The GAVI Alliance
Health Systems Strengthening
Program Funding Application

From:

The Islamic Republic of Afghanistan
10th May 2007

Executive Summary

A. Background: After two decades of war, when the Taliban fell, Afghanistan suffered from some of the worst health outcomes in the world including a maternal mortality ratio of 1600 per 100,000 live births and an infant mortality rate of 165 per 1,000 live births. In one district of mountainous Badakshan province, a maternal mortality ratio of 6,500 was found, the highest ever recorded. The limited health infrastructure provided so few services that a household survey in 2003 found that, in rural areas, Antenatal Care was only 5.5% and DPT3 coverage was only 19.5%.

In response to this desperate situation the Ministry of Public Health (MOPH), with donors and partners, undertook a series of bold reforms, launched in March 2003: (i) it established a Basic Package of Health Services (BPHS) which focused on the most critical and cost-effective services, including immunization, and entailed training of a cadre of community health workers (CHWs); (ii) it contracted with NGOs to deliver services through standardized health centers and outreach in most of the country and held them accountable for results, and (iii) it ensured that rigorous evaluation of health sector performance was undertaken through contracting an international organization to survey a reasonable sample of health facilities twice a year.

The results of the MOPH policy and strategy since 2003 are beginning to be evident. A household survey done in 2006 indicates that the infant mortality rate (IMR) has fallen to about 135 per 1,000 live births (an 18% reduction which translates into 40,000 fewer infant deaths every year compared to during Taliban times). The same survey found that Antenatal Care has increased to 30% and skilled birth attendance increased from 4.5% in 2003 to almost 19% in 2006. According to routine EPI reporting, immunization coverage (DPT3) has increased from 54% in 2003 to 77% in 2006.

The decline in IMR is very encouraging, however, it is still higher than that of Chad or Somalia and the Antenatal Care coverage remains very low by South Asian standards. Another indication that Afghanistan is lagging behind is measles coverage which is 68% nationally with only 28% of the districts having over 80% coverage of measles vaccine. Measles outbreaks in several provinces in 2006 triggered the plan and launching of another measles campaign for children aged 9 to 59 months.

There are, therefore two important conclusions about the health sector in Afghanistan: First, it has made impressive progress since the fall of the Taliban; and second, there is still a long way to go until Afghanistan has acceptable health outcomes and an adequate health care system.

B. Barriers: Afghanistan faces some serious challenges such as insecurity and a lack of domestic resources to finance health services. However, health sector assessments and discussions with key stakeholders reveal the following barriers that are both important and amenable to improvement:

a) **Limited Physical Access to Services:** Despite a large expansion in the number of functioning health facilities, only 39% of the rural population lives within one hour's travel of a health facility. In some provinces the situation is even worse, reflecting the difficult terrain of Afghanistan and the dispersion of its population. The recent household survey found that skilled birth attendance was 27% among women living within an hour's travel of a health facility, but that this quickly declined to less than 6% among women living more than 3 hours' travel from a health center. Similarly, of the 14 provinces with the lowest immunization coverage, 9 have difficult terrain, seasonal blockages of roads, and scattered population while the remaining 5 have security problems.

b) **Weak Demand for Health Services:** Even where health services are physically accessible, there is still only modest demand. There are many evidences that show lower level of demand; for example, the fact that only 36% of women living within 2 hours travel of a health facility have received Antenatal Care indicates the socio-cultural obstacles that women face in using services. This issue is exacerbated by very low female literacy rates and limited female involvement in family decision-making. Similarly, the drop-out rate from DPT1 to Measles has been over 20% for the last three years, showing low awareness

among families of the immunization benefit and less motivation to seek immunization services.

c) **The Need to Further Strengthen Stewardship:** The MOPH has made significant strides in carrying out its stewardship role in the health sector. For example, the MOPH now manages many of the grants and contracts with NGOs. However, there are other stewardship functions that need to be strengthened, including: (i) a monitoring and evaluation (M&E) system that needs to be institutionalized at MOPH and fully equipped to track a rapidly evolving health sector; (ii) inadequate coordination capacity at the field level (i.e. below the level of the province) to ensure that immunization coverage is maximized through more effective integration of services and micro-planning; and (iii) an inability to mobilize the financial resources needed to maintain the progress of the health sector and sustain provision of basic health services including immunization.

C. Overcoming Barriers: To overcome the above barriers the MOPH proposes to use GAVI HSS support for the following activities:

a) Improved Access to Quality Health Care: To improve access to health services, the MOPH will work with its implementing partners (mostly NGOs) to: (i) establish "sub-centers" in under-served areas that will extend the reach of BPHS. Based on positive initial experiences, sub-centers will be staffed by one male and one female health worker providing basic services and immunization in a building provided by the community; (ii) expand the use of mobile health teams to provide a package of promotive and preventive maternal-child health services, including immunization, to communities at least 20 km away from existing BPHS facilities; (iii) strengthen the ability of the existing 15,000 CHWs to promote immunization, preventive maternal services and referrals, and to appropriately provide children with ORS for diarrhea and antibiotics for pneumonia through implementation of community IMCI; and (iv) fill the gaps in training of BPHS health workers so that lack of quality is not an impediment to use of services.

b) Increased Demand for and Utilization of Health Care: To increase the demand for services, the MOPH will also work with its partners to implement the following activities: (i) implement a nationwide information, education, and communication campaign focused on a limited set of measures related to maternal and child health, including recognition of the danger signs of ARI and the promotion of immunization, Antenatal Care, and skilled birth attendance; (ii) pilot testing, on a meaningful scale, the use of demand side financing (i.e., cash or an appropriate gift) to promote uptake of immunization and skilled birth attendance; and (iii) providing performance-based incentives to the volunteer CHWs based on their successful promotion of skilled birth attendance and full immunization of children.

c) Strengthen the Stewardship Functions of the MOPH: To further strengthen the MOPH's stewardship role, GAVI HSS support will be used to: (i) expand a capacity-building program for MOPH managers at central and provincial level focused on management, health care financing, and use of key M&E data for decision-making; (ii) strengthen the physical and information/ communications infrastructure of the MOPH including making sure every provincial health office has internet connectivity to improve timely and effective communication with the field; (iii) establish a demographic surveillance system at community level that will provide annual estimates of mortality rates, cause of death, birth rates, and use of health services; (iv) initial establishment of a cadre district health officers (DHOs) who will represent MOPH in the field, coordinate immunization activities, and coordinate the response to emergencies; and (v) strengthen the ability of the MOPH to effectively advocate for additional resources for provision of basic health services including immunization and the health sector in general.

D. Sustainability: MOPH is applying for GAVI HSS support to fill the gaps in the funding of its plans. For example, the World Bank (WB) recently agreed to support 130 "sub-centers," EC is requesting proposals from NGOs, and MOPH will use GAVI support for the remaining 120 sub-centers. While the activities MOPH is requesting support for may appear ambitious, the MOPH has a track record of success over the last 5 years of successfully implementing externally financed activities. The sustainability of the planned activities is likely because the MOPH: (i) will

pilot test activities to make sure that they are effective before expanding them; (ii) focus on activities (such as immunization, treatment of ARI, and breastfeeding promotion) that are regarded as highly cost-effective; (iii) use workers on contract so as to avoid long-term Government obligations and allow flexibility in re-deployment of staff; and (iv) rely, wherever possible, on existing human and financial resources to carry out new activities (e.g. redeploying health workers from under-utilized CHCs to new sub-centers). It is important to be realistic in assessing sustainability in Afghanistan and to use an appropriate time horizon. Given the depth of poverty and a limited ability to collect taxes, the Government will not be able to finance a reasonable level of health services within the next 10 years. In the long-term the prospects are much better especially given the growing economy.

E. Objectives and Indicators:

The overall objectives to improve access and utilization of services can be translated to the following specific impact/outcome objectives:

1. To increase national DPT3 coverage under age one from 77% in 2006 to 90% by 2012.
2. To increase the number/percent of districts achieving >80% DPT3 coverage under age one from 161 (49%) in 2006 to 329 (100%) by 2012.
3. To reduce under five mortality rate from 210/1000 live births in 2006 to 168 /1000 live births by 2012.
4. To increase the national Measles coverage under age one from 68% to 90% by 2012.
5. To increase the proportion of births attended by skilled health personnel from 19% in 2006 to 40% in 2012.
6. To increase the percent of children receiving treatment for diarrhea and ARI at the community level from baseline in 2006 AHS to 30% above baseline in 2012.

The following specific output objectives, reflecting planned activities, will be:

1. To increase contacts per person per year with the health care system from 0.6 visits/person/year in 2006 to 1.0 visit per person per year in 2012.
2. To increase average number of persons referred by CHWs per quarter from 3.9 in 2006 to 20 referrals per quarter in 2012.
3. To improve “Provider Knowledge Score” of BSC from 68.7% in 2006 to 90% in 2012.
4. To increase the % of mothers in rural communities knowledgeable about prioritized heath messages from baseline in 2006 AHS to 40% above baseline in 2012.
5. To increase % of CHWs trained in community IMCI from 2% in 2006 to 80% in 2012
6. To increase the % of provinces receiving monitoring visits using national monitoring checklist per quarter from 25% in 2006 to 100% in 2012.

F. Use of GAVI Funds: This application is based on the Afghan National Development Strategy for the health sector from 2008-2012. The total funds estimated to be available from GAVI at the rate of $5 per birth cohort from 2008 to 2010, with possible extension to 2012, would be approximately $34,228,000. MOPH is proposing to allocate about half of the budget improving access to services including immunization through support to sub-centers and mobile health teams, and the rest for improvement in monitoring and public health management at the periphery, and remaining projects in communication and improving utilization of health services.

Table of Contents

Abbreviations and Acronyms

ADB	Asian Development Bank
AHS	Afghanistan Household Survey
ANDS	Afghan National Development Strategy (Interim Poverty Reduction Strategy Paper)
APHI	Afghan Public Health Institute
AREU	Afghanistan Research and Evaluation Unit (NGO)
ARI	Acute Respiratory Infection
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BSC	Balanced Scorecard (Afghanistan Health-Sector Balanced Scorecard)
CAO	Control and Audit Office (Government of Afghanistan)
CGHN	Consultative Group on Health and Nutrition (HSCC equivalent in Afghanistan)
CHC	Comprehensive Health Center
CHS	Community Heath Supervisor
CHW	Community Heath Worker
CJCMOTF	Coalition Joint Civil-Military Operations Task Force
cMYP	Comprehensive Multi-Year Plan for Immunization
DH	District Hospital
DFID	Department for International Development (United Kingdom)
DHO	District Health Officer
EC	European Commission
EMRO	Eastern Mediterranean Regional Office (of the World Health Organization)
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
FSP	Financial Sustainability Plan
GAVI	The GAVI Alliance (formally known as the Global Alliance for Vaccines and Immunizations)
CBHC	Community Based Health Care
GCMU	Grants and Contracts Management Unit
GDP	Gross Domestic Product
GDPP	General Director of Policy & Planning
GIVS	Global Immunization Vision and Strategy
GOA	Government of Afghanistan
HMIS	Health Management Information Systems
HSCC	Health Sector Coordination Committee
HSS	Heath System Strengthening
ICC	Interagency Immunization Coordination Committee
ICRC	International Committee of the Red Cross and Red Crescent
IEC	Information Education and Communication
IHS	Institute of Health Service
IIHMR	Indian Institute of Health Management Research
IMCI	Integrated Management of Childhood Illnesses
C-IMCI	Community Integrated Management of Childhood Illnesses
ISAF	International Security Assistance Force
ISS	Immunization Support Services
JHU	Johns Hopkins University
JHPIEGO	International health organization affiliated with Johns Hopkins University
JICA	Japan International Cooperation Agency
JRF	Joint Reporting Format (UNICEF, WHO, MOPH annual Joint Reporting for EPI Coverage)
MICS	Multi-Indicator Cluster Survey (UNICEF & Afghan Central Statistics Office)
MOF	Ministry of Finance
MOHE	Ministry of Higher Education
MRDR	Ministry of Rural Development and Rehabilitation
MSH	Management Science for Health (nonprofit international health organization)
MYPoA	Multi Year Plan of Action (of the Expanded Program of Immunization in Afghanistan)

