GAVI Alliance

Annual Progress Report 2011

Submitted by

The Government of

Afghanistan

Reporting on year: **2011**
Requesting for support year: **2013**
Date of submission: **5/23/2012**

Deadline for submission: 5/22/2012

Please submit the APR 2011 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

Important problems that were encountered and how the country has tried to overcome them

Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners

Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released

How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.

1. Application Specification

Reporting on year: **2011**

Requesting for support year: **2013**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2011	Request for Approval of
ISS	Yes	ISS reward for 2011 achievement: N/A
HSS	Yes	next tranche of HSS Grant N/A
CSO Type A	Yes	Not applicable N/A
CSO Type B	Yes	CSO Type B extension per GAVI Board Decision in July 2011: N/A

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2010 is available here.

2. Signatures

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

By signing this page, the Government of Afghanistan hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of Afghanistan

Please note that this APR will not be reviewed or approved by the Independent Review Committee (IRC) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Dr. S. Dalil	**Name**	Mr. H.O. Zakhelwal
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr. Dost	NIP Manager	+93 799814812	nationalepi05@yahoo.com
Dr. A. Shakoor	NPO/WHO/AFG	+93 700025888	abdulghafoora@afg.emro.who.int
Dr. Abdul Wali Ghayur	Health System Strengthening Coordinator and focal point	+93 799353178	drabwali@yahoo.com
Dr.Najla Ahrari	Health System Strengthening Deputy Coordinator	+93 799302996	najlaahrari@gmail.com
Dr.Haseebullah Neyaish	CSO Type B Coordinator	+93 776912180	dr.niayesh@gmail.com
Dr.Saifurrahman"Ibrahimkhail"	EPHS Technical Advisor HealthNet TPO Afghanistan EPHS Technical Advisor HealthNet TPO Afghanistan	+93700638370	saif_ibrahimkhail@yahoo.com
Engg Asmatullah Sahban	Finance consultant	+93700025888	enggasmatullah@gmail.com

2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), 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.

Name/Title	Agency/Organization	Signature	Date

HE Minister of Public Health	MOPH		
DG of Policy & Planning	MOPH		
DG of Preventive Medicine Department	MOPH		
Representative of MoF	MoF		
National EPI Manager	MOPH		
HSS Coordinator	MOPH		
Representative	USAID		
Representative	WB		
Representative	EC		
Country Representative	WHO		
Country Representative	UNICEF		
Chairperson	NITAG		
Representative (NGO)	MSH		

Representative (NGO)	BRACK		
Representative (NGO)	AHDS		

ICC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

1. The NEPI is advised to use the available GAVI ISS fund for expansion of immunization services by establishing EPI fixed centers in the functional health facilities (>500) without immunization services.<?xml:namespace prefix = o />

2. The ICC advised NEPI to strengthen immunization monitoring system and increase the use of GAVI ISS fund for this purpose.

3. NEPI is advised to develop criteria and user-friendly indicators for measuring implementation of RED strategies

4. Emphasizing on carrying out EPI coverage evaluation survey, ICC has advised NEPI and UNICEF to prepare activity timeline for planning, implementation and reporting the result of EPI coverage survey and share with DG of preventive medicine as soon as possible.

5. Expansion of cold storage capacity at national level for preparation in introducing PCV vaccine in January 2013: UNICEF has ordered the required number of cold rooms from its core budget and as mentioned the cold rooms are expected to be installed before the end of July 2012.

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), HSS Steering Committe , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organization	Signature	Date
Dr.Salehi / Head of Health Economic & Finance Department	HEFD /MoPH		
Dr. Ahamad Jan Naeem / Acting Deputy Minister for policy and Planning	MoPH		
Dr.Iqbal Roshani	USAID		

Dr. Yasin Rahim Yaar	CAF/ CSO representative		
Dr. A. Wali Ghayur / HSS coordinator and focal point	MoPH		
Dr. Haseebullah / CSO Type B Coordinator	WHO		
Dr. Khaksar	UNICEF		
Dr.Ahmad	WHO		
Dr. Mashal / General Directorate of Preventive Care	MoPH		
Dr. Sajed / National EPI	MoPH		
Khesrow Momand	MoF		
Dr. Sefatullah Habib	EU		
Dr.Najla Ahrari / HSS Deputy Coordinator	MoPH		

HSCC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

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 to help implement the GAVI HSS proposal or cMYP (for Type B funding).

2.4.1. CSO report editors

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

Name/Title	Agency/Organization	Signature	Date
Dr. Haseebullah / CSO Support Type B Coordinator	WHO		
Dr.Saifurahman Ibrahimkhil	Health Net TPO		

2.4.2. CSO report endorsement

We, the undersigned members of the National Health Sector Coordinating Committee (or equivallent committees)- , endorse this report on the GAVI Alliance CSO Support.

