI Board Advisor		

HSCC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.4. Signatures Page for GAVI Alliance CSO Support (Type A & B)

This report has been prepared in consultation with CSO representatives participating in national level coordination mechanisms (HSCC or equivalent and ICC) and those involved in the mapping exercise (for Type A funding), and those receiving support from the GAVI Alliance to help implement the GAVI HSS proposal or cMYP (for Type B funding).

2.4.1. CSO report editors

This report on the GAVI Alliance CSO Support has been completed by

Name/Title	Agency/Organization	Signature	Date
Dr. Haseebullah Niayesh	WHO		

Munaza Munawara Kakar	WHO		
Dr. Saifurrahman	HN-TPO		

2.4.2. CSO report endorsement

We, the undersigned members of the National Health Sector Coordinating Committee (or equivallent committees)- , endorse this report on the GAVI Alliance CSO Support.

Name/Title	Agency/Organization	Signature	Date
Dr. Ahmad Jaan Naeem	MoPH		
Mashal MD. PHD	MoPH		
Sefatullah Habib	EC		
Ahmad Shah Salehi	MoPH		
Khalid Betani	MoF		
Nasreen khan	UNICEF		
Dr. SM. Moazzem Hossain	UNICEF		
Dr. Noor Shah Kamawal	HSS/ MoPH		
Niayesh	WHO		

Yasin Rahimyar	CAF (CSO representative)		
Dr. Emal Latif	MoPH		
Dr. Gula Khan Ayub	National EPI		
Dr. Najla Ahrari	HSS/ MoPH		

Signature of endorsement does not imply any financial (or legal) commitment on the part of the partner agency or individual.

3. Table of Contents

This APR reports on Afghanistan's activities between January – December 2012 and specifies the requests for the period of January – December 2014

Sections

4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Number	Achievements as per JRF		Targets (preferred presentation)					
	2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
Total births	1,445,958	1,443,139	1,480,661	1,480,661	1,516,196	1,516,196	1,552,585	1,552,585
Total infants' deaths	186,529	186,529	191,006	191,006	195,589	195,589	200,283	200,283
Total surviving infants	1259429	1,256,610	1,289,655	1,289,655	1,320,607	1,320,607	1,352,302	1,352,302
Total pregnant women	1,445,958	1,443,139	1,480,661	1,480,661	1,516,196	1,516,196	1,552,585	1,552,585
Number of infants vaccinated (to be vaccinated) with BCG	1,357,983	1,354,463	1,317,788	1,317,788	1,364,576	1,364,576	1,397,326	1,397,326
BCG coverage	94 %	94 %	89 %	89 %	90 %	90 %	90 %	90 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,095,703	1,158,416	1,147,792	1,147,792	1,188,546	1,188,546	1,217,072	1,217,072
OPV3 coverage	87 %	92 %	89 %	89 %	90 %	90 %	90 %	90 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,234,240	1,341,174	1,263,861	1,263,861	1,294,194	1,294,194	1,325,255	1,325,255
Number of infants vaccinated (to be vaccinated) with DTP3	1,095,703	1,158,416	1,147,792	1,147,792	1,188,546	1,188,546	1,217,072	1,217,072
DTP3 coverage	87 %	92 %	89 %	89 %	90 %	90 %	90 %	90 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	20	0	0	0	0	0	0
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.25	1.00	1.00	1.00	1.00	1.00	1.00
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	902,220	1,341,174	1,263,861	1,263,861	1,294,194	1,294,194	1,325,255	1,325,255
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	902,220	1,158,416	1,263,861	1,263,861	1,188,546	1,188,546	1,217,072	1,217,072
DTP-HepB-Hib coverage	87 %	92 %	89 %	98 %	90 %	90 %	90 %	90 %
Wastage[1] rate in base-year and planned thereafter (%) [2]	0	20	0	20	25	25	25	25
Wastage[1] factor in base-year and planned thereafter (%)	1.33	1.25	1.33	1.25	1.33	1.33	1.33	1.33
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,032,731	1,032,731	1,096,206	1,096,206	1,162,134	1,162,134	1,217,071	1,217,071
Measles coverage	82 %	82 %	85 %	85 %	88 %	88 %	90 %	90 %
Pregnant women vaccinated with TT+	1,127,847	1,127,847	1,184,528	1,184,528	1,288,766	1,288,766	1,397,326	1,397,326

Number	Achievements as per JRF		Targets (preferred presentation)					
	2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
TT+ coverage	78 %	78 %	80 %	80 %	85 %	85 %	90 %	90 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0	0	0
Vit A supplement to infants after 6 months	0	0	0	0	0	0	0	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	11 %	14 %	9 %	9 %	8 %	8 %	8 %	8 %

** Number of infants vaccinated out of total surviving infants

*** Indicate total number of children vaccinated with either DTP alone or combined

**** Number of pregnant women vaccinated with TT+ out of total pregnant women

1 The formula to calculate a vaccine wastage rate (in percentage): [(A B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

2 GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2012 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2012.** The numbers for 2013 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  No change made in births. All the data are consistent with cMYP based on the 1st and the only population census conducted in 1979 with 2.4% annual growth rate.

- Justification for any changes in **surviving infants**

  No change made in surviving infants (though the latest Maternal Mortality Survey shows reduction in infant mortality rate in 2010 77/1000LB compared to 129/1000LB in 2010)

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

  No change made in targets by vaccines

- Justification for any changes in **wastage by vaccine**

  The NIP has shifted from single dose vials to 10 dose vials effective 1st July 2012, therefore the wastage rate is changed from 5% initially considered to maximum 25%.

5.2. Immunisation achievements in 2012

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2012 and how these were addressed:

The Afghanistan's NIP achievement and key activities carried out in 2012:

Antigens	Target	Achievement
BCG	94 %	94%
DPT3 (Penta3)	87 %	92%
OPV3	87 %	92%
MVC1	82%	85%
MCV2		

	60%
	54%
TT2+	
	80%
	76%
DoR	
	12%
	14%

Program planning & management:

•□□□□□□□□□ Revision/update of cMYP 2011-2015,

•□□□□□□□□□ Update of EPI guidelines

•□□□□□□□□□ Conducting of three ICC meetings

•□□□□□□□□□ 3 NITAG meetings with recommendations of introduction Rotavirus vaccine, Hepatitis B birth dose, and replacing measles vaccine with MR

•□□□□□□□□□ Establishment of national measles validation committee (NMVC)

•□□□□□□□□□ Conducting of two NMVC technical consultative meetings

•□□□□□□□□□ Meeting the GAVI conditions for introduction of PCV in coordination and collaboration with partners

•□□□□□□□□□ Conducting weekly EPI Task Force Committee meetings

•□□□□□□□□□ Close coordination with GCMU for increasing vaccinators' salaries and benefits

•□□□□□□□□□ Implementation of comprehensive EPI Review, sharing of report with all partners, donors and stakeholders,

•□□□□□□□□□ Development plan of actions based on the recommendations of EPI-review.

Service Delivery

Delivery of immunization service through health facilities, outreach and mobile sessions and implementation of 2 rounds of TT camping in girls' schools

Measles SIAs

- The 3rd Nation-wide Measles follow up SIAs conducted in two phases (1st phase:7-12 July 2012 and 2nd phase: 1-6 December 2012
- The target age group for measles was set based on epidemiological data (9M-10Y)
- In addition, measles mop-up campaign conducted (18-22 Nov, 2012) in 16 districts that could not achieve the target >90%
- OPV was integrated with measles and the target age group included all children 0-10Y
- Total target for measles was10,002,669
- Total number of children vaccinated: 10,879,500 (104% reported coverage)
- Post campaign assessment coverage: 94%
- There are 27 districts where the measles SIAs conducted partially and not conducted.
- Totally, 11,679,211 (92%) received a full dose of OPV during measles SIAs.

Polio eradication: conducting of 4 NIDs, 5 SNIDs and detection of 37 polio confirmed cases in 2012.

2. Service Delivery

•□□□□□□□□ Delivery of immunization service through 1451 EPI fixed centers, outreach and mobile sessions

•□□□□□□□□ Implementation of 2 rounds of TT camping in girls' schools

4. Cold chain & Logistics management

•□□□□□□□□ Training of 34 cold chain/logistic officers on VSSM

•□□□□□□□□ Installation of 4 new cold rooms with total capacity of 120cm3

•□□□□□□□□ Training of 4 national cold chain officer on vaccine management outside the country

5. Advocacy

•□□□□□□□□ Inauguration of national vaccination week at different levels with extensive broadcasting on national and local media

•□□□□□□□□ Broadcasting of radio/TV spots on routine vaccination

•□□□□□□□□ Printing of 3 types of posters that distributed to the health facilities

•□□□□□□□□ Printing of booklet about 8 vaccine preventable diseases & vaccines for health workers and parents

6. Capacity building

•□□□□□□□□ Training of 70 EPI supervisors of NGOs

•□□□□□□□□ Revision/printing of national EPI guideline for immunization health workers

•□□□□□□□□ Printing of 2000 WHO manual “Immunization in Practice”

•□□□□□□□□ Training of 28 national staff on comprehensive EPI review and implementation

•□□□□□□□□ Refresher training courses for 687 vaccinators

•□□□□□□□□ Training of 71, 872 health workers, volunteers, supervisors, monitors and evaluators on measles/polio SIAs.

7. VPD surveillance

•□□□□□□□□ WHO continues it support in keeping functional measles, MNT, rotavirus, meningitis, pneumonia surveillance with lab support

•□□□□□□□□ Totally, 4254 suspected cases of measles reported through AFP surveillance. Of which 2787 were positive for measles. The genotype isolated in 2012 was B3. The measles genotypes have/had been circulating during the last four years (D4, H1, B3).

•□□□□□□□□ Total MNT cases detected in 2012 – 37

•□□□□□□□□ Accreditation of National Measles Laboratory by WHO/EMRO expert in March 2012

•□□□□□□□□ Training of 4 VPD surveillance staff on data management

•□□□□□□□□ Rotavirus surveillance continues to provide evidence index of the burden of rotavirus disease among those infants suffering from acute watery diarrhea. Currently, the rotavirus surveillance program is sustained in three hospitals which are collecting diarrheal stool samples, screen for rotavirus by ELISA test and ship the samples to EMRO reference lab for genotyping. About 55% of samples tested are positive for rotavirus.

8. Monitoring & Evaluation

•□□□□□□□□ Due to unknown reason and after two rounds of field tests, the Central Statistic Office (CSO) rejected to carry out the planned EPI coverage evaluation survey.

•□□□□□□□□ UNICEF/MOPH has agreed to contract out with a qualified organization to perform the coverage survey in 2013.

•□□□□□□□□ According to field reports, on average 4 visits were paid to each health facility either by EPI/MOPH or NGOs supervisors.

5.2.2. If targets were not reached, please comment on reasons for not reaching the targets:

•□□□□□□□□ Inaccessibility of about 34% of population to immunization services

•□□□□□□□□ Poor quality of HF/District micro-planning & implementation

•□□□□□□□□ Inadequate implementation of EPI strategies

•□□□□□□□□ Inadequate management of human resources and fund at service delivery levels

•□□□□□□□□ Weak coordination and collaboration among MOPH and NGOs at lower levels

•□□□□□□□□ Shortage of cold chain equipment such as RCW50, cold boxes and vaccine carriers

•□□□□□□□□ Inadequate implementation of cold chain and logistic development plan

•□□□□□□□□ Shortage of spare parts for cold chain equipment

•□□□□□□□□ Poor stock control practices regarding vaccines and injection material & calculation of vaccine/supplies need and wastages

•□□□□□□□□ Weak monitoring through disease surveillance and service delivery

•□□□□□□□□ Inaccuracy in reporting of antigen coverage and drop-out rates

•□□□□□□□□ Poor monitoring of stakeholders (NGOs) performance

•□□□□□□□□ Shortage of trained immunization health workers especially in rural and remote areas

•□□□□□□□□ Geographical constraints

•□□□□□□□□ Inaccurate denominator

security in certain areas of the country

5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **no, not available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

Note: in all EPI recording materials (vaccination card, registration book and tally sheet) the sex of all vaccinated children are recorded. But the reporting sheet does not include disaggregated data and accordingly not reported to the national level.

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Yes**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

Considering GAVI gender policy, the NIP has planned to revise the EPI reporting form for reporting disaggregated coverage data in 2013.

5.4. Data assessments

5.4.1. Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)

No EPI coverage survey conducted in 2012.

* Please note that the WHO UNICEF estimates for 2012 will only be available in July 2013 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2011 to the present? **No**

If Yes, please describe the assessment(s) and when they took place.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2010 to the present.

•□□□□□□□□ The DQAs conducted in all 34 provinces in 2009 and 2010

Strengthening quality of routine vaccination data is one of the most important components of all EPI related training courses.

5.4.4. Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

•□□□□□□□□□□□□□□□□□□□□ EPI coverage evaluation survey

•□□□□□□□□□□□□□□□□□□□□ Conduct DQS in 2013

•□□□□□□□□□□□□□□□□□□□□ Planning and Implementation of recommendations of PIE assessment

•□□□□□□□□□□□□□□□□□□□□ Revision of guidelines/tools for monitoring & supervision

•□□□□□□□□□□□□□□□□□□□□ Strengthening monitoring and supervision involving all partners and stakeholders

Conduct quarterly EPI review workshops with more focus on quality of the data

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 54	Enter the rate only; Please do not enter local currency name

Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	**Expenditure Year 2012**	**Source of funding**						
		Country	**GAVI**	**UNICEF**	**WHO**	**USAID**	**WB**	**EC**
Traditional Vaccines*	5,259,395	0	0	5,259,395	0	0	0	0
New and underused Vaccines**	7,466,324	776,000	6,690,324	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	1,383,484	0	0	1,383,484	0	0	0	0
Cold Chain equipment	350,000	0	0	350,000	0	0	0	0
Personnel	7,121,200	287,900	474,300	234,000	57,000	2,344,675	2,123,675	1,599,650
Other routine recurrent costs	1,174,245	634,125	427,346	112,774	0	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	32,000,000	0	0	22,324,755	9,675,245	0	0	0

USAID, World Bank, EC		1,698,025	7,591,970	29,664,408	9,732,245	2,344,675	2,123,675	1,599,650
Total Expenditures for Immunisation	54,754,648							
Total Government Health		3,396,050	15,183,940	59,328,816	19,464,490	4,689,350	4,247,350	3,199,300

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2013 and 2014

UNICEF has committed to continue providing traditional vaccines/injection supplies.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Yes, fully implemented**

If Yes, briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

Action plan from Aide Mémoire	Implemented?
Action plan was not developed under EPI	No

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

Not implemented

If none has been implemented, briefly state below why those requirements and conditions were not met.

Almost all GAVI FMA findings and recommendations are generally related to the whole health system and the plan/policy/HSS department addresses this issue.

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2012? **3**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2013 endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.5 Overall Expenditures and Financing for Immunisation

As per reported coverage for 2102, the target set for almost all antigens are achieved (section 2.2.1). But, due to particular reasons indicated in section 5.2.2, and lack of accurate denominator the reported coverage data may not reflect the actual situation and there is need for verification through conducting EPI coverage evaluation survey. Since the official population figure published by government Central Statistic Office (CSO) seems to be underestimated, therefore the NIP has been using UNIDAT population figure (based on the 1st and the only census carried out in 1975) for routine EPI planning purposes and there is no change in baseline and annual targets and remained as stated in cMYP 2011-2015.

The EPI is mainly depends on external assistance. As per cMYP and annual plan of action, the total amount planned for 2012 was US $23,170,192 while the actual expenditures for routine immunization programs in 2012 was about $22millions (table 5.5a shows the amount spent for routine EPI activities). There was a gap of around 1.2million mainly needed for delivery of immunization services.

Therefore, the ICC has recommended to Grant Contract Management Unit of MOPH to coordinate with MoF and donors to allocate additional fund to fill in the gap.

Are any Civil Society Organisations members of the ICC? **Yes**

If Yes, which ones?