NDB	National Development Budget
NDF	National Development Framework
NEDLA	National Essential Drug List - Afghanistan
NEM	National EPI Manager
NHCC	National Health Coordinating Committee
NHP	National Health Policy
NIDs	National Immunization Days
NIP	National Immunization Program
NNT	Neonatal Tetanus
NRVA	National Risk and Vulnerability Assessment
PEI	Polio Eradication Initiative
PEMT	Provincial EPI Management Team
PHCC	Provincial Health Coordinating Committee
PHD	Provincial Health Director
PHO	Provincial Health Office
PICC	Provincial Interagency Coordination Committee
PPAs	Performance Based Partnership Agreements
PPGs	Performance Based Partnership Grants
PPHD	Provincial Public Health Directorate
P/PPTF	Public/Private Partnership Taskforce
PRR	Priority Reform and Restructuring
REACH	Rural Expansion of Afghanistan's Community-Based Healthcare (Management Sciences for Health Project in Afghanistan)
REMT	Regional EPI Management Team
SWaP	Sector Wide Approach
SCA	Swedish Committee for Afghanistan
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Section 1: Application Development Process

1.1: The Consultative Group on Health and Nutrition (HSCC equivalent in Afghanistan)

The Consultative Group on Health and Nutrition (CGHN) is the Government of Afghanistan's equivalent of the Health System Consultative Committee. The overall objective[1] of the CGHN is to increase the effectiveness and efficiency of the health sector in support of the attainment of the goals and purpose of the Ministry of Public Health. This objective is achieved by the MOPH bringing together its partners to coordinate policies and initiatives relevant to the development and implementation of the Ministry of Public Health's strategies, policies and budgets. The key roles of the CGHN are to:

- Advise the Ministry of Public Health on the development of strategic policies and measurable output and outcome indicators;
- Establish health sector targets (also referred to as benchmarks);
- Assist with the preparation of public investment programs, including resource mobilization;
- Assist in the acceleration of the implementation of the National Development Budget;
- Assist with the monitoring and evaluation of implementation progress, including data collection for the tracking of aid streams;
- Information sharing.

CGHN Operational Since:

The CGHN has been operational since November of 2002. An ad hoc working group was established to guide and support the preparation of this application to the GAVI Alliance for Heath Systems Strengthening funding on 31 January 2007.

Organizational Structure:

The CGHN is chaired by the Technical Deputy Minister of Public Health with the General Directorate of Policy and Planning serving as the secretariat. In addition to the Ministry of Public Health, its members include a senior representative of the Ministry of Finance and key health sector international organizations and donors such as the World Health Organization, UNICEF, the World Bank, United Nations Population Fund, United States Agency for International Development, European Commission, International Committee of the Red Cross and Red Crescent Societies, Johns Hopkins University, London School of Hygiene and Tropical Medicine, the Swedish Committee for Afghanistan, the Japan International Cooperation Agency, Management Sciences for Health, Coalition Joint Civil-Military Operations Task Force and the International Security Assistance Force.

Written terms of reference for the CGHN are updated regularly. It should be noted that the ICC is a subset of the CGHN; all of the members of the ICC are also members of the CGHN and they also were part of the proposal development process.

Frequency of Meetings:

Meetings of the CGHN are held on a weekly basis, depending on availability of agenda. Minutes of all meetings are recorded, signed by the Chair, distributed to members, and kept on file.

1.2: Overview of Application Development Process

Who coordinated and provided oversight to the application development process?

The CGHN provided the coordination and oversight of the GAVI-HSS application process by

[1] Source: Consultative Group for Health and Nutrition Terms of Reference; August, 2004

designating a Working Group (WG) of CGHN members who would develop and draft the application and report regularly to the CGHN on its progress. Several representatives from the ICC were included in the WG – from NEPI, WHO, UNICEF, NGO and donor side.

Who led the drafting of the application and was any technical assistance provided?

The WG for the GAVI-HSS application development was delegated by the CGHN at its January 31, 2007 meeting and consisted of:

Chair: Director General for Policy and Planning, Dr. Shukrullah Wahidi

Members:

1. Dr. Abdul Wali, Advisor to GD P&P, MoPH
2. Dr. Gula Khan, EPI/MOPH
3. Dr. Shakoor Waciqi, EPI and national GAVI Advisor, WHO
4. Dr. Abdi Momin Ahmed, PHC, WHO
5. Dr. Ghulam Hayder Rafiqi, EPI, UNICEF
6. Dr. Khakirah Rashidi, MoPH Capacity Building, Techserve, USAID
7. Dr. Ibneamin, SCA
8. Dr. Izzeldin Abueliash, Health System Dev, WHO
9. Mr. Said Alam, Ministry of Finance

During the process, other experts and stakeholders were also invited to WG meetings and contributed to different segments of the application and reviewing the different drafts. See list below.

To provide additional technical assistance, one national and one international consultant were contracted by MOPH (with funds from the GAVI Secretariat channelled through WHO) to organize input into, and draft the text of, the application. The consultants collected input from a wide variety of sources, including existing evaluations, planning documents, health sector leaders and other representatives of government, private medical practice and non-governmental organizations (NGOs) involved in the provision of healthcare in Afghanistan.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

The CGHN-designated WG for GAVI-HSS application development met on a weekly basis starting February 2007, and was supported by a number of international agencies, including the World Health Organization who played an important role in the development of the application.

In March 2007 the national and international consultants were hired to assist in organizing inputs and drafting the text of the application. The process of developing the application was scheduled to include regular coordination and feedback meetings with CGHN, key stakeholders and resource persons.

In addition to the weekly meetings of the WG, key meetings for development of the application and feedback on drafts included:

- Workshop held with MOPH partners to identify the barriers or bottlenecks of the health system in providing immunization services, on March 13th;
- Meeting with MOF on March 25th;
- Presentation to CGHN progress to date on March 28th;
- International consultant arrived on March 29th;
- Meeting with MOF on April 9th;
- Presentation of the first full draft of the GAVI HSS application to the CGHN on April 11th;
- Meeting with MOPH's implementing partner NGOs (Agency for Assistance and Development of Afghanistan; Swedish Committee for Afghanistan; Aid Medical International), April 12th;
- Meeting with the Head of Mission and Representative of the World Health Organization on April 14th;
- Meeting with the Curative and Medicine Directorate of the MOPH on April 15th;
- Meeting with Human Resource Directorate of the MOPH on April 16th;

- Meeting with UNICEF Representative on April 17th;
- Meeting with USAID / Tech-Serve project on April 17th;
- Meeting with GCMU (MOPH) on April 17th;
- Meeting with USAID/ Service Support project on April 18th;
- Meeting with WHO on April 19th;
- Meeting with the Ministry of Public Health GCMU Procurement department on April 22nd;
- Meeting with the World Bank on April 23rd;
- Meeting with the Afghan Physicians Association on April 23rd;
- Meeting with the Afghan Private Hospital Association on April 23rd;
- Meeting with the Afghan Pharmacy Association on April 23rd;
- Meeting with Ibn Sina (Afghan Health NGO) on April 24th;
- Meeting with USAID on April 24th;
- Presentation of the 2nd full draft of the GAVI HSS Application to the CGHN on April 25th;
- Discussion of the latest draft of the GAVI HSS Application with Provincial Health Directors and Implementing partner NGOs (Agency for Assistance of Afghanistan; Health Net International; Care of Afghan Families; Bakhter Development Network; Ibn Sina; Swedish Committee for Afghanistan) was held on April 26th;
- Meeting with the World Bank on April 29th;
- Presentation and discussion with the Deputy Minister Technical, Dr. F. Kakar on April 30th
- Presentation of sub-final draft to the full membership of the CGHN on May 2nd with their endorsement

Who was involved in reviewing the application, and what was the process that was adopted?

As mentioned above, key stakeholders of the health sector were involved in reviewing drafts of the application through presentations at the CGHN meetings and individual consultations. Also various drafts were sent by email and comments received by the same.

Following is a list of key contributors to the application process outside the WG:

- Dr. Mohammed Daim Kakar – General Director, Preventive &Primary Healthcare, MOPH
- Dr. Ahmad Jan Naeem – Director, Grants and Contracts Management Unit, MOPH
- Dr. Abdullah Fahim Advisor to the Minister of Public Health
- Dr. Hassebullah Niayesh – Head, Monitoring and Evaluation Department, MOPH
- Dr. Agha Gul Dost – National EPI Program Manager, MOPH
- Dr. Ali Shah Alawi – Director of Child and Youth Health, MOPH
- Dr. Saleh Rahmani – Director IMCI, MOPH
- Dr. Ronald Waldman – Consultant, MOPH

Contributors from outside WG and MOPH:

- Dr. Mounir Farag – GAVI-HSS Focal Point, WHO EMRO
- Dr. Benjamin Loevinsohn – Lead Public Health Specialist, Human Development Unit, South Asia Region, World Bank
- Dr. Rana Graber Kakar – WHO International EPI Officer
- Dr. Hemlal Sharma – Project Officer for EPI – UNICEF
- Mr. Peter Hansen – JHU M&E Project Director
- Dr. Omid Ameli – M&E Advisor Tech serve USAID
- Dr. Paul Ickx – Technical Advisor, MSH, USAID
- Dr. G. Sayed – Public Health Specialist, World Bank

Who approved and endorsed the application before submission to the GAVI Secretariat?

The application has been approved and endorsed by the CGHN members at the 2nd May 2007 meeting when the sub-final draft was presented. The WG made further improvements in organization and presentation of the application including inputs from WHO, UNICEF, and WB without changing the chief components presented for funding. The final draft was approved by the Deputy Minister Technical MOPH, and final approval for the application was given by the Minister of Public Health and Minister of Finance.

It should be noted that the ICC members were fully active in preparation, approval and endorsement of the GAVI-HSS application in their role as CGHN and WG members. In the ICC meetings in March and April 2007, they approved the comprehensive Multi-Year Plan and the

applications for GAVI-ISS and GAVI-NVS. In the applications, it was carefully observed what part of the activities could be covered by the ISS and NVS grants and what part could be covered by the HSS grants

1.3: Roles and Responsibilities of Key Partners (CGHN Members and Others) in Application development

Title / Post	Organization	CGHN member yes/no	Roles and Responsibilities of this Partner in the GAVI HSS Application Development
General Director of Policy &Planning	MOPH	Yes	Leadership of the application development process, through chairing GAVI HSS WG's weekly meetings & provision of input into the content of the application.
Advisor to the GD P&P, Ministry of Health	MOPH	Yes	Key role in the GAVI HSS WG provided overall guidance on the development of the application with regard to current health system implementation and planning
National EPI Officer	MOPH	Yes	Member of the GAVI CGHN WG & provided assistance in collecting information on the EPI program in Afghanistan.
Sector Manager	MOF	Yes	Member of the GAVI HSS WG & Coordinated communication between MOPH and MOF related to the GAVI HSS application & provided information on the means by which donor funding is managed by the GOA.
Medical Officer	WHO	Yes	Member of the GAVI – HSS WG & provided documents of health sector assessment and GAVI guidelines
Technical Officer	WHO	Yes	Member of the GAVI – HSS WG & contributed strategy on system development
National GAVI Advisor	WHO	Yes	Member of the GAVI – HSS WG & provided technical input concerning the field-level implementation of the EPI program.
Project Officer	UNICEF	Yes	Member of the GAVI – HSS WG & provided information on vaccine procurement and cold chain.
Program Manager	MSH / Tech-Serve	Yes	Member of the GAVI – HSS WG & provided info on implementing partners' view of HSS
Health Coordinator	SCA	Yes	Member of the GAVI – HSS WG & provided info on implementing partners' view of HSS
General Director, Preventive&PHC	MOPH	Yes	Contributed strategy of GD Prev &PHC in increasing immunization coverage
Director Grants& Contracts Managemt Unit	MOPH	Yes	Information about management and coordination of donor inputs and NGO contracts
Advisor to the Minister	MOPH	Yes	Introduced guidelines of GAVI-HSS after attending WHO Cairo meeting
Head, M&E Dept	MOPH	Yes	Contributed M&E strategy in MOPH
National EPI	MOPH	Yes	Contributed linkages to immunization strategy

Prog. Man.			and other GAVI proposals
Director of Child &Youth Health	MOPH	No	Contributed to IMCI background and strategy
Director, IMCI	MOPH	No	Contributed to IMCI background and strategy
Consultant	MOPH	No	Contributed to ANDS background
GAVI-HSS Focal Point	WHO EMRO	No	Assisted in identifying key partners in health system strengthening and conducting workshop with provincial teams to identify barriers
Lead Public Health Specialist	World Bank	No	Assisted in formulating and summarizing strategy in context of other donor inputs and Afghan health sector situation
Technical Officer, EPI / surveillance	WHO	Yes	Assisted in linking EPI and HSS strategies and in editing application document
Program Officer for EPI	UNICEF	Yes	Assisted in formulating and linking EPI and HSS objectives
M& E Director	JHU Afg Project	Yes	Assisted in strategies for M&E strengthening
M&E Advisor	Tech Serve, MSH, USAID	No	Assisted in strategies for M&E strengthening
Technical Advisor	Tech Serve, MSH, USAID	No	Assisted in strategies for M&E strengthening
Public Health Specialist	WB, Afg	Yes	Provided information on implementing partners' view of HSS

1.4: Additional Comments on the GAVI HSS Application Development Process

The process used in preparation of the application to the GAVI Alliance for Health System Strengthening Support was both consultative and inclusive. Multiple drafts of the application were vetted by a wide range of stakeholders who provided feedback which was incorporated into this application. All key stakeholders involved in the preparing this document reached a consensus on the key barriers to sustainable improvement and expansion of maternal and child care and immunization.

