Joint Appraisal Report 2019

Country	Afghanistan
Full JA or JA update[1]	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	June 9-12, 2019 Uzbekistan/ Tashkent
Participants / affiliation[2]	Annex 1
Reporting period	January 2018-December 2018
Fiscal period[3]	January 2018-December 2018
Comprehensive Multi Year Plan (cMYP) duration	2015-2019
Gavi transition / co-financing group	*Initial self-financing phase*

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes √	No ☐	
Does the vaccine renewal request include a switch request?	Yes ☐	No √	N/A ☐
HSS renewal request	Yes ☐	No √	N/A ☐
CCEOP renewal request	Yes ☐	No √	N/A ☐

2. GAVI GRANT PORTFOLIO

Existing vaccine support

Introduced / Campaign	Date	2017 Coverage (WUENIC) by dose	2018 Target		Approx. Value $	Comment
			%	Children		
Penta	2009	65% (3rd dose)	90%	1,259,612	758,500	
PCV	2013	65% (3rd dose)	90%	1,259,612	12,797,000	
IPV	2015	65%	90%	1,259,612	1,423,000	
Rota	2018	Not available as yet	90%	1,259,612	5,393,500	Introduced in January 2018
Measles FU campaign	2018	Admin 91% Survey 90%	95%	13,388,273	Ops Cost $8,702,378	Conducted in Sept and Nov 2018

Existing financial support (in US$ millions)

Grant	Channel	Period	First disb-ursement	Cumulative financing status @ May 2019				Compliance	
				Comm.	Appr.	Disb.	Util.	Fin.	Audit
HSS3	TOTAL	2016-20	July 2016	47.5m	47.5m	28.9m	61%	2017	Audit submitted
	MoPH	2016-20	July 2016		21.0m	12.5m	60%	2017	
	UNICEF	2016-20	July 2016		24.8m	15.3m	62%		
	WHO	2016-20			1.7m	1.1m	65%		
DQIP	MoPH	2017-18	2017	2.3M	2.3M	1.3m	57%	2017	Audit submitted

[1] Information on the differentiation between full JA and JA update can be found in the Guidelines on reporting and renewal of Gavi support, https://www.gavi.org/support/process/apply/report-renew/
[2] If taking too much space, the list of participants may also be provided as an annex.
[3] If the country reporting period deviates from the fiscal period, please provide a short explanation.

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	NA		

Grant Performance Framework – latest reporting, for period 2017 This part needs to revised based on GPF

Intermediate results indicator	Target	Actual
Number of sub-centres (HSCs) upgraded to EPI fixed centres	214	211
Proportion of provinces in which 80% of its existing BPHS, EPHS health facilities are monitored quarterly by PPHOs, DHOs and/or Central M&E Team	48%	56%
Proportion of health facilities with negative drop-out rate (Penta1-Penta3)	8%	16%
Number of districts where religious leader orientations held	27	42
Percentage of facilities with at least one vaccinator trained	100%	99%

PEF Targeted Country Assistance: Core and Expanded Partners at APRIL 2019

	Year	Funding (US$m)			Staff in-post	Milestones met	Comments
		Appr.	Disb.	Util.			
TOTAL CORE	2017	1.9	1.6	1.6	9 of 9	37 of 52	Overall, there are major challenges in identifying high quality TA willing to work in country.
	2018	1.9	1.2	1.1	9 of 9	61 of 81	
	2019	1.8	1.4	--	--	--	
UNICEF	2017	1.0	1.0	1.0	3 of 3	11 of 25	
	2018	1.0	0.7	0.6	3 of 3	20 of 37	EVM assessment and KAP surveys carried out. However, final reports no published yet
	2019	0.9	0.7	--	--	--	
WHO	2017	0.9	0.6	0.6	6 of 6	26 of 27	
	2018	0.9	0.6	0.5	6 of 6	41 of 41	Among others TA was provided for Measles surveillance support
	2019	0.9	0.7	--	--	--	
CDC	2018	0.06	0.06	--	--	0 of 3	Support on Congénital Rebella Syndrome (CRS) surveillance
TOTAL EXPAND	2018	0.057	0.054	0.054	--	1 of 1	Expanded partners paid upon invoices, not disbursements
	2019	0.20	--	--	--	--	
Acasus	2018	0.057	0.054	0.054	--	1 of 1	Recently submitted draft report. Potential further engagement for reinforce Accountability at EPI
GDS	2019	0.20	--	--	--	--	--

[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.
Countries are encouraged to highlight in subsequent sections, and particular in the Action Plan in Section 7, key activities and potentially required technical assistance for the preparation of investment cases, applications and vaccine introductions, as applicable.

3. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

Context

The total estimated population of Afghanistan for 2019 is 32,225,560 (National Statistics and Information Authority); of which 16.4 million are male and 15.8 million are female; 71.4% reside in rural areas while only 23.9% - in urban areas; 17.25% are under the age of 5 years. According to the findings of Afghanistan Living Condition Survey (ALCS 2017), 54.5% of the country's population lives below the poverty line. Prevalent poverty, high proportion of dependency, large number of returnees and Internally Displaced People (IDPs) increase the vulnerability of the Afghan population and affect their access to health services. The security situation has worsened. Civilian casualties are at their highest level since 2002, with an unprecedented scale of conflict-induced displacement. Since 2007, the number of injuries and deaths has increased five-fold, and in 2016 and 2017, more than 1.1 million Afghans were displaced internally due to conflict.

Update on the political context

Elections: The parliamentary elections took place on 20th October 2018. However, due to number of irregularities and complaints during the elections, the final results of the election are not yet declared. The presidential elections are planned for September 2019 that may increase political tension among different parties and, therefore, increase number of security incidences. It is hoped that the results of ongoing peace talks in Doha will have direct impact on peace and stability in Afghanistan. The political developments may affect access to health services and the performance of EPI program.

Insecurity, IDPs and natural disasters: Afghanistan suffers from one of the longest protracted complex emergencies due to the conflict, natural disasters and mass population movements. In 2018, the conflict and severe drought expanded to other regions that resulted in increased number of internally displaced people and cases of trauma. The displacement called for need in additional emergency service support.

Leadership, governance, and program management:

Financing of SEHATMANDI activities: according to the agreement between World Bank and Ministry of Finance, Sehatmandi is financed by Afghanistan Reconstruction Trust Fund (ARTF). The current contracts under SEHATMANDI have started in January 2019 and will end by June 2021. In the new contracts, the budget for contracting BPHS NGOs has been significantly reduced (up to 40% in some provinces). SEHATMANDI provides the operational costs for service delivery of immunization program, therefore, this decrease in budget/funding may adversely affect the routine immunization service provision.

Health and EPI Financing:

Based on the WB estimates, Afghanistan's total Gross Domestic Product (GDP) was USD 20.815 billion in 2017, which shows a relative increase compared to 2016 (19.469 billion).

Total Health Expenditure (THE) in 2017 was about USD 2.58 billion, an increase by approximately 30% compared to the previous National Health Accounts (NHA,2014); government expenditures on health were around USD 123 million. THE, as a percentage of GDP, was about 12.7%, an increase of 3.2% compared to 2014. The current health expenditure (CHE) as a percentage of GDP was around 11.9% which indicates an increase of 2.4 percentage point compared to the previous round of NHA (9.5 %).

Approximately 75% of THE is paid by households out of pocket (OOP); this remains the major source of health financing in the country; 5% was financed by the Government of Afghanistan and about 19% by donors. The Government of Afghanistan manages some of the donor funds, estimated at around 6% of CHE, whereas the donors manage around 13.6% of health expenditure themselves. The remaining large portion is spent out of pocket and managed by individual households.

Polio situation:

Afghanistan reported 21 Wild Polio Virus (WPV) cases in 2018 compared to 14 WPV cases in 2017. The polio transmission is limited to the geographic areas in South and East of the country. 16 out of 21 WPV cases in 2018 did not receive any routine OPV dose. 6 WPV cases were reported in 2019 (as of April 21, 2019).

Fig 1. Geographical distribution on WPV cases in Afghanistan, 2018 (n=21)

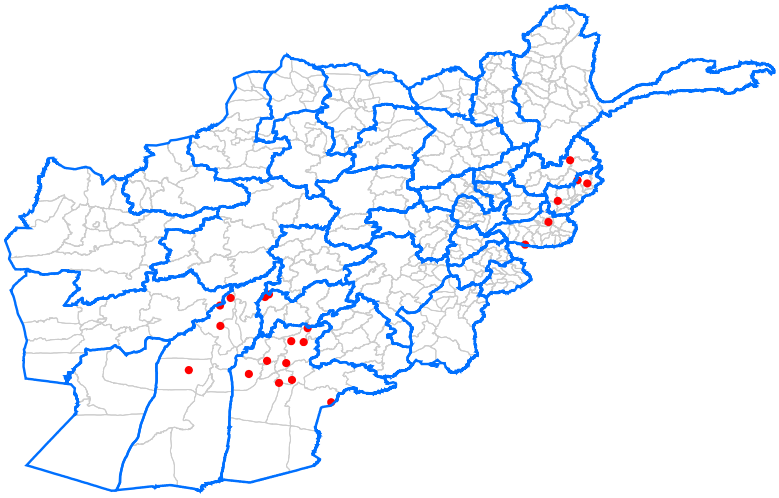
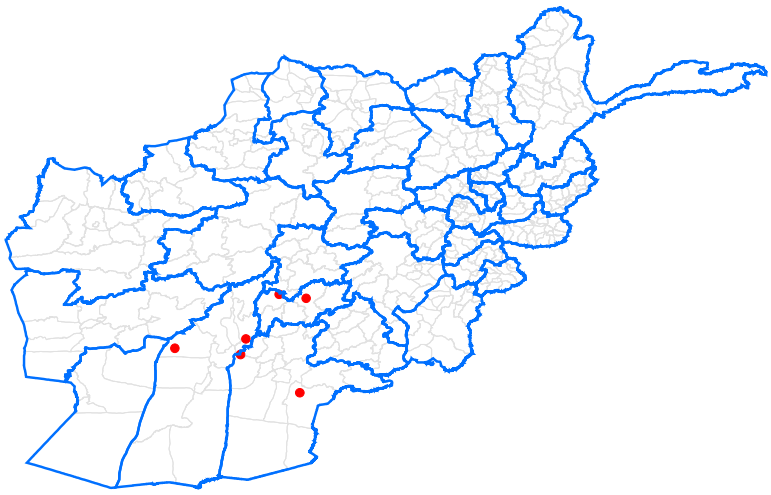


Fig 2. Geographical distribution on WPV cases in Afghanistan, 2019 (n=6)



Supplementary Immunization Activities (SIAs) implemented in the house-to-house fashion are the cornerstone of the polio eradication strategy; 3 National Immunization Days (NIDs) covering entire under five population of the country with OPV (more than 10 million children) and 6 sub-NIDs focusing on the high-risk areas of the country (more than 6 million U5 children) are planned for 2019. More than 60,000 vaccinators, almost 6,000 supervisors and some 7,000 social mobilizers are involved in NIDs. Due to the ban on house-to-house approach in the southern part of the country, SIAs had been partly implemented in site-to-site mode that was less effective than house-to-house.

Afghanistan is expected to develop Polio Transition Plan twelve months following the interruption of polio transmission. However, considering large polio human and material resources in Afghanistan, the process of establishing polio transition governing structure and engaging stakeholders has commenced. Polio Transition Framework for Afghanistan has been drafted; implementation will start following interruption of transmission. The existing ICC/HSS Steering Committee (so called Inter-Agency Coordination Steering Committee/ICSC) could assume the functions of the governing body for the polio transition process. The separate working group will be established under ICSC to provide technical support to the polio transition process as well as implement, monitor and supervise the activities

Potential future issues (risks)

1. There are serious concerns that the government of Japan may not support the procurement of traditional vaccines beyond 2019;
2. The new "pay for performance" modality of contracts with NGOs (direct link between the number of children vaccinated and the payment of NGOs) may lead to inflating the coverage of immunization at the health facility level;
3. Low budget absorption capacity of NGOs and other partners mainly due to increased insecurity;

4. Reduced NGOs budget under Sehatmandi (up to 40% in some provinces) and linking the salary of vaccinators with the number of children vaccinated in each health facility may affect the quality of data and forged over performance of EPI;
5. The upcoming presidential elections planned for October 2019 might be associated with increased level of violence that will negatively affect the provision of EPI services.

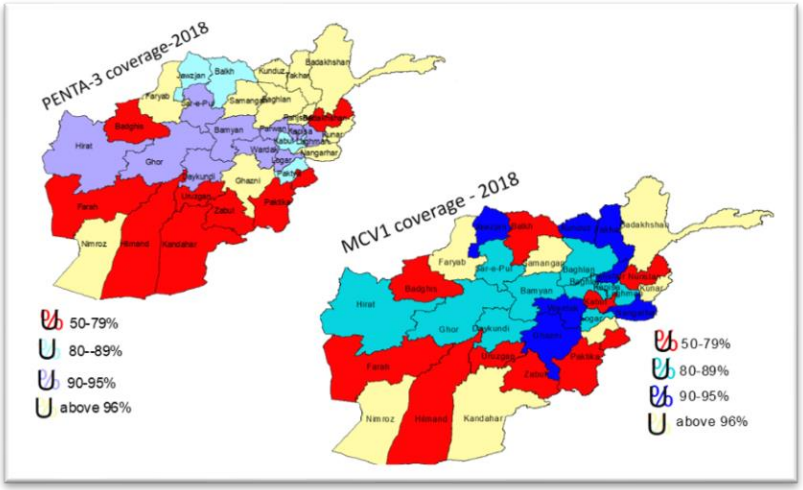
4. PERFORMANCE OF THE IMMUNISATION PROGRAMME

4.1. Coverage and equity of immunisation

Coverage: DTP3, MCV1&2, etc.

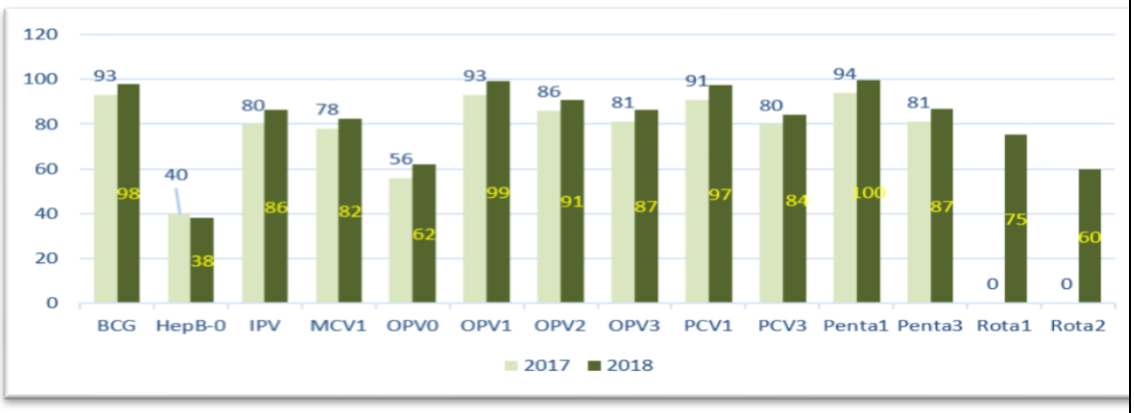
The reported routine Penta-3 and Measles-1 coverage in 2018 is 86.8% and 82% respectively; large inter-district difference is observed as shown on the maps below:

Fig.3: Penta-3 and MCV1 coverage at the district level



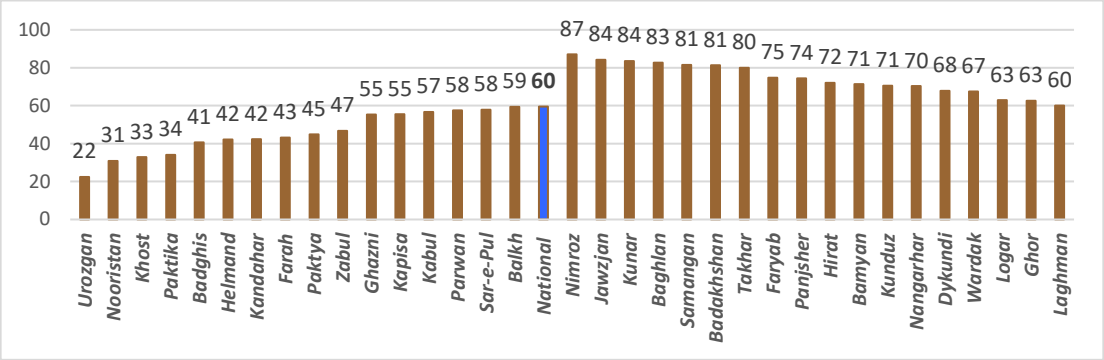
There are slight increases in the administrative coverage for almost all antigens in 2018 compared to 2017. This could be associated with improved knowledge, attitude, and behavior of parents and caregivers due to consistent Behavior Change Communication (BCC) messages using multiple media (leaflets, posters, banners, Radio and TV spots). However, it needs to be validated.

Fig.4a: Administrative coverage (%), 2017 and 2018



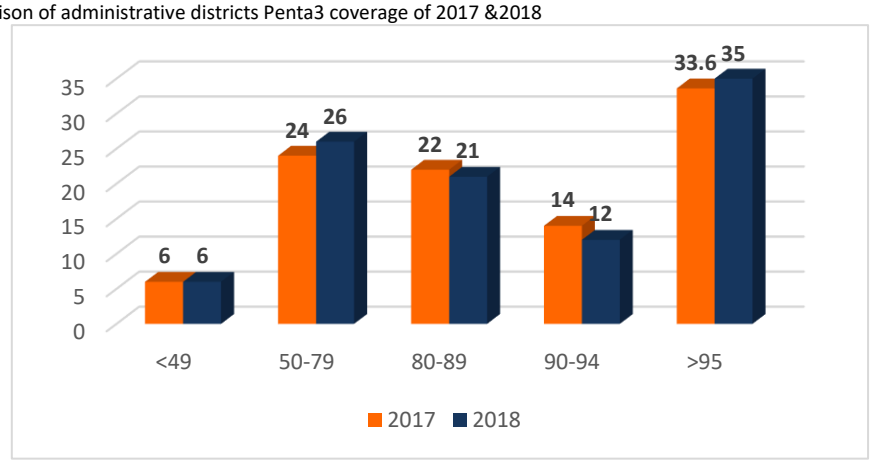
The coverage by the 2nd dose of MCV at the national level increased in 2018 to 60% compared with 51% MCV2 coverage in 2017. However, it still needs improvement. At the provincial level 16 provinces (53%) reported MCV2 coverage less than the national average and 18 provinces (57%) reported a higher percentage (Fig.4b).

Fig.4b: Routine reported MCV2 coverage percentage-2018



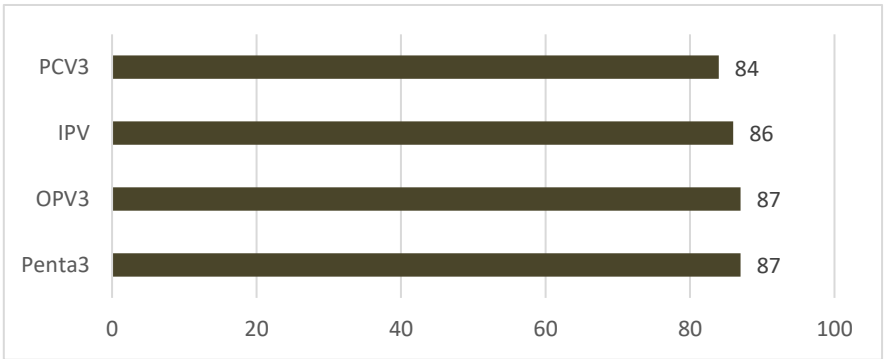
Overall 130 districts (32%) reported less than 80% Penta3 coverage, while 133 (33%) and 144 (35%) reported between 80%-95% and more than 95% coverage, respectively. As per the Joint Reporting Form; (JRF), the districts are divided into 5 categories: with penta3 coverage >95 %, between 90-94%, 80-89, 50%-79% and <49%. In 2017, 34% districts were in the first category; however, the percentage increased to 35% in 2018. Second and third categories changed from 14% in 2017 to 12% in 2018 and from 22% in 2017 to 21% in 2018 respectively. The percentage of districts in the 4th category increased from 24 in 2017 to 26 in 2018. The percentage of districts with less than 50% Penta-3 coverage remains the same in 2018 as compared to 2017.

