Health Systems Funding Platform (HSFP)

Health Systems Strengthening (HSS) Support

COMMON PROPOSAL FORM

This common proposal form is for use by applicants seeking to request Health Systems Strengthening (HSS) Support from GAVI and/or the Global Fund.

HSS Funding requests to the Global Fund using the Common Proposal Form and Guidelines can only be made when the application materials are launched on 15 August 2011

This form is structured in three parts:

- Part A - Summary of Support Requested and Applicant Information
- Part B - Applicant Eligibility
- Part C - Proposal Details

All applicants are required to read and follow the accompanying guidelines in order to correctly fill out this form.

Part A - Summary of Support Requested and Applicant Information

Applicant:	***Ministry of Public Health (MoPH)***			
Country:	***Afghanistan***			
WHO region:	***Eastern Mediterranean Region***			
Proposal title:	***Strengthening the health system in Afghanistan***			
Proposed start date:	***01/04/2013***			
Duration of support requested:	***Two years***			
Funding request:	**Amount requested from GAVI:**	**18,199,607**	**Amount requested from Global Fund:**	
Currency:	◉ USD		○ EUR	

List of Abbreviations

AMS	**Afghanistan Mortality Survey (2010)**
ANDS	**Afghanistan National Development Strategy**
ARI	**Acute Respiratory Illness**
BPHS	**Basic Package of Health Services**
CSOs	**Civil Society Organizations**
CGHN	**Consultative Group of Health and Nutrition**
CHWs	**Community Health Workers**
CBHC	**Community Based Health Care Program**
DHOs	**District Health Officers**
DPT	**Diphtheria, Pertussis and Tetanus trivalent vaccine**
EPHS	**essential Package of Hospital Services**
EPI	**Expanded Program of immunization**
EOC	**Emergency Obstetrics Care**
EU	**European Union**
EMRO	**Eastern Mediterranean Region of World Health Organization**
EVM	**Effective Vaccine Management**
GoA	**Government of Afghanistan**
GAVI	**Global Alliance for Vaccination and Immunization**
GF-ATM	**Global Fund**
HRD	**Human Resources Development**
HSS	**Health System Strengthening**
HSS-SC	**Health System Strengthening Steering Committee**
HMIS	**Health Management Information System**
HSC	**Health Sub-centre**
IEC	**Information, Education and Communication**
IMCI	**Integrated Management of Childhood Illness**
MoPH	**Ministry of Public Health**
MICS	**Multiple Indicator Cluster Survey**
MCH	**Mother and Child Health**
M&E	**Monitoring and Evaluation**
NIP	**National Immunization Program**
NMC	**National Monitoring Checklist**
NGOs	**Non-Governmental Organizations**
NRVA	**National Risk and Vulnerability Assessment**
PPP	**Public Private Partnership**
PHDs	**Provincial Health directorates**
RH	**Reproductive Health**
RED	**Reach Each District**
TB	**Tuberculosis**
TA	**Technical assistance**
ToR	**Terms of Reference**
UNICEF	**United Nations Children's Fund**
USAID	**United States Agency for International Development**
UN	**United Nations**
WHO	**World Health Organization**
WB	**World Bank**

Contact details	
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Executive Summary
→ Please provide an executive summary of the proposal.

TWO PAGES MAXIMUM

BACKGROUND (1st draft)

Since 2002, Afghanistan has made substantial progress in improving the accessibility of health care. As a result, noticeable impact on the health of the population is now well documented. However, the country continues to face many challenges and remains among the countries with the poor health indicators. In addition to high infant and child mortality, high maternal mortality[i] the health sector faces the challenges of poor nutrition, poor sanitation and high burden of communicable diseases in a country where population growth remains very high.

The primary health care is delivered through Basic Package of Health Services which is a selective set of primary health care interventions. The BPHS is being implemented in 31 provinces by NGOs and in 3 provinces by MOPH. Secondary care is partly covered at the District Hospitals within BPHS but mainly it is delivered through the Essential Package of Hospital Services (EPHS). The EPHS is delivered in almost 15 hospitals. Most of the hospitals at the central and provincial levels remain with inadequate support and in messy condition.

NGOs have been a fundamental factor in rebuilding the Afghan health sector. MoPH, re-constructed in 2002, would have never had the capacity to deliver alone. While the MoPH focused on its stewardship responsibilities, the NGOs were the field agents expanding the coverage of health care to the people of Afghanistan, including those living in the remote and isolated areas. In addition, the for-profit private sector provides more than have of the available health services in the country. Despite the significant role of the private sector, information about its structure and performance is poorly documented.

Trends of infant and child mortality, known to be among the highest in the world, were the first signals of success. Infant and child mortality rates were decreased from 165 and 257/1000 in 2002 to 129 and 191 respectively in 2008. Further the Afghanistan Mortality Survey 2010 (AMS) shows a further reduction to 77 and 97/1000 live births respectively. In addition the AMS shows that Maternal mortality is reduced from 1600/100000 live births in 2002 to 327/100000 live births in 2010 which is significantly impressive. Number of outpatient consultations per person per year increased from 0.6 in 2006 to 1.04 in 2010. As a result, TB case detection has

increased from 10% in 2002 to 70% 2010, Malaria PV cases has dropped from over 300,000 cases in 2002 to less than 80,000 cases in 2010. In addition, number of institutional delivery has increased from 130,000 per year in 2006 to over 350,000 deliveries in 2010. At the community level, to date over 21,000 CHWs have been trained and there is significant increase in the number of ARI and Diarrhea cases managed at community level.

WHO-UNICEF estimate s of immunization coverage shows considerable increase in the proportion of targeted children covered by the various antigens. Regarding EPI in particular, it worth mentioning that when Afghanistan made its first application to GAVI in 2007, the DPT3 coverage was 77%. EPI reporting estimates the DPT3 coverage to be 87% in 2010.

All these gains are attributed to the support of all health sector partners including but not limited to donors, NGOs, other GoA organizations, UN agencies and dedicated health workers.

The implementation of HSS in Afghanistan started in 2007 with the financial support of GAVI. This was a significant development and led to major important outcomes far exceeding the planned objectives. The HSS program introduced and implemented a number of innovative initiative to promote the coverage and performance of, in particular, EPI and basic MCH services. The training of community midwives in remote provinces through partnership with NGOs and the use of the private sector capacity in security compromised areas proved successful innovation in the health system of Afghanistan. In 2007, the DPT coverage was 77% and jumped to 87% in 2010 is an example for the major achievements (reports of routine EPI).

Although having impressive gains, still there are myriad of challenges. 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.

CHALLENGES

- *There is considerable difference in access to health care between the urban population in one hand and the rural and Kochi population on the other. Similarly, access is low in remote and isolated provinces. In addition, security is a major obstacle affecting the functioning of the public health facilities.*
- *Access to water and sanitation remains very poor. Only 27% of population has access to safe drinking water. Sanitation facilities are even poor. Only 5% of population has improved sanitation facilities. The environment health is significantly poor. Huge efforts are paid for Health education, however, still require immense attention. The MOPH needs to further coordinate with other key GOA and partner organizations to promote the health of the people. For example, although 54% of women reside in one hour walking distance from HFs , the AMS 2010 shows that only 27% of women seeking care for ANC, delivery and postnatal.*
- *Lack of sufficient capacity at the provincial level leading to dependence on the*

central ministry to perform governance, monitoring and supervisory functions. The result was only 30% of the provinces were regularly monitored on quarterly basis in 2010 according to the M&E department of MoPH.

- *The BPHS agreements between MoPH and implementing NGOs do not sufficiently elaborate the role of such NGOs regarding some important health care services.*
- *There is apparent lack of balance in funding different services. Many hospitals, as an example, remained dependent only on the scarce government resources resulting in miserable situations and poor quality services.*
- *Lack of qualified health workers especially female in remote areas and distribution of health professionals and workers over the various provinces suffers major inequality. In general, urban areas have more what they need of doctors, nurses, midwives and other health cadres while in remote areas there is immense need.*
- *EPI program faces significant challenges mainly in its cold chain system and equipment although the GOA, WHO, UNICE and GAVI are providing support.*
- *The achievements made led to increasing public expectations and emergence of new demands and challenges. Quality of hospital care is an example of those challenges. The contribution of the hospital sector in promoting the health status of the Afghan population remains limited.*
- *Limited financing of the health sector is one of the main challenges. Although the MOPH in coordination with its partners have been very successful, still the financing levels are significantly low.*

The GAVI HSS support has been very instrumental where the documented evidences are timely reported. GAVI HSS support, through establishing sub centres, mobile health teams and many other interventions, improved access and utilization to the highest possible level, however, there are many more critical areas that requires immediate attention.

This proposal aims at contributing to MoPH efforts to improve the quality of life and health status of the Afghan population. The strategic Goal for this proposal is: To reduce maternal and child mortality by strengthening the health system through improving the access to, and utilization of, immunization, maternal and child health services.

<u>Objectives and key interventions:</u>

Objective 1: <u>To improve access and increase the coverage of immunization and other essential health services particularly for the underserved population</u>

1.1: To increase DTP3 coverage in Kochi children from 16% in 2010 to 30% in 2014

1.2: To establish partnership with for-profit private sector at different levels of health care delivery system

1.2.1: To continue and scale up the CSO type B project focused on the delivery of EPI and other essential maternal and child health services in remote and insecure areas of the country

1.3: To implement the Community Integrated Management of Childhood Illnesses (CIMCI) program in the remaining 7 out of 34 provinces.

Objective 2: To improve quality, effectiveness and utilization of health care and immunization services.

2.1: To improve quality and performance of EPI program at different levels

2.2: To do a critical analyses of the implementation of BPHS at different levels and improve contracting process to ensure EPI and other essential Maternal and Child health priorities are well managed through contracting process

2.3: To promote health through awareness raising initiatives

Objective 3: To improve the ability of MOPH to fulfil its stewardship responsibilities at all levels with a more focus on peripheral level

3.1: Improving Monitoring and Evaluation processes at different levels with a more focus on peripheral levels

3.2: Streamlining procurement of non-consultancy services

SUSTAINABILITY

- *The proposed interventions are aligned with the national health policy and strategies. They were proposed based on a thorough review of HS, its performance, achievements and challenges.*
- *The interventions build on and benefit from existing HS structures and activities.*
- *The proposal focuses on activities (such as immunization, treatment of ARI, and awareness raising) that are regarded as highly cost-effective. In addition, use workers on contract so as to avoid long-term Government obligations and allow flexibility in re-deployment of staff and rely, wherever possible, on existing human and financial resources to carry out new activities.*
- *The interventions foreseen to build the capacity of MoPH and to maximize the community support to the health sector.*
- *Building capacity at the provincial level increases effectiveness of management, decreases dependence on the centre, promotes ownership and consequently support by the beneficiaries in addition to reducing the management costs.*
- *The interventions benefit from the huge existence and capacity of the private sector.*

The MOPH is applying for GAVI HSS support to fill the gaps in the funding of its plans. The

MOPH has a track record of success over the last years of successfully implementing externally financed activities. 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 5-10 years. In the long-term the prospects are much better especially given the growing economy.

