Annual Progress Report 2008

Submitted by

The Government of

Islamic Republic of Afghanistan

Reporting on year: 2008

Requesting for support year: 2010/2011

Date of draft submission: 23rd April 2009

Date of submission: 14th May 2009

Deadline for submission: 15 May 2009

This report reports on activities in 2008, specifically Afghan fiscal year 1387, equivalent to-21 March 2008--20 March 2009, and specifies requests for January – December 2010

Please send an electronic copy of the Annual Progress Report and attachments to the following e-mail address: **apr@gavialliance.org**

and any hard copy could be sent to :

GAVI Alliance Secrétariat,
Chemin de Mines 2, CH 1202 Geneva, Switzerland

Enquiries to: **apr@gavialliance.org** or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public.

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

Please note that Annual Progress reports will not be reviewed or approved by the Independent Review Committee without the signatures of both the Minister of Health & Finance and their delegated authority.

By signing this page, the whole report is endorsed, and the Government confirms that funding was used in accordance with the GAVI Alliance Terms and Conditions as stated in Section 9 of the Application Form.

For the Government of [*Name of Country*]……..……

Minister of Health:
Dr. S.M.A Fatimie
Title: Minister of Public Health

Signature:

Date: ……

Minister of Finance:
Dr. Hazrat Omar Zakhelwal
Title: Minister of Finance

Signature:

Date: ……

This report has been compiled by:

Full name: Dr. Aghagul Dost

Position: National EPI Manager, MOPH

Telephone: +93 799 814812

E-mail: nationalepi05@yahoo.com

ICC Signatures Page

If the country is reporting on ISS, INS, NVS support

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

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The ICC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date
See attached list			

Comments from partners:
You may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

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As this report been reviewed by the GAVI core RWG: y/n

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HSCC Signatures Page

If the country is reporting on HSS, CSO support

We, the undersigned members of the National Health Sector Coordinating Committee, HSS steering committee (CGHN) Consultative Group for Health and Nutrition endorse this report on the Health Systems Strengthening Programme and the Civil Society Organisation Support. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The HSCC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date
Attached			
Scanned pages (Annex 24)			

Comments from partners:
You may wish to send informal comment to: apr@gavialliance.org
All comments will be treated confidentially

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

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

Name: Dr. A.Wali Ghayur
Post: HSS coordinator and focal point

Organisation : MOPH

Date: 14/05/09

Signature: ……

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

The consultation process has been approved by the Chair of the National Health Sector Coordinating Committee, HSCC (or equivalent) on behalf of the members of the HSCC:

Name: Dr. Faizullah Kakar

Post: ……

Organisation:……...

Date: ……

Signature: ……

We, the undersigned members of the National Health Sector Coordinating Committee, …… (insert name) endorse this report on the GAVI Alliance CSO Support. The HSCC certifies that the named CSOs are bona fide organisations with the expertise and management capacity to complete the work described successfully.

Name/Title	Agency/Organisation	Signature	Date
Attached			

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

Annual Progress Report 2008: Table of Contents

This APR reports on activities in 2008, specifically Afghan fiscal year 1387, equivalent to-21 March 2008--20 March 2009, and specifies requests for January – December 2010

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided

Table A: Latest baseline and annual targets (*From the most recent submissions to GAVI)*

Number		Achievements as per JRF	Targets						
		2008	2009	2010	2011	2012	2013	2014	2015
Births		1,315,091	1,346,653	1,378,973	1,412,068				
Infants' deaths		169,647	173,718	177,887	182,157				
Surviving infants		1,145,444	1,172,935	1,201,086	1,229,911				
Pregnant women		1,315,091	1,346,653	1,378,973	1,412,068				
Target population vaccinated with BCG		1,116,419	1,279,320	1,310,024	1,341,465				
BCG coverage*		85%	95.0%	95.0%	95.0%				
Target population vaccinated with OPV3		969,149	1,020,453	1,080,977	1,131,518				
OPV3 coverage**		85%	87.0%	90.0%	92.0%				
Target population vaccinated with DTP(DTP3)***		969,149	1,020,453	1,080,977	1,131,518				
DTP3 coverage**		85%	87.0%	90.0%	92.0%				
Target population vaccinated with DTP (DTP1)***		1,101,584	1,137,747	1,201,086	1,229,911				
Wastage[1] rate in base-year and planned thereafter		96%	97.0%	100.0%	100.0%				
Duplicate these rows as many times as the number of new vaccines requested									
Target population vaccinated with **3rd dose** of DPT-HepB3/DPT-HepB-Hib3			1,020,453	1,080,977	1,131,518				
…… Coverage**			87.0%	90.0%	92.0%				
Target population vaccinated with **1st dose** of DPT-HepB3 /DPT-HepB-Hib3			1,137,747	1,201,086	1,229,911				
Wastage[1] rate in base-year and planned thereafter			97.0%	100.0%	100.0%				
Target population vaccinated with **1st dose** of Measles		857,008	1,114,288	1,141,032	1,168,415				
Target population vaccinated with **2nd dose** of Measles		449,578	1,114,288	1,141,032	1,168,415				
Measles coverage**		75%	95%	95%	95%				
Pregnant women vaccinated with TT+		848,421	875,324	896,332	917,844				
TT+ coverage****		65%	65.0%	65.0%	65.0%				
Vit A supplement	Mothers (<6 weeks from delivery)	NA							
	Infants (>6 months)	Integrated	with	NIDs					
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100		12%	10%	10%	10%				
Annual Measles Drop out rate (for countries applying for YF)		NA	NA	NA	NA				

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants
*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women

[1] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check table α after Table 7.1.

Table B: Updated baseline and annual targets (No changes)

Number		Achievements as per JRF	Targets						
		2008	2009	2010	2011	2012	2013	2014	2015
Births									
Infants' deaths									
Surviving infants									
Pregnant women									
Target population vaccinated with BCG									
BCG coverage*									
Target population vaccinated with OPV3									
OPV3 coverage**									
Target population vaccinated with DTP (DTP3)***									
DTP3 coverage**									
Target population vaccinated with DTP (DTP1)***									
Wastage[2] rate in base-year and planned thereafter									
Target population vaccinated with **3rd dose** of DPT-HepB-Hib									
Coverage**									
Target population vaccinated with **1st dose** of DPT-HepB-Hib ……..									
Wastage[1] rate in base-year and planned thereafter									
Target population vaccinated with **1st dose** of Measles									
Target population vaccinated with **2nd dose** of Measles									
Measles coverage**									
Pregnant women vaccinated with TT+									
TT+ coverage****									
Vit A supplement	Mothers (<6 weeks from delivery)								
	Infants (>6 months)								
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100									
Annual Measles Drop out rate (for countries applying for YF)									

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants
*** Indicate total number of children vaccinated with either DTP alone or combined*
*** Number of pregnant women vaccinated with TT+ out of total pregnant women

[2] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check table α after Table 7.1.

1. Immunization Programme Support (ISS, NVS, INS)

1.1 Immunization Services Support (ISS)

Were the funds received for ISS on-budget in 2008? (Reflected in Ministry of Health and/or Ministry of Finance budget): Yes
If yes, please explain in detail how the GAVI Alliance ISS funding was reflected in the MoH/MoF budget in the box below.
If not, please explain why the GAVI Alliance ISS funding was not reflected in the MoH/MoF budget and whether there is an intention to get the ISS funding on-budget in the near future?

Totally, the MOPH of Afghanistan is going to receive the amount of USD 137.91 millions (25% operation cost and 75% for developmental activities) against the annual plan of actions for health sector operational and developmental activities during 2009 from the core budget of Ministry of Finance. This is about 7.6% of the total National Budget for the fiscal year of 1388 (21 March 2009 to 21 March 2010). The GAVI vaccine fund support is included into the government core budget as grant routed through the Ministry of Finance and specified for immunization program of MOPH. The GAVI vaccine fund is also reflected in the National Development Budget of Afghanistan, 2008-2013, as part of the allocations for the Ministry of Public Health. The GAVI/ Vaccine Fund Support are detailed in the revised MoPH comprehensive Multi-Year Plan (2007-2010) for immunization program.

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC).
Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

The ISS fund provided by GAVI is one of the components of government core budget. The mechanism for management of GAVI fund is based on government policy. The MOPH policy document of "activity – based disbursement mechanism guidelines" for utilization and management of government budget and grants for delivery of health care services including immunization is the basic document for management of MOPH budget including ISS fund. This document clarifies the role and responsibilities of National EPI office, GCMU and admin/finance directorate for disbursement and utilization of GAVI ISS fund. According to this document, the MOPH Grant Contract Management Unit (GCMU) is responsible to oversee and follow the MoPH procedures for disbursement of foreign grants including GAVI vaccine fund.

Based on National cMYP for immunization program; National EPI Policy; national immunization goals, objectives, strategies and priority areas of action for strengthening immunization services and having a picture and understanding of financial performance for the previous year and using this information for financial planning in the forthcoming year and under the guidance of EPI Task Force Committee, the NEPI develop detailed bottom up annual plan of actions in coordination with all stakeholders and partners and estimate budget for each service. The EPI Task Force Committee review the plan and help the NEPI in directing GAVI ISS fund to the areas of national immunization program where the resources are most needed and best utilized. The annual plan of actions is submitted to ICC meeting chaired by Deputy Minister of Policy and Planning for approval and final endorsement. The endorsed plan of action with required fund is used by NEPI only for the purpose of implementation of the plan of action approved by ICC. The endorsed plan is shared with GAVI secretariat, MOPH line Departments and all concerned partners

The procedure for releasing of fund is based on MOPH rules and regulations for disbursement of fund. The request is originated by NEPI based annual plan of action and submitted to the Minister or Deputy Minister through Directorate of Preventive Medicine & PHC for approval. The approved request is then officially sent to General Directorate of Administration and GCMU for further process of fund disbursement.
Transfer of funds to the provinces is done either through the bank or private money dealers. National EPI office is responsible to immediately inform Provincial Health Directorate/ Provincial EPI Management Teams (PEMT) by email, phone or any other means about the transfer of cash and specification of the representative of contracted money dealer in the province.
All documentation in connection with the above transaction is attached to the files for financial auditing and liquidation of accounts. All payments and purchases are done according to the activity plan using standard formats and following official procedures. Copies of the documents (stipend role, receipts etc) signed by PEMT managers and Provincial Health Directors are sent with budget expenditure summary sheet to national EPI office. Copies of all such documents are kept at PEMT level for the purpose of auditing

as well. All payment documents and vouchers are reviewed and rechecked and are sent to GCMU for further actions.
The plan of work and the time line as defined in the approved plan of action may be modified based on ICC agreement taking into account the operating experience and needs of the Program.
The NEPI submit the semi-annual and annual reports to ICC indicating the activities carried out and the amount spent against each budget line.

Problem:
The length administrative procedures in both MoPH and MoF usually cause delay in releasing fund for implementation of planned activities, procurement of required equipment and expansion of EPI infrastructure.

1.1.2 Use of Immunization Services Support

In 1387 fiscal year, the following major areas of activities have been funded with the GAVI Alliance Immunization Services Support contribution.
Funds received during 1387 fiscal year: US$ 2,048, 475 (Reward 4 for 2008), Hib pre-Introduction fund: 403,975; Total: US$ 2,452,450
Remaining funds (carry over) from 1386 fiscal year: US$ 7,236,461
Total spent in 1387 fiscal year: US$ 4,340,041
Balance to be carried over to 1388 fiscal year: US$5,348,870

Table 1.1: Use of funds during 2008*

Area of Immunization Services Support	Total amount in US $	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines	0	0	0	0	0
Injection supplies	0	0	0	0	0
Personnel	401,342	40,134	133,781	227,427	
Transportation	94,232	18,846	31,411	43,975	
Maintenance and overheads	100,200	20,040	33,400	46,760	
Training	473,258	23,663	47,326	402,269	
IEC / social mobilization	628,551	20,952	157,138	450,462	
Outreach	0	0	0	0	
Supervision	65,349	6,535	16,337	42,477	
Monitoring and evaluation	38,560	3,856	12,853	21,851	
Epidemiological surveillance	64,972	2,166	16,243	46,563	
Vehicles	77,789	3,889	38,895	35,005	
Cold chain equipment	1,875,813	23,448	1,490,200	362,165	
Other: *Conducted MMRC Campaign in 8 Provinces*	519,977	5,200	25,999	488,778	
Total:	**4,040,043**	**168,729**	**2,003,583**	**2,167,732**	

Outreach conducted by NGOs contracted by MOPH as part of Basic Package of Services

1.1.3 ICC meetings

How many times did the ICC meet in 2008? Four
Please attach the minutes (DOCUMENT N°.....) from all the ICC meetings held in 2008 specially the ICC minutes when the allocation and utilization of funds were discussed.

Are any Civil Society Organizations members of the ICC: ***[Yes]***
if yes, which ones?

NGOs: Afghan Health and Development Services (AHDS), Ibne Sina, and Management Sciences for Health (MSH)-Tech Serve are members of ICC.

Please report on major activities conducted to strengthen immunization, as well as problems encountered in relation to implementing your multi-year plan.

A. Planning & management

1. Four ICC meetings were conducted during 2008. The national inter-agency coordination committee as coordination body for immunization program comprised of MOPH line department directors and EPI partners such as UNICEF, WHO, World Bank, European Commission, USAID, and NGOs. ICC is playing essential roles in ensuring that Governments and their partners work together to strengthen immunization services in Afghanistan. ICC is coordinating all aspects of immunization program including management of GAVI fund. ICC played imperative role in revision of national immunization policy, coordination of immunization program with all stakeholders, revision and overseeing of EPI annual plan of actions, implementation of the plan, monitoring of utilization of GAVI ISS fund, monitoring of immunization programs, establishing appropriate linkages with HSS, CSO, enhancing stakeholders roles for following MOPH immunization strategies in providing immunization services, advocacy and social mobilization especially for introduction of new Hib (Pentavalent) vaccine into national immunization program, and providing financial expertise to national EPI.
2. The bottom up annual plan of action was developed, approved by ICC and accepted by MoF.
3. The EPI Task Force Committee comprised of Director of Preventive Medicine & PHC, NEPI, UNICEF, WHO, and main NGOs. The EP TFC meet every two weeks to help national EPI in developing annual plan of actions, running of planned and ongoing immunization activities such as developing and revision of immunization policy, adapting and developing EPI related training materials and other EPI related documents, preparing schedule for training of EPI staff, facilitating the training courses, reviewing of quarterly reported immunization data and providing feedback, supporting NEPI in monitoring of routine immunization program, strengthening advocacy and social mobilization, preparing agendas for ICC meetings and national and regional semi-annual and annual EPI review workshops, facilitating the EPI review workshops; developing plan of actions for supplementary immunization activities and taking part in monitoring of such activities, reviewing vaccine preventable disease surveillance data, and taking decision on planning and controlling of vaccine preventable diseases outbreaks, delegating the EPI related activities and responsibility to the task force members, coordinating with HSS for strengthening and integration of immunization services into health sub-centers, and mobile health teams and etc.

4. Conducting of monthly provincial, quarterly regional and national semi-annual and annual EPI review workshops involving all partners and stakeholders is a procedure practiced by all levels. The purpose of the EPI review workshops is to review the overall immunization situation, analyze the problems, prioritize the problems and take corrective measures for solving the problems and improving immunization program.

5. The national immunization policy was revised by EPI Task Force Committee members and endorsed by ICC. The national strategies for implementation of immunization services are clearly defined and submitted to Grant Contract Management Unit of MOPH to be included into revised BPHS policy.