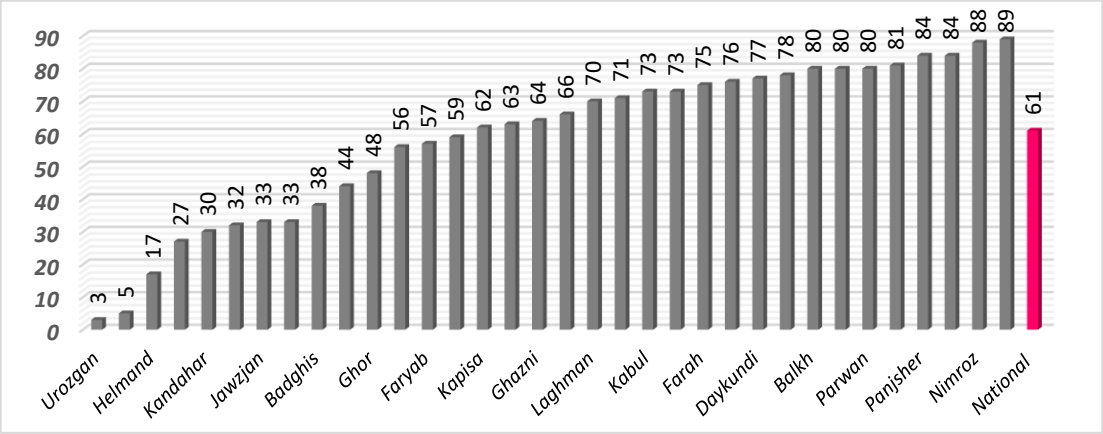
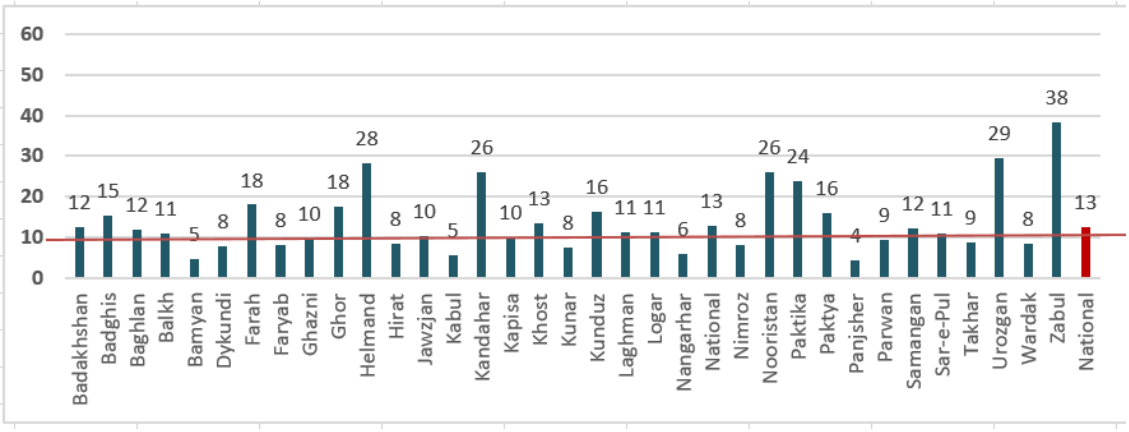
Fig.5: Comparison of administrative districts Penta3 coverage of 2017 &2018



Rota vaccine was introduced at the end of January 2018 and low coverage by Rota-1 and Rota-2 vaccine doses was observed in 2018. Having compared coverage by antigens given at the same time, the coverage of mentioned antigens appears more or less the same indicating ability of the system to administer different antigens in the same visit thereby reducing missed opportunity.

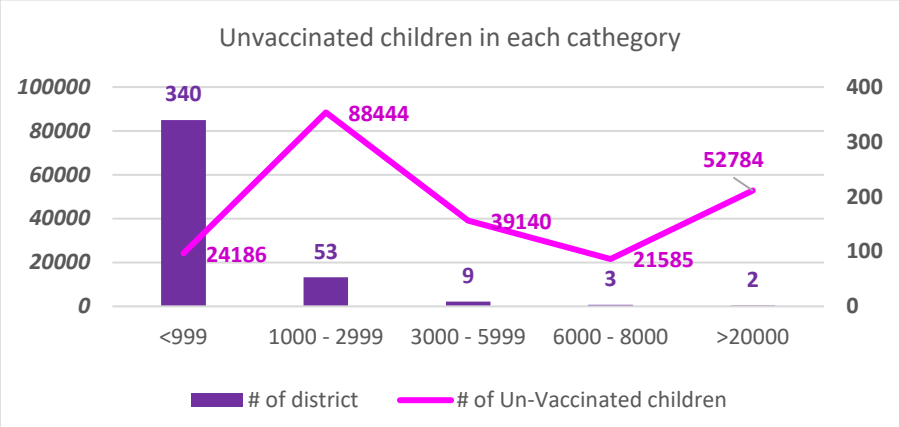
Fig.6: Coverage by various antigens given at the same time



	The reported Penta-3 coverage in 2018 is 86.8% compared to 81% in 2017. According to the findings of the Afghanistan Health Survey (AHS 2018), Penta-3 coverage at the national level is 60.8% that shows a small increase in comparison with the latest AfDHS 2015 results (57. 7%). However, there is a large inter-provincial difference ranging from 3.1% in Zabul to 89% in Bamyan provinces. The Penta-3 coverage in 8 (23.5%) of the provinces is greater than 80% and in the five (14.7) provinces is lesser than 20%, with eight provinces of south and southeast having the lowest coverage (less than 35%). Fig.7: Penta3 coverage Afghanistan AHS 2018  Based on routine reported coverage at national level the drop-out rate is 12.5% which is differ among provinces. There are 15 provinces (44%) with DOR less than 10%, while 6 provinces (18%) of provinces have reported the DOR more than 20%. Fig.7b: Penta3 coverage Afghanistan AHS 2018 
Coverage: Absolute numbers of un- or under-immunised children	At the national level, 226,138 children of the target age did not receive Penta3 doses and 299,833 children did not receive first dose of the Measles vaccine. Based on the number of children unvaccinated with Penta3, the districts are divided in four categories: • A total of 74,368 unvaccinated children are living in 5 districts with a range of 6,000- 31,079 unvaccinated children (with average of 14,870 children per district). This category includes two outliers, Kabul city and Khost cities with 31,079 and 21,705 unvaccinated children respectively. • The number of unvaccinated children in nine districts is 39,140 ranging from 3,000 to5,500 children (with average of 4,349 unvaccinated children per district). • 88, 444 unvaccinated children reside in 53 districts with the range of 1,000-2,999 children (average of 1,669 per district). • 340 districts have the lowest number of unvaccinated children (less than 999). It could be concluded that the largest number of unvaccinated children is living in 14 districts with a range of 3,000 to31,079 children, this includes the big cities such as Kabul, Mazar, Kandahar and Jalal-Abad with the high number of unvaccinated children of 31,079 (an outlier); 8, 56, 5,278 and 4,065 respectively. The un vaccinated children number are high (3999-6700 children) in the Musa Qala (Helman), Qarabag (Kabul), Khas Urozgan (Urozgan), Kandahar City (Kanadahar), Nahre Shahi (Balkh) , Shindand (Herat)

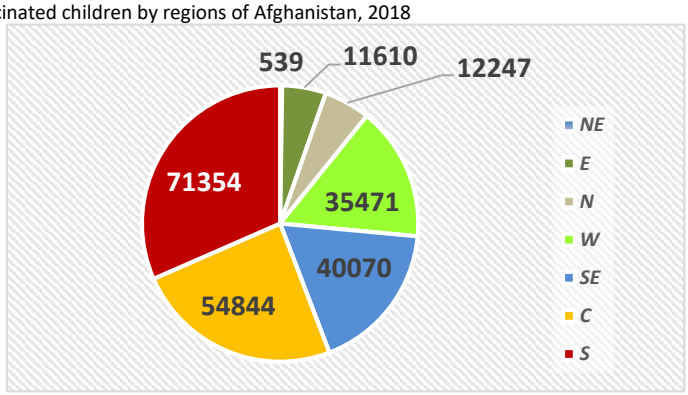
and NadeAli (Helmand) though it is very high in the Mazar-e-Sharif (8567 children), Khost (21000 children) and Kabul city (31000 children).
Above-mentioned data are based on routine administrative reports, which might not reflect the actual picture of the ground.

Fig.8: Number of un-vaccinated children by category of districts



At the regional level the biggest number of unvaccinated children (32%) is living in the South region followed by Central region (24%), South East (18%), West, North (16%) and East (5%) regions, the lowest number of unvaccinated children (0.2%) live in the North East region. Fig 9 demonstrates the number of unvaccinated children by the region.

Fig.9: Number of un-vaccinated children by regions of Afghanistan, 2018

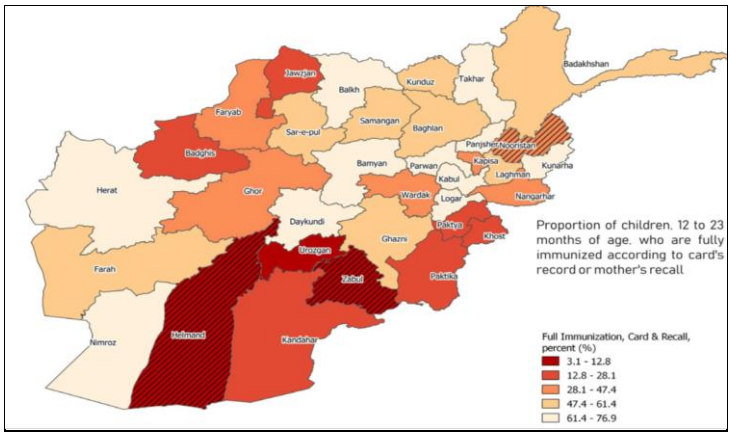


Equity:
Wealth (e.g. high/low quintiles)
Education (e.g. un/educated)
Gender
Urban-rural
Cultural, other systematically marginalised groups or communities e.g. from ethnic religious minorities, children of

Equity and Coverage

According to the recent Afghanistan Health Survey (AHS 2018), the full immunization coverage at the national level is 51.4%, and there is large inter-provincial difference in the coverage at, as shown in the fig. 9 below

Fig .9: Province wise full immunization coverage in Afghanistan (AHS 2018)



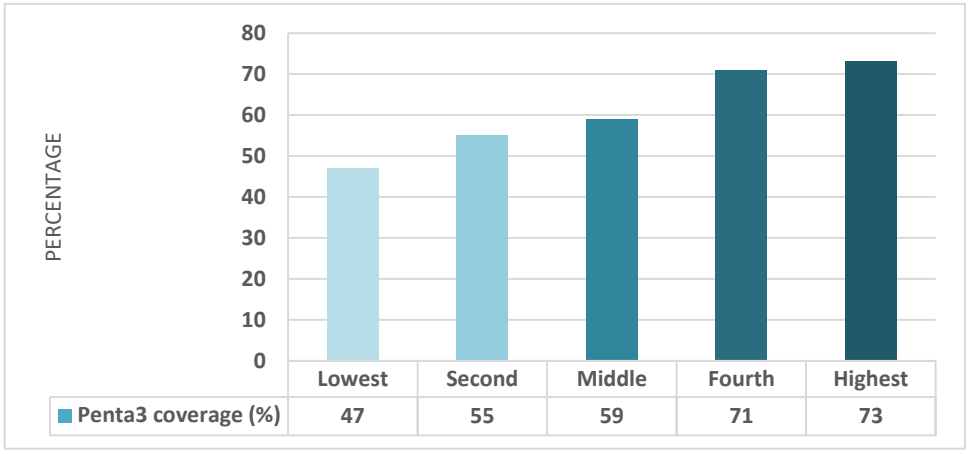
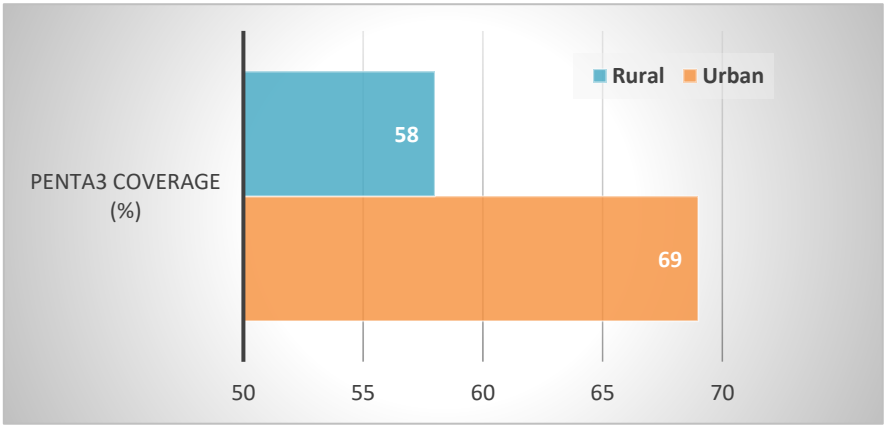
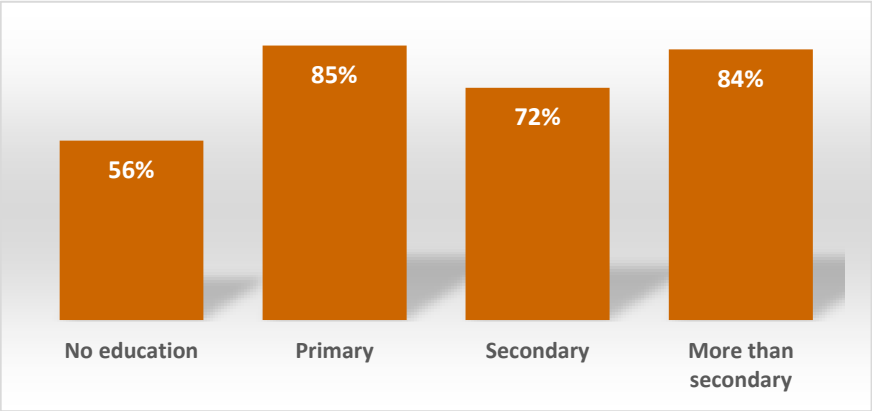
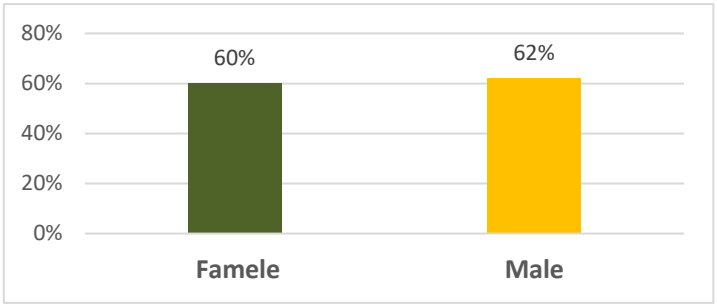
female caretakers with low socioeconomic status, etc.	The map demonstrates a proportion of children aged 12-23 months that were fully immunized at the time of the survey. Staggeringly low levels are observed in Urozgan and Paktika, as well as in Helmand and Zabul, but in the latter two provinces it was not possible to collect the complete desired sample, so could the results are based on a smaller (and perhaps more biased) sample. The survey also shows that there is a wide variation in immunization coverage rates between the regions, wealth quintiles, education level of the mother and areas of residence: • The household wealth plays a substantial role in vaccination coverage. In general, there is a direct correlation between household wealth and receipt of vaccines as seen in fig. 10 below (AHS 2018) Fig.10: Penta3 coverage by wealth quintile (AHS 2017)  • The survey compared immunization coverage rates between rural and urban areas; t the rural areas are generally slightly behind the urban areas; however, this still represents an achievement considering the difficulties of immunization in rural areas. Fig.11: Penta3 coverage by Urban and Rural (AHS 2017)  • Immunization coverage was also analysed by the educational level of the mother. Children of mothers with no education have lowest levels of immunization coverage while the children of mothers with primary education or more, have higher immunization coverage.

Fig.12: Penta3 coverage by Mather Education (AHS 2017)



- There is no significant gender difference in the immunization rates of EPI antigens. Although the immunization coverage is low, the services are accessed and utilized almost equally by the parents and caregivers of both boys and girls.

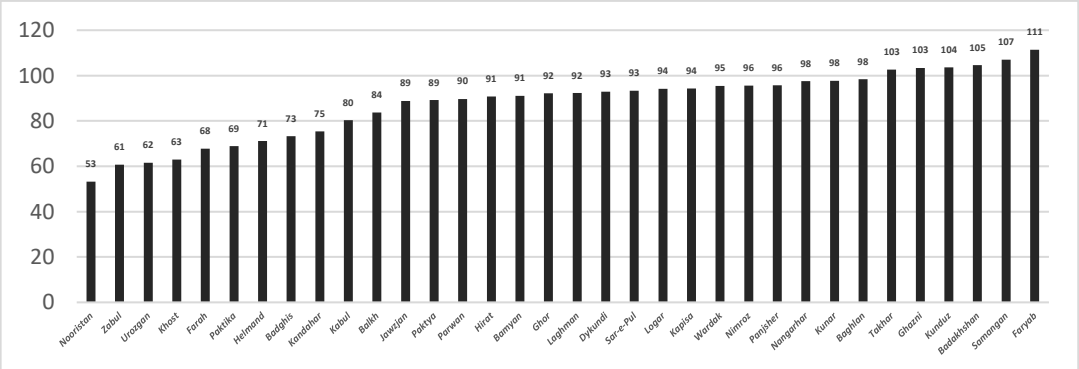
Fig.13: Percentage of children immunized by Gender (AHS 2017)



In addition to the inter-provincial difference in the immunization coverage, there is a variation based upon the residential area. The percentage of full immunization coverage is 19 points higher in children residing in urban areas than in rural areas. The full immunization coverage is also affected by the income of the families. It is higher in wealthiest quintile (62%) as compared to the poorest quintile (37%).

The 2018 Penta-3 administrative coverage in 26% of provinces is between 50% -79% and in 41% of provinces is between 80%-95%. This figure is between 95%-99% in 15% of provinces while 18% of provinces reported over 100% Penta-3 coverage.