List CSO member organisations:
AHDS, BRAC

5.8. Priority actions in 2013 to 2014

What are the country's main objectives and priority actions for its EPI programme for 2013 to 2014

In order to reduce child morbidity, morbidity and disability due to vaccine preventable diseases and to move forward towards reaching MDG4, the main objective of NIP is to achieve and sustain at least 90% coverage for all antigens nationally and at least 80% coverage in each district. The key activities for 2013 include:

•□□□□□□□□ Expansion of immunization services to reach the unreached children through increasing the number of vaccination centers, integration of services with health sub-centers and mobile health teams.

•□□□□□□□□ Strengthening organization of immunization system and improving delivery of services through enhancing the knowledge and skills of provincial EPI management teams in HF/District micro-planning and implementation based of RED strategy

•□□□□□□□□ Introduction of PCV and Hepatitis B birth dose into national immunization program

•□□□□□□□□ Continuation of planned activities for measles/MNT elimination

•□□□□□□□□ Keeping on efforts to stop transmission of wild polio virus

•□□□□□□□□ Undertake EPI coverage evaluation survey

•□□□□□□□□ Strengthening routine EPI monitoring and surveillance systems including conducting DQS

Developing plan of actions based recommendations of comprehensive EPI review and advocate for funding and implementation.

5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2012

Vaccine	Types of syringe used in 2012 routine EPI	Funding sources of 2012
BCG	AD syringe –Medico Inj 0.05ml	UNICEF
Measles	AD syringe –Medico Inj 0.5ml	UNICEF
TT	AD syringe –Medico Inj 0.5ml	UNICEF
DTP-containing vaccine	AD syringe –Medico Inj 0.5ml	GAVI through UNICEF

Does the country have an injection safety policy/plan? **Yes**

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

If No: When will the country develop the injection safety policy/plan? (Please report in box below)

The injection policy was developed in 2005 and the country has reached 100% injection safety - EPI uses AD syringes for all injectable vaccines.

Please explain in 2012 how sharps waste is being disposed of, problems encountered, etc.

As part of health facility waste management, the common method is incineration where there incinerators are available. Where there are not incinerators the burning/burying method is used.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2012

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	0	0
Remaining funds (carry over) from 2011 *(B)*	3,082,577	166,459,158
Total funds available in 2012 *(C=A+B)*	3,082,577	166,459,158
Total Expenditures in 2012 *(D)*	790,481	42,685,974
Balance carried over to 2013 *(E=C-D)*	2,292,096	123,773,184

6.1.1. Briefly describe the financial management arrangements and process used for your ISS funds. Indicate whether ISS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of ISS funds, such as delays in availability of funds for programme use.

The procedure for ISS fund includes:<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

1. Development of annual plan of actions with budget and timeline by MOPH.
2. Review of plan of actions in EPI Task Force Committee and recommendation to ICC.
3. Review, approval and endorsement by ICC.
4. Submission of plan to MoF for releasing of fund to MOPH and provinces through government channel
5. All payments and purchases are done according to the planned activities using standard formats and following MoF rules.
6. Copies of the documents (stipend role, receipts, bills and etc) signed by PEMT managers and Provincial Health Directors are sent with budget expenditure summary sheet to MOPH.
7. Copies of all documents are kept at National EPI office and at provincial EPI at least for 3 years.
8. The NEPI submit the semi-annual and annual financial reports to ICC indicating the activities carried out and the amount spent against each budget line.
9. The work plan may be modified every six months and is in effect after approval and endorsement of ICC

The government prolonged procedure for releasing of fund at provincial levels cause delay in implementation of planned activities.

6.1.2. Please include details on the type of bank account(s) used (commercial versus government accounts), how budgets are approved, how funds are channelled to the sub-national levels, financial reporting arrangements at both the sub-national and national levels, and the overall role of the ICC in this process

The ISS fund channeled to the government bank with the following details<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Da Afghanistan Bank Head Office Branch

Da Afghanistan Bank Head Office Branch

MOF-GAVI Project for MOH (792902)

Ministry of Finance

Pashtunistan Avenue

Kabul

Branch Code: 3000

Currency Code: USD

Customer ID: 491

Email: info@mov.gov.af

Account: MOF-NonInt. Bearing Current Account in F

Account N0: 3000208027039

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2012

- □□□□□□□□□ Program planning and management <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />
- □□□□□□□□□ Training of 150 health care workers
- □□□□□□□□□ Immunization service delivery
- □□□□□□□□□ Advocacy, education and communication
- □□□□□□□□□ Program monitoring and supervision
- □□□□□□□□□ Vaccine preventable diseases surveillance
- □□□□□□□□□ Transportation & maintenance and overheads

6.1.4. Is GAVI's ISS support reported on the national health sector budget? **Yes**

6.2. Detailed expenditure of ISS funds during the 2012 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2012 calendar year (Document Number 7) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **Yes**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number 8).

6.3. Request for ISS reward

Calculations of ISS rewards will be carried out by the GAVI Secretariat, based on country eligibility, based on JRF data reported to WHO/UNICEF, taking into account current GAVI policy.

7. New and Under-used Vaccines Support (NVS)

7.1. Receipt of new & under-used vaccines for 2012 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2012 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2012 vaccinations against approvals for 2012

	[A]	[B]		
Vaccine type	**Total doses for 2012 in Decision Letter**	**Total doses received by 31 December 2012**	**Total doses of postponed deliveries in 2012**	**Did the country experience any stockouts at any level in 2012?**
DTP-HepB-Hib	3,599,858	2,478,000	314,700	No

**Please also include any deliveries from the previous year received against this Decision Letter*

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  There was no stock -out of vaccine as the stock of Pentavalent vaccine on 1st January 2012 was 2,021,170 doses (not 1,200,000 as mistakenly reported in APR2011). Because of delay in transferring of co-finance amount to UNICEF, the 314,700 doses was postponed.

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

  The government is transferring the 2012 and 2013 co-finance amounts for Penta to UNICEF within 1-2 months.

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

no

7.2. Introduction of a New Vaccine in 2012

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2012, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Note: the PCV is planned to be introduced during the 3rd quarter of 2013

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **June 214**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9))

PIE report is attached

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFI expert review committee? **Yes**

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **Yes**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

Does your country conduct special studies around:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **Yes**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

<p class="MsoNoSpacing" style="MARGIN: 0in 0in 0pt">MOPH continues VPD surveillance (measles, MNT, rotavirus, meningitis, pneumonia) with lab support. Totally, 4268 suspected cases of measles reported, which 2800 were positive. The genotype isolated in 2012 was B3. The measles genotypes circulating during the last four years (D4, H1, B3). Total MNT cases detected in 2012 -37 . Accreditation of National Measles Laboratory by WHO/EMRO expert in March 2012. More than 50% of all gastroenteritis cases are due to Rotavirus. NITAG has recommended to introduce Rotavirus vaccine, Hepatitis B birth dose, and replacing measles vaccine with MR</p>

7.3. New Vaccine Introduction Grant lump sums 2012

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2012 (A)	0	0
Remaining funds (carry over) from 2011 (B)	0	0
Total funds available in 2012 (C=A+B)	0	0
Total Expenditures in 2012 (D)	0	0
Balance carried over to 2013 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2012 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2012 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

No

Please describe any problem encountered and solutions in the implementation of the planned activities

No

Please describe the activities that will be undertaken with any remaining balance of funds for 2013 onwards

No

7.4. Report on country co-financing in 2012

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2012?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	520,793	238,676
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2012 from the following sources?	
Government	520793	
Donor		

Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	11,769	261,543
	Q.4: When do you intend to transfer funds for co-financing in 2014 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2014	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	June	Government
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	The NEPI personnel and relevant staff of MOPH are in need for training to improve their knowledge and skills in using guideline and tools for developing financial sustainability plan.	

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy: http://www.gavialliance.org/about/governance/programme-policies/co-financing/

The delay in transferring co-finance amount was due to misunderstanding and approval of fund from GAVI ISS by parliament. Therefore, the MOPH reprocessed the procedure for approval and transferring of co-finance to UNICEF.

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **August 2011**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Are there any changes in the Improvement plan, with reasons? **Yes**

If yes, provide details

To meet one the GAVI requirement for Pentavalent introduction, the EVM was conducted in 2011

When is the next Effective Vaccine Management (EVM) assessment planned? **June 2014**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2012

Afghanistan does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

Afghanistan does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2013

Renewal of multi-year vaccines support for Afghanistan is not available in 2013

7.9. Request for continued support for vaccines for 2014 vaccination programme

In order to request NVS support for 2014 vaccination do the following

Confirm here below that your request for 2014 vaccines support is as per 7.11 Calculation of requirements **Yes**

If you don't confirm, please explain

Confirmed

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	1,256,610	1,289,655	1,320,607	1,352,302	5,219,174
	Number of children to be vaccinated with the first dose	Table 4	#	1,341,174	1,263,861	1,294,194	1,325,255	5,224,484
	Number of children to be vaccinated with the third dose	Table 4	#	1,158,416	1,263,861	1,188,546	1,217,072	4,827,895
	Immunisation coverage with the third dose	Table 4	%	92.19 %	98.00 %	90.00 %	90.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.25	1.25	1.33	1.33	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	87,000				
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	87,000				
	Number of doses per vial	Parameter	#		10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.04	2.04	1.99	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

Stock of pentavalent doses on 31st December 2012 - 87000 and the same amount on 1st January 2013.

Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group	Low

	2012	2013	2014	2015
Minimum co-financing	0.20	0.20	0.20	0.20
Recommended co-financing as per APR 2011			0.20	0.20
Your co-financing	0.20	0.20	0.20	0.20

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2013	2014	2015
Number of vaccine doses	#	4,302,400	4,783,900	4,815,800
Number of AD syringes	#	4,208,700	4,427,500	4,447,500
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	46,725	49,150	49,375
Total value to be co-financed by GAVI	$	9,543,500	10,598,000	10,412,000

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2013	2014	2015
Number of vaccine doses	#	437,700	486,600	503,500
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country ^[1]	$	948,000	1,054,500	1,064,000

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	9.23 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,341,174	1,263,861	116,684	1,147,177
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B X C*	4,023,522	3,791,583	350,051	3,441,532
E	Estimated vaccine wastage factor	*Table 4*	1.25	1.25		
F	Number of doses needed including wastage	*D X E*	5,029,403	4,739,479	437,564	4,301,915
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		0	0	0
H	Stock on 1 January 2013	*Table 7.11.1*	87,000			
I	Total vaccine doses needed	*F + G – H*		4,739,979	437,610	4,302,369
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		4,208,658	0	4,208,658
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		46,717	0	46,717
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		9,650,598	890,974	8,759,624
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		195,703	0	195,703
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		27,096	0	27,096
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		617,639	57,023	560,616
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*		10,491,036	947,996	9,543,040
U	Total country co-financing	*I x country co-financing per dose (cc)*		947,996		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		9.23 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2014			2015		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.23 %			9.46 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,294,194	119,485	1,174,709	1,325,255	125,433	1,199,822
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	3,882,582	358,453	3,524,129	3,975,765	376,297	3,599,468
E	Estimated vaccine wastage factor	*Table 4*	1.33			1.33		
F	Number of doses needed including wastage	*D X E*	5,163,835	476,742	4,687,093	5,287,768	500,475	4,787,293
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	106,089	9,795	96,294	30,984	2,933	28,051
H	Stock on 1 January 2013	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	5,270,424	486,583	4,783,841	5,319,252	503,455	4,815,797
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	4,427,425	0	4,427,425	4,447,492	0	4,447,492
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	49,145	0	49,145	49,368	0	49,368
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	10,730,584	990,682	9,739,902	10,564,035	999,860	9,564,175
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	10,730,584	0	205,876	10,564,035	0	206,809
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	28,505	0	28,505	28,634	0	28,634
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	686,758	63,404	623,354	676,099	63,992	612,107
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	11,651,723	1,054,085	10,597,638	11,475,577	1,063,851	10,411,726
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,054,085			1,063,851		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.23 %			9.46 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2012**. All countries are expected to report on:

   a. Progress achieved in 2012

   b. HSS implementation during January – April 2013 (interim reporting)

   c. Plans for 2014

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2012, or experienced other delays that limited implementation in 2012, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2012 fiscal year starts in January 2012 and ends in December 2012, HSS reports should be received by the GAVI Alliance before **15th May 2013**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2013, the HSS reports are expected by GAVI Alliance by September 2013.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2012

   b. Minutes of the HSCC meeting in 2013 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2012 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

9.1. Report on the use of HSS funds in 2012 and request of a new tranche

Please provide data sources for all data used in this report.

9.1.1. Report on the use of HSS funds in **2012**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.

9.1.2. Please indicate if you are requesting a new tranche of funding **No**

If yes, please indicate the amount of funding requested: US$

These funds should be sufficient to carry out HSS grant implementation through December 2014.

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	6700000	8950000	7200000	6600000	4650000	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	2500000	10091209	8157346	10634411	11050232	
Total funds received from GAVI during the calendar year (*A*)	6699975	4594975	7318000	7977346	2999975	4149629
Remaining funds (carry over) from previous year (*B*)	0	6556888	5544305	3316412	5114945	3558848
Total Funds available during the calendar year (*C=A+B*)	6699975	11151863	12862305	11293758	8114920	7712585
Total expenditure during the calendar year (*D*)	143087	5607558	9545893	6178813	4650867	5061451
Balance carried forward to next calendar year (*E=C-D*)	6556888	5544305	3316412	5114945	3558848	2651134
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)				
Total Funds available during the calendar year (*C=A+B*)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	6700000	462981710	372454560	303045600	303045600	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	125994250	522016223	421977877	488289615	533825658	
Total funds received from GAVI during the calendar year (*A*)	337663330	237697138	356840316	366287819	144925792	216942604
Remaining funds (carry over) from previous year (*B*)	0	330452074	278071358	169434826	252016267	175451235
Total Funds available during the calendar year (*C=A+B*)	337663330	568149212	634911674	535722645	396942059	402123953
Total expenditure during the calendar year (*D*)	7211256	290077854	465476849	283706378	224678757	263628696
Balance carried forward to next calendar year (*E=C-D*)	330452074	278071358	169434826	252016267	175451235	138495257
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)				
Total Funds available during the calendar year (*C=A+B*)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Report of Exchange Rate Fluctuation

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January	50.18	50.39	51.86	48.76	45.91	48.31
Closing on 31 December	50.39	51.86	48.76	45.91	48.31	52.085

Detailed expenditure of HSS funds during the 2012 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2012 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2013 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

Briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the HSCC in this process.

The financial management of the HSS funds follows the similar financial procedures as other donors such as World Bank, Global Fund, Government of Afghanistan, and USAID. All developmental budgets currently being channeled through Ministry of Finance. First of all work plans are made at the departmental level and follow the normal procedures for approval. This includes approval from the donors; in case of GAVI-HSS, the approval is being received from the the HSS-SC. Later on all of the departments' plans are shared with The Finance Directorate of The MoPH. According to Chart of Accounts of The Ministry of Finance; the development budget unit of finance directorate categorizes the expenditures and all relevant forms are being completed. At this stage the finance directorate makes requests for allotments of required budget on the basis of approved work-plans received the various departments of the MoPH from The Ministry of Finance. The requests of allotments are signed by the finance director and the leadership of MOPH. Once the allotments are approved the relevant departments are accountable for the implementation of the approved work plans. In order to start the implementation of the work plans by the relevant department, once again the approval obtains from the leadership of MoPH. In case the activities reflected in the work plans are complemented or adjustments are needed to request more funds ,the leadership of MoPH (The Ministers or Deputy Ministers) approve it and forward it to Finance Directorate of MoPH for processing. Inorder to ensure transparency and , the head of departments are signing accountability the relevant financial documents and once again the signatures of the leadership of MoPH are obtained. The documents are being sent to the teams controllers seconded by the Ministry of Finance to The Ministry of Public Health for further scrutiny in order to make sure that the documents are properly processed in accordance to the defined rules and regulations; Once the relevant documents are being cleared up by the team of controllers , the controllers singed the relevant documents and forward them to Ministry of Finance. <?xml:namespace prefix = o />

At the provinciallevel, once the financial allotments arereceived , the provincial health officesliquidate the budgets in line with the approved rule and regulations of AfghanGovernment under the oversight of Mustufiates, (The Ministry Financial set upat provincial level) the provincial Ministry of Finance structures). It is worth mentioning that the HSS is theonly source which transfers the funds to all 34 provinces. The rest of MOPHdevelopment budget is either sent through a parallel structure, or not sent tothe provinces.

