Internal Appraisal 2014

Afghanistan

1. Brief Description of Process

This Appraisal was developed by Anne Cronin, the CRO for Afghanistan, with support from Technical Expert, Assad Hafeez. It is based on the 2013 APR submitted by the country, and other relevant documentation. The report was shared with the program and country partners and their inputs incorporated.

2. Achievements and Constraints

The 2013 coverage targets have been met with respect to most vaccines. Reported coverage (based on administrative data) for BCG, OPV3 and DTP-HepB-Hib 3 is 101% compared to the targets of 89%. The 2013 JRF data is not yet published hence this figure will be revised. However the country coverage estimate of 101% highlights the need for proper data management and the denominator problem. The PCV coverage target that had been set at 98% is reported as 0%, this is due to the delay in supply constraints.

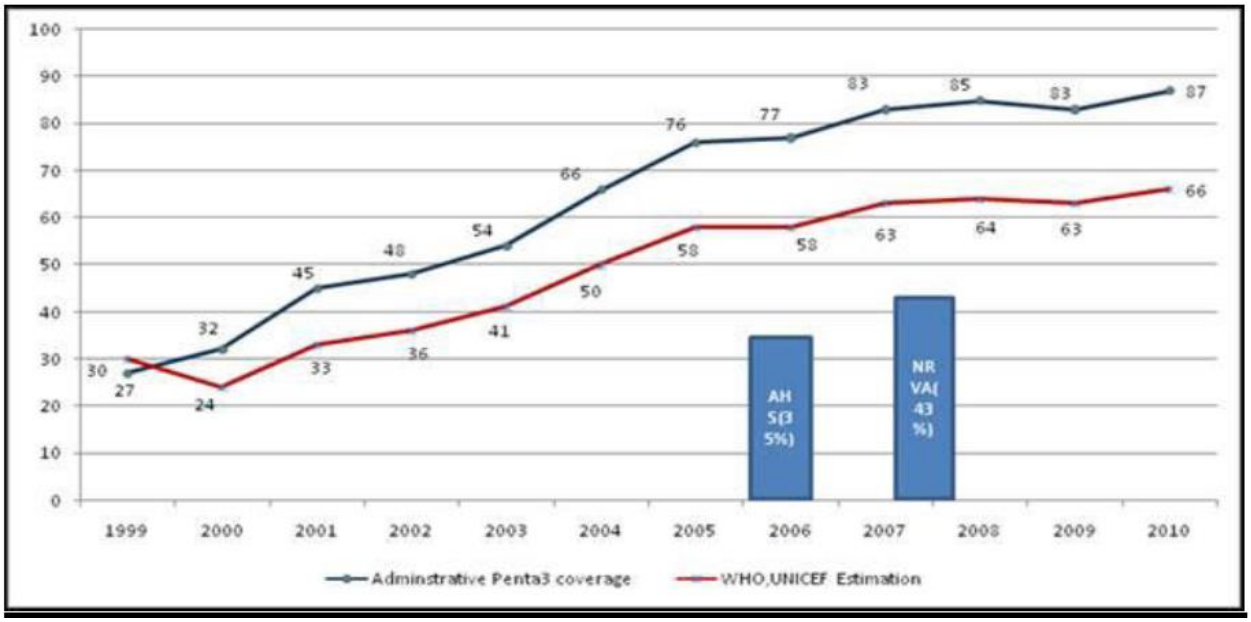
TT targets were missed as well, with 63% coverage against 80% target. The country highlights gains in 2013 in coverage as compared to previous years. The dropout rates were higher at 10% compared to the estimated 9%. The report of independent coverage survey was provided subsequent to the submission of the documents accompanying APR.

Results from recent coverage surveys suggest steady progress is under way (see Figure) and the current figures for each antigen were reported as 77.9% for BCG, 59.7% for Penta 3 and 58.8% for measles vaccination before their second birthday. There is persistent difference in administrative data vs independent coverage estimations. As depicted in the figure below, there was more than a 20 percentage point different between administrative and WHO-UNICEF best estimates of coverage in 2010 (i.e., administrative coverage being higher). In addition, evidence indicates that socio-economic factors contribute significantly to coverage inequities with fully immunized coverage higher in urban areas than rural (61.8% vs 49%), among children of educated mothers than children of mothers with no education (65.9% vs 48.7%) and among children belonging to families in wealthiest quintile than those belonging to families in poorest quintile (60% vs 38%) .