Impact/outcome Indicators and targets:

To reduce under five mortality rate by 5% (from 97/1000 live births in 2010) in 2014

To reduce infant mortality rate by 5% (from 77/1000 live births in 2010) in 2014

To increase Penta 3 coverage from 87% in 2010 to 92% in 2014 (routine reports)[ii]

To increase Penta 3 coverage in Kochi children from 16% in 2010 to 30% in 2014

To reduce dropout rate (Penta1- Penta 3) from 12% in 2010 to <10% in 2014

To improve equity in immunisation coverage: Percentage point difference between Penta 3 coverage in the lowest wealth quintile vs DTP3 coverage in the highest wealth TBD

To increase % of women seeking care for ANC, delivery and postnatal from 27% in 2010 to 35% in 2014

To increase proportion of provinces capable to implement the M&E strategy (NMC implemented and replica provided) from 40% in 2010 to 80% in 2014

Part B - Applicant Eligibility

If this application includes a request to the Global Fund, please fill out the eligibility and other requirements section available here.

If this application includes a request to GAVI, please click here to verify the applicant's eligibility for GAVI support.

Part C - Proposal Details

1. Process of developing the proposal

1.1 Summary of the proposal development process

→ Please indicate the roles of the HSCC and CCM in the proposal development process. Also describe the supporting roles of other stakeholder groups, including civil society, the private sector, key populations and currently unreached, marginalised or otherwise disadvantaged populations. Describe the leadership, management, co-ordination, and oversight of the proposal development process.

ONE PAGE MAXIMUM

The Consultative Group on Health and Nutrition (CGHN) is the Government of Afghanistan's equivalent of the Health System Consultative Committee. The overall objective 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. In Afghanistan the CGHN sub group for all HSS initiatives is the Health System Strengthening Steering Committee.
The steering committee consists of the members from the WB, USAID, EU, WHO, UNICEF, Ministry of Finance, NGOs elected representative and key departments of MOPH which is led by Acting Minister of Public Health.

The CGHN (HSS-SC) discussed in several meetings the joint health system funding platform for both GAVI and GF. Also the platform was explained by GAVI mission with HSS-SC key members and Civil Society Organizations through separate meetings. After release of the guidelines, the HSS-SC assigned a team of technical experts to coordinate and draft the proposal. The team was consisted of the following individuals:

1. Dr. Abdul Wali, Health System Strenghtening Coordinator and Focal Point MOPH MoPH
2. Dr. Gula Khan/Dr. Aqa Gul Dost, EPI/MOPH
3. Dr. Shakoor Waciqi, EPI and national GAVI Advisor, WHO
4. Dr. Ashfaq Ahmed PHC officer , WHO
5. Dr. Ghulam Farooq Mujadidi , EPI, UNICEF
6. Dr. Yasin Rahimyar Representative of Civil Society organizations
7. Dr. Iqbal Roshani (USAID) representing donors
8. Dr. Ahmed Abdul Rahman HSS WHO

Desk review where all the evaluation reports, survey reports, HMIS, assessments and other available evidences were reviewed. Criteria for intervention selection were set and a national gap analyses work shop was conducted to define priorities. Through this gap analyses workshop, after lengthy discussions, priorities were identified (Annex 2). Based on the criteria and guidelines, relevant departments of MOPH along with their relevant stakeholders were invited to support proposal development. During the process, other experts and stakeholders were also invited to WG meetings or provided useful comments and contributed to different segments of the application and reviewing the different drafts who are mainly including:

- Dr. Nadera Haya Burhani Deputy Minister of Public Health
- Dr. Ahmad Jan Naeem – General Director of Policy and Planning
- Dr. Ibn Amin – 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. Motawali Younosi – Director IMCI, MOPH
- Dr. Najib Safi WHO
- Dr. Mounir Farag – GAVI-HSS Focal Point, WHO EMRO
- Dr. Ghulam Dastgir Sayed – Public Health Specialist, World Bank
- Dr. Zahra EPI UNICEF
- Dr. Kayhan Natiq – JHU and Silk Route NGO
- Dr. Christ– M&E Advisor Tech serve USAID
  In addition heads of the departments of Kochi Health Directorate, EPI department, Child and Adolescent Health Department, Health Promotion Department, Procurement directorate and GCMU, provided support to the process.

The proposal was shared with the entire country Provincial Health Directors on 11-12 Dec in PHDs coordination work shop and comments were noted. In addition, the proposal was regularly shared with Health Civil Society Organizations Network and use full comments were provided. In addition, the CSO network provided full support in the drafting one segment of this proposal. In addition, the drafts were emailed to all stakeholders. To provide additional technical assistance, one international consultant was

provided by WHO.

Finally the proposal was presented to the CGHN meeting on Dec 28 2011 for endorsement. The meeting endorsed the application and also endorsed that considering the duration of the requested and the urgent needs of Afghan people, since the contracting through Gov system will be too long, WHO system to be used for management. (Annex 8).

Comments of the IRC concluded that proposal to be resubmitted taking in consideration a number of points. The proposal development team convened several times to study the IRC comments. The comments were presented to the HSS Steering Committee for guidance and advice. Meanwhile, the various programs involved were contacted to review their proposed interventions; inputs required and expected outputs in line with the IRC comments. Based on a presentation by the HSS Coordination unit, a special EPI stakeholders meeting made fresh discussion on the proposal and the IRC comments and reaffirmed their support to the proposal being priority oriented and evidence-based. All the inputs from these different forums were incorporated into the proposal. Inputs that are not directly related to the content of the proposal, i.e Financial Gap Analysis, cMYP and EPI in Depth Review, were prepared and/or revises by or in collaboration with the relevant MoPH unit with WHO support. In addition, 3 audio conference were held during March/April 2012 with WHO EMRO to discuss key issues related to the proposal and get the inputs. The proposal development team developed the final draft of the new version of the proposal and shared it with the HSS Steering Committee for final review prior to the resubmission. (Annex 6)

1.2 Summary of the decision-making process

→ Please summarise how key decisions were reached for the proposal development.

As discussed above, the decisions were made by CGHN (HSS-SC) who assigned the panel and decided the way the proposal to be submitted. The work shop on gap analyses with wide participation from stakeholders defined the priorities. In this work shop all lessons learned from first GAVI HSS support was presented to the work shop. Later on it was followed by the presentations of National Health Sector Strategy and EPI program achievements and challenges. The work shop participants based on the available information and extensive experience about the health system in Afghanistan were grouped into working groups working on health system building blocks under the guided criteria and lesson learned from initial GAVI support.

The criteria were:
- Being in line with national strategies
- Consider current related outcomes including the quality of evidence
- Linkages with EPI outcomes
- Effect size
- Cost effectiveness
- Feasibility of implementation (both demand and supply side)
- Gender considerations
- Equity considerations
- Probability of producing outcomes
- Additionally
- Sustainability

Keeping in mind the ceiling, the selected interventions were discussed in several meetings of proposal development committee, grouped under relevant objective and then shared with the chair of CGHN and also shared with CSOs, PHOs, and MOPH departments. All the applicable comments were incorporated. Finally the CGHN endorsed the application on Dec 28 2011.

2. National Health System Context

2.1 a) National Health Sector

→ Please provide a concise overview of the national health sector, covering both the public and private sectors at the national, sub-national and community levels.

FOUR PAGES MAXIMUM

Afghanistan is a land locked country with approximately 25 million populations. Afghanistan has been one of the most under developed countries the HDI of which is ranked 158 out of 172 countries. The illiteracy is a major challenge for the country especially the low literacy rate among women (12%) and the mean for marriage is 17.9 years old which looks to be too early.

The Health Status indicators in Afghanistan were one of the poorest in the world. According to UNCEF estimates Afghanistan was ranked second by having the highest under five-mortality rate in the world. Based on the latest available data, Afghanistan had the highest maternal mortality ratio at 1,600/100,000 live births. However, prevalence of stunting has been at the high rate of 59% which has been increased from previous estimates. In addition, wasting has been alarming.

Since 2002, Afghanistan health sector maintained a steady progress from one success to the other. A substantial improvement has been made in health care coverage and accessibility inducing noticeable positive impact on the health of the Afghan population. However, the country continues to face many challenges and remains among the countries with the worst health indicators. In addition to high infant and child mortality, high maternal mortality the health sector faces the challenges of poor nutrition, poor sanitation and high burden of communicable diseases in a country where population growth remains very high.

The health sector in Afghanistan is characterized by the strong cooperation between the MoPH and the NGOs. The Ministry assumes the role of stewardship and governance responsible for policy and strategy formulation in addition to regulation, coordination, health financing, monitoring and evaluation and accreditation. The NGOs are the main public care providers.

More than 75% of the total health care expenditures in Afghanistan are from private sources (out of pocket). Meanwhile, the public sector is almost fully dependent on external assistance. The funds mainly come from USA, EC, the World Bank, the GAVI, the GFATM, and UN in addition to the Government of Afghanistan.

The primary health care is delivered through Basic Package of Health Services which is a selective set of primary health care interventions. The BPHS is implemented in 31 provinces by NGOs and in 3 provinces by MOPH. Secondary care is partly covered at the District Hospitals within BPHS but mainly it is delivered through the Essential Package of Hospital Services (EPHS). The EPHS is delivered in almost 15 hospitals. Most of the hospitals at the central and provincial levels remain without support and in messy condition.

NGOs have been a fundamental factor in rebuilding the Afghan health sector. The MoPH, re-constructed in 2002, would have never had the capacity to deliver alone. While the MoPH with the opportunity focused on its stewardship responsibilities, the NGOs were the field agents expanding the coverage of health care to the people of Afghanistan, including those living in the remote and isolated areas.

In addition to the active role of the non-profit NGOs in the public health sector, the for-profit private sector provides more than have of the available health services in the country. Despite the significant role of the private sector, information about its structure and performance is poorly documented. Through a previous GAVI round of funding, the MoPH has successfully piloted the involvement of the private sector in EPI and other health preventive interventions in security compromised areas.

Trends of infant and child mortality, known to be among the highest in the world, were the first signals of success. Infant and child mortality rates have decreased from 165 and 257/1000 in 2002 to 129 and 191

respectively. A recent study whose result will be made public very soon indicates that maternal mortality, as well, has considerably decreases.

These successful indications highlight the efforts made to increase the availability, coverage and utilization of various health services. According to the National Risk and Vulnerability Assessment (NRVA) report 2008, 85% of the population can reach at least one type of health facility within one hour using any way of transport (57% of population lives in 1 hour walking distance). However, the report notices considerable difference between the urban population in one hand and the rural and Kochi population on the other. Similarly, access is low in remote and isolated provinces. Utilization figures show significant improvement. Number of outpatient consultations per person increased from 0.6 in 2006 to 1.04 in 2010. As a result, TB case detection has increased from 10% in 2002 to 70% 2010, Malaria PV cases has dropped from over 300,000 cases in 2002 to less than 80,000 cases in 2010. In addition, number of institutional delivery has increased from 130,000 per year in 2006 to over 350,000 deliveries in 2010. At the community level, to date over 21,000 CHWs have been trained and there is significant increase in the number of ARI and Diarrhoea cases managed at community level.