Name/Title	Agency/Organization	Signature	Date
Dr.Saifurahman Ibrahimkhil	Health Net TPO		
Dr. Ahamad Jan Naeem / Acting Deputy Minister for policy and Planning	MoPH		
Dr.Salehi / Head of Health Economic & Finance Department	HEFD /MoPH		
Dr.Iqbal Roshani	USAID		
Dr. Yasin Rahim Yaar	CAF / CSO representative		
Dr. A. Wali Ghayur / HSS coordinator and focal point	MoPH		
Dr. Haseebullah / CSO Type B Coordinator	WHO		
Dr. Khaksar	UNICEF		

Dr.Ahmad	WHO		
Dr. Mashal / General Directorate of Preventive Care	MoPH		
Dr. Sajed / National EPI	MoPH		
Khesrow Momand	MoF		
Dr. Sefatullah Habib	EU		

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

3. Table of Contents

This APR reports on Afghanistan's activities between January – December 2011 and specifies the requests for the period of January – December 2013

Sections

4. Baseline & annual targets

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Total births	1,412,068	1,409,401	1,445,958	1,445,958	1,480,661	1,480,661	1,516,196	1,516,196	1,552,585	1,552,585
Total infants' deaths	182,155	182,155	186,529	186,529	191,006	191,006	195,589	195,589	200,283	200,283
Total surviving infants	1229913	1,227,246	1,259,429	1,259,429	1,289,655	1,289,655	1,320,607	1,320,607	1,352,302	1,352,302
Total pregnant women	1,412,068	1,408,760	1,445,958	1,445,958	1,480,661	1,480,661	1,516,196	1,516,196	1,552,585	1,552,585
Number of infants vaccinated (to be vaccinated) with BCG	1,228,499	1,267,519	1,357,983	1,357,983	1,317,788	1,317,788	1,364,576	1,364,576	1,397,326	1,397,326
BCG coverage	87 %	90 %	94 %	94 %	89 %	89 %	90 %	90 %	90 %	90 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,045,426	1,087,210	1,095,703	1,095,703	1,147,792	1,147,792	1,188,546	1,188,546	1,217,072	1,217,072
OPV3 coverage	85 %	89 %	87 %	87 %	89 %	89 %	90 %	90 %	90 %	90 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,205,314	1,227,586	1,234,240	1,234,240	1,263,861	1,263,861	1,294,194	1,294,194	1,325,255	1,325,255
Number of infants vaccinated (to be vaccinated) with DTP3	1,045,426	1,087,210	1,095,703	1,095,703	1,147,792	1,147,792	1,188,546	1,188,546	1,217,072	1,217,072
DTP3 coverage	85 %	89 %	87 %	87 %	89 %	89 %	90 %	90 %	90 %	90 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	5	0	0	0	0	0	0	0	0
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.05	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	1,229,911	1,227,586	1,234,240	1,234,240	1,263,861	1,263,861	1,294,194	1,294,194	1,325,255	1,325,255
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	1,045,426	1,087,210	1,095,703	1,095,703	1,147,792	1,147,792	1,188,546	1,188,546	1,217,072	1,217,072
DTP-HepB-Hib coverage	85 %	89 %	87 %	87 %	89 %	89 %	90 %	90 %	90 %	90 %
Wastage[1] rate in base-year and planned thereafter (%)	5	25	25	25	25	25	25	25	25	25
Wastage[1] factor in base-year and planned thereafter (%)	1.05	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33
Maximum wastage rate value for DTP-HepB-Hib, 10 doses/vial, Liquid	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	971,631	1,000,611	1,032,731	1,032,731	1,096,206	1,096,206	1,162,134	1,162,134	1,217,071	1,217,071
Measles coverage	79 %	82 %	82 %	82 %	85 %	85 %	88 %	88 %	90 %	90 %
Pregnant women vaccinated with TT+	1,059,051	1,062,423	1,127,847	1,127,847	1,184,528	1,184,528	1,288,766	1,288,766	1,397,326	1,397,326
TT+ coverage	75 %	75 %	78 %	78 %	80 %	80 %	85 %	85 %	90 %	90 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0	0	0	0	0
Vit A supplement to infants after 6 months	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	13 %	11 %	11 %	11 %	9 %	9 %	8 %	8 %	8 %	8 %

*

** Number of infants vaccinated out of total 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.

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2011 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2011.** The numbers for 2012 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  All the data are consistent with cMYP based on the 1st and the only population census conducted in 1975 with 2.4% annual growth rate and NIP has been using for planning of immunization programs since its inception. Therefore, no change considered in births.

- Justification for any changes in **surviving infants**

  No change made in surviving infants (though the latest but limited and unpublished Maternal Mortality Survey shows reduction in infant mortality rate in 2010 77/1000LB compared to 129/1000LB in 2006)

- Justification for any changes in **targets by vaccine**

  No change made in targets by vaccines (though there was not remarkable improvement in EPI coverage in 2011 due to problems that the program faces chiefly at service delivery levels)

- Justification for any changes in **wastage by vaccine**

  The NIP has shifted from single dose vials to 10 dose vials effective 1st July 2012, therefore the wastage rate is changed from 10% initially considered to maximum 25%.