Included among the primary stakeholders who were extensively consulted were Afghan and International Non-Governmental Organizations who provide the bulk of health service delivery in Afghanistan. Their contribution was critical to the development of this application, including its objectives and priority activities. NGOs will continue to play a critical role in service delivery and in the development of healthcare delivery strategies in Afghanistan.

While guidelines for the implementation of the activities for health system strengthening proposed in the application will be provided by the MOPH, several of the key initiatives outlined in this application will be implemented by the MOPH's national and international partners. These partners have both the management capacity to quickly scale up to implement this program and the technical expertise.

Though some of the key initiatives proposed in this application are new, they have been included in the existing health sector development plans and there will be no parallel staff or systems developed for the GAVI-HSS funded program. The GAVI Alliance's financial support to the Government of Afghanistan will allow for the implementation of these innovations which otherwise would not be possible by filling the gaps from the existing donor support.

The key themes of this application are intended to overcome system-wide or structural impediments (or bottlenecks) and increase the effectiveness BPHS and EPHS delivery and the sustainable expansion of immunization coverage in Afghanistan.

In the preparation of this application, it was widely acknowledged that the key to success in strengthening the health system in Afghanistan in ways that will lead to meaningful improvements in the health of the population is the preparation of clear goals and objectives, establishment of realistic budgets and timeframes for implementation, and the institutionalization of effective monitoring systems.

Section 2: Country Background Information

2.1: Current Socio-Demographic and Economic Country Information

Information	Value	Information	Value
Population (Source – cMYP Afghanistan, 2007)	26,549,294	GNI per capita (UNICEF – Basic Indicators for Afghanistan – 2005)	U.S. $250
Annual Birth Cohort (Source – cMYP Afghanistan, 2007)	1,274,366	Under five mortality rate (UNICEF – Best Estimates for Social Indictors for Children in Afghanistan – 2006)	230 / 1000
Surviving Infants* (Source – cMYP Afghanistan, 2007)	1,076,839	Infant mortality rate (Source – cMYP Afghanistan, 2007)	155 / 1000
Percentage of GNI Allocated to Health (Afghanistan Ministry of Finance Fact Sheet, 2007)	5%	Percentage of Government expenditure on Health (Afghanistan Ministry of Finance Fact Sheet, 2007)	4.19%

* Surviving infants = Infants surviving the first 12 months of life

2.2: Overview of the Afghan National Health Sector Strategy[2]

After two decades of war, when the Taliban fell, Afghanistan suffered from some of the worst health outcomes in the world including a maternal mortality ratio of 1600 per 100,000 live births and an infant mortality rate of 165 per 1,000 live births. In one district of mountainous Badakshan province, a maternal mortality ratio of 6,500 was found, the highest ever recorded. The limited health infrastructure provided so few services that a household survey in 2003 found that, in rural areas, Antenatal Care was only 5.5% and DPT3 coverage was only 19.5%.

In response to this desperate situation the Ministry of Public Health (MOPH), with donors and partners, undertook a series of bold reforms, launched in March 2003: (i) it established a Basic Package of Health Services (BPHS) which focused on the most critical and cost-effective services, including immunization, and entailed training of a cadre of community health workers (CHWs); and (ii) it contracted with NGOs to deliver services through standardized health centers and outreach in most of the country and held them accountable for results.

The MOPH sees its mission as "to improve the health of the people of Afghanistan through the provision of quality health services and the promotion of healthy lifestyles in an equitable and sustainable manner." To achieve this mission, MOPH is focusing on four program areas for its health system re-development efforts as described below:

1) Provision of the Basic Package of Health Services to all Afghans, especially to those living in remote and under-served areas and concentrating on seven major components: i) maternal and newborn heath; ii) child health and immunizations; iii) nutrition; iv) communicable disease treatment; v) mental health; vi) disability services; and vii) essential drug management.

A major accomplishment of the MOPH and its implementing NGO partners is that coverage of the BPHS has increased significantly between 2002 and 2006 and now is being implemented in more than 800 health facilities (BHCs, CHCs, and DHs, all providing routine EPI) (more than 70% of which have at least one female staff) throughout the country. The Balanced Scorecard Survey indicates that there has been a 25% increase in a broad index of quality of care from 2004 to 2006. Many of the advances being made in the healthcare system can be attributed to improvements in human resource management which has involved: (i) the training of hundreds of community mid-

[2] Source: Afghan National Development Strategy

wives selected from under-served rural areas; (ii) payment of higher salaries for health workers in remote areas under the national salary policy; and (iii) the recruitment, training and supervision of more than 15,000 Community Health Workers who have extended the reach of the health system to many of the most remote areas of Afghanistan.

2) Provision of the Essential Package of Hospital Services consisting of four core clinical functions: medicine, surgery, pediatrics, and obstetrics/gynecology and defining for each hospital the minimum level and quality of services to be provided, the minimum staffing levels and patterns, and the minimum level of drugs and equipment needed to provide the mandated services. So far only 11 Provincial Hospitals have been provided support through grants to MOPH to implement EPHS out of 30 existing Provincial Hospitals.

There is a growing presence, in urban areas, of for-profit hospitals and clinics (approximately 170 according to the Afghan Hospital Association). The Ministry of Public health is working cooperatively with private healthcare providers to build the basis on which healthcare standards, licensing and credentialing bodies for healthcare professionals and institutions can be developed.

3) Control of Communicable and Non-Communicable Disease. Specific disease control programs are part of, and implemented by, the BPHS/EPHS implementing partners but have support and guidance structures at the central level. They are dedicated to the achievement of program-specific objectives. Examples include National EPI, National Tuberculosis Program, the Malaria Control Program, and the National HIV/AIDS Control Program.

4) Institutional Development. The MOPH has established a Grants and Contracts Management Unit with the support of donors especially the World Bank where dedicated and qualified staff have successfully managed the contracts and built the trust among all major donors. For example, European Commission is in the process of decentralizing its funds through MOPH. The MOPH has identified a number of institutional challenges on which it intends to focus its development efforts. These include the strengthening of administrative and financial management capacity at all levels (central, provincial, and district), the development of an improved health financing system that includes innovative financing schemes; human resource capacity building; the establishment of a legal and regulatory framework for overseeing private sector activities; and, importantly, the progressive delegation of authority from central to provincial levels, including the responsibility for detailed planning, budgeting and the appropriation of financial resources.

The results of the MOPH policy and strategy since 2003 are beginning to be evident. A household survey done in 2006 indicates that the infant mortality rate (IMR) has fallen to about 135 per 1,000 live births (an 18% reduction which translates into 40,000 fewer infant deaths every year compared to during Taliban times). The same survey found that Antenatal Care has increased to 30% and skilled birth attendance increased from 4.5% in 2003 to almost 19% in 2006. According to routine EPI reporting, immunization coverage (DPT3) has increased from 54% in 2003 to 77% in 2006.

Remaining Challenges:

The decline in IMR is very encouraging, however, it is still higher than that of Chad or Somalia and the prenatal care coverage remains very low by South Asian standards. Another indication that Afghanistan is lagging behind is measles coverage which is 68% nationally with only 28% of the districts having over 80% coverage of measles vaccine. Measles outbreaks in several provinces in 2006 triggered the plan and launching of another measles campaign for children aged 9 to 59 months.

There are, therefore two important conclusions about the health sector in Afghanistan: First, it has made impressive progress since the fall of the Taliban; and second, there is still a long way to go until Afghanistan has acceptable health outcomes and an adequate health care system.

Despite the progress that has been made to date in the health sector, progress is uneven at the district and provincial level and many challenges remain. Afghanistan faces some serious challenges such as insecurity and a lack of domestic resources which affect health but are outside

the purview of the MOPH. Insecurity inhibits the use of healthcare services by the population and limits the accessibility of healthcare workers to the communities. While the Afghan economy is growing briskly, the country is still very poor after many years of war and a destroyed infrastructure. It is unrealistic to expect Afghanistan to be able to finance its public healthcare system from internal sources for the next several years.

Other challenges are more amenable to change and are in the hand of the MOPH. The coordination and oversight of this system of "contracting out" to NGOs and the areas that are not contracted out should be with MOPH but the human, technical and financial resources are insufficient for this work. Some donors monitor BPHS in the areas they support, some have good training programs for health care providers in the facilities they support, and some develop microplans for EPI in the provinces they support, but the MOPH has scarce resources to fill the gaps and ensure the overall equity and quality standards. Through GAVI-HSS funds MOPH hopes to strengthen its own monitoring mechanisms at district, provincial and central levels.
Further, when MOPH identifies a problem at the field level, the NGO implementers are restricted by their contracts and do not have much flexibility to expand their efforts to new physical or technical areas. For example, the tough geography in some parts of the country, the scattered pockets of population, the absence of basic infrastructure such as roads and bridges over the rivers, ethnic problems and so on, all have posed some questions to the definitions of the BPHS health facilities and their basis purely on population factors when physical access may be limited. MOPH has developed a new strategy of establishing sub-centers in the areas with these problems, especially in 9 provinces with low immunization coverage. However, some donors are already stretched to the limit.

Thus, the GAVI-HSS funds would empower the MOPH to fill gaps in health service provision and coordination and monitoring of donor inputs and ensure equity and quality of services.

This proposal for GAVI funds for health system strengthening is fully aligned with the ANDS Health Sector Strategy in objectives, strategy and duration.

In early 2006, during the London Conference, the GOA announced the "Afghanistan Compact", promising the international community as well as the people of Afghanistan to intensify efforts to address the Millennium Development Goals (MDGs). This Compact now forms the basis for the Afghan National Development Strategy (ANDS), being developed for years 1387 to 1391 (21 March 2008 to 20 March 2013). The Health Sector Strategy within the ANDS is focused on four "high benchmarks" regarding reducing maternal and child mortality rates and improving coverage of BPHS and full immunization.

Other official documents also considered include the National Policy and Strategy of 2005-2009 and the pilot project of the Ministry of Finance to institute "program-based budgeting" in four ministries including the Ministry of Public Health from 1386-1388 (21 March 2007 to 20 March 2010). The Afghan EPI cMYP is aligned with this budget document.