WHO-UNICEF coverage estimate s of immunization coverage shows considerable increase in the proportion of targeted children covered by the various antigens. EPI services covers the whole country including the remote areas. They are available at the various levels of health facilities. In addition to the trained vaccinators, on-going efforts include some other health workers to provide the EPI services. This effort needs to be reinforced among the currently marginalized populations like the Kochi and in the more peripheral health facilities like the health sub-centres.

Access to water and sanitation remains very poor. Only 27% of population has access to safe drinking water. Sanitation facilities are even poor. Only 5% of population has improved sanitation facilities. The environment health is significantly poor. Huge efforts are paid for Health education, however, still require immense attention. The MOPH needs to further coordinate with other key GOA and partner organizations to promote the health of the people.

2.1 b) National Health Strategy or Plan

→ Please highlight the goals and objectives of the National Health Strategy or Plan.

In 2002 the Ministry of Public Health began a process to determine the major issues in the redevelopment of the national health system. This resulted in a number of key decisions, polices and priorities that influenced the performance of the health sector over the next years. The mission of the Ministry of Public Health (MoPH) is to improve the health and nutritional status of the people of Afghanistan in an equitable and sustainable manner through quality health care services provision (HCSP) and the promotion of a healthy environment and living conditions along with living healthy life styles.

Immediately after, Afghanistan started to develop the Afghanistan National Development Strategy (ANDS) for the year 2008-2013. As part of ANDS, the Health and Nutrition Sector Strategy (HNSS) for the year 2008-2013 is developed with the goal to work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and under-served areas of the country.

The MoPH, in consultation with Government of Afghanistan (GoA) officials, external donors, United Nations (UN) agencies, and other stakeholders, has adopted eighteen strategies for reducing morbidity and mortality and strengthening institutional development. These strategies are being worked on through nine core programs, five related to health care service provision and four related to institutional development. Health Care Services Provision Programs are Primary Health Care Program, Hospital Care Program, Disease Control Program, Reproductive Health (RH) and Child Health Program and Public Nutrition Program. Institutional Development Programs are Policy and Planning Support Program, HRD and Research Program, Pharmaceutical Management Support Program and Administration Program.

The BPHS is the main strategic pillar of the health service delivery. It is implemented mainly through a partnership between the ministry and the implementing NGOs through a contracting out agreements

funded largely by the international donors. Implementation of the BPHS was decisive in the remarkable increase in coverage, access and utilization of health services. To increase effectiveness of the BPHS, a number of strategies were implemented over the course of years since 2005. Training of thousands of community midwives, for example, aimed at increasing the number of female health workers and in addressing the reproductive health needs of Afghan women. Health sub-centres and mobile clinics were introduced to increase the accessibility of health care in remote, isolated areas with scattered populations. Thousands of volunteer Community Health Workers (CHWs) are trained and deployed all over the country to provide preventive and promotional health care.

The MopH functions through a strong central body in Kabul, the capital, and directorates of health in the province. The MoPH has established specialized technical working groups and taskforces to provide opportunity to its partners to contribute to policy and strategies formulation and to monitor the performance of the health projects and programs. Due to the inadequate capacities of the provincial health directorates, most the MoPH functioning remains strongly central. That calls for reforms to improve the governance and management of health care at the peripheral level.

MOPH has developed M&E strategy which has a set of key indicators and targets. In addition, in each contract with NGOs there are indicators of performance with the set targets. The health care delivery through BPHS and EPHS are evaluated by third party on annual basis using the balance score card. The MOPH in 2008 developed the National Monitoring Checklists and the implementation is improving gradually.

For-profit private sector is a key player in the health sector being the main service provider. The private sector maintains its presence all over the country including the areas where security obstructs the expansion of public services. In 2008 the MOPH in response to security challenges, in limited scale, started to test the feasibility of partnership with for-profit providers with the support of WHO and financial support from GAVI alliance as part of Civil Society Organizations support initiative. The results so far have been promising encouraging the expansion of the initiative.

2.1 c) Health Systems Strengthening Policies and Strategies

→ Please describe policies or strategies that focus on strengthening specific components of the health system that are relevant to this proposal (e.g. human resources for health, procurement and supply management systems, health infrastructure development, health management information systems, health financing, donor coordination, community systems strengthening, etc.)

The MOPH in the past several years has made significant progress. One of the main key factors behind has been development of policies and strategies in collaboration with its partners. The MOPH as discussed in section 2.1b, focuses its efforts mainly on women and children. The initial key reform was the development of the BPHS in 2003 and EPHS in 2005. Contracting out the NGOs to implement the BPHS was critical to benefit from the enormous capacity and experience of those organizations. The recent piloting of the for-profit private sector proved successful in expanding health coverage to security compromised areas (CSO Type B Evaluation reports Annex). For BPHS it was decided to be based on contract out and contract in. NGOs were contracted and the coverage gradually increased to 85% in 2009. The EPHS since 2005 has covered over 50% of the hospitals.

Equity in provision of care has been one of the priorities of MOPH and to the extent possible, efforts has been made to ensure it. The BPHS defines level of HFs per pocket of population as well geographical distance, however, considering the difficult terrain and scattered population, it was difficult to cover all the population therefore, the MOPH added sub centres (SCs) with the support of GAVI and later on other donors in BPHS and established few mobile health teams. The SCs are being absorbed by other donors. The evidence shows that some groups of people are not getting required care such as Kochi population. The MOPH polices in order to ensure equity, allows interventions to address the health needs of such marginalised population.

Community system strengthening through establishment of councils and training of the CHWs has been

part of BPHS policy for primary health care delivery.

Other reform interventions followed based on the evaluation of the performance of the sector. Human resources, especially female, were found to be a great obstacle to effectively respond to women's and children's needs. Therefore, community midwives and community nurses were introduced as new cadres in health workforce. The curricula of both cadres prepare them to contribute to EPI services effectively. In addition, smaller and mobile health facilities were introduced to cover the marginalized populations of remote isolated areas.

Awareness raising is one of the focus areas of the health system, studies shows that after all efforts only 27% of women seeking care for ANC, delivery and postnatal (AMS 2010). Based on the health strategy, this area has been a focus area. As discussed above MCH is the top priority, among this immunization is a key area which is the main area of the focus for this proposal.

Meanwhile, the MoPH has developed laws, regulations that organize health care and regulates it functioning. In addition, the ministry has developed large number of guidelines and standards to provide guidance to the NGOs and health workers and to ensure the safe, quality and effective health services. Nevertheless, there is much more to be done in the area of regulation, guidance and control.

All these initiatives were important to streamline the service delivery and organization of the health system in order to improve the health of the people with a strong focus on maternal and child health.

2.2 Key Health Systems Constraints

→ Please describe key health systems constraints at national, sub-national and community levels preventing your country from reaching the three health MDGs (4, 5 and 6) and from improving immunisation, and from improving outcomes in reducing the burden of (two or more of) HIV/AIDS, tuberculosis and malaria. Include constraints particular to key populations and other unreached, marginalised, or otherwise disadvantaged populations (including gender related barriers).

TWO PAGES MAXIMUM

The hostile security situation in wide areas of the country is a major constraint facing health care delivery. Due to security problems that pose substantial risk to the public health workers, some health facilities were closed. In other areas, the security situation limits the movements of the beneficiaries, in particular women and children, and their access to health care. Similarly the movements of outreach vaccinators become limited.

Afghanistan, in its endeavour to reconstruct the health sector, has succeeded to build a strong ministry of health at the central level. This was extremely important to ensure proper decision and policy making, regulation of health care and coordination of the efforts and contribution of the large number of stakeholders. However, this was not paralleled by a similar attention to the provincial level partly because of lack of sufficient capacity to accommodate the managerial requirements at both levels simultaneously. This resulted into inadequate quality of health management, poor contribution in developing plans appropriate to the specific local situations and inability to effectively monitor and support the on-going health activities. Many of such functions remain to be performed by missions from the central level which undermines further the role of the peripheral managerial bodies.

It was observed that the BPHS agreements between MoPH and implementing NGOs do not sufficiently elaborate the role of such NGOs regarding some important health care services. Consequently, inadequate resources were allocated for those services providing an excuse for poor performance. EPI is a strong example for such gap. That affects the performance of EPI and its coverage mainly in the rural areas.

Despite the substantial resources invested in health, there is apparent lack of balance in funding different services. As BPHS was considered the priority strategy of health care in Afghanistan, most of

the funding available was directed to cover its expenses. Meanwhile, many hospitals, as an example, remained dependent only on the meagre government resources resulting in miserable situations and poor quality services. In addition, funding predictability is a major problem. Almost for the upcoming 2-3 years, the MOPH does not have committed funds either from Gov and external sources.

Distribution of health professionals and workers over the various provinces suffers major inequality. In general, urban areas have more what they need of doctors, nurses, midwives and other health cadres. Rural areas, in particular in remote and isolated provinces, suffer from shortage in health workers. That is very serious in regard to female health workers. According to the conservative traditions in the rural areas of Afghanistan, lack of female health workers deprives women and children of health care.

The high illiteracy rate in Afghanistan is a major cause behind the poor health awareness among the Afghan people especially in the rural area. Meanwhile, high illiteracy decreases the effectiveness of many communication tools used to propagate health messages and to promote health awareness.

Due to the nature of the terrain in Afghanistan and the lifestyle of a large sector of its population, the conventional health care services remain inaccessible to a proportion of the Afghan populations. In mountainous areas, where scattered populations live along narrow inaccessible valleys, there is a need for different approach to cover their health needs. Similarly, the continuously moving Kochi population, estimated at around three millions, requires innovative approach to provide them with equitable health care.

The achievements made led to increasing public expectations and emergence of new demands and challenges. Quality of hospital care is an example of those challenges. While many of existing hospitals lack adequate support, suffer of poor management and provide low quality services, new ones are under construction adding new challenges to MoPH. The public dissatisfaction of the quality of tertiary care has already manifested itself in the growing number of Afghan patients seeking such care outside the country adding considerable burden to the economy of the country. Unless different innovative approaches are applied, it will be difficult to the over-stretched limited capacity of MoPH to repeat its success in primary care at hospital care level.

The private sector plays an important role in health care delivery in Afghanistan. The sector has the potentials to play larger, more effective role as it is characterized by flexibility, community connections and high motivation. However, there is poor documentation of information of its structure and performance. There are limitations of government regulations to benefit from the private sector and there is lack of enough resources to use its potentials. Therefore, the contribution of this sector in promoting the health status of the Afghan population remains limited.

Channelling funds through government financial system is a lengthy and complicated process. Much of the resources available to health care projects and activities by various donors are controlled by the government system which, in principle, is a positive choice as it promotes the governance role of the government and promotes the sense of ownership and mutual accountability. However, as the system is not responsive enough and characterized with complicated regulations and lengthy procedures, delay in channelling the funds became the rule and not the exception. That leaves its negative impact on the implementation of many activities.