5.2. Immunisation achievements in 2011

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2011 and how these were addressed:

The Afghanistan's NIP key activities carried out and achievements for 2011:

Antigens

	Target	Reported coverage achieved
BCG	87%	90%
OPV3	85%	82 %
DPT(Penta)3	85%	82%
Measles 1st dose	80%	75%
Measles 2nd dose		

60%

48%

TT2+P

75%

75%

District coverage reported for routine immunization services in 2011:

Antigens

<50%

50-79%

80-89%

90-94%

>90%

# of districts not reported

DPT3(Penta3)/OPV3

37

97

40

24

123

8

Measles 1st dose

47

104

45

26

99

8

TT2+P

94

94

18

11

104

8

DPT1-DPT3 Drop-out rate reported: 13%. Around 185,000 children missed opportunity to be immunized with Penta/OPV in 2011.

❖· **Program Management**

- Revision/update of cMYP 2011-2015 in light with new WHO/NITAG recommendations and development/ changes in MOPH policies and strategies

- Application to GAVI for support in introduction of PCV vaccine into NIP in January 2013.
- Conditional approval of Afghanistan's application by GAVI IRC.
- Coordination with partners and government the GAVI conditions
    - Revision/update of NIP Policy and National EPI guidelines
    - Conducting of 4 NITAG meetings (recommendation for introduction of PCV and Rota vaccines, conditional (availability of resource) recommendation of birth dose of Hepatitis B, identifying of target groups for measles SIAs, possibility of Rubella vaccine inclusion with GAVI long term support, and some other policy issues)

•□□□□□□□□ Conducting of DQAS in 22 provinces in 2011.

•□□□□□□□□ Re-schedule of health facility/district micro-plans based on RED in about 65% of the districts

- Establishment of national measles elimination validation committee to oversee progress in measles elimination
- Conducting of quarterly EPI review workshops at provincial levels
- Conducting annual EPI review workshop with all partners and stakeholders
- Close coordination with finance directorate of MOPH and donors for increasing vaccinators' salaries and benefits
- Conducting of weekly EPI Task Force Committee meetings
- Conducting of three ICC meetings
- Implementation of PIE with the support of WHO

❖· **Service Delivery**

- Delivery of immunization service through 1300 EPI fixed centers, outreach and mobile sessions, sub-centers and mobile health teams (MHT).
- Implementation of 3 rounds of accelerated immunization activities in 43 low performing districts
- Conducing of measles outbreak response and selective measles mop-up campaign in 46 districts immunizing 1.3 million children of 9M-10Y.

❖· **Cold chain & Logistics management**

- The Effective Vaccine Management Assessment (EVMA) as one of GAVI conditions for introduction of pneumococcal vaccine conducted in 2011. All the indicators are above 80%.
- Introduction of new version of WHO developed VSSM at national, regional and provincial levels
- Training of 5 national staff on vaccine management outside the country

❖· **Advocacy**

- The national vaccination week aiming at increasing community awareness about immunization and focusing on advocacy, education and communication and involving MOPH high authorities, partners and stakeholders conducted in April 2011

❖· **Capacity building**

- Initial training courses conducted for 80 new vaccinators
- Totally 2562 national EPI managers, supervisors and immunization health workers, laboratory staff on different aspects of EPI were trained (including refresher training courses for 1200 vaccinators)

❖· **VPD surveillance**

- WHO continues it support in keeping functional measles, rotavirus, meningitis, pneumonia surveillance with lab support & polio and MNT surveillance
- Totally, 3041 cases of measles reported through AFP surveillance and the solation of measles genotype (D4, H1).

•□□□□□□□□ Total MNT cases detected - 20

- Rotavirus surveillance continues to provide evidence index of the burden of rotavirus disease among those infants suffering from acute watery diarrhea. Currently, the rotavirus surveillance program is sustained in three hospitals which are collecting diarrheal stool samples, screen for rotavirus by ELISA test and ship the samples to EMRO reference lab for genotyping. About 55% of samples tested are positive for rotavirus
- WHO/EMRO (VPI)/WRO Afghanistan continued the financial and technical support of the meningitis and pneumococcal surveillance program to assess the burden of the both diseases and hence, provide evidence based recommendation to MoPH regarding the vaccination strategy.