Sex-disaggregated data are routinely available. The APR is silent on equity issues. This is of concern given the significant prevailing inequity in access to health services that is present in the country, based on its size, geography, educational status and social-economic indicators. Also noticeably absent from the APR is mention of reducing the high dropout rate between the first and the third dose of pentavalent vaccine. The APR notes that coordination has been satisfactory over the past year and lists a number of activities that have been implemented, in the areas of cold chain improvement planning and maintenance, use of outreach and mobile services, training, monitoring and supervision.

The main challenges identified in the APR relate to the security situation, expansion of EPI services to remote areas and inadequacy of micro plans at district and facility level. Financial constraints, operational issues associated with staff (high turnover and low morale), and the use of management tools and reporting systems are some of the other difficulties faced by the country. The programme is working however to strengthen coordination and data management systems, especially at peripheral levels, with support from development partners (WHO,UNICEF and CDC).

Figure No 1. Trends in Immunization coverage



Stated priorities for 2014 and 2015 cover many areas, from strengthening routine immunization activities in remote areas to increasing data quality.

3. Governance

The ICC is adequately engaged in EPI issues. Its membership includes government, international organisations and NGOs. The ICC met 3 times in 2013-14 and discussed the following topics: EPI performance results, review and approval of the APR, issues related to IPV & measles application to GAVI, EVM, Co-financing and support for civil society organizations. The Health System Strengthening Steering Committee has been meeting regularly and as per provided record the committee met 6 times in 2013-14 with agenda items related to NIP and HSS grants. It has the required representation from all ministries, organisations and civil society.

The minutes of the meetings of the Health System Strengthening Steering Committee and of the ICC held in 2013 and 2014 are provided.

4. Programme Management

The cMYP covers the period 2011-2015 and is in line with the application and with other national health documents, principally the National Health Policy documents. It gives an excellent overview of the EPI and its place within the health system, as well as of plans for vaccine delivery and coverage. The proposal for introduction of new vaccines is aligned with national health documents. It gives specific year wise targets and gives commitment to polio eradication, new vaccine introduction and improving surveillance of targeted diseases. The costing component is comprehensive and takes into account indigenous as well as donor funding mechanisms.

5. Programme Delivery

The last EVM assessment was done in August 2011 and the next is due in early 2015. The EVM assessment report and the improvement plan are attached. The 2011 EVM assessment showed only a few scores below 80% at central level whereas only few reached the benchmark of 80% at facility level. Temperature control, maintenance and management information system were found to be weak at central level. EVM improvement plan 2011-12 contains recommendations for multiple levels. APR indicates that significant progress in achieving the targets has been made.

The country has a safe injection plan and has reached 100% injection safety by using AD syringes, safety boxes and incinerators. Sharp wastes are incinerated or burnt and buried where such facility is not present.

AEFI system is present but APR does not contain specific information on its functioning and structure. The APR mentions that there is now a surveillance system for various VPDs but no illustrative data of the burden of VPDs is provided. A technical committee of the ICC is charged with following information about outbreaks and results of surveillance and surveys and making recommendations to the broader group.

6. Data Quality

The discrepancy between independent coverage surveys and administrative data is consistently visible in the past few years as well as in the latest survey of 2013. Data quality has been recognised as an issue in the APR and various measures have been carried out and proposed. Implementation of the recommendations of data quality self-assessment, training of EPI staff on improving recording/reporting and initiation of WHO/CDC project focusing on improving routine data including development of software for RI reporting are some of the measures undertaken recently.

Planned activities to improve the data management system include:

- WHO/MOPH will conduct DQS in 2014 and GAVI could partner with stakeholders in this process.
- Strengthening management of EPI program by development of guidelines, training curriculums, standards and tools of supervision.
- Ongoing training of vaccination staff on the use of data management tools;
- Quarterly reviews in each province focusing on districts, supporting each province for development and use of dashboard information for programme management purposes.
- Support in improvement and implementation of micro plans
- Provision of HR support to undertake above functions

7. Global Polio Eradication Initiative, if relevant

Very little specific information is given in the APR about this topic though country's commitment for polio eradication initiative has been clearly stated elsewhere. WPV transmission – imported from Pakistan – was detected a few months ago. Hence, the SIA schedule has likely been intense. Efforts made on using the PEI assets for EPI is currently being rolled out in low performing districts (LPD's). It is envisaged that this will immensely help in improving demand of immunization services in the polio LPD's which also have low EPI coverage.