2.3 Current HSS Efforts

→ Please describe current HSS efforts in the country, supported by local and/or external resources, aimed at addressing the key health systems constraints.

THREE PAGES MAXIMUM

The Health System in Afghanistan has demonstrated unwavering ability to face the incredible challenges facing the sector. Over the course of the last few years, a number of innovative strategies

have induced significant change in the development of the HS, its performance and achievements. The MoPH is aware that many challenges ahead and works hard to introduce appropriate strategies to meet those challenges. This proposal describes, in fact, some of MoPH proposed plans to strengthen its HS in an endeavour to provide solutions to related health challenges.

The design and the implementation of the BPHS and EPHS strategies have been the first steps on the road to reform HS in Afghanistan. The implementation of those strategies defined the priority reform areas needed to meet the identified challenges and to set priorities to achieve the objectives of the health sector. Reform policies included almost all components of HS. However, due to issues related mainly to funding balance and available capacity, the implementation of reform was not identical.

The MoPH has been tackling the main control buttons including Financing, Payment, Organization, Regulation and Behavior. With support from partners, including donors, UN agencies, NGOs and relevant government authorities, The MoPH has been able to produce a numerous policies, strategies, guidelines, laws and regulations. That was important to provide guidance, consistency, coordination and control over the sector. It emphasized the MoPH leadership and its governance and stewardship functions assumed after many years of ineffectiveness.

BPHS is being implemented in full partnership with NGOs. The MoPH plans to continue that arrangement to benefit from the capacity and experience of NGOs in addition to their flexibility and ability to work in challenging areas. Meanwhile, the MoPH opted to take the responsibility of tertiary care. As sector of care kept expanding and as the demand and political pressure for hospital care are increasing and new hospitals are constructed, the MoPH capacity is overstretched and it needed a different approach to address the medical and operational requirements of quality hospital care. MoPH is planning to introduce the necessary regulations and to develop the appropriate tools for Public-Private Partnership (PPP) in hospital care. This effort is led by the HSS Coordination unit and the PPP unit of MoPH.

The private sector has already proved effective partner. Funded by GAVI, the HSS coordination unit of MoPH has piloted the partnership with the private sector to provide health services to people living in security compromised areas. As the evaluation of this initiative was positive, MoPH is preparing to expand this strategic approach to new provinces. This particular experience has highlighted the potentials of the private sector and the advantages of strategic PPP.

In addition to involving the private sector in health care delivery, the MoPH is busy developing the strategies and tools to ensure effective engagement of the private sector. The MoPH has developed plans to strengthen the PPP unit. In addition to planning studying the financial feasibility and gains of PPP at hospital level, the ministry is designing the M&E tools, guidelines and regulations of hospital PPP. This will be major reform initiative. It adds considerable capacity to health care provision in the country while providing leverages to improve the quality of the care provided by the private sector and to inspire the sector to play an effective in improving health of Afghan people.

Regarding the coverage of the population, the MoPH is concerned about the marginalized populations who have little access to health care. Those include the nomadic (Kochi) population and the populations of the remote isolated inaccessible areas of the country. As the MoPH plans to involve the private sector to meet the needs of the remote areas, it has already significant steps to address the health needs and problems of the Kochi. A new department was established within the MoPH to care for the Kochi health care requirements and to develop policy and strategies and to design appropriate and responsive health services responsive to their needs.

Quality of health care is a central issue in MoPH policy. In addition to developing quality strategies and strengthening M&E activities, the ministry is occupied with establishing medical professional regulations and professional councils to emphasize standards of professional practice to improve the performance and conduct of health professional s. professional associations of doctors, nurses and midwives are fully involved in these efforts.

The professional regulations are among a number of reform strategies regarding human resource for health. The ministry planned and implemented a number of human resource interventions to respond to the sector’s needs and to improve quality of health care. The training of thousands of community

midwives and community nurses was instrumental in expanding health services to previously deprived people, mainly women and children, living in remote areas of the country. The training of these categories, with great funding contribution from USAID, EU, WB GAVI and GF-ATM, has been one of the positive outcomes of the MoPH partnership with national and international NGOs.

Building the capacity of the peripheral health management structures has gained has gained great momentum over the last few years. The MoPH realizes the need for effective governance to ensure the effectiveness of M&E and to provide guidance and support for health care delivery all over the country. The MoPH is aware of the diversity of challenges at the peripheries which can only be addressed through locally tailored solutions by capable provincial management structures. That is particularly true in provinces with ethnic diversity, scattered and Kochi populations, security instability and mountainous areas. MoPH endeavors to ensure the ability of the provincial managers to engage with the local political and administrative authorities, to build partnerships with the key players, to generate knowledge and information necessary for effective management and to provide leadership for the health sector at the provincial level. Great effort was made to develop the capacity of the provincial managers through training workshops to promote their knowledge, skills and leadership quality. There is an increasing consideration paid to the involvement of the peripheral managers in policy design and decision making best flagged in the regular management workshop to review performance, discuss challenges, exchange experiences and make the policy related implementation to improve the performance of the health system. As described in this proposal, efforts of MoPH continue to improve the peripheral M&E capacity as an essential component to improve quality and effectiveness of health care.

A number of ongoing initiatives to promote the peripheral health management capacity, including one funded by GF-ATM, are envisaged to make substantial difference in the future. Having the appropriate organizations, the qualified staff and the appropriate division of responsibilities and tasks among the central and sub-central levels will ensure stronger MoPH governance role and effective monitoring and supervision for the ongoing health activities. This proposal benefits from, builds on and boosts those initiatives. GF, for example, focuses on maintaining the structures and the motivation of the staff. This proposal looks into the effective utilization of those organizations and staff for effective support and robust monitoring of health services and activities.

Currently the BPHS is funded by USAID, WB and EU. GAVI and GF resources are supporting key elements within the package. The same HR is supported by all major donors. HMIS is being supported by GF and USAID. M&E is being supported by the WB for third party evaluation and GAVI for overall M&E strengthening which is at the last stages. Pharmaceutical sector is supported by USAID and CIDA. Some other donors such JICA is contributing to urban health project. Meanwhile there are support projects from EU and USAID to support implementation in their related 23 provinces (13 USAID, 10 EU).

The Ministry of finance is supporting few projects with the focus on Hospitals. In addition, some hospitals are supported by USAID and EU. The requested is thoroughly additional, to current financing of the health system.

As overall there are significant gaps in financing the health sector and also funding predictability.

3. Health Systems Strengthening Objectives

3.1 HSS objectives addressed in this proposal

→ Please describe the HSS objectives to be addressed by this proposal and explain how they relate to, and flow from, the information provided in section 2 (National Health System Context). Please demonstrate how the objectives proposed to GAVI will improve health outcomes related to immunisation, and how the objectives proposed to the Global Fund will improve health outcomes for (two or more of) HIV/AIDS, tuberculosis and malaria.

The strategic Goal for this proposal is: To reduce maternal and child mortality by strengthening the health system through improving the access to, and utilization of, immunization, maternal and child health services.

1. Objective 1: <u>To improve access and increase the coverage of immunization and other essential health services particularly for the underserved population</u>

   As described above, Afghanistan has made remarkable achievements in increasing the coverage of health care. Nevertheless, further expansion of coverage faces momentous challenges. Despite the strategies to extend services to remote and isolated areas, mountainous and security compromised areas, through mobile clinics and health sub-centres (HSC), the quality and contents of the package of services provided remains inadequate. EPI coverage, for example, remains low due to structural and operational problems. In addition, the regular health system is unable to effectively respond to the needs of the Kochi population, around three million, and callas for dedicated approach that considers their different style. The proposal builds on the experiences gained and lessons learnt from the piloting of the GAVI funded CSO type B activities in two security compromised provinces. The proposal envisages expansion of the same approach, in collaboration with the private sector, to more provinces where the populations suffer poor coverage and low accessibility of health care.
   This proposal endorses strategies to address the weaknesses of the mobile clinics and HSCs through improving those facilities to provide full high quality package of health care. The proposal identifies the problematic areas and proposes activities and outputs that remedy the problems and ensure better access and higher utilization for the scattered populations and those living in isolated areas. An obvious example is the training of the health workers of the HSCs, most of which does not provide EPI services, to effectively include these facilities, 300, in attaining the coverage targets of immunization. In addition, the proposal identifies the challenges of reaching the Kochi populations and proposes adaptation to the delivery provision to ensure continuous availability of services for this mobile population.
   The expansion of BPHS coverage, as the strategy of primary care delivery, increases the demand for secondary and tertiary hospital care beyond the capacity of MoPH. There is growing public and political pressure to increase the availability of hospital care, through establishing new hospitals, and to improve the quality of such care. It is high time that MoPH explores the social impact, the cost effectiveness and the capacity of the private sector to run the newly established hospitals. The proposal envisioned a number of activities of outputs to study the feasibility of this strategy and to improve the MoPH capacity to regulate and monitor the private sector involvement in hospital care.

2. <u>Objective 2: To improve quality, effectiveness and utilization of health care and immunization services.</u>
   Although the BPHS responds to almost all priority needs of the Afghan population, there are serious observations on the quality and effectiveness of certain components of the package. As an example, EPI coverage and utilization in remote areas, where services are provided by HSCs, remains low in comparison with other areas. Utilization is generally higher in urban areas where literacy rates are higher and where access to media is better. This proposal proposes activities that address the problems of service package and quality in the peripheral health facilities, mainly

the HSCs to strengthen the capacity of the staff to deliver the full package with higher quality. As an example, the proposal examines the role of community midwives of the HSCs and plans to provide them additional training to involve them in providing EPI services. The proposal foresees the involvement of the private sector as an alternative in isolated and security compromised areas.

There are, in addition, operational problems affecting the effective delivery of care. Regarding EPI, there are cold chain problems that affect regular supply and availability of vaccines. The proposal provides a plan to strengthen the capacity and performance of the cold chain to ensure availability of supplies and the ability to timely distribute vaccines to all health facilities including the very remote ones.

The utilization of health services in the rural areas is negatively affected by the low literacy rates. Using the media in communication with the target populations proved useful in the urban areas. However, the use of the media in the rural areas was less effective. This proposal approaches the issue of communication using the new communication technology of mobile phone. The mobile communication coverage is wide and the use of this important communication facility is expected to make a difference in awareness, and as result in utilization of health services, as more people will be reached with appropriate health messages.

Improving the monitoring capacity of the provincial health structures is among the proposed interventions. Stronger monitoring capacity will certainly influence the performance of health services and provides the health authorities at the provincial level with the information required to guide the implementation of health activities and to identify the weaknesses and provide the locally appropriate solutions for the problems and constraints.