6. Introduction of Hib (Pentavalent) vaccine into national immunization program. Afghanistan launched nationwide introduction of Hib vaccine (Pentavalent) into national immunization program on 2nd January 2009 in all 1,210 public health facilities throughout the country. The official ceremony of introducing Hib vaccine took place on 11th January 2009 by President Hamid Karzai at presidential palace and in the presence of Dr. Fatimie, Minister of Public Health of Afghanistan, Dr. Hussein A. Gezairy, Regional Director, WHO/EMRO, Mr. Kae Aide, Special Representative of United Nations for Afghanistan, Diplomatic Representatives, UNICEF and WHO country representatives, MOPH high authorities, national and international mass media by vaccinating the children. Dr. Hussein A. Gezairy, Dr. Fatimie, and Mr. Kai Aide while delivering their speeches indicated that GAVI support for the introduction of this expensive new vaccine represents a golden opportunity for preventing Hib-related diseases and saving children's lives in Afghanistan.

B. Immunization Service Delivery

Afghanistan implements the Expanded Programme on Immunization (EPI) in majority of the districts (321). People in 8 districts are deprived of any health care services including immunization.
The country is currently a beneficiary of a 5-year plan of support from GAVI spanning the period 2006-2010, to strengthen the immunization system.
The EPI in the country has a three-tier management system. At the national level, EPI comes under the Preventive Medicine & PHC

Directorate together with other programmes. At the provincial level, EPI service is integrated into the public health system under the leadership of the provincial health directorate. There are provincial EPI management teams in each province comprised of provincial EPI managers, supervisors, cold chain technicians and supportive staff.
At the district level, the District Public Health Officer manages EPI activities. Efforts are going on to establish District Health Management Teams to coordinate all health care services at district level.
Afghanistan is a country in crisis and due to the ongoing conflict in some parts of south, east, south-east and western regions; around half of the population in these areas have no access to immunization services. Despite the conflict and insecurity in certain areas, Afghanistan has witnessed a slight increase in infant immunization coverage (DPT3 – 85%) in 2008. The increase in immunization coverage is due to improvement of the program in secured of the country, strengthening of outreach and mobile activities and integration of EPI into health sub-canters and mobile health teams initiated by HSS. In spite of this achievement, around 200,000 children less than one year in the country did not receive routine childhood vaccines. Totally, 1210 EPI fixed centers are functional in all over the country providing immunization services in the health facilities, and the immunization health workers are performing outreach and mobiles activities. In addition, immunization services have been included into health sub-centers and mobile health teams functions established in different parts of the country and with the support of GAVI HSS fund support. In terms of access to routine immunization services, the NEPI focused on training of different categories of EPI staff to strengthen their managerial capacity especially in proper planning and re-scheduling district micro-plans and identification of areas with low coverage and implementing micro-plans to ensure provision of regular immunization services.
Comparing to 2007 reported immunization coverage, the national BCG coverage in 2008 has increased from 77% to 85%, DPT-HepB3 coverage from 83% to 85%, measles from 70 % to 75% and TT2+ from 60% to 65%.

C. Capacity building:

In Afghanistan, the performance of immunization is hampered especially in remote and difficult to reach areas by the shortage of qualified and experienced immunization health workers. The delivery of immunization undermined by human resource problems such as the inappropriate employment of staff, high staff turnover, low pay and poor supportive supervision. To meet the need of population, the NEPI has planned to conduct initial training courses for 350 new vaccinators during 2008 - 2010 using GAVI ISS fund. Of the planned number of new vaccinators, 120 new immunization health workers were selected from the remote areas and were trained for three months during 2008.
To strengthen the quality of vaccine and cold chain management at national and regional levels, the 9 cold chain officers were recruited by national EPI office and were trained on vaccine and cold chain management with the support of WHO and UNICEF.
For introduction of new vaccine (Hib) into NEPI program, there was need to building capacity of all categories of EPI staff. WHO provided technical support in adapting and developing of guideline on Hib – related diseases and Hib vaccine supported national EPI technically and financially in conducting two batches of TOT. Training was considered the most important preparatory activity for the introduction of the new vaccine. WHO training guidelines and materials on Hib disease and vaccine were adapted after inputs from all partners and then were recommended by national EPI Task Force Committee for training of staff. The two batches of TOT for 59 trainers on HI and Hib vaccine conducted with the technical and financial support of WHO at national level. GAVI funds provided to Afghanistan were used for training of all categories of staff involved in the immunization program. Totally, 2765 EPI managers, supervisors, immunization health workers, cold chain officers and technicians were trained before the launching of the new vaccine. The GAVI fund allocated for pre-introduction activities were used for training of 2521 immunization health workers, 40 PEMT supervisors, 68 cold chain technicians and 80 EPI supervisors and printing of training materials. Totally, 2709 EPI staff was trained.
To strengthen capacity of EPI managers and supervisors in EPI planning and particularly in HF/District micro-planning based on RED approach, the NEPI with the support of WHO conducted a TOT for 24 EPI managers and supervisors in southern provinces of the country.
For strengthening and sustaining the quality of immunization practices, services, vaccine & cold chain at service level and immunization recording and reporting system, the refresher training courses conducted for 685 immunization health workers focusing on the districts with poor performance.
Vaccine and cold chain management is a key issue for NEPI to ensure that vaccines are not damaged due to mishandling; keep under controlled temperatures at all levels and reach all children safely. 39 cold chain technicians in southern provinces where there was need for strengthening cold chain and vaccine management were trained by NEPI with the technical support of WHO.
To strengthen the capacity of EPI managers and supervisors on different aspects of immunization system and particularly immunization data management, the 8 batches of MLM training courses conducted for 152 EPI managers and supervisors from 32 provinces.
For expansion and improvement of measles case –based and NNT surveillance; in addition to the existing 629 AFP/DEWS surveillance sentinel sites reporting AFP, measles, NNT cases and other vaccine preventable diseases, the NEPI conducted training courses for 476 medical doctors and nurses from the health facilities throughout the country and the new surveillance sentinel sites are established.
Concerning the new vaccines, 35 medical doctors and laboratory technicians from six hospitals and central public health laboratory were trained by WHO experts to perform surveillance and sample tests for rotavirus and meningitis.

D.VPD Surveillance

To measure the impact of immunization services and burden of diseases and taking appropriate control action and decision for introduction of new vaccines, the MOPH emphasizes on strengthening of surveillance of vaccine-preventable disease such as AFP, Measles, NNT, Rotavirus and Meningitis. The lab-based surveillance of Rotavirus and Meningitis was established in late 2007 with the technical and financial support of WHO. During 2008, out of 1383 cases of AFP detected, 31 were positive for polio, and 319

cases were positive for measles out of 1521 cases detected were detected. Totally, 12 cases of NNT reported from 12 districts. Out of 605 specimens from the patients with gastroenteritis, 341were positive for Rotavirus. For the first time in the country, 12 cases of whooping cough were laboratory confirmed. And 6 cases of Hib positive meningitis were confirmed by lab from 124 samples tested. The measles genotype (D4) was confirmed for the first time by reference laboratory. The lab-based Rotavirus and Meningitis surveillance is established in six hospitals with cross-checking of the samples in central public health laboratory. WHO continues providing support to MOPH in running of bacterial meningitis and rotavirus surveillance including laboratory and epidemiology training by network experts, provision of reagents, supplies and equipments, regional quality assurance and quality control, data management and monitoring through follow-up visits and on-site training. The GAVI ISS fund is used as payment of small amount of incentive for encouraging hospital surveillance staff to work overnight. The national manuals on vaccine preventable diseases outbreaks and response were developed with the support of WHO and passed by EPI Task Force Committee.

F. IEC and social mobilization

Generally, the NEPI role in IEC and social mobilization was limited in production of few radio/TV spots and some banners and leaflets. As planned, the NEPI could not develop effective strategies on IEC and community awareness. Instead, the HSS cell in MOPH played important role in developing effective strategies for community mobilization and community awareness through contracting out with six national and international Radio/TV stations regularly broadcasting information on the importance of immunization. The HSS cell in MOPH together with IEC department developed TV/Radio spots that are regularly disseminate on National and Private Radio/TV stations. In addition, the HSS cell developed and printed around one million posters on immunization and distributed throughout the country.

G. Cold chain and infrastructure

The GAVI ISS fund used for procurement of 10 walk-in cold rooms, 57 Ice lined Refrigerators, 45 Ice Pack Freezers through UNICEF. The national cold chain staffs were able to install all the cold rooms at national and regional levels before arrival of single dose Pentavalent vaccine. Totally, the cold chain capacity reached 97m3 including national, regional and provincial VSFs. The national EPI has ordered 2 freezer rooms, 308 RCW50 Refrigerators, 500 cold boxes, 6000 Vaccine carriers and spare parts for refrigerators from ISS fund to be purchased by UNICEF.
The GAVI ISS fund was used for construction of 4 buildings for accommodation of provincial EPI Management Teams, procurement of 4 vehicles and 10 sets of computers, maintenance of cold chain equipment, and other capital equipment.

H. Supervision and monitoring

Although monitoring and supervision is an integral part of NEPI annual, quarterly and monthly work plan, provincial EPI management teams and NGOs, but less data on the number of supervisory visits, findings, reports and what corrective actions taken were discussed in EPI Task Force Committee Meetings. The NEPI manager is responsible to regularly review supervision plans of all staff from the national up to the districts/health facilities levels and to make sure that the supportive supervisory visits are going on according to the plan and provide all the necessary support including transport and budget. Most importantly, provincial EPI managers to organize monthly review meeting with the supervisors together with the NGOs with poor routine EPI performance and based on the supervisory findings reach consensus on improving the quality of routine immunization coverage and increasing immunization coverage following the national strategies (fixed, outreach and mobile) to reach all children and women under the catchment areas of the each stakeholders with particular attention in under served areas.

Problems:

- **Insecurity** is a key problem in preventing access to the children in south, south-east and some areas in the western and eastern parts of the country. Special efforts are needed to establish contacts with tribal leaders, religious and community elders to help the vaccination teams to provide immunization services through outreach and mobile immunization activities in insecure areas and areas where the health care services are not available.
- **Poor monitoring and supportive supervision**: there is need to strengthen supportive supervision by providing training and feedback and helping to improve the capacity of health facility staff to fulfil their duties for providing quality immunization services, accuracy of recording and reporting immunization data, vaccine wastage, and AEFI and increasing immunization coverage. Careful attention is needed to rescheduling health facility and district micro-plans for reaching every child with particular attention to remote and underserved areas.
- **Poor monitoring of stakeholders (NGOs) immunization performance:** Strengthening implementation of immunization program requires strong coordination and cooperation between NEPI and implementing NGOs, the key health care service providers in Afghanistan, and stakeholders at all levels to ensure that the RED approach is implemented and all the children are reached.
- **Weak management capacity and lack of competent staff**: strong coordination between NEPI and NGOs is needed to improve the knowledge and skills of NGOs staff in management of immunization program and particularly immunization data management.
- **Shortage of trained immunization health workers** especially in rural and remote areas of the country
- **Low level of payment** to immunization health workers
- **Geographical constraints**, long winter in certain parts of the country, and bad road condition prevent access to immunization services in certain areas of the country.

- **Poor implementation of HF/District micro-plans** developed based on RED by the stakeholders (NGOs).
- **Shortage of transport means** for timely monitoring and supervision
- **Discrepancy between different sources of population data**: the government's Central Statistic Office (CSO) data seems to be underestimated and the data derived from NIDs is overestimated. The UNIDATA population figure, used by NEPI as the closest to information received from the field, is based on a population census carried out in 1979 and updated annually by an estimated population growth rate. This is a challenging factor in planning, implementation, monitoring and evaluation of the immunization program.

Attachments:

Three (additional) documents are required as a prerequisite for continued GAVI ISS support in 2010:

a) Signed minutes (DOCUMENT N°……) of the ICC meeting that endorses this section of the Annual Progress Report for 2008. This should also include the minutes of the ICC meeting when the financial statement was presented to the ICC.
b) Most recent external audit report (DOCUMENT N°……) (e.g. Auditor General's Report or equivalent) of **account(s)** to which the GAVI ISS funds are transferred.
c) Detailed Financial Statement of funds (DOCUMENT N°……) spent during the reporting year (2008).
d) The detailed Financial Statement must be signed by the Financial Controller in the Ministry of Health and/or Ministry of Finance and the chair of the ICC, as indicated below:

Note: all the requested documents are attached.

1.1.4 Immunization Data Quality Audit (DQA)

If a DQA was implemented in 2007 or 2008 please list the recommendations below:

Afghanistan was looking forward to conduct a self-DQA and immunization coverage survey in 2008. But both important activities could not happen due to the following reasons:

1. UNICEF was committed to provide fund for immunization coverage survey, but due to the shortage of fund the immunization coverage survey could not be conducted.
2. Planned self-DQA of 2008 was delayed due to competing priorities and was finally conducted in February-March 2009 after training of NEPI M & E officer and Director of preventive medicine in Jordan.

Has a plan of action to improve the reporting system based on the recommendations from the last DQA been prepared?

YES ☑ *NO* ☐

If yes, what is the status of recommendations and the progress of implementation and attach the plan. **(Please note that the self DQS was just completed and following are the recommendations. The action plan will follow next month.)**

Provincial Level:

- The National EPI Program should develop a mechanism to aggregate the reported EPI data from fixed centres at the district level of the country.
- The National EPI Program should receive the health facility based EPI and district level aggregated data in addition to current provincial layer.
- The program should develop tables to monitor completeness & timeliness of monthly reports from health canters.
- Supervision should be on regular basis and supervisory log book should fill-in completely by supervisors during each visit.
- Feedback from PEMTs in term of quality of reported data, findings from supervision, and completeness of reports should be provided to EPI fixed canters.
- The quality of refresher trainings should verify by internal or third party evaluation to ensure that vaccinator gained the proper knowledge and they have ability to put the gained knowledge in the practice.
- The DQS practice should be extended to other fixed centres of the sampled 12 provinces by the trained EPI health workers.
- Emphasis was made to train provincial EPI health workers of remaining 22 provinces in the country, to use the

DQS as strong monitoring tool for enhancement of EPI Program.

- The National EPI Program should follow implementation of DQS recommendations through EPI Annual Plan of Action-2009.

- The staff from Provincial EPI Management Team appreciated the exercise as a first opportunity to assess their activities in-depth and notice the strength and weakness of the program
- Staff in addition to the EPI health workers in the Health Facilities learned from Data Quality Self-assessment exercise in order to improve their achievements

Health Facility/District Level

- The standard stock book for vaccination supply should be available in order to register the amount of vaccine and dry-supply received, utilized and balances of them including additional information such as vaccine batch number, expiration date.
- The link between EPI fixed canter with-in health facility and out-patient department (OPD) should improve to establish a strong referral for all eligible infants and mother to the fixed canter.
- The register for follow up of defaulters should be available and in use with the fixed canter.
- Develop the forms to record the timeliness and completeness of monthly reports to the Provincial EPI Management Teams (PEMTs).
- The national EPI program should organize the EPI initial training course (3 months) for those vaccinators who only received short term refresher training courses.
- The Provincial EPI Management Teams (PEMTs) should provide the written feed-back on the achievements, reports and technical capacity of EPI health workers in the fixed canters.
- The address column of register book should have enough information (village, street, house, name of famous mosque, community leader) to easily retrieve the child within community.
- Ensure the proper and timely use of standard immunization monitoring chart in all fixed canters.
- Enforce the availability of job description for vaccinators which is know and translated at local language in all fixed centers.
- The vaccinators should be fully aware of their job description and this issue should strictly follow during the supervisory visits.
- An uniform filing system (i.e; filling by activity in alphabets order) should be establish in all EPI fixed canters, the vaccinators should be trained about and follow-up during supervision should be make that this practice is in place.