Section 3: Situation Analysis / Needs Assessment

3.1: Recent Health System Assessments

Title of the Assessment	Participating Agencies	Areas / Themes Covered	Dates
Afghan National Development Strategy	Ministry of Public Health and many development partners	Includes a general overview of the four "pillars" of the MOPH: 1. BPHS 2. EPHS 3. Control of Communicable and non-Communicable Diseases 4. Institutional Development	December, 2006
National Health Policy 2005- 2009 & Strategy	Ministry of Public Health and development partners	Includes the priority areas which are: ▪ Implementing health services ▪ Reduction of Maternal and child mortality ▪ Human resources Management Translates 18 priorities into 18 strategies	2005
Mission Report, Department of Health Systems, Eastern Mediterranean Regional Office, WHO	Ministry of Public Health, World Health Organization	▪ Human Resources ▪ Management Capability ▪ Operational Context ▪ Logistics	2006
Afghanistan's Health System Since 2001 – "Condition Improved; Prognosis: Cautiously Optimistic"	Afghanistan Research and Evaluation Unit	▪ BPHS ▪ Institutional Development	2007
Afghanistan Health Sector Balanced Score Card	Monitoring and Evaluation Department of the General Directorate of Policy and Planning, MOPH; Johns Hopkins University; Indian Institute of Health Management Research	Performance & delivery of the BPHS; 29 indicators organized into the following domains: 1. Patients & communities 2. Health staff 3. Capacity for service provision 4. Service provision 5. Financial systems 6. MOPH values & vision	2006, 2005, 2004
REACH Baseline / End-line Household Surveys	Management Sciences for Health	▪ Reproductive Health including safe motherhood ▪ Child Health	2006, 2004
Capacity Building and Learning Needs Assessment Report	MOPH; Johns Hopkins University; Indian Institute of Health Management	▪ Capacity building needs and related perceptions among central and provincial MOPH staff.	2006

	Research		
Best Estimates of social indicators for children in Afghanistan1990-2005	UNICEF	▪ Heath and nutrition ▪ Vaccinations ▪ Education ▪ Water and sanitation ▪ Vulnerabilities	2006
Kabul Private Hospital Survey	USAID/ Constella Futures Group/ MOPH	▪ Explores gaps in Public-Private Partnership in the Health System Development	2006
National Risk and Vulnerability Assessment	National Surveillance System, Central Statistics Office, Ministry of Rural Rehabilitation and Development. Johns Hopkins University provided technical assistance in the analysis of the health data.	▪ Contraceptive Prevalence Rate (modern) ▪ Proportion of live births in the previous two years attended by skilled attendants ▪ Antenatal care ▪ Vitamin A supplementation ▪ Measles vaccination ▪ BCG vaccination ▪ Polio vaccination ▪ DPT vaccination	2005
Public Expenditure Review (Health Chapter)	World Bank	▪ Review of health sector policy recommendations	2005
Health Policy in Afghanistan: Two Years of Rapid Change	London School of Hygiene and Tropical Medicine	▪ Health Policy	2005
Public Health System in Afghanistan	Afghanistan Research and Evaluation Unit (AREU)	▪ Overview of Health Policy Issues faced by the Transitional Islamic Republic of Afghanistan.	2002

3.2: Major Barriers to Improving Immunization Coverage Identified in Recent Assessments

The following challenges and constraints to improving the quality and coverage of immunization services were raised on page 19 of the Immunization Comprehensive Multi-year Plan (cMYP):

- Insufficient number of experienced and trained EPI health workers, especially female. (ISS)
- Inadequate transport and communication at the district level to enable monitoring and delivery of supplies to the periphery. (HSS)
- Discrepancy between different sources of population data: the government's Central Statistic Office (CSO) data seems to be underestimated and the data derived from NIDs looks like it is overestimated. The UNIDATA population figure is based on population census carried in 1979. This is a challenging factor in planning, implementation, monitoring and evaluation of immunization program. (HSS)
- Shortage of cold chain equipment (mainly refrigerators) at service level due to prolonged use, poor maintenance, unavailability of spare parts and skilled technicians. In addition, the BPHS implementing partners having the responsibility of running immunization service do not have access to the manufacturers offering standard cold chain equipment for storage of vaccines. (ISS)
- Poor capacity of some NGOs in management of EPI program as they have only recently become involved in health care services. (ISS)

- Poor coordination and communication between the micro-planning at district /provincial level and the GCMU at central level to ensure that all populations are covered with immunization services. The contracting NGOs in some cases have identified a narrow catchment area for provision of immunization service, including only areas served by fixed centers and outreach and not including remote and hard-to-reach areas. The GCMU at the central level may not be aware of the deficiencies in the NGO's contract. (HSS)
- The process of contracting out BPHS is competitive between NGOs and the process of handing over health facilities from one NGO to another creates gap during which the immunization service might be stopped and the vaccinators are not paid. (ISS)

In a further analysis, the cMYP identified the following list of "basic" causes of low immunization coverage.

a. vertical program (i.e. problems with planning, monitoring and supervision of an integrated and coordinated program),
b. scattered population,
c. geographical barriers,
d. poor security environment, and
e. socio-cultural obstacles to access.

During the last five years, HMIS has been introduced in all BHCs and CHCs implementing the BPHS. In addition, MOPH has contracted a twice yearly review of quality of care at a sample of health facilities called the Balanced Score Card. This year MOPH has also contracted the Afghan Household Survey to try to understand the penetration of the BPHS to the household level. The analysis of the barriers to coverage of health services obtained from these documents is remarkably similar to the analysis in the cMYP, emphasizing access to and utilization of services, monitoring and coordination, as outlined below:

A) Contextual Factors: There are a number of obvious contextual challenges that confront efforts to improve health services in Afghanistan, primary among which is insecurity:

a) Insecurity inhibits the use of healthcare services by the population and limits the accessibility of healthcare workers to the communities. In one province, Helmand, 11 health workers were killed in the last year (out of a workforce of 440 or 2.5%) and almost 40% of the existing health facilities in that province have had to close. The effects of this are obvious. Outpatient visits to a health facility in Helmand, on a per capita basis, are less than a third of what they are in a more secure province (Saripul) where the same NGO is providing BPHS services.

b) Lack of domestic investment in health: While the Afghan economy is growing briskly, the country is still very poor after many years of war and a destroyed infrastructure. The ability of the Government to mobilize domestic resources is modest although this will improve over time. However, it is unrealistic to expect Afghanistan to be able to finance its public health care system from internal sources for years to come. What the GOA can do is devote more of its existing resources to the health sector which will decrease its reliance on external financing.

B) Physical Access to Services: The difficult geography and dispersed population of Afghanistan make it very challenging to provide physical access to services. The mountainous terrain, very poor road infrastructure, limited public transportation, and closure of many mountain roads during the winter months obstructs access even though the number of functioning health facilities has expanded considerably over the last few years.

Overall, only 39% of the rural population of Afghanistan lives within one hour's travel (usually walking) of a health facility. The effect of physical access on utilization of services is evident. Preliminary data from the Afghanistan Household Survey (AHS) from 2006 showed that utilization of skilled birth attendance was 27% among women living within an hour's walk of a health facility but declined to less than 6% among those living more than 3 hours travel from the facility.

Furthermore, despite the expansion of the primary health care system and the employment of many more female staff, only 30% of mothers received Antenatal Care during their previous pregnancy (AHS 2006). While this represents a big improvement from the 5% Antenatal Care coverage found in 2003 (MICS), it does indicate that physical access remains a critical bottleneck given Afghanistan's difficult and mountainous geography.

Similarly, of the 14 provinces with the lowest immunization coverage, only 5 have security problems while the remaining 9 have difficult terrain, seasonal blockages of roads, and scattered population, again showing the interplay between physical access and utilization of services.

C) Weak Demand for Services: Weak demand for health care services has been identified as a critical constraint to improving the health of women and children in Afghanistan. For example, even when experienced and capable mid-wives are available and the health facility is within reach, women are still reluctant to use available services. Among women who live within 2 hours' travel of a health facility, only 36% have received antenatal care despite the fact that 71% of facilities have skilled female staff. This suggests that there are still socio-cultural obstacles that prevent women from accessing services even if they are close to health facilities.

Similarly, the drop-out rate from DPT1 to Measles has been over 20% for the last three years, showing low awareness among families of the immunization benefit and low motivation to seek immunization services.

These obstacles are exacerbated by the very low female literacy rates in rural areas (currently varying between 5% and 10% by province) and the limited influence of women on family decision-making in some areas.

D) Gaps in Stewardship: In the Afghan National Development Strategy, the government acknowledges that stewardship of the health sector is its foremost responsibility. In practice stewardship entails establishing a constructive policy environment, setting technical standards, monitoring the performance of the sector, ensuring it has sufficient resources, overseeing the health-related activities of the private sector, and coordinating the inputs of a wide variety of donor organizations. The MOPH has made significant strides in carrying out its stewardship role in the health sector. For example, the MOPH now manages many of the grants and contracts with NGOs. However, there are other stewardship functions that need to be strengthened, including the following:

a) M&E: The M&E system needs to be institutionalized at MOPH and fully equipped to track a rapidly evolving health sector and the health status of the population. Some information is not available and what is available is often not used for decision-making. There is insufficient data on population, including births and deaths, causes of death and coverage of heath services (including EPI). This lack of data has become a limiting factor in improving the effectiveness of delivery of the Basic Package of Health Services.

b) Coordination: There are also weaknesses in coordination below the level of the province where PHO staff are stretched to reach. MOPH staff are needed at the district level to coordinate micro-planning for inter-sectoral response to outbreaks and emergencies as well as immunization campaigns and monitor effective integration of public health services.

c) Health Care Financing: The health sector is still highly dependent on external resources and the MOPH is trying to mobilize the financial resources needed to maintain the progress that has been achieved. Domestic resources are limited and the Government allocates only 0.8% of GDP to public health. The MOPH is trying to increase the share of the budget dedicated to health and is experimenting with various means of mobilizing resources at community level.

E) Insufficient numbers and high turnover of qualified healthcare staff (especially women) in rural areas;

F) Limited capacity of the MOPH to respond rapidly to infectious disease outbreaks (e.g. measles and emerging diseases);

3.3: Barriers that are being adequately addressed[3] with Existing Resources

The following four constraints identified in the Afghan EPI cMYP (2006-2010) are being addressed through GAVI-ISS funds:

- Insufficient number of ... EPI health workers
- Shortage of cold chain equipment ...
- Poor capacity in management of EPI ...
- Unpaid vaccinators

The following barriers are being addressed by several of the MOPH's donors to some degree, though on-going assistance to overcome these challenges will be required for several years to come.

The insufficient number of qualified healthcare staff (especially women) in rural areas is being addressed by several NGOs, and the Government of Afghanistan who are implementing nurse/midwifery and allied healthcare training programs. Nineteen community midwifery schools had over 1200 graduates last year, and an increasing number will be graduated in the coming years.

The road and transportation infrastructure limitations are being addressed by several bi-lateral donors in coordination with Provincial Reconstruction Teams.

Limited capacity of the MOPH to respond rapidly to infectious disease outbreaks is being addressed by grant support to the MOPH Afghan Public Health Institute (APHI) from multiple sources. APHI with support from WHO is in the process of upgrading the Disease Early Warning System; this will be further coordinated at field level by District Health Officers funded by GAVI-HSS.

3.4: Barriers that Require Additional Support from GAVI HSS

The following constraints identified in the Afghan EPI cMYP (2006-2010) require additional support through the GAVI-HSS funds:

- Inadequate resources for monitoring at the district level ...
- Discrepancy between different sources of population data...
- Poor coordination and the micro-planning at district /provincial level ...
- Vertical program (i.e. problems with planning, monitoring and supervision of an integrated and coordinated program),
- Limited access to services: scattered population, geographical barriers,
- Limited utilization of services: socio-cultural obstacles to access.

The summary below indicates how this application is proposing to address the identified barriers requiring additional support from GAVI-HSS:

a) Insecurity will be affected positively by the GAVI HSS funds by developing and strengthening community-level institutions, such as the existing cadre of Community Health Workers (the closest cadre of health system workers to the community) and the proposed sub-centers that reduce the amount of travel necessary for the population and health team to reach the point of healthcare delivery. Locating healthcare facilities close to the

[3] These barriers are being addressed by several of the MOPH's donors to some degree, though on-going assistance to overcome these challenges will be required for several years to come.

communities will generate a sense within the community that the government is committed to their wellbeing.

b) Barriers to physical access will be addressed by creation of sub-centers and the institution in some high priority locations of mobile health-clinic outreach programs, as well as by building the capacity of the existing cadre of Community Health Workers to provide health care at the local level;

c) The limited demand for highly efficacious preventive and promotive healthcare for women and children including immunizations will be addressed by a program for appropriate healthcare demand generation. The misconceptions about risks involved with some vaccinations and inappropriate demand for some ineffective or dangerous interventions (e.g. over utilization of antibiotics and I.V. fluids) will be addressed by an IEC campaign;

d) Insufficient data on population, including births and deaths, causes of death and coverage of health services (including EPI) will be addressed by instituting a program of community based health and demographics monitoring system; The sub-optimal use of health information by MOPH staff will be addressed by a program to strengthen the M&E systems of the Ministry;

e) Inadequate oversight of healthcare provision in remote areas will be addressed by filling gaps in needed training and tools (including means of transportation) necessary for the MOPH to fulfill their oversight and stewardship roles;

f) The weak coordination between the district-level healthcare provision and the Ministry of Public Health at higher levels will be addressed by the incremental role out of a cadre of District Health Officers;

g) The limited ability of the Ministry of Public Health to advocate internally with the Government of Afghanistan to access a greater share of governmental funding will be addressed by a program to improve the capacity of the MOPH to advocate for improved healthcare within the government and population in Afghanistan.