3. Objective 3: To improve the ability of MOPH to fulfil its stewardship responsibilities at all levels with a more focus on peripheral level

This is one of the priority objectives according to MoPH strategic plan. It is envisaged that strengthening the provincial structures and their ability to monitor health services in the provinces will induce substantial change. It will help to improve the performance, the quality and the effectiveness of health care. It will enable the provincial health authorities to interfere when there are deviations from the plans or inability to achieve the planned targets. They will be able to identify the specific package components or geographical areas where performance is weak and explore the most appropriate solutions and provide the implementing agency with the right support to address the problems and challenges.

Building the capacity of the provincial structures will promote their ability to coordinate health services among the implementers and to build partnerships with various parties influencing health services to maximize their inputs for the betterment of people's health. Stronger capacity will improve communication with the centre to ensure informed policies and decisions and responsiveness to national policies and strategies.

TWO PAGES MAXIMUM

3.2 a) Narrative description of programmatic activities

→ Please provide a narrative description of the goals, objectives, Service Delivery Areas (SDAs) and key activities of this proposal.

3.2 b) Logframe

→ Please present a logframe for this proposal as Attachment 2.

3.2 c) Evidence base and/or lessons learned

→ Please summarise the evidence base and/or lessons learned related to the proposed activities. Please provide

details of previous experience of implementing similar activities where available.

SIX PAGES MAXIMUM

Objective 1: To improve access and increase the coverage of immunization and other essential health services particularly for the underserved population

1.1: To increase DTP3 coverage in Kochi children from 16% in 2010 to 30% in 2014

The Afghanistan population is overwhelmingly rural; 74percent (around 18.5 million people) live in rural areas and only 20% (5.0 million) in urban areas, whereas 6% (1.5 million according to Central Statistics Office figures while other sources indicated 3 million) belong to nomadic Kochi.iii Kochi and nomads are found among vulnerable social groups. Poverty among the Kochi population is very high (54%) comparing to other rural (36%) and urban (29%) communities. In the Kochi population literacy rates are extremely low for both girls and boys, respectively, around 10% and 20%.

There are significant equity concerns for this big group of population. For example, the NRVA 2008 shows that DTP3 coverage among Kochi children is 16% while in rural and urban areas this figure is 39% and 72% respectively. Only 17% of Kochi women use antenatal care services and 8 % of Kochi women likely to use skilled birth attendance.

The proposed intervention aims to address essential health needs of Kochi communities. Generally, there are several provinces where Kochi live and move in between. They include Balkh, Faryab, Jawzjan, Ghazni, Samangan, Herat, Kabul, Kunduz, Nengarhar, Badakhshan, Kandahar and Logar. The interventions will be implemented by the CSOs under the stewardship of MoPH aiming to improve Penta3 coverage.

Service Delivery Areas:

1.1.1: To establish Mobile Health teams for nomadic population

The most applicable and useful strategy to provide health services to Kochis are mobile health teams. Each province where major groups of Kochi commuting will have at least one MHT staffed with one male doctor, midwife and vaccinator. In total there will be 15 MHTs providing MCH, child health, immunization and health promotion services to the Kochi Khails (each Kochi community consist of several sub community called Khail) according to predefined schedules. In addition, complicated cases of maternal and child health and emergencies will be referred to the nearest HF using the MHT vehicle. The staff of mobile health team will receive BPHS related trainings such as IMCI, EOC, Mental health, HMIS, EPI, Rational Drug use (RDU), Family planning and other ad hoc sessions. The MoPH and health related CSO will provide the necessary trainings to the male and female staff of MHT, vaccinators and CHWs. Information flow from MHTs will be part of national HMIS system through coding the MHTs.

The mobile teams will be established and the CHWs will be trained through partnership with the NGOs. The MoPH/WHO will prepare the ToRs, sign the contracts with NGOs and oversee the implementation of the activities.

Key actions

- To develop the specific mobile health care package and guidelines for Kochi population
- Development of the HMIS and M&E related tools and materials
- Contracting the BPHS implementers in the target provinces

1.1.2: To train volunteer community health workers for Nomadic Population

Training of community health workers among Kochi population is considered among the high priority and most cost effective intervention in order to deliver community based and sustainable basic health services. The CHWs will provide basic health services and health promotion activities in a regular and sustainable way. The MOPH standard CHW manual for Kochis will be used. The CSO and provincial CBHC officer of provincial public health directorate will strictly follow coordination of the training of Kochi male and female CHWs using the Kochi map. In total there will be 1,200 CHWs trained (Appx. 100 per province, male/female ratio 1:1. These CHWs will be trained in Immunization and will be providing immunization services in close coordination with the nearest HFs. In addition, these CHWs will be equipped with Mobile phones to facilitate consultation and referral from nearest HFs.

The training of CHWs will be outsourced to partner NGOs. As the process of incorporating the trained CHWs into the provincial BPHS structure requires time and preparation, MoPH/WHO will provide direct support to the CHWs during this transitional period.

Key Actions

- Development of modified CHW training package
- Development of reporting and M&E tools
- Recruitment of implementing NGOs

1.1.3: To raise awareness among nomadic population

The MoPH standard IEC and health promotion materials will be developed and used throughout the MHT and CHWs for Kochi people. As most of the Kochi people are illiterate, (the literacy rate among girls 10% and among boys 20%), pictorial messages and IEC materials will be developed and used for further health promotion among Kochi people.

Key Actions

- To design pictorial and other relevant IEC messages (by Health Care Promotion)
- Systematic distribution of materials through contracted NGOs to Kochi population
- Use of MHTs to have IEC sessions with Kochi population

1.1.4: To standardize care for Kochi population through systematic mapping of Kochis and developing the package of care:

There are several assessments that show the location of Kochi population within the provinces. A separate map will be developed for the Kochis location and their travelling routes within the provinces. This map will identify when Kochis move and where they will locate and for how long. This map will help the health providers for effective health service provision as well as follow up of EPI, MCH and CBHC services provision. The PHD of each province will have a copy of the map for planning, monitoring and service provision to the Kochis. In addition, the draft package of Kochi health will be reviewed by a national review committee and further adjusted to the ground realities.

Key Actions

- To develop mapping assessment tools by the Kochi Department of MoPH
- Implementing NGOs to develop Kochi population profiles in their respective provinces

- To link plan and activities of the Kochi MHTs to the locations, numbers and movements of the Kochis

1.2: To establish partnership with for-profit private sector at different levels of health care delivery system

Increasing the coverage of BPHS services has been always a prime objective of MoPH. Although a large network of health facilities, has been expanded, some districts are still completely uncovered (currently 8) or partially covered due either to security challenges or because of the remoteness and isolation. The populations in the peripheries of some districts are scattered and seriously compromising the cost efficiency of public health services. Besides, there are provinces where the coverage of EPI through the public facilities is considerably low. In such areas, private practitioners, mainly doctors and midwives from the same areas, represent an alternative outlet for health care able to continue working, benefiting from the community support and the absence of public services.

The implementation of the GAVI funded CSO Type B project in two security compromised provinces was very successful in providing the populations there with EPI and basic reproductive and child health services and in building an effective public private partnership. The experiences gained and lessons learnt encourage the MoPH to repeat the same approach in two more provinces with a CSO type B bridge funding opportunity. This intervention ensures the continuation of CSO support beyond the bridge funding while, by adding two additional provinces, increasing the number of covered provinces to six.

The activities envisaged include outsourcing the planned package of services to partner NGOs to cover the two provinces of Helmand and Kandahar.

1.2.1: To continue and scale up the CSO type B project focused on the delivery of EPI and other essential maternal and child health services in remote and insecure areas of the country

The MoPH will contract the BPHS implementing NGOs to identify the private facilities, train the private practitioners, support them and monitor and report their performance. The planned intervention includes strengthening the cold chain to accommodate the private facility network.
The training of the private practitioners will focus on EPI, basic reproductive and child health services. Each private facility will be linked to the nearest public health facility which provides the supervisory support and the regular EPI and other supplies.

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

Key Actions
- To review and update the existing relevant packages and protocols
- Mapping of CSO in each province and establish associations
- Contracting BPHS implanting NGOs to train service providers, supply them and through them deliver services
- Monitoring of implementation

1.4: To implement the Community Integrated Management of Childhood Illnesses (CIMCI) program in the remaining 7 out of 34 provinces.

Community Integrated Management of Child Illnesses (CIMCI) is an important component of BPHS &

under 5 and infant mortality in Afghanistan are still high (under five mortality is 191 and infant mortality is 129 in 10000 live births). The Child and Adolescent Health Policy and Strategy 2009-2013 make clear the priority interventions for promoting child survival activities at the community level. C-IMCI is a proven evidence based approach which has an important role in decreasing the child mortality and improving their health. It total in 27 out of 34 provinces so far CIMCI is implemented which has been supported by GAVI and UNICEF and there are gaps in 7 provinces.

Through this proposed intervention, by end 2013, the C-IMCI will be expanded to 7 remaining provinces (Heart, Farah, Helmand, Zabul, Ghor, Urozgan, Kandahar). At least 80% of currently active BPHS Community Health Workers (CHWs) and Community Health Supervisors (CHSs) in the mentioned provinces of Afghanistan receive high quality training in Community-IMCI component.

Activities of this intervention include the development of the ToR, contracting the implementing NGO to train 4325 CHWs in CIMCI and to monitor the progress of implementation.

Key Actions

- Review the existing training materials of CIMCI
- Contracting implementing NGOs
- Monitor the performance of NGOs based on national protocols

Objective 2: To improve access and increase the coverage of immunization and other essential health services particularly for the underserved population

2.1: To improve quality and performance of EPI[1] program at different levels focusing on cold chain

The Effective Vaccine Management (EVM) Assessment was carried out in July 2011 which necessitates the need to take quick actions to fix the problems revealed. Accordingly the cold chain development plan has been developed. The introduction of two new vaccines pneumococcal Rotavirus vaccine) is planned for 2013 and 2014 where current capacity does not allow introducing these vaccines. Using WHO EPI-Log-forecasting tool the requirement for additional cold chain capacity has been estimated to accommodate the new vaccine. The major components of cold chain equipment are used for more than 6 years and require spare parts and repairing or replacement. Most of regional and provincial cold rooms are using power generators. These generators have been used for 5-10 years and the NIP is in need for replacing old generators and to provide backup generators. High priority is given to the maintenance of the cold chain including the main equipment such as cold rooms, freezer rooms, refrigerators, freezers, cold boxes, and back-up generators. The cold chain repair technicians and storekeepers should receive proper training to manage this important component of the EPI.