8. Health System Strengthening

Afghanistan performed well in the HSS component in last few years. The major targets were achieved in time by the end of 2012, the stipulated time for the HSS support. The uptake of immunization has improved as a result of this project in the provinces that have received GAVI support.

The major components of the program were establishment of outreach and mobile teams, implementation of community based integrated IMCI, building capacity of BPHS providers in 3 provinces and strengthening the ability of MOPH at various levels to provide stewardship responsibilities. The reported issues in implementation were security, arduous administrative processes, geographical constraints, lack of trained manpower and inadequate commitment from MOPH. Despite the difficulties however, targets were achieved in most areas. HSSC oversaw the project and provided active guidance. The monitoring mechanism is satisfactory and 7 international CSOs were implementing partners in the project – Afghanistan uses performance

based contracting with CSOs for grant implementation. The HSS evaluation has brought out strengths and weaknesses and has suggested remedial measures as well. There is no information on how the country is taking into account findings from the evaluation.

For the old HSS grant, the activities in 2014 are to be carried out using the left over funding available which has been approved by the HSCC in its minutes. These include purchase of medicine, publication of IEC material and supplies to promote EPI coverage in Kochi population. GFATM also supports activities contributing to health system strengthening. Afghanistan is expected to utilise these funds by June 2015

Afghanistan's second HSS grant is subject to PBF (it's a phase 1 PBF country approved in 2012). Less than half of the first year planned budget appears to have been utilised. The country reports that although the actual expenditure at 45% of planned 2013 budget, the accrued expenditures and execution rate are actually $ 5,021,791.07, 75.9 %, respectively of budget. Reasons for variance include GAVI funds being transferred to World Health Organization after 2 months delay, procurement delay for Service Contracts and delay in paying NGOs.

There are large variances in original and planned 2012 PBF-HSS expenditures across some activities/objectives. The reasons for the budget changes are delayed implementation of activities for increasing DTP3 coverage in Kochi children and establishing Mobile Health teams for nomadic population as there was no budget allocated for implementation of some important activities, such as activity 2.3 " Establishing Health Call Centre in the Ministry of Public Health, Kabul Afghanistan" for the implementation of IPCC, BCC training and for development of IEC materials no HR were planned, budget was allocated during the budget revision in the very start of the project in consultation with GAVI secretariat and approval of steering committee. All changes are controlled within 15% (actually less than 8%), which ensures that by the end of the project, Afghanistan will be able to efficiently accomplish the objectives of the HSFP proposal and implement all the activities

GAVI Secretariat worked closely with Afghanistan to support them to update the M&E framework of the second HSS/PBF grant to incorporate mandatory immunisation outcome indicators and intermediate results. Final revised M&E framework was provided with the recent APR - the M&E framework has significantly improved from the original version that was submitted along with the HSS proposal in 2012. It is important that the indicated targets are in line with the national M&E framework or any other national health document. Values for equity indicator were not provided for 2013. Eleven intermediate results indicators have been included in the M&E framework, out of which actual figures have been reported for 6 of them with targets met.

Funding for 2014 activities was approved previously for $9.1 million for last year of grant implementation – half of these funds ($4.57million) have been disbursed. Given that the PBF M&E framework is now finalised the second tranche of previously approved funding will be released following the HLRP. Afghanistan is expected to end its current grant by July 2015 and will apply for a new HSS grant in 1st quarter 2015.

9. Use of non-HSS Cash Grants from GAVI

Afghanistan did not receive any ISS award in 2013, however USD 2.29 million were carried forward from the previous year into 2013. The country spent USD 939,000 out of the above in 2013 primarily on capacity building of workers, monitoring, program planning, and advocacy, surveillance and maintenance overheads. An external audit of the accounts was conducted. The country is not eligible to receive an ISS award in 2014.

The country had USD 336,904 available for CSO type B support in 2013. WHO serves as FMA for CSO type B funds and releases these funds on quarterly instalments to CSOs. The HSSC oversees and provides guidance to this support in which four provinces with high security risks are included. A number of independent CSOs and consortiums in collaboration with private providers are extending BPHS services to remote areas. The evaluation of the project has been very positive though no external financial audit has been undertaken in 2013.

10. Financial Management

GAVI had performed an FMA in 2012 which highlighted numerous issues. As the Government acknowledged that it will take time to address these weaknesses, the Government of Afghanistan had requested that HSS funds are sent to partners. Consequently, the HSS funds and VIG funds disbursed in 2013, have been sent to WHO.