Please highlight in which ICC meeting the plan of action for the last DQA was discussed and endorsed by the ICC. ***27th September 2007***

Please report on any studies conducted and challenges encountered regarding EPI issues and administrative data reporting during 2008 (for example, coverage surveys, DHS, house hold surveys, etc).

List studies conducted: ***Not conducted***

List challenges in collecting and reporting administrative data:

Please see recommendations above from last month's self DQS.
Also there has been no census so the target and denominator for coverage are estimated.
Monitoring insecure areas is still a challenge.

1.2. GAVI Alliance New & Under-used Vaccines Support (NVS)

1.2.1. Receipt of new and under-used vaccines during 2008

When was the new and under-used vaccine introduced? Please include change in doses per vial and change in presentation, (e.g. DTP + HepB mono to DTP-HepB)

The Hib vaccine (Pentavalent: DPT-HepB-Hib, single dose/vial), was introduced into national immunization program on 1st January, 2009. The pentavalent vaccine has replaced tetravalent vaccine.

[There was not any change in doses and vial sizes in vaccines used during 2008]

Dates shipments were received in 2008.

Vaccine	Vials size	Total number of Doses	Date of Introduction	Date shipments received (2008)
DPT-HepB (tetra)	10 dose vial	1,500,000	June, 2006	15/feb/08
DPT-HepB-Hib	Single dose, liquid	1,000,000	01/01/2009	4/dec/2008
DPT-HepB-Hib	Single dose, liquid	1,600,000	01/01/2009	07/mar/2009

Please report on any problems encountered.

[the VAR received one week before the arrival and the vaccine arrived in good condition]

1.2.2. Major activities

Please outline major activities that have been or will be undertaken, in relation to, introduction, phasing-in, service strengthening, etc. and report on problems encountered.

Immunization service is hampered by insecurity in certain areas of the country. The factors such as poor monitoring and supervision especially supportive supervision, poor coordination between NEPI and NGOs, geographic barriers, cold weather and unclear demarcation of responsibilities have negative effect on improving immunization coverage.
All the problems were shared with NGOs during the mid-term and annual EPI Review meetings, and the revised version of national immunization policy with clear immunization strategies are submitted to Grant Contract Management Unit (GCMU) to be clarified with NGOs BPHS- implementing partners to be implemented. The staffs of both MOPH and NGOs were trained on HF/District micro-planning and the micro-planning completed in more than 90% of the districts. Guidelines and training on district micro-planning were disseminated.
Further efforts are on-going to fill gaps in service delivery. GAVI HSS, WB, EC and USAID are supporting health sub-centres and mobile health teams to increase immunization coverage in less accessible areas. GAVI CSO will pilot private sector provision of EPI in two insecure, remote areas.
In relation to introduction of new vaccine (Pentavalent) there is needed to monitor adverse effects following immunization (AFEI) of Pentavalent vaccine.
Surveillance of meningitis has established in one hospital and need to be expanded into five more hospitals to assess the effect of vaccine.

1.2.3. Use of GAVI funding entity support for the introduction of the new vaccine

These funds were received on: *[08.09.2008]*

Please report on the proportion of introduction grant used, activities undertaken, and problems encountered such as delay in availability of funds for programme use.

Year	Amount in US$	Date received	Balance remaining in US$	Activities	List of problems
2008	403,975	08.09.2008	0	The fund used for training of all categories of immunization staff, printing of training materials, transportation of cold rooms to the regions, installation of cold rooms, procurement of materials for installation of cold rooms, payment of incentive for cold chain officers and technicians for installation, printing of all revised immunization recording and reporting materials that meet two years requirement of the program, and social mobilization activities. There was some delay in releasing of fund from the MoF of Afghanistan.	

1.2.4. Effective Vaccine Store Management/Vaccine Management Assessment

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? **September, 2007**

If conducted in 2007/2008, please summarize the major recommendations from the EVSM/VMA.

EVSM/VMA concluded that in general, the central vaccine store is very well managed. Average EVSM score in this follow up assessment was 89 percent.

Staff members are highly motivated. Participation in the Global Training Network (GTN) Vaccine Management Training Courses should be arranged for the cold chain technicians. Store manager may also attend these courses as a resource person.

The store is appropriately equipped and maintained. There are no vaccine losses due to poor handling, freezing or heat exposure. The areas for improvement are as follows:

1. Logistics system should be revised at all levels. Appropriate minimum and maximum stock levels and distribution periods should be set.
2. Vaccine forecasting should be inline with the current EPI guidelines. Forecasts should be compared with the actual consumption to calculate forecasting accuracy.
3. There should be a lot release certificate from the country of origin for each and every vaccine batches.
4. Temperature of vaccine packing area should be kept between 15-25^{O}C during operations.
5. A contingency action plan should be developed and implemented to respond to emergencies.
6. Shelves for ice pack conditioning should be installed in the room where cold rooms and freezer room are located. It should be noted that 1m^2 surface is required for conditioning of approximately 25 ice packs. Shelves should be 75cm above the floor level.
7. Audible temperature alarms should be installed to all cold chain equipment

Was an action plan prepared following the EVSM/VMA? Yes

If yes, please summarize main activities under the EVSM plan and the activities to address the recommendations and their implementation status.

A data-base was developed with financial support of UNICEF and is in use at national and regional levels and is planned to be used at provincial levels for adequate management of vaccines and supplies. The storage volume calculation including Hib vaccines was done by an expert from EMRO. The vaccine forecasting is based on population figures given by UNIDATA. UNICEF provides vaccine product information at least three days before the arrival of vaccines and the VARs are usually sent to UNICEF within 24 hours.

Additional cold rooms are installed at national and regional levels and ILRs are installed at provincial levels to accommodate all routine vaccines including OPV for NIDs. A multi channel temperature recorder is provided by UNICEF. The AC/heaters are installed to keep the vaccine packing area within the required range. The audible temperature alarms are installed. The National cold room is now connected with regular city power supply with generator back-up.

*All the recommendations made by EMRO and WHO HQ were met and the Afghanistan National Cold Store was internationally certified***.**

When will the next EVSM/VMA* be conducted**? *[July, 2010]***

**All countries will need to conduct an EVSM/VMA in the second year of new vaccines supported under GAVI Phase 2.*

Table 1.2

Vaccine 1: ..... DPT-HepB-Hib (pentavalent).....	
Anticipated stock on 1 January 2010	**.600,000 doses.**
Vaccine 2:	
Anticipated stock on 1 January 2010	**.....**
Vaccine 3:	
Anticipated stock on 1 January 2010	**.....**

1.3 Injection Safety

1.3.1 Receipt of injection safety support (for relevant countries)

Are you receiving Injection Safety support in cash or supplies? No, The GAVI injection safety support for Afghanistan was ended in 2006.

If yes, please report on receipt of injection safety support provided by the GAVI Alliance during 2008 (add rows as applicable).

Injection Safety Material	Quantity	Date received

Please report on any problems encountered.

[List problems]

1.3.2. Even if you have not received injection safety support in 2008 please report on progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report how injection safety supplies are funded.

The topics of immunization injection safety and AEFI are part of almost all the immunization related training courses. UNICEF continues providing AD syringes, injection supplies and safety boxes as part of the concept of "bundled" vaccines.

The following were received from UNICEF last year:
AD syringes 0.5ml for TT, DPT-HepB, Measles vaccines – 5,707,100 Units
BCG syringes – 1,544,800 Units
Mixing syringes – 76,800 Units
Safety boxes – 214,700 Units

Injection safety supplies for non-vaccine injections are provided in the Basic Package of Health Services (BPHS) at public health facilities supported by MoPH through contracting out to NGOs.

Please report how sharps waste is being disposed of.

MoPH requires and monitors all health facilities providing BPHS to:

- Use safety boxes at all service levels.
- Incinerate all sharps waste or bury it in places where there are no incinerators.

According to the 2007 third-party assessment of BPHS health facilities called the Balanced Score Card, 84% of health facilities implemented "proper sharps disposal

Please report problems encountered during the implementation of the transitional plan for safe injection and sharps waste.

[No problem]

1.3.3. Statement on use of GAVI Alliance injection safety support in 2008 (if received in the form of a cash contribution)

The following major areas of activities have been funded (specify the amount) with the GAVI Alliance injection safety support in the past year:

[List items funded by GAVI Alliance cash support and funds remaining by the end of 2008]

NA

2. Vaccine Immunization Financing, Co-financing, and Financial Sustainability

Table 2.1: Overall Expenditures and Financing for Immunization

The purpose of Table 2.1 is to guide GAVI understanding of the broad trends in immunization programme expenditures and financial flows.
Please the following table should be filled in using US $.

	Reporting Year 2008	Reporting Year + 1	Reporting Year + 2
	Expenditures	Budgeted	Budgeted
Expenditures by Category			
Traditional Vaccines	$5,942,088	$19,311,811	$15,455,487
New Vaccines		14,842,889	12,885,992
Injection supplies	$1,595,818	$1,661,180	$1,708,664
Cold Chain equipment	$1,655,963	$454,197	$456,094
Operational costs	$6,858,697	$6,711,698	$7,344,958
Vehicles	$236,455	$289,420	$262,408
Personnel	$4,796,711	$4,985,259	$5,179,431
Other operational expenditures (Transportation, maintenance, training, IEC, surveillance, program management, other capital equipment, shared costs and routine recurrent cost	$6,858,697	$6,711,698	$7,344,958
Others (campaign operational costs including vaccines)	$18,834,270	$29,119,124	$19,800,223
Total EPI	**$39,920,002**	**$77,375,578**	**$63,093257**
Total Government Health	$2,091,657	$2,212,157	$2,204,122

Exchange rate used	Afs 50/$1

Please describe trends in immunization expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunization program over the next three years; whether the funding gaps are manageable, challenge, or alarming. If either of the latter two is applicable, please explain the strategies being pursued to address the gaps and indicate the sources/causes of the gaps.

Considering the "secured" as well as "probable" funds, there is a funding gap of US$ 1.786 million during the plan period - US$ 813,224 and US$ 980,397 is anticipated during 2009 and 2010 respectively – only about 2% of the budget for the mentioned period, and appears to be manageable.

Despite the fragile economic situation in Afghanistan, the GoA contributed at least 11% of the routine immunization cost in 2006, 2007 and 2008. With high political commitment to EPI and its inclusion in the Basic Package of Health Services, it is expected that Health Sector Partners will continue contributing towards this cause. Without internal sources of funding at present, EPI will rely on external funding for the near future. However, as GoA rehabilitates its infrastructure and increases its capacity for resource generation, it is expected that it will not only maintain the baseline, but will gradually increase its contribution towards immunization and work toward sustainability of the EPI Program.

Strategies being pursued to improve financial sustainability:
ICC has approved an action plan and monitoring framework to pursue the following strategies for improving financial sustainability:

- Improve mobilization of resources from government, donors and private sector for immunization
- Increase reliability of resources through budgeting and reporting

Increase efficiency of the resources by promoting integration and maximizing efficiency of immunization and reducing vaccine wastage.

Future Country Co-Financing (in US$)

Please refer to the excel spreadsheet Annex 1 and proceed as follows:

- Please complete the excel sheet's "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.

- Then please copy the data from Annex 1 (Tab "Support Requested" Table 2) into Tables 2.2.1 (below) to summarize the support requested, and co-financed by GAVI and by the country.

Please submit the electronic version of the excel spreadsheets Annex 1 (one Annex for each vaccine requested) together with the application.

Table 2.2.1 is designed to help understand future country level co-financing of GAVI awarded vaccines. If your country has been awarded more than one new vaccine please complete as many tables as per each new vaccine being co-financed (Table 2.2.2; Table 2.2.3; ….)

Table 2.2.1: Portion of supply to be co-financed by the country (and cost estimate, US$)

1st vaccine: ***DPT-HepB-Hib (pentavalent)***.		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose		$0.10	$0.15	$0.15	$0.15		
Number of vaccine doses	#	115,400	187,300	205,000	264,900		
Number of AD syringes	#	122,000	198,000	216,800	280,100		
Number of re-constitution syringes	#	0	0	0	0		
Number of safety boxes	#	1,375	2,200	2,425	3,125		
Total value to be co-financed by country	**$**	$383,500	$585,000	$599,000	$613,000		

Table 2.2.2: Portion of supply to be co-financed by the country (and cost estimate, US$)

2nd vaccine:……		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose							
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by country	**$**						

Table 2.2.3: Portion of supply to be co-financed by the country (and cost estimate, US$)

3rd vaccine:……		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose							
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by country	**$**						

Table 2.3: Country Co-Financing in the Reporting Year (2008)

Q.1: How have the proposed payment schedules and actual schedules differed in the reporting year?			
Schedule of Co-Financing Payments	Planned Payment Schedule in Reporting Year	Actual Payments Date in Reporting Year	Proposed Payment Date for Next Year
	(month/year)	(day/month)	
1st Awarded Vaccine *:* ***DPT-HepB-Hib (pentavalent)***	Sept/2008	Mar/2009	Dec/2009
2nd Awarded Vaccine (specify)			
3rd Awarded Vaccine (specify)			

Q. 2: How Much did you co-finance?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine *:* ***DPT-HepB-Hib (pentavalent)***	$448,000	120,200 doses out of total 4,480,000
2nd Awarded Vaccine (specify)		
3rd Awarded Vaccine (specify)		

Q. 3: What factors have slowed or hindered or accelerated mobilization of resources for vaccine co-financing?
1. Difference in calendar year made some confusion, and not understanding that payment for vaccines for 2009 must be done in 2008, but MOPH & MOF showed support and goodwill.
2. MOPH required invoice from UNICEF, but UNICEF needed advance payment.
3.
4.

If the country is in default please describe and explain the steps the country is planning to come out of default.

3. Request for new and under-used vaccines for year 2010

*Section 3 is to the request new and under-used vaccines and related injection safety supplies for **2010**. **No new vaccine is planned for 2010***

3.1. Up-dated immunization targets

*Please provide justification and reasons for changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the **WHO/UNICEF Joint Reporting Form** in the space provided below.*

Are there changes between table A and B? Yes/no

If there are changes, please describe the reasons and justification for those changes below:

Provide justification for any changes ***in births**:*

*Provide justification for any changes **in surviving infants**:*

*Provide justification for any changes **in Targets by vaccine**:*

*Provide justification for any changes **in Wastage by vaccine**:*

Vaccine 1: .....

Please refer to the excel spreadsheet Annex 1 and proceed as follows:

- Please complete the "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.

- Please summarise the list of specifications of the vaccines and the related vaccination programme in Table 3.1 below, using the population data (from Table B of this APR) and the price list and co-financing levels (in Tables B, C, and D of Annex 1).

- Then please copy the data from Annex 1 (Tab "Support Requested" Table 1) into Table 3.2 (below) to summarize the support requested, and co-financed by GAVI and by the country.

Please submit the electronic version of the excel spreadsheets Annex 1 together with the application.

(Repeat the same procedure for all other vaccines requested and fill in tables 3.3; 3.4; .....)

Table 3.1: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#						
Target immunisation coverage with the third dose	*Table B*	#						
Number of children to be vaccinated with the first dose	*Table B*	#						
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#						
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$						

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.2: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by GAVI	**$**						

Vaccine 2: .....