Human resource problems such as shortage of qualified staff, inappropriate employment of staff by NGOs, high staff turnover, low pay and poor supportive supervision is challenging adequately the delivery of immunization services. To meet the need of population for safe and effective delivery of immunization service, the NIP has to increase the number of immunization health workers through initial training of new vaccinators and training of health sub-centres staff (midwives & nurses) and improve the performance of existing staff through refresher trainings. At the same time major efforts are required to strengthen immunization systems. The NIP monitoring/supervision system is faced with challenges such as shortage of qualified supervisors and low technical capacity of BPHS implementing NGOs supervisors; shortage of fund for transport; inadequate planning, irregular monitoring/supervision particularly supportive supervision, inaccurate reporting, feedback and rare use of data for actions. To further strengthen monitoring and supervision there is need to update monitoring and supervision policies and procedures; supervisors job descriptions, tools, recording & reporting system, norms, standards and

[1] According to the routine EPI reports, the DPT3 coverage in 2010 was 87% but only 66% according to WHO/UNICEF estimates of the same year. NRVA 2008 estimated the DPT3 coverage at only 43%.

work plans. In addition, there is need to revise the performance goals for supervisors to be more realistic, attainable and measurable and indicators for being accurately measurable. The NIP is in attempt to engage the well trained supervisors with updated information and skills on immunization issues to deliver effective monitoring/supervision including supportive supervision providing sufficient vehicles, per diems and time.

The planned interventions aims to Strengthen vaccine and cold chain management and increase cold storage capacity from 130 m3 to 170 m3 till 2013 for safe storage and handling of existing and new vaccines, build capacity and support universal implementation of adopted RED approach to all districts, Replacement and expansion of cold chain equipment's at the service delivery level, improve data collection, reporting , address the challenge of lack of trained vaccinators and build the capacity of cold chain staff.

This intervention focuses on the cold chain to improve its capacity at the central and provincial levels inaddition to replacing the old equipment at the facility level. In addition, the staff of the cold chain will be trained to operate and maintain the equipment. The intervention plans to train 300 new vaccinators to fill the gaps and compensate for the drop out. The registration and reporting system of EPI will be revised and strengthened.

Key Actions

1. To provide cold chain equipment in the areas where no vaccination is done and replace old cold chain equipment in areas needed
2. To increase the capacity of the cold storage by establishing cold chain stores at central and provincial level
3. To train cold chain staff
4. To train health workers of HSCs in immunization
5. To train 300 new vaccinators
6. Reviewing the existing package, protocols and guideline
7. Contracting BPHS implementing NGOs
8. Revision of EPI HMIS forms

2.2: To do a critical analyses of the implementation of BPHS at different levels and improve contracting process to ensure EPI and other essential Maternal and Child health priorities are well managed through contracting process

The MOPH through contracting implements the BPHS in Afghanistan. The lessons learned so far indicates that there are problems in operationalization of BPHS through contracting process. First of all, all the key services such as immunization should be well defined in the contracts and secondly there should be strong follow up of the implementation according to the contracts.

As per global rules bidders (NGOs-CSOs) are selected mainly through processes where cost is one of the main factors for selection, therefore, it has been noticed that in order to win the bids, some NGOs try to submit lower costs. This affects implementation of essential health care including immunization throughout the country.

This intervention aims to standardize contracting processes in a way that immunization services and other MCH services are well defined in the contracting process. In order to do this, a critical assessment will be made and mechanisms will be explored to address this critical problem. Further, coordination between different MOPH departments including but not limited to EPI will be ensured and relevant tools and guidelines will be developed.

A consultant will be recruited by MoPH/WHO to perform the study. HSS Coordination unit will facilitate the study and the implementation of the report recommendations with GCMU to adapt the contracts to the needs of EPI and other mother and child services.

Key Action:

Contracting a national consultant to develop the critical analysis of implementation of BPHS.
To Produce a report to assist policy and program people to take evidence based decision.

2.3: To promote health through awareness raising initiatives

Although efforts are being made to implement awareness raising initiatives, still there is long way to raise the awareness in Afghanistan. Literacy rate according the latest survey is 27% overall and 12% among the women who are the main care givers for children. Even further only 105 of women are literate within the whole Kochi population. Although 54% of women reside in one hour walking distance from HFs , the AMS 2010 shows that only 27% of women seeking care for ANC, delivery and postnatal. In addition, the AMS shows that 92% of women have knowledge of modern contraceptive methods; only 20% of those women use those methods. This indicates that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behaviour.

Still there are significant challenges such as weak inter-governmental coordination to support health promotion efforts and significantly low community awareness and poor health seeking behaviour.
The planned interventions aim to take further the health promotion initiatives in order to raise awareness and influence behaviours of mothers and children with a strong focus on EPI and other essential MCH services.

Through this intervention, health workers will be trained in IEC/BCC and IPCC. Related materials will be printed and distributed in the provinces. A KAP survey will be conducted to establish better understanding of the beneficiary attitude and behaviour regarding EPI and reproductive care. A health hotline operated through a call centre will be established to be used in strengthening referral services and propagate focused health messages to the public. CHWs trained for the marginalised Kochi population will be linked to the call centre.

Key Action

Design IEC and distribute IEC materials
Provide IEC/BCC/IPCC trainings for health workers
Contract BPHS implementing NGOs to training CHWs on awareness raising/health education

Objective 3: To improve the ability of MOPH to fulfil its stewardship responsibilities at all levels with a more focus on peripheral level

3.1: Improving Monitoring and Evaluation processes at different levels with a more focus on peripheral levels

The Monitoring and Evaluation is one of the key steward functions of the Ministry of Public Health; therefore, the MoPH places strong emphasis on M&E. There is noticeable progress especially with the support of donors such as GAVI, WB, GF and USAID in M&E, however, the M&E remains an area of great concern especially in the context where all services are contracted out to NGOs and CSOs. The MoPH could develop the strategy, initiate monitoring from different levels, contracted the third party for annual evaluation of BPHS and EPHS, provided some training and developed some standards. Right now the USAID and the GF are supporting the HIS, the WB is supporting third party evaluation and the GAVI HSS is supporting the M&E. However, since the current HSS support is being finished, M&E achievements will drop suddenly while there is a long way to go to reach the desired level to ensure

standardized M&E.

The National M&E Strategy in line with the Health and Nutrition Sector Strategy, has focused on results defined by the Strategy, Health and Nutrition pillars of Afghanistan National Development Strategy (ANDS) and Millennium Development Goals.

In order to assess objectively the performance and progress of its contracted NGOs, M & E directorate is engaged. Reliable and accurate data is the key for proper planning of the programs and making evidence based policy decisions. Data use is as important as data management. It is crucial to enhance M&E capacity in different level which will, in turn, improve evidence based decision making at all layers of management and ensures transparency and accountability.

Stewardship is particularly critical in the Afghan context because the MOPH contracts almost 91% of health services delivery to not for profit non-governmental organizations (NGOs). Meanwhile, the provincial health directorates significantly lack the capacity and the tools for monitoring. Besides all efforts, the PHOs only monitored 25 % of the existing HFs in their related provinces on quarterly basis in 2010. With the support from GAVI, NMC was developed but to date only 40 % of the PPHDs have recorded NMC replica. Ensuring implementation of joint monitoring missions at the provincial level by stakeholders mainly the MOPH-NGO is a key issue to be addressed.

In addition, DHOs who were recruited with the support from GAVI HSS require support, steering and need to be monitored. These 152 DHOs who were paid from GAVI are now part of Government system and sustainability is ensured. However, in the upcoming three to five years, this requires follow up to ensure full institutionalization of the support.

The M&E system requires extensive TA assistant in the long run. In addition, ensuring the IT support for M&E is critical such as internet support which facilitates data sharing, communication, and timely reporting.

The proposed intervention aims to build up on early gains and to streamline M&E activities at different levels. Current monitoring tools at central level will be revised. Regular joint central and provincial joint monitoring missions to the districts will be organized in at least 82% of the provinces. The M&E department of MoPH will be equipped with necessary communication and transportation facilities and provided strong technical assistance. The newly established unit of private sector monitoring will be strengthened. The existing MoPH database will upgrade to accommodate revised PHC and hospital M&E/NMC. Guidelines for monitoring at the provincial level addressing related issues, coordination, reporting, advocacy, monitoring lists, quality of data etc., will be developed. 37 central and 34 provincial staff members will be trained in M&E to be able to use the revised tools and the new guidelines. An annual result conference will be held in MoPH to discuss the health information collected and processed over the year.

Key Actions
To review the existing M and E tools
Conduct Monitoring mission and provide technical assistance
To encourage and facilitate MoPH leadership monitoring site visits

3.2: Streamlining procurement of non-consultancy services

Routine, efficient procurement for health programs requires specialized knowledge and expertise in essential goods, medicines and consumables, and the markets where quality products can be obtained. It involves careful selection of products and development of specifications, accurate forecasting, precise tender preparation, and a capacity for testing (equipment, protocols, and procedures). It also involves sustained and adequate financial resources, the willingness and ability to maintain a transparent process. Procurement of goods, works and services are integral parts of the ministry of public health and core

departments including EPI and other MCH departments. Increasing capacity and efficacy of procurement will increase the efficiency and effectiveness of all MCH programs. A non-well functional procurement influences significantly the performance of the entire health system.
The current procurement model of the ministry of public health comprise of three main units of Goods, Works and Services. The consultancy service unit has been established through financing MOPH main donors such as WB, USAID and GAVI. This unit has been certified by USAID and Ministry of Finance and authorized for procurement of the consultancy services with unlimited threshold and has been the first and the only unit authorized in the state yet. However, the procurement of non-consultancy services remains a major area of concern. It has affected the performance of MOPH in general and all MCH and other essential health programs in particular. The MOPH with all its partners in the Retreat meeting held in 2009 decided to move GCMU under umbrella of procurement directorate to unify and strength the capacity of other procurement section of goods and works.

Currently, procurement of goods and works over 200,000 USD is proceeding by ARDS and is much time-consuming, since this organization proceeding procurement of all ministries for above threshold, therefore remarkable delays experienced in the accomplishing the procurement plans. The MOPH is the past several years has been able to implement approximately 60% of its budget. The remaining is carry forwarded from year to year which significantly affects the health of the people of Afghanistan for not receiving the out puts expected from the carry forwarded funds.

The proposed interventions aims to standardize, development of the database for bidders, provide TA, needed equipment, define SOPs and as overall streamline the procurement at different levels.

All the interventions will contribute to improve immunization outcomes. Activities include the establishment a database for the procurement directorate, defining its SOPs and providing it with the necessary equipment. The staff will be trained in standard procurement procedures and supported by national TA.

In relation to the stewardship role of MoPH, this intervention plans few activities to strengthen the involvement of the leadership in stronger communication and monitoring of the on-going services at the peripheral level particularly EPI. That includes provision of communication tools and facilitation of field trips to the chairman and members of the HSS Steering Committee.

Key Action
Review the existing Procurement guidelines/protocols and simplified them
Develop required guidelines and provide trainings
Provide technical assistance to Procurement Directorate

3.2 c. Evidence base or lessons learnt

The implementation of HSS activities over the last few years generated plenty of useful evidence and lessons which are duly considered in this proposal. The successful implementation of CSO type B is evidence that health services can expand and continue to function, despite the adversary conditions, when the appropriate methodologies and approaches are selected and properly implemented. It provides evidence the potential capacity of the private sector that if well guided can promote the public efforts to improve the health status of the Afghan population.