The HSS fundsare fully reflected in the national health plan according to the agreedframework of HSS proposal. The accounts where the HSS funds are kept, are theGovernment current accounts and no commercial bank account is used, therefore,no interests are generated. This is the case for all health sector donors inAfghanistan who uses Government channels.

Financial reporting system is is user friendly at central level. At provincial level, the financial reports are provided by the Ministry of Finance Mustufiates. On one hand, there is limited capacity in most of MOPH provincial offices and on the other hand, the same is with most of Mutufiates. Experiences in the past years show that by approaching the new fiscal year which coincides with the 20th of March, The Mustufiates provide mixed reports which puts up the MOPH to a challenge. Clearing up the financial accounts takes two to three more months at provincial level and this can cause slight changes in the financial statements provided because the statements are provided by 15th of May while clearing up all the relevant accounts with provincial level reaches normally at the end June every year. In some instances, the other donor’s money comes to the account or vice versa which requires more time to fix the problem.

It looks thatthis problem may resolve over the passage of years while the system getsmatured enough. Although there were some suggestions appreciated by MOPH totransfer the funds through a commercial bank and a letter was provided by GAVIto support this suggestion. But after consultation and thoroughly studying theissue, it was found that it might create room for corruption because theGovernment procedures although very complicated and bureaucratic, are good toprevent corruption. That is why MOPH never used this mechanism for HSS funds.

The ICC does not play any major role in the management of HSS funds since there is the HSS-Steering Committee involved in the process of approval of HSS plans,allocation of funds, modifications of budget, and recommendations for procurement decisions and so on. The HSS steering committee consists of USAID,EU, WB, WHO, UNICEF, MOF, CSOs and MOPH representatives. This committee is setof the key partners of the Consultative Group for Health and Nutrition which is the high level health sector coordination forum. The support of this committee has been tremendously important and instrumental in implementation of HSS funds to date.

Has an external audit been conducted? Yes

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

9.2. Progress on HSS activities in the 2012 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2012 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Activity1.1:Establishing Sub-Centers in under-served areas Activity1.2:Deploying mobile health outreach teams	• Contract management and continuation of SHC&MHT projects until absorbed by main BPHS donors (USAID and World Bank) • Smooth hand over and absorption of all health facilities to PCH and PPA grants •Close out of SHC&MHT •Archive of all documents •Collection and entry of all assets of project in a adapt base such as inventory of assets, hand over documents, softwares, whole project data and analysis, pictures, clips). •Conduct monitoring from grant management perspectives and conduct external audit	100	Grant and Contract Management Department based on NGOs quarterly reports, HMIS and MHT evaluation report. (100% for SC and MHTs continuation means that they are established and functioning but also need continuation)
Activity 1,3:Expanding integrated management of childhood illness (IMCI) to community level	• Start the process of proper close out and hand over of the first round of C-IMCI project. • Monitor the implementation of the second round of project by conducting visits from training sites, pre project survey and monitor CHWs who received C-IMCI training. • Provide technical assistance to the new implementers. • Review of progress of narrative reports in quarterly bases and provide feedback to implementers through MOPH official channels or face to face meetings • To assist implementer NGOs to conduct post project survey • Start the process of proper close out and hand over of the first round of C-IMCI project.	95	• IMCI department of Child and adolescent directorate of MoPH reports • NGOs quarterly reports, • Monitoring Reports,

Activity 1,4: Develop an in-service training program for BPHS primary healthcare providers			
Activity 2.1: Implementing a nationwide Information, Education and Communication (IEC) campaign for immunization and other MCH messages	• Print of IEC materials • Print and providing of flip charts • Preparing of TV spots about different health issues • Printing of books about different health issues • Airing of TV spots •Airing of Radio spots •National Monitoring of IEC materials • Conduct of IPCC workshops for 170 persons for 34 provinces • Translation and printing of HPD policy and strategy • Establishing of call center (Giving information about health issues through mobile phones)		Health Promotion Department reports
Activity 2.2: Pilot a model of demand side financing (DSF). Activity 2,3: Piloting a program to provide monetary performance incentives to volunteer Community Health Workers	The project has already completed by June 2011	100	- Health Economic and Financing Department reports - End line survey report - Final report of the project
Activity 3.1: Up-grade the physical, information /communication technology infrastructure and means of transportation of the M&E Department	• HHS with JHU on measuring impact of HHS indicators (13) • Train PPHOs in NMC database • Design vital registration system • Conduct result conference • Conduct M/E advisory board meeting • Conduct mini results workshop for MoPH leadership • Review GAVI indicators on quarterly basis	85	- M&E directorate reports - NMC data base

Activity 3.2: Launch a community demographic surveillance system	This activity was already cancelled and cancellation approval obtained in the APR 2008. The reason was the limited availability of resources. This activity funding is being discussed with the World Bank which will probably fund the activity. The demographic surveillance system will be funded through SEHAT project funded by World Bank		Not applicable
Activity 3.3: Expanding capacity building program for MOPH managers at the Central and Provincial levels.	• Continue monitoring the implementation of the QPHC round 2nd project. • Provide technical assistance to the implementer. • Review the progress of narrative reports on quarterly basis and provide regular feedback to implementer through MOPH official channels or face to face meetings • Evaluation and final report of the project • Preparation for the evaluation and close out the project	82	- Afghan National Public Health Institute / Training department reports - NGO quarterly Reports, and monitoring reports
Activity 3.4:Developing a communications and internal advocacy program to seek increased funding	• Organizing PR Conference • Follow up of production of three documentary films on Vaccination, Mobile Teams, and Midwifery Education Programs which remained from past years. • Contract with different TV channels for the broadcasting produced films. • Develop and publish the MoPH Monthly Newsletter. • Print the advertising papers, (envelope, folder, calendar, and Dairy). • Further development of MoPH web-site	90	Public Relation department reports
Activity 3.5: Launching an initial cadre of District Health Officers	• Coordinating technical issues of the DPHOs with the provincial and central level departments • Revision of DPHOs TOR • Conduct DPHOs coordination workshop • Develop Non communicable diseases control and communicable diseases control guideline. • Follow up of implementation of the MoPH policies and strategies at the district level. • Conduct monitoring visit	100	- District Health System Strengthening department of MoPH, - DPHOs third party evaluation report

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
	continuation of provision of health services through establishment of 121 sub health centers and 26 mobile health teams across the country. The entire health facilities operating under GAVI-HSS fund were functional during the reporting period. The contracting NGOs were regularly reporting on successful implementation of project planed interventions on quarterly basis according to the standard reporting format to MoPH. regular feed- backs were provided to ensure the smooth implementation of planned activities to implementing partners. The HMIS data shows that implementing NGOs maintain the achievements with regard to overall project indicators versus to previous year's achievements in-spite of increasing security challenges in the country which can be a reasonable justification; however in most cases the trend of HMIS data shows a steady increase on project overall indicators. During the reporting period totally 1613018 OPD visits, 3736 assisted deliveries , 23097 new ANC visits, 11284 new PNC visits, 23361 family planning visits, 14587 Penta III (0-11 months), 29173 TT2+ and 146811 children under five years of age screened for malnutrition. it is worth mentioning that Children under 5 years old were 15% of the total OPDs and female beneficiaries consultations account for 59% of the total OPDs. In general, while reviewing the quarterly reports the progress compared to the set plans and completeness of HMIS data were thoroughly commented. Additionally in cases where prompt response were needed by the NGOs to cope with unpredictable micro-level implementation issues and challenges such as security problems or lack of female staff in far remote areas where most of the sub health centers are located and or problems such as lack of female staff in general worsen by security threats has led the female staff to hesitate working with a mobile health team in particular with continuous traveling schedule and moving to different parts of province some with remarkable security problems, NGOs were provided with the necessary guidance through emails and official correspondence helping them to adjust carrying out the activities accordingly and 64% (HMIS-FSR 2012) of the entire health facilities were with required female health workers during the reporting period. In the meantime MOPH continued its endeavors to coordinate and discuss with donors supporting BPHS to consider the support of the GAVI funded SHCs and MHTs in future. After successful inclusion of 42 sub health centers and MHTs in the BPHS contracts of EU supported provinces, MoPH realized that USAID were reluctant to support the remaining 72 health facilities in 13 provinces under USAID funded BPHS contracts. Despite a great deal of efforts in justifying the rationality of the need for establishing these facilities and providing required detailed information to USAID as per their request the communications with USAID at different levels failed to reach to a consensus with USAID to support the MHT and SHCs and MoPH inevitably explored additional alternate options. Finally MoPH could convince the World Bank to fund the remaining HSS funded health facilities through absorbing them in the MoPH run Strengthening Mechanism (SM) project through which the health care service delivery is funded by WB while MoPH has the responsibility of direct provision of services through provincial public health directorates.
Activity1.1:Establishing Sub-Centers in under-se	In order to guide the NGOs on how to approach the close out process and proceed the hand over process as well as to make sure that all their contract obligations are adequately addressed, a

	detailed close out notice in the form of an official letter with signature of HE the Minister of Public Health developed and communicated with the NGOs prior to approaching the contract ending date. Since mostly contract ending dates were corresponded with beginning of or some happened in the mid-winter season, while the majority of the roads to the clinics were likely to be closed for about 4-6 months, thus NGOs were instructed to cover the winterization supplies for extra 3 to 6 months more beyond the contracts ending date (29th December 2012) as it was foreseen difficult for the SM to manage winterization, drug and non-drugs supplies in the short time left. However, the issuing of close out notice was a successful experience in appropriately guiding the NGOs to consider and meet their contract obligations in terms of preparing the end of project reports and other necessary information needed to close the contracts. However, apart from lengthy process of reviewing the end of project reports and relevant documents, as usual closing out the project also had its implications in terms of keeping the existing staff at their posts because first level health workers were prone to suspicions of losing their jobs or if the next implementer will continue to keep them hired, particularly when there are opportunities of getting better jobs at the local areas e.g. BPHS projects at the same province and locations offer sustainable job opportunities . Nevertheless, the overall process of absorption of HSS supported facilities is likely to be positive and depended on how soon the hand over process completed following a detailed phase of negotiation and coordination at the Ministry level with the next donor who will fund the HSS facilities. Reviewing the end of project reports has been a time consuming activity which is undertaken by a review committee comprised of finance, grant and monitoring and evaluation experts. The committee is assigned to check the consistency and completeness of the required information considering the technical project implementation and contractual and financial aspects. For example as part of the review process it has to be verified that the financial transactions took place during the life of the project recorded in the ledgers to be double checked with the assets list and hand over documents submitted by NGO and this should be verified by the representatives of provincial MoPH, Mustofiates (Ministry of Finance provincial authorities, current NGO and the next administration authority taking over the project e.g. MoPH Strengthening Mechanism). The review team in addition to carrying out their job, will need much time and effort to do all the required process for all the contracts one by one and finally prepare a short report authenticating the final payment to the NGOs in support of external audit report. All the project related documents are archived and appropriate filing system is in place to ensure safeguarding and timely access to relevant information for each of the projects with respect to different phases such procurement, contract administration and close out. The end of project documents has been an integral part of this package and is properly filed. On the other hand as part of the contractual obligations, contracted NGOs will also need to keep the project related documents till five years beyond the contract ending for any possible inquiry which has been emphasized as part of further instructions given during close out process. The project assets have been handed over to provincial MoPH directorates in accordance to the MoPH hand over guideline and a detailed list of handed over items has been part of the end of project report package which has been verified by related MoPH authorities undergone the review process and these asset lists are integral part of project documents.

Activity 1,3:Expanding integrated management of ch	• The second phase of C-IMCI project focusing on northeast and southeast zones covering 8 provinces of Baghlan, Kundoz, Badakhshan , Takhar , Ghazni, Paktika, Khost and Paktya started from 1st March 2012 and ended by 28th February 2013. 4837 CHWs and CHSs were planned to be trained in two modules of ARI and Control of Diarrheal Diseases. By the end of project totally the implementer NGOs succeed to trained 4571(94.5%) CHWs and CHSs (2026 Female & 2510 Male CHWs and only 2 female and 133 male CHSs) . • The C-IMCI training sessions regularly monitored jointly by provincial child health officers and implementer NGOs. • The Post project Assessment of second round of C-IMCI training project carried out by contractor NGOs the data entry and analysis process is under process and the results will be available by end of May, 2013. • The implementing NGOs have received regular technical assistance and guidance on the basis of request or reviewing quarterly reports and recommendations of monitoring missions. Face to face, meetings have also been arranged with NGOs whenever needed • NGOs reported their activities using the standard activity-reporting format on quarterly basis which is followed by the reviewing the process and provision of feedbacks to NGOs through email and face to face meeting. • The contract expiration notice sent to the NGOs to prepare them for properly close out of the projects and hand over of the assets to MoPH. Accordingly the NGOs shared the project supplies inventory list along with the with procurement documents to IMCI department and other MoPH related departments. The project assets have been handed over to provincial MoPH directorates in accordance to the MoPH hand over guideline and a detailed list of handed over items has been part of the end of project report package which has been verified by related MoPH authorities undergone the review process and these asset lists are integral part of project documents. • Some steps have taken to ensure the sustainability of the project; the lists of CHWs and CHSs who received C-CIMCI training were shared to Community Based Health Care department and Provincial Health Directorates for the post follow up the training and further refresher training. • The final payment of the NGOs pending until completion of the review of final technical and financial report.
Activity 1.4:Develop an in-service training progra	As it was mentioned in last APRs , the in service training project after one year terminated and the budget shifted to C-IMCI project, after steering committee approval.

Activity 2.1: Implementing a nationwide Informat	• During the reporting period totally 500000 Brushers reflecting different health issues in regard of mental health ,epilepsy , family planning , ORS, Eye care , Oral health , pregnancy and totally 500000 posters regarding Hand washing , Oral health , DS, Eye care , TT Vaccine , child vaccine , ARI , Family planning , hygiene , New born care ,Diarrhea printed by IEC department. • The Health Promotion department with the assistance of IEC task-force produced 15 TV spots regarding Eye care , oral health , mental health , blood donation , Nutrition , ARI , Hepatitis as well as disadvantages of using Qailon , use of plastic bags. • During the reporting period 1000 copies of ISLAM and Health book printed in Dari language, 500 copies of Health and Sport book printed in both Dari and Pashto languages and 2000 copies of Basic Health Massages Package printed and distributed to the relevant beneficiaries. • In the reporting period, totally 484 minute key health messages spots broadcasted via different TV channels and 1703 minute key health messages spots have been broadcasted through Radio channels. • One capacity building IPCC workshops for 150 Nangarhar, Kunar , Nooristan, Laghman, Logar and wardak provinc were conducted. • The translation and printing of Health Promotion policy and Strategy is under the process. • Based on NGOs requests and through HP department, totally 371272 IEC materials distributed to health facilities all over the country. • IEC packages (banner, invitation card, posters for different events, ROGHTIA magazine, Newsletter, Certificates, Calendars and Report for the MoPH designed during the reporting period. • The establishment of call center is a new initiative in the country, and needed number of meetings and consultations with the relevant stakeholders especially with Ministry of Information Technology (MoIT) and lack of capacity with MoIT and Health Promotion Department of MoPH, the development of the design and establishment of call center initiative which postponed for 2012, will be schedule to implement under HSFP project.