Same procedure as above (table 3.1 and 3.2)

Table 3.3: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#						
Target immunisation coverage with the third dose	*Table B*	#						
Number of children to be vaccinated with the first dose	*Table B*	#						
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#						
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$						

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.4: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by GAVI	**$**						

Vaccine 3: .....

Same procedure as above (table 3.1 and 3.2)

Table 3.5: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#						
Target immunisation coverage with the third dose	*Table B*	#						
Number of children to be vaccinated with the first dose	*Table B*	#						
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#						
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$						

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.6: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by GAVI	**$**						

4. Health Systems Strengthening (HSS)

Instructions for reporting on HSS funds received

1. As a Performance-based organisation the GAVI Alliance expects countries to report on their performance – this has been the principle behind the Annual Progress Reporting –APR- process since the launch of the GAVI Alliance. Recognising that reporting on the HSS component can be particularly challenging given the complex nature of some HSS interventions the GAVI Alliance has prepared these notes aimed at helping countries complete the HSS section of the APR report.
2. All countries are expected to report on HSS on the basis of the January to December calendar year. Reports should be received by 15th May of the year after the one being reported.
3. This section **only needs to be completed by those countries that have been approved and received funding for their HSS proposal before or during the last calendar year**. For countries that received HSS funds within the last 3 months of the reported year can use this as an inception report to discuss progress achieved and in order to enable release of HSS funds for the following year on time.
4. It is very important to fill in this reporting template thoroughly and accurately, and to ensure that **prior to its submission to the GAVI Alliance this report has been verified by the relevant country coordination mechanisms** (ICC, HSCC or equivalent) in terms of its accuracy and validity of facts, figures and sources used. Inaccurate, incomplete or unsubstantiated reporting may lead to the report not being accepted by the Independent Review Committee (IRC) that monitors all APR reports, in which case the report might be sent back to the country and this may cause delays in the release of further HSS funds. Incomplete, inaccurate or unsubstantiated reporting may also cause the IRC to recommend against the release of further HSS funds.
5. Please use additional space than that provided in this reporting template, as necessary.

4.1 Information relating to this report:

a) Fiscal year runs from 21 March (month) to 20 March,.

b) This HSS report covers the period from 21 March 2008 to 20 March, 2009 (month year)

c) Duration of current National Health Plan is from 2008 to 2013.

d) Duration of the immunisation cMYP: 2006-2010

e) Who was responsible for putting together this HSS report who may be contacted by the GAVI secretariat or by the IRC for any possible clarifications?

Dr Abdul Wali Ghayur,

HSS coordinator and Focal point, MoPH

e-mail: drabwali@yahoo.com:

Phone: 0093-799-353-178

It is important for the IRC to understand key stages and actors involved in the process of putting the report together. For example: '*This report was prepared by the Planning Directorate of the Ministry of Health. It was then submitted to UNICEF and the WHO country offices for necessary verification of sources and review. Once their feedback had been acted upon the report was finally sent to the Health Sector Coordination Committee (or ICC, or equivalent) for final review and approval. Approval was obtained at the meeting of the HSCC on…….. Minutes of the said meeting have been included as annex XX to this report.'*

This report was prepared by the Health System Strengthening (HSS) Coordination at the Policy & Planning Directorate of the Ministry of Public Health. It was then submitted to the WHO and UNICEF country offices for necessary verification of sources and review. In addition it was sent through email to all HSS steering committee members for review and feedback including the WB, EC, USAID, Ministry of Finance, and interim representative of CSOs. Then the report was presented to the HSS Steering committee on 13th April 2009 and revised version was presented at the HSS Steering Committee on May 7th 2009 (Minutes at annex 1 and 2), the report was presented to the Consultative Group on Heath& Nutrition (CGHN) (equivalent to the Health Sector Coordination Committee) for final review and approval. Approval was obtained at the meeting of the CGHN on 13th May 2009. Minutes of the said meeting have been included as Annex 3 to this report.'

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any clarifications			
Dr Abdul Wali Ghayur,	MoPH	Coordinated and supervised the preparation of HSS and CSO components of the report.	drabwali@yahoo.com Phone: 0093-799-353-178
Dr. Najla Ahrari	MOPH	Assisted HSS coordinator	najlaahrari@gmail.com, Phone: 0093- 799-302-996
Other partners and contacts who took part in putting this report together			
Dr. Rana Kakar	WHO	Worked together with HSS coordinator in preparation of the report	Email kakarr@afg.emro.who.int, Phone: 0798220230
Dr. Ashfaq Ahmed	WHO	Worked together with HSS coordinator in preparation of the report	Email ahmeda@afg.emro.who.int, Phone: 0788011458

f) Please describe briefly the main sources of information used in this HSS report and how was information verified (validated) at country level prior to its submission to the GAVI Alliance. Were any issues of substance raised in terms of accuracy or validity of information and, if so, how were these dealt with or resolved?

This issue should be addressed in each section of the report, as different sections may use different sources. In this section however one might expect to find what the MAIN sources of information were and a mention to any IMPORTANT issues raised in terms of validity, reliability, etcetera of information presented. For example: *The main sources of information used have been the external Annual Health Sector Review undertaken on (such date) and the data from the Ministry of Health Planning Office. WHO questioned some of the service coverage figures used in section XX and these were tallied with WHO´s own data from the YY study. The relevant parts of these documents used for this report have been appended to this report as annexes X, Y and Z.*

The main sources of information used have been the independent third party evaluation conducted by JHU/IIHMR, HMIS, Routine reports of different involved directorates of MOPH in planning and implementation of Health System Strengthening activities, results conference held Nov 2008, reports of NGOs involved in implementation of the HSS grant and WHO and UNICEF data and JRF 2008.

g) In putting together this report did you experience any difficulties that are worth sharing with the GAVI HSS Secretariat or with the IRC in order to improve future reporting? Please provide any suggestions for improving the HSS section of the APR report? Are there any ways for HSS reporting to be more harmonised with existing country reporting systems in your country?

The country programs and reporting timelines are according to the solar calendar which starts from 21st March and ends on 20th March. 15th of May. It is better if the APR is left flexible for the country to report but for sure countries must prevent duplications in the reporting.

There were some trivial problems in the format. Each section has guidance on that, if the guidance is re looked would be better. If this is possible through a mini work shop, countries are brought together and in detail discuss the format.

4.2 Overall support breakdown financially

Period for which support approved and new requests. For this APR, these are measured in calendar years, but in future it is hoped this will be fiscal year reporting:

	Year							
	2007	2008	2009	2010	2011			
Amount of funds approved	6,699,975	4,594,975	7,318,000 (letter)					
Date the funds arrived	30th Oct 2007	13th April 2008	Not received yet					
Amount spent	143,871	6,018,856	11,805,620					
Balance	6,556,104	5,132,223	644,603					
Amount requested	4,595,000	7,317,904	8,157,346					

Amount spent in 2008: 6,018,856 US$

Remaining balance from total: 12,450,223 US$ including 2009 ($ 7,318,000) request which has not been received yet by the Afghanistan Bank.

Table 4.3 note: This section should report according to the original activities featuring in the HSS proposal. It is very important to be precise about the extent of progress, so please allocate a percentage to each activity line, from 0% to 100% completion.. Use the right hand side of the table to provide an explanation about progress achieved as well as to bring to the attention of the reviewers any issues relating to changes that have taken place or that are being proposed in relation to the original activities.

Please do mention whenever relevant the **SOURCES** of information used to report on each activity. The section on **support functions** (management, M&E and Technical Support) is also very important to the GAVI Alliance. Is the management of HSS funds effective, and is action being taken on any salient issues? Have steps been taken to improve M&E of HSS funds, and to what extent is the M&E integrated with country systems (such as, for example, annual sector reviews)? Are there any issues to raise in relation to technical support needs or gaps that might improve the effectiveness of HSS funding?

Table 4.3 HSS Activities in reporting year (ie. 2008)						
Major Activities	**Planned Activity for reporting year**	**Report on progress[3] (% achievement)**	**Available GAVI HSS resources for the reporting year (2008)**	**Expenditure of GAVI HSS in reporting year (2008)**	**Carried forward (balance) into 2009)**	**Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements**
Objective 1: Improved Access to Quality Healthcare.						
Activity 1.1: Establishing Sub-Centers in under-served areas	To establish 120 Sub-Centers and deploy 26 mobile health teams in remote and underserved areas of the country	90 %	(the estimated amount in APR 2007 3,972,488 USD	3,123,589	1,026,333	• In the original proposal the amount requested for both activities in total for five years was 13,000,000 USD but according to the contracts signed, MOPH is committed to pay 14,617,458 USD excluding management cost and price of 26 vehicles that are purchased recently, to the implementing partners. According to the initial plan of the year 2008 submitted in the APR 2007, the estimated planned amount was 3,972,488 USD, however the revised work plan for 2008 required the amount of 4,149,922 USD. The reason for this change is that the exact amount of contracts prices were not known until contracts were awarded. To fill this gap, some costs were cut from other activities for the year. Activity 1 and 2 under the objective 1 had already been merged because both focused on service delivery and planned to be contracted out with the same implementer. • In general all standard formats of Expression of Interest (EOIs) were developed and released. In some insecure areas it was announced
Activity 1.2: Deploying 80 mobile health outreach teams			The allocation in the work plan for 2008 4,149,922 USD			

[3] For example, number of Village Health Workers trained, numbers of buildings constructed or vehicles distributed

						more than one time, Request For Proposal (RFP) finalised and released. Contract forms developed (Annex 4 zip) and translated in local language. Moreover, the standard formats for proposal evaluation, conflict of interest, confidentiality letter, developed and translated, a proper hard and electronic filing system for service procurement of each activity developed. • The Sub-centers concepts incorporated in to revised Basic Package of Health Services (BPHS) and MPHs (Mobile Package of Health services and maps of NGOs implementing the intervention) developed (Annex 5). • Proposals for establishment of Sub centers (SC) and (MHT) Mobile Health Teams evaluated in two rounds: • In the first round 15 contracts for establishing 59 sub-center and 15 MHT in Laghman, Nangarhar, Balkh, Takhar,, Wardak , Sari-pul, Nemroz, Ghazni, Paktia, Khost, Bamyan, Baghlan, Badghis, Zabul and Daykundi provices with the winner NGOs for the period of 40 months on Sep 1st 2008 singed. • In the second round in total 8 contracts were signed for establishing 53 sub-centers and 9 MHTs for Ghor, Badakhshan, Hirat, Jawzjan, Kunuz, Samangan, Kunar and Logar provinces on 1st of November 2008 with the winner NGOs for a period of 38 months. • The sub-centers and MHT establishment for Nooristan, Faryab, and Paktika provinces were re-announced and finally contracts were signed for Nooristan and Faryab provinces. Because of security, for Paktika , none of the NGOs applied therefore the MOPH called for single source selection which also did not work. Finally the Strengthening Mechanism (SM) of MOPH which is responsible to implement the BPHS in three provinces of the country took the responsibility to establish sub centres in mentioned province. The remaining 6 sub-centers in Paktika and 2 in Kabul and 4 MHTs are covered by SM. • In total 30 contracts has been singed for establishing Sub-center and MHTs and total amount which the MOPH is committed up to end of 2011 is 14,617,457 USD to be paid to NGOs and SM which is 1,617,457 USD more than what was expected in the original proposal. • Out of contracted MHTs and Sub centers so far 100 out of 120 sub

						centers and 24 out of 26 MHTs have been established. Only one sub center in MAARA village of Daichopna district of Zabul province was attacked by Anti Government Elements and looted on 1st Nov 2008. • According to the reports of implementers so far, in total 7,664 children and 7,319 Child Bearing Age Women (CBAW) have received vaccines of DPT, BCG, Measles and TT. Totally 184,686 OPD visits conducted out of which 46,671 children treated for ARI and Diarrhoea. (Annex 6) Initially, it was planned to deploy 80 Mobile Health Teams. However, because of lack of appropriate evidence that could prove the effectiveness and efficiency of the MHTs, it was decided by the HSS Steering Committee to deploy 26 mobile teams, and during the course of implementation, study the effectiveness and efficiency for further decisions. Anecdote evidences shows that MHTs are quite useful and there are demands from provinces to deploy more teams. MOPH is planning to study the effectiveness of MHTs in the course of the year 2009 to have documented evidence. The decision is taken that the assessment should be conducted by MOPH and one of its partners and implementing organizations rather than one entity alone. (One of the teams was visited by GAVI and WHO high level mission during the year 2008 in Mazar province which was very impressive). (Faryab MHT one photo Annex 7).
Activity 1.3:	80% of entire cadre of 15,000 Community Heath Workers in Afghanistan will be trained on appropriate care seeking behaviour; promotion of immunizations; exclusive breastfeeding	50%	(the estimated amount in APR 2007 $374,402 USD) The allocation in	148,703	339,539	• At the original proposal the total amount planned for this activity was 1,100,000 USD. The proposals submitted by the NGOs reflected the cost of more than 4,500,000 USD. According to the HSS Steering Committee decision, contracts for three regions with the lowest prices and more need awarded but because of fund limitation, the contracts for the rest three regions can not be awarded. • In total 16 NGOs expressed their interest in consortium with other organizations to implement the activity. RFP was sent to the eligible NGOs and 17 Proposals were received (some of the NGOs bid for more than one contract) , out of 17 proposal, one proposal refused by evaluation committee due to lack of required documents, the south zone proposal failed due to technical problems. Contracts for

	complementary feeding and appropriate treatment for diarrhoea, ARI and fever at first-level facilities		the work plan for 2008 488,242 USD			three zones (East, Norht and central) are singed with the total amount of 1,843,735 USD which will be paid based on their expenditure and technical and financial report according to Payment schedule set in the contracts. • ARI and Diarrhoea pictorial charts for CHW training module after field testing, finalized and printed. Baseline and end of project survey questionnaire with the technical assistance of USAID/BASICS and implementer NGOs developed and translated in local languages. In addition, survey questioner was developed by C-IMCI working group and implementing NGOs. (Annex 8). • Facilitator guidelines developed, finalized, translated in Dari and printed. • In total 38 Master trainers (23 male and 15 female) from Implementer NGOs received six day training on Facilitators' Guide of Community Case Management, Charts for CHWs and community case Management, pictorial charts for CHWs in Kabul. • In total 30 provincial child health officers from 30 provinces received 4 days C-IMCI orientation workshop on Facilitators' Guide of Community Case Management Charts for CHWs, community case Management pictorial charts for CHWs, and monitoring checklist. • It is worth mentioning that at the time proposal submitted to GAVI, there were 15,000 CHWs while now the number of CHWs is more than 20,000.