The weakness of the provincial health structures was found to be a major obstacle in implementing effective activity monitoring. The dependence on the central M&E unit alone will never be sufficient for effective monitoring.
HSS activities had influenced the capacity and performance of various programs. While it is challenging to institutionalize the project oriented HSS activities, this remains extremely important and was demonstrated in the improved conceptual fluency and performance of involved MoPH directorates. Similarly, the quality of contacting has improved considerably due to the involvement of those departments.

HSS team established new tradition in the MoPH when it developed standard documents for bidding and contracts. Donors and other partners within GCMU are now using the formats initially developed as an outcome of HSS support.

The HSS support has made the agenda of EPI more important. It has paved the ground for I more EPI advocacy, coordination and follow up.

The HSS support has been catalytic in Afghanistan at it was envisaged initially while launching the support. It has also significantly improved coordination and communication with CSOs.

In addition, the independent evaluations of different activities funded by GAVI in Afghanistan shows that all those planned interventions have produced reduced results and contributed.

3.3 Main Beneficiaries

→ Please describe how the proposed activities under each objective contribute to equity (e.g., gender, geographic, economic), reach the unreached, underserved and marginalised populations with health services, and benefit the poorest and other disadvantaged populations, including any measures to reduce stigma and discrimination that these populations may face.

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The main beneficiaries of this support are the mothers and children mainly in remote areas of the country.

Under objective one, the Kochi population which are neglected population and are suffering from the poorest health indicators are the targeted beneficiaries. This population according to the estimates is around 1.5 Million in total. In the provinces where the Public Private Partnership is going to be scaled up which is the continuation of CSO type B support, again the beneficiaries are the mothers and children. In total these provinces are 10 out of 34 provinces where approximately 30% of population reside. CIMCI ultimate beneficiaries in the planned 7 provinces are again the communities and mainly the mothers and children. CHWs will receive CIMCI training and will serve relevant communities in the respective provinces.

Under objective 2 again the ultimate beneficiaries are the mothers and children throughout the country. In addition, EPI program staff including cold chain staff will benefit from trainings and availability of equipment. Information Education and Communication will target the entire population with a special focus on mothers and children, particularly the immunization.

Under objective three, again the ultimate beneficiaries will be the people of Afghanistan and in line with MOPH policies and strategies and the MDGs, the mothers and children will benefit. However, immediate beneficiaries are the M&E and Procurement system.

As overall, all the objectives have strong links with immunization outcomes which indicates that main beneficiaries are the children and mothers.

4. Performance Monitoring and Evaluation

4.1 National Monitoring and Evaluation (M&E) Plan and Performance Framework

→ Please present your National M&E Plan as Attachment 3, and the Performance Framework for this proposal (using prescribed template) as Attachment 4.

4.2 a) M&E arrangements

→ Please describe how the Performance Framework in this proposal uses existing national indicators, data collection tools and reporting systems.

4.2 b) Strengthening M&E systems

→ Please describe the M&E systems strengthening activities to be funded through this proposal.

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The HSS Steering Committee is responsible for providing guidance, support and monitoring the HSS activities. Due to its structure, described elsewhere in this proposal, the Committee plays a strong coordination role for the HSS related activities and liaising them with other activities and initiatives in the country to ensure synergy and harmony. The HSS Coordination unit of MoPH is the executive body responsible for the management, implementation and monitoring the HSS activities. Manned by a number of health professionals and administrator, unit receives the field reports from various MoPH departments and sub-implementers for review, compiling and feedback. The unit staff pays monitoring visits and keep in continuous communication with M&E directorate and with PHDs in the provinces.

The indicators and targets are all in line with national reporting and M&E framework and are using current reporting systems. The equity in immunization coverage indicator can be reported only according to the findings of MICS survey. However, efforts will be made to include this important indicator that is recommended by GAVI in the national M&E framework as a routine indicator.

Based on the past experience of CSO Support Type B project, it will be more effective and efficient to assign the BPHS implementing NGOs through supplementary contracts to implement the planned activities of this proposal in their provinces. In addition to the avoidance of building parallel structures, this ensures synergy of various interventions, increases the impact of the proposed activities in strengthening the health system and ensures accountability for the project performance. This approach shall be used for the implementation of the Public Private Partnership, the Kochi package and CIMCI. As the management of health is province oriented, this approach will conform to the structures and facilitate monitoring, supervision and support. Nevertheless, this option will be applied where the NGO had a good BPHS performance record

Meanwhile, NGOs involved in training activities, i.e vaccinators and CHWs, will be selected through transparent competitive selection process as such activities of neighboring provinces can be clustered at regional level.

Ministry of Public Health, through the relevant departments, and WHO will develop a clear guideline documents stipulating the process, conditions and criteria of selection. A selection committee composed of MoPH and WHO will ensure the transparency of the selection process.

Monitoring NGOs performance is basically the responsibility of the provincial health directorates. However, due to the limitations described and addressed in this proposal, monitoring will be done jointly by the relevant MoPH department, including the HSS Coordination Unit, the provincial health directorates and WHO. These parties will share, review and send feedback on progress reports, organize joint monitoring site visits and meet regularly to review the performance of each NGO based on the contractual obligations and performance indicators in addition to providing regular reports to. As the managerial capacity at the province increases, in line with MoPH strategy and as a result of the activities of this proposal and related activities funded by other donors including GF-ATM.

This proposal activates and enhances the monitoring role of the HSS Steering Committee members including the MoPH leadership. In addition to being motivating to the PHDs and the implementing NGOs, it will enable the members to get first-hand information on the implementation progress, the problems and challenges of the HS at the peripheral levels. The members, including MoPH leaders, will have the opportunity to interact with the PHDs, assess their needs and be able to make informed decisions to further improve the capacity and performance of the provincial health structures.

MOPH's partners will have important roles to play in monitoring the program.

Many areas have been improved for example transportation and to some extend the staff capacity. Tools and NMC have been developed and third party evaluations are supported by the M&E directorate. However, still long way to ensure a proper functional M&E. 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 is included in this plan. It is planned that during the course of the next two to five years that the necessary capabilities will become further resident within the MOPH's Monitoring System to fully fulfil its mandates.

5. Gap Analysis, Detailed Work Plan And Budget

5.1 Detailed work plan and budget

→ *Please present a detailed work plan and budget as Attachment 5.*

5.2 Financial gap analysis

→ *Please present a financial gap analysis (and counterpart financing table for Global Fund applicants).*

5.3 Supporting information to explain and justify the proposed budget

→ *Please include additional information on the following:*

- *Efforts to ensure Value For Money*
- *Major expenditure items*
- *Human Resources costs and other significant institutional costs*

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The proposed activities are all in line with the national health policy and strategies. The activities build on existing structures and complement on-going activities where gaps or weaknesses were identified or here there is a strong need to enhance capacities or provide additional expertise.

The proposed intervention to address the kotchi health care issues, for example, is a response to the consistent concern about the coverage and access of this sector of the population to health services, in particular EPI and basic MCH services. This concern is derived from increasing demands of the Kotchi people and their representatives, the observations of the health professionals and the systematic surveys including NRVA. It is obvious that PI cold chain, functioning without substantial replacements for many years, became too old and if not renovated, it will negatively affect the EPI performance in general. Meanwhile, there is a growing awareness that without strengthening the provincial health structures, M&E will remain short of full effectiveness.

The interventions and activities of this proposal builds on and benefit from the structures of MoPH, the large network of NGOs working in BPHS and the public health infrastructures. Implementing NGOs are selected through a bidding process that observes the technical as well as the financial aspects of the bidding proposals.

It is known that the country's own resources are too scarce to accommodate these activities at the time being. Health services are almost totally dependent on external funding. Nevertheless, the existing funding leave gaps well identified by MoPH which continue to seek funding in order to achieve its objectives including the MDGs.

As overall there are no outlier expenditures in any line items, however, the major one is the provision of cold chain equipment to EPI several layers as well as HFs. It constitutes 25.5% of the budget over two years. The other major lines are, TA (20.6%) and trainings (18%) which are mainly the services including trainings of CHWs and vaccinators that will be delivered by CSOs after competitive bidding process

The last major expenditure item is the infrastructure 12% which is basically partial expansion of cold chain system for EPI. Afghanistan will never be able to introduce further new vaccines if the cold chain is not expanded.

HR costs constitute 5% of the budget. The " other " in the summary budget means the % of admin cost that will be charged by WHO based on the MOU between the WHO and GAVI.

6. Implementation Arrangements, Capacities, and Programme Oversight

6.1 a) Lead Implementers (LI)

-> For each LI, please list the objectives they will be for responsible to implement. Please describe what lead to their selection, including their technical, managerial and financial capacities to manage and oversee implementation of objectives, including previous experience managing Global Fund and/or GAVI grants. Describe any challenges that could affect performance (refer to any current assessments of capacity if available) as well as mitigation strategies to address this.

→ Please copy and paste the tables below if there are more than two Lead Implementers (LI). Where a LI will act for more than one objective, list all objectives.

Lead Implementer:	Ministry of Public Health – Afghanistan and WHO
Objective(s):	1) To improve access and increase the coverage of immunization and other essential health services particularly for the underserved population 2) To improve access and increase the coverage of immunization and other essential health services particularly for the underserved population 3) To improve the ability of MOPH to fulfil its stewardship responsibilities at all levels with a more focus on peripheral level

→ Description of the Lead Implementer's technical, managerial and financial capabilities.

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MoPH is the national body responsible for designing policies, coordination and overseeing the implementation of health related activities in the country. The ministry is involved in the implementation of significant portion of public health care as well. It functions through an organization made of departments and units where the best health expertise is positioned to formulate policies and strategies, provide management and support to the various components of the sector in addition to monitoring and reviewing the performance of the implementers. At the provincial level, MoPH is represented by the provincial health directorates to perform the same functions at the peripheral level. Moreover, MoPH established a specific unit to coordinate and support the HSS activities. Over years, the MoPH has acquired stronger management capacity, learnt from its own experience and achieved a steady progress in improving its capacity to achieve its goals.

WHO, being the partner of the Lead Implementer, maintains strong existence in Afghanistan represented by the country office. WHO involvement in Afghanistan goes back to many years meaning long experience and good knowledge of the health sector in the country. The office has a number of technical offices and programs manned by qualified and experienced international and national professionals.

Implementation at the provincial level of service delivery and training activities will be outsourced to NGOs. Further details on the selection and monitoring of NGOs are described under section 4.