Activity 2.2: Pilot a model of demand side financ	The DSF project was piloted in sixteen districts of four provinces of Badakhshan, Kapisa, Faryab, and Wardak from December 2008 to May 2011 by HOPE worldwide. The aim of the project was to assess the impact of providing incentive to improve maternal 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 at a public health facility and $3 for bringing a child to the health facility for 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 are provided incentive and 4) in the control arm, no incentive were provided. The Demand Side Financing pilot project has already been completed by end of June 2011, after submission of the financial and technical as well as assets which were purchased from DSF budget handed over to MoPH based on MoPH hand over guideline the last installment paid to the implementer NGO by November 2012.

Activity 3.1: Up-grade the physical, information /	The Johns Hopkin's University (JHU) conducted a nationwide household survey to measure MoPH key indicators including indicators reported by GAVI/HSS. The survey is designed to measure the impact of health system intervention at national level. The M&E Directorate requested the JHU to incorporate HSS related indicators as well as provide analysis of coverage indicators including immunization based on different wealth quintiles. The M&E department facilitated the field work and assisted them administratively. 5 M&E officers were assisting the facilitation of field work, as well as analysis and report writing that results in capacity building of M and E directorate staff. 97% of provinces were monitored on implementation of BPHS and EPHS using NMC tool at least once in a quarter. The monitoring visits were conducted according to the set plan. The facilities monitored namely Regional, provincial and district hospitals; CHCs, BHCs, SHCs, MHTs, CHMS and CHNSs. A few provinces such as Nooristan, Daikundi, Zabul and Nimroz were not monitored each quarter due to harsh winter and security situation. 2 PPHOs in the 95% of visited provinces were trained to use NMC for monitoring purpose; and how to maintain NMC database. The PPHOs were particularly trained in the database interface, how to collect, enter and primary analyze the data. However as few as 10% of these PPHOs conducted field visit to monitor health facilities at their catchment area mainly due to lengthy financial processes. In addition, in some areas PPHOs turnover also caused deferment and cancellation of monitoring visits. It was decided by the leadership of MoPH That The Afghanistan National Public Health Institute (APNHI) should take the lead in the process of designing vital registration system. The department has already done some preparatory work with Ministry of Interior and requested M&E to hold on. The M&E will be however contacted for technical support if needed in future. It was also agreed with WB and EU to earmark a fix budget for designing, development and field testing vital registration system in Afghanistan. In almost 70% of monitoring missions a representative from Provincial department and GCMU were present. The missions were coordinated with the said departments prior to the missions. In 30% cases the missions were coincided with other activities that were either ad hoc or pre planned by said departments. It is very important to share the findings of M&E department in a structured way with other MoPH department to utilize for decision making effectively. M&E technically and financially supported the result conference which acted as a platform to share their experience and findings with NGOs, CSOs and government institutions. The evidence based findings and interventions were also shared with the MoPH leadership through a mini result workshop. Due to lengthy and complex administrative and financial procedures at MoPH, the M/E team was not able to provide good enough on the job training to provincial and central staff. Two M&E advisory board meetings were held during the reporting period. The M&E advisory board ToR was revised and were given more authority to review and revise tools relevant to M&E of MoPH. Participants from different departments including the bilateral organizations proposed to hold the meetings when needed. M&E department, in order to save time and resources, agreed to conduct the meetings at ad hoc basis. The internet fee of entire MoPH and upgrading of IT systems are supported from GAVI - HSS grant.

Activity 3.2:Launch a community demographic survei	This activity was already cancelled and cancellation approval obtained in the APR 2008. The reason was the limited availability of resources. This activity funding is being discussed with the World Bank which will probably fund the activity. The demographic surveillance system will be funded through SEHAT project funded by World Bank
Activity 3.3: Expanding capacity building program	The second round of the Quality Public Health Management Course project contracted through competitive bidding to the winner NGO. This project initially agreed duration was from 1st May 2011- 30th April 2012, however, because of heavy winter and several health emergencies, since there was the need to have the provincial offices staff to be on service rather in training, based on MoPH leadership decision, the project received a no cost extension till 15 June 2012. The QPHMC round 2nd project objective is to strengthening the capacity of provincial health officers in fundamentals of leadership, principles of management, disaster management, proposal and report writing skills. According to the original plan , 266 PHO staff were planned to receive training in 34 provinces. Out of 266 trainee , 167 PHOs from 24 provinces was planned to be trained in all five modules while 99 PHOs from 10 European Union supported provinces will be trained in three modules (Fundamental /basic leader ship, Basic Management, Proposal writing ,Disaster Management ,Report writing). During the reporting period in total there are 912 people out of 1112 were trained in 5 modules, 222 people trained in Basic Management, 117 people trained in Fundamentals of leadership, 194 people trained in Disaster Management, 201 people trained in Proposal writing and 178 people trained in Report writing modules. The main reason that the implementer NGO could not meet the target is the continued absenteeism of the participants. • The training department of Afghanistan National Public Health Institute (ANPHI) continuously provided technical support in the process of developing the training modules and during the training sessions in the field. Meanwhile technical assistance provided on due time the implementing NGOs on the basis of their request, recommendation of monitoring missions and reviewing the technical reports. • The quarterly technical and financial of the project report regularly reviewed by the training department of ANPHI and finance section of the MoPH and regular feedback through MoPH official channels and face to face meetings. • The Training department of ANPHI focal point conducted regular monitoring visits from the training session and provided on spot feedback. The ACTD training department and senior management and IIHMR also conducted supervisory visits from the training centers in regular basses. • In total there have been post training evaluation from 8 provinces of Parwan, Panjsher , Wardak , Logar , Laghman , Kunar , Hirat and Baghlan conducted jointly by MoPH and implementer NGOs using the newly developed checklist to measure the trainees knowledge and skill learned from the training. Meanwhile the team during its visits from the PHO offices conducted direct observation from the workplace of the PHOs. The general findings : - In general the participants found satisfied from the training that they received - They feel comfortable to write and evaluate proposals and write the report. - They use the newly learned Technic and approaches in their daily work and monitoring visits. - They are using the HR management principles at the PHO level and able to provide feedback to the NGOs. • The implementing NGO's quarterly technical report has been regularly reviewed and regular feedback provided to them. • The capacity building program continued for MoPH central level based on TNA and criteria, the HSS-SC, recommended a group of 23 people to different courses of institution based or distance.

	• The project assets have been handed over to provincial MoPH directorates in accordance to the MoPH hand over guideline and a detailed list of handed over items has been part of the end of project report package which has been verified by related MoPH authorities undergone the review process and these asset lists are integral part of project documents. • The final project report and project close out activity according to Afghanistan procurement law is in the process. The last payment of the NGO will be released after in-depth review all financial technical report documents.
Activity 3.4:Developing a communications and inter	• Press tours for reflection of MoPH's Success Stories conducted in eight provinces of Parwan , Kandahar, Nangarhar, Balkh, Sar-e- Pul, Faryab, Logar and Maidan wardak to overseeing of health situation and news coverage. In these travels the Minister of Health accompanied by the popular TV channels. • Over 138 Press conferences have been launched during reporting period. The press conferences covered different health events such as International and National Health Days, Contracts & MoUs signing and etc,… and more than 420 Press and NEWS Releases, and Statement in Dari, Pashto and English were developed and also sent to the National and International media outlets for broadcasting. • 12 issues of Newsletter were published, each issues contains 20 pages in Dari, Pashto and English languages reflecting important e events. Printing of advertising papers, (envelope, folder, calendar, and Dairy) were completed and distributed to different department of MoPH, The process of Year Calendar Designing was completed. • The production of documentary film on vaccination, midwifery education program and mobile teams completed under the direct supervision of the assigned technical committee and ready for broadcasting. Steps have been taken to contract with interested TV channels to start broadcasting of the films. (Attached the CD) • Two coordination meetings have been conducted with authorities of domestic media to strengthen better coordination between Public Relation and media for publishing the news related- MoPH's activities. • Over 500 news bulletin and events were published under MoPH's website in Dari, Pashto and English versions along with their photos, audios and videos.

Activity 3.5: Launching an initial cadre of Distri	The District Public Health Officer's project office conducted quarterly meetings with relevant departments in the central MoPH and all provinces that DPHOs are present. The project discussed different topics including DPHOs coordination of activities, plans and supervision by PPHO team. DPHOs ToR was revised in close consultation with CBHC and other relevant departments to accommodate the revised BPHS requirements that are related to DPHOs at district level. In order to accommodate communicable and non communicable disease strategies requirements, the revised amendments were included in the DPHOs ToR and therefore the guidelines for DPHOs were developed. The central DPHO project conducted visits from the provinces and coordinated DPHOs activities with the PPHO team. The project team facilitated to implement and monitor MoPH policies and strategies that come in the DPHOs ToR. The central DPHO team and DPHOs in the districts conducted quarterly monitoring reports to make sure the services are according to BPHS strategy and the quality of health services is gradually improved. The reports are shared and compiled the central DPHO office and were shared with the MoPH leadership and provided DPHOs necessary feedback if any.

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

All activities based on original proposal were completed as planned. After successful inclusion of 42 sub health centers and MHTs in the BPHS contracts of EU supported provinces, MoPH faced with the reluctance of USAID for absorption of remaining 72 health facilities in 13 provinces under USAID funded BPHS contracts. Despite a great deal of efforts in justifying the rationality of the need for establishing these facilities and providing required detailed information to USAID as per their request the communications with USAID at different levels failed to reach to a momentous end and MoPH inevitably explored additional alternate options. Finally MoPH could convince the World Bank to fund the remaining HSS funded health facilities through absorbing them in the MoPH run Strengthening Mechanism (SM) project through which the healthcare service delivery is funded by WB while MoPH has the responsibility of direct provision of services through provincial public health directorates.

Design of vital registration system was planned in M&E 2012 work plan, It was decided by the leadership of MoPH to give lead of designing vital registration system to Afghanistan Public Health Institute (APHI) as a more concern department for this activity, the project will be implemented by SEHAT project funded by World Bank.

IEC activities were carried out as planned since the establishment of call center is a new initiative in the country, and needed number of meetings and consultations with the relevant stakeholders especially with Ministry of Information Technology (MoIT) and lack of capacity with MoIT and Health Promotion Department of MoPH, the development of the design and establishment of this call center which postponed for 2012,again MoPH could not recruit the short term consultant to develop design guideline for this intervention will cover under HSFP.

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All the activities completed as plan, only the last payment of NGOs will remain pending till receiving the 2012 audit report as well completion of end project financial and technical reports review and proper close out of all contracts which will take at least 60 days.

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

Efforts are made to deny payment of irrelevant to HSS staff of MoPH. In Afghanistan, all other donors and technical partners in a way contribute to payment of some MoPH essential staff. These include but not limited to USAID, EU, WB, WHO, UNICEF, UNFPA, Global Fund and so on. From GAVI funds, one procurement officer, two HR advisors, one legal advisor, and few staff of MoPH minister have been paid. The procurement has been challenge the person paid works for all donors and Gov funds, the HR advisors work for MoPH and are leading the reform process which will significantly impact the all MoPH programs, legal advisor checks all the contracts and MoUs signed with NGOs including GAVI funded contracts with NGOs. Only a group of six staff who are cleaners and guards of new MoPH Minister are paid with a small amount. It is worth mentioning that the payments toall this group are ceased and efforts are made to pay the HR advisors from WB which is already communicated (WB already pays 4 HR advisor) , legal advisor from some other source (maybe through Gov channel). Six staff of HE MoPH Minister will remain on the payroll until end 2012. The rest of HE staff are paid from other sources such as WB or USAID. All these issues have been very transparently decided by the HSS-SC.

Although upon the closing of HSS grant the above mentioned staff were given notice for the end of their contracts, based on their contribution directly and indirectly for the implementation of previous HSS grant and in the HSFP , the MoPH leadership approved the contract extension of the following people; the senior Advisor in the Provincial Liaison Directorate who will follow up and facilitate HSS activities at the provinces, the HR consultant will facilitate the HSS recruitments, the M & E director , the secretary for the deputy minister of policy and planning, the stock keeper who is looking after of all assets purchased from HSS grants, the MoPH a Gate Guard and the Public Relation department team salary will be paid from HSFP based on HSS steering committee meeting approval (SC minute April 16 / 2013)<? xml:namespace prefix = o />

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2011 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2012 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2008	2009	2010	2011	2012		

1.1: To increase National DTP3 coverage for the children under age one (% of children under age one received DPT3 vaccine)	77%	JFR/EPI/2007	90% (2012)	90%	85%	83%	87%	89%	87%	EPI	• Insecurity in most parts of the country that prevented vaccinators to go for mobile and outreach activities • Vaccinators' turn over in most part of the country is another main challenge which has contributed to this problem • Remuneration policy for vaccinators is very controversial because MoPH has pledged to pay their counterparts such as doctors, nurses and midwives the hardships at the rate of 50, 150 and 200% while it is not applicable for vaccinators in the respective places. This is also a discouraging factor in achieving vaccinators target in their facilities.
1.2: To increase the number/percent of districts achieving >80% DPT3 coverage under age one (% of districts achieving DPT3 coverage >80%)	49%	J FR 2007	100% (2012)	100%	58%	56%	58%	57%	61%	EPI	The same as above
1.3 To reduce under five mortality rate from 210/1000 live births in 2006 to 168/1000 live births by 2012.	210/1000	AHS 2006	153/1000 (2012)	191/1000	191/1000	161/1000	161/1000	97/1000	97/1000	AMS 2010	The target for 2012 was 153 but now it reached to 97
1.4 To increase National Measles coverage (% of children received at least one dose of Measles vaccine)	68%	J FR 2007	90% (2012)	90%	75%	76%	79%	82%	81%	JFR/EPI	
1.5 To increase skill birth attendance (% of deliveries attended by skill birth attendants)	19%	AHS/HHS	40% (2012)	40%	32%	35%	35%	45%	46%	AHS 2012	

1.6 To increase treatment of diarrhea and ARI at community level (% of children treated for ARI and diarrhea at community level)	30%	HMIS/IMCI	30%(2012)	30%	30%	32%	34%	73%	57%	HMIS	
2.1: To increase contacts per person per year with the health care system (Number of contacts per persons/year)	0.6%	HMIS	1(2012)	1.0/ person/ year	1.08	1.16	1.30	1.5	1.8	HMIS	
2.2: To increase average number of persons referred by CHWs per quarter (Avg # of persons referred by CHWs/ quarter)	14.8	HMIS	20/ Quarter	20/ Quarter	24/Quarter	20	22	23.3	34.4	HMIS	
2.3: Provider knowledge score	67.8	BSC	90% (2012)	90%	79.3%	Not measured	70.6%	64.6%	69.5%	BSC	
2.4: To increase the % of mothers in rural communities knowledgeable about prioritized heath messages (% of mothers in rural communities knowledgeable about prioritized heath messages)	?	HMIS/ AHS	40% (2012)	40%							The data for Indicator 9: Proportion of mothers in rural communities knowledgeable about prioritized health does not exist in AHS 2012. The indicator was proposed in 2008 to be included in household survey but was later changed by MoPH leadership and technical committee. The indicator is switched with following indicators: Proportion of mothers having “appropriate” knowledge about introducing complementary food; Proportion of children whose parents are able to name danger signs of diarrhea and ARI and the appropriate response; and Proportion of women (12-49 years) knowledgeable about at least one modern contraceptive method

2.5: To increase % of CHWs trained in community IMCI from 2% in 2006 to 80% in 2012 (% of CHWs trained in community IMCI)	2%	IMCI/HMIS	80% (2012)	80%	Started in late 2008	20.30 %	34.30 %	56%	62%	IMCI	• CHWs dropout • Harvesting time and winter was a challenge in some areas. During the harvesting time male CHW was not available to attend the training
2.6: To increase the % of provinces receiving monitoring visits using national monitoring checklist per quarter from 25% in 2006 to 100% in 2012	29%	M&E Dep	100% (2012)	100%	33%/ Quarter	47.10 %	56.50 %	47%	85%	M&E	• Insecurity in some provinces such as Nooristan, Zabul, Orozgan, Helmand and Farah • Harsh weather conditions in central and northern provinces such as Bamyan, Daikundi and Badghis and Badakhshan • Shortage of enough personnel to cover all country for monitoring missions

9.4. Programme implementation in 2012

9.4.1. Please provide a narrative on major accomplishments in 2012, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

The GAVI – HSS funds as envisaged in the GAVI guidelines and reported in the previous APRs have been indeed catalytic and instrumental for the health system of Afghanistan. <?xml:namespace prefix = o />

A. Management

1. Five HSS steering committee meetings were conducted during reporting period. The Health System Strengthening Steering committee (HSS-SC) with the presence of key CGHN members within the health sector of Afghanistan is actively supporting the health sector for successful implementation of global health initiatives related to HSS especially the GAVI support. The HSS-SC as coordination and monitoring body for HSS program is comprised of three MOPH voting members (key departments), representatives of UNICEF, WHO, World Bank, European Commission, USAID, Civil Society Organizations interim representative and Ministry of Finance.
2. The bottom up annual plan of action (form 11 MOPH departments) was developed, approved by HSS-SC and accepted by MoF.
3. GAVI support type B bridging ended by end of January 2013, one quarter no cost extension approved by GAVI secretariat till end of April 2013, based on NGOs financial records still some amount is remained unspent which could cover two months of May and June 2013, at the other hand , there is not budget allocated in the HSFP proposal for the implementation of PPP till first of July 2013.
4. HSS components of Global Fund R8 and R10 funded projects are being implemented.
5. Timely support has been given to implementing departments of MOPH for planning, implementation and monitoring of the activities
6. The GAVI- HSS program evaluation is under procurement process
7. The HSFP proposal approved and steps are taken for proper implementation as follow:

<!--[if !supportLists]-->- A Collaborative session of role and procedure of WHO by WHO administration team and MoPH / HSS team has been conducted,

<!--[if !supportLists]-->- <!--[endif]-->The HSFP budget revised in order to increase WHO administrative cost from 4.4% to 7% as agreed at beginning of proposal development.