Activity 1.4 To provide in-service trainings for BPHS implementers in 13 USAID funded provinces	Totally 3162 (in three years each year 1054) health care providers will be trained in Advanced/ Basic EOC, Facility IMCI, Nutrition, ANC, PNC, Rational use of drugs / Essential drug management and Family Planning	50%	(the estimated amount in APR 2007 $494,100 USD) The allocation in the work plan for 2008 315,524 USD	186,855	128,669	• Based on RFP sent to eligible NGOs for the implementation of in service training program for BPHS primary healthcare providers in 13 provinces where this was a huge gap, four proposal received and after evaluation of the technical proposals the winner NGOs identified and after completion of the procurement process the contract singed with the winner NGOs on 1st of February 2009, the total contract price for this project is 1.749.206 USD for three years. In the original proposal, the amount was proposed 2,000,000 USD for 5 years. • According to the implementing NGOs report, so far, 4 courses with the duration of 6-12 days have been conducted for Master Trainers and clinical staff where, 63 people have been trained.
Objective 2: Increased Demand for and Utilization of Healthcare.						
Activity 2.1: Implementing an Information, Education and Communication (IEC) campaign for immunization and other MCH messages	A limited set of key messages regarding the dangers signs and appropriate responses to ARI and diarrhea, uptake of immunization, and promotion of Antenatal Care and skilled birth attendance, will be broadcast through mass media campaign (especially local radio stations), complemented by personal contact by	70%	(the estimated amount in APR 2007 758,060 USD The allocation in the work plan for 2008 758,060 USD WP	369,276	388,784 (some of the media channels although have broadcasted but not yet paid because the fiscal year completed and reports were not submitted	• The EOI for conducting research to determine the level of knowledge attitude and practice of people was released. Only two EOIs received, based on procurement law of Afghanistan it was announce for the second time and RFP was sent to four NGOs who sent EOI and after completion of deadline only one proposal was received, and based on MOPH leadership decision it was announced as a restricted biding method again two proposals were received, according to procurement law of Afghanistan, in restricted biding, the bidders should not be less than three, it was again decided to take advice from Special Procurement Committee of MOF. Right now technical evaluation is completed and financial evaluation will be made soon. • The last year printed 740,000 IEC brochures and 300,000 posters from GAVI HSS funds were distributed to the health facilities by BPHS implementers. (samples Annex 9) • Construction of IEC materials stock in MOPH central stock completed and officially inaugurated by MOPH leadership. (Annex 10). • 4 TV channels contracted and IEC important messages

	BPHS staff, and focused on awareness building for community leaders, teachers and Mullahs.				on time)	broadcasted via 4 TV network and the contracts has been extended for six months. The messages included prevention of Diarrhoea, use of Vaccines, Hand Washing, danger sings of pregnancy and utilization of health care. • Seven top radios which have huge number of hearers were listed by the IEC taskforce and called for singing contracts with MOPH. 5 radio channels accepted but two channels because of their policies refused the request (BBC and Azadi voice of America affiliated). The radios have so far, broadcasted 5,112 minutes the IEC messages including but not limited to Personal hygiene and hand washing, danger signs of pregnancy, ARI, vaccines, and child and reproductive health related messages. • Production of 30 TV spots, 40 radio spots and 40 short dramas completed and being broadcasted (Annex 11 but because of high load internet can not up load, the CD will be sent through DHL). • 8 billboards which are reflecting key health messages about child and maternal health and immunization has been installed in four major roads extended to Kabul city. (photo Annex 12) • 150.000 Posters, 300.000 brochures, and 2500 flipcharts which are reflecting health key massages are printed and distributed through BPHS implementers to health facilities and health posts. • 50 IEC officers of Kabul hospitals and private clinics, 48 Provincial Public Health Directors and Hospitals directors trained in IEC/BCC and communication through 4 workshops. • Information Education and Communication strategy of MOPH is being finalized and translated (Annex 13).
Activity 2.2: Testing models of demand side financing. Activity 2.3: Piloting a program to	Incentive (either cash or an appropriate gift) will be provided to families that use existing maternal and child health services, particularly		(the estimated amount in APR 2007 522,570 USD The allocation in the work	263,417	85,149	• In order to be more efficient, based on the Steering Committee decision, both pilots of DSF and CHWs performance incentive were merged into one pilot. • Based on gathered and analyzed HMIS data Wardak, Badakhshan, Kabpisa and Faryab provinces are selected where in each province, in four districts one arm of the study will be implemented (DSF, DSF+CHW incentive, CHW incentive and control districts) . • Six EOIs were received from six NGOs and four proposals were received from four NGOs, after the completion of procurement process, the winner NGO selected and the contract singed on 2nd

provide monetary performance incentives to volunteer Community Health Workers	immunization, ANC, and skilled birth attendance	90%	plan for 2008 348,566 USD			November 2008. The total contract price for 30 months is 1.376.130 USD. The total amount for both activities in the original proposal was planned 3,300,000 USD. • Soon after singing contract one day orientation workshop held in MOPH for Provincial Health Directors of four provinces and BPHS implementers. MOUs singed between BPHS implementers in the targeted provinces and implementing agency. Field offices established in each province. • A workshop conducted to overview the community based health care program through inviting 32 Community Health Supervisors (CHSs) from 26 provinces. • Timely coordination meetings are held with Hope World Wide (the contracted organization) to make sure there are no major obstacles for proper project implementation.
Objective 3: Improve the ability of the MOPH, at all levels, to fulfill their Stewardship Responsibilities						
Activity 3.1: Up-grading the physical and technology infrastructure of the M&E Department	Up-grade the physical and information/ communication technology infrastructure of the M&E system	>60%	(the estimated amount in APR 2007 1,002,260 USD) The allocation in the work plan for 2008 802,342 USD	377,729	424,613	• Five Monitoring officers recruited to strengthen monitoring department of the MOPH. In addition, one GIS specialist recruited to develop the required maps for MOPH. • Monitoring dept structure modified and Balance Score Card which is a national tool revised with the strong support of third party evaluator. • National Monitoring checklist (NMC) revised which is being used. Out of 34 provinces, (Annex 14) in 24 provinces trainings for the use of Monitoring Checklist were conducted. Data base of NMC modified and provided to all 34 provinces of the country. • In total 117 Sub-centers, MHT, District officers , comprehensive Health centers and Basic health centers monitored by using National Monitoring Checklist in Parwaan, Pangshir, Samangan, Balkh, Sari-i-pul, Wardak, Jawzjan, Nangarhar, Badghis, Takhar, Hirat, Faryab, Logar, Kunduz, Badakhshan, Kapisa, Nimroz, Khost, Baghlan, Laghman, Di kundi, Ghazni, Kandahar, Paktika and Bamyan provinces. (25 out of 34) • Based on EOI evaluation for capacity building of the M&E department of the MOPH (one year M&E course) , RFP sent to the eligible NGOs, due to uncertainty about the provision of diploma or certificate for graduates , only one NGO submitted proposal and proposed to provide certificate for the graduates. Based on MOPH decision the EOI modified and the new TOR developed and calls for

						proposals made and currently proposals are being evaluated. • In total 31 vehicles rented for strengthening M&E activities at provincial level which is to be exclusively used for monitoring purposes. • Health and Nutrition Sector Strategy (HNSS) printed from GAVI HSS funds (Annex 15). • Monitoring checklist to monitor the performance of district health officers (DHO) developed (Annex 16).
Activity 3.2: Establishing a community sentinel demographic health monitoring program	The community demographic surveillance system will be rolled out in a representative sample of communities. In each community enumerators will record births and deaths, causes of deaths and a limited amount of additional information.	5%	(the estimated amount in APR 2007 450,000 USD) The allocation in the work plan for 2008 450,000 USD	1,213	448,787	• The original budget for the activity in the original proposal was 1,650,000 USD. This very highly technical project where almost none of the NGOs have the experience in Afghanistan was two times announced with issuing the EOIs. In second round only two organizations were short listed. Out of these two, one was disqualified because of not obtaining the minimal technical scores. Only one organization left which is not acceptable by procurement law of Afghanistan and probably needs once again to be announced. The amount requested by the organization is more than 2,300,000 USD (MOPH M&E and management costs not included) which is Johns Hopkins University. In the original proposal the requested amount in total was 1,650,000. • Negotiations were made with the Ministry of Interior Affairs and Central Statistics Office of Afghanistan. • As per lack of funds, and direct relation of this project with reduction of Mortality and Morbidity of mothers and children, in relation to other activities proposed, the HSS Steering Committee decided to stop the process for the moment (please refer to Annex 1&2).
Activity 3.3: Expanding capacity building program for MOPH managers at the Central and Provincial levels	The aim is to build the capacity of health managers at the central and provincial level through strengthening their basic management skills.	>65%	(the estimated amount in APR 2007 853,506 USD) The allocation in the work plan for	445,891	486,363	• RFPs were sent to 9 eligible organizations and three proposal received from the NGOs. After completion of procurement procedures the winner NGO identified and the contract singed on 1st December 2008. The total contract price is 563,180 USD for one year. • The Procurement and development budget training curriculum developed and in total 25 people from different departments of central MOPH and 18 Provincial Health Directors and Service / finance officers received 8 days procurement course through two separate courses in central MOPH. • 28 people received three days training on how to conduct a Training Needs Assessment and methodology of Transfer of Learning at the

			2008 932,254 USD			field level. Training Need Assessment of provincial health directorates and transfer of learning evaluation conducted in 24 provinces of the country. (APHI documents Annex 17). • MOPH central level TNA forms developed, TNA conducted, database of TNA developed and analyzed. Five years training plan developed. • In total 409 (115 female and 294 male) medical graduates from Kabul, Mazar-i-sharif , Nangarhar, Hirat provinces received 6 weeks Public Health Management course in two rounds.
Activity 3.4: Developing a communications and internal advocacy program.		>70%	(the estimated amount in APR 2007 232,510 USD The allocation in the work plan for 2008 278,016 USD	79,159	198,857	• More than 80 press releases and media advisory developed and released, more than 70 press conferences held for public awareness regarding key issues within the health sector of Afghanistan and all of them broadcasted by several media sources. (Samples Annex 18). • Three separate training workshops about relation with media conducted for 34 Provincial Health Directors, 35 Hospital directors and 26 MOPH Head Quarter's managers. • Press conference room of MOPH equipped with required furniture and necessary equipment. • 1000 file folders, 1000 diaries, 1000 MOPH calendar and 500 pocket calendars, printed and distributed. • MOPH website developed and being up dated, web site manger recruited. • Media coordinator recruited and media resource center is being established
Activity 3.5: Launching an initial cadre of District Health Officers (250)	Deployment of 100 DPHOs in targated districts		(the estimated amount in APR 2007 822,453 USD	668,512	290,896	• The recruitment process of 50 District Health Officers according to 2007 plan completed and the process to make them part of MOPH regular staff is on the progress. The districts for recruitment of 100 District Health Officers based on the following criteria identified: 1: Low DPT3 coverage 2: Districts with security problems which prevent Provincial Health

		90%	The allocation in the work plan for 2008 959,408 USD			Offices to monitor health service delivery. 3: Districts with more than 20,000 population 4: District with geographical problem in the winter time In total out of 150 DHOs planned, 134 of them recruited. (up dated Map of districts Annex 19). • With the assistance of a technical group TOR for District Coordination Committee meeting developed and sent to targeted districts, the coordination meeting at the district level is conducted usually on monthly basis and chaired by DHOs. (Annex 20 DHCC and DHO TORs) • The Training Needs of newly hired DHOs conducted and based on the findings a training plan developed and implemented. 134 DHOs received two rounds training.
Support Functions						
Management			747,806	354,512	393,294	
M&E			0	0	0	The M&E support costs and TA, funds based on the need and decision of HSS Steering Committee initially shifted to activities. Some amount of TA included in the management part.
Technical Support			0	0	0	

Table 4.4 note: This table should provide up to date information on work taking place in the first part of the year when this report is being submitted i.e. between January and April 2009 for reports submitted in May 2009.

The column on Planned expenditure in coming year should be as per the estimates provided in the APR report of last year (Table 4.6 of last year´s report) or –in the case of first time HSS reporters- as shown in the original HSS proposal.
Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right.

Table 4.4 Planned HSS Activities for current year (ie. January – December 2009) and emphasise which have been carried out between January and April 2009

Major Activities	Planned Activity for current year (ie.2009)	Planned expenditure in coming year (2009)	Balance available (To be automatically filled in from previous table)	Request for 2009 * = remaining balance – revised 2009 work plan	Explanation of differences in activities and expenditures from original application or previously approved adjustments**
Objective 1:					
Activity 1.1: Establishing Sub-Centers in under-served areas Activity 1.2: Deploying 80 mobile health outreach teams	• Monitor the implementation of the projects and make sure that SC and MHT provide quality health services to the communities. • Develop a mechanism to measure the effectiveness of MHTs for further decision making. • Provide technical support to the implementers based on SC and MHT concept note. • Review of progress of narrative reports and provide feedback to implementers through official channels or face to face meetings on quarterly	$ 2,955,988 (as per APR 2007) Revised 2009 work plan $ 5,326,186	$1,026,333	$ 2,163,476 (as per APR 2007) * $ 4,299,853 (as per revised work plan of 2009)	As per APR 2007, $2,163,476 was requested for the year 2009 for these specific activities but as mentioned above, after the contracts were signed with implementing partners and actual prices were determined, there was considerable increase in the amounts. For example, in the original proposal for the first year, the cost of each Mobile Health Team was budgeted around 5,000 US$ while the actual running cost for one year is more than $ 40,000. As the costs are currently quite clear for the MOPH, the required amount for the year 2009 for activity 1 and 2 is $ 5,326,186 out of which $ 1,026,333 is carry forwarded from the previous year.

	bases. • Supply vehicles for MHTs • Make sure availability of EPI equipments in SCs and MHTs.				
Activity 1.3: Expanding integrated management of childhood illness (IMCI) to community level	• Monitor the implementation of the project by conducting visits from training sites, baseline survey and monitor CHWs who received C-IMCI training. • Provide technical assistance to the implementers. • Review of progress of narrative reports on quarterly bases and provide feedback to implementers through MOPH official channels or face to face meetings	$ 367,382 (as per APR 2007) Revised 2009 work plan $ 633,101	$ 339,539	$ 445,691 (as per APR 2007) * $ 293,562 (as per revised work plan of 2009)	The amount envisaged in the original proposal was 1,100,000 while the amount required after the completion of the bidding process is several times high. For three regions with the total price of 1,843,735 $ were signed but three regions left. The cost for the other three regions is approximately 2,000,000 which can not be entirely funded from GAVI HSS funds. Please refer to Annexes (1&2)
Activity 1.4: Develop an in-service training program for BPHS primary healthcare providers	• Monitor the implementation of the project by conducting visits from training sites • Provide technical assistance to the implementers. • Conduct post training evaluation from the health facility staff. • Provide feedback to the implementing agency and the targeted NGOs	$ 471,070 (as per APR 2007) Revised 2009 work plan $ 626,478	$ 128,669	$ 416,157 (as per APR 2007) * $ 497,809 (as per revised work plan of 2009)	

Objective 2: Increased Demand for and Utilization of Healthcare					
Activity 2.1: Implementing a nation wide Information, Education and Communication (IEC) campaign for immunization and other MCH messages	• Identify the winner NGO based on proposal evaluation for conducting KAP survey • Monitor from the KAP survey process in the failed • Conduct IEC campaign based on KAP survey findings • Continuation of IEC Key messages broadcasted via media • Monitoring of health facilities to make sure, the presence and use of IEC developed materials. • Conduct IEC/BCC workshops for different health personnel. • Finalize MOPH IEC strategy	$ 553,320 (as per APR 2007) Revised 2009 work plan $ 875,455	$ 388,784	$ 269,760 (as per APR 2007) * $ 486,671 (as per revised work plan of 2009)	
Activity 2.2: Pilot a model of demand side financing (DSF). Activity2.3: Piloting a program to provide monetary performance incentives to volunteer Community Health Workers	• Assist implementer NGOs in developing baseline survey tool, a transparent mechanism for paying incentive to the family and CHWs. • Monitor the baseline survey and regular monitoring of the project implementation. • Provide technical assistance and direction to the implementer NGOs	$ 518,570 (as per APR 2007) Revised 2009 work plan $ 451,680	$ 85,149	$ - 24,664 (as per APR 2007) * $ 366,531 (as per revised work plan of 2009)	

	based on the project TOR				
Objective 3: Improve the ability of the MOPH, at all levels, to fulfill their Stewardship Responsibilities					
Activity 3.1: Up-grade the physical, information /communication technology infrastructure and means of transportation[4] of the M&E Department	• Identify winner NGO for Capacity building training on strengthening Monitoring and evaluation system of MOPH • Develop a unified checklist for monitoring of all HSS activities with all implementing departments. • Provision of transport facilities for provincial monitoring • Provision of equipments • Nation wide monitoring of all BPHS implementation and EPHS implementation • Train 10 provinces in NMC and take over the national Monitoring check list data base from Tech Serve (USAID funded project) • Enhance data use at different levels through conducting workshops and follow up visits • Support to implementation of nation wide use of BSC • Renovation of offices and provision of internet	$ 717,760 (as per APR 2007) Revised 2009 work plan $ 1,162,030	$ 424,613	$ 760,996 (as per APR 2007) * $ 737,417 (as per revised work plan of 2009)	

[4] Included in "means of transportation" are: per diems, fuel, and provision of motorcycles and bicycles at the Provincial level.