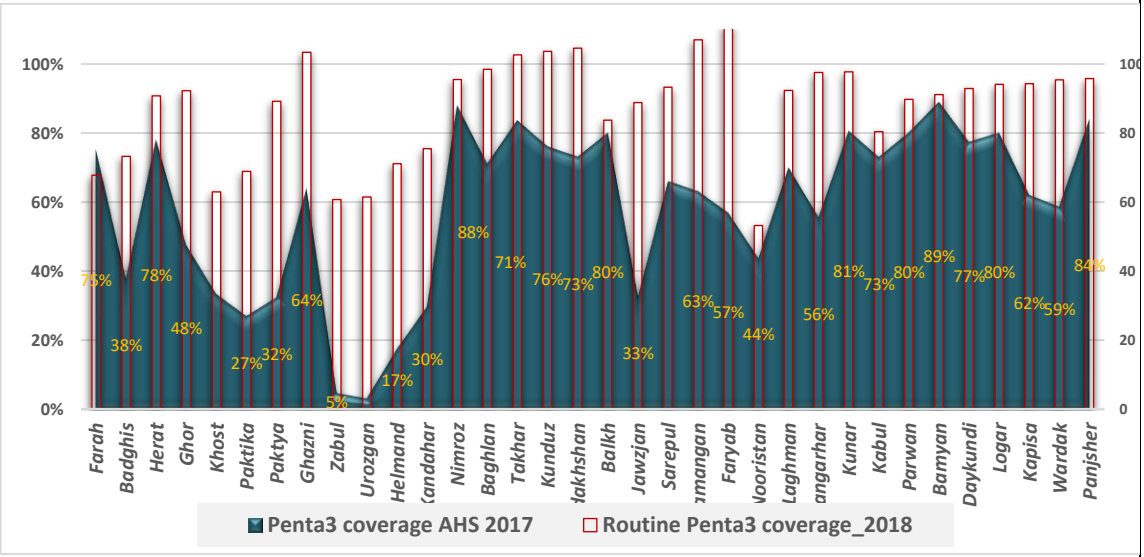
Fig.14.: Provincial routine reported Penta3 coverage (2018)



At the provincial level, there are differences between routine Penta-3 coverage in 2018 and the results of AHS 2018. Largest difference is observed in Zabul, Urozgan, Kandahar and Helmand provinces; however, this difference is big in most of provinces. It is worth to mention that the difference between

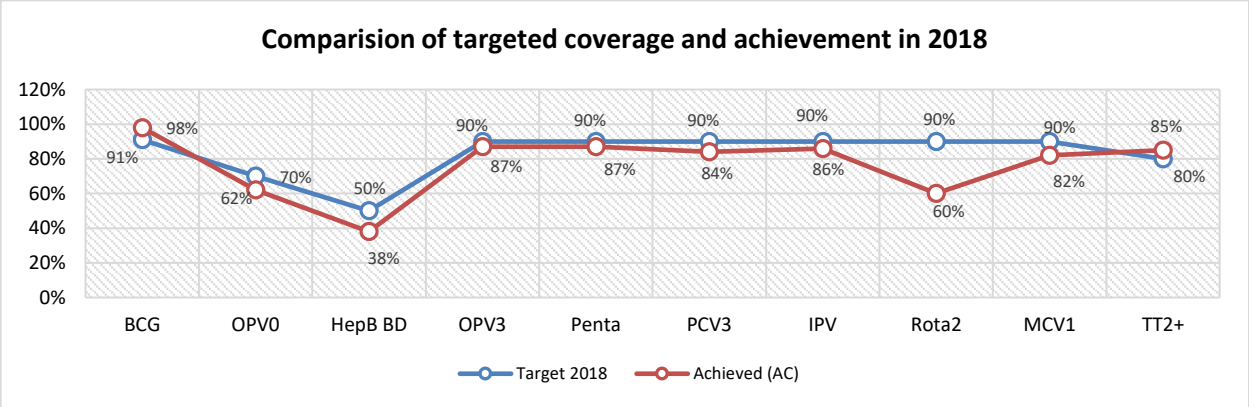
AHS 2018 results and routine reported coverage (2018) is small in provinces such as Bamyan, Kunar, Balkh, Nimroz and Panjsher.

Fig.15: Comparison of provincial Penta3 coverage (routine 2018 vs AHS 2018)



There is large gap between the targeted coverage for 2018 in the cMYP 2015-2019 and the reported coverage for 2018, except BCG, Hepatitis B birth dose and Rota2. The target for BCG is 91% while the administrative coverage reported in 2018 is 98%. It is a sign of good access to BCG vaccine through health facilities with delivery services. On the other hand, there is a big gap between the second dose of Rota vaccine targeted coverage (90%) for 2018 and the coverage (60%) achieved; so the difference is 30%. In addition, the Hepatitis B birth dose is very low (38%) compared to the target (50%) set in cMYP. The reason behind the low Hep B birth dose is that this vaccine administered only in the health institutions where deliveries are taking place during the day time. The trend of other vaccines based on administrative coverage is almost close to the target set in cMYP and with average differences of 8% (see fig. 16).

Fig. 16. Comparison of cMYP (2015-2019) targets and 2018 reported coverage



4.2. Key drivers of sustainable coverage and equity

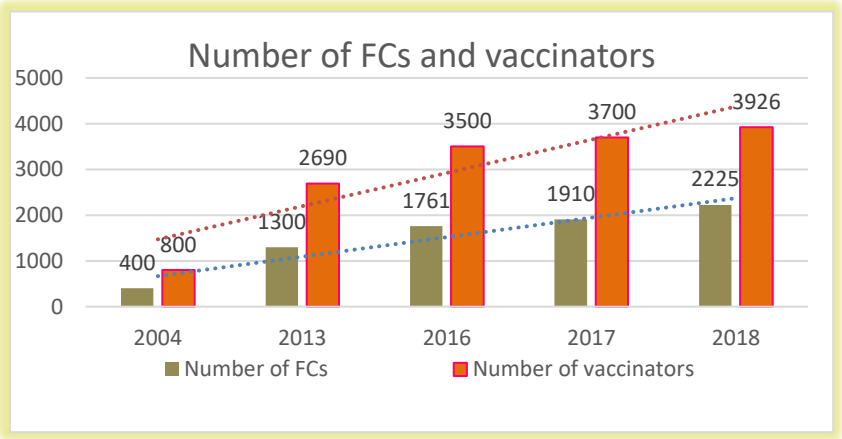
Workforce and Human Resources:

Around 3,926 vaccinators, of which 1,275 (32.4%) are females, provide vaccination in the field. Majority of female vaccinators work in the urban and secure areas. This is an important barrier as it is unacceptable for women to get Tetanus Toxoid by male vaccinators. There is also an attrition of vaccinators due to low salary. Human resource problems such as high staff turnover, low pay and poor supportive supervision are challenging issues for delivery of immunization services.

In addition to that a total of 280-300 officials are employed in REMTs (Regional EPI Management Teams) and PEMTs (Provincial EPI Management Teams) throughout the country. At the central level in NEPI department, National EPI program manager leads a team of more than 20 officials.

The number of fixed centres and vaccinators has increased from 400 and 800 in 2004 to 2,225 and 3,926 respectively in 2018, as shown in fig. 17 below:

Fig. 17: Number of Fixed centres and vaccinators in Afghanistan



Supply chain:

- EVM assessment was successfully conducted in 2018. A total of 48 sites were assessed including national cold store, cold chain facilities at all seven REMTs, 11 randomly selected PEMTs and HFs corresponding to the selected PEMTs. According to the results of the study, some of the nine EVM criteria did not meet WHO recommended levels of 80% score and above. At the national level, three criteria/areas need to be improved: 1) distribution of supplies (59 %); 2) storage capacity (67%); and 3) maintenance (78%). At the regional level, maintenance and Management Information System (MIS) supportive functions were found lower than recommended threshold; at the provincial level, poor maintenance, stock management and MIS were identified. Almost all criteria were lower than 80% except building space at the health facility level (table 1)

Table 1: EVM assessment mean criteria scores, 2018

-

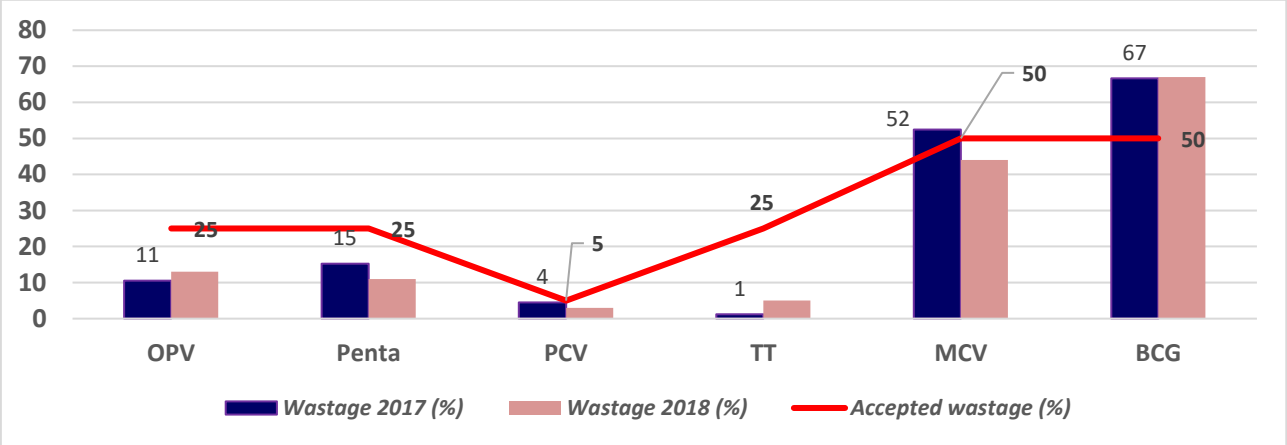
#	Criteria	Levels			
		National	Regional	Provincial	Service delivery
1	Pre-Shipment and vaccine arrival procedures	96%	Not Applicable		
2	Storage Temperature	86%	83%	88%	74%
3	Capacity	67%	87%	88%	79%
4	Building Equipment and transport	87%	85%	84%	82%
5	Maintenance	81%	76%	72%	66%
6	Stock management	93%	81%	74%	64%
7	Distribution	59%	82%	81%	83%
8	Vaccine Management	98%	97%	90%	88%
9	MIS and supportive Supervision	92%	74%	65%	77%

- The Cold Chain Optimization Platform (CCEOP) proposal was submitted by country partners and approved by GAVI.
- 456 Solar Direct Drives (SDDs) have been procured in 2017-2018 with Gavi HSS funds. 95% of procured supplies were installed. The SDDs have been installed with Remote Temperature Monitoring (RTM) devices. These RTMs were provided by Dometic manufacturer (supplier of the refrigerators) and are monitored by Dometic for performance and by national team (MoPH and partners) for performance and maintenance needs.

- Construction of cold chain facilities: first phase (3 regional warehouse and 4 provincial cold rooms) is completed. 11 facilities of the second phase were contracted out, and construction is in process, expected to be completed before winter (except national cold room for which the design is pending review by Ministry of Urban). Preparation for bidding of the last phase is underway and will be contracted subject to timely assistance by Ministry of Urban.
- The Measles vaccine wastage rate were reduced to 44% in 2018, compared to 52% in 2017, but the BCG wastage remain the same for 2018 and 2017 (67%).The BCG vaccine wastage is high in 2018 due the need to dispose of the vaccine vial of 10 or 20 doses6 hours after reconstitution. The wastage rate of other antigens is not high.
-

Fig.18: Wastage rates of vaccines at the national level, 2017- 2018

-



Vaccine Management:

Afghanistan has been using **VSSM (offline version)** for than five years and presently this is being implemented at National,7 Regional and 34 (?) Provincial vaccine stores. The benefits of implementing the VSSM is quite evident from the 2014 and 2018 EVM scores (E6) at National, Regional and Province level stock management. **ViVA** a stock visibility dashboard application is in use with the support of UNICEF since 2017. ViVa helps in vaccine forecasting visibility and monitor purchase orders(POs) issues by UNICEF-SD. Input for ViVa is obtained from VSSM and POs issued from supply division of UNICEF.

In 2016, an integrated Real Time Vaccine Logistics and Temperature Monitoring System was conceptualized by UNICEF for Afghanistan and two years intensive efforts were put to establish the system. However, this system could not be put in place due to capacity deficiency of the vendor and the overambitious requirement specified to the vendor in the Afghanistan context. Considering the access, human resource, infrastructure, connectivity, MOH, UNICEF, WHO, GAVI, and other partner agencies need to redefine their expectation and can limit to Effective Vaccine Management (EVM) requirement

What Afghanistan EPI SC system need?

As per the Effective Vaccine Management requirement, Afghanistan needs followings:

- Good stock and wastage documentation system with physical records of vaccine management at all levels of the supply chain, like stock, issue records, receipts and issue vouchers
- Real-time stock management tool implemented at least up to the province or district level and updated within 24 hrs. of transaction
- Real-time cold chain equipment inventory at least up to province or district level and updated within 24 hrs. of transaction. However, all HF equipment should be part of the inventory and updated at least every month through offline or online mode whichever is feasible
- Real-time temperature monitoring system for all the cold rooms and SDDs and 30 Days temp recording devices for all ILRs on priority and DFs, if resource allows.

In addition to the above minimum requirement of EVM, Afghanistan also need followings for a good EPI-SC system,

- Six monthly structured reviews of EPI-SC system with the provinces
- Functional National Logistics working group
- Multi-year budgeted functional National EPI-SC action plan
- Good cold chain maintenance system with a functional cold chain training center

- Regular capacity building of staffs on different types of relevant training

Present situation

Presently**, VSSM (offline version)** is in use for than five years for the vaccine and logistics stock management for the store levels; National,7 Regional and 34 (?) Provincial vaccine stores. However, since it is not online, so all these stores are not interconnected data is stored in several local computers.
Staffs managing stocks are very well trained on VSSM tool and procedures which are based on EVM principles.

The **cold chain equipment inventory component** of VSSM is not used rather a separate excel sheet is used as an inventory and not regularly updated.

A system is in place for **Online temperature monitoring system for all the WICs and WIFs** and these are being monitored at the National and regional level. **80% of newly deployed CCEs at the province and HFs level are SDD with integrated online temp monitoring system**,

Key decisions and way forward based on the following two meetings:

- MOPH-EPI-SC Team with UNICEF Country Office and ROSA on 15.05.2019
- Afghanistan JA meeting at Tashken t(9-12 June 2019)

1. It was agreed by National EPI manager, GAVI-SCM, UNICE-CO and RO, WHO-CO and Regional Office to upgrade the present offline version of the **VSSM to wVSSM(online version)** in order to have **online stock visibility and management of vaccine at all the three supply chain levels, in addition to the cold chain equipment inventory.**

2. A technical team can visit Afghanistan and will work closely with the country team (MOPH, UNICEF, and WHO) to take it forward.

3. There may be a requirement for the inclusion of additional EPI-SC field, coverage data or others, which need to be discussed with the country team.

4. Additional development work can be supported by UNICEF

5. For the training, travel and any other activities including TA support from the WHO-EMRO team, UNICEF CO is willing to provide required financial support if required.

Service Delivery:

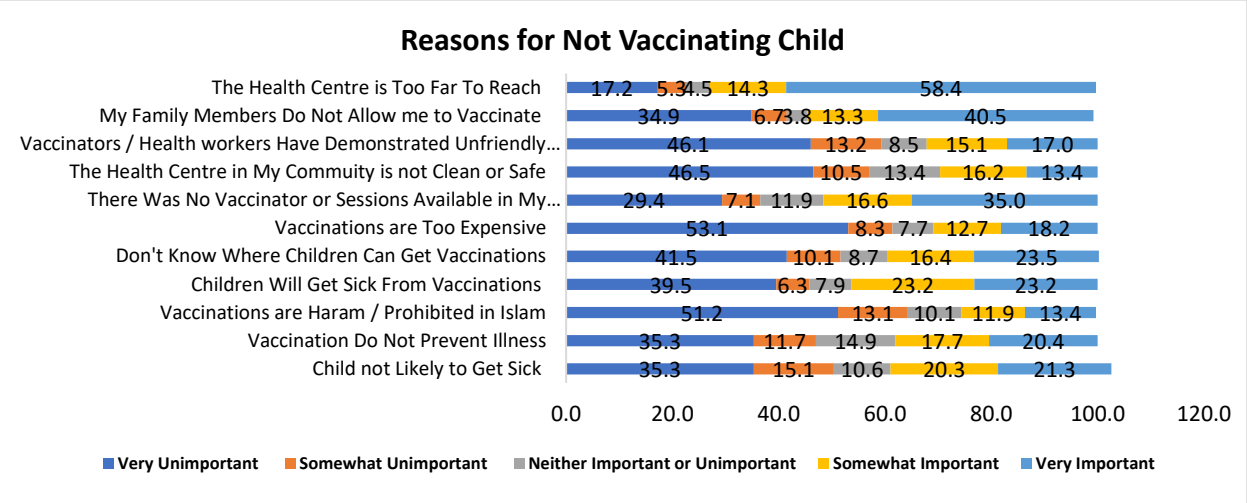
EPI services being provided through fix, outreach and mobile strategies. Immunization coverage is low among population in insecure and remote areas as well as nomadic and illegal settlements. Displaced populations and nomads that are on the move are especially difficult to reach, but with support of the technical partners, the EPI services use specific strategies for service provision. Although the immunization coverage rates are usually higher in urban than rural areas, reports indicate that largest number of unimmunized children live in urban areas.

Demand Generation:

- Training of religious leaders: The selected trainers of MoPH/EPI department and Ministry of Haj and Religious Affairs participated at the TOT. To date, 27 master trainers from nine provinces (Kandahar, Helmand, Zabul, Urozgan, Farah, Nangarhar, Laghman, Kunar and Noristan) participated in the TOT and trained 3,030 religious leaders in the provinces.
- **Measles campaign:** Based on the Measles SIAs communication plan, the Measles IEC materials were designed in local languages (Dari and Pashto) and after thorough review by communication sub-committee established at MoPH, the materials were revised, tested and finalized. A total of 13,200 banners, 4,550 flags, 20,500 posters, 1,270,000 leaflets and 1,0250 brochures were printed for both phases of Measles SIA. A brief guideline about the distribution and use of IEC/BCC material was also developed to enable the REMTs and PEMTs to systematically distribute the material to health facilities, vaccination teams and the community.
- Mass media campaign has been conducted during the year 2018. The purpose of the mass media campaign was to raise awareness on RI for people, measles SIA through national and sub-national TV and Radio stations using Routine Immunization messages and Minister of Public Health message about measles SIAs. The RI and measles specific video and audio clips were produced in both national languages (Dari and Pashto) and broadcasted based

on the media plan during the year and during both phases of the Measles SIA. A total of 36 TV and 78 radio stations broadcasted the Routine Immunization and Measles messages during both phases of Measles SIAs. 4,423 TV and 14,898 radio insertions were broadcasted using different Gavi funds.

- The fig. 19 shows the reasons for not vaccinating children identified by the KAP survey that was conducted in 2018.
- Fig.19. Reasons for not vaccinating children



Gender related barriers faced by caregivers:

There is no significant gender related barriers for infants to be vaccinated but there are barriers preventing the mother and female caregiver of children to go to immunization post alone or to make decision about children vaccination. Additionally, the services are accessed and utilized equally by the parents and caregivers of boys and girls.

Data information System:

The current immunisation information systems track progress on an aggregate basis. Paper-based registries and tally sheets are completed at the facility level; these forms are then entered into a MS Access database at the provincial level. Supportive supervision for data quality is conducted at the facility level on a monthly basis to ensure that quality information is recorded.

Dashboard that provides automated reports and analytics at the subnational and national levels was developed/activated recently; however, due to some technical problems and long period of recruitment of new TA it is not yet inaugurated officially.

The HMIS system includes only Measles1, Penta3 and TT vaccination data, therefore it is planned to introduce the immunisation module for DHIS-2 which will provide the opportunity to add reports on coverage of all doses of all antigens.

With implementation of Data Improvement Plan (DIP) planned activities in 34 provinces as well as recruitment of data officers' significant changes occurred in availability of the data from the provincial level, since they are responsible for improving data use at provincial and HF level.

Data Quality Improvement (DQI) Committees are established in all 34 provinces; these committees are headed by PHD and include REMT/PEMT staff, Data quality officer, EPI supervisor, Cold chain manager, BPHS NGO implementer representative, HMIS officer, WHO, UNICEF staff. This committee will review, analyse and give feedback on the data gathered from all health facilities and make action plan for solving data related issues by related departments.

Total of 2,901 vaccinators have been trained on data management from 34 provinces, 4,000 copies of SOPs and training guidelines in Dari and Pashto languages were printed, sent to provinces and distributed to HFs. 1,954 supportive supervision visits by provincial data officers and EPI supervisors have been conducted, one-day orientation workshop for BPHS leadership on data quality improvement was conducted.