❖· **Monitoring & Evaluation.**

•□□□□□□□□ Conducting of DQAs in 22 provinces in 2011

•□□□□□□□□ The EPI coverage survey is planned in June 2012

5.2.2. If targets were not reached, please comment on reasons for not reaching the targets:

❖· The target set for 2011 could not be achieved due to poor access to and utilization of immunization services and factors contributing:

➢· Inaccessibility of about 38% of population to immunization services (current BPHS coverage is 62%)

➢· Insecurity in certain areas of the country

➢· Poor implementation of EPI strategies by NGOs

➢· Poor implementation of HF/District micro-plans

➢· Inadequacy in management of staff and fund at service delivery levels

➢· Weak management of program coordination

➢· Shortage of refrigerators for replacement of old/no-functional refrigerators and equipping new health centres

➢· Inadequate cold chain and logistic development plan

➢· Poor maintenance of ageing cold-chain equipment and vehicles

➢· Shortage spare parts for cold chain equipment at all levels

➢· Weak monitoring through disease surveillance and service delivery

➢· Inaccuracy in reporting of antigen coverage and drop-out rates

➢· Poor monitoring of stakeholders (NGOs) performance

➢· Widespread outbreaks of measles and polo and frequent NIDs and SNIDs

➢· Shortage of trained immunization health workers especially in rural and remote areas

➢· High immunization health workers (shortage of fund & Low level of salaries & benefits)

Geographical constraints □□

5.3. Monitoring the Implementation of GAVI Gender Policy

In the past three years, were the sex-disaggregated data on immunisation services access available in your country? Choose one of the three: **no, not available**

If yes, please report all the data available from 2009 to 2011

Data Source	Timeframe of the data	Coverage estimate
0	0	0

How have you been using the above data to address gender-related barrier to immunisation access?

Note: According to country constitution, both males and females have equal right and access to immunization services

If no sex-disaggregated data is available at the moment, do you plan in the future to collect sex-disaggregated data on routine immunisation reporting? **Not selected**

What action have you taken to achieve this goal?

Note: The NIP will revise the EPI recording and reporting materials considering GAVI gender policy

5.4. Data assessments

5.4.1. Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)

There was no assessment in 2011. But the EPI coverage survey is planned to be conducted June-July 2012.

* Please note that the WHO UNICEF estimates for 2011 will only be available in July 2012 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2010 to the present? **Yes**

If Yes, please describe the assessment(s) and when they took place.

- The DQAs conducted in all 34 provinces
- The NRVA (2009-2010) included some immunization indicators
- The MICS included immunization indicators, but with small sample size
- The planned EPI coverage evaluation survey is likely to be held in June-July 2012

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2009 to the present.

- Strengthening routine monitoring and supervision involving all stakeholders and partners
- Training of NGOs EPI supervisors (70)
- Revision of National EPI guideline and tools for monitoring and supervision
- Training of all provincial EPI managers and supervisors on new tools and strengthening supportive supervision

5.4.4. Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

EPI coverage evaluation survey

In-depth EPI review

Planning and implementation of PIE assessment recommendations

Revision of monitoring & supervision guidelines and tools

Strengthening monitoring and supervision involving all partners and stakeholders

Conduct quarterly EPI review workshops

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** and **Table 5.5b** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 50	Enter the rate only; Please do not enter local currency name

Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	Expenditure Year 2011	Source of funding						
		Country	GAVI	UNICEF	WHO	USAID	WB	EC
Traditional Vaccines*	3,352,935	0	0	3,352,935	0	0	0	0
New and underused Vaccines**	11,996,576	585,000	11,411,576	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	906,030	0	281,755	624,275	0	0	0	0
Cold Chain equipment	0	0	0	0	0	0	0	0
Personnel	4,626,491	652,800	756,345	265,400	0	1,256,200	1,017,311	678,435
Other routine recurrent costs	1,674,545	652,800	756,345	265,400	0	0	0	0
Other Capital Costs	3,178,028	150,000	543,655	654,000	378,373	654,000	476,000	322,000

Campaigns costs	19,076,947	0	0	14,307,710	4,769,237	0	0	0
0		0	0	0	0	0	0	0
Total Expenditures for Immunisation	44,811,552							
Total Government Health		2,040,600	13,749,676	19,469,720	5,147,610	1,910,200	1,493,311	1,000,435

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

Please state if an Annual Action Plan for the year 2011, based on the cMYP, was developed and costed.

5.5.1. If there are differences between available funding and expenditures for the reporting year, please clarify what are the reasons for it.

According to Annual Plan of Actions, the total fund planned for 2011 was $37,825,736 and the actual fund expenditure was $42,871,606 with difference of $5,045,870. The extra expenditure was due to widespread of polio and measles outbreaks and increased N0 of NIDS/SNIDs and measles outbreak responses and selective measles campaigns. UNICEF provided fund to fill in the gap.

5.5.2. If less funding was received and spent than originally budgeted, please clarify the reasons and specify which areas were underfunded.

The areas underfunded were mainly related to service delivery (transportation for monitoring and supervision, outreach and mobile activities, low level of salary and other benefits for immunization service providers)

5.5.3. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2012 and 2013

UNICEF will continue providing traditional vaccines/injection supplies.

Table 5.5b: Overall Budgeted Expenditures for Immunisation from all sources (Government and donors) in US$.