<!--[if !supportLists]-->- <!--[endif]-->A comprehensive operational plan for smooth HSFPimplementation developed based onrelevant department work plan used WHOwork plan format and shared with WHO andGAVI secretariat

<!--[if !supportLists]-->- <!--[endif]-->With the technical support from HSS coordination unit; the HSFP detailed annual work plan has been developed by relevant departments and approved by HSS steering committee.

- Letter for the Record between WHO and MoPH has been developed through a participatory process in consultation with WHO, MoPH and relevant departments, in order to define the role and responsibilities of both parties for HSFP grant implementation and approved by Steering Committee.

B.1: Establishment of sub centres and Mobile Health teams in remote andunderserved areas of the country:

`continuation of provision of health services through establishment of 121 sub health centers and 26 mobile health teams across the country. The entire health facilities operating under GAVI-HSS fund were functional during the reporting period. The contracting NGOs were regularly reporting on successful implementation of project planed interventions on quarterly basis according to the standard reporting format to MoPH. regular feed- backs were provided to ensure the smooth implementation of planned activities to implementing partners.

The HMIS data shows that implementing NGOs maintain the achievements with regard to overall project indicators versus to previous year's achievements in-spite of increasing security challenges in the country which can be a reasonable justification; however in most cases the trend of HMIS data shows a steady increase on project overall indicators. During the reporting period totally 1613018 OPD visits, 3736 assisted deliveries , 23097 new ANC visits, 11284 new PNC visits, 23361 family planning visits, 14587 Penta III (0-11 months), 29173 TT2+ and 146811 children under five years of age screened for malnutrition. it is worth mentioning that Children under 5 years old were 15% of the total OPDs and female beneficiaries consultations account for 59% of the total OPDs.

In general, while reviewing the quarterly reports the progress compared to the set plans and completeness of HMIS data were thoroughly commented. Additionally in cases where prompt response were needed by the NGOs to cope with unpredictable micro-level implementation issues and challenges such as security problems or lack of female staff in far remote areas where most of the sub health centers are located and or problems such as lack of female staff in general worsen by security threats has led the female staff to hesitate working with a mobile health team in particular with continuous traveling schedule and moving to different parts of province some with remarkable security problems, NGOs were provided with the necessary guidance through emails and official correspondence helping them to adjust carrying out the activities accordingly and 64% (HMIS-FSR 2012) of the entire health facilities were with required female health workers during the reporting period.

In the meantime MOPH continued its endeavors to coordinate and discuss with donors supporting BPHS to consider the support of the GAVI funded SHCs and MHTs in future. After successful inclusion of 42 sub health centers and MHTs in the BPHS contracts of EU supported provinces, MoPH realized that USAID were reluctant to support the remaining 72 health facilities in 13 provinces under USAID funded BPHS contracts. Despite a great deal of efforts in justifying the rationality of the need for establishing these facilities and providing required detailed information to USAID as per their request the communications with USAID at different levels failed to reach to a consensus with USAID to support the MHT and SHCs and MoPH inevitably explored additional alternate options. Finally MoPH could convince the World Bank to fund the remaining HSS funded health facilities through absorbing them in the MoPH run Strengthening Mechanism (SM) project through which the health care service delivery is funded by WB while MoPH has the responsibility of direct provision of services through provincial public health directorates.

In order to guide the NGOs on how to approach the close out process and proceed the hand over process as well as to make sure that all their contract obligations are adequately addressed, a detailed close out notice in the form of an official letter with signature of HE the Minister of Public Health developed and communicated with the NGOs prior to approaching the contract ending date. Since mostly contract ending dates were corresponded with beginning of or some happened in the mid-winter season, while the majority of the roads to the clinics were likely to be closed for about 4-6 months, thus NGOs were instructed to cover the winterization supplies for extra 3 to 6 months more beyond the contracts ending date (29th December 2012) as it was foreseen difficult for the SM to manage winterization, drug and non-drugs supplies in the short time left.

However, the issuing of close out notice was a successful experience in appropriately guiding the NGOs to consider and meet their contract obligations in terms of preparing the end of project reports and other necessary information needed to close the contracts. However, apart from lengthy process of reviewing the end of project reports and relevant documents, as usual closing out the project also had its implications in terms of keeping the existing staff at their posts because first level health workers were prone to suspicions of losing their jobs or if the next implementer will continue to keep them hired, particularly when there are opportunities of getting better jobs at the local areas e.g. BPHS projects at the same province and locations offer sustainable job opportunities . Nevertheless, the overall process of absorption of HSS supported facilities is likely to be positive and depended on how soon the hand over process completed following a detailed phase of negotiation and coordination at the Ministry level with the next donor who will fund the HSS facilities.

All the project related documents are archived and appropriate filing system is in place to ensure safeguarding and timely access to relevant information for each of the projects with respect to different phases such procurement, contract administration and close out. The end of project documents has been an integral part of this package and is properly filed. On the other hand as part of the contractual obligations, contracted NGOs will also need to keep the project related documents till five years beyond the contract ending for any possible inquiry which has been emphasized as part of further instructions given during close out process. The project assets have been handed over to provincial MoPH directorates in accordance to the MoPH hand over guideline and a detailed list of handed over items has been part of the end of project report package which has been verified by related MoPH authorities undergone the review process and these asset lists are integral part of project documents.

B.2: Implementation of community basedIntegrated – Management of Childhood Illnesses:

<!--[endif]-->The second phase of the C-IMCI project focusing on northeast and southeast zones covering 8 provinces of Baghlan, Kundoz, Badakhshan , Takhar , Ghazni, Paktika,Khost and Paktya started from 1st March 2012 and ended by 28th February 2013. 4837 CHWs and CHSs were planned to be trained in two modules of ARI and Control of Diarrheal Diseases. By the end of project totally the implementer NGOs succeed to trained 4571(94.5%) CHWs and CHSs (2026 Female & 2510 Male CHWs and only 2 female and 133 male CHSs) The C-IMCI training sessions regularly monitored jointly by provincial child health officers and implementer NGOs. The Post project Assessment of second round of C-IMCI training project carried out by contractor NGOs the dataentry and analysis process is under process and the results will be available soon. Contract expiration notice sent to the NGOs to prepare for properly close out of the projects and handover of the assets to MoPH. Accordingly the NGOs shared the project supplies inventory list along with the with procurement documents to IMCI department and other MoPH related departments. The project assets have been handed over to provincial MoPH directorates in accordance to the MoPH hand over guideline and a detailed list of handed over items has been part of the end of project report package which has been verified by related MoPH authorities undergone thereview process and these asset lists are integral part of project documents. Steps have taken to ensure the sustainability of the project; the lists of CHWs and CHSs who received C-CIMCI training were shared to Community Based Health Care department and Provincial Health Directorates for the post follow up the training and further refresher training.

B.3: To build the capacity of BPHS primary health care provider in 13 provinces:

As reported last year, this activity is handed over to USAID. Only the last payment is pending.

<!--[if !supportLists]-->C. <!--[endif]-->Increases demand for and utilization of health care services

The Health Promotion department with the assistance of IEC taskforce produced 15 TV spots regarding the disadvantages of using Qailon ,plastic and Eye care , oral health , mental health , blood donation , Nutrition, ARI and Hepatitis. During the reporting period 1000 copies of ISLAM and Health book printed and published in Dari language, 500 copies of Health and Sport book printed in both Dari and Pashto languages and 2000 copies of Basic Health Massages Package printed and distributed to the relevant beneficiaries. In the

reporting period totally 484 minute key health messages broadcasted via different TV channels and 1703 minute key health messages have been broadcasted through Radio channels.

The establishment of call center is a new initiative in the country, and needed number of meetings and consultations with the relevant stakeholders especially with Ministry of Information Technology (MoIT) and lackof capacity with MoIT and Health Promotion Department of MoPH, the development of the design and establishment of this call center which postponed for 2012,again MoPH could not recruit the short term consultant to develop design guideline for this intervention

C.2: Pilot the effectiveness of a model of demand sidefinancing and Provide monetary performance incentives to Community Health Workers:

The DSF project was piloted in sixteen districts of four provinces of Badakhshan, Kapisa, Faryab, and Wardakfrom December 2008 to May 2011 by HOPE worldwide. The aim of the project was toassess the impact of providing incentive to improve maternal and immunization services. It was a quasi-experimental study with four arms 1) Providing Incentive to families to utilizematernal health and vaccination; families were given $6 for each delivery at a public health facility and $3 for bringing a child to the health facility forDPT3 vaccination. 2) Providing incentive to community health workers; $3 forthe referral of a pregnant woman in order to promote institutional delivery atthe public health facilities as well as referral of a child to receive DPT3vaccination. 3) In the combined arm, both household and CHWs are providedincentive and 4) in the control arm, no incentive were provided.

The Demand Side Financing pilot project already completed by end of June 2011, after submission of the financial and technical as well as assets which were purchased from DSF budget handed over to MoPH based on MoPH hand over guideline the last installment of the implementer NGO paid by November 2012.The final project report has already shared with GAVI secretariat along with 2011 APR.

D: Improve the ability of the MOPH, at various levels,to fulfill its Stewardship Responsibilities.

D.1: Up-grade the physical, information/communicationtechnology infrastructure and means of transportation<!--[if !supportFootnotes]-->[1]<!--[endif]-->of the M&E Department:

Johnhs Hopkin's University (JHU) conducted a nationwide household survey to measure MoPH key indicators including indicators reported by GAVI/HSS. The survey is designed to measure the impact of health system intervention nationally. M&E requested JHU to incorporate HSS related indicators as well as provide analysis of coverage indicators including immunization on different wealth quintiles. The M&E department facilitated the field work and assisted them administratively. 5 M&E officers were always present in the field work, analysis and report writing which helped them built their capacities. The first draft report is due in April 2013. 97% of provinces were monitored for BPHS and EPHS using NMCtool at least once in a quarter. The monitoring visits were conducted accordingto the set plan. The facilities monitored included Regional, provincial anddistrict hospitals; CHCs, BHCs, SHCs, MHTs, CHMS and CHNSs. A few provinces such as Nooristan, Daikundi, Zabul and Nimroz were not monitored each quarter due to harsh winter and security situation.

2 PPHOs of 95% visited provinces were trained to use NMC for monitoring purpose; and how to maintain NMC database. The PPHOs were particularly trained in the database interface, how to collect, enter andprimary analyze the data. However as few as 10% of these PPHOs conducted field visit to monitor health facilities at their catchment area mainly due to lengthy financial processes. In addition, in some areas PPHOs turnover also caused deferment and cancellation of monitoring visits.

The GAVI has contributed significantly to improve M&E especially the routine, however, further intensive support is required to reach to a desired system for M&E.

D.2: Launch a community demographic surveillance system

This activity already cancelled from GAVI funds in 2008.

D.3: Expand capacity building program for MOPH managersat the Central and Provincial levels.

The second round of the QPHMC project contracted through an open bidding with the winner NGO. This project initially agreed duration was from 1st May 2011- 30th April 2012, however,because of heavy winter and several health emergencies, since there was then eed to have the provincial offices staff to be on service rather in training,based on MoPH leadership decision, the project received a no cost extension till 15 June 2012. The QPHMC round 2nd project objective is to strengtheningthe capacity of provincial health officers in fundamentals of leadership,principles of management, disaster management, proposal and report

writingskills. According to the original plan , 266 PHO staff were planned to receive training in 34 provinces. Out of 266 trainee , 167 PHOs from 24 provinces was planned to be trained in all five modules while 99 PHOs from 10 European Union supported provinces will betrained in three modules (Fundamental /basic leadership, Basic Management, Proposal writing ,Disaster Management ,Report writing). During the reporting period in total thereare 912 people out of 1112 were trained in 5 modules, 222 people trained in Basic Management, 117 people trained in Fundamentals of leadership, 194 people trained in Disaster Management, 201people trained in Proposal writing and 178 people trained in Report writing modules. The main reason that the implementer NGOhas not met the target is continues absenteeism of the participants. Despite ofsharing the problem with the MOPH related departments by the ACTD,unfortunately the problem remained unsolved. The training department of Afghanistan National Public Health Institute (ANPHI) continuously provided technical support in developing the training modules and during the training sessions in the field. Meanwhile technical assistance provided on due time the implementing NGOs on the basis of their request, recommendation of monitoring missions and reviewing the technical reports. The capacity building program continued for MoPH central level based on TNA and criteria, the HSS-SC,recommended a group of 23 people to different courses of institution based or distance.

The project assets have been handed over to provincial MoPH directorates in accordance to the MoPH hand over guideline and a detailed list of handed over items has been part of the end ofproject report package which has been verified by related MoPH authorities undergone the review process and these asset lists are integral part of project documents..

D.4: Develop a communications and internal advocacyprogram to seek increased funding:

Press Travels for reflecting MoPH's Success Stories conducted in eight provinces of Parwan , Kandahar,Nangarhar, Balkh, Sar-e- Pul, Faryab, Logar and Maidan wardak to overseeing of health situation and news coverage. In these travels the Minister of Health accompanied by the popular TV channels. Over 138 Press conferences launched during reporting period. The press conferences covered different health events such as International and National Health Days, Contracts & MoUs signing and etc,… and more than 420 Press and NEWS Releases, and Statemen tin Dari, Pashto and English were developed and also sent to the National and International media outlets for broadcasting. The production of documentary film on vaccination, midwifery education program and mobile teams completed under the direct supervision ofthe assigned technical committee and ready for broadcasting. Steps have been taken to contract with interested TV channels to start broadcasting of the films

D.5: Launch an initial cadre of District Health Officers

The DPHO project team conducted quarterly meetings with relevant departments in the central MoPH and provincial level with the presence of the DPHOs to exchange experiences, DPHO achievements at the district leveland provision technical assistance for better DPHOs performance at the field level. DPHOs ToR was revised with close consultation of CBHC and other relevant departments to accommodate the revised BPHS requirements that are related to DPHOs at district level. In order to accommodate communicable and non-communicable disease strategies requirements, the revised amendments were included in the DPHOs ToR and therefore the guidelines for DPHOs were developed and shared with DPHOs through a workshop. The central DPHO team conducted visits from the provinces and coordinated DPHOs activities with the PPHO team.