25 supportive supervision visits were conducted by National EPI staff in 26 provinces, 1,700 copies of job aids were sent to 34 provinces and distributed to HFs, 2,087 tracking bags were sent to provinces and distributed to fixed centers. 77 Data Quality Improvement provincial committee meetings have been conducted so far in 34 provinces headed by PHD/ REMT/PEMT. 4,000 copies of data quality improvement SOPs in both local languages were printed, sent to provinces and distributed to HFs. External Audit of DQIP completed and the final version have been shared for further comments and feedback. TORs for DQI committee meeting, Regional Review, Sensitization, External Audit and GLM have been developed.

Annual reviews of immunization data quality improvement at six regions have been conducted in 2018 with participation of 280 EPI/NGOs staff; data from HFs verified at provincial level. Then the findings have been discussed in review meeting with provincial/regional EPI teams. Bottlenecks and problems on data quality were identified and solutions were proposed

for each problem. The review teams of each province in the region gave specific recommendations. Feedback mechanism established for better communication between review committee for data quality improvement, HFs and NEPI, sensitization of the provincial EPI committee members was conducted in six regions, for EPI/NGOs staff as well as three HFs managers with poor performance. The aim of the workshop was to train EPI committee members on importance of data quality, the EPI committee should help immunization staff in field to produce high quality data, learn basic terms used in data, Improve accuracy, completeness, timeliness, validity of immunization data and usage of data for planning and program improvement as well as ultimate improvement in immunization coverage. Total of 270 provincial staff were trained in sensitization workshop in six regions.

Vaccines/biologicals registration and post marketing surveillance:

The targeted improvement of pharmacovigilance, establishing vaccine and biological registration as part of National Regulatory Authority and strengthen post-marketing (AEFI) surveillance is planned by MoPH. Following activities carried out by NMHRA and NIP with the support of WHO in relation to this: introductory workshop on biological products registration for 40 staff of NIP and NRA. WHO EMRO and HQ provided technical support for training workshop on vaccine registration and AEFI surveillance for 50 staff of pharmacovigilance department and national EPI staff. In addition, the following activities were carried out:

- Establishing regulations for vigilance function, in conjunction with the new law, to encourage distributors, importers, exporters, health- care institutions, other stakeholders and consumers to report the vigilance events to the MAH and/or NRA;
- Development of vaccine and biological products registration guideline and training registration staff on how to implement the guideline;
- Developing biological products dossier evaluation checklist and guideline;
- Developing biological product registration data management system (database);
- Development of biological products Market Authorization guideline;
- Technical support to develop SOPs for recall system based on documented communication to the appropriate level of the distribution channel with a feedback mechanism;
- Technical support for to develop of policy and/or procedure for recognition and relying on other NRAs decisions.

The newly established NRA for drugs, vaccines and biologicals is a new initiative to establish pharmacovigilance including vaccines and biologicals registration aiming at importing and using safe and effective drugs, vaccines and biologicals in health system of the country. NRA needs further technical support for building capacity enabling NMHRA to fully functional, expand its regulatory authority to all provinces, and take the responsibility of AEFI surveillance for to vaccines and biologicals.

Key challenges pertaining to data availability, quality and use

The denominator problem remains as the total population estimate of the central statistical office (CSO) is 31.6 million while UNIDATA estimate the population in 2018 as36 million inhabitants using the annual growth rate of 2.4%. The SEHATMANDI contracted based on CSO estimation.

The main challenges of DQIP fund flow in 2018 were as follows: (1) MoF introduced CF (Commitment Form) at the beginning of year 2018, but the innovation was not accepted by MoF system. (2) The disbursement from MoF to provincial mustofyat Fund flow at the provincial level; which affects the MOPH's ability to conduct quality and timely supervision and monitoring sessions at the provincial level. (3) The budget was sent to provinces but there was problem with spending it by provincial PHDs.

In response to the first issue, MoF had to return to the previous system. In spite of these challenges, USD 550K out of USD 660K for 2018 were utilized.

4.3. Immunisation financing[5]

- Based on the WB estimates, Afghanistan's total Gross Domestic Product (GDP) was USD 20.815 billion in 2017, which shows a relative increase compared to 2016 (19.469 billion in 2016). Total Health Expenditure (THE) in 2017 was around USD 2.58 billion, an increase by approximately 30% compared to the previous NHA (2014); government expenditure on health was around USD 123 million. THE, as a percentage of GDP, was around 12.7%, an increase of 3.2% compared to 2014. While, the current health expenditure (CHE) as a percentage of GDP was around 11.9% which represents an increase of 2.4 percentage point compared to the previous round of NHA (9.5 %).

[5] Additional information and guidance on immunisation financing is available on the Gavi website https://www.gavi.org/support/process/apply/additional-guidance/#financing

- Approximately 75% of THE is paid by households out of pocket (OOP) that remains the major source of health financing in the country; 5% is financed by the Government of Afghanistan and about 19% - by donors. The Government of Afghanistan manages some of the funds provided by the donors, estimated at around 6% of CHE, whereas the donors managed around 13.6% of health expenditure themselves. The remaining large portion is spent out of pocket and managed by individual households.
- The national budget expenditures for the EPI program were mainly incurred with payment of Government's share under co-financing of GAVI-supported vaccines (Pentavalent, PCV, IPV and Rota) as well as immunization service delivery by BPHS and EPHS. The total financing of the immunization program by Government of Afghanistan has continued its incremental pattern and reached around USD 2 million in 2018 compared to USD 1.5 million in 2017. The major donors to EPI program in Afghanistan are GAVI (ISS, NVS and HSS), WHO, UNICEF, JICA, World Bank, USAID, European Union and GPEI.
- The immunization is part of services being provided by SEHATMANDI project. All the operational cost of the immunization service delivery is covered through Sehatmandi program while UNICEF covers operations cost of vaccine storages in 34 provinces and transportation/handling cost up to the provincial level. However, as the program is provided in an integrated manner it's difficult to disaggregate the financial data by each component of the Sehatmandi. Gavi has supported the immunization service for many years and still remains one of the main donors for Immunization services in Afghanistan. Currently, the funds are being utilized through MoPH, UNICEF and WHO. The cMYP costing projections include operational costs of service delivery, costs of the traditional and new vaccines (PCV-13, IPV and Rota), SIAs, monitoring and surveillance as well as shared health system costs.
- EPI program is part of annual planning and budgeting. However, the government only covers operation cost and co-financing as an integral part of the national health plan/budget.
- Traditional vaccines are covered though a Japanese grant to UNICEF. However, it is more likely that this support may not continue beyond 2019.
- The budget execution for the EPI and HSS programs is satisfactory. Nevertheless, frequent delays occur in procurement of services and goods and transferring funds to provinces. Reporting on financing of immunization programs following regular national budgetary cycle are used for resources allocation and evidence based decision making.

5. PERFORMANCE OF GAVI SUPPORT

5.1. Performance of Gavi HSS support (if country is receiving Gavi HSS support)

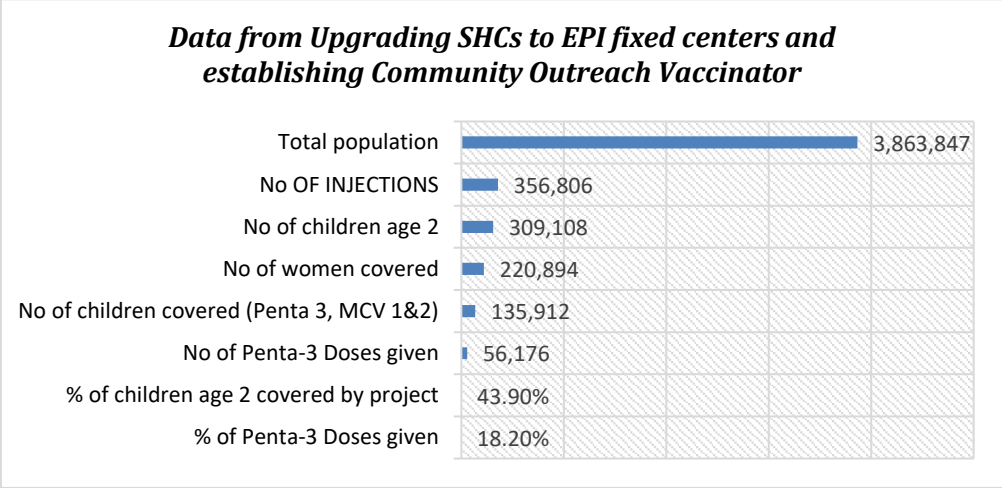
Objective 1	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Enhancement of equitable access and effective coverage of immunization services through integrated public health care system, private health sector-PPPs, and community participation with more focus on underserved population;** *Activity 1.1: Upgrading the 310 existing health sub-centers (HSCs) to EPI service delivery points;* *Activity 1.2: Establishing community-based outreach by vaccinators to cover 2,878 villages;* *Activity 1.3: To continue the 15 MHTs for nomadic (Kuchi) population which are established under HSS;* *Activity 1.4: To continue, scale up and revise the Public Private Partnership PPP (CSO type B) project focused on the delivery of EPI and other essential maternal and child health services in remote and insecure areas;* *Activity 1.5: Supporting micro-planning through RED strategy using CHWs and BASIC tools to improve the immunization services.*
Priority geographies / population groups or constraints to C&E addressed by the objective	**By implementing the Objective 1, equitable and effective immunization services are being provided** to a total population of **3.8** million people through training of female vaccinators , providing cold chain equipment to **208** upgraded HSCs, deployment of **173** community-based outreach vaccinators covering 2,754 villages in "white areas" targeting an additional **4.2** million people covered by continuing service delivery through PPPs (CSO type B) and continuing Kuchi Mobile Health Teams (MHTs) supported by 1,102 CHWs. These four interventions are cost-effective, sustainable and integrated with BPHS and immunization services to build synergies and share costs with BPHS and SEHAT projects, target the inequities and underserved populations and boost the immunization coverage throughout the country. Equity in health care provision is one of the key priorities of MoPH, and BPHS has been designed to be pro-rural and pro-poor, defining the level of HFs by geographical distance as well as the size of catchment population. However, despite significant expansion in BPHS, the access to primary health care remain limited. On average, only **57%** population has access to a health facility within thirty

	minutes walking distance and over 90% could reach a facility within two hours (AHS 2018). Besides physical accessibility, the health services utilization by females is low due to affordability and acceptability of services because they are dependent upon a male member to accompany them to any health facility, and they often need to have a female health care provider. The interventions under objective 1 come under the service delivery component of the EPI program which address the mentioned gaps particularly the routine availability of service to remote rural population and increase the coverage and access to the immunization services such as upgrading sub-health centers to EPI fixed centers and establishing community outreach vaccinators in **17** provinces that covers **3,863,847** populations in hard to reach and remote areas improving equity. The Private Health Providers (PHP) intervention covers 42 districts and **841,321** populations in the **six** insecure provinces. The PHP project has remained effective especially when the security deteriorated in Urozgan province and they were the only option for provision of healthcare when all the public health facilities were closed by AGEs for a temporary period in mid-2018. All upgraded SHCs under HSS were successfully included in the SEHATMANDI contracts except in Zabul due to technical error in inclusion of this province in the list. Upgrading the SHCs with EPI and cold chain has been advocated by the HSS program for sustainable EPI service provision in remote areas targeting inequities and reaching the underserved populations. Priority recruitment of female vaccinators in the new CBOV teams will further improve social accessibility and acceptability of vaccination by women that are not willing to receive vaccines from male vaccinators due to cultural reasons. The Kochi MHTs staff also receive initial and refresher trainings on BPHS components to improve the quality and equitable access of nomads to BPHS and other RMNCH services and also to contribute in polio eradication and measles elimination. 1,102 volunteer Kuchi CHWs who had already been trained will continue to coordinate immunization services at the community level. In addition to that, the required cold chain equipment has also been provided to health facilities which ensures continued access to immunization services. **Constraints:** Security constraints on the way to some of the service delivery points (SDPs), low level of education, low interest for vaccination and social conflicts among nomad tribes.
% activities conducted / budget utilisation	**Activities 1& 2:** In total, 208 out of 310 (67%) planned sub-health centers were upgraded to EPI fixed center and 173 out of 316 (55%) community based outreach vaccinator teams had been established and provide EPI services under HSS funds in 2018. The NGOs received 95% of planned budget based on the payment schedule and 77% of the received budget was utilized by the implementing NGOs. It is worth mentioning, that the NGOs returned 18 % of unspent budget to MoF after submission end of project reports. **Activity 1.3:** 15 MHTs for Kochi population had been established and the required staff recruited. The implementer NGO received the 71%of planned budget, and the utilization rate by NGO exceeded 100%. **Activity 1.4:** All 236 (100%) PHPs in six targeted provinces continued to function; 64% of planned budget was transferred to NGOs and the utilization rate reached more than 100%. It is worth mentioning that in 2017 the budget absorption by the NGOs was low due to previous delays in mapping the PHPs mainly due to security challenges. Therefore, in 2018 the implementer NGOs received only one installment out of four planned for 2018. **Note:** ***The utilization rate is calculated using 2018 annual planned vs utilized. Sometimes, the unspent amount from previous year was carried over to 2018 and it was also utilized along with the planned amount of 2018 cumulatively. This lead to the financial implementation of two fiscal years rendered in one fiscal year i.e. 2018. Therefore, the expenditure exceeded 100%. This means that there is no change in budget line, but instead there is change in utilized amount vs annual planned amount of the year itself****.* **Activity 1.5** The provincial EPI management teams in Kabul, Kandahar, Helmand, Nangarhar and Kunar were trained to develop/re-schedule the HF/District micro-plans and coverage improvement plan for low performing /conflict affected districts/provinces based on the updated micro-plans focusing on populations not reached by immunization services. Four rounds of accelerated immunization activities were conducted in three out of five conflict affected and high-risk provinces based on PPHDs/PEMTs, PEI team, and NIP request. 100% of allocated budget for this activity has been utilized.
Major activities implemented &	***Activity 1&2: Upgrading SHCs to EPI fixed centers and establishing Community Outreach Vaccinators*****:** • The contracts for upgrading SHCs and community based outreach vaccination were ended on June 2018 corresponding to the SEHAT timeframe. However, the SEHAT contracts were extended for another six months till end of December 2018. This affected the decision already

Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption

taken that the Gavi supported upgraded SHCs will be absorbed by SEHAT contracts upon starting up the new contracts. Therefore, the MoPH decided to continue funding the upgraded SHCs under HSS funds for another six months till SEHAT contracts end date. Since the total cost of extensions for upgrading SHCs were exceeding the threshold allowed for "extension" and as per the procurement rules of procedures, the project has been restarted under single source selection with the same BPHS implementers in respective provinces. The GCMU repeated the same procedures and re-new the contracts till end of December 2018. Fig. 20 illustrates the vaccination data of four quarters of 2018.

Fig. 20. Performance of the upgraded SHCs and CBOVs



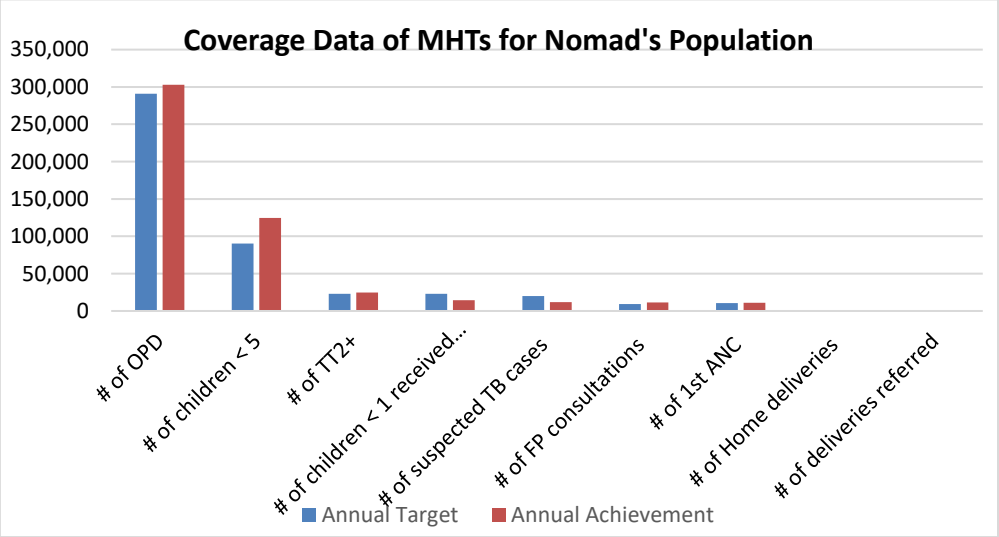
- Following ending the contracts for upgrading SHCs and CBOVs a close out notice was sent to NGOs in December 2018 and they were instructed to hand over the entire upgraded SHCs and CBOV to the next BPHS implementer as per the MoPH hand over guidelines. It was also included in the instructions that the upgraded SHCs will be operated under SEHATMANDI contracts in respective provinces. However, only Zabul province with 22 SHCs was not included by SEHATMANDI team to their RFP. The Zabul SHCs has been included in the 50% HSS funding proposal. At the same time the NGOs were told that the CBOV part of the contract will be still continued under the Gavi HSS funds but a separate procurement process as single source with new BPHS implementers in 20 provinces is needed; the procurement process already started by National Procurement Committee (NPC).

Activity 1.3: To continue the 15 MHTs for nomadic (Kuchi) population which are established under HSS

- All 15 MHTs established and are functional in 12 targeted provinces;
- A total of 224 service delivery points' (SDPs) has been identified in 12 targeted provinces and as average each MHT will cover 15 SDPs per month;
- Nomads population elders (Sarkhails) and influential people had been oriented about provision of MHT services;
- Regular provision of medicines, medical and non-medical supplies for MHTs and CHWs has been ensured;
- 28 out of 60 MHT staff received clinical trainings on IMCI, Basic Emergency Obstetric Care, HMIS, EPI, M&E, Malaria and Leishmaniosis, and Community Based Malaria Management (CBMM);
- Regular monitoring from the MHTs services conducted by M&E central and provincial staff;
- Awareness raising of nomad population on health key messages in particular vaccination and MCH is going on, as well as regular health education sessions have been conducted by all MHTs.

Fig 21. Coverage data by MHTs for nomads

Coverage data:

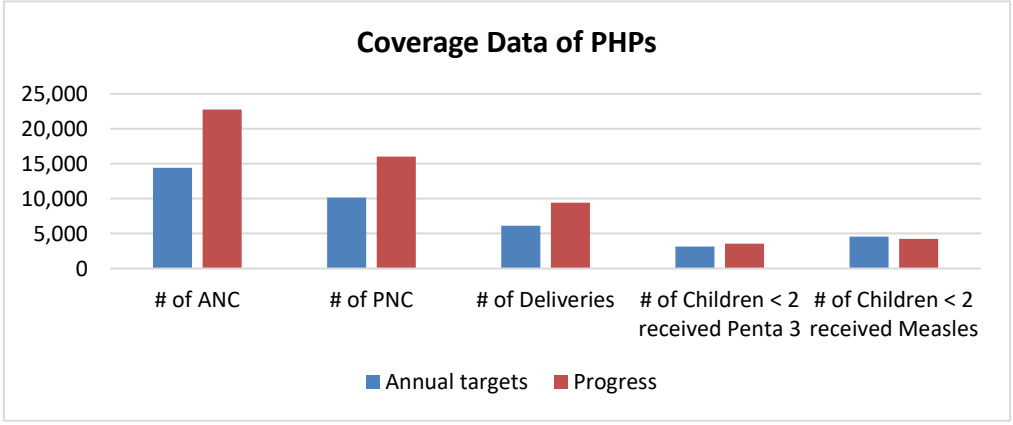


Activity 1.4: To continue, scale up and revise the PPP (CSO type B) project focused on the delivery of EPI and other essential maternal and child health services in remote and insecure areas

- The PHPs continued to operate in six provinces. There were few replacements mainly because of defaulters which have been re-activated by respective NGOs. Moreover, because of the security challenges in Urozgan province around six PHPs were shifted from areas they were operating to the province center temporarily. However, this has been brought to the attention of provincial public health authorities to affirm and remain committed to relocate them to their original places once the security situations are stabilized. The PHPs registered in the HMIS system and the NGOs were instructed to provide the data on quarterly basis.
- PHPs are being supplied with the required medical and non-medical supplies including cold chain and vaccines (for PHPs agree/able to provide EPI services).
- Routine supervision by NGOs and monitoring visits by M&E staff are continuously being carried out from the respective project sites and PHPs.