Expenditure by category	Budgeted Year 2012	Budgeted Year 2013
Traditional Vaccines*	12,932,762	31,466,086
New and underused Vaccines**	11,996,576	18,711,835
Injection supplies (both AD syringes and syringes other than ADs)	792,574	1,142,885
Injection supply with syringes other than ADs	180,453	190,358
Cold Chain equipment	673,244	696,759
Personnel	1,629,891	1,735,075
Other routine recurrent costs	7,610,951	8,052,502
Supplemental Immunisation Activities	27,814,792	12,000,000
Total Expenditures for Immunisation	63,631,243	73,995,500

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

If there are major differences between the cMYP projections and the budgeted figures above, please clarify the main reasons for it.

5.5.4. Are you expecting to receive all funds that were budgeted for 2012 ? If not, please explain the reasons for the shortfall and which expenditure categories will be affected.

The country is expecting to receive fund for routine EPI expenditures except for routine operation/recurrent (partially) and supplementary immunization activities. The shortfall of fund will affect routine immunization service delivery and polio/measles campaigns

5.5.5. Are you expecting any financing gaps for 2013 ? If yes, please explain the reasons for the gaps and strategies being pursued to address those gaps.

Yes, yet there is not commitment from UNICEF and other donors for continuation of their financial support to the country in 2013.

The strategies to fill in the gaps are to:

- Mobilize government resources for NIP (Follow up with set target for government financial commitment to routine immunization.
- Promote integration of EPI as integral part of health system
- Advocate for mobilizing donors' and partner's funding for immunization
- GAVI will be requested to support country for further strengthening of immunization program in addition to the new vaccine/s
- Involve private sector in routine immunization

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2011 calendar year? **Yes, fully implemented**

If Yes, briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

Action plan from Aide Mémoire	Implemented?
Yet NEPI/MOPH has not received any Aide Mémoire from GAVI.	Not selected

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

The FMA external assessment carried out in April 2012 and waiting the report.

If none has been implemented, briefly state below why those requirements and conditions were not met.

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2011? **3**

Please attach the minutes **(Document N°)** from all the ICC meetings held in 2011, including those of the meeting endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.5 Overall Expenditures and Financing for Immunisation

- The ICC has recommended to economic directorate of MOPH to allocate additional fund for increasing the salary and benefits of immunization health workers and transportation enabling them to follow the NEPI strategies and particularly outreach and mobile activities for increasing routine immunization coverage
- As the government share in immunization is minimal, therefore ICC has recommended EPI as priority program for allocation of government fund as integral part of health system and will follow with relevant departments of MOPH.

Are any Civil Society Organisations members of the ICC? **Yes**

If Yes, which ones?

List CSO member organisations:
MSH, BRAC, AHDS,

5.8. Priority actions in 2012 to 2013

What are the country's main objectives and priority actions for its EPI programme for 2012 to 2013?

The main objectives of NIP and priority actions for 2012 and 201 are

1. To achieve and sustain 90% coverage nationally and at least 80% coverage with all routine antigens in every district.
2. To achieve polio eradication goal, sustain and reach certification of polio eradication
3. To achieve and maintain measles and MNT elimination.
4. To strengthen measles/NNT/Rotavirus/Meningitis/Pneumonia surveillance system with lab support
5. To Improve vaccine and cold chain management
6. To reduce child morbidity and mortality by introducing Pneumococcal vaccine
7. To work towards ensuring financial sustainability of immunization programs

The priority actions planned are:

- Maximize population access to immunization services through expansion of immunization services with more focus on outreach and mobile activities with more focus on remote and difficult to access areas
- Strengthen Reaching Every District (RED) approach to reach all eligible children and women with immunization services
- Strengthen integration of immunization with sub-centers, mobile health teams and other child health intervention
- Plan and Implement recommendations of EVMA and PIE
- Conduct nation-wide measles SIAs in 2012
- Expansion of cold storage capacity and warehousing for dry supplies
- Introduction of pneumococcal vaccine into NIP in 2013
- Conduct national vaccination week and continue advocacy, education and communication on immunization throughout the year for increasing community awareness and demand for immunization
- Under the vaccination, implement TT campaign in girl schools of major cities to disseminate vaccination week messages among the school girls
- Strengthening measles and other vaccine preventable disease surveillance system
- Advocacy for mobilization of resources for immunization
- Revision of EPI monitoring/supervision guideline and tools and enforcing routine monitoring system

Conduct EPI coverage evaluation survey

Are they linked with cMYP? **Yes**

5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2011

Vaccine	Types of syringe used in 2011 routine EPI	Funding sources of 2011
BCG	AD	UNICEF
Measles	AD+Mixing Syr	UNICEF
TT	AD	UNICEF
DTP-containing vaccine	AD	GAVI

Does the country have an injection safety policy/plan? **Yes**

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

If No: When will the country develop the injection safety policy/plan? (Please report in box below)

The injection policy was developped in 2005

Please explain in 2011 how sharps waste is being disposed of, problems encountered, etc.