Activity 3.2: Launch a community demographic surveillance system. .	To be decided once fund availability and duplications with Ministry of Interior Affairs is thoroughly solved.	$ 448,000 (as per APR 2007) Revised 2009 work plan $ 0	$ 448,787	$ 438,000 (as per APR 2007) * $ 0 (as per revised work plan of 2009)	
Activity 3.3: Expanding capacity building program for MOPH managers at the Central and Provincial levels.	• Announcement , procurement and contract of the second round quality public health course for 240 provincial officers • Monitoring the quality public health training course. • Develop and up date national training data base for MOPH managers	$ 893,900 (as per APR 2007) Revised 2009 work plan $ 607,212	$ 486,366	$ 1,399,631 (as per APR 2007) * $ 120,846 (as per revised work plan of 2009)	
Activity 3.4: Developing a communications and internal advocacy program to seek increased funding.	• Arranging press Travels (For Reflecting MoPH Success Stories) • Organizing PR Conferences • Conducting PR Trainings for MoPH Programme Managers • Support MoPH Monthly Publication • Maintain MOPH web site • Establish Media resource center at MOPH • Develop documentary films, video talk shows and audio	$ 180,820 (as per APR 2007) Revised 2009 work plan $ 129,010	$ 198,857	$ 195,267 (as per APR 2007) * $ - 69,847 (as per revised work plan of 2009)	

	talk shows				
Activity 3.5: Launching an initial cadre of District Health Officers	• Complete the PRR process of 50 DPHOs • Start the PRR process for second round (100) DPHO. • Evaluation of DHOs effectiveness through joint venture of MOPH and NGOs • Take initial steps to recruit the last batch of 100 DHOs • Conduct trainings for DHOs • Supervise and monitor the performance of DHOs • Provide support to District Health Coordination committees	$ 682,453 (as per APR 2007) Revised 2009 work plan $ 948,552	$ 290,826	$ 1,150,673 (as per APR 2007) * $ 657,696 (as per revised work plan of 2009)	
Support costs					
Management costs		$ 300,000 (as per APR 2007) Revised 2009 work plan $ 1,045,917	$ 393,294	$ 612,917 (as per APR 2007) * $ 652,623 (as per revised work plan of 2009)	
M&E support costs					
Technical support					
TOTAL COSTS		$ 8,339,263 (as	$ 4,211,284	$ 7,017,904 (as per APR 2007) but we received the	

		per APR 2007) Revised 2009 work plan $ 11,805,620		letter of $ 7,318,000 * $ 7,594,336 (as per revised work plan of 2009) (This figure should correspond to the figure shown for 2009 in table 4.2)	

Table 4.5 Planned HSS Activities for next year (ie. 2010 FY) This information will help GAVI's financial planning commitments					
Major Activities	**Planned Activity for the year (2010)**	**Planned expenditure in coming year (2010)**	**Balance available (To be automatically filled in from previous table)**	**Request for 2010**	**Explanation of differences in activities and expenditures from original application or previously approved adjustments****
Objective 1: Improved Access to Quality Healthcare					
Activity1.1: Establishing Sub-Centers in under-served areas Activity 1.2: Deploying 80 mobile health outreach teams	• Monitor the implementation of the project and make sure that SC and MHT provide quality health services to the communities. • Provide technical support to the implementers based on SC and MHT concept note. • Provide technical review of progress of narrative reports • Provide feedback to implementers through official channels or face to face meeting on quarterly bases.	$ 3,946,566	$ 644,603 This amount is expected to be remaining by the end of 2009 from all the activities and funds transferred to date to Afghanistan (please read the last column on the right side)	$ 3,301,953	As mentioned above, the costs of the implementation of activities were precisely determined after the contracts were singed with implementing partners therefore, from the total amount that GAVI has sent which are: 1: 6,699,975 for 2007 2: 4,594,975 for 2008 3: 7,318,000 for 2009 (not yet received by the Afghanistan Bank (till April 7th 2009) which makes a total of $18,612,950 out of these amounts: 143,871 spent in 2007 6,018,856 spent in 2008 which make a total of 6,162,727. The total remaining balance is: $ 12,450,223 out of the total remaining balance according to the revised work plans of 2009, 11,805,620 will be spend in 2009 and the an expected remaining balance

					of 644,603 will be available from the transferred funds to date for the year 2010.
Activity 1.3: Expanding integrated management of childhood illness (IMCI) to community level	• Monitor the implementation of the project by conducting visits from training sites, baseline survey and monitor CHWs who received C-IMCI training. • Provide technical assistance to the implementers. • Review of progress of narrative reports in quarterly bases and provide feedback to implementers through MOPH official channels or face to face meetings • Based on fund availability Sing the contracts with winner NGOs for North East, West and south east zones	$ 694,531	0	$ 694,531	
Activity 1.4: Develop an in-service training program for BPHS primary healthcare providers	• Monitor the implementation of the project by conducting visits from training sites • Provide technical assistance to the implementers. • Conduct post training evaluation from the health facility staff. • Provide feedback to the	$ 364,578	0	$ 364,578	

	implementing agency and the targeted NGOs				
Objective 2: Increased Demand for and Utilization of Healthcare					
Activity 2.1: Implementing a nation wide Information, Education and Communication (IEC) campaign for immunization and other MCH messages	• Continuation of IEC Key messages broadcasted via media • Print IEC material and distribute to Health facilities and Health posts at community level • Monitoring of health facilities to make sure, the presence and use of IEC developed materials. • Conduct IEC/BCC workshops for different health personnel.	$ 357,692	0	$ 357,692	
Activity 2.2: Pilot a model of demand side financing (DSF). Activity 2.3: Piloting a program to provide monetary performance incentives to volunteer Community Health Workers	• Monitor the quality implementation of the project • Provide technical assistance and direction to the implementer NGOs • Conduct evaluation work shop with all key partners	$ 722,370	0	$ 722,370	
Objective 3: Improve the ability of the MOPH, at all levels, to fulfill their Stewardship Responsibilities					
Activity 3.1: Up-grade the physical, information /communication	• Provision of transport facilities for provincial monitoring • Nation wide monitoring of	$ 700,000	0	$ 700,000	

technology infrastructure and means of transportation[5] of the M&E Department	all BPHS implementation and EPHS implementation • Enhance NMC use at provincial level • Support to implementation of nation wide use of BSC • Generate and compile all evidences to date for the effectiveness of HSS interventions • Graduation and certification of students from one year M&E strengthening course.				
Activity 3.2: Launch a community demographic surveillance system.	• To be decided later	0	0	0	
Activity 3.3: Expanding capacity building program for MOPH managers at the Central and Provincial levels.	• 3rd round of TNA for provincial level MOPH • Announcement , procurement and contract of the third round quality public health course for 240 provincial officers • Monitoring the quality public health training course. • Maintain the national training data base for MOPH managers at all levels • Design new and up dated	$ 526,212	0	$ 526,212	

[5] Included in "means of transportation" are: per diems, fuel, and provision of motorcycles and bicycles at the Provincial level.

	modules for trainings				
Activity 3.4: Developing a communications and internal advocacy program to seek increased funding.	• Arranging press Travels (For Reflecting MoPH Success Stories) • Organizing PR Conferences • Conducting PR Trainings for MoPH Programme Managers • Support MoPH Monthly Publication • Develop documentary films, video talk shows and audio talk shows	$120,000	0	$120,000	
Activity 3.5: Launching an initial cadre of District Health Officers	• Complete the PRR process of 100 DPHOs • Recruit the last batch of 100 DHOs • Conduct trainings for DHOs • Supervise and monitor the performance of DHOs • Provide support to District Health Coordination committees	$ 750,000	0	$ 750,000	
Support costs					
Management and TA costs		$ 620,000	0	[6]$ 620,000	

[6] Out of 620,000 based on need and approval of HSCC (SC), 180,000 $ is requested to be routed through WHO for provision of one WHO expert for Health System Strengthening to work with MOPH.

M&E support costs					
Technical support					
TOTAL COSTS		$ 11,805,620	$ 644,603	$ 8,157,346	

4.6 Programme implementation for reporting year:

a) Please provide a narrative on major accomplishments (especially impacts on health service programs, notably the immunization program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. Any reprogramming should be highlighted here as well.

This section should act as an executive summary of performance, problems and issues linked to the use of the HSS funds. This is the section where the reporters point the attention of reviewers to **key facts**, what these mean and, if necessary, what can be done to improve future performance of HSS funds.

Major accomplishments:

The GAVI – HSS funds as envisaged in the GAVI guidelines have been indeed catalytic and instrumental for the health system of Afghanistan.

A. Management

1. Ten HSS steering committee meetings were conducted during reporting period. The Health System Strengthening Steering committee (HSS-SC) with the presence of key CGHN members within the health sector of Afghanistan is actively supporting the health sector for successful implementation of global health initiatives related to HSS especially the GAVI support. The HSS-SC as coordination and monitoring body for HSS program is comprised of three MOPH voting members (key departments), representatives of UNICEF, WHO, World Bank, European Commission, USAID, Civil Society Organizations interim representative and Ministry of Finance.
2. The bottom up annual plan of action (form 11 MOPH departments) was developed, approved by HSS-SC and accepted by MoF.
3. Proposals for GAVI support Type A, GAVI support type B developed which was approved by the GAVI.
4. HSS component proposal was developed for Global Fund R8 which was approved
5. Timely support has been given to implementing departments of MOPH for planning, implementation and monitoring of the activities
6. Preparations started to put up HSS component in GF R9 proposals.

B. Improved access to quality health care:

B.1: Establishment of sub centers and Mobile Health teams in remote and under served areas of the country:

All the bidding process completed and 25 contracts awarded to implementing NGOs. In 5 provinces the MOPH – Strengthening Mechanism assigned responsible for establish SC and MHTs. The Sub-centers concepts incorporated in to revised Basic Package of Health Services (BPHS). So far out of contracted MHTs and Sub centers , 100 out of 120 sub centers and 24 out of 26 MHTs have been established. Only one sub center in MAARA village of Daichopna district of Zabul province was attacked by Anti Government Elements and looted in 1st Nov 2008. According to the reports of implementers so far, in total 7,664 children and 7,319 Child Bearing Age Women (CBAW) have received vaccines of DPT, BCG, Measles and TT. Totally 184,686 OPD visits conducted out of which 46,671 children treated for ARI and Diarrhoea.

B.2: Implementation of community based Integrated – Management of Childhood Illnesses:

All the necessary technical documents for bidding developed. Facilitator guidelines developed, finalized, translated in Dari and printed. ARI and Diarrhoea pictorial charts for CHW training module after field testing, finalized and printed. Baseline and end of project survey questionnaire with the technical assistance of BASICS and BPHS implementer NGOs developed and translated in local languages. All the bidding processes completed and contracts awarded to train CHWs in 3 regions of the country.

So far, in two separate training courses in total 38 Master trainers (23 male and 15 female) from Implementer NGOs received six day training on Facilitators' Guide of Community Case Management, Charts for CHWs and community case Management, pictorial charts for CHWs in Kabul and In total 30 provincial child health officers from 30 provinces received 4 days C-IMCI orientation workshop on Facilitators' Guide of Community Case Management Charts for CHWs, community case Management pictorial charts for CHWs, and monitoring checklist.

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

Terms of Reference and RFP developed for implementation of in service training program for BPHS primary healthcare providers in 13 provinces where this was a huge gap. Procurement process completed and the contract singed with the winner NGOs on 1st of

February 2009 for three years. According to the implementing NGOs report, so far, 4 courses with the duration of 6-12 days have been conducted for Master Trainers and clinical staff where, 63 people have been trained.

C. Increases demand for and utilization of health care services

C.1: Implement a nationwide strategic Information, Education and Communication (IEC) initiative:

National IEC strategy is in the final process of finalization. The EOI for conducting research to determine the level of knowledge attitude and practice of people was released and after long processes technical evaluation is completed. The survey will be used a national level baseline and a tool to revise the National IEC strategy. The last year printed 740,000 IEC brochures and 300,000 posters from GAVI HSS funds were distributed to the health facilities by BPHS implementers. Construction of IEC materials stock in MOPH central stock completed and officially inaugurated by MOPH leadership.

4 TV and 5 radio channels contracted to broadcasted important IEC messages. The messages included prevention of Diarrhoea, use of Vaccines, Hand Washing, danger sings of pregnancy and utilization of health care, ARI and other child and reproductive health key messages. So far, for more than 5,000 minutes, the IEC messages have been broadcasted. In addition this year 30 new TV spots, 40 new radio spots and 40 short dramas produced. 8 billboards which are reflecting key health messages about child and maternal health and immunization has been installed in four major roads extended to Kabul city.

150.000 Posters, 300.000 brochures, and 2500 flipcharts which are reflecting health key massages are printed and distributed through BPHS implementers to health facilities and health posts. Further more, 50 IEC officers of Kabul hospitals and private clinics, 48 Provincial Public Health Directors and Hospitals directors trained in IEC/BCC and communication through 4 workshops.

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

In order to be more efficient, based on the Steering Committee decision, both pilots of DSF and CHWs performance incentive were merged into one pilot and based on gathered and analyzed HMIS data Wardak, Badakhshan, Kabpisa and Faryab provinces are selected where in each province, in four districts one arm of the study will be implemented (DSF, DSF+CHW incentive, CHW incentive and control districts). All the bidding processes completed and contract awarded to implementing organization. Soon after singing contract one day orientation workshop held in MOPH for Provincial Health Directors of four provinces and BPHS implementers. MOUs singed between BPHS implementers in the targeted provinces and implementing agency. Field offices established in each province. A workshop conducted to overview the community based health care program through inviting 32 Community Health Supervisors (CHSs) from 26 provinces. Timely coordination meetings are held with Hope World Wide (the contracted organization) to make sure there are no major obstacles for proper project implementation. The project has newly started implementation for 30 months.

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

D.1: Up-grade the physical, information/communication technology infrastructure and means of transportation[7] of the M&E Department:

Monitoring dept structure modified and Balance Score Card which is a national tool revised with the strong support of third party evaluator. 6 competitive staff recruited for M&E department. National Monitoring checklist (NMC) revised which is being used. Out of 34 provinces, in 24 provinces trainings for the use of Monitoring Checklist were conducted. Data base of NMC modified and provided to all 34 provinces of the country. In total 117 Sub-centers, MHT, District officers , comprehensive Health centers and Basic health centers monitored by using National Monitoring Checklist in Parwaan, Pangshir, Samangan, Balkh, Sari-i-pul, Wardak, Jawzjan, Nangarhar, Badghis, Takhar, Hirat, Faryab, Logar, Kunduz, Badakhshan, Kapisa, Nimroz, Khost, Baghlan, Laghman, Di kundi, Ghazni, Kandahar, Paktika and Bamyan provinces. (25 out of 34). Monitoring and Evaluation capacity building course is in the final stage contract award. In total 32 vehicles rented for strengthening M&E activities at provincial level which is to be exclusively used for monitoring purposes. Monitoring checklist to monitor the performance of district health officers (DHO) developed. Health and Nutrition Sector Strategy (HNSS) printed and distributed from GAVI HSS funds.