Although very challenging context, with the support of all health sector partners, the MOPH succeeded to fully implement the successfully accomplished all planned activities to certain extent. Indicators as stated in the relevant table's shows satisfactory progress during the year 2012, however, two indicators as a result of security has not been improved and even reduced.

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9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

- **Insecurity** in some parts of the country: to cope with insecurity problem the MOPH has piloted the partnership with for profit health service provider to provide reproductive health, child health and immunization services in insecure and under served areas under CSO type B Project.<? xml:namespace prefix = o />
- **Long and tedious administrative procedures** inside and outside of the MOPH: reforming is under way . However, the proposed reforms are not effective to the extent where pragmatic changes take place.
- **Suboptimal capacity and commitment of** MOPH authorities at provincial level to fulfill the stewardship act of MoPH and effectively monitor NGOs implementing health related interventions.
- **Lack of qualified health workers** particularly female health workers in remote and underserved areas. Various initiatives are underway to train and recruit more female health workers in insecure and underserved areas.
- **Geographical constraints**, prolonged and harsh winter in certain parts of the country, and bad road conditions.

The new HSFP application will contribute to ease some of these challenges especially the administrative process related to procurement which is next to the insecurity challenge. In addition,volunteer health workers will be trained mostly female in Kochi population through HSFP which will produce evidence based results and further ensure equity.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

HSS has been providing support to improve the capacity of M and E Directorate thorough assigning national consultant and Mand E officer as well as providing regular backstopping and training to M and E set up in MoPH.. Therefore, the budget allocated to support M and E activities was reallocated to the M and E workplan.. In addition, the Afghanistan the current GAVI/HSS proposal has a specific activity called "upgrading the physical technology infrastructure of the M&E department". Therefore, the M&E department receives its prime source of support from GAVI– HSS funds. It includes supporting salaries of M and E Directorate staff , provision of,equipment, vehicles and technical asistance and backstopping at central and provincial levels. In addition,M&E directorate is assisted to expand their role in the process of designing M and E tools and checklists for monitoring the HSS supported initiatives. <?xml:namespace prefix = o />

In addition;,the Balanced Score Card, a national evaluation tool aiming at evaluating the MoPH strategies on an annual basis implemented by The Third Party Evaluation (The Johns Hopkins University) funded by the World Bank, has also captures important information for some of the GAVI/HSS Program indicators . HMIS department of MoPH has been collecting information from the BPHS health facilities on a quarterly basis where information from MHT and SHC are also collected , processed and analyzed to assist program and policy people to take evidence based policy decisions During the year 2011 USAID/Tech serve supported the evaluation of "launching a new cadre of District Health Officers". UNICEF has supported the MHT initiatives. In addition, The different department of MoPH are involve in implementing different activities and their staff receive support from GAVI/HSS Program are involve in monitoring of HSS supported activities.. HSS initiative has promoted in incorporation of in-built monitoring mechanism with the projects/interventions being supported by GAVI fund, for instance, C-IMCI project has a baseline and follow up evaluation in built within the scope of C-IMCI Project.The Mid term evaluation of GAVI/HSS supported interventions has been conducted and recommendation has been provided to take remedial actions. It is also planned to conduct external evaluation of GAVI/HSS program during the year 2012 in order to measure the HSS implementation, the effectiveness of its interventions and its contribution to the improvement of health and in relation to immunization coverage and to draw the necessary lessons to influence the future policy and implementation of HSS interventions. The evaluation will cover the period of GAVI financing 2007-2012. It should consider all stages of implementation from the very beginning to the end: preparation of the application to GAVI, submission, implementation of activities, preparation and submission of annual reports; and follow through of results.

The findings and recommendations of the evaluation will provide information and guidance for the implementation of the next phase of GAVI funding in Afghanistan (HSFP). As the next phase builds on the achievements and the experiences of the first phase, the evaluation will provide an evidence based review of the strengths and the weaknesses as well as the achievements and the shortcomings of the current phase contributing, as such, in maximizing the outputs and the effectiveness of the next phase.;This document will serve as a good lessons learned not only in Afghanistan but also for other countries receiving GAVI funds.

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

GAVI/HSS avail the opportunity to integrate the M and E activities with the country system; HSS provide technical support to conduct annual health sector review so called results conference and health sector retreat where the progress in the health sector has been reviewed and the gap analysis exercise has been conducted and policy and program recommendations proposed. HSS support the M and E directorate to collect information on GAVI/HSS indicators as well as health sector indicators and review those indicators on regular basis; in future , GAVI HSS support will be used to strengthen the reporting and stewardship act of MoPH at Provincial level as well. GAVI/HSS supported initiative is the sole added initiative to assist MoPH to integrate and support M and E activities on a regular basis in Afghanistan.

Health service delivery is monitored by M&E officers using a structured checklist known as National Monitoring Checklist(NMC) all over Afghanistan. GAVI fund supported MoPH to build the capacity of provincial officers to use NMC and report it to central M&E department. NMC is approved checklist that is also used by Grants and Contracts Management unit to monitor health service delivery in monitoring visits jointly with M&E officers. The evaluation of health services is conducted by a third party annually. The Evaluation directorate of M&E department is closely working with the third party in devising, revising, executing and analyzing the evaluation data. Given the circumstances, the M&E is going to prepare a strategic plan to transfer the knowledge, tools and skills required for annual evaluation to M&E department so that the M&E officers will be able to conduct health facility assessments in next three years. <?xml:namespace prefix = o />

Monitoring and evaluation reports are widely shared with the MoPH leadership and other policy makers. However, in order to build consensus around most of the findings; and set up a platform for secondary analysis and timely action, GAVI/HSS is supporting two important national events, a result conference and a health sector retreat workshop.

As a result of the GAVI/HSS technical support to M&E and HMIS departments, M&E advocated for establishing an umbrella department known as Health Information System (HIS) where the data of departments including HMIS, M&E, Research and Disease Early Warning System(DEWS) etc can be properly channeled, analyzed and disseminated. This will also help to standardized the process of data collection and avoid duplication byother departments.

As explained earlier, HMIS and M&E departments collect mostly input and process data while the third party is responsible for output and outcome data. As a part of the health system strengthening efforts,the majority of indicators that MoPH reported were input and process with very few outcome. In the meantime, some indicators as part of HSS were collected from vertical departments such as IMCI and Community Based Health Care department. In order to organize the HSS funding, efforts should be made to select and report on already established input, process, output and outcome indicators in the HMIS and M&E departments. In addition, efforts should be made to incorporate indicators pertaining vertical programs into the national HMIS and M&E data.

The current phase of the GAVI funded HSS has already closed by the end of 2012. It is important for MoPH and its partners to review the HSS implementation, the effectiveness of its interventions and its contribution to the improvement of health and in relation to immunization coverage and to draw the necessary lessons to influence the future policy and implementation of HSS interventions. The evaluation will cover the period of GAVI financing 2007-2012. It should consider all stages of implementation from the very beginning to the end: preparation of the application to GAVI, submission, implementation of activities, preparation and submission of annual reports; and follow through of results.The findings and recommendations of the evaluation will provide information and guidance for the implementation of the next phase of GAVI funding in Afghanistan (HSFP). As the next phase builds on the achievements and the experiences of the first phase, the evaluation will provide an evidence based review of the strengths and the weaknesses as well as the achievements and the shortcomings of the current phase contributing, as such, in maximizing the outputs and the effectiveness of the next phase.

The proposed M&E intervention in the HSFP proposal aims to build up on early gains and to streamline M&E activities at different levels. Current monitoring tools at central level will be revised. Regular joint central and provincial joint monitoring missions to the districts will be organized in at least 82% of the provinces. The M&E department of MoPH will be equipped with necessary communication and transportation facilities and provided strong technical assistance. The newly established unit of private sector monitoring will be

strengthened. The existing MoPH database will upgrade to accommodate revised PHC and hospital M&E/NMC. Guidelines for monitoring at the provincial level addressing related issues, coordination, reporting, advocacy,monitoring lists, quality of data etc., will be developed. 37 central and 34 provincial staff members will be trained in M&E to be able to use the revised tools and the new guidelines. An annual result conference will be held in MoPH to discuss the health information collected and processed over the year.

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

At the oversight level, the HSS-SCprovides a significant level of support to GAVI HSS supported initiatives in theprocess of design and implementation.Other stakeholders such as the world bank, USAID, WHO, UNICEF , and EU play an important role in the process ofoversight and provison of technical input andbackstopping of GAVI HSS supported activities. The MOPH Afghanistan and itspartners believe that the use of Civil Society Organizations (CSOs) will helpthe health sector of Afghanistan to timely and efficiently achieve its nationaland, consequently the international, health targets. Therefore, the MOPHAfghanistan has adopted the stewardship role and contracted out most health servicedelivery to NGOs. Form HSS support, over 65% of activities is being implementedby NGOs.

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The CSO type B initial phase wasimplemented by the six national and International NGOs. Four CommunityMidwifery Education (CME) programs were implemented in four provinces ofGhazni, Nimroz, Kunar and Zabul provinnces and completed last year. Two pilotpublic-private for profit partnership projects are running in the two insecureprovinces of Uruzgan and Farah and two more are added in CSO bridging inNooristan and Paktya provinces.

The achievements so far in Afghanistan can be attributed to the significant involvement of CSOs in the health sector. In 31 out of 34 provinces NGOs are implementing a Basic Package of Health Services (BPHS) in Basic Health Centres, Comprehensive Health Centres, and District Hospitals. NGOs are also involved in the implementation of Essential Package of Hospital Services (EPHS). Other CSOs are involved in training programs and in monitoring and evaluation.

The GAVI - HSS Program evaluation will be done by the winner CSO, the will be give to those CSOs who have not received fund for the implementation of any GAVI - HSS activities.

The majority of HSFP activities will be implemented by the winner CSOs through open Bidding process according WHO procurement rule and regulation.

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

The majority of the HSS activities are being implemented by the National and International NGOs since beginning of the HSS program, some projects being implement by one NGO and some of the in consortium with one or two NGOs<?xml:namespace prefix = o />

The Sub centers and MHT implemented by 7 International NGOs like Swedish Committee for Afghanistan (SCA), Aid Medical International (AMI) , BRAC , HNTPO, Aga Khan Health System (AKHS), Merlin and MARCA and 7 National NGOs like Bakhter Development Network(BDN), Care of Afghan Families (CAF), Ibnsina, STEP Health and development Organization (STEP), Solidarity for Afghan Family (SAF), Humanitarian Assistance Development of Afghanistan (HADAF) and Coordination for Humanitarian Assistant throughout the country.

The C-IMCI projects are also running by two International of Save children / US, HNTO and Agency for Assistance and Development of Afghanistan (AADA) a National NGO covering 25 provinces.

The Quality Public Health Management courses for the capacity building of health managers at the central and provincial level also implementing with a consortium by HADAF and IIHMR (both National and International NGOs) throughout the country.

M&E diploma course for training of 27 M&E officers conducted by Ibnsina , meanwhile the KAP survey conducted under health promotion activity conducted by IIHMR.

The Demand Side Financing project was implemented by Hope World Wide an International organization.

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

As stated in several parts of the report, the GAVIHSS support has been very instrumental to address the challenges and bottlenecks of existed in the health system of Afghanistan.. There have been no changes in the management of HSS funds. The overall management is overseen by General Directorate of Policy and Planning and Deputy Minister Policy and Planning and coordinated by HSS Unit, being implemented by different departments of MoPH as well as CSOs and NGOs. Given the nature of activity, the HSS funds are managed by different departments of MOPH. The finance directorate development budget unite is responsible for the financial management, M&E for monitoring and evaluation and the procurement directorate is responsible for procurement.

The GAVI HSS Program oversight by Health System Strengthening Steering Committee. The Health System Strengthening Steering committee (HSS-SC) consist of representative from the WB, USAID, EU, Ministry of Finance, WHO, UNICEF and CSOs as well as presence of key CGHN members within the health sector of Afghanistan is actively supporting the implementation of GAVI HSS supported initiatives and promote the implementation of global health initiatives related to GAVI/HSS The HSS-SC as coordinating and monitoring body for HSS program is comprised of three MOPH voting members (key departments), representatives of UNICEF, WHO, World Bank,European Commission, USAID, Civil Society Organization representatives and Ministry of Finance. The bottom up annual plan of action (form 11 MOPH departments) are developed, approved by HSS-SC and MoPH Minister and accepted by MoF. Each relevant MOPH department has at least one designated staff for HSS and each department plans and implements its relevant activities. The relevant running costs of each department are covered from HSS support and other costs are covered by either the Government of Afghanistan or other donor's support.To date, the HSS support has been very helpful to strengthen the health system;for example, some of the departments severely lacked the capacity of planning,reporting, or following up the issues. Now all of the relevant departments know the concepts of planning, coordination, implementation, and are actively involved in management and implementation of their plans whether it is GAVI or other donors or Government resources. <?xml:namespace prefix = o />

MoPH follows GOA rules and regulations for budget execution process. Following are the recommendations suggested by FMA conducted in 2012.

► We recommend that the action should be taken to review the bottlenecks in the procurement process. Action plan should be determined and implemented to resolve the same.

► The process for the approval and disbursement of annual funds should be revisited, to remove the bottlenecks leading to delays.

► We recommend that a Budget Committee should be formed by MoPH which should be responsible for overseeing the budget preparation process, review and finalization of budget and utilization of budget.

► We recommend that while preparing the variance analysis for development budget, the reasons for the variances should also be documented. A threshold may be determined (such as +/- 10%), and if there is any variance above the threshold, the reasons should be documented and investigated in detail. The same should be submitted to GAVI as well on a monthly basis. Further, the same should be bifurcated into activity level expenditure.We recommend that BPET and HMIS should be integrated in order to facilitate generation of reports which links financial and physical progress of the projects.

Since the HSFP two year program financial management will be done through WHO using WHO rule and regulations , within this period of time the MoPH committed to seriously consider all suggestions pointed out by FMA for the improvement of financial , Administrative, procurement systems in MoPH.