Fig 22. Coverage data by PHPs

Coverage Indicators:



Note: Budget consumption by NGOs was low because by preceding delays in mapping the PHPs mainly due to security challenges. Therefore, in 2018 these NGOs have received only one installment out of four planned installments.

Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[6]

Activity 1&2:

1. Proposal evaluation, negotiation and award of contract for the implementation of COBV;
2. Project implementation based on the contract;
3. Regular monitoring from the implementation and provision of technical support to NGOs;
4. Start the procurement of urban immunization services upon approval 50% HSS funding proposal;

Activity 1.3

1. Continuing service provision to the nomadic population in 12 provinces;
2. Continuing clinical training of MHTs staff based on plan;
3. Establishing Community Monitoring System;
4. Conducting the Catchment Area Annual Census (CAAC) survey;
5. Continuing CHWs refresher trainings;
6. Establishing Steering committee.

Activity 1.4

1. Continuing the support of PHPs throughout the life of the project;
2. Reviewing the incentive scheme of implementation i.e. data verification and technical assistance if required;
3. Completing the planned trainings for PHPs by NGOs;
4. Monitoring from the implementation of the project.

Objective 2:

Objective of the HSS grant (as per the HSS proposal or PSR)

Strengthening of cold chain and vaccine logistics management system by increasing the physical capacity, maintenance and effective vaccine management (EVM) with provision of adequate infrastructure throughout the country.

Activity 2.1: Expansion of existing cold chain capacity for the introduction of new vaccines and opening of new service delivery facilities.

Activity 2. 2: Capacity building of the cold chain and vaccine logistics managers and initial training for 400 (300 females and 100 male) vaccinators.

Activity 2. 3: Construction of vaccine and non-vaccine storage facilities.

Priority geographies / population groups or constraints to C&E addressed by the objective

Objective 2 aims to **strengthen the cold chain and vaccine logistics management** system by increasing the physical capacity with cold rooms and warehouses and improving the human resource capacity for vaccine management to effectively and efficiently track vaccine supplies with new enabling technology, minimizing delays and wastage.

The cold chain related activities are implemented in all 34 provinces.

Provision of CCE to EPI centre's: 208 out of 310 sub-centres were upgraded to EPI centres', and upgrade of 22 SHCs is in progress. All the upgraded centres are equipped with required cold chain.

Cold chain equipment: the following cold chain equipment was purchased:

50 SDD plus 5 sets of standard spare parts (1/10 SDD), 3 freezers, 135 cold boxes, 440 vaccine carriers, 20,000 icepacks, 2,000 fridge tags, 200 voltage regulators (to avoid the risk of electricity fluctuation), 9,000 freeze tags. 2018 CCE provision is detailed in below table:

Table 2. Cold chain equipment provided in 2018

Items	Planned	Procured/ In pipeline	Balance / Variance	Remarks
Solar Direct Drives (SDDs)	80	50	30	
Spare parts for Solar refrigerators	8	5	3	
Vaccine carrier 1.5-3L	428	440	-12	Amount increased in consultation with NEPI
Icepack,0.6 litres capacity	14,025	20,000	-5975	Amount increased in consultation with NEPI
Cold box, RCW 25	135	135	0	
Cold box Long Term Storage	50	0	50	Will not be procured (decision taken in consultation with NEPI)

Electronic refrigerator logger,30 days	988	2,000	-1012	Amount increased in consultation with NEPI
Irreversible Freeze Indicator	1,500	9,000	-7500	Amount increased in consultation with NEPI
Freezer, Vestfrost MF 314	12	0	12	Will not be procured (decision taken in consultation with NEPI)
Vestfrost MK 304	26	0	26	Will not be procured (decision taken in consultation with NEPI)
Cold room, walk-in type,30 m^3	3	0	3	These will be procured, based upon the requirement (no request during the reporting period)
Freezer room,20 m^3	0	3	-3	Amount increased in consultation with NEPI
Water packs freezer TFW	7	0	7	Will not be procured (decision taken in consultation with NEPI)
Remote Temperature Monitoring Device	1	0	1	Will be procured in 2019
Spare parts for all CC equipment	1	1	0	7 cooling units each for WIC and WIF
Refrigerated vehicle	0	1	-1	Part of 2016-17 procurement plan
Refrigerated pickup	0	7	-7	Procurement in progress
Voltage stabilizers	48	200	-152	Qty increased based on need and consultation with NEPI
Generators 27KV	0	8	-8	Will be procured based upon the need
Fire Extinguisher 25kg, Powder ABC	0	5	-5	It was not in GAVI budget plan, due to urgent need we procure from that grant
Forklift Truck, 03 tons, Diesel	0	1	-1	
Hand Pallet Truck	0	4	-4	

As part of preparation for implementation of CCEOP, ODP was prepared and submitted to UNICEF Supply Division for tendering process. In addition, temperature monitoring study has started and is expected to be completed in two months. Another round (in different season) will be started in cold weather.

Capacity building for cold chain management: During the reporting period, the trainings for installation of Solar Direct Drives (SDDs) were completed in all seven regions. A total of 141 regional and provincial level officials were trained and to date 413 SDDs have been installed and 75 units of cold chain equipment were repaired. This can be listed as success story presenting significant achievement since less than 100 SDDs were installed by the end of 2017.

Construction: The construction activities took place in the selected sites based upon the need of cold chain stores and warehouses. The initial plan was to construct 22 storage facilities for vaccines and dry supplies. 12 more facilities were added in ACE proposal which made the total to 34. The construction projects are divided into three phases (8 in phase 1, 12 in phase 2, and 14 in phase 3). Out of 8 projects in phase 1, 7 are completed. Construction projects of phase 2 are ongoing. Designs for projects in phase 3 are ready, and site assessment is going on. Phase 3 will be contracted soon.

% activities conducted / budget utilisation

Activity 2.1: 100% of planned cold chain equipment procured and distributed to the provinces, and budget utilization is 117%.

Activity 2. 2: *100% of* training on installation of SDD has been completed in seven regions. 100% of SDDs (purchased in 2017) had been installed and installation of 50 SDD, purchased in 2018, is ongoing. 100% of allocated budget was utilized.

Activity 2. 3: *100% of planned structures (8 construction projects) have been completed, construction of 10 projects is going on. Actual budget utilization is 190%.*

Note: *The utilization rate is calculated using 2018 annual planned vs utilized. Sometimes, the unspent amount from previous year was carried over to 2018 and it was also utilized along with the planned amount of 2018. Therefore, the expenditure exceeds 100%. This means that there is no change in budget line, but instead there is change in utilized amount vs annual planned amount of the year itself.*

Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption

***Activity 2.1: Expansion of existing cold chain capacity for the intro of new vaccines and opening of new service delivery facilities*.**

Activity 2. 2: Capacity building of the cold chain and vaccine logistics managers and initial training for 300 female vaccinators and 100 male vaccinators

The trainings for installation of Solar Direct Drives (SDDs) have been completed in seven regions (Mazar, Kunduz, Nangarhar, Herat, Gardez, Kabul and Kandahar). A total of 141 cold chain staff was trained at regional and provincial levels and to date, 413 SDDs have been installed.

UNICEF has contracted an agency for facilitating initial training of vaccinators. The training module has been developed and finalized. The ToT has been completed and the training has been completed in two batches at two locations in Kabul and Herat. MoPH has identified the eligible participants. As per the plan, a total of 400 vaccinators received 3-month initial training (75% female and 25% male). NEPI, UNICEF and WHO have regularly monitored the training, findings were shared and recommendations acted upon in timely manner.

Activity 2. 3: Construction of vaccine and non-vaccine storage facilities

With the support of HSS funds, UNICEF will support following vaccines and non-vaccine storage facilities:

Table 3. Construction of vaccine and non-vaccine storage facilities by phases:

Phase 1:

No	Province	Provincial Warehouse	Regional warehouse	Provincial cold room (or PEMT office)	Regional Cold Chain Building	NEPI Building	Remarks
1	Balkh		1				Completed
2	Paktya		1				Completed
3	Kunduz		1				Completed
5	Logar			1			Cancelled
6	Ghazni			1			Completed
7	Takhar			1			Completed
8	Baghlan			1			Completed
9	Zabul			1			Completed
Total		**0**	**03**	**05**	**0**	**0**	

Phase 2:

No	Province	Provincial warehouse	Regional Warehouse	Provincial cold room (or PEMT office)	Regional Cold Chain Building	National EPI Building	Remarks
10	Parwan	1					On going
11	Bamyan	1					Contract awarded – Physical work to be

							started by end of Apr 19
12	Paktika	1					Evaluation in progress
13	Badakhshan			1			On going
14	Sarepul	1					On going
15	Faryab	1					On going
16	Ghore	1					On going
17	Badghis	1					On going
18	Kapisa	1					On going
19	Balkh				1		On going
20	Samangan	1					Pending due to change in location
21	Kabul					1	Design approval pending at MUDA
Total		**09**		**01**	**01**	**01**	

Phase 3:

No	PROVINCE	Provincial warehouse	Regional Warehouse	Provincial cold room (or PEMT office)	Regional cold chain building	National EPI Building	Remarks
1	Panjsheer	1					Site assessment to be done (hiring of consultancy firm is in final stage)
2	Daikundi	1					
3	Khost	1					
4	Jowzjan	1					
5	Nooristan			1			
6	Logar	1					
7	Ghazni	1					
8	Baghlan	1					
9	Takhar	1					
10	Badakhshan	1					
11	Herat		1		1		
12	Nangarhar				1		
13	Kunduz				1		
Total		**09**	**01**	**01**	**03**	**0**	

Summary:

Provincial warehouse	Regional warehouse	Provincial Cold Chain Buildings	Regional Cold Chain Buildings	National EPI Building
18	**04**	**07**	**04**	**01**

The need for construction of cold store rooms and warehouses has further been supported by the findings of recently concluded EVM assessment that indicated shortage of cold chain space. EVM was conducted in April 2018, and final report was shared.
The major challenges are to obtain approval from the Ministry of Urban for designs of construction projects and frequent change in project sites (land) by provincial health departments and other sub-national authorities.

Major activities planned for upcoming period (mention significant	***Activity 2.1:*** Installation of remaining 108 SDDs, procurement of remaining cold chain equipment planned for 2019, completion of temperature monitoring study, initiation of CCEOP project (if supplies reach the country). MoPH has requested Gavi to de-link the CCEOP in-country operational support and

changes / budget reallocations and associated **changes in technical assistance**[6]	let country partners take over the responsibility. The request was sent along with justification, and feedback from Gavi is expected. ***Activity 2.3:*** Construction of phase 2 will be completed, and phase 3 will be contracted.
Objective 3:	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Improvement of demand for immunization services by implementing context specific communication interventions to cover the disadvantaged population.** *Activity 3.1: Increasing awareness and promoting immunization through the mobilization of religious leaders.* *Activity 3.2: Implementation of BCC activities through mass media, ICT and IPC.* *Activity 3.3: Evidence and Knowledge Generation (KAP Survey).*
Priority geographies / population groups or constraints to C&E addressed by the objective	The demand generation activities are being implemented in all 34 provinces. The KAP survey was conducted in 420 villages of 84 districts in 21 randomly selected provinces. The religious leaders training is planned to be conducted in 17 provinces, the school teacher and frontline health workers training will be conducted in 20 provinces and the HIC counsellors provide counselling to the general public health queries throughout the country via 166 toll free number for promoting health programs esp. immunization by using mobile phone technology.
% activities conducted / budget utilisation	**Activity 3.1:** 100% of activities completed, and actual fund utilization is 103% **Note:** *The utilization rate is calculated using 2018 annual planned vs utilized. Sometimes, the unspent amount from previous year was carried over to 2018 and it was also utilized along with the planned amount of 2018. Therefore, the expenditure exceeds 100%. This means that there is no change in budget line, but instead there is change in utilized amount vs annual planned amount of the year itself.* **Activity 3.2:** • 30% school teachers and frontline health workers have been trained on IPCC and BCC focused on immunization in three regions. The implementer NGO received 100 % of the planned budget through four instalments based on the contract payment schedule and 71% has been utilized. • The procurement process of Health Information Center (HIC) was completed in 2017 and was sent to national procurement commission (NPC) for approval along with the procurement files by early 2018. There were several investigations on every detail of the procurement process including several meetings between the MoPH and NPA officials. Upon provision of answers to the questions raised by NPA in a written form, the procurement process of HIC was satisfactorily accepted by the NPC and the contract was signed with the winner organization following its approval by NPC in March 2019. • In total, 2,720 minutes of radio spots for public awareness on immunization have been aired through local radios across 34 provinces and 100% of planned budget utilized. • 60 health workers from national hospitals received training on Inter Personal Communication and Counselling (IPCC) and Behaviour Change Communication (BCC) focused on immunization and 100 % of planned budget has been utilized. **Activity 3.3:** 100% of planned activity is completed, and actual fund utilization is 111%.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	**Activity 3.1:** ***Increasing awareness and promoting immunization through the mobilization of religious leaders.*** • The National EPI, in close collaboration with the Ministry of Haj and Religious affairs, is conducting training for religious leaders on importance of vaccine and immunization from Islam perspective. The training content consists of both basic information about EPI program and vaccines and Islamic point of view about vaccine and prevention of diseases. The master trainers were selected by NEPI and Ministry of Haj and religious affairs. The training modality included TOT for master trainers and cascade training in selected provinces. It is intended that trained religious leaders support EPI program and provide messages about importance of vaccination during their Friday speeches from their respective mosques and in other local events. In the TOT, a total of 27 master trainers of nine provinces including Kandahar, Helmand, Zabul, Uruzgan, Farah, Nangarhar, Laghman, Kunar and Nooristan were trained. The master trainers in consultation of REMTs and

	PEMTs and Provincial Directorate of Haj and Religious affairs planned one-day training for religious leaders. To date, a total of 3,030 religious leaders have been trained in 68 districts. **Activity 3.2:** ***Implementation of BCC activities through mass media, ICT and IPC.*** • The school teachers and frontline health workers training was contracted with the winner NGO that has been selected through an open bidding process by GCMU on March 2018. During the preparatory period, project staff has been hired and received five-day ToT training at national level. A Learning Resource Package (facilitators and participants training manuals) was developed and approved by Technical Working Group consisting of NEPI, school health, monitoring, HSS, HPD, UNICEF and MoE. Subsequently, for proper collection of the participants' data a training database was developed. A strong coordination network was established at the national and sub-national level including relevant stakeholders such as provincial economy directorate, PPHD, education directorate and BPHS implementing NGO. During the reporting in total, 6,939 frontline health workers (473 vaccinators, 74 pharmacists, 689 nurses, 427 midwives, 363 medical doctors, 126 lab technicians 4,565 CHWs and 223 CHSs) and 4,477 school teachers) have been trained at the target provinces/districts and were regularly monitored by M&E officer and/or regional coordinators using monitoring checklist developed by monitoring and health promotion departments. Meanwhile periodic joint monitoring conducted by HPD, NEPI, school health and monitoring departments. • The Health Information Centre (HIC) has been contracted out with the winner NGO after one-year delay in National Procurement Committee with a total budget of $ 859,648 to provide counseling and information through 166 toll-free helplines on the health issues mainly immunization and referring the caregivers to take their children to the health facilities for vaccination. The project is in its inception phase and the inception payment has been done upon submission of inception report. **Activity 3.3:** The KAP survey was conducted in 420 villages of 84 districts in 21 randomly selected provinces. The results were shared with partners, and incorporated into the EPI communication strategy.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[6]	**3.1 Increasing awareness and promoting immunization through the mobilization of religious leaders.** Significant delay in implementation of religious leader's training has been observed. Country partners suggested to outsource this activity aiming to speed up the process. ToR is being developed, and activity will be contracted soon. **3.2: Implementing multi-pronged behavior change communication activities through mass media, local media, ICT and IPCC/BCC** • Providing IPCC and BCC trainings focused on immunization coverage and equity to the 9,923 school teachers and 17,061 frontline health workers as per the project work plan at target provinces at district levels and regularly monitoring the project. • Providing counselling and information to the public esp. caregivers on immunization and referring them to the nearest health facilities for vaccination through HIC 166 toll-free helplines. • Airing 2,000 minutes of radio spots for increasing public awareness on immunization though local radios across 34 provinces. • Developing and printing IEC materials for promotion of immunization services. • Training of 216 hospital based health workers at regional levels on IPCC and BCC focused on immunization.
Objective 4	
Objective of the HSS grant (as per	**Strengthening of management and leadership capacity of the decentralized health system at peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services:**

[6] When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

the HSS proposal or PSR)	*Activity 4.1: Improving supportive supervision and monitoring of BPHS HFs at different levels with more focus on decentralization* *Activity 4.2: Conduct Periodic evaluations to ensure accountability for equity at district and provincial level.* *Activity 4.3: Improving the data flow system and improvement of HR accountability at national and sub national level* *Activity 4.4: Internal Audit system strengthening, procurement and finance system strengthening based on FMA 2012 findings to ensure the accountability of NGOs performance.*
Priority geographies / population groups or constraints to C&E addressed by the objective	The objective 4 aims to strengthen the health system management through decentralization of planning and monitoring to peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services. The monitoring of grant implementation and NGOs performance at national level is the responsibility of the monitoring directorate and at the sub-national level it is the responsibility of Provincial Health Directorates. In addition, 250 District Health Officers (DHOs), who were introduced in the health system of Afghanistan with Gavi HSS1/other donors and are now supported by the Government of Afghanistan under the provincial structure, also contribute to the monitoring of insecure districts where HSS grant is being implemented. The expected intermediate result is an increase in proportion of provinces in where 48% and 36% of existing BPHS and EPHS HFs respectively monitored by PPHOs and DPHOs and 54% of the HFs of all provinces are monitored by central monitoring teams during 2018. **Constraints:** Insecurity in some provinces hindered appropriate and effective monitoring visits of some HFs, lack of female staff within monitoring structure that makes difficult for male monitors to monitor some services which are gender sensitive mainly those services provided to pregnant women in labor and health services delivery in the OPD and delivery room.
% activities conducted / budget utilisation	***Activity 4.1:*** 36% of districts and 48% health facilities monitored and 271 provincial staff received M&E decentralized system training and 69% of planned budget utilized in the reporting period. ***Activity 4.2:*** *Data Quality Self-Assessment were not conducted in 2018* ***Activity 4.3:*** *The two* databases for residency specialization program and students essay research of internship program still in progress ***Activity 4.4:*** The Internal Audit Policy and Strategy and Anti-Corruption mechanism has been finalized and ready for MoPH approval.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	**Activity 4.1** 36% of districts and 48% health facilities monitored by PPHOs and DPHOs during the reporting period and 54 % of all provinces monitored by central M&E team. In total 271 PPHOs, DPHOs, EPI supervisors and M&E officers and implementer NGOs' supervisors received training on strengthening the M&E decentralized system. In total 462 health facilities in 9 piloted provinces were monitored by PHOs and DHOs using GLM technology and the data has been synchronized in M&E data base. Insecurity in some provinces hindered appropriate and effective monitoring visits of some health facilities; lack of female staff within the monitoring structure makes it difficult for male monitors to monitor some services that are gender sensitive namely those provided for pregnant women in labor and health services delivery in the OPD and delivery room. As a result of monitoring visits in the EPI program, the following actions have been taken at the facility level, 1) female vaccinator hired for the vacant positions 2) vaccine supply mechanism strengthened and 3) the EPI officers and supervisors were trained in monitoring & supervisions technics.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in**	***Activity 4.1: Improving supportive supervision and monitoring of BPHS HFs at different levels with more focus on decentralization*** • 25 monitoring visits from BPHS, EPHS and HSS relevant projects in each quarter • Strengthening and continuing GLM project in 9 piloted provinces • Evaluating the GLM piloted project • Conducting decentralization training for PPHOs, DHOs and M&E officer/ NGOs supervisors • Convert and developing of GLM technology from windows to android system • Expansion of GLM project • Developing and designing of a community based monitoring system as piloted strategy for three insecure provinces