D.2: Launch a community demographic surveillance system

This very highly technical project where almost none of the NGOs have the experience in Afghanistan was two times announced with issuing the EOIs. In second round only two organizations were short listed. Out these two one was disqualified because of not obtaining the minimal technical scores. Only one organization left which is not acceptable by procurement law of Afghanistan and probably needs once again to be announced. Negotiations were made with the Ministry of Interior Affairs and Central Statistics Office of Afghanistan. (please refer to the HSS steering committee minutes 7th May 2009)

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

After completion of procurement procedures the winner NGO identified and the contract singed on 1st December 2008. The total contract price is 563,180 USD for one year. Under this contract 240 MOPH provincial PHDs and Provincial Health officers will be

[7] Included in "means of transportation" are: per diems, fuel, and provision of motorcycles and bicycles at the Provincial level.

trained on six modules of Planning and Budgeting, Supervision/Monitoring and evaluation, MOPH policies and strategies, Financial Management, English language and computer skills. So far, according to the implementing agency reports, in total 178 staff has received trainings through 11 courses. In addition, the Procurement and development budget training curriculum developed and in total 25 people from different departments of central MOPH and 18 PHDs and Service / finance officers received 8 days procurement course through two separate courses in central MOPH. 28 people received three days training on how to conduct a Training Needs Assessment and methodology of Transfer of Learning at the field level. Training Need Assessment of provincial health directorates and transfer of learning evaluation conducted in 24 provinces of the country. At MOPH central level TNA forms developed, TNA conducted, database of TNA developed and analyzed. Five years training plan developed. Further more, in total 409 (115 female and 294 male) medical graduates from Kabul, Mazar-i-sharif , Nangarhar, Hirat provinces received 6 weeks Public Health Management course in two rounds.

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

More than 80 press releases and media advisory developed and released and more than 70 press conferences held for public awareness regarding key issues within the health sector of Afghanistan and all of them broadcasted by several media sources. Three separate training workshops about relation with media conducted for 34 Provincial Health Directors, 35 Hospital directors and 26 MOPH Head Quarter's managers. Press conference room of MOPH equipped with required furniture and necessary equipments. 1000 file folders, 1000 diaries, 1000 MOPH calendar and 500 pocket calendars, printed and distributed. Media coordinator recruited and media resource center is being established. Wes site manger recruited and MOPH website developed and being up dated.

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

The recruitment process of 50 District Health Officers according to 2007 plan completed and the process to make them part of MOPH regular staff is on the progress. The districts for recruitment of 100 District Health Officers identified. In total out of planned 150 DHOs planned, so far, 139 of them have been recruited. With the assistance of a technical working group TOR for District Coordination Committee developed and sent to targeted districts, the coordination meeting at the district level is conducted usually on monthly basis and chaired by DHOs. The Training Needs of newly hired DHOs conducted and based on the findings a training plan developed and implemented. 134 DHOs received two rounds training.

Almost all the targets set in the proposal are being achieved. (Please refer to table 4.8)

Problems:

- **Insecurity** in some parts of the country
- **Long administrative procedures inside and out side of the MOHP**
- **Poor commitment and capacity of MOPH provincial level to monitor the implementing NGOs and provide them support**
- **Lack of qualified health workers especially female in remote areas of the country**
- **Geographical constraints**, long winter in certain parts of the country, and bad road conditions.

b) Are any Civil Society Organizations involved in the implementation of the HSS proposal? If so, describe their participation? For those pilot countries that have received CSO funding there is a separate questionnaire focusing exclusively on the CSO support after this HSS section.

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.

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

For the GAVI HSS proposal, most of the activities are being implemented through CSOs. So far more than 30 contracts with the value of more than 24 Million USD has been awarded to the CSOs.

In addition, many CSOs are members of the MOPH central level Technical Advisory Groups (TAG), Consultative Group on Health & Nutrition (CGHN) and HSS Steering Committee, where HSS activities are designed and implementation is monitored. CSO organizations are involved in provision of information, planning, coordination, provision of technical support, and in implementation of the most of the HSS activities through contracting.

4.7 Financial overview during reporting year:

4.7 note: In general, HSS funds are expected to be visible in the MOH budget and add value to it, rather than HSS being seen or shown as separate "project" funds. These are the kind of issues to be discussed in this section

a) Are funds on-budget (reflected in the Ministry of Health and Ministry of Finance budget): Yes/No If not, why not and how will it be ensured that funds will be on-budget ? Please provide details.

Yes.
Totally, the MOPH of Afghanistan is going to receive the amount of USD 137.91 millions (25% operation cost and 75% for developmental activities) against the annual plan of actions for health sector operational and developmental activities during 2009 from the core budget of Ministry of Finance. This is about 7.6% of the total National Budget for the fiscal year of 1388 (21 March 2009 to 21 March 2010). The GAVI- HSS fund support is included into the government core budget as grant routed through the Ministry of Finance.

b) Are there any issues relating to financial management and audit of HSS funds or of their linked bank accounts that have been raised by auditors or any other parties? Are there any issues in the audit report (to be attached to this report) that relate to the HSS funds? Please explain.

The management of HSS funds takes place in the finance department for the development budget of the MOPH like the grants of World Bank, Global Fund and other donors. As initially envisaged the audit of the GAVI HSS funds were supposed to be done by General Auditor's office of the Government. So far, the government audit has not able to do detailed audit of entire MOPH funds and on random bases they control the system for entire MOPH. Based on this constraint and lack of capacity in the government auditing system, the HSS steering committee decided to hire an independent auditor for HSS funds. The auditor after completing the required processes is recruited and audit is going on. As soon as the audit report is available will be shared with GAVI.

4.8 General overview of targets achieved

Table 4.8 Progress on Indicators included in application

Strategy	Objective	Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target	Current status	Explanation of any reasons for non achievement of targets
1. Improved Access to Quality Healthcare particularly maternal and child health through establishment of sub centers and MHTs , building the capacity of BPHS providers and implementation of community IMCI 2. Increased Demand for and Utilization of mother and child health care services through strengthening IEC, and pilot DSF and CHWs performance incentives	To increase National DPT3 coverage for the children under age one	% of children under age one received DPT3 vaccine	Total number children received DPT3 vaccine	Total number of surviving new born	MOPH routing reports and JRF 2008	77%	JRF	2007	90%	2012	85%	
	To increase the number/percent of districts achieving >80% DPT3 coverage under age one	% of districts achieving DPT3 coverage >80%	Number of districts achieved > 80% coverage	Total number of districts	MOPH routing reports and JRF 2008	49% (161 district)	JRF	2007	100% (329)	2012	58% (191)	
	To reduce under five mortality rate from 210/1000 live births in 2006 to 168/1000 live births by 2012.	Under five mortality rate	Number of children under age 5 died	Total number of children under age 5	MOPH / UNICEF/ GOA surveys	191/1000 live births	Afghanistan Household Survey 2006 (AHS)	2006	153 (Reduced by 20%)	2012	Not measured recently	
	To increase National Measles coverage	% of children received at least one	Total number children received	Total number of surviving new born	MOPH routine reports and JRF	68%	JRF	2007	90%	2012	75%	

3. Improve the ability of the MOPH, at various levels, to fulfill its Stewardship Responsibilities through strengthening M&E , building the capacity of MOPH managers, strengthen public relations , pilot the DSS and recruit DHOs		dose of Measles vaccine	Measles vaccine									
	To increase skill birth attendance	% of deliveries attended by skill birth attendants	Total number of deliveries attended by skilled health workers	Total number of pregnant women	HHS /HMIS	19%	Afghanistan Household Survey 2006 (AHS)	2006	40%	2012	No survey conducted but HMIS reports shows 30%	
	To increase treatment of diarrhoea and ARI at community level	% of children treated for ARI and diarrhoea at community level	Number of children treated for ARI and diarrhoea at community level	Total number of surviving children	HMIS	30%	HMIS	2007	30% from baseline	2012	30%	

Continuation of Table 4.8 Progress on out put Indicators included in application												
Strategy	**Objective**	**Indicator**	**Numerator**	**Denominator**	**Data Source**	**Baseline Value**	**Source**	**Date of Baseline**	**Target**	**Date for Target**	**Current status**	Explanation of any reasons for non achievement of targets
1. Improved Access to Quality Healthcare particularly maternal and child health through establishment of sub centers and MHTs , building the capacity of BPHS providers and implementation of community IMCI 2. Increased Demand for and Utilization of mother and child health care services through strengthening IEC, and pilot DSF and CHWs performance incentives 3. Improve the ability of the MOPH, at various levels, to fulfill its	To increase contacts per person per year with the health care system	Number of contacts per persons/year	# of OPD visits	Total estimated population	HMIS	0,6 visits /person /year	HMIS	2006	1	2012	1.08	
	To increase average number of persons referred by CHWs per quarter	Avg # of persons referred by CHWs/ quarter	HMIS reported "Referrals In"/ quarter	Total # of CHWs working in that quarter	HMIS	14.8/quarter	HMIS	2007	20/quarter	2012	24/quarter	
	Provider knowledge score	Provider knowledge score	#of providers interviewed showing satisfactory score	Total # of providers interviewed during BSC survey	Balanced Scorecard	68.7	BSC	2007	90%	2012	82.7%	The indicator is changed in the BSC revision
	To increase the % of mothers in rural communities knowledgeable about prioritized heath messages	% of mothers in rural communities knowledgeable about prioritized heath messages	# of mothers responding correctly to questions during survey	Total # of mothers interviewed	Afghanistan Household Survey (AHS)	TBD	AHS	2006	40% from the baseline	2012	No available data	Survey will be conducted soon
	To increase % of CHWs	% of CHWs trained in	# of CHWs	Total # of	Training reports,	2%	UNICEF/Save the children	2006	80%	2012	Implementation	

Stewardship Responsibilities through strengthening M&E , building the capacity of MOPH managers, strengthen public relations , pilot the DSS and recruit DHOs	trained in community IMCI from 2% in 2006 to 80% in 2012	community IMCI	trained	CHWs	HMIS		US NGO				is just started	
	To increase the % of provinces receiving monitoring visits using national monitoring checklist per quarter from 25% in 2006 to 100% in 2012.	% of provinces receiving monitoring visits using national monitoring checklist / quarter	#of provinces visited by M&E team in a quarter	Total # of provinces accessible during that quarter	M&E department monitoring report	29%/quarter	M&E department reports	2007	100%	2012	33%/quarter	

4.9 Attachments

Five pieces of further information are required for further disbursement or allocation of future vaccines.

a. Signed minutes of the HSCC meeting endorsing this reporting form
b. Latest Health Sector Review report (Annex 21 Retreat Report, Annex 22 Balance Score Card 2008)
c. Audit report of account to which the GAVI HSS funds are transferred to
d. Financial statement of funds spent during the reporting year (2008)
e. This sheet needs to be signed by the government official in charge of the accounts HSS funds have been transferred to, as below.

Financial Comptroller Ministry of Health:

Name: Mr. Ahmed Shafiq Akbari

Title / Post: Head of Development Budget Department
Signature:

Date:

5. Strengthened Involvement of Civil Society Organisations (CSOs)

1.1 TYPE A: Support to strengthen coordination and representation of CSOs

This section is to be completed by countries that have received GAVI TYPE A CSO support[8]

Please fill text directly into the boxes below, which can be expanded to accommodate the text.

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

Abbreviations and Acronyms

BPHS	Basic Package of Health Services
CGHN	Consultative Group on Health and Nutrition (HSCC equivalent in Afghanistan)
HNSS	Health and Nutrition Sector Strategy
GAVI	The GAVI Alliance (formally known as the Global Alliance for Vaccines and Immunizations)
MOPH	Ministry of Public Health
HSS	Heath System Strengthening
PHCC	Provincial Health Coordinating Committee
PHD	Provincial Health Director
PHO	Provincial Health Office
PPHD	Provincial Public Health Directorate
WHO	World Health Organization

5.1.1 Mapping exercise

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation. Please identify conducted any mapping exercise, the expected results and the timeline (please indicate if this has changed).

The MoPH according to its submitted proposal is in process of re-invigorating the coordination mechanisms of the CGHN (HSCC equivalent) and the ICC for the coming implementation of the new Health and Nutrition Sector Strategy (2008-2013). NGOs selected to be the member of CGHN and ICC was long ago and based on the evolving health sector reconstruction and implementation of contracting out NGOs for BPHS means that dramatic changes have taken place. Thus the CGHN and the ICC need to review and revise their membership lists and qualifications for membership.

In addition to NGOs, it is recognized that academic institutions, professional organizations and other civil society organizations at central and provincial levels may play important roles in the health sector and have a contribution to the strategy to reach the public health goals such as improved immunization coverage.

Thus, a methodology was proposed to recruit 2 national consultants to conduct a mapping exercise by drafting an appropriate questionnaire to identify the CSOs contributing to child health and immunization. The questionnaire will be filled by the PHCCs, monitored and collected by the MOPH Monitoring Officers, and entered into a database at the MOPH.

In order to improve CSO participation in the important coordination bodies of CGHN and ICC, the CSO profiles derived from the database will be ranked based on the levels of experience and

[8] Type A GAVI Alliance CSO support is available to all GAVI eligible countries.

degree of involvement in health and immunization services delivery or involvement in health system strengthening. By the end of Aug 2009, the short list of prioritized CSOs will be presented to the Civil Society Organizations for nomination of ten candidates for each forum such as CGHN and ICC membership. Through a selection system agreed with the CSOs, voting through their Coordination Bodies or selection by a large shura, they will nominate ten candidate CSOs and rank them from 1 to 10.

The final short list will be presented to the CGHN and the ICC to approve the selected CSO candidates as members, depending on the number of CSO members specified in the revised TOR of the CGHN and the ICC.

There are slight changes. First of all in addition to the above mentioned issues, MOPH is planning that throughout the course of mapping implementation, interviews to be conducted with key informants at the both public and private sector to derive recommendations for how to better utilise CSOs in Afghanistan to improve the child and maternal health. There fore the expected results would be:

1: Have a ready made database of CSO available for MOPH and its partners
2: Elected representatives of CSOs are part of key coordination bodies for the health sector
3:Derived recommendations from the study available to MOPH and its partners for further decision making

The amount for mapping exercise of CSOs was approved in mid 2008 while it took long time till the issue was finalized among MOPH, WHO and GAVI and by the end of 2008 it was finalized that the WHO will handle the funds. MOPH with the support of WHO will carry out the implementation. The time line according to the work plan finalized is from 15th March 2009 to 14th March 2010.

Now the MOPH is in the preparatory phase and so far the following activities are carried out:

1. *Mapping exercise work plan developed and finalized*
2. *The Mapping exercise implementation manual drafted*
3. *Current information available with key agencies such as ACBAR, ANCB, AWN, requested that will be available soon*
4. *The National TA for conducting mapping exercise hired (after four times announcements)*
5. *The existing mapping exercise tool (downloaded from GAVI alliance site) was modified based on Afghan context translated in two local languages (Dari and Pashto) and will be presented to CGHN. (Annex 23)*

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

Information not yet available

5.1.2 Nomination process

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

Not yet done

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

Appropriate information not yet available

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

To be reported next year

5.1.3 Receipt of funds

Please indicate in the table below the total funds approved by GAVI (by activity), the amounts received and used in 2008, and the total funds due to be received in 2009 (if any).