Vaccines are supplied in bundle to all service delivery points. The common methods are incineration where there incinerators are available and burning/burying of waste in places where there are not incinerators. According to the 2007 third-party assessment only 84% of health facilities implemented “proper sharps disposal

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2011

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	0	0
Remaining funds (carry over) from 2010 *(B)*	4,044,677	202,233,858
Total funds available in 2011 *(C=A+B)*	4,044,677	202,233,858
Total Expenditures in 2011 *(D)*	961,027	48,051,355
Balance carried over to 2012 *(E=C-D)*	3,083,650	154,182,503

6.1.1. Briefly describe the financial management arrangements and process used for your ISS funds. Indicate whether ISS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of ISS funds, such as delays in availability of funds for programme use.

The procedure for ISS fund includes:<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

1. Development of annual plan of priority actions with time-frame and budget and based on provincial plan of actions.
2. Review of plan of actions by EPI Task Force Committee and recommendation to ICC.
3. Review, approval and endorsement by ICC.
4. The endorsed plan is shared with MOPH line Departments and all concerned partners.
5. Submission of plan to MoF for releasing of fund to national and provinces through government channel
6. All payments and purchases are done according to the planned activities using standard formats and following MoF rules.
7. Copies of the documents (stipend role, receipts, bills and etc) signed by PEMT managers and Provincial Health Directors are sent with budget expenditure summary sheet to national EPI office quarterly.
8. Copies of all such documents are kept at National EPI office and at provincial EPI for the purpose of auditing at least for 3 years.
9. The NEPI submit the semi-annual and annual financial reports to ICC indicating the activities carried out and the amount spent against each budget line.
10. The work plan may be modified every six months and is in effect after approval and endorsement of ICC

The only proble is prolonged government procedures for releasing fund.

6.1.2. Please include details on the type of bank account(s) used (commercial versus government accounts), how budgets are approved, how funds are channelled to the sub-national levels, financial reporting arrangements at both the sub-national and national levels, and the overall role of the ICC in this process

The ISS fund channeled to the government bank with the following details:<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Da Afghanistan Bank Head Office Branch

Da Afghanistan Bank Head Office Baranch

MOF-GAVI Project for MOH (792902)

Ministry of Finance

Pashtunistan Avenue

Kabul

Bracnch Code: 3000

Currency Code: USD

Customer ID: 491

Email:info@mov.gov.af

Account:MOF-NonInt. Bearing Current Account in F

Account N0: 3000208027039

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2011

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Program planning and mamangement

- Training of health care workers
- Immunization service delivery
- Advocay, education and communication
- Program monitoring and supervision
- Vaccine preventable diseases surveillance
- Transportation & maintenace and overheads

Base Year**2010

2011

A

B

1

Number of infants vaccinated with DTP3* (from JRF) **specify**

1,037,889

1,087,210

2

Number of **additional** infants that are reported to be vaccinated with DTP3

42321

3

Calculating

$20

per additional child vaccinated with DTP3

$986,420

4

Rounded-up estimate of expected reward

$986,420

The software could not recompute calculation of expected ISS reward for 2011 (6.3). Therefore, we copied the table on this page.

6.1.4. Is GAVI's ISS support reported on the national health sector budget? **Yes**

6.2. Detailed expenditure of ISS funds during the 2011 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2011 calendar year (Document Number) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **Yes**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number).

6.3. Request for ISS reward

Request for ISS reward achievement in Afghanistan is not applicable for 2011

7. New and Under-used Vaccines Support (NVS)

7.1. Receipt of new & under-used vaccines for 2011 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2011 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below **Table 7.1**

Table 7.1: Vaccines received for 2011 vaccinations against approvals for 2011

	[A]	[B]	
Vaccine type	**Total doses for 2011 in Decision Letter**	**Total doses received by 31 December 2011**	**Total doses of postponed deliveries in 2012**
DTP-HepB-Hib		3,897,000	4,617,270

**Please also include any deliveries from the previous year received against this Decision Letter*

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  There NIP anticipated shortage of DPT-HepB-Hib vaccine; therefore UNICEF provided additional 720,270 doses in the last shipment. There was no stock-out of vaccine and any cold chain problem at national and intermediate levels. The vaccines arrived in good condition without any change in VVM and with adequate expiry dates

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  Vaccine arrived based on planned schedule of shipments (4).

7.1.2. For the vaccines in the **Table 7.1**, has your country faced stock-out situation in 2011? **No**

If **Yes**, how long did the stock-out last?