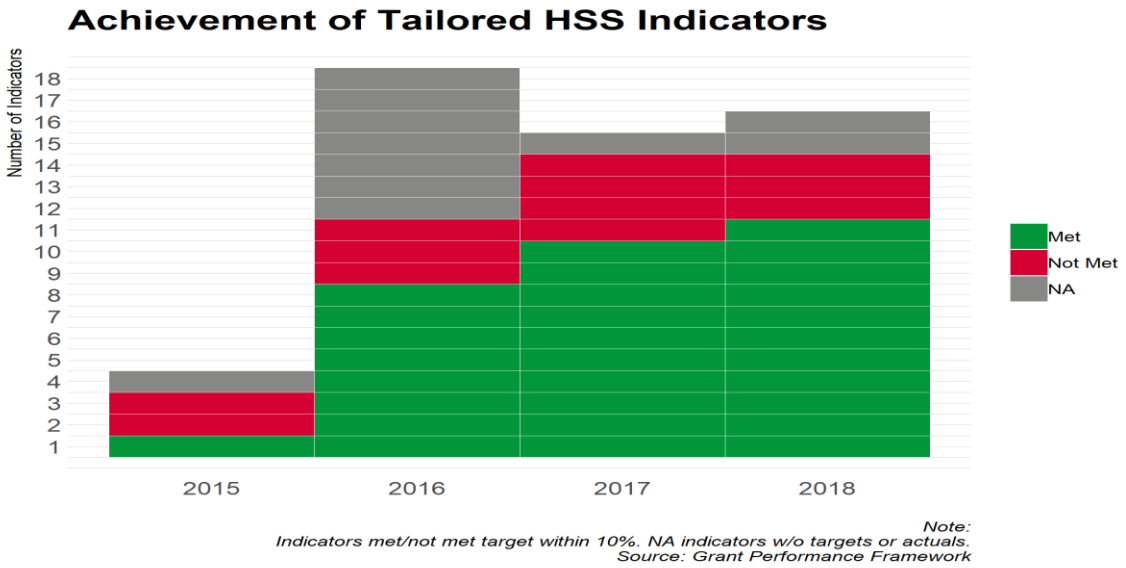
technical assistance[7]	

HSS 3 grant

The third Health System Strengthening (HSS3) program commenced in June 2016 following a Program Capacity Assessment (PCA) held in March/April 2016. With the approval of USD 7.6 million additional funding, the budget allocation has been increased as follows MOH $20,9m (45, 9%), UNICEF $22,9m (50,3%), WHO $1.7m (3,8 %).

The majority of the initial activities under HSS3 remain relevant and contribute to increase of the coverage and equity. Despite overall security challenges, the HSS3 implementation progress on the right track however the implementation of activities that have been contracted out to the NGOs slowed down which resulted in low budget absorption.

With the implementation of three major interventions such as upgrade of SHCs/ Community Based Outreach Vaccinators (COBV) in 17 provinces, Kochi MHTs in 12 provinces and Improve access to and scale up maternal and child healthcare services (PHP) in six insecure provinces, totally 149,439 children <2 and 241,773 women received Penta3, MCV1 and TT2 vaccines respectively.



Afghanistan has been selected as one of the third wave countries for the Global Financing Facility (GFF). In fact, a governance structure has been established to oversee the integration of GFF into the wider health strategy. Significantly, the GFF avails considerable opportunities for the country, including its emphasis on adolescent and reproductive health and health financing. Furthermore, the GFF contributed to the current SEHATMANDI project extensively and duly fills the funding gap in terms of BPHS and EPHS implementation.

The national EPI has been providing a number of private hospitals with vaccines and supplies when these hospitals were willing to provide immunization free of charge, using their own staff and refrigerators, as part of their service package. Start-up private health facilities had a high interest in providing this public good, but their involvement seemed to wane after their clientele base had become established. This intervention had limited success and also raised quality concerns, partly because the MoPH had limited means to ensure quality and supervise the hospital employees that performed the immunizations, often part-time.

The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) are implementing by Non-Governmental Organizations (NGOs) under contracting-out mechanism through Sehatmandi project. The

[7] When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

World Bank, USAID, EU, GFF and Canada government had been supporting Sehatmandi and the World Bank is doing administration work of Sehatmandi on behalf of donors.

The majority of Gavi funded interventions also is being implementing through BPHS and EPHS implementers' NGOs and civil society organizations following open and competitive bidding process in different provinces of the country. The procurement of mentioned Interventions is performing thorough the GCMU/MoPH and National Procurement Authority (NPA) which is led by H.E president of Afghanistan.

a. **Performance of vaccine support**

NVS introduction and switch:
Rota vaccine introduced in 2018, all planning including capacity building of program managers and vaccinators, validation of cold chain availability, plan for vaccine logistic management, demand generation and social mobilization was completed in 2017. The vaccine was launched in Afghanistan in January 2018.The implementation has been smooth and there has not been any stock out of vaccine at any level. Since the Rota vaccine was introduced at the end of January, it resulted in low coverage of Rota-1 and Rota-2 vaccine 75% and 60% respectively.
There was shortage of Rota vaccine at national cold room and one of regions (East/Nangarhar), the main reason was the shipment issues "delayed shipment". As it was supposed to be arrived at 10th may 2018, but finally arrived at 13th June. It is worth to mention the shortage did not happen in other PEMTs and HF level all over the country.

Campaigns/SIAs:

1. **Measles follow-up campaign:**

Measles SIAs that targeted children 9 month–10 years of age with one dose of measles vaccine irrespective of vaccination status or disease history was conducted in two phases. The readiness assessment was conducted with more than 88% national score. One national monitor was assigned for each province to facilitate and support provincial team for developing of measles SIAs micro-plain, preparation, monitoring of the training courses and implementation process, and sharing daily feedback to the national coordination team.

- During campaign 12,616,665 out of 13,7055,901 children (9 m – 10 Years) received one dose of measles vaccine, with an average coverage of 92% at national level.
- Strong commitment of authorities (Inauguration/ceremony of measles SIAs by his Excellency Minster of Public Health) & UN partners.
- Very high community demand for measles vaccine over the country.
- Measles vaccination card provided for target children to prove vaccination coverage by conducting post campaign evaluation survey.
- Successful negotiation of field technical staff in some provinces with AGE.
- AEFI surveillance was one of the components of training for all category of staffs, which were involved in the SIAs.
- Establishment of Provincial AEFI committee to closely follow up AEFI reported cases.
- There has not been any vaccine/logistic stock out including vaccine and non-vaccine supply observed during the SIAs and good safe disposal /waste management applied.
- Less than 10 % vaccine wastage.
- No any evidence of missed part or cluster/village has been reported from the field.
- Major problems and challenges during the SIAs
  - Late start of measles operation in Paktya, Ghazni, Badghis and Ghor provinces due to insecurity.
  - Internal displacement of population due to insecurity.
  - Not accurate denominator in some provinces due to change and population density compared to UN-Data.
  - Reaction of field staff against outsourcing of transport for SIAs operation.
  - Weak participation of NGOs in the all aspects of measles SIAs.

Communication activities for MCV campaign: Based on the Measles SIA communication plan, the Measles IEC materials were designed in local languages (Dari and Pashto) and after thorough review by communication sub-committee established at MoPH, the materials were revised, tested and finalized. A total of 13,200 banners, 4,550 flags, 20,500 posters, 1,270,000 leaflets and 1,0250 brochures were printed for both phases of Measles SIA. A brief guideline about the distribution and use of IEC/BCC material was also developed to enable the REMTs and PEMTs to systematically distribute the material to health facilities, vaccination teams and the community.

Mass media campaign: has been conducted during the year 2018. The purpose of the mass media campaign was to raise awareness on RI for people, measles SIA through national and sub-national TV and Radio stations using Routine Immunization messages and Minister of Public Health message about measles SIA. The RI and measles specific video and

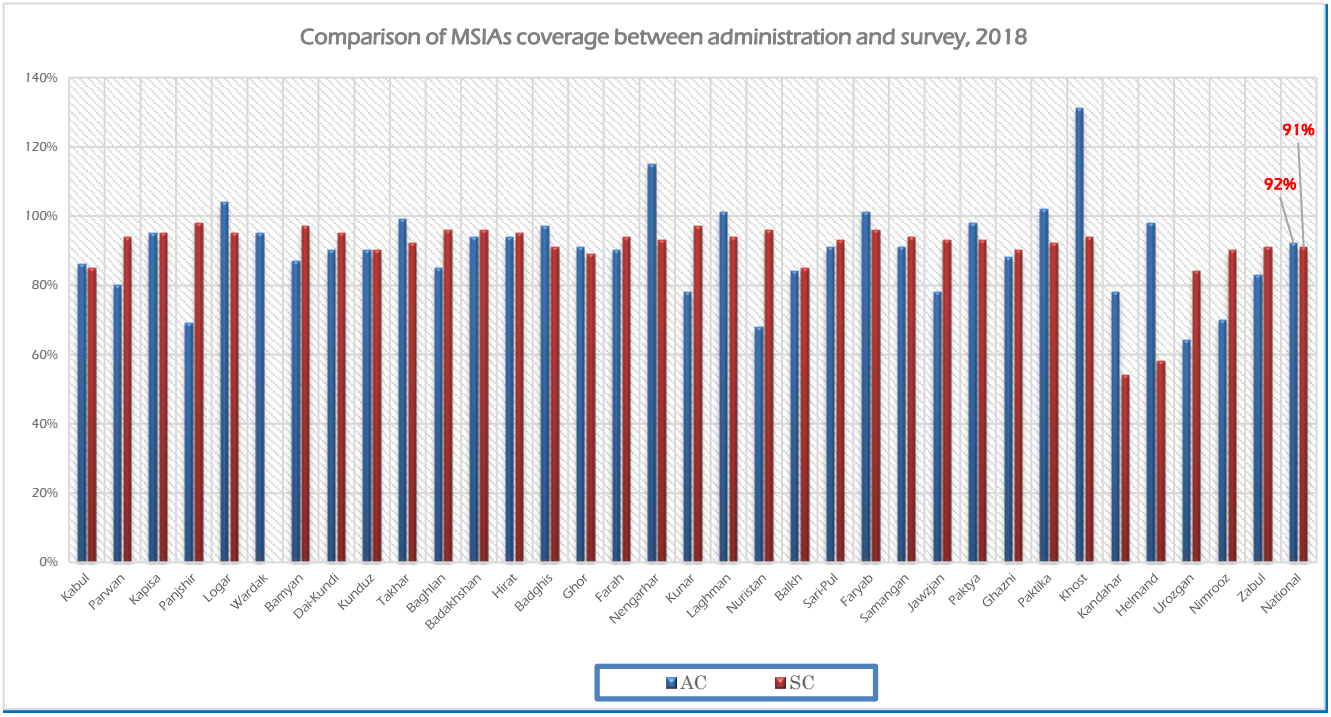
audio clips were produced in both national languages (Dari and Pashto) and broadcasted according to the media plan during the year and during both phases of the Measles SIA. A total of 36 TV and 78 radio stations broadcasted the Routine Immunization and Measles messages, and both phases of measles SIA. 4,423 TV and 14,898 radio insertions were broadcasted using different Gavi funds.

Post- MSIAs coverage survey:

As planned, coverage survey was conducted in 33 provinces. Post-MSIAs following phase I and phase II in randomly selected samples throughout the country. Sampling done to obtain a coverage estimate for a region of +/- 10%.

The data collection for the coverage survey targeting all provinces covered during the Phase I and II of measles SIAs. A two-day training workshop conducted to 132 coordinators/supervisors who had at least a first degree in Health or the Social Sciences. The training courses conducted by a team from MOPH and WHO. The training concentrated on the study instrument, enumeration area map reading. Training completed one month after the campaign, though data collection delayed for administrative reasons. Data collection piloted in Kabul city that helped to assess the quality of the data before involving other areas. Thereafter data collection was done in 33 provinces and data was compiled at national level. A total of 724 data collectors and 180 supervisors had been trained for 2 days in Kabul. Each supervisor was responsible for 2-3 teams of data collectors. The MSIAs coverage survey based on a stratified 3-stage cluster sample. Provinces defined as the strata, districts as the first stage cluster, enumeration areas (EAs) the second-stage cluster, and households the third stage cluster on all eligible age children within selected households collected/will be collected. The WHO regional office has supported in random selection and development of sampling frame.

Fig 23. Comparison of administrative and survey MSIAs coverage, 2018



2. NIDs and sub-NIDs:

Three NIDs and more than 6 sNIDs conducted in 2018, targeting 9.9 million (NIDs) and 4-6 million (sNID) children aged 0-59 months. Using these opportunities, the "Vitamin-A" also been provided for children of 6-59 months' children as well as Albendazol tablets for children between 2-5 years. Around one million targeted children remained unvaccinated during these campaigns mostly in the south of country due to insecurity.

Situation Analysis for Measles/Rubella:

The national measles/rubella surveillance with lab support has reached the capacity to detect MR cases/outbreaks and take timely corrective actions. Totally, 2,954suspected cases of measles detected/samples tested during 2018, of which 2,004 cases were positive for measles and 37 cases were positive for rubella. The total number of MNT cases reported during 2018 is 23. The national immunization guidelines/tools, VPD surveillance guidelines and AEFI surveillance guidelines were updated/printed/distributed and used during training courses. After implementation of national measles SIAs, the incidence of measles dropped down significantly. The 2018 measles virus circulating in Afghanistan was type B as detected by RRL. The quality of national lab performance was 100% as per RRL. Below table shows measles situation in 2018:

Table 4. Measles cases in 2018

Country	Total suspected cases for M/R	Measles case finding report						Rubella case finding report					
		Specimens tested for measles	Lab confirmed	Epid link	Clinical compatible	Total Measles cases	Discarded cases	Specimens tested for Rubella	Lab confirmed	Epid link	Clinical compatible	Total Rubella cases	Discarded cases
Afghanistan	2954	2980	2004	0	0	2012	968	961	37	0	0	37	924

Describe key actions related to Gavi vaccine support in the coming year

In the year 2018-19, Government of Japan will support the traditional vaccines viz. BCG, Hepatitis B (birth dose), TT, Measles and OPV. The IPV, Pentavalent, PC and Rota vaccines are being provided through Gavi support.

Afghanistan is not eligible to introduce the MR vaccine in the routine program because as recommended, the country doesn't have Penta3 coverage ≥70% and also doesn't meet one of the following two criteria:

- Routine MCV1 coverage ≥ 80% for the last three consecutive years (as determined by WUENIC released July 2016), OR
- Measles SIA coverage ≥ 80% (by a reliable coverage survey) in the most recent nationwide measles campaign.

a. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)

Gavi has approved CCEOP proposal in March 2019 for the total cost of USD 9.9 million. The CCEOP project funding had a ceiling from GAVI for $7.5 million and deficit money was included to be sources through 50% HSS additional funding proposal (proposal was recently approved with clarifications). A total of 1,499 SDD will be purchased. Types of equipment are summarized in below table.

Table 5. Cold chain equipment to be provided under CCEOP

Supply chain level	Models	Extension	Expansion	Replacement
Large service delivery (Solar)	TCW 2043 SDD	2	73	2
Small service Delivery (Solar)	TCW 40 SDD	53	151	778
Province (Solar)	VLS 154		3	0
Small Service delivery (Electric)	VLS 200 A		109	148
Large service delivery (Electric)	VLS 300 A		41	0
Province (Electric)	VLS 400 A		73	66
Grand Total		**55**	**450**	**994**

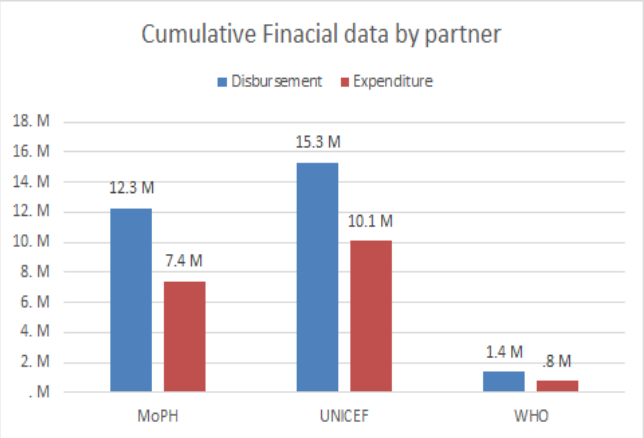
Country partners have developed and finalized Operational Deployment Plan (ODP) and submitted to UNICEF Supply Division for tendering. The tendering/procurement has been requested to happen in one go while the project execution will be completed in three years. MoPH has requested Gavi (along with justification) the implementation of in-country operation be de-linked and implemented by country partners.

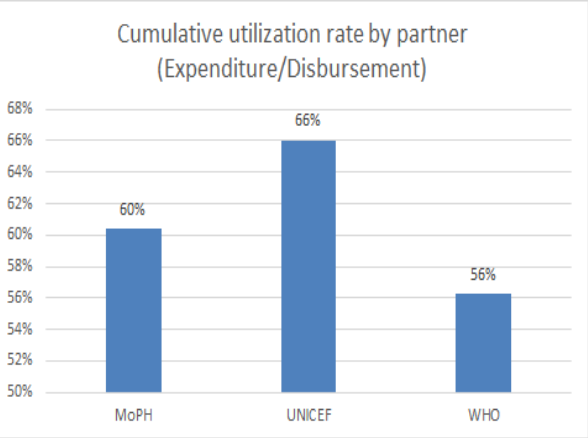
b. Financial management performance

- HSS3: The HSS3 grant covers a period of 4 years from June 2016 to May 2020. An estimated budget of USD 47,500,000 is approved for implementation of GAVI HSS3 jointly by three lead implementers MoPH, UNICEF and WHO. The financial performance of HSS3 support is showed in the graph below.
- **Compliance with Financial reporting requirements and audit:**
- For HSS 3, the 2018 audit is under way and the final report will be available by end of June 2019.
- For HSS 3, UNICEF and WHO 2018 financial statements were also submitted by their respective HQ to Gavi.
- Steps have been taken for the 2018 DQIP external audit.

Financial performance of the portfolio:

- ***HSS 3 Performance:***
- By end of May 2019, the utilization rate for the HSS3 is 63% (Total Expenditure/Total approval for the period July 2016 to December 2018).
- MoPH, UNICEF and WHO have respective burn rates (Total expenditure/Total budget) of 60%, 66% and 56% by end of December 2018.
- This shows a good improvement compared to the burn rate by end of 2017 that was only 35%.
- However, the current financial performance is still sub-optimal. This is mainly due to delays at different levels and mainly with regards to low absorption capacity of implanting NGOs, delays due to lengthy procurement process by National Procurement Committee and National Procurement Authority (NPC & NPA).
- It is now expected that the implementation pace would be accelerated as the issues encountered at the start of the implementation are countered. However, the country will develop an acceleration plan to catch-up on the delays.
- Please see below, a chart summarizing the financial performance of the HSS support overall and by partner.