Cost of core activities	***Cost per year in US$ (,000)***		**TOTAL COSTS**
	2009	**2010**	
Mapping exercise & Nomination process & Follow up			
1. Recruitment of two national consultants to manage the process of mapping exercise and nomination process	26,820	7,500	34,320
2. Develop mapping protocol	5,500	0	5,500
3. Communication & Transport cost	6,390	1,450	7,840
4. Training of M&E officers in mapping tool use	300	0	300
5. Data collection	24,000	0	24,000
6. Workshops with CSOs to assure their participation in mapping exercise and developing strategy and planning to improve immunization coverage	5,000	2,000	7,000
7. Provision of equipment and stationery	12,040	0	12,040
8. Printing of the report	0	2,000	2,000
Management costs	**7,000**	0	7,000
TOTAL COSTS	**87,050**	**12,950**	**100,000**

5.1.4 Management of funds

Please describe the mechanism for management of GAVI funds to strengthen the involvement and representation of CSOs, and indicate if and where this differs from the proposal. Please identify who has overall management responsibility for use of the funds, and report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

The amount for mapping was decided to be transferred through WHO. A detailed work plan jointly developed by MOPH and WHO. The financial management will be done according to the WHO Financial systems. There is an MOU between WHO and MOPH so that according to the activities accomplished WHO is provided with the report for processing the payment. For TA recruitment APW (WHO contract) contract is signed by WHO with the TA recruited for this purpose.

Experiences show that so far no problems encountered with WHO.

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

This section is to be completed by countries that have received GAVI TYPE B CSO support[9]
Please fill in text directly into the boxes below, which can be expanded to accommodate the text.

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

ACTAD	Afghanistan Center for Training and Development
BDN	Bakhtar Development Network
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BRAC	Building Resources Across the Community (INGO)
CGHN	Consultative Group on Health and Nutrition (HSCC equivalent)
CHA	Coordination of Humanitarian Assistance (NGO)
CHC	Comprehensive Health Center
CME	Community Midwifery Education
CMW	Community Midwife
cMYP	Comprehensive Multi-Year Plan for National EPI
CSO	Civil Society Organization
DH	District Hospital
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
FMA	Financial Management Agency
GAVI	The GAVI Alliance
GCMU	Grants and Contracts Management Unit
GDPP	General Director of Policy and Planning
GOA	Government of Afghanistan
HADAAF	Humanitarian Assistance and Development Association for Afghanistan
HMIS	Health Management Information Systems
HNI-TPO	Health Net-International Transcultural and Psychosocial Organization
HSCC	Health Sector Coordination Committee
HSS-CU	Health System Strengthening Coordination Unit
INGO	International Non-Governmental Organization
LOA	Letter of Agreement
MCH	Maternal and Child Health
MOPH	Ministry of Public Health
NGO	Non-Governmental Organization
NMEAB	National Midwifery Education and Accreditation Board
NNGO	National Non-Governmental Organization
PPP	Private Public Partnership
SC	Steering Committee
TOR	Terms of Reference
WB	World Bank
WHO	World Health Organization

5.2.1 Programme implementation

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

[9] Type B GAVI Alliance CSO Support is available to 10 pilot GAVI eligible countries only: Afghanistan, Burundi, Bolivia, DR Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan.

Due to delay in identifying a financial mechanism for channelling funds, all six of the projects have been delayed and will officially start this month.

The workplan has been finalized with WHO as follows:
By mid 2011, improved accessibility to maternal and child health services in remote and under served areas will be realized. Community midwifery education (CME) will be established in four new provinces and two pilot projects on Private-Public Partnership for MCH health services in insecure areas will be completed

1. Establishing community midwifery education in Zabul province: by Ibnsina (CSO)
2. Establishing community midwifery education in Kunar Provice : by Norwegian Afghanistan Committee (CSO)
3. Establishing community midwifery education in Ghazni province: by Bakhtar Development Network (BDN) (CSO)
4. Establishing community midwifery education in Nimroz Province : by BRAC (CSO)
5. Conducting pilot project on PPP for MCH health services in Farah Province: by CHA (CSO)
6. Conducting pilot project on PPP for MCH health services in Uruzgan Province: by Health Net TPO
7. Technical & financial monitoring/ management of project
    a. Recruitment of National consultants to monitor the activities of the CSOs - 1 tech, 1 finance
    b. Workshops and activities to coordinate, manage, and evaluate grant
    c. Mission transport, per diem, logistics, communication, security
8. Audit of CSOs accounts to ensure that the Grant Goals are achieved in accordance with the aim of the agreements signed with the CSOs

Costs and Funding for GAVI Alliance CSO Support:
The estimated budget for the GAVI CSO proposal is US$2,267,288
plus WHO Program Support Cost of 7% makes total US$2,425,998.
US$1,154,591 (50%) is allocated for CME programs in four provinces and
US$831,791 (37%) for developing partnerships with private providers in two provinces.
Total management costs of the NGOs are US$99,485 (4.4%) while the joint WHO and CGHN/ GDPP management costs including monitoring and supportive supervision of the projects, external audit, and an independent evaluation of the projects at the end stage are US$ 181,421 (8%).

The amount scheduled for the first year of the project is US$ 1,018,169.

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

Due to delay in identifying a financial mechanism for channelling funds, all six of the projects have been delayed and will officially start this month.

The plan to channel funds through WHO has now been accepted by all parties, and a Letter of Agreement (LOA) has been signed between GAVI and WHO this month (May 2009). Revision in Implementation Arrangements is explained below.

Implementation Arrangements: The six different NGOs (consortiums in some cases) will be directly responsible for implementation and providing financial and technical reports to MOPH General Directorate of Policy and Planning (GDPP) and the Consultative Group on Health and Nutrition (CGHN or HSCC). Coordination and oversight of the GAVI–HSS-CSO funded projects will be with GDPP. CGHN HSS Steering Committee will provide technical support to GDPP and HSS Coordinator; review and endorse work plans and progress; and endorse funds disbursement and reports to GAVI.

The selected CSOs or consortiums will receive funds by making contracts with World Health Organization (WHO) which would be endorsed by MoPH /CGHN. WHO will collaborate with MOPH/CGHN in financial management, disbursement and accounting and charge 7% Program Support Cost. The MOPH/CGHN will be responsible to conduct reviews to judge progress toward the expected results and will commission an independent evaluation of the projects at the end stage. WHO, using grant funds, will be responsible to conduct an external financial audit of the grant projects.

Change of plans occurred when MOPH found another partner to implement community midwifery education in Faryab, and the process is now underway to identify another CSO to implement community midwifery in Kunar – another province meeting the established criteria for "need" and feasibility.

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

Gap analysis, proposal drafting and negotiation of budgets have created opportunities for intense interaction between MOPH HSSCU and CSOs involved in the grant during each phase of the process.

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

The key service delivery strategies of the MoPH are the MOPH uses donor funds for health services provision of the Basic Package of Health Services (BPHS), including EPI, and the Essential Package of Hospital Services (EPHS) in 31 of the 34 provinces, **by contracting out to implementing agencies, mainly CSOs.**

On the other hand, this proposal is developed by the CGHN to enhance partnership with CSOs to **address critical service delivery bottlenecks in the country, mainly, the shortage of female service providers and the lack of access to communities due to insecurity with the resultant inequity.**

The GAVI CSO Type B projects will be implemented by six different CSOs who are already involved in health service provision in the same or nearby provinces. This fund however helps them build the health system to address current barriers to health services.

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

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

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2008	Outcomes achieved
No GAVI support distributed to CSOs for Type B project nor implementation yet			

Please list the CSOs that have not yet been funded, but are due to receive support in 2009/2010, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

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

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities from May 2009 to April 2010	Expected outcomes by April 2011
IbnSina National NGO (NNGO)	implementing BPHS in Zabul Province	- CME programme assessed and accredited by the NMEAB. - 20 qualified females from un-served areas of Zabul province enrolled in CME program.	- 20 CMWs graduate from CME program. - 20 CMWs deployed in the BPHS facilities not having community midwives.
Norwegian Afghanistan Committee International / National NGO (INNGO)	providing health services in Kunar Province	- CME programme assessed and accredited by the NMEAB. - 20 qualified females from un-served areas of Kunar province enrolled in CME program.	- 20 CMWs graduate from CME program. - 20 CMWs deployed in the BPHS facilities not having community midwives.
Bakhtar Development Network NNGO.	implementing BPHS in Ghazni Province, who	- CME programme assessed and accredited by the NMEAB. - 25 qualified females from un-served areas of Ghazni province enrolled in CME program.	- 25 CMWs graduate from CME program. - 25 CMWs deployed in the BPHS facilities not having community midwives.
BRAC Afghanistan in consortium with **Afghanistan Centre for Training and Development**	INGO implementing BPHS in Nimroz Province in consortium with an NNGO working primarily in capacity development.	- CME programme assessed and accredited by the NMEAB. - 18 qualified females from un-served areas of Nimroz province enrolled in CME program.	- 18 CMWs graduate from CME program. - 18 CMWs deployed in the BPHS facilities not having community midwives.
Coordination of Humanitarian Assistance (CHA)	NNGO implementing BPHS in Farah Province	- Formal partnership agreements developed with selected Private Service Providers in Farah province. - About 25 selected private service providers trained to provide EPI and basic RH services - About 25 private sector health service provision outlets of Farah province upgraded.	A replicable model of partnership with private service providers to provide access to EPI and basic RH services to about 121,000 population living in three insecure and underserved districts of Farah: Bakwa, Gulistan and Purchaman.- DPT-3 coverage in the targeted areas increased to >80%
HealtNet TPO and **Humanitarian Assistance and Development Association for Afghanistan (HADAAF),**	An INGO and an NNGO, are both implementing BPHS.	- Formal partnership agreements developed with selected Private Service Providers in Uruzgan province. - Over 30 selected private service providers trained to provide EPI and basic RH services - Over 30 private sector health service provision outlets of Uruzgan province upgraded.	A replicable model of partnership with private service providers to provide access to EPI and basic RH services to about 450,000 population living in insecure and under-served areas of Uruzgan Province. - DPT-3 coverage in the targeted areas increased to >80%

5.2.2 Receipt of funds

Please indicate in the table below the total funds approved by GAVI, the amounts received and used in 2008, and the total funds due to be received in 2009 and 2010. Please put every CSO in a different line, and include all CSOs expected to be funded during the period of support. Please include all management costs and financial auditing costs, even if not yet incurred.

NAME OF CSO	Total funds approved	2008 Funds US$			Total funds due in 2009*	Total funds due in 2010*	Total funds due in 2011*
		Funds received	Funds used	Remaing balance			
IbnSina	298,395	0	0	0	150,198	148,198	0
NAC	300,000	0	0	0	130,000	130,000	40,000
BDN	295,639	0	0	0	119,003	134,047	42,589
BRAC and ACTD	297,870	0	0	0	185,819	112,051	0
CHA	446,757	0	0	0	212,022	224,735	10,000
HealtNet TPO and HADAAF	447,206	0	0	0	101,322	223,423	122,461
Management costs (of HSCC)**	168,422	0	0	0	51,865	75,404	41,154
Financial auditing costs (of all CSOs)***	12,999	0	0	0	1,332	9,000	2,667
Program Support Cost WHO 7%	158,710	0	0	0	66,609	73,981	18,120
TOTAL COSTS	2,425,998	0	0	0	1,018,169	1,165,098	242,731

***8 months in 2009, 12 months in 2010, and 4 months in 2011 for 24 months' project.**
****CGHN/MOPH management costs include monitoring and supportive supervision of the projects and an independent evaluation of the projects at the end stage.**
*****Management Costs of CSO projects have been included in their contracts and could not reasonably be separated out as an expense line.**

5.2.3 Management of funds

Please describe the financial management arrangements for the GAVI Alliance funds, including who has overall management responsibility and indicate where this differs from the proposal. Describe the mechanism for budgeting and approving use of funds and disbursement to CSOs,

Mechanism for channelling fund of GAVI to CSOs

After consultations with the partners through CGHN, it was agreed that the CSO funds should be channelled through WHO which will support the CGHN/MOPH in all aspects of financial management, disbursement and accounting. An LOU will be signed between WHO and MOPH and supported by an LOU between GAVI and WHO. MOPH will endorse contracts signed between CSOs and WHO.

Funds provided by The GAVI Alliance will be used only for the purposes explicitly described in the funding application and signed agreement, including any subsequent amendments.

Please give details of the management and auditing costs listed above, and report any problems that have been experienced with management of funds, including delay in availability of funds.

5.2.4 Monitoring and Evaluation

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

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

Activity / outcome	Indicator	Data source	Baseline value	Date of baseline	Current status	Date recorded	Target	Date for target
Percentage of BPHS health facilities with at least one female health worker in Kunar, Nimroz, Zabul and Ghazni		HMIS	56%	End 2007	**TBD**	**2007**	80%	March 2010
DPT-3 coverage in the targeted areas of Uruzgan and Farah increased >80%		Monthly EPI coverage reports	70% for Farah and 30% for Uruzgan	End 2007	TBD	2007	>80%	End 2009
No. of new CME programs in Kunar, Nimroz, Zabul and Ghazni accredited by the NMEAB		CSOs self assessment report of CME	0	2009	0	2009	4	End 2009
No. of skilled CMWs graduated from the four CME programs in Kunar, Nimroz, Zabul and Ghazni		CSOs CME completion report	0	2009	0	2009	83	End 2009
No. of graduated CMWs deployed in the BPHS health facilities of Kunar, Nimroz, Zabul and Ghazni provinces		CSOs and BPHS joint report on deployment of newly trained CME graduates	0	2009	0	2009	At lest 80 %	End 2010
No. of private sector service providers from Farah and Uruzgan provinces trained		CSO activity report/monitoring visits report	0	2009	0	2009	About 40 from both provinces	End 2010
No. of private sector service provision outlets of Farah and Uruzgan provinces upgraded		Baseline assessment report of the CSO/ monitoring visits report	0	2009	0	2009	At least 10 from each of the two provinces	End 2010
No. of private sector service provision		CSO activity report/m	0	2009	0	2009	At least 10 from each of the two	End 2010

outlets of Farah and Uruzgan provinces delivering immunization and basic RH service	onitoring visits report/end project assessment					provinces	

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

These indicators will be monitored through joint review process at the provincial level by a forum convened by PHD. Such forum will have implementing CSO, BPHS partners, local government, traditional decision makers and representatives of each of the target groups. The review of progress of the indicators/ milestones at national level will be done on a quarterly basis with a major mid-term review and end-of-project review which will include all key stakeholders. In addition to above indicators, the CSO routine reports and HMIS data will be used to track progress on immunization and basic RH service utilization.

6. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission		
Reporting Period (consistent with previous calendar year)		
Government signatures		
ICC endorsed		
ISS reported on		
DQA reported on		
Reported on use of Vaccine introduction grant		
Injection Safety Reported on		
Immunisation Financing & Sustainability Reported on (progress against country IF&S indicators)		
New Vaccine Request including co-financing completed and Excel sheet attached		
Revised request for injection safety completed (where applicable)		
HSS reported on		
ICC minutes attached to the report		
HSCC minutes, audit report of account for HSS funds and annual health sector review report attached to Annual Progress Report		

7. Comments

ICC/HSCC comments:

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review.

~ End ~