Lead Implementer:	
Objective(s):	1) 2) 3) etc.
→ *Description of the Lead Implementer's technical, managerial and financial capabilities.*	
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6.1 b) Coordination between and among implementers

→ *Please describe how coordination will be achieved (a) between multiple Lead Implementers, if there is more than one nominated for the proposal; and (b) between each nominated Lead Implementer for the proposal and its respective Sub-Implementers.*

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There is strong intra-ministerial coordination between the various departments of MoPH. Through regular meetings and continuous communication, the department exchange information and discuss issues related to performance of programs and projects. This level of coordination is extremely important as many interventions and programs are cross-cutting involving more than one department. In addition, it represents a form that formulates recommendations for decisions to be made the ministry leadership.
Established in 2002, The Consultative Group on Health and Nutrition (CGHN) is the main coordination body in the health sector. The overall objective of the CGHN is to increase the effectiveness and efficiency of the health sector and support of the attainment of the goals and purpose of the Ministry of Public Health. The key roles of the CGHN include advice to the MoPH on strategic policies, establish health sector targets, assist with budgeting and resource mobilization; assist with the monitoring and evaluation of implementation progress and information sharing. Chaired by the Acting Minister of Public Health, CGHN is the forum where key units of MoPH, donors, UN agencies, CSOs and representatives of Ministry of Finance (and when necessary other ministries).
In addition, the HS Steering Committee (HSSC), headed currently by the Acting Minister of Public Health, is the platform to monitor and support the HSS activities. The regular HSS meetings provide the Lead Implementer and the partner wide room for discussions and coordination. In addition to MoPH, the HSSC includes representatives of CSOs, UN agencies and donors. It should be noted that the same are also members in the Country Coordination Mechanism (CCM) of GF adding further dimension to coordination.

Established by GAVI CSO Type A project, Afghanistan has a network of CSOs. The network is a forum for CSOs to discuss and decide on issues related to their role and functioning, coordinate their activities and exchange experiences.

At the provincial level, the coordination is manifested mainly in the Provincial Health Coordination Committees (PHCCs). They represent the provincial versions of CGHN. They play important role in supporting the provincial health authorities to assume its governance functions.
In addition, WHO regional offices provide an additional coordination platform. These offices, headed by qualified managers, provide an additional oversight on the on-going activities and communication channels to the implementing partners in the provinces.

6.1 c) Sub-Implementers *(Not Applicable for GAVI applicants)*	
(i) Will other departments, institutions or bodies be involved in implementation as Sub-Implementers?	○ Yes → *go to section 6.1 c) (iii) and 6.1 c) (iv)* ◉ No → *go to section 6.1 c) (ii)*
(ii) If no, why not?	
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(iii) List the identified Sub-Implementers and, for each Sub-Implementer, describe: • The roles and responsibilities to be fulfilled; • Past implementation experience; • Geographic coverage and a summary of the technical scope; • Challenges that could affect performance and mitigation strategies to address these challenges.	
TWO PAGES MAXIMUM	
iv) If the private sector and/or civil society are not involved as Sub-Implementers or only involved in a limited way, explain why.	
The MOPH Afghanistan and its partners believe that the use of Civil Society Organizations (CSOs) will help the health sector of Afghanistan to timely and efficiently achieve its national and, consequently the international, health targets. Therefore, the MOPH Afghanistan has adopted the stewardship role and contracted out most health service delivery to NGOs. Form HSS current support, over 70% of activities is being implemented by NGOs. In this proposal again most of the activities will be implemented by CSOs who will be selected through competitive bidding process. The CSO type B is being implemented now by the 2 national and International NGOs. 2 more CSOs are selected under bridge funding and the continuation of this support is requested within this proposal.	

6.1 d) Strengthening implementation capacity

(a) Applicants are encouraged to include a funding request for technical assistance to achieve strengthened capacity and high quality services, supported by a summary of a technical assistance (TA) plan. In the table below, please provide a summary of the TA plan.

→ *Please refer to the Strengthening Implementation Capacity information note for further background and detail.*

Management and/or technical assistance **objective**	Management and/or technical assistance **activity**	**Intended beneficiary** of management and/or technical assistance	Estimated timeline	Estimated cost → *same as proposal currency*
Strengthen the capacity of HSS Coordination Unit	Planning and supporting HSS activities	HSS Coordination unit- and all involved MoPH departments	2 years	
Timely financial and procurement arrangements	Financial management and procurement	HSS Coordination Unit/Finance and GCMU departments MOPH	2 years	
Strengthen the capacity of the M&E unit	Train and support staff Advice to the management	M&E at central and provincial levels	2 years	

(b) Describe the process used to identify the assistance needs listed in the above table.

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There has been extensive experience now after five years implementation of HSS support. Based on the previous experience, the MOPH departments do not have readily available staff to plan, implement and monitor the projects and development activities. On the other hand, the MOPH has been trying to institutionalize the HSS support and has been very successful in this process. Based on the experience the capacity of implementing department is well known. On the other hand, WHO technical assistance proved very effective and most appropriate for HSS activities in Afghanistan. The proposal writing team recognized the need to build on the past experience in benefitting from the technical and managerial support of WHO and qualified staff who are managing the HSS activities in Afghanistan. Areas of needs and aspects of TA were thoroughly discussed and a recommendation was made to HSS Steering Committee. The Committee approved the recommendation.
The proposal writing team reviewed the technical needs of M&E and the relevant department of MoPH as described in their draft contributions in the proposals. Those needs were discussed with those departments to elucidate the nature, the objectives and the activities related to TA. Later the draft were shared with all partners and useful comments were received from departments and partners. Finally the application was fully presented to the CGHN and was endorsed including the TA section.

(c) If no request for technical assistance is included in the proposal, provide a justification below.

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6.2 Financial management arrangements

➔ *Please describe:*

a) *The proposed financial management mechanism for this proposal;*

b) *The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for planning and budgeting, treasury (fund management and disbursement), accounting and financial reporting, internal control and internal audit, procurement, asset management and external audit.*

c) *Technical Assistance (TA) proposed to strengthen the financial management capacities in order to fulfil the above functions.*

The proposed financial arrangements include WHO as the Recipient responsible for the management of GAVI funding on behalf of the MoPH. Through such arrangements, the project will avoid the unnecessary delays and the complicated government procedures.

A MOU will be signed between the MoPH and WHO describing the arrangements and defining the responsibilities of each party. Individuals and/or bodies authorized as signatories, decision makers or administrators from both MoPH and WHO will be clearly defined in the MoU. The fund will be used only for the expenditure related to the project and released on receiving instructions from the MoPH. Nevertheless, funding management will be in accordance with financial regulations and financial and administrative rules and practices of WHO.

WHO will start overseeing the project financial requirements in response to the advice of the MoPH starting from the date when funds are received. On behalf of MoPH, WHO shall be in charge of any transactions or procurement processes, including the contracts of the implementing partners and sub-contractors. Any such transaction or process will be reviewed beforehand by the HSS Steering Committee and approved by MoPH leadership.

In order to ensure financial capacity and to benefit from the experience of the existing financial management of HSS Coordination Unit, it is envisaged that the same team will be contracted by WHO to oversee the financial and related operational issues of this project.

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6.3 Governance and oversight arrangements

➔ *Please describe:*

a) *The committee(s) responsible for the governance of the HSS support in the country (this should include the roles of the HSCC and the CCM, including how the roles of these bodies are aligned with Global Fund or GAVI requirements);*

b) *The mechanisms for coordinating the proposed HSS support with other health system strengthening activities and programs;*

c) *Plans (where appropriate) to strengthen governance and oversight;*

d) *Technical Assistance (TA) requirements to enhance the above governance processes.*

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Health System Strengthening Steering Committee (HSSSC) is the body responsible for the governance of HSS activities including the activities of this proposal. The committee includes, in addition to the HSS Coordinator, representatives from the key departments of MoPH, elected representatives of CSOs, WHO, UNICEF and the main donors such as USAID, EU, WB. It is chaired by the Deputy Minister of policy and Planning (the Acting Minister of Public Health). It provides support to the activities, monitor the performance and discuss and approve related policy and decisions. The committee meets regularly and document and distribute the minutes of its meeting. The committee is considered a subdivision of the Consultative Group of Health and Nutrition the main health sector coordination body.

The committee reviews the procurement documents and approves the contracts with the implementing partners. The members of the committee receive the field report of implementation, review them and, during the meeting, provide feedback raising issues of concern, providing advice and recommendations to the implementing parties. Meanwhile, the members ensure the alignment of the activities with National health policy and strategies and emphasize the coordination with other HS activities.

In order to strengthen the governance, monitoring and coordination role of the committee, it is planned to organize field visits to the members to have first-hand insight of the on-going activities, their performance, achievements and the challenges facing the implementers. There are plans, as well, to invite member of GAVI Technical Review Committee to establish strong communication and consideration for the situation and the progress of HSS activities.

HSS Coordination unit requires TA that will help further build the capacity of HSS activity management, to help in analysing needs and challenges, to review the progress and to recommend interventions to maximize the outcomes and impact of the activities. TA helps the HSS coordination to benefit from lessons learnt from global experiences and to review several options and make the appropriate choices for the country. TA, in addition, enables the MoPH to access additional support from WHO and other global organizations and to be involved in the relevant technical and think tank groups of health system and health development.

7. Risks and Unintended Consequences

7.1 Major risks

➔ *Please describe any major "internal" risks (within the control of those managing the implementation of the HSS support) and "external" risks (beyond the control of those managing the implementation of the HSS support) that might negatively affect the implementation and performance of the proposed activities.*

Risks	Mitigating strategies
Cold chain capacity unable to accommodate expansion made by the involvement of many private facilities into the delivery of EPI services	Strengthening the cold chain at central, provincial and facility level
Misuse of the PPP to make more profit	Regular monitoring by implementing NGOs and PHD
Adversary social norms and traditions could represent an accessibility barrier, decreasing the utilization of services	Use health professionals, CHWs and CHWs supervisors belonging to the same communities
Complicated government fiscal arrangements delaying transfer and use of funds	Funds to be managed by WHO

7.2 Unintended consequences

➔ *Please describe any possible unintended consequences that might occur as a result of implementing the proposal and the strategies to mitigate these unintended consequences.*

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As overall there are no unintended consequences are expected. However, the implementation of the PPP will add large number of privates heath facilities to HS network, That will overstretch the limited management capacity of the provincial health directorates. One of the proposal's interventions addresses this issue and plans to enhance the performance and the capacity of provincial health structures to effectively assume their expected role in monitoring health services including the accommodation of this project activities.

Mandatory Attachments → *Please tick when the attachment is included*		
No.	*Attachment*	✓
1	Health and Nutrition Sector Strategy	
2	Logframe	
3	National M&E Plan	
4	Performance Framework	
5	Financial gap analysis, detailed work plan and detailed budget	

Optional Attachments → *Please tick when the attachment is included*		
No.	*Attachment*	✓
6	HSS Steering Committee meeting endorsing the proposal	
7	EPI stakeholders meeting endorsing HSFP application	
8	CGHN endorsement of application	
9	Gap analysis workshop	
10	District Health Officers evaluation Report	
11	CSO Type B mid and End of project evaluation Report	
12	Mobile Health Team Evaluation Report	
13	Afghanistan Mortality Survey 2010 key findings (AMS 2010)	
14	Afghanistan National Risk and vulnerability assessment 2007-2008	
15	Detailed costing annexes	
16	Revised cMYP March 2012	
17	EPI review report	

[i] MoPH has publicly announced recently substantial decrease in both maternal and child mortality rates

[ii] The NRVA 2008 shows DTP3 coverage of 43% and WHO/UNICEF estimates for 2010 has been 66%