11. NVS Targets

The reported coverage with the third dose of DTC-HepB-Hib was 101% in 2013 compared to the 89% target. However, the coverage survey shows a figure of 59.7% which is far short of the stated target. The wastage rate is 25% as targeted in 10 dose vial preparation. There is a large stock of penta vaccine shown at the beginning of 2014 (i.e. 1.95 million doses) and the country is planning to reach 1.21 million children (90%) with the third dose of this vaccine in 2015. The country urgently needs to review its targets in the context of coverage figures in the recent independent survey report. When this is done the dose calculation can be updated.

Coverage with the third dose of PCV13 on the other hand was reported as 0% in 2013 (0% vs 98%) because of delays in receiving supply of the vaccine. The country is planning to reach the target of 90% by 2015, which again needs revision in the current coverage rates. The wastage rate for 2015 is 5% is acceptable and the dropout rate for 2015 is 8% is also acceptable. The introduction of IPV is planned for 2014-15. Despite some improvement in coverage performance in 2013, the ambition of the program to take on more new vaccines in 2014 and subsequent years looks challenging. The compromised security, weakness of the vaccine logistics system and lack of human resources for health at peripheral levels are major obstacles to achieving further improvements in coverage and to the ability of the programme to introduce additional vaccines.

Immunization Decision support will draft the dose calculations for 2015 for all NVS programs using the approved targets (numbers of infants & wastage). The number of doses to be allocated (and planned for shipment) for 2015 for the programmes pentavalent are based on the approved targets (2015) as well reported opening stocks (Jan 2014), shipment plan (2014) and target closing stocks (2015). For others programmes, a stock analysis is carried out to determine the right level of stock to be deducted from 2015 allocation. Syringes and safety box calculations are derived from dose calculation. All this is done in consultation with the Vaccine programme manager and (if there are any significant changes) the country, and are signed off by the CRO or Head.

Action:

- Adjust the 2014-15 targets for DPT-HepB-Hib vaccine to account for the fact that the achieved coverage rates are much lower than target in coverage survey.
- Review the implementation plans and targets for PCV13

12. EPI Financing and Sustainability

The Government of Afghanistan contributes 1.2 million USD out of total cost of 34.7 million USD for immunization services in the country. UNICEF supplies traditional vaccines and GoA contributes towards personnel and other recurrent costs only. Co-financing obligations for Afghanistan are 1.2 million USD for reporting year 2013 for which the country is in the list of default because of complex processes involved in government payments. Actions have been taken to get the government approval for 2 million USD to disburse the pending amount of 2013 and partial 2014 co-financing in 2014.

The country is concerned about escalating costs and its ability to sustain the immunization costs and is requesting technical support to develop resource mobilization and financial sustainability strategies.

13. Renewal Recommendations

Topic	Recommendation
NVS	• Renew support, with final figures based on subsequent targets revised on the basis of the recent coverage survey and JRF.

14. Other Recommended Actions

Topic	Action Point
	• Revise its targets for 2015 in view of the results of the coverage survey and JRF. • Implement better vaccine management particularly in remote and distant areas • Identify a strategy to address the high dropout. • Strengthen data quality by applying DQS and other mechanisms • The country to consider how to strengthen its AEFI and surveillance systems. • Improve routine immunization coverage through improved coordination with the MOPH's contracts management UNIT for better oversight and monitoring of BPHS performance related to immunization. • The program to increase incrementally government contribution for immunization to strengthen sustainability. • Ensure timely payment to co-financing requirement in 2014 as the program has now been in default for 2 consecutive years
Financial Reporting	**ISS**: Country to submit the 2011/2012 and 2012/2013 ISS audit reports (periods ended respectively on 20 March 2012 and 20 March 2013). **HSS (former grant, funds provided to Government)**: Country to provide the audit report for 2013. (CRO clarification: Procurement of audit firm ongoing report to be submitted by Q4.) **HSS (new grant, funds provided to WHO)**: WHO to explain the difference of $ 2,643,091 between the expenditure received according to 2013 APR ($ 2,961,176) and 2013 Financial statements ($5,604,267); WHO to resubmit a 2013 financial statement for the period of Jan 1 – Dec 31, 2013. (CRO clarification: resolved) **NVS**: Country to explain the difference of $ 77,523 between funds received according to 2013 APR and 2013 Financial statements ($ 1,107,477) and GAVI records ($ 1,185,000). CRO clarification: WHO clarified this discrepancy as the 6.54% oversight charge