No

Please describe the reason and impact of stock-out, including if the stock-out was at the central level only or at lower levels.

no

7.2. Introduction of a New Vaccine in 2011

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2011, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

Vaccine introduced	N0	
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Application for PCV submitted pending final GAVI IRC aproval

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **June 2014**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 20))

The latest PIE conducted in 2011 (Report is attached)

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **No**

Is there a national AEFI expert review committee? **No**

Does the country have an institutional development plan for vaccine safety? **No**

Is the country sharing its vaccine safety data with other countries? **No**

7.3. New Vaccine Introduction Grant lump sums 2011

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2011 (A)	0	0
Remaining funds (carry over) from 2010 (B)	0	0
Total funds available in 2011 (C=A+B)	0	0
Total Expenditures in 2011 (D)	0	0
Balance carried over to 2012 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2011 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2011 calendar year (Document No 14) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

NA

Please describe any problem encountered and solutions in the implementation of the planned activities

NA

Please describe the activities that will be undertaken with any remaining balance of funds for 2012 onwards

NA

7.4. Report on country co-financing in 2011

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2011?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	566,391	323,652
	Q.2: Which were the sources of funding for co-financing in reporting year 2011?	
Government	Government	
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	585,000	
	Q.4: When do you intend to transfer funds for co-financing in 2013 and what is the expected source of this funding	

Schedule of Co-Financing Payments	Proposed Payment Date for 2013	Source of funding
1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	August	Government
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	Building capacity of key related staff of MOPH and partners in improving their knowledge in mobilizing fund & financial sustainability for immunization.	

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy: http://www.gavialliance.org/about/governance/programme-policies/co-financing/

No

Is GAVI's new vaccine support reported on the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **June 2011**

Please attach:

(a) EVM assessment **(Document No 15)**

(b) Improvement plan after EVM **(Document No 16)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 17)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Kindly provide a summary of actions taken in the following table:

Deficiency noted in EVM assessment	Action recommended in the Improvement plan	Implementation status and reasons for for delay, if any
Poor documentation of T monitoring	Conduct the temperature mapping study	Done
Old /not continous system is in use	Upgrade Temperature Monitoring System	Under discussion with UNICEF for support
Old version of VSSM was in use	Use the updated version of the VSSM	In use at national, regional and province levels
SOPs were not updated	Update and Distribute SOPs	The existing SOPs are in use
The old stock registration and voucher in use	Update the stock registration books and voucher	Revised/updated and distributed
Need for increasing CC capacity at national level	Expand net storage capacity (12m3	UNICEF will provide as has been agreed in ICC meet
Poor stock management of dry supplies and equipmen	Re arrange the dry store	Going on
Lack of additional ground shelves	Install platform/ additional shelves for ground	Under the process
Lack of continous T monitoring system	Explore shifting to continuous temperature	not done, lack of fund
0	monitoring	0

Are there any changes in the Improvement plan, with reasons? **Yes**

If yes, provide details

The cold chain development plan is under process, But there is need for WHO/EMRO/UNICEF support to develop a comprehensive multi-year plan for cold chain expansion for Afghansitan.

When is the next Effective Vaccine Management (EVM) assessment planned? **August 2013**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2011

Afghanistan does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

Afghanistan does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2012

Renewal of multi-year vaccines support for Afghanistan is not available in 2012

7.9. Request for continued support for vaccines for 2013 vaccination programme

In order to request NVS support for 2013 vaccination do the following

Confirm here below that your request for 2013 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don't confirm, please explain

Confirmed

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2011	2012	2013	2014	2015
DTP-HepB, 10 dose(s) per vial, LIQUID	10					
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1		2.182	2.017	1.986	1.933
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10		2.182	2.017	1.986	1.933
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2		2.182	2.017	1.986	1.933
HPV bivalent, 2 dose(s) per vial, LIQUID	2		5.000	5.000	5.000	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1		5.000	5.000	5.000	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10		0.242	0.242	0.242	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10		0.520	0.520	0.520	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10		0.494	0.494	0.494	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2		3.500	3.500	3.500	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1		3.500	3.500	3.500	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10		0.900	0.900	0.900	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5		0.900	0.900	0.900	0.900
Rotavirus, 2-dose schedule	1		2.550	2.550	2.550	2.550
Rotavirus, 3-dose schedule	1		5.000	3.500	3.500	3.500
AD-SYRINGE	0		0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-PENTAVAL	0		0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-YF	0		0.004	0.004	0.004	0.004
SAFETY-BOX	0		0.006	0.006	0.006	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2016
DTP-HepB, 10 dose(s) per vial, LIQUID	10	
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1	1.927
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10	1.927
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2	1.927
HPV bivalent, 2 dose(s) per vial, LIQUID	2	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	0.900
Rotavirus, 2-dose schedule	1	2.550
Rotavirus, 3-dose schedule	1	3.500
AD-SYRINGE	0	0.047
RECONSTIT-SYRINGE-PENTAVAL	0	0.047
RECONSTIT-SYRINGE-YF	0	0.004
SAFETY-BOX	0	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	500,000$	
			<=	>
DTP-HepB	HEPBHIB	2.00 %		
DTP-HepB-Hib	HEPBHIB		23.80 %	6.00 %
Measles	MEASLES	14.00 %		
Meningogoccal	MENINACONJUGATE	10.20 %		
Pneumococcal (PCV10)	PNEUMO	3.00 %		
Pneumococcal (PCV13)	PNEUMO	6.00 %		
Rotavirus	ROTA	5.00 %		
Yellow Fever	YF	7.80 %		