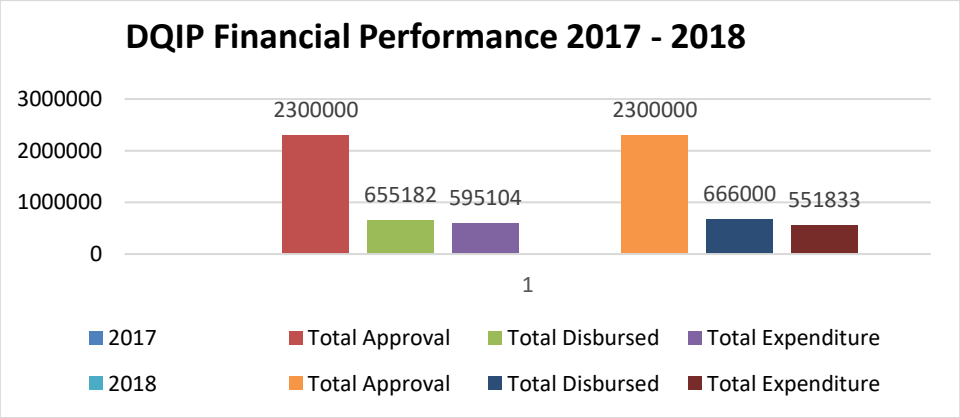




DQIP Performance:

By end of December 2018 almost all DQIP planned activities were conducted and from USD 666,000 allocated budget total 551,833 USD (83%) were utilized, although there was some difficulty in fund flow at provincial financial departments (Mustofeyats) but the new proposed modality of fund transferring for provincial supportive supervision were introduced which the supportive supervision budget directly is being transferred to the bank account of data officers.

Financial performance of the DQIP support.



c. Transition plan monitoring (applicable if country is in accelerated transition phase)

If your country is transitioning out of Gavi support, specify whether the country has a transition plan in place. If no transition plan exists, please describe plans to develop one and other actions to prepare for transition.

NA

d. Technical Assistance (TA) (progress on ongoing TCA plan)

UNICEF:

Development of Immunization communication training guideline: MoPH and UNICEF team have developed communication for immunization training guideline. The guideline is used to train and develop the capacity of EPI provincial staff and communication focal points on communication for immunization, demand generation aiming to build their capacity and implement demand generation interventions in their concerned provinces.

Development of EPI communication strategy: EPI communication strategy including its operational plan were developed. Formal endorsement will follow soon.

Development of training guideline RI for polio ICN team: Training guideline has been developed and finalized to be used for training of polio ICN staff. The training guideline is used to build capacity of polio social mobilizers and their involvement in Routine Immunization demand generation activities at the grass root level. Preparation for the training is going on.

WHO

Vaccines/biologicals registration and post marketing surveillance:

The following activities carried out by NMHRA and NIP with the support of WHO 1) an introductory workshop to introduce biological products registration for 40 staff of NIP and NRA. 2) WHO EMRO and HQ provided technical support to a training workshop on vaccine registration and AEFI surveillance for 50 staff of pharmacovigilance and national EPI staff. 3) The newly established NRA for drugs, vaccines and biologicals is a new initiative to establish pharmacovigilance including vaccines and biologicals registration in health system of the country. NRA needs further technical support for building capacity enabling NMHRA to be fully functional, expand its regulatory authority to all provinces, and take the responsibility on AEFI surveillance.

Convergence of WHO PEI staff in EPI to provide technical support in RI planning, monitoring, and surveillance

PEI established a procedure on monthly reporting on the zero routine dozers among 0-59 month in January 2018; the reports are well recognized by NEPI and EOC and shared with BPHS NGOs for their follow-up and immunization of unvaccinated AFP cases and their communities; PEI field staff visit four fixed, outreach and mobile routine immunization sessions and fill in supervisory checklists. The results are analyzed and shared with NEPI and EOC on the monthly basis from March 2019; PEI provided technical support to the development of package of documents on the micro planning in Kandahar.

VPD surveillance

The VPD surveillance data reported regularly analyzed and provided to MOPH, WHO and other interested organizations. WHO has been supporting MOPH in establishing 4 new surveillance sites with the required equipment, reagents and recording/reporting materials in the regional labs of Balkh, Jalalabad, Kandahar and Herat children hospitals and regional labs and one additional children hospital (Maiwand Child Hospital) in Kabul city. Prior to the establishment of labs/surveillance, the WHO together with NIP and CPHL conducted a need assessment of all five sites (hospitals/labs). Based on the assessment, the team developed a plan of actions for establishing five new VPD surveillance sites. The list of equipment including cold chain, lab reagents, IT equipment, supplies and recording/reporting materials and renovation of labs prepared and WHO procured internationally and provided the following items to the labs/hospitals during 2018.

In addition, the required recording and reporting materials were developed, printed and distributed to the new surveillance sites. The database for CRS and intussusception developed and used in surveillance. The WHO database for MR, Rotavirus and IBD readily available and staff trained to use it. WHO provides reagents on quarterly basis to all labs as the shelf life of reagents are short. Meanwhile, during the assessment staff for surveillance sites selected in consultation with PPHDs and directors of hospitals. The 48 surveillance officers and lab technicians trained and the five new sites are functional.

Measles/Rubella surveillance:

The national measles/rubella surveillance with lab support has reached the capacity to detect MR cases/outbreaks and take timely corrective actions. Totally, 2,954 suspected cases of measles detected/samples tested during 2018, of which 2004 cases were positive for measles and 37 cases were positive for rubella. The total number of MNT cases reported during 2018 is 23. The national immunization guidelines/tools, VPD surveillance guidelines and AEFI surveillance guidelines were updated/printed/distributed and used during training courses. After implementation of national measles SIAs, the incidence of measles dropped down significantly. The 2018 measles virus circulating in Afghanistan was type B as detected by RRL. The quality of national lab performance was 100% as per RRL. Table 6 below shows measles situation in 2018.

Table 6. Measles and rubella cases in 2018

Country	Measles case finding report							Rubella case finding report					
	Total suspected cases for M/R	Specimens tested for Measles	Measles lab confirmed	Measles Epi-Linked	Measles clinically compatible	Total Measles	Measles discarded cases	Specimens tested for Rubella	Rubella lab confirmed	Rubella Epi-Linked	Rubella clinically compatible	Total Rubella	Rubella discarded
Afghanistan	2954	2980	2004	0	0	2012	968	961	37	0	0	37	924

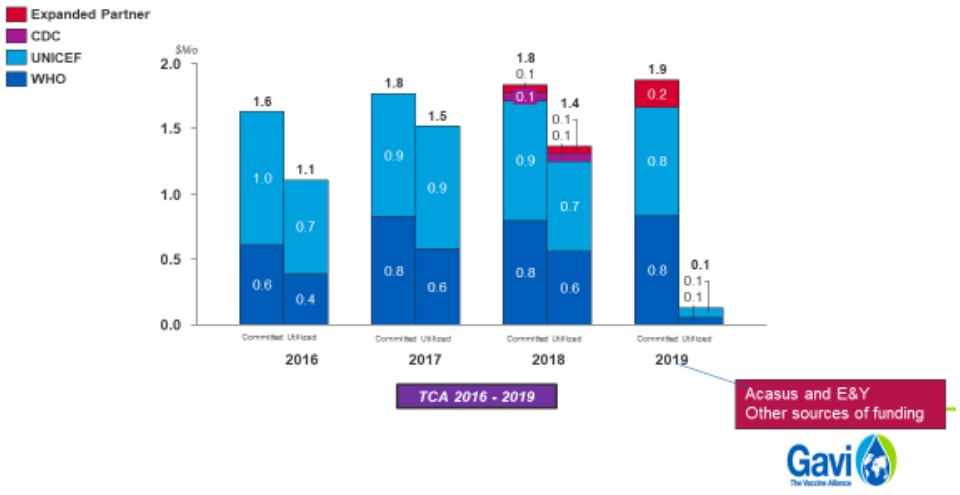
CRS Surveillance: CRS surveillance started in 2018 through five surveillance sites.

Rotavirus surveillance & Intussusception:
During September- November 2018, the 4 new sites detected/tested 1,725 samples, of which 545 (32%) were positive for rotavirus. Totally, 54 suspected intussusception cases detected, of which 25 received two doses of rotavirus vaccine. 5 out of 54 detected patients died, one missed and 48 underwent surgical operation and have survived.
Improving immunization coverage rates of birth doses of vaccines (BCG, Hepatitis B and OPV0): WHO provided technical and financial support to PPHDs in conducting a two-day training courses for 54 midwives and nurses from public health institutions where services for birth delivery are available. The objective of the course is to provide knowledge and skills in proper of vaccination of newborns with Hepatitis B vaccine, OPV0 and BCG soon after birth and around the clock.

Update/revise cMYP 2015-2019: WHO together with NIP and with inputs from all partners has updated the immunization cMYP in 2018. The current cMYP is valid up to the end of 2019 and needs to be updated/developed by the end of 2019.
RI data quality WHO provided laptops and other office equipment to the national EPI and provincial EPI data management staff
Vaccine safety & injection safety and AEFI training course: WHO provided technical and financial support in conducting the training courses of vaccine/injection safety and AEFI surveillance for 80 trainers, managers and supervisors from all the provinces.

(Update as of September 2019)

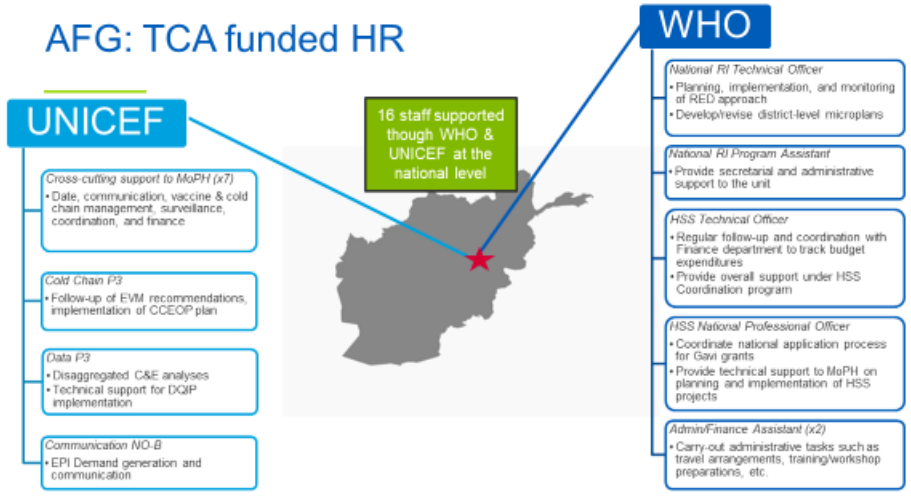
The latest 2018 PEF-TCA information is reflected in the graph below. Which show an historical trend of the committed vs utilized PEF-TCA amounts by partners in Afghanistan. The absorptive capacity of WHO, UNICEF and CDC as compared to PEF-TCA 2018 approved amounts has been 66% (853k/562k), 75% (913k/685k) and 100% (64k/64k) respectively



For UNICEF delays in hiring international staff and turnover of NTA staff, which account for an important part of its PEF budget, have affected their burn rates. The activities under PEF 2018: i.e. 1) Temperature monitoring study; 2) Training of polio network on RI; and 3) Training of communication focal points were done as per planning. The first activity has been completed, the data is being analyzed and the report will be available by end of September. Activities 2 and 3 have been completed and the funds were fully utilized for these two activities

As regards WHO there were some activities postponed to 2019 and reallocation of the budget for EPI coverage survey - reduced the burn rate for PEF TCA

Below is the specific PEF-TCA 2018 staff investment for Afghanistan.



Regarding PEF-TCA 2019: PEF TCA 2019 first reporting shows low absorption to date. However, funds were received in April 2019. UNICEF and WHO staff salaries from PEF TCA 2019 have been so far funded through other sources in the meantime. Thus, not yet spent against PEF TCA budget.

3. **UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL**

Key finding / Action 1	**Uncertain availability of financing for traditional vaccines from beyond 2019. JICA has announced to stop funding by end of 2019.**	**Status**
Current response	JICA has agreed to support the traditional vaccines till November 2019	Advocacy and negotiations with other potential stakeholders are ongoing.
Agreed country actions	• Explore alternatives to financing of traditional vaccines following withdrawal of JICA funding beyond 2019. i.e. mobilization of domestic resources, advocacy with MoF, advocacy with JICA for a phased withdrawal of support.	MOPH has requested the JICA to gradually reduce the financial support for traditional vaccines, as the government did in GAVI co-finance.
Expected outputs / results	• Alternate modalities/areas for funding of traditional vaccines identified	Discussion and negotiations is ongoing with MOF, JICA, Canadian Government, USAID for supporting the traditional vaccine cost
Associated timeline	• Immediate (the discussions with the different stakeholders will be initiated at the earliest possible after the JA meeting)	Ongoing
Required resources / support	• No funding support from Gavi is required for this action , however, strong advocacy needs to be done for different stakeholders to find a long term solution to ensure availability of traditional vaccines in the country	NA
Key finding / Action 1	**High dropout rate (13% for 2016 &2017) Penta1 – Penta3**	**Status**
Current response	Provision of 1,000 tracking bags for defaulter tracking Creating linkages between health facilities within the province to review vaccination records and reconcile doses received by individual children at multiple facilities	As per plan 2,000 tracking bags were distributed to HFs, but due to unavailability of new designed vaccination cards they are not fully functional.

Agreed country actions	• Identify provinces with dropout rate >10 • 1,000 tracking bags were already distributed to selected health facilities; distribution of 2,200 tracking bags is planned to cover all the needs. The second copy of the routine immunization card will be printed for entire birth cohort of 1.5 million children for use in the tracking bags; the costs required are $27, 000. • Utilize the opportunity of supervisory visits to 1) ensure proper use of tracking bags and availability of copies of vaccination cards for the bags, 2) review vaccination registers for defaulters 3) focus on interpersonal communication messages to care givers to complete primary vaccination series • Social mobilization and demand generation to return for additional doses, including utilization of CHW to find defaulters • Reduce missed opportunities during non-vaccination health centers visits	• There are 15 provinces (44%) with DOR less than 10%, based on routine reported coverage. • The new designed vaccination cards printed in March 2019 and distributed to all HFs, therefore the usage of tracking bags for tracing the defaulters to avoid dropout started on May 2019.
Expected outputs / results	• Decrease drop-out rate to <10%	The DOR is decreased to <10% in the 15 provinces.
Associated timeline	• Identify provinces by October 2018 • Other activities November 2018- Dec 2019	Rest of activities for decreasing the DOR including tracing defaulters will be tack in place in 2019.
Required resources / support	• Advocacy with BPHS teams • Utilization of DQIP resources	One-day orientation workshop was conducted in 2018 and will continued for 2019.
Key finding / Action 2	**Inconsistent data particularly JRF 2016-2017**	**Status**
Current response	To conduct a data time series analysis with the help of WHO and UNICEF	Done
Agreed country actions	A workshop for time series analysis planned at Kabul for Jan/Feb 2019	The issue have been discussed during meetings/desk reviews
Expected outputs / results	The data both denominators and numerators to be re adjusted through triangulation of data from various sources WHO/UNICEF to be estimates to be updated	After conducting meetings with technical collaborates, the JRF-2016 was updated/adjusted.
Associated timeline	1st Quarter, 2019	Done
Required resources / support	Technical support from WHO/UNICEF Financial support for the workshop participation local around USD5000 and international WHO/UNICEF USD 5000-10000	Done
Key finding / Action 3	**Inconsistent administrative data reported for 2016 and 2017 reported to the JRF**	**Status**
Current response	To conduct a desk review of existing data sources (i.e. administrative, surveys, polio and surveillance) to revise the time series for numerators, denominators and rates	Desk review of existing data sources conducted and the JRF-2016 revised
Agreed country actions	▪ Conducting the annual data quality desk review for 2018 ▪ An analytical workshop for reviewing and revising current time series planned in Kabul (with support from technical partners). *This exercise is similar to what was conducted in Pakistan in 2018.*	Due to unclear source of fund the review was not conducted

Expected outputs / results	Revised time series for numerators, denominators, coverage rates that will inform Afghanistan's official coverage estimates	NA
Associated timeline	First quarter of 2019 (Jan or Feb)	NA
Required resources / support	• Technical support from WHO and UNICEF for both the annual data quality desk review for 2018 and the analytical workshop • Financial support for hosting the workshop (overall cost is approximately USD 15,000 which includes USD 5,000 for local participants and USD 10,000 for international technical partners)	NA
Key finding / Action 4	**Delayed implementation of Afghanistan's Data Improvement Plan (DIP) owing to challenges relating to fund flow from national to provincial levels**	**Status**
Current response	• Following the hiring of the epidemiologist within the EPI Team, work plan has been revised to accelerate pace of implementation. While this has resulted in some activities (e.g. supportive supervision) being implemented, owing to fund flow related challenges, implementation rate has been slower than expected.	Almost all DQIP planned activities in 2018 were completed except DQI review and sensitization in South East region which is planned for 2019 besides fund utilization was accelerated with more that 80% of allocated budget spent
Agreed country actions	▪ To modify the financial management arrangements of the DIP, mirroring the approach currently used for Gavi's HSS investments (i.e. MoPH contracting a non-governmental organisation [NGO]) • To review the findings of supportive supervision reports in Nov/Dec 2018 in order to see if improvements in data collection and analysis practices have been observed. DQIP activities can be fine-tuned accordingly	▪ External audit was done and report was shared with GAVI ▪ New modality for supportive supervision was introduced at provincial level, it is ongoing and this new modality will be reviewed and analysed in mid2019
Expected outputs / results	▪ Funds being available at provincial level for the implementation of fundamental activities at the operational level (i.e. independent monitoring, data quality review and check, etc.) • DIP work plan is reviewed and/or revised in light of the findings from supportive supervision	▪ Fund flow for implementation of DIP activities at provincial level was accelerated and outcome was also good. According to reviewed work plan activities were planned for 2019
Associated timeline	• Jan / Feb 2019; process for contracting a NGO takes approximately 6-7 months	Due to time consuming process for contracting NGO the budget was transferred to provinces
Required resources / support	▪ Gavi Secretariat to review and approve the terms of reference for the bid • Gavi Secretariat to review proposed revisions, if any, to the DIP work plan	GAVI colleagues will update
Key finding / Action 5	**National and subnational immunisation staff responsible for data management and analysis have limited capacity in data use**	**Status**
Current response	▪ The DIP includes basic training for vaccinators on basic immunisation as well as monitoring and evaluation training for national staff	In 2018 total 2,901 vaccinators have been trained on data management, however training for DIP national staff is not conducted yet
Agreed country actions	▪ To develop a training plan for staff at all levels to improve data use capacity, which would include (1) a training for subnational staff on basic analyses (using Excel) to check quality of data; and (2) inclusion of national staff to WHO AFRO's next data quality workshops	It was decided in last JA that the DQIP national will get the training on data management in January- February 2019, and they will train the provincial staff, but still the training for NEPI national staff is not conducted

Expected outputs / results	▪ Analytical tool for facilitating data analysis and use at the operational level is available ▪ National and subnational staff are exposed to best practices relating to data strengthening	Analytical tools are available but for data use we have to conduct training for subnational level
Associated timeline	▪ By next Joint Appraisal (i.e. mid-2019)	The training was not conducted yet
Required resources / support	▪ Technical support for developing new and/or adapting existing analytical tool for facilitating data analysis ▪ Financial support for organising/participating in learning opportunities	Not done yet
Key finding / Action 6	**Fragmentation of surveillance data systems; for example, two parallel systems exist for measles surveillance**	**Status**
Current response	▪ Data from both measles surveillance systems are analysed and compared; no consensus reached yet for the way forward	Currently measles surveillance data is collected through two different following surveillance system in the country: National Disease Surveillance and Response (NDSR) department of MoPH which collects measles data both from sentinel sites and outbreak based and WHO collects the AFP surveillance through regional, provincial and district polio officers on monthly basis
Agreed country actions	▪ Conduct a review of current surveillance systems for all vaccine-preventable diseases (surveillance for polio, measles/rubella, CRS, Invasive Bacterial Disease, Rotavirus, neonatal tetanus)	The preliminary meetings conducted with National Disease Surveillance and Response (NDSR) department of MOPH but due to some issues did not reach to final decision. Because the NDSR is responsible for 16 diseases with outbreak-based reporting system while the surveillance for EPI needs to be active with case based reporting system.
Expected outputs / results	▪ A roadmap is developed for integrated disease surveillance systems based on recently published WHO guidelines	NA
Associated timeline	▪ By the next Joint Appraisal (i.e. mid-2019)	
Required resources / support	Technical assistance to conduct the review and develop the roadmap ▪ Financial support for conducting the review as well as implementing recommendations resulting from this exercise	
Key finding / Action 7	**No reporting for adverse event following immunisation (AEFI) is happening at the facility level. *This is because vaccinators link the occurrence of AEFIs with their individual performance.***	**Status**
Current response	A supervision checklist has been rolled out recently that looks at reporting done at the facility level	The AEFI reports (including zero report) is a part of routine EPI database The AEFI was an important topic in the trainings measles campaign. The reporting forms are updated and being used.
Agreed country actions	Use the upcoming measles campaign to reinforce vaccinators' knowledge and capacity relating to AEFI reporting	The AEFI farms (investigation and reporting forms) updated and a focal person was assigned at national and provincial level to have close contact for the AEFI reporting and actions during the Measles follow-up campaign
Expected outputs / results	• Vaccinators understand the importance of reporting AEFI resulting an improved reporting rate	• The AEFI was part of training package and vaccinators trained on how to report and use the AEFI reporting and investigation forms.