9.5. Planned HSS activities for 2013

Please use **Table 9.5** to provide information on progress on activities in 2013. If you are proposing changes to your activities and budget in 2013 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2013 actual expenditure** (as at April 2013)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)

Activity 1.1-1.2: Establishing Sub-Centers and deploying mobile health outreach teams in under-served areas Activity 1.2: Deploying mobile health outreach teams	Both activities ended by end of December 2012, only the last payments of the NGOs pending until receiving the 2012 audit report	961396	398043	563,353 $ will be paid to NGOs after the final project reports reviewed by MoPH.	Since the format did not allow writing additional comment out of the table, Please have comments as following: The GAVI- HSS funded five year program officially closed by end of December 2012. As per our 2011 APR which was mentioned in Table 9.6 Planned HSS Activities for 2013 Only for the first three months of 2013 activities are planned and accommodated in 2012 work plans because of the calendar difference (March to March). Unless there are delays in 2012 plans implementation because insecurity and political changes are unpredictable in Afghanistan. On the other hand, experience shows that clearing the accounts with NGOs including finalization of the final report and taking over the assets of NGOs, may take 3-6 months. This may cause some management extensions to 2013. Since the Ministry of Finance changed the financial calendar year from 21 of March to 21 of December, which made the 2012 year shorter (nine month) As it was agreed by HSS steering committee member to keep the 30% of NGOs budget until submission of final technical and financial project report and 2012 audit report. due to change of calendar year, there was no any payment has been done in first quarter of new financial year. On the other hand clearing the accounts with NGOs including finalization of the final report and taking over the assets of NGOs is time consuming process, Allotments for all remaining budget have been taken and the payments will be started upon finalization of the final project reports.	563353

Activity 1,3:Expanding integrated management of childhood illness (IMCI) to community level	The second round of C-IMCI project ended by February 2013.	328430	93977	234,453 $ will be paid to NGOs after the final project reports reviewed by MoPH.	The last payment of the NGOs will be released until submission of final project report and 2012 audit report	234453
Activity 1,4: Develop an in-service training program for BPHS primary healthcare providers	Already completed	0				
Activity 2.1: Implementing a nationwide Information, Education and Communication (IEC) campaign for immunization and other MCH messages	Few payments did not released due to short fiscal year of 2012	118987	96265	22,722 $ in the process to be paid	payments released	22722
Activity 2.2: Pilot a model of	completed	0				
Activity 3.1: Up-grade the physical, information /communication technology infrastructure and means of transportation of the M&E Department	Some paymens remained unpaid from 2012	345188	80576	264,612$ will be paid upon completion of the activities.	Payment of Per dium monitoring officers who conducted monitoring visit for the last two quarter of year 1391, the HSS program evaluation budget, audit company fee and the last payment of internet fee remained from 1391 fiscal year.	264612
Activity 3.2: Launch a community demographic surveillance system	already conceled	0			The total budget already shifted to C-IMCI	
Activity 3.3:Expanding capacity building program for MOPH managers at the Central and Provincial levels	The Project closed by end of 15 June 2012	247576	105848	141,728$ will be paid to NGOs after the final project reports reviewed by MoPH.	The payments from capacity building program of MoPH staff , the last payment of NGOs are pending due audit report and final project report	141728
Activity 3.4:Developing a communications and internal advocacy program to seek increased funding	planed Activities completed by end of December 2012	98500	19729	78,771$ will be paid up on completion of planned activities	The payment of some activities did not released due to short fiscal year of 2012	78771
Activity 3.5: Launching an initial cadre of District Health Officers	completed	0				

Management cost	the operation cost of HSS unit and relevant departments who are involved for project closing	443879	310774	133,105$ is the salary of management staff and other operation cost	Payment of staff salary for the last 3 month of 1391 as well as based on availability fund in the Management part of the GAVI-HSS budget, it has been decided by MoPH leadership to cover salary for the first two month of year 1392 for those staff who directly involved in closing of GAVI - HSS and will be involved in the implementation of HSFP from the current grant + Operation cost, purchasing some new IT equipment's, top up cards, renting vehicles, fuel, stationary and ect.....	133105
		2543956	1105212			1438744

9.6. Planned HSS activities for 2014

Please use **Table 9.6** to outline planned activities for 2014. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 9.6: Planned HSS Activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
		0			

9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded

Global Fund (consolidation R8 and R10)	21198000	2 year (1st Nov. 2012- 20 Dec. 2014)	There are many other sources of funding by WB , USAID, WB and other donors/partners. The following table only outlines the funds that are labeled HSS and provided by the GAVI and GFATM. Improve the coverage and quality of health services delivered to and within communities by critical assessments and improving the recruitment and supervision of CHW (training of 250 female CHS and training of 510 community nurses) Strengthen the quality of peripheral laboratory performance through the creation of a regional reference laboratory system (establishment 3 reference laboratory at regions and providing equipment in given hospitals and health facilities; 13 provinces, 20 districts, 160 CHC/BHC). Improvement of health management information system and Field Epidemiology Training Program at the level of Master degree Strengthening the performance and services of laboratory through establishment lab services at BHC levels Strengthening the community health services through establishment of community nursing education program (training of 300 community nurses)

9.8.1. Is GAVI's HSS support reported on the national health sector budget? **Yes**

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Afghanistan Mortality Survey 2010	A huge nationwide survey	
HMIS 2012	Routine checks by HMIS department	
JRF 2011	EPI department , WHO, UNICEF	
National Monitoring Data base	Routine checks by M&E department	
NRVA 2011	Central Statistics office records	

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

1. There is no space out the tables to write information
2. In the attachment part of the portal , not allow to up load more than one file, if we try the zip folder again its not accepted .
3. In the country like Afghanistan, if the internet speed is low its difficult to save what you write in the portal.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2012?5

Please attach:

1. The minutes from the HSCC meetings in 2013 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

10.1. TYPE A: Support to strengthen coordination and representation of CSOs

This section is to be completed by countries that have received GAVI TYPE A CSO support 1

Please list any abbreviations and acronyms that are used in this report below:

CSO initial Type A support was already completed and in due time reported to GAVI.
Since there in no place to download the CSO Type A support 2 , please find the complete report in the attachment list
number 23 .

The CSO type A audit Report and financial statement are up loaded in the attachment 0 .

10.1.1. **Mapping exercise**

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation.

Please describe the mapping exercises, the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed **(Document number 23)**

Already completed and reported to GAVI

If there is still remaining balance of CSO type A funds in country, please describe how the funds will be utilised and contribute to immunisation objectives and outcomes as indicated in the original proposal.

N/A

Please describe any hurdles or difficulties encountered with the proposed methodology for identifying the most appropriate in-country CSOs involved or contributing to immunisation, child health and/or health systems strengthening. Please describe how these problems were overcome, and include any other information relating to this exercise that you think it would be useful for the GAVI Alliance secretariat or Independent Review Committee to know about.

N/A

10.1.2. **Nomination process**

Please describe progress with processes for nominating CSO representatives to the HSCC (or equivalent) and ICC, and any selection criteria that have been developed. Please indicate the initial number of CSOs represented in the HSCC (or equivalent) and ICC, the current number and the final target. Please state how often CSO representatives attend meetings (% meetings attended).

Already reported

Please provide Terms of Reference for the CSOs (if developed), or describe their expected roles below. State if there are guidelines/policies governing this. Outline the election process and how the CSO community will be/have been involved in the process, and any problems that have arisen.

The AHO Charter is attached .....

Please state whether participation by CSOs in national level coordination mechanisms (HSCC or equivalent and ICC) has resulted in a change in the way that CSOs interact with the Ministry of Health. Is there now a specific team in the Ministry of Health responsible for linking with CSOs? Please also indicate whether there has been any impact on how CSOs interact with each other.

Although already reported, but we are gettingmore systematic inputs from CSOs. We see positive changes around
working withCSOs as well within CSOs interactions.

Please provide the list of CSOs, name of the representatives to HSCC or ICC and their contact information

Full name	Position	Telephone	Email
Dr.Yasin Rahimyar / CSOs representative	Country Director of CAF	0093(0)700709317	yasinrahimyar@gmail.com

10.1.3. **Receipt and expenditure of CSO Type A funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type A funds for the 2012

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	0	0
Remaining funds (carry over) from 2011 *(B)*	200,288	10,018,409
Total funds available in 2012 *(C=A+B)*	200,288	10,018,409
Total Expenditures in 2012 *(D)*	80,993	4,157,362
Balance carried over to 2013 *(E=C-D)*	119,295	5,861,047

Is GAVI's CSO Type A support reported on the national health sector budget? **No**

10.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

This section is to be completed by countries that have received GAVI TYPE B CSO support1

Please list any abbreviations and acronyms that are used in this report below:

BCC	Behaviour Change Communication
BDN	Bakhtar DevelopmentNetwork (NGO)
BPHS	Basic Package of Health Services
BRAC	Building Resources Across the Community
CGHN	Consultative Group on Health and Nutrition (HSCC equivalent)
CH	Child Health
CHA	Coordination of Humanitarian Assistance (NGO)
CME	Community Midwifery Education
CMW	Community Midwife
cMYP	Comprehensive Multi-Year Plan for National EPI
CSO	Civil Society Organisation
EPI	Expanded Program on Immunization
FMA	Financial Management Agency
GAVI	Global Alliance for Vaccination and Immunization

10.2.1. **Programme implementation**

Briefly describe progress with the implementation of the planned activities. Please specify how they have supported the implementation of the GAVI HSS proposal or cMYP (refer to your proposal). State the key successes that have been achieved in this period of GAVI Alliance support to CSOs.

The CSO Support Type B Project implementationcontinued during the year 2012 and 2013. The CSOs have received their quarterlyinstallments in return for successful submission of quarterly technical andfinancial reports. Two CSOs have been continued in Urozgan and Farah Provinces,while two other CSOs have been expanded in Nurisatan and Paktia Provinces. **<?xml:namespace prefix = o />**

<!--[if !supportLists]-->• <!--[endif]-->30 private for profit health service providers have been operating in 4 districts(12 private for profit health service providers in Chora District, 8 private for profit health service providers in Trinkot district, 4 private for profit health service providers in Khas-Urozgan District and 6 private for profit health service providers in Charchiny District) of Urozgan Province during they ears 2012-2013. The CSO support type B Project contracted out to Health NetTPO, an international NGO. The private practitioners have received initial and refresher training on immunization, C- IMCI, basic reproductive health services,Health Management Information System (HMIS) reporting and basic management and Infection prevention. The PHFs received regular supplies of required medicines,equipment and supplies. The PHFs were also renovated for provision of required services. The project facilitated establishment of Private Medical Association(PMA) in Uruzgan Province.The PHM has been registered with the Ministry of Justice. The PMA representative have actively participated in Provincial Public Health Coordination Committee (PPHCC), the PHCC is considered the coordinating as well as decision making body at the provincial level on the issues related to the health sector. The private practitioners have actively participated in NIDs and assisted to expand the vaccination interventions insecure districts where it was impossible to vaccinate. 17 out 30 PHFs provide vaccination services,outpatient services, referral and health education, 6 PHFs provide Reproductive health, outpatient services, referral and health education and 7 PHFs provide out patient services (treatment of common diseases), referral and health education services.

<!--[if !supportLists]-->• <!--[endif]-->24 private for profit health service providers have been operating in 3 districts of Farah Province; (9 private for profit health service providers in Purchaman District, 7 private for profit health service providers in Gulistan District, 8 private for profit health service providers in Bakwa District).The project is contracted out to Coordination of Humanitarian Assistance (CHA), a national NGO. 24 private for profit health facilities have renovated in Fara Province. The private practitioners receive dinitial and refresher trainings on immunization- IMCI, basic reproductive health services, Health Management Information System (HMIS) reporting and basic management, Infection Prevention and First Aid. The PHFs received regular supplies of required medicines, equipment and commodities. The project facilitated establishment of Private Medical Association (PMA) in Farah province. The PMA representative regularly participated in Provincial Public Health Coordination Committee (PPHCC) meetings on quarterly basis. The private practitioners actively participated in NIDs and through their assistance some uncovered areas were covered with NIDs. 16 out 24 PHFs are providing vaccination services, reproductive health, outpatient, referral and health education services and the remaining 8 PHFs are providing reproductive health services, outpatient, referral and health education services. It is planned that the implementing NGO will increase the number of PHFs providing direct vaccination.

<!--[if !supportLists]-->• <!--[endif]-->20 private for profit health service providers have been operating in 6 Districts of Nuristan Province;(3PPHSPs in Paroon2 PPHSPs in Wama, 5 PPHSPs in Noorgram,3PPHSPs in Doaba , 5 PPHSPs in Want-waygal and 2 PPHSPs in Kamdish District).10 out for 20 PHFs provide services; 1 PHF provide reproductive health services, outpatient services, referral and health education services, and 9out of 20 PHFs provide reproductive health, outpatient services and referral services. The project is outsourced to Humanitarian Assistance and Development Organization for Afghanistan, a national NGOs.20 Private for profit health facilities have been renovated; 20 private for profit health service providers have received initial and refresher training on HMIS reporting and data use, reproductive health ,treatment of common disease EPI.

<!--[if !supportLists]-->• <!--[endif]-->40 private for profit health service providers have been operating in 4 districts of Paktia Province (8 PPHSPs in Dandi-Patan, 10 PPHSPs in Ahmadkhil, 8 PPHSPsin Jajaryob, 9 PPHSPs in Wazizadran and 5 PPHSPs in Gardiz District). 23 out of 40 PHFs provide EPI services, 8 PHFs provide reproductive health, out patient and referral services and health education; and 9 PHFs provide out patient services, health education and referral services. The CSO support type B Project contracted out to Health Net TPO, an international NGO. 40 PHFs have been renovated in Paktia Province; all private for profit health service providers have received training on HMIS reporting and data use, C-IMCI, EPI,and Infection prevention procedures.40 PHFs have been regularly supplied with medicine, incentives, equipment and commodities.

The CSO type B Project has been evaluated by third party in year 2013 , the report is attached in attachment 0 .

Please indicate any major problems (including delays in implementation), and how these have been overcome. Please also identify the lead organisation responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

Insecurity is a major challenge which hampers the project activities. This problem is addressed through close cooperation with community. Community health councils are established per each PHF. Commitment of private practitioner for providing quality services is a challenge .Providing training, timely incentives,community health council and regular supportive supervision and monitoring will be among the strategies to motivate private practitioners to deliver quality immunization and basic RH services. In addition private for profit health service providers (PPHSPs) have been involved in the process of negotiation while there have been any impediments posed during the project implementation.Some of districts happened to be extremely insecure it was difficult of Provincial Health Directorate staff and NOGs to travel , in order to monitor, conduct supportive supervision, and training , therefore District Focal Points have been recruitedto carry out monitoring, supportive supervision and on job training. <?xml:namespace prefix = o />

WHO isresponsible for coordination, grant management, contract administration andmonitoring and evaluation of the projects implemented by CSOs. The HSS SteeringCommittee revises and endorses all work plans, budgets, reports and amendments.It also provides technical support to the CSO type B project. Meanwhile, asPPHSP is a new intervention, a separate steering committee is established to

providetechnical support and review progress of the four projects of PPHSP.

WHO servesas Management Agency for the CSO type B support. WHO releases funds to CSOs as quarterlyinstallments, review financial reports of CSOs and financial audit at the endof the project. Also Grant Management and Contract Management are the tasks ofWHO.

WHO is responsible for coordination, and monitoring and evaluation of the projects implemented by CSOs. The HSS Steering Committee revises and endorses all work plans, budgets, reports and amendments. It also provides technical support tothe CSO type B project.

Please state whether the GAVI Alliance Type B support to CSOs has resulted in a change in the way that CSOs interact with the Ministry of Health, and or / how CSOs interact with each other.

The CSOs submit regular technical and financialreports to WHO. Meanwhile, they participate in MOPH/PPP taskforce and<?xml:namespace prefix = o />

Workshops. A PPP coordination committee is established to coordinate technical issues between the CSOs implementing PPP projects. The CSOs also participate in PPHCC meetings at provincial level contributing to the provincial planning and coordination. CSOs have introduced by free elections a representative to HSS Steering Committee. Recently, a coordination body has been established among CSOs working in health sector.

The steering committee has been establishedrepresenting CSOs, WHO and Ministry of Public Health staff in order interactwith each other's, in order to coordinate the issues relevant to the project,exchange technical views and lesson learned and review the progress andchallenges encountered during the project implementation and constructiverecommendations have been provided.

Data relevant to the project regularly reviewedand efforts are made to improve the culture of data among

CSOs , private providers and different departments of MoPH.

Please outline whether the support has led to a change in the level and type of involvement by CSOs in immunisation and health systems strengthening (give the current number and names of CSOs involved, and the initial number and names of CSOs).

Theimplementation of BPHS is contracted out to CSOs. Child health and immunisationis the second priority layer of the BPHS. The CSOs are already implementingBPHS in many provinces of Afghanistan.<?xml:namespace prefix = o />

CSOsupport type B project is implementing by 4 different CSOs and consortiums insome occasions. Under CSO type B support, and bridge fund under the four PPHSPprojects, contracts are signed with 144 private health practitioners forproviding immunisation and basic reproductive and child health services inreturn for incentives. They are provided trainings, vaccines, equipment andother necessary supplies.

There has been a large network of CSOs has been established representing wide range of CSOs in Afghanistan by the name of Alliance of Health Organization (AHO) to response to the need for strengthening the CSOs in health and nutrition sector and maximize use of them and improve coordination of health system delivery in Afghanistan. The AHO is an independent alliance of Afghan and international health NGOs that exists to serve and facilitate the work of its member in order to address efficiently and effectively health of Afghans. 26 health NGOs (CSOs) closely coordinate and cooperate under AHO in order to maximize the role of CSOs in the health sector of Afghanistan.

Please outline any impact of the delayed disbursement of funds may have had on implementation and the need for any other support.