Section 4: Goals and Objectives of GAVI HSS Support

4.1: Goals of GAVI HSS Support

The strategic Goal is to reduce maternal and child mortality by improving the access to, and utilization of, maternal and child health services, including immunization, and strengthening the health system.

4.2: Objectives of GAVI HSS Support

The general objectives of the GAVI HSS support are to:
1. Improved Access to Quality Healthcare particularly maternal and child health.
2. Increased Demand for and Utilization of mother and child health care services.
3. Improve the ability of the MOPH, at various levels, to fulfill its Stewardship Responsibilities.

The general objectives can be translated to the following specific impact/outcome objectives:

1. To increase national DPT3 coverage under age one from 77% in 2006 to 90% by 2012.
2. To increase the number/percent of districts achieving >80% DPT3 coverage under age one from 161 (49%) in 2006 to 329 (100%) by 2012.
3. To reduce under five mortality rate from 210/1000 live births in 2006 to 168/1000 live

births by 2012.

4. To increase the national Measles coverage under age one from 68% to 90% by 2012.
5. To increase the proportion of births attended by skilled health personnel from 19% in 2006 to 40% in 2012.
6. To increase the percent of children receiving treatment for diarrhea and ARI at the community level from baseline in 2006 AHS to 30% above baseline in 2012.

The following specific output objectives, reflecting planned activities, will be:

1. To increase contacts per person per year with the health care system from 0.6 visits/person/year in 2006 to 1.0 visit per person per year in 2012.
2. To increase average number of persons referred by CHWs per quarter from 3.9 in 2006 to 20 referrals per quarter in 2012.
3. To improve “Provider Knowledge Score” of BSC from 68.7% in 2006 to 90% in 2012.
4. To increase the % of mothers in rural communities knowledgeable about prioritized heath messages from baseline in 2006 AHS to 40% above baseline in 2012.
5. To increase % of CHWs trained in community IMCI from 2% in 2006 to 80% in 2012
6. To increase the % of provinces receiving monitoring visits using national monitoring checklist per quarter from 25% in 2006 to 100% in 2012.

Section 5: GAVI HSS Activities and Implementation Schedule

5.1: Sustainability of GAVI HSS Support

The initiatives being proposed in this application will be co-financed with GAVI HSS funds, the Afghan Ministry of Public Health (and other governmental bodies in Afghanistan) and the international donor community, which provides the bulk of the financing for healthcare in the country. It is intended that the initiatives planned to be financed with GAVI HSS funding in this program will not result in the creation of parallel posts in the healthcare system. All new positions created in the implementation of this health system strengthening program are part of the planning and strategy of the Ministry of Public Health and will be absorbed into the regular payroll.

Some of the issues debated related to financial, technical and social/cultural sustainability are as follows:

Financial Sustainability:

1) Limiting growth in the staffing levels of the Ministry of Public Heath to those already planned, and by seeking multiple sources of on-going financing from internal and external sources for all new positions. Explicit plans for assuming the personnel costs for new positions developed in this application are presented herein and commitments from the Ministry of Finance have been obtained for absorbing those positions;

2) Improving the efficiency and cost-effectiveness of existing Ministry of Public Health functions through better oversight, stewardship and resource allocation of existing programs by means of the implementation of better monitoring and evaluation processes, more effective coordination of public and private healthcare programs via the deployment of District Health Officers. In addition, more efficient use of ministry personnel and material resources will be achieved by targeting under-served areas for expansion of health services (and a concurrent de-emphasis of health care provision where surplus supply exists);

3) The expansion of innovative and promising cost-sharing schemes for curative services under development by MOPH partners with stringent mechanisms and guidelines to ensure exemption schemes for the poorest population.

4) Improving accountability to international donors to demonstrate that their investments in the development of the health systems in Afghanistan are indeed resulting in lasting improvements (and are thus worthwhile);

5) Capitalizing on community willingness to share in costs of expanded local healthcare. Recent experience of the MOPH and its partners demonstrate that communities are willing to provide substantial levels of material support such as land and buildings and in repairing or improving roads for transport. Communities have also been able to provide some funds for transportation for patients being referred to higher level health care facilities for treatment.

6) Improved intersectoral cooperation between Ministries and with NGOs in remote areas;

7) Provision of capacity building through training and mentoring of healthcare providers to sustainably improve the effectiveness (including efficiency) of their performance;

8) The lives saved and diseases prevented will lead to a more productive society and less expenditures on curative healthcare.

9) The development of a culture of use of the preventive services (including immunizations) will be developed in this program.

Technical Sustainability:

1) Capacity building through skills training is the primary strategy being employed to maintain the impact of the initiatives being proposed in this program.

2) Reliance on professional Afghan staff to implement the bulk of systems development that will be undertaken in this program will lead to a continuity of leadership in health sector. Where external technical assistance is required, it will be provided in a way that will intentionally lead to the development of the local expertise.

3) The growing role of national NGOs in the delivery of healthcare is leading to an increased indigenous ability to provide health care. This process is being actively facilitated by many actors in the healthcare sector through a broad process of transfer of technology and capability from internationals to locals.

Social/Cultural Sustainability

Strategies for ensuring the social/cultural sustainability of the proposed initiatives include the following important aspects of the heath strengthening program:

1) Localization of the delivery of the healthcare services though the sub-center initiative will dramatically increase the feeling of 'ownership' of the program at the local level with the benefits of increased community support and reduced exposure to hostile acts, as has been shown by recent small-scale trials;

2) Increased confidence of the healthcare system is achieved when the delivery of those services is closer to home. The utilization of healthcare services including, notably, immunization, is enhanced by the proximity that the sub-centers (and mobile health teams) will provide. Mothers are able to access locally provided healthcare when they are close enough to home so that traveling to the healthcare provider does not interfere with their household responsibilities and when their male family members feel confident that their safety is not endangered (as is the perception when they must travel hours from home);

3) Meaningful engagement of local traditional village-level leadership in the planning, establishment, upkeep and sanctioning of local delivery of healthcare, which will lead to the creation of local ownership of the healthcare system.

4) Strengthening the role of the existing cadre of Community Health Workers through improved, ongoing communication between them and the larger health system; on-going training and enhancement of their role in the entire system.

5) Establishment of District Health Officers who will constitute mechanism of liaison between communities and the higher levels of the healthcare system.

6) The localization of healthcare services through the sub-center initiative will not only lead to improved access, it will also make for a safer environment for both the healthcare providers and users. It is known that locally recognized entities are much less targeted by insurgents than government entities.

5.2 .A: Major Activities and Implementation Schedule

1. **Improved Access to Quality Healthcare** particularly maternal and child health**.** Household surveys in Afghanistan indicate that many people living in rural areas still do not have physical access to health services. Despite the expansion of the primary healthcare system and the employment of many more female staff, only 30% of mothers received prenatal care during their previous pregnancy (AHS 2006). While this represents a big improvement from the 5% prenatal care coverage found in 2003 (MICS), it does indicate that physical access remains a critical bottleneck given Afghanistan's difficult and mountainous geography. Similarly, the nine provinces with the lowest immunization coverage (less than 50%) and no security problem are the most remote provinces having difficult terrain, seasonal blockages of major roads, and scattered population. To overcome this constraint and increase access to quality healthcare GAVI HSS support will be used to:

   1.1) Establish 120 sub-centers in under-served communities that will provide most of the Basic Package of Health Services including immunizations through just two health workers (a male nurse and a female nurse or midwife). The World Bank (WB) recently agreed to support 130 "sub-centers," EC is requesting proposals from NGOs in their provinces, and MOPH would use GAVI support for the remaining 120 sub-centers providing basic health services for a total of 600,000 people not currently served by the healthcare system. The sub-centers which would be managed by the NGOs implementing the BPHS (or by the MOPH itself in Kapisa, Parwan, and Panjshir Provinces), typically would operate out of existing buildings in the community, have a catchment population of, on average, 5,000 people, and be within two hours walk of the target population. A portion of the costs for running the sub-centers will be obtained by the transfer of resources from other underutilized service delivery points.

   1.2) Deploy 80 mobile health outreach teams to visit isolated villages that are too far (in excess of 20 km) from existing health facilities and are un-served by the existing healthcare system. These mobile outreach teams will provide, as an interim measure until the facility-based healthcare system is adequately expanded, a wide range of health services including health education, immunization, Antenatal Care, family planning, TB case detection and basic curative care including treatment of Diarrhea and Pneumonia that are part of the BPHS. At least 240,000 people per year will be served by this system who would not otherwise receive any preventive or promotive healthcare. A part of the work of the mobile teams will be to refer serious cases to health facilities so that the deployment of these teams will strengthen the referral system. Staff of the mobile teams will be drawn from the existing cadre working in Basic Health Centers (BHCs) and Comprehensive Health Centers (CHCs) and will be managed by NGOs implementing the BPHS. The experience with mobile outreach in Afghanistan is that it is feasible in reasonably secure areas, and when used strategically with other approaches, can efficiently increase coverage of services. It should be noted that a limited number of mobile teams are functioning effectively in parts of the country (funded by the World Bank and other donors).

   1.3) Expand and build upon a pilot Integrated Management of Childhood Illness (IMCI) project.[4] Another way of improving access to health services is strengthening the skills of the existing cadre of Community Heath Workers (CHWs) that are part of the structure of the BPHS. While CHWs receive a standardized training course before beginning their work, a recent rapid assessment found that less than 50% knew the appropriate use of oral rehydration salts (ORS) and fewer knew the danger signs of ARI. In order to strengthen the skills of the CHWs, they will be provided with focused IMCI training. The program will focus on the promotion a set of key practices: antenatal care; appropriate care seeking behavior; promotion of immunizations; exclusive breastfeeding during first six months; complementary feeding and appropriate treatment for diarrhea, ARI and fever at

[4] UNICEF/Save the Children USA implemented this pilot project in four districts of Kabul and Mazar Provinces.

first-level facilities; personal hygiene; and micronutrient supplementation[5]. This program will be rolled out incrementally over three years to cover at least 80% of entire cadre of 15,000 Community Heath Workers in Afghanistan.

1.4) Develop of an in-service training program to be implemented for BPHS primary healthcare providers who have not received previous in-service training through other projects[6]. Though there has been a steady improvement in the quality of care provided by the majority of primary health care providers, significant gaps exist in the coverage of in-service training. The training will be given to at least 3,500 healthcare providers each year in 13 provinces and focus on the seven primary components of the BPHS which are: i) maternal and newborn heath; ii) child health and immunizations; iii) nutrition; iv) communicable disease treatment; v) mental health; vi) disability services; and vii) essential drug management.

2. **Increased Demand for and Utilization of mother and child healthcare services.** Under-utilization of existing healthcare services has been identified as a critical constraint to improving the health of women and children in Afghanistan. For example, even when experienced and capable mid-wives are available, women are still reluctant to deliver in nearby health facilities. This partly explains the finding that 19% of women have skilled birth attendance in rural areas (AHS 2006) despite the fact that 71% of facilities have skilled female staff. While skilled birth attendance has increased significantly from the 5% found in 2003 (MICS), it is still less than half of the average rate for South Asia. Similarly, the drop-out rate from DPT1 to Measles has been above 20% for the last three years, showing low awareness among families of the benefits of immunization and too little motivation to seek immunization services. To increase demand for maternal and child health services GAVI HSS support will be used to:

2.1) Implement a nationwide strategic Information, Education and Communication (IEC) initiative. This will involve a mass media campaign (especially local radio stations), complemented by personal contact by BPHS staff, focused on awareness building for community leaders, teachers and Mullahs. A limited set of key messages regarding the dangers signs and appropriate responses to ARI and diarrhea, uptake of immunization, and promotion of Antenatal Care and skilled birth attendance, will be used.