	• Based on AEFI reported, additional training needs will be identified and addressed	• The AEFI topic is included in the training manual and it is part of MLM.
Associated timeline	By the next Joint Appraisal (i.e. mid-2019)	
Required resources / support	Technical assistance to prepare training materials on AEFI reporting	Done
Key finding / Action 8	**Polio resource support for RI**	**Status**
Current response	As per the recommendation by Polio TAG (Technical Advisory Group), PEI network is committing 20% of its time on EPI services. Currently, the main domain of support of monitoring of immunization sessions.	PEI is contributing to the monitoring of routine immunization sessions, development of micro-plans in Kandahar province. PEI network monitored the Measles SIAs in 2018.
Agreed country actions	Capacity building of PEI staff by EPI teams (NEPI, WHO and UNICEF) on basic principles of routine immunization Congruence of PEI and EPI micro plans in four polio high risk provinces (Kunar, Nangarhar, Kandahar and Helmand) Monitoring of immunization sessions Monitoring of Measles SIA Following proposal of HSS /ICC to be the governing body of the Polio transition process, country to take it forward.	UNICEF trained PCOs and DCOs to the basics of routine immunization; WHO and UNICEF field staff conduct monitoring of the fixed, outreach and mobile sessions on a weekly basis; analysis of monitoring checklists is conducted monthly. HSS/ICC has been agreed as governing body for polio transition process; Polio transition framework has been developed but implementation is pending due to continued transmission of wild polio virus.
Expected outputs / results	PEI staff in the field is well conversant with the basic principles of routine immunization programme PEI colleagues do quality monitoring of immunization sessions and provide hands-on support EPI micro plans, congruent with PEI micro plans, prepared in four provinces Quality monitoring of Measles SIA is done by PEI colleagues	Development of micro plan is under way in Kandahar province; efforts are actively supported by PEI; PEI field staff conducted monitoring of two phases of the Measles SIAs in 2018; findings were shared with REMT/PEMT for follow-up;
Associated timeline	Capacity building of PEI staff by end September Formulation of EPI micro plans prepared in four provinces by end October Monitoring of immunization sessions is an ongoing activity and will continue for the whole year Measles monitoring will be done in Phase 1 (September 1-10) and Phase-2 (November 1-10), depending on the field presence of polio colleagues	PEI was charged with post Measles SIAs coverage survey that was conducted in all provinces of the country except Wardak to validate the reported administrative coverage. PEI staff in Kabul contributed to the development of methodology, sampling frame design and preparation. The PEI field staff (Provincial and District Polio Officers) performed actual implementation of the survey following the training. PEI staff used the summarized survey data for further analysis and prepared report of the survey.
Required resources / support	Funds for training of PEI colleagues are available under PEF TCA Funds for microplanning are available under HSS-3 No additional funds are required	
Key finding / Action 9	**Country plan for Measles SIAs 2018**	**Status**
Current response	Measles SIAs in Afghanistan targeting children 9 month – 10 years of age with one dose of measles vaccine irrespective of vaccination status or disease history will be conducted in two phases: 1-10 September and 17-26 November, 2018 (17 provinces each). The most recent readiness assessment at the national level indicates 88% of	Measles SIAs was planned in 2018 in Afghanistan, proposal and budget plan developed by national team (National EPI, WHO & UNICEF) and submitted to GAVI for approval, in March, 2018 the final proposal approved by GAVI and measles SIAs conducted in two phases for target children

	readiness. Measles vaccine and dry supplies have been delivered to the national level.	(9m–10 Years) regardless of their previous vaccination status. • 1st phase: 1-10 September 2018 • 2nd phase: 17-26 November 2018
Agreed country actions	• Thorough preparation for quality Measles SIAs is under way, in particular: • Ensure thorough training of vaccinators building strong knowledge on the vaccine management and administration; • Using any opportunity to target inaccessible communities even outside campaign dates; • Risk communication activities, appointment and training of spokespersons at provincial and national levels. • Access negotiation with Anti-Government Elements (AGE) and DAESH; • Under take Post Coverage Assessment.	Under the stewardship of training subcommittee of the National Technical Committee, the measles SIAs field guideline used in the previous follow up SIAs was reviewed in depth and updated to include updated technical information and findings from the best practices workshop. Training was planned to take place at least one month prior to the SIAs dates of implementation. The national coordination committee and sub-committee developed a cascade training plan outlining the dates for training at each level and the target participants and facilitators for each phase. The central level training of trainers (TOT) workshops were held in Kabul. Provincial level training was conducted The training courses were facilitated by trainers as well as selected SIA facilitators. In some provinces, AGE were not allowing the measles SIAs implementation, and after close negotiation between AGE and provincial EPI management team they have been convinced by the team to allow implementation of measles SIAs.
Expected outputs / results	To achieve high coverage (≥95%) during both phases of campaign verified by the independent coverage survey.	As planned, so far coverage survey was conducted in 33 provinces except Wardak province, and the data collected from all 33 provinces, complete report will be submitted soon. Post-MSIAs following phase I and II in randomly selected samples throughout the country. Sampling was done to obtain a coverage estimate for a region of +/- 10%. The data collection for the coverage survey targeting all provinces covered during the Phase I and II of measles SIAs. A two-day training workshop conducted to 132 coordinators/supervisors who had at least a first degree in Health or the Social Sciences. The training courses conducted by a team from MOPH and WHO. The training concentrated on the study instrument, enumeration area map reading. Data collection piloted in Kabul city that helped to assess the quality of the data before involving other areas. Thereafter data collection done 33 provinces and completed at national level. A total of 724 data collectors and 180 supervisors trained for 2 days in Kabul. The MSIAs coverage survey (PCA) conducted based on a stratified 3-stage cluster sample. Provinces defined as the strata, districts as the first stage cluster, enumeration areas (EAs) the second-stage cluster, and households the third stage cluster on all eligible age children within selected households collected/will be collected.

		The WHO regional office has supported in random selection of sample. Resulted a **91 %** of post measles SIAs coverage Survey
Associated timeline	July 2018 – March 2019	Done
Required resources / support	Funds for the planned SIA are available. TA for measles surveillance system review	
Key finding / Action	**Shortage of funds under the SEHATMANDI project on EPI**	**Status**
Current response	• Based on past expenditures of BPHS and EPHS we would need 600 Million USD only for BPHS and EPHS services for three years. Due to shortage of fund, currently only 570 Million USD for BPHS and EPHS service are available, 20 Million USD for 3rd party monitoring and MOPH management cost and only 10 Million USD for community engagement and health promotion campaign. • Due to this shortage, HSS activities dropped out, except waste management and extra activities will not be supported as well. • Further to that, following issues might happen with this shortage of fund; • Problem on sustaining the same level of BPHS and EPHS services (with 30 Million USD shortage) • Limitation on expansion of primary health care • No any health system strengthening program at the Central and provincial level and • Shortage of local technical staff for MoPH programs	Afghanistan has been selected as one of the third wave countries for the Global Financing Facility (GFF). In fact, a governance structure has been established to oversee the integration of GFF into the wider health strategy. Significantly, the GFF avails considerable opportunities for the country, including its emphasis upon adolescent and reproductive health and health financing. Furthermore, the GFF contributed to the current Sehatmandi project extensively and duly filled the funding gap in terms of BPHS and EPHS implementation, respectively. The Sehatmandi project is a multi-donors trust fund project and its total cost is US$600 million, financed through multiple sources including the Afghanistan Reconstruction Trust Fund (ARTF) in the amount of US$425 million, Global Financing Facility (GFF) in the amount of US$35 million and IDA Grant in the amount of US$140 million. The project includes three components: 1. Service delivery which will support the financing of performance contracts to deliver BPHS and EPHS services and establish an innovation fund with an allocation of 550 million USD. 2. Strengthening the Health System and its Performance (40 million USD) will support shifts towards greater performance management of NGOs, reform of tertiary and national hospitals and improvement in the procurement and supply chain management of pharmaceuticals. 3. Strengthening demand and community accountability for key health services with 10 million USD allocation will use the potential of CCAP and Community Development Committees (CDCs) including its female members to build demand and strengthen accountability mechanisms for critical health and nutrition services especially for maternal health, nutrition and family planning.
Agreed country actions	• For smooth and quality of immunization services, capable health system should be in place.	With the approval of 7.6 million USD additional fund to HSS3 the following interventions are in place:

	• Priority uncovered areas for immunization services such as Community Based Outreach in white areas, should be covered through GAVI fund. • Complementary activities to improve immunization services needs to be identified and will be included under HSS additional funding opportunity. • Identify potential immunisation gaps due to SEHATMANDI shortage of funds and submit proposal within the +50%HSS financing for Gavi consideration	- Continuation and expansion of community outreach vaccination in 20 provinces. - Construction of additional EPI cold room - Strengthening EPI in southern and Eastern focused on 5 polio high risk provinces. - Improving urban immunization in Kabul city. The following bottle necks and immunization gaps considered under 50% HSS funding proposal. - Improvement of immunization services in urban setting particularly six major cities of the country - Particular attention in polio affected provinces and district - Improvement in the quality of data and introduction of tested successful innovation of SPT. - Quality improvement and focus on hard and very hard to reach areas - Increasing demand for immunization - Involvement of private sector in implementation of immunization services
Expected outputs / results	• Uncovered white areas will be covered and consequently coverage and equity will be increased particularly for deprived population in remote areas. • Supporting Health system strengthening activities will help smooth implementation of immunization services in the country.	- The white areas will be covered by the implementation of community based outreach vaccinator (COBV) under USD 7.6 million - Improve the supply of immunization opportunities, in both quantity and quality, in 6 major cities under 50% HSS funding proposed.
Associated timeline	January 2019 – December 2021	
Required resources / support	Not applicable. Proposal will be submitted to Gavi after MOPH and partners discussion on gap analysis and immunisation.	The 50% HSS additional fund proposal submitted to Gavi. Proposal was developing in close consultations with immunization stakeholders, partners, implementers and sub national people following gap analysis workshop and round tables. It was approved by IRC with clarifications.
Additional significant IRC / HLRP recommendations (if applicable)		**Current status**

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 7 below).

1. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

*Briefly summarise the **key activities to be implemented next year** with Gavi grant support, including if relevant any **introductions** for vaccine applications already approved; preparation of **new applications**, preparation of **investment cases** for additional vaccines, and/ or plans related to HSS / CCEOP grants, etc.*

*In the context of these planned activities and based on the analyses provided in the above sections, describe the five **highest priority findings and actions to be undertaken to enhance the impact of Gavi support or to mitigate potential future risks to programme and grant performance**.*

*Please indicate if any **modifications** to Gavi support are being requested (indicating the rationale and main changes), such as:*

- *Changes to country targets as established earlier, either from the agreed Grant Performance Framework (GPF) or as part of the NVS renewal request submitted by 15 May;*
- *Plans to change any vaccine presentation or type;*
- *Plans to use available flexibilities to reallocate budgeted funds to focus on identified priority areas.*

Overview of key activities planned for the next year and requested modifications to Gavi support:

This table draws from the previous JA sections, summarizing key findings and agreed actions, as well as indicating required resources and support, such as associated needs for technical assistance[8].

Key finding / Action 1	**Maping of service delivery providers (both BPHS and non-BPHS)**
Current response	Polio programme has mapped for Kandhahar, plans further to do for southern provinces
Agreed country actions	EPI plans to do for eastern provinces: Laghaman, Kunar and Nangarhar
Expected outputs / results	Identification of additional implementers active in the provinces and bring them under Accountability framework
Associated timeline	Q4 2019
Required resources / support and TA	Needs short term national TA (HSS3 50% funding)
Key finding / Action 2	**Polio-RI Synergy : Development of Roles & Responsibilites at subnational level**
Current response	Currently there is a framework of the RI-Polio synergy.
Agreed country actions	Develop Polio-RI implementation plan based on the framework (the plan to include specific activities, expected outputs, responsible persons and resources)
Expected outputs / results	Implementation plan, Field implementation of the plan in polio priority provinces
Associated timeline	Q3 2019
Required resources / support and TA	WHO with existing resources
Key finding / Action 3	**Limited implementation of micro plans and RED/REC**
Current response	Developed comprehensive routine EPI micro plan in one province (Kandahar) Planned development of RI micro plans in rest of the 33 provinces (HSS flexi).
Agreed country actions	• Development of RI micro plans in the 33 provinces • Implementation of RI micro plans in the context of RED /REC scale up. • Monitoring the RI session functionality in all provinces (including five provinces supported by ACASUS). • Identify the service delivery gaps and quantify for resource needs.
Expected outputs / results	• EPI Micro plans available for all the provinces. • The service delivery gaps and resource needs are addressed. • Targets are achieved as per the RI micro plan
Associated timeline	Q4 2019 (Nine priority provinces) Q2- 2020 (all).

[8] The needs indicated in the JA will inform the TCA planning. However, when specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. The TA menu of support is available as reference guide.

Required resources / support and TA	TA (WHO & UNICEF) Implementation and monitoring (MOPH, UNICEF, NGOs, WHO) Resources available (HSS flexi)
Key finding / Action 4	**Vaccine Management**: Web-VSSM system for vaccine logistics management system
Current response	Currently VSSM 1.0 in place but not connected with the lower stores
Agreed country actions	Implementation of Web – VSSM system
Expected outputs / results	Web –VSSM based Vaccine logistics management system in place ((Real time up to provincial level).
Associated timeline	Q2 2020
Required resources / support and TA	WHO to provide TA UNICEF –all other support
Key finding / Action 5	**Demand** • Communication strategy: Costed operational plan • Religious leaders follow up after training to establish network – Ulema, polio EPI lessons, Including the ICN network
Current response	• KAP survey was done in 2018. The national and regional fact sheets for KAP survey will be developed by end July. • The communication strategy has been drafted and will be submitted to NEPI in the first week of July. • The costed action plan for communication strategy will be developed in consultation with UNICEF Regional office and Headquarters. • UNICEF, in consultation with NEPI, will finish the trainings of religious leaders in all provinces by Q1 2020. The discussion for continuous engagement will be initiated immediately with NEPI, Health Promotion Department and Ministry of Hajj and religious affairs.
Agreed country actions	• National and Regional fact sheets for KAP developed • National EPI communication strategy finalized • Costed action plan for communication strategy developed • Concept note for continuous engagement of religious leaders developed
Expected outputs / results	• National and Regional fact sheets for KAP **July 2019** • National EPI communication strategy **July 2019** • Costed action plan for communication strategy **Q4 2019** • Concept note for continuous engagement of religious leaders developed **Q3 2019**
Associated timeline	Q4 2019
Required resources / support and TA	UNICEF will have used existing resources for KAP facts sheets, communication strategy and the costed action plan. Additional funds may be required for continuous engagement of religious leaders, however, it will be clear subsequent to discussions with HPD, NEPI and Ministry of Hajj and religious affairs
Key finding / Action 6	**EPI and HMIS data currently collected through parallel systems**
Current response	DHIS2 has been inaugurated and is just starting to be used at national level; EPI data is not fully operational
Agreed country actions	• EPI to share DHIS2 roadmap (with EPI focus) • ToR for University of Oslo and HISP to be reviewed by Gavi and country team • Planning for exchange of experience with country that has implemented DHIS2 (e.g. Bangladesh) • National capacity for utilisation of DHIS2 is built
Expected outputs / results	All EPI indicators are captured in DHIS2 and EPI visualisation module is fully customized for all target antigens
Associated timeline	July 2020
Required resources / support and TA	UiO TCA

	Explore option for experience exchange on DHIS2 and related resources TBC
Key finding / Action 7	**Despite improvements in recent years, efforts to improve data quality must be continued to ensure more accurate data for programme planning and monitoring**
Current response	DQIP is moving forward and implementation has been accelerated.
Agreed country actions	Address some outstanding gaps in data improvement: - DQS planned for 2020 (previous in 2017) - Training of national data officers on data improvement Key action points out of routine desk reviews and meetings
Expected outputs / results	DQS completed in 2020, with review of findings Data quality improvement committee reviews include reviews of existing data: admin coverage, surveillance, vaccine wastage
Associated timeline	2020
Required resources / support and TA	WHO EMRO training of national staff, including one day on DHIS2 Data quality reviews to be supported by existing budget in DQIP TCA for DQS TBC

Based on the above action plan, please outline any specific technology or innovation demand that can be fulfilled by private sector entities or new innovative entrepreneurs.

2. **JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS**

A team consisting the representatives from HSS, NEPI, WHO UNICEF and CSOs and other stakeholders was assigned to proceed the process of joint appraisal. The team was led by HSS unit of MoPH and the preliminary meeting held to review the JA guideline and distribute tasks among assigned team on 9th April 2019. The members divided the task into two activities, technical and financial as well as review of existing documents. The JA report has been prepared based on the desk review, program reports and field reports provided by the NGOs (which have been verified by PHDs). The second JA meeting held on 13th May 2019 to discuss the JA agenda point for Tashkent meeting. The zero draft of JA prepared on 5th June 2019 and reviewed jointly by JA country team and after incorporation of team comments the latest draft shared with Gavi secretariat and partners prior to Tashkent meeting. The draft was jointly reviewed with Gavi team and other partners from 9-12th June 2019 in Tashkent and the final draft was presented to ICC/HSS steering committee June 25th 2019 for the endorsement. The ICC/ HSS steering committee minute which endorsed the 2019 JA is attached.

3. ANNEX: Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal. ***It is important to note that in the case that key reporting requirements (marked with *) are not complied with, Gavi support will not be reviewed for renewal.***

	Yes	No	Not applicable
End of year stock level report (due 31 March) *****	√		
Grant Performance Framework (GPF) * reporting against all due indicators	√		
Financial Reports *			
Periodic financial reports	√		
Annual financial statement	√		
Annual financial audit report			
Campaign reports *			
Supplementary Immunisation Activity technical report	√		
Campaign coverage survey report	√		
Immunisation financing and expenditure information			
Data quality and survey reporting	√		
Annual data quality desk review			
Data improvement plan (DIP)			
Progress report on data improvement plan implementation			
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)			
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	√		
CCEOP: updated CCE inventory	√		
Post Introduction Evaluation (PIE) (specify vaccines):		√	
Measles & rubella situation analysis and 5 year plan			√
Operational plan for the immunisation programme	√		
HSS end of grant evaluation report			√
HPV demonstration programme evaluations			√
Coverage Survey			√
Costing analysis			√
Adolescent Health Assessment report			√
Reporting by partners on TCA and PEF functions			

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.