There have been some delays to start the CSO support type B intervention in Nuristan and Paktia Provinces. Given the fact that CSOs operate in the most insecure provinces, the process of negotiation with communities, CSOs and through CSOs and communities with anti-government elements took more time to convince them and practically start the CSO support type B project interventions.

Please give the names of the CSOs that have been supported so far with GAVI Alliance Type B CSO support and the type of organisation. Please state if were previously involved in immunisation and / or health systems strengthening activities, and their relationship with the Ministry of Health.

For each CSO, please indicate the major activities that have been undertaken, and the outcomes that have been achieved as a result. Please refer to the expected outcomes listed in the proposal.

Table 10.2.1a: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2012	Outcomes achieved
Bakhtar Development Network, BDN	Implemented BPHS in Balkh, Daikundi and Baghlan provinces	25 students enrolled in CME training in Ghazni province	25 students graduated and deployed in HFs at their districts of residence
Bakhtar Development Network, BDN	mplemented BPHS in Balkh, Daikundi and Baghlan provinces	25 students enrolled in CME training in Ghazni province	25 students graduated and deployed in HFs at their districts of residence
BRAC Bangladesh (International)	Implemented BPHS in Balkh, Nimroz, Kabul and Badghis provinces	20 students enrolled in CME training in Nimroz province	20 students graduated and deployed in HFs at their districts of residence
Coordination of Humanitarian Assistance, CHA (National)	Implemented BPHS in Farah and Herat provinces	Contracts signed with 25 private health practitioners for providing immunisation and basic reproductive and child health care	25 Private practitioners continue delivering immunisation and basic RH and CH services
Health Net TPO (International)	Implemented BPHS in Nangarhar, Paktya and Khost provinces.	Contracts signed with 30 private health practitioners for providing immunisation and basic reproductive and child health care	30 Private practitioners continue delivering immunisation and basic RH and CH services

IBNSINA Public Health Programme for Afghanistan, IBNSINA (National)	Implemented BPHS in Laghman, Zabul, Paktya, Hirat and Helmandprovinces	21 students enrolled in CME training in Zabul province	21 students graduated and deployed in HFs at their districts of residence
Norwegian Afghanistan Committee, NAC (international)	Implemented BPHS in Ghazni province	25 students enrolled in CME training in KunarProvince	25 students graduated and deployed in HFs at their districts of residence

Please list the CSOs that have not yet been funded, but are due to receive support in 2012/2013, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

Please also indicate the new activities to be undertaken by those CSOs already supported.

Table 10.2.1b: Planned activities and expected outcomes for 2012/2013

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2012/2013	Expected outcomes
Afghan Health and Development Service (AHDS) a national NGO	AHDS (a national NGO) currently implements the BPHS in Kandahar and Urozgan Provinces, However NGOs have submitted the Proposal for the implementation of BPHS under SEHAT , in case AHDS will be the winner NGOs , CSO support type B will be contracted with AHDs, otherwise with the newly selected NGOs	To be determined	To be determined
Health Net TPO (International)	Implementing BPHS in Nangarhar, Paktya and Khost provinces.	Contracts signed with 30 private health practitioners for providing immunisation and basic reproductive and child health care	30 Private practitioners continue delivering immunisation and basic RH and CH services
Humanitarian Assistance and Development Association for Afghanistan (HADAAF). A national NGO	Implementing BPHS in Nooristan province	Contracts signed with 20 private health practitioners for providing immunisation and basic reproductive and child health care	20 Private practitioners continue delivering immunisation and basic RH and CH services
Ibn-sina	Ibn-Sina (a national NGO) currently implements the BPHS in Zabul and Helmand Provinces.	To be determined	To be determined

10.2.2. **Future of CSO involvement to health systems, health sector planning and immunisation**

Please describe CSO involvement to future health systems planning and implementation as well as CSO involvement to immunisation related activities. Provide rationale and summary of plans of CSO engagement to such processes including funding options and figures if available.

If the country is planning for HSFP, please describe CSO engagement to the process.

The implementation of the GAVI funded CSO Type B project in two security compromised provinces was very successful in providing the populations there with EPI and basic reproductive and child health services and in building an effective public private partnership. The experiences gained and lessons learnt encourage the MoPH to repeat the same approach in two more provinces in CSO type B bridge funding opportunity. This intervention will ensure continuation of CSO support when the bridge funding for CSO support is completed while further expanding the support to six more provinces. <?xml:namespace prefix = o />

In addition, there are several buildings constructed by various donor's support to establish new HFs mainly hospitals.The MOPH and the donors are not inthe position to fund operationalization of these hospitals. However, these HFs will be able to cover significant number of population and ensure delivery of care including EPI and other maternal and child essential services. At this stage, this is very critical for the health sector in Afghanistan to explore partnership opportunities with for profit National or International partners for operationalization of these hospitals.

Afghanistan has already developedand send HSFP proposal to GAVI which include of an activity (To continue andscale up the CSO type B project focused on the delivery of EPI and otheressential maternal and child health services in remote and insecure areas ofthe country). up on approval of HSFP, the MoPH will contract the BPHSimplementing NGOs to identify the private facilities, train the private practitioners,support them and monitor and report their performance. The plannedintervention includes

strengthening the cold chain toaccommodate the private facility network.

The training of the private practitionerswill focus on EPI, basic reproductive and child health services. Each private facilitywill be linked to the nearest public health facility which provides thesupervisory support and the regular EPI and other supplies.

In addition to the provinces ofUruzgan,Farah, Paktia and Niristan, six more provinces will be covered by the PPP. The main criterion to select thoseprovinces was the EPI performance measured by DPT coverage compared to thenational coverage (87%). The new provinces are Helmand (51%), Panjsher (62%), Badghis(65%), Ghor (65%), Samangan (66%) and Parawn (66%).

The HSFP has been developed widelywith the CGHN sub group for all HSS initiatives is HSS steering committee whichis consists of the members from WB, USAID, EU, WHO , UNICEF , Ministry ofFinance, NGOS elected representative.

The CGHN (HSS-SC) discussed inseveral meetings the joint health system funding platform for both GAVI and GF.Also the platform was explained by GAVI mission with HSS-SC key members andCivil Society

Organizations through separate meetings. After release of the guidelines, the HSS-SC assigned a team of technical experts to coordinate and draft the proposal.

10.2.3. Please provide names, representatives and contact information of the CSOs involved to the implementation.

Dr.Ismail Hail HADAAF General Director hadaaf_2005af@yahoo.com, 0093(0) 773333606<?xml:namespace prefix = o />

Dr.A.Majeed Sediqi HNTPO Head of Mission majeed@healthnettpoaf.org 0093(0)700294627 . HNTPO is

theimplementer in two provinces of Paktia and Urozgan.

Eng. Yahya Abas Country director of CHA abbasy@cha-net.org 0093(0)799446055

10.2.4. **Receipt and expenditure of CSO Type B funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type B funds for the 2012 year

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	1,165,100	60,585,200
Remaining funds (carry over) from 2011 *(B)*	0	0
Total funds available in 2012 *(C=A+B)*	1,165,100	60,585,200
Total Expenditures in 2012 *(D)*	828,196	43,066,192
Balance carried over to 2013 *(E=C-D)*	336,904	17,519,008

Is GAVI's CSO Type B support reported on the national health sector budget? **No**

Briefly describe the financial management arrangements and process used for your CSO Type B funds. Indicate whether CSO Type B funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of CSO Type B funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the HSCC in this process.

World Health Organization (WHO)serves as the FMA of the CSO Type B project. Funds are transferred from GAVI to WHO. WHO releases funds to CSOs as quarterly installments, review financial reports of CSOs and financial audit at the end of the project. The CSOs submits financial reports on quarterly basis to WHO. A standard financial reporting format is developed for this purpose. Financial information is collected from the field by CSOs and sent to CSO country office. The CSO country office aggregates and compiles the information and prepares the quarterly report. The quarterly financial reports are reviewed by MOPH/WHO and approved. The quarterly installments to CSOs are subject to successful submission of quarterly technical and financial reports.<?xml:namespace prefix = o />

The CSOs prepares detailed budget for running the projects and the budgets are approved by MOPH/WHO.

Detailed expenditure of CSO Type B funds during the 2012 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2012 calendar year **(Document Number)**. Financial statements should be signed by the principal officer in charge of the management of CSO type B funds.

Has an external audit been conducted? No

External audit reports for CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number).

10.2.5. **Monitoring and Evaluation**

Please give details of the indicators that are being used to monitor performance; outline progress in the last year (baseline value and current status), and the targets (with dates for achievement).

These indicators will be in the CSO application and reflect the cMYP and / or GAVI HSS proposal.

Table 10.2.5: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target
Established four models of partnerships with priv	PENTA 3 coverage in targeted districts of Uruzgan,	Monthly EPI coverage reports	78% Urozgan 83% Farah 56% Paktia 41% Nuristan	90% Urozgan 90% Farah 82 % Paktia 54 % Nuristan	January 2010	80	Dec 2012
Established four models of partnerships with priv	Number of private for profit service provision out	Baseline assessment report of the CSO/ monitoring	55	114	February 2012	114	March 2013
Established four models of partnerships with priv	No. of private sector service provision outlets of	CSO activity report/monitoring visits report/end p	55	89	February 2012	89	March 2013
Established four models of partnerships with priv	No. of private sector service providers from Farah	CSO activity report/monitoring visits report	55	114	February 2012	114	March 2013

Planned activities :

Please give details of the mechanisms that are being used to monitor these indicators, including the role of beneficiaries in monitoring the progress of activities, and how often this occurs. Indicate any problems experienced in measuring the indicators, and any changes proposed.

CSO support type B,partnership with private for profit health service providers will be continuedin, Urozgan, Farah, Paktia and Nuristan Provinces. Two CSOs will be expandedwithin two other insecure provinces of Qandahar and Helmand Provinces in <?xml:namespace prefix = o />

Some of thedistricts are extremely insecure, in Nuristan, Farah, Urozgan and PaktiaProvince. Therefore it is required to strengthen community based monitoringsystem. Currently there are multiple level of monitoring are in place tomonitor the implementation of the CSOs; CSOs are being monitored by WHO andCetral MoPH staff, however it is challenging WHO and MoPH staff to go to someof the insecure provinces. Certain monitoring tools and system are in place tomonitor the CSOs.

HMIS format havebeen developed, CSO have received training on HMIS and reporting system; theformat are exited in health private health facilities; private healthfacilities are filling the Health Information System Forms; PPHSPs sent theHMIS form on quarterly basis; the reports have been reviewed by WHO/NGO andfeedback provided to PPHSPs.

In addition;Implementing NGOs staff, and District Officers are monitoring the CSO supporttype B project implementation on regular basis; NGOs staff monitor theimplementation of CSO project, on the job training, regular and refereshertrainings are being provided to PPHSPs.

The major challengein the process of monitoring is prevailing insecurity; there are some districtsthat active fighting and artillery shelling in going on, e.g some district in Nuristan;It make it difficult to monitor; however , the District Officers are recruitedfrom the same districts and they are living there, therefore it make itpossible to monitor the CSOs implementation;

In addition we may need to training community elders in monitoring (simple but robust), that they could also monitor the CSO support Type B project.

11. Comments from ICC/HSCC Chairs

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Cover letter for the submission of 2012 APR.pdf File desc: Date/time: 5/12/2013 4:18:00 AM Size: 371200
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature of MoF and MoPH0001.pdf File desc: Date/time: 5/14/2013 12:04:52 AM Size: 482242
3	Signatures of members of ICC	2.2	✓	HP001.docx File desc: Signatures of ICC members endorsed APR12 Date/time: 5/9/2013 2:42:46 AM Size: 4140099
4	Minutes of ICC meeting in 2013 endorsing the APR 2012	5.7	✓	Minute_ICC_April9 13.doc File desc: Minute of ICC meeting Date/time: 5/9/2013 2:49:36 AM Size: 181248
5	Signatures of members of HSCC	2.3	✗	Steering Committee Signature0001.pdf File desc: Date/time: 5/12/2013 5:00:34 AM Size: 4967341
6	Minutes of HSCC meeting in 2013 endorsing the APR 2012	9.9.3	✓	Steering committee Endorsement and minutes0001.pdf File desc: Date/time: 5/14/2013 1:06:32 AM Size: 13999566
7	Financial statement for ISS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	HP0006.jpg File desc: GAVI ISS financial statement Date/time: 5/13/2013 11:18:48 PM Size: 207092
8	External audit report for ISS grant (Fiscal Year 2012)	6.2.3	✗	GAVI FMA Report - Assessment of GAVI PFM V4 13-10-12 (2).pdf File desc: External audit report 2012 Date/time: 5/9/2013 3:23:54 AM Size: 2486147
9	Post Introduction Evaluation Report	7.2.2	✓	ReportPieAfghanistanNov2011.docx File desc: PIE report Date/time: 5/9/2013 2:53:10 AM

				Size: 277824
10	Financial statement for NVS introduction grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	Not Applicable.doc File desc: Not applicable Date/time: 5/12/2013 2:39:56 AM Size: 22016
11	External audit report for NVS introduction grant (Fiscal year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.3.1	✓	Not Applicable.doc File desc: Not applicable Date/time: 5/12/2013 2:40:57 AM Size: 22016
12	Latest EVSM/VMA/EVM report	7.5	✓	AFG EVM_report_Final.doc File desc: EVM Report Date/time: 5/9/2013 2:59:40 AM Size: 2215936
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	EVM-Improvement-Plan for national level.xls File desc: Cold chain improvement plan Date/time: 5/9/2013 3:01:03 AM Size: 195072
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	EVM-Improvement-Plan for national level.xls File desc: Status of cc improvement plan Date/time: 5/9/2013 3:02:49 AM Size: 195072
15	External audit report for operational costs of preventive campaigns (Fiscal Year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.6.3	✗	Not Applicable.doc File desc: Not applicable Date/time: 5/12/2013 2:38:41 AM Size: 22016
16	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	Minute_ICC_April9 13.doc File desc: Minute of ICC requesting extension of GAVI vaccine support Date/time: 5/9/2013 3:07:18 AM Size: 181760
17	Valid cMYP if requesting extension of support	7.8	✗	cMYP-Upd-12.docx File desc: cMYP 2011-2015 Date/time: 5/9/2013 3:12:22 AM Size: 2266300
18	Valid cMYP costing tool if requesting extension of support	7.8	✓	AFG cMYP_Costing_PneumoRota (19 Apr 11) F.xls File desc: cMYP costing tool Date/time: 5/9/2013 3:16:09 AM

				Size: 3575808
19	Financial statement for HSS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✗	GAVI-HSS-Financial Statement0001.pdf File desc: Date/time: 5/14/2013 12:46:38 AM Size: 7243669
20	Financial statement for HSS grant for January-April 2013 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✗	Financial Report from Jan to April 20130001.pdf File desc: Date/time: 5/14/2013 12:48:34 AM Size: 453152
21	External audit report for HSS grant (Fiscal Year 2012)	9.1.3	✗	The External audit for 2012 has already conducted by audit company.docx File desc: Date/time: 5/14/2013 12:15:49 AM Size: 12752
22	HSS Health Sector review report	9.9.3	✗	MoPH Health Results Conference Report April 2013.pdf File desc: Date/time: 4/14/2013 6:23:58 AM Size: 957666
23	Report for Mapping Exercise CSO Type A	10.1.1	✗	Annual Report of HSS-MoPH-Revised.doc File desc: Date/time: 4/21/2013 6:10:26 AM Size: 160256
24	Financial statement for CSO Type B grant (Fiscal year 2012)	10.2.4	✗	CSO support Type B financial statement.pdf File desc: Date/time: 5/12/2013 5:59:08 AM Size: 1960669
25	External audit report for CSO Type B (Fiscal Year 2012)	10.2.4	✗	CSO YPE B Audit.docx File desc: Date/time: 5/7/2013 2:06:08 AM Size: 13635
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2012 on (i) 1st January 2012 and (ii) 31st December 2012	0	✓	Bank Statement.pdf File desc: Date/time: 5/11/2013 6:24:11 AM Size: 17018436