2.2) Pilot the effectiveness of a model of demand side financing. In six provinces an incentive (either cash or an appropriate gift) provided to families[7] that use existing maternal and child health services, particularly immunization, Antenatal Care, and skilled birth attendance will be evaluated. Such demand side financing may be useful in overcoming socio-cultural obstacles that impede the use of services especially by women. It is envisaged that this is a short-term solution that will only be required until women are convinced of the value of the services and until female literacy rates have improved. Demand-side financing has been used only recently on a small scale in Afghanistan by NGO implementing agencies, but it has been shown to be remarkably effective in increasing utilization of health services in other countries. Randomized trials (in Mexico, Nicaragua, and Honduras) indicate that substantial improvements in utilization and health status can be achieved through such initiatives.

[5] An evaluation of a Community IMCI program implemented by UNICEF and Save the Children USA in Afghanistan is attached as an annex.

[6] Similar training has already been provided to healthcare workers in provinces supported by the World Bank and the European Commission. In the 13 provinces supported by USAID there are significant gaps in this needed training, which this GAVI HSS program will fill.

[7] Approximately 230,000 incentives will be provided to families in the six target provinces (some families will receive more than one incentive). This program will be evaluated along with the Community Health Worker incentive program which will also be piloted in six Provinces. Out of this 12 provinces, in three Provinces, incentives will be given to both Community Health Workers and to Families for utilization of preventive healthcare use. It is important to note that incentives will only be provided for preventive healthcare use (full immunization and skilled birth attendance). These incentives will not be provided for curative services, for which incrementally increasing user fees are in the process of being established.

2.3) Provide monetary performance incentives to Community Health Workers (CHWs): in six priority provinces. According to 2006 HMIS data, each CHW only referred an average of 3.9 persons to health facilities per quarter, a figure which is considered alarmingly low. The intent of this pilot program is to test whether provision of incentives for CHWs, who otherwise are volunteers, will increase the accomplishment of priority targets (increasing the percentage of deliveries by skilled birth attendants and achievement of full immunization of children) of the BPHS. The program, which will be implemented by partner NGOs, will be tailored to the conditions and needs of each location. A formal evaluation of the program will be conducted after two years of implementation.

3. **Improve the ability of the MOPH, at various levels, to fulfill its Stewardship Responsibilities.** In the Afghan National Development Strategy, the government acknowledges that stewardship of the health sector is its foremost responsibility. In practice stewardship entails establishing a constructive policy environment, setting technical standards, monitoring the performance of the sector, ensuring it has sufficient resources, overseeing the health-related activities of the private sector, and coordinating the inputs of a wide variety of donor organizations. The MOPH needs an effective monitoring and evaluation (M&E) capacity to track the health status of the population and to monitor the performance of the healthcare system. Both health status and health system performance are evolving quickly and the MOPH needs reliable information in near-real time. In addition the leadership of the MOPH needs to engender a "culture of data" and focus on objective results. While many observers think that this has improved over the last few years, there is still a need to have managers and other stakeholders use data more effectively for decision-making. To improve the stewardship capacity of the MOPH, GAVI HSS support will be used for:

3.1) Up-grade the physical, information/communication technology infrastructure and means of transportation[8] of the M&E Department of the Ministry of Public Health adequately at the central, provincial and district levels. The Ministry of Public Health has recently completed a strategic plan for upgrading the M&E function within the Ministry of Public Health[9]. Currently the M&E Department has very limited space and lacks the technology to process and analyze the data that comes to it. Included in this initiative will be to insure that all of Afghanistan's 34 Provincial Health Directorates have internet connectivity;

3.2) Launch a community demographic surveillance system to provide valid and timely information on trends in births, deaths and coverage of healthcare services. Currently, data on infant mortality rates come only from household surveys that provide estimates centered 2.5 to 3 years before the survey was conducted. Hence, current estimates reflect the IMR before the BPHS was being widely implemented. The lag in acquiring data on the performance of the healthcare system is inadequate for making informed decisions and in ensuring that progress towards the MOPH's goals remains on track. The community demographic surveillance system will be rolled out in a representative sample of communities and will be based on a similar system in India (the Sample Registration System). In each community enumerators will record births and deaths, causes of deaths and a limited amount of additional information. This information would be regularly collected and sent to the MOPH's provincial and central office for analysis[10]. This registration system will be evaluated after 24 months, modified based on findings and then rolled out more broadly.

3.3) Expand capacity building program for MOPH managers at the Central and Provincial levels. This program would fill the gaps in management and financial training

[8] Included in "means of transportation" are: per diems, fuel, and provision of motorcycles and bicycles at the Provincial level.
[9] The 2007 ME& Department Strategic Plan is attached as an annex.
[10] A concept paper describing this program is attached as an annex.

previously provided to some provincial officers by some donors but not systematically across the country. This GAVI HSS funded program would build upon the lessons learned in those programs, including the training materials and trainers available.

Also included in this activity would be training aimed at developing the capacity of the M&E Department to conduct and manage the Health Management Information System, the annual national Balanced Scorecard evaluations, and Household Surveys every two years, analyzing the data collected and effectively disseminating information gained in workshops and written reports.

3.4) Develop a communications and internal advocacy program to seek increased funding from the GOA and the international community for the Ministry of Public Health. Currently less than 0.8% of GDP is spent from domestic sources on publicly provided healthcare in Afghanistan. Without an increase in government financing, ,the sustainability of the healthcare system is impossible. A communications campaign, managed by the publicity department of the MOPH , will be aimed at demonstrating the value of greater investments in public health, disseminate the recent achievements of the MOPH, and assist in engendering a culture of results. The activity will include print, radio and television advertisements and the management of media and other events to disseminate what has been learned in the MOPH.

3.5) Launch an initial cadre of District Health Officers who will extend the MOPH's reach into more remote areas of the country. District Health Officers (DHOs) will fill a gap that currently exists at the district level where most other government sectors are represented but MOPH has no officer. DHOs will (i) help coordinate inter-sectoral responses to disease outbreaks and other emergencies; (ii) play an important role in coordinating immunization coverage through support to micro-plan development and monitoring; and (iii) support and monitor the work of the front line health care providers implementing the BPHS[11]. GAVI support will be used to provide orientation, training and material support (such as transportation [motorcycles], office furniture and supplies) to newly recruited DHO staff that will be on the payroll of the MOPH. The program will be rolled out with an initial cadre of 50 DHOs in 2007. After one year their effectiveness and cost efficiency will be evaluated. If promising results, 100 additional DHOs will be introduced in each of the years 2008 and 2009. The DHOs will be located in priority Districts or clusters of Districts[12].

Targeting

Two of the major initiatives in this program aimed at improving access to healthcare services, the sub-center and mobile health clinics, will be rolled out in a limited number of geographic locations, focusing on the most under-served areas of the country (it was specifically noted that the provinces of Nooristan, Daikundi, Ghor and Badakhshan are particularly under-served and will be included). The programs that provide performance incentives for Community Health Workers and health system use incentives for families will be tested on a pilot basis in a limited number of representative provinces. The training programs will be implemented in locations where similar training has not been given (in this way the GAVI HSS funds will be filling a critical gap in healthcare professional training). In the programs noted above, evaluations will be conducted on the cost effectiveness of the intervention so that evidenced based judgments can be made on whether to expand or discontinue the interventions.

[11] A Scope of Work for the District Health Officer is attached as an annex.
[12] A total of 250 DHOs would be deployed to districts or clusters of districts based on population size and geographic specifications. The recent number of Afghanistan Government administrative structure shows 388 districts.

5.2. B: Major Activities and Implementation Schedule

Major Activities	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)				Year 4 (2011)				Year 5 (2012)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1: Improved Access to Quality Healthcare particularly mother child health.																				
Activity 1.1: Establish Sub-Centers in under-served areas.																				
Activity 1.2: Deploy mobile health outreach teams.																				
Activity 1.3: Expand and build upon a pilot integrated management of maternal and childhood illness (IMCI) project at community level																				
Activity 1.4: Develop an in-service training program to be implemented for BPHS primary healthcare providers																				
Objective 2: Increased Demand for and Utilization of maternal and child healthcare services.	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 2.1: Implement a nationwide strategic Information, Education and Communication (IEC) initiative through the existing BPHS staff.																				
Activity 2.2: Pilot the effectiveness of a model of demand side financing.																				
Activity 2.3: Pilot a program to provide monetary performance incentives to volunteer Community Health Workers																				

Objective 3: Improve the ability of the MOPH, at various levels, to fulfill its Stewardship Responsibilities.	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 3.1: Up-grade the physical and information/ communication technology infrastructure of the M&E system																				
Activity 3.2: Launch a community demographic surveillance system																				
Activity 3.3: Expand a capacity building program for MOPH Leaders at the Central and Provincial levels.																				
Activity 3.4: Develop a communications and internal advocacy program to seek increased funding.																				
Activity 3.5: Launch an initial cadre of District Health Officers in priority districts or clusters of districts																				

Section 6: Monitoring, Evaluation and Operational Research

6.1: Impact and Outcome Indicators

Indicator	Data Source for reporting on Indicator	Baseline Value	Source for Baseline Value	Date of Baseline	Target	Date for Target
1. National DPT3 Coverage under age one (%)	MOPH Routine Reporting System	77%	EPI Joint Reporting Format (JRF) 2007	2006	90%	2012
2. Number / % of Districts Achieving ≥80% DPT3 Coverage	MOPH Routine Reporting System	161 (49%)	JRF 2007	2006	329 (100%)	2012
3. Under Five Mortality Rate (per 1000)	MOPH / UNICEF/ GOA surveys	210 / 1,000	UNICEF – Best Estimates for Social Indictors for Children in Afghanistan	2006	168 (Reduced by 20%)	2012
4. National Measles Vaccine Coverage under age one (%)	MOPH Routine Reporting System	68%	JRF 2007	2006	90%	2012
5. Proportion of birth attended by skilled birth attendant (%)	MOPH / UNICEF/ GOA surveys	19%	Afghanistan Household Survey 2006 (AHS)	2006	40%	2012
6. % of children receiving treatment for diarrhea and ARI at community level	MOPH/ AHS / UNICEF/ GOA surveys	TBD	Afghanistan Household Survey 2006 (AHS)	2006	Increase by 30% from the baseline	2012

6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source for indicator	Baseline Value	Source for Baseline	Date of Baseline	Target	Date for Target
1. Contacts/person/year with the healthcare system	# of OPD visits	Total estimated population	Balanced Scorecard; HMIS	0.6 visits /person/ year	ANDS	2006	1.0 / Person / Year	2012
2. Avg # of persons referred by CHWs/ quarter	HMIS reported "Referrals In"/ quarter	Total # of CHWs working in that quarter	HMIS	3.9 referrals/ quarter/ CHW	HMIS, 2006	2006	20	2012
3. Provider knowledge score	#of providers interviewed showing satisfactory score	Total # of providers interviewed during BSC survey	Balanced Scorecard	68.7%	Balanced Scorecard, 2006	2006	90%	2012
4. % of mothers in rural communities knowledgeable about prioritized heath messages	# of mothers responding correctly to questions during survey	Total # of mothers interviewed	Afghanistan Household Survey (AHS)	Soon TBD	Afghanistan Household Survey (AHS)	2006	To increase by 40% from the baseline	2012
5. % of CHWs trained in community IMCI	# of CHWs trained	Total # of CHWs	Training reports, HMIS	2%	UNICEF/Save the children	2006	80%	2012

6. % of provinces receiving monitoring visits using national monitoring checklist / quarter	#of provinces visited by M&E team in a quarter	Total # of provinces accessible during that quarter [13]	M&E department monitoring report	25%	M&E department monitoring report	2006	100 %	2012

[13] Provinces may be inaccessible due to insecurity or weather-related problems such as snow blocked roads, floods, landslides. Every effort should be made to use windows of opportunity to make missions to less accessible provinces.

6.3: Data Collection, Analysis and Use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DPT3 Coverage under age one (%)	MOPH Routine Reporting System	Regular National EPI data collection and analysis	Indicator of protected children, also reflects access and utilization of preventive services; Resource Allocation
2. Number / % of Districts Achieving ≥80% DPT3 Coverage	MOPH Routine Reporting System	Regular National EPI data collection and analysis	Comparison of Districts; Performance Monitoring; Equity Assessment; Resource Allocation
3. Under Five Mortality Rate (per 1000)	MOPH / UNICEF/ GOA surveys	JHU/IIHMR is currently conducting and analyzing AHS. They will train MoPH team to enable them conduct such surveys	Proxy indicator of healthcare system performance; Resource Allocation
4. National Measles Vaccine Coverage under age one (%)	MOPH Routine Reporting System	Regular National EPI data collection and analysis	Indicator of full immunization and protection of children against vaccine preventable diseases (VPD); Resource Allocation
5. Skilled birth attendance (%)	MOPH / UNICEF/ GOA surveys	JHU/IIHMR is currently conducting and analyzing AHS. They will train MoPH team to enable them conduct such surveys	Indicator of safe deliveries; also reflects CHW referrals, access and utilization of available health services; Resource Allocation
6. Children receiving treatment for diarrhea and ARI at community level (%)	MOPH / UNICEF/ GOA surveys	JHU/IIHMR is currently conducting and analyzing AHS. They will train MoPH team to enable them conduct such surveys	Indicator of CHW effectiveness ; efficiency in the health sector , usefulness of trainings ; Resource Allocation
Output			
1. Contacts/person/year with the healthcare system	HMIS	HMIS team analysis	National access and utilization of health services
2. Avg # of persons referred by CHWs/ quarter	HMIS	HMIS team analysis	Affects of provision of incentives on service utilization , assessment of incentive pilot project, bases to more investigate

			efficiency and effectiveness gains in the health system
3. Provider knowledge score	Balanced Scorecard	JHU/IIHMR is currently conducting and analyzing BSC surveys and will train MoPH team	Capacity of service providers , Quality of care; trend of provision of right trainings for right staff, Resource allocation
4. % of mothers in rural communities knowledgeable about prioritized heath messages	Afghanistan Household Survey (AHS)	JHU/IIHMR who are currently conducting and analyzing AHS, will train MoPH team	Overall assessment of IEC program in terms of feasibility of implementation , affects on changing attitudes and behaviors as well utilization of health care
5. % of CHWs trained in community IMCI	Training reports, HMIS	HMIS team analysis	Track the status of trainings provided to CHW, to investigate successes and obstacles in the process
6. % of provinces receiving monitoring visits using national monitoring checklist/ quarter	M&E department Monitoring Reports	Policy & Planning and M&E dept analysis	Making sure the Implementation of M&E plan, effects on coordination , policies implementation , capacity building , provision of equitable technical support to the provinces, identify build the capacity or dismiss unqualified field managers, making sure efficient use of resources

6.4: Strengthening M&E System

The Monitoring and Evaluation Department, under the Supervision of the General Director of Health Policy and Planning within the Ministry of Public Health will be charged with monitoring the performance of the GAVI-Funded Health Systems Strengthening activities. Though the overall monitoring will be the responsibility of the M&E Department, all of the MOPH's partners will have important roles to play in the monitoring of the program.

A strategic plan for Monitoring and Evaluation within the Ministry of Public Health has recently been developed (final draft April 2007). The plan details a list of priority actions required to empower it with the necessary tools, skilled staff and office and information/communication technology infrastructure necessary for it to completely fulfill its mission. Key elements of the capacity building plan are:
1) Clarifying its roles within the MOPH;
2) Developing the staff capacity to fulfill their roles;
3) Establish the necessary physical office space and information/communication technology for effective work;
4) Obtain the necessary transportation budget and vehicles to conduct adequate field monitoring.

The primary means by which the Monitoring and Evaluation System will fulfill its obligations is through the expansion of the National Health Services Performance Assessment (currently covering the BHC/CHC and DH levels) to include the sub-centers and communities targeted by the GAVI Alliance-funded Health Systems Strengthening program. Currently the Monitoring and Evaluation System is dependent upon external assistance to conduct the National Health Services Performance Assessment. Funding necessary to build the necessary capability within the Monitoring and Evaluation Department is included in this plan. It is planned that during the course of the next three to five years that the necessary capabilities will become resident within the MOPH's Monitoring System to fully fulfill its mandates.

6.5: Operational Research

1) Determination of effective means of generating demand for healthcare services among the population, especially for maternal and child care and immunizations with an orientation to examining the increasing of demand for appropriate healthcare (Demand-Side Financing).

2) Evaluate the effectiveness of IEC approaches at influencing key community-level decision makers in relation to the acceptance and use of healthcare provision for maternal and child care and immunizations.

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS Support

Management Mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	General Director of Policy & Planning Directorate of the MOPH ▪ GCMU ▪ Monitoring & Evaluation Department
Role of CGHN in implementation of GAVI HSS and M&E	▪ On-going high-level oversight ▪ Coordination of intersectoral programs and activities
Mechanism for coordinating GAVI HSS with other system activities and programs	▪ CGHN ▪ BPHS Implementers Meeting PPA; PPG; PPC (meet monthly basis) ▪ Provincial Health Coordinating Committee

7.2: Roles and Responsibilities of Key Partners (CGHN Members and Others) for implementation

Title / Post	Organization	CGHN member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
General Directorate of Policy & Planning	Policy and Planning Directorate of the Ministry of Public Health	Yes	Coordination and oversight of GAVI –HSS inputs through CGHN Technical Contribution
Director	Grants and Contracts Unit of the MOPH	Yes	Management of Implementing Partners' sub-contracts
Medical Officer	World Health Organization	Yes	Technical Contribution
Program Officer	UNICEF	Yes	Technical Contribution Material Assistance
Deputy Director, Kabul	World Bank	Yes	Technical Contribution Co-Funding of Related activities (principally BPHS funded activities).
Health Sector Manager	European Community	Yes	Technical Contribution Co-Funding of Related activities (principally BPHS funded activities).
Health Specialist	USAID	Yes	Technical Contribution Co-Funding of Related activities (principally BPHS funded activities).
Project Officer	UNFPA	Yes	Technical Input

			Material Assistance
Country Directors	NGO Implementing Partners	Yes	Implementation Technical Contribution
	Academic and Consulting Institutions	Yes	Technical Contribution Building Capacity of MOPH in M&E
	Community Health Shuras	No	Support to Sub-centers and CHWS Community Input/Guidance

7.3: Financial Management of GAVI HSS Support

Mechanism / Procedure	Description
Mechanism for channelling GAVI HSS funds into the country	Upon approval of the Health System Strengthening application, a tripartite agreement between the Afghan Ministry of Finance, Ministry of Public Health and the GAVI Alliance will be signed. The agreement will be based on the conditions set forth in the application, the relevant provisions of the Government of Afghanistan's finance management system and applicable Afghan law. Based on the signed agreement, a dedicated bank account will be established in the Afghan Central Bank (*Da Afghanistan Bank*) which is in the custody of the Ministry of Finance[14]. The GAVI Alliance will be given instructions to transfer funds according to the schedule set forth in the agreement. Replenishments of expenditures will be made by the GAVI Alliance based on the agreed to schedule and receipt of financial and performance reports as specified in the application and referenced in the agreement. The Treasury Department of the Ministry of Finance will produce English language expenditure reports in the form and according to the schedule acceptable to the all parties as noted in the agreement. Funds provided by The GAVI Alliance will be used only for the purposes explicitly described in the funding application and signed agreement, including any subsequent amendments.

[14] If it would be preferred by The GAVI Alliance, the Ministry of Finance in Afghanistan can open a sub-account in the existing bank account for the GAVI ISS program.

Mechanism for channeling GAVI HSS funds from central level to the periphery	The Ministry of Public Health will have access to the GAVI Alliance's Health System Strengthening funds through fund disbursement mechanisms that have been established by the Ministry of Finance and the Grants and Contracts Management Unit of the Ministry of Public Health. The primary reference document guiding the disbursal of funds is the approved budget and detailed budget Allocation (form B-27). Based on the instructions by authorized personnel of the Ministry of Public Health to the Ministry of Finance, funds from the Central Bank (Da Afghanistan Bank) can be wire transferred to line Ministries within the Government or to specified sub-contractors either within Afghanistan or internationally.
Mechanism (and responsibility) for budget use and approval	The responsibility for management of the GAVI Alliance's Health System Strengthening funds will be with the Ministry of Public Health's Grants and Contracts Management Unit (GCMU). The GAVI Health System Strengthening implementing partners (including NGOs and consultants) as we as departments within the MOPH will prepare annual operational plans and budgets for submission to the Grants and Contracts Management Unit. These plans will be reviewed by the GCMU and if acceptable will then be forwarded to the Ministry of Finance which will authorize them. The Ministry of Finance is responsible for the organization of the execution of the appropriations of the State Budget and enforcement of the financial management requirements as established by the Public Financial and Expenditure Management Law and annual budget procedures as adopted by the Parliament.

Mechanism for disbursement of GAVI HSS funds	The mechanism for disbursement of GAVI Health System Strengthening funds are as follows: a) The project must be authorized in the annual (core) budget or in the Mid Year Review or Supplementary Budget, with approval of the President of Afghanistan. b) MOPH will prepare a Project Coding Sheet (PCS) and allotment forms (B27) and submit them to the Budget Department of the Ministry of Finance. These forms must be authorized by a delegate from the MOPH (usually the Minister or Deputy Minister). c) The Budget Department of the Ministry of Finance checks the validity and accuracy of the information in the forms which are then authorized by the Director General of Budgeting. d) Individual disbursements of funds to the implementing partners and departments within the MOPH are accomplished by the submission of a payment request (form M16) which is submitted to the Treasury Department of the Ministry of Finance along with the Allotment form (B27). The Treasury Department enters the allotment and payment information into the Afghanistan Financial Management Information Systems (AFMIS). e) If there are no discrepancies between the authorized allotments and the payment request, the payment is made by the Treasury Department. f) The Ministry of Finance and the Ministry of Public Health have close coordination through the Grants and Contracts Management Unit of the MOPH.
Auditing procedures	The Control and Audit Office (CAO) of the Islamic Republic of Afghanistan is the supreme audit institution in the Country. It is responsible for auditing the financial statements and accounting transactions of those entities that receive funding from the Afghanistan budget. By mutual agreement, donors may require specific audits on the use of their funds to be to be performed by the CAO and/or external approved auditing agencies. The procedures used by the Control and Audit Office are fully compliant with the requirements of the International Association of Supreme Audit Institutions. The CAO is ready, upon request, to assist with further audits for donors. All new donor agreements are added to the list of grant agreements subject to annual audit. The audit reports are signed by the Auditor-General.

7.4: Procurement Mechanisms

Procurement of goods and services by entities of the Government of Afghanistan are governed by the revised procurement law, which was signed into effect in 2005. Procurement procedures in accordance with Afghan law have been established to ensure that the best value for money is obtained in the acquisition of goods and services. The fundamental principles on which the

procurement procedures were established are: 1) Safeguards against corruption; 2) Transparency; and, 3) Efficiency.

The Grants and Contracts Management Unit manages procurement for the Ministry of Public Health and will manage the acquisition of goods and services procured in the implementation of the GAVI HSS program.

Spending authorization limits for Deputy Ministers, Director Generals and other senior managers within the Ministry of Public Health are formally established by the Minister of Public Health on a regular basis. Specific managers are given authority to approve expenditures for specific projects based on operational plans and budgets for the project. These spending limits are codified in the in an authorizing document (B-51) issued by the Minister of Health and sent for approval to the Minister of Finance. This process is done annually or more frequently if there are major changes in the budget during the course of the year.

Detailed procedures for procurement, as described below, have been established for the procurement of goods and services. Separate procedures have been established for the procurement of items with a value of than less than $5,000.

For Items with a value of less than $5,000, a streamlined process of procurement from pre-authorized vendors is used. The process entails:

1) A Requisition is made from an implementing department for goods or minor services from pre-qualified vendors;

2) The requisition is forwarded for approval from an authorized manager (as specified in the B51 authorizing document);

3) The approved Requisition is sent to the GCMU procurement department for purchase;

4) The GCMU procurement department seeks three quotations for each item being procured. The procurement department will chose the offer from the vendor which offers the best value for money considering price, quality and timeliness of delivery.

For Items with an estimated value of $5,000 to $200,000 the GCMU follows the following tendering procedures for procurement of the goods and services:

1) Detailed requisition of the good or service needed is prepared by the initiating Department with generic specifications fully describing the goods and services needed. Brand names or the names of service providers are not included.

2) Publication of tender – An invitation to bid on the goods or services to be procured is published in nationally circulated publications.

3) Bidding documents – Bidding documents, which provide detailed specifications of the goods or services being procured, are provided to all bidders responding to the invitation to bid.

4) Submission of Bids – Only signed bids submitted in sealed envelopes by the bidder or their authorized representatives are accepted. The deadline for submission, which is between one and three months after distribution of the bid documents, is included in the bidding instructions.

5) Opening and evaluation of bids – Bids are opened at a specified time and place in the presence of the bid selection committee and bidders or their legal representatives.

6) Selection of bid – The selection of the bid is done by committee based on the best value for money considering primarily: low price; fulfillment of criteria; reputation of vendor and assessment of quality of offer.

For Procurement of items of estimated value of greater than $200,000, the above described procedures are followed. In addition, all tenders are published in English and publicized in internationally circulated publications.

Other Procedures:

Two Stage Tendering may be used when the Ministry is unsure of the specifications necessary to accurately describe the good or service needed. The first stage of this process is to seek offers with fully described specifications. The initial stage is conducted with open competition on the basis of bidding documents. The second stage of the process entails solicitation of final offers, including prices of all offers selected in the first stage who presented fully acceptable technical offers.

Requests for Proposals are sought from National and International for profit agencies for the procurement of goods.

Request for Applications are sought from National and International for profit and not-for-profit organizations for the provision of services.

Evaluation of Proposals – Awards are made to bidders whose proposal meets the needs and evaluation criteria described in the request for proposals.

Goods and Services necessary for the implementation of GAVI funded activities will entail the solicitation of national and International offers from new and pre-qualified vendors, consulting firms, universities and non-governmental organizations. Special requirements, if any, required by the GAVI alliance may be included in the funding agreement. More details regarding the procurement process of the Grants and Contracts Unit within the Ministry of Finance may be obtained upon request.

7.5: Reporting Arrangements

Reporting on the GAVI Alliance-funded activities will be the responsibility of the Directorate of Policy and Planning, Ministry of Public Health, who will be responsible for completing the Annual Progress Report. The Monitoring and Evaluation Department of the MOPH will contribute to the reporting process by conducting regular monitoring of progress against benchmarks and targets of the priority impact and outcome indicators as described in this application. The annual progress report will also include a financial report on the use of GAVI HSS funds.

The monitoring of specific HSS project components will be conducted by the operational departments within the Ministry of Public Health and its implementing NGO partners and contractors. These reports will be compiled by a national consultant within the M&E Department for inclusion in the regular reports provided to the GAVI Alliance.

7.6: Technical assistance requirements

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1.IEC	Three years	year one;	Local Consultant/ Organization/Existing NGO Partners[15]
2.M&E	Five years	Year one;	Local & International Consultant/ Organization
3.IMCI	Two years, on intermittent basis	Year one	International Consultant/ Organization/Existing NGO Partners[16]
4.Demand-side Financing	Two years, On intermittent basis	Year one	Local & International Consultant/ Organization

[15] IEC department is receiving International TA from USAID funds.
[16] IMCI program has local consultant.

Section 8: Costs and Funding for GAVI HSS

8.1: Cost of Implementing GAVI HSS Activities

MOPH Afghanistan is applying to GAVI for funds for HSS up to 2010 according to the limits of the first GAVI offer. The budgeted activities below extend to year 2012 to be aligned with the Afghan National Development Strategy (1387-1391).

Area for support	***Cost per year in US$ (,000)***						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	Year 5 of implementation	**TOTAL COSTS**
	2007	2008	2009	2010	2011	2012	
Activity Costs							
Objective 1: **Improved Access to Quality Healthcare.**							
Activity 1.1		$2,200,000	$2,200,000	$2,200,000	$2,200,000	$1,200,000	$10,000,000
Activity 1.2		$400,000	$700,000	$700,000	$700,000	$500,000	$3,000,000
Activity 1.3		$200,000	$250,000	$250,000	$200,000	$200,000	$1,100,000
Activity 1.4		$300,000	$500,000	$400,000	$400,000	$400,000	$2,000,000
Objective 2: **Increased Demand for and Utilization of Healthcare.**							
Activity 2.1		$200,000	$1,000,000	$300,000	$300,000	$200,000	$2,000,000
Activity 2.2		$200,000	$650,000	$300,000	$300,000	$200,000	$1,650,000
Activity 2.3		$200,000	$400,000	$400,000	$350,000	$300,000	$1,650,000
Objective 3: **Improve the ability of the MOPH, at all levels, to fulfill its Stewardship Responsibilities.**							
Activity 3.1		$650,000	$650,000	$450,000	$350,000	$250,000	**$2,350,000**
Activity 3.2		$450,000	$400,000	$300,000	$300,000	$200,000	$1,650,000
Activity 3.3		$300,000	$300,000	$300,000	$300,000	$200,000	$1,400,000
Activity 3.4		$200,000	$200,000	$200,000	$200,000	$200,000	$1,000,000
Activity 3.5		$200,000	$300,000	$300,000	$300,000	$100,000	$1,200,000
Support Costs							
Management costs		$100,000	$100,000	$100,000	$100,000	$100,000	**$500,000**
M&E support costs		$300,000	$300,000	$300,000	$300,000	$300,000	**$1,500,000**
Technical support		$800,000	$1,000,000	$700,000	$300,000	$300,000	**$3,100,000**
TOTAL COSTS		**$6,700,000**	**$8,950,000**	**$7,200,000**	**$6,600,000**	**$4,650,000**	**$34,100,000**

8.2: Calculation of GAVI HSS Country Allocation

GAVI HSS Allocation	Allocation per year (US$)						TOTAL FUNDS
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	Year 5 of implementation	
	2007	2008	2009	2010	2011	2012	
Birth cohort	1,274,366	1,304,951	1,336,270	1,368,340	1,401,180	1,434,809	
Allocation per newborn		$5.00	$5.00	$5.00	$5.00	$5.00	
Annual allocation		**$6,524,754**	**$6,681,348**	**$6,841,700**	**$7,005,901**	**$7,174,043**	**$34,227,746**

Source and date of GNI and birth cohort information:

GDP: Ministry of Finance, Islamic Republic of Afghanistan (Note: GNI Not Available)

Birth Cohort: Afghan Comprehensive Multi-Year Plan for Immunization 2007.....

Total Other: Population growth rate = 2.4% Afghan Comprehensive Multi-Year Plan for Immunization 2007 .....

8.3: Sources of All Expected Funding for Health Systems Strengthening Activities[17]

Funding Sources	Allocation per year (in millions of US$)						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	Year 5 of implementation	TOTAL FUNDS
	2007	2008	2009	2010	2011	2012	
GAVI	$0.00	$5.27	$9.28	$7.23	$6.68	$5.73	$34.19
Government	$26.50	$26.50	$26.50	$26.50	$0.00	$0.00	$106.00
Donor 1: USAID	$20.05	$20.05	$20.05	$20.05	$0.00	$0.00	$80.20
Donor 2: EC	$2.95	$2.95	$2.95	$2.95	$0.00	$0.00	$11.80
Donor 3: WHO	$1.28	$1.28	$1.28	$1.28	$0.00	$0.00	$5.10
Donor 4: ICRC	$0.73	$0.73	$0.73	$0.73	$0.00	$0.00	$2.90
Total Other	$0.68	$0.68	$0.68	$0.68	$0.00	$0.00	$2.70
TOTAL FUNDING	$52.18	$57.45	$61.46	$59.41	$6.68	$5.73	$242.89

[17] There is apparently some degree of uncertainty regarding how much external funding is provided to the Government of Afghanistan for Health System Strengthening. The figures provided in this table are the best estimates that we were able to obtain.

Source of Information on Funding Sources:	
GAVI:	May 2007 GAVI HSS Funding Application
Government:	Ministry of Finance
Donor 1:	USAID Afghanistan
Donor 2:	EC Office in Afghanistan
Donor 3:	WHO Office in Afghanistan
Donor 4:	ICRC
Other:	Aga Khan Health Services; UNICEF; Global Fund

Section 9: Endorsement of the Application

9.1: Government Endorsement

The Government of the Islamic Republic of Afghanistan commits itself to providing immunization and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Public Health:	***Ministry of Finance:***
Name: Dr. Sayed Mohamad Amin Fatimi	Name: Dr. Anwarulhaq Ahadi
Title / Post: Minister of Public Health	Title / Post: Minister of Finance
Signature:	Signature:
Date:	Date:

9.2: Endorsement by Consultative Group on Health & Nutrition (HSCC Equivalent)

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on 2 May 2007. The signed minutes are attached as Annex 13.

Chair of CGHN (HSCC equivalent):

Name: Dr. Faizullah Kakar And Dr. Shukrullah Wahidi	Post / Organization: Deputy Minister Technical and General Director of Policy and Planning
Signatures:	Date:

9.3: Person to contact in case of enquiries:

Name: Dr. Abdul Wali Title: Consultant to General Director of Policy and Planning

Tel No:+93-799-353 178

Email:moph_ppgd@yahoo.com, or drabwali@yahoo.com
OR moph.tdd@gmail.com

Address: Ministry of Public Health
Great Masood Circle,
Wazir Akbar Khan
Kabul, Afghanistan

ANNEX 1 Documents Submitted in Support of the GAVI HSS Appli

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
Afghan National Development Strategy (Interim Poverty Reduction Strategy Paper)	Yes	Through 2012	#1 draft
National Health policy 2005-2009 & National Health strategy 2005-2006	Yes	2005-2009	#2
Comprehensive Multi-Year Plan for Vaccinations (cMYP)	Yes	2006-2009	#3
Afghanistan's Health System Since 2001 – Condition Improved; Prognosis Cautiously Optimistic	Yes	2007	#4
Mission Report Department of Health System EMRO, WHO	Yes	2006	#5
Afghanistan Health Sector Balanced Score Card	Yes	2006	#6
REACH Baseline / End-line Household Surveys	Yes	2006	#7
Capacity Building and Learning Needs Assessment Report	Yes	2006	#8
Best Estimate of Social Indicators for Children: Afghanistan 1990-2005	Yes	2006	#9
Kabul Private Hospital Survey	Yes	2007	#10
National Risk and Vulnerability Assessment	Yes	2005	#11
Public Expenditure Review (Health Chapter)	Yes	2005	#12
Health Policy in Afghanistan: Two Years of Rapid Change	Yes	2005	#13
Public Health System in Afghanistan	Yes	2002	#14
Consultative Group for Health & Nutrition Minutes (signed by the Chair)	Yes	2007	#15
Annex:			
Basic Package of Health Services (BPHS)	Yes	2005	#1
Essential Package of Hospital Services (EPHS)	Yes	2005	#2
Concept Paper for Sub-Centers	Yes	2007	#3
Terms of Reference – District Health Officers	Yes	2007	#4
Monitoring and Evaluation Strategy, MOPH	Yes	2007	#5
Concept Paper for a Community Health Monitoring System in Afghanistan	Yes	2007	#6
Community IMCI Pilot Project Final Report	Yes	2006	#7
Presentation on AHS	Yes	2007	#8
Rapid assessment of CHW knowledge compared with knowledge of doctors and Nurses	Yes	2007	#9
IEC 10 prioritized messages	Yes	2007	#10
Summary pages of the attachments of GAVI-HSS Application	Yes	2007	#11

ANNEX 2 Banking Form

GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION	Banking Form

SECTION 1 ***(To be completed by payee)***

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunization dated . . . . . , the Government of . . . . . hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: ***(Account Holder)***		
Address:		
City – Country:		
Telephone No.:	**Fax No.:**	
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**
For credit to: ***Bank account's title***		
Bank account No.:		
At: ***Bank's name***		

Is the bank account exclusively to be used by this program? **YES (√) NO ( )**

By whom is the account audited? _____

Signature of Government's authorizing official:

Name:		**Seal:**
Title:		
Signature:		
Date:		

SECTION 2 *(To be completed by the Bank)*

FINANCIAL INSTITUTION	**CORRESPONDENT BANK (*In the United States)***
Bank Name:	
Branch Name:	
Address:	
City – Country:	
Swift code:	
Sort code:	
ABA No.:	
Telephone No.:	
Fax No.:	

I certify that the account No. . . . . Is held by (*Institution name)* . . . . . .at this banking institution.

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name:	**Signature :**
Title:	**Date:**
2 Name:	**Seal:**
Title:	
3 Name:	
Title:	
4 Name:	
Title:	

COVERING LETTER

(To be completed by UNICEF representative on letter-headed paper)

TO: GAVI – Secretariat
Attention: Dr Julian Lob-Levyt
Executive Secretary
C/O UNICEF
Palais de Nations
CH 1211 Geneva 10
Switzerland

On the …… I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	.....	.....
Bank's authorizing official	.....	.....

Signature of UNICEF Representative:

Name .....

Signature .....

Date .....