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2011	2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	1,227,246	1,259,429	1,289,655	1,320,607	1,352,302	6,449,239
	Number of children to be vaccinated with the first dose	Table 4	#	1,227,586	1,234,240	1,263,861	1,294,194	1,325,255	6,345,136
	Number of children to be vaccinated with the third dose	Table 4	#	1,087,210	1,095,703	1,147,792	1,188,546	1,217,072	5,736,323
	Immunisation coverage with the third dose	Table 4	%	88.59 %	87.00 %	89.00 %	90.00 %	90.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.33	1.33	1.33	1.33	1.33	
	Vaccine stock on 1 January 2012		#	1,200,000					
	Number of doses per vial	Parameter	#		10	10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	Vaccine price per dose	Table 7.10.1	$		2.18	2.02	1.99	1.93	
cc	Country co-financing per dose	Co-financing table	$		0.20	0.20	0.20	0.20	
ca	AD syringe price per unit	Table 7.10.1	$		0.0465	0.0465	0.0465	0.0465	
cr	Reconstitution syringe price per unit	Table 7.10.1	$		0	0	0	0	
cs	Safety box price per unit	Table 7.10.1	$		0.0058	0.0058	0.0058	0.0058	
fv	Freight cost as % of vaccines value	Table 7.10.2	%		6.00 %	6.00 %	6.00 %	6.00 %	
fd	Freight cost as % of devices value	Parameter	%		10.00 %	10.00 %	10.00 %	10.00 %	

Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group	Low

	2011	2012	2013	2014	2015
Minimum co-financing	0.15	0.20	0.20	0.20	0.20
Recommended co-financing as per APR 2010			0.20	0.20	0.20
Your co-financing	0.15	0.20	0.20	0.20	0.20

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2012	2013	2014	2015
Number of vaccine doses	#	3,408,700	4,597,900	4,700,700	4,799,600
Number of AD syringes	#	4,117,400	4,241,500	4,343,300	4,447,500
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	45,725	47,100	48,225	49,375
Total value to be co-financed by GAVI	$	8,095,000	10,048,000	10,118,500	10,062,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2012	2013	2014	2015
Number of vaccine doses	#	322,700	474,500	493,500	519,200
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0

Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country	$	746,500	1,014,500	1,039,000	1,064,000

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	8.65 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,227,586	1,234,240	106,726	1,127,514
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B X C*	3,682,758	3,702,720	320,178	3,382,542
E	Estimated vaccine wastage factor	*Table 4*	1.33	1.33		
F	Number of doses needed including wastage	*D X E*	4,898,069	4,924,618	425,836	4,498,782
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		6,638	574	6,064
H	Stock on 1 January 2012	*Table 7.11.1*	1,200,000			
I	Total vaccine doses needed	*F + G – H*		3,731,256	322,645	3,408,611
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		4,117,388	0	4,117,388
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		45,704	0	45,704
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		8,141,601	704,012	7,437,589
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		191,459	0	191,459
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		266	0	266
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		488,497	42,241	446,256
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		19,173	0	19,173
T	Total fund needed	*(N+O+P+Q+R+S)*		8,840,996	746,252	8,094,744
U	Total country co-financing	*I x country co-financing per dose (cc)*		746,252		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		8.65 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.35 %			9.50 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,263,861	118,228	1,145,633	1,294,194	122,955	1,171,239
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	3,791,583	354,682	3,436,901	3,882,582	368,864	3,513,718
E	Estimated vaccine wastage factor	*Table 4*	1.33			1.33		
F	Number of doses needed including wastage	*D X E*	5,042,806	471,727	4,571,079	5,163,835	490,589	4,673,246
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	29,547	2,764	26,783	30,258	2,875	27,383
H	Stock on 1 January 2012	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	5,072,353	474,491	4,597,862	5,194,093	493,464	4,700,629
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	4,241,455	0	4,241,455	4,343,253	0	4,343,253
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	47,081	0	47,081	48,211	0	48,211
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	10,230,937	957,049	9,273,888	10,315,469	980,018	9,335,451
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	10,230,937	0	197,228	10,315,469	0	201,962
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	274	0	274	280	0	280
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	613,857	57,423	556,434	618,929	58,802	560,127
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	19,751	0	19,751	20,225	0	20,225
T	Total fund needed	*(N+O+P+Q+R+S)*	11,062,047	1,014,471	10,047,576	11,156,865	1,038,820	10,118,045
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,014,471			1,038,819		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.35 %			9.50 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 3)

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	9.76 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,325,255	129,358	1,195,897
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B X C*	3,975,765	388,073	3,587,692
E	Estimated vaccine wastage factor	*Table 4*	1.33		
F	Number of doses needed including wastage	*D X E*	5,287,768	516,137	4,771,631
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	30,984	3,025	27,959
H	Stock on 1 January 2012	*Table 7.11.1*			
I	Total vaccine doses needed	*F + G – H*	5,318,752	519,162	4,799,590
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	4,447,492	0	4,447,492
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	49,368	0	49,368
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	10,281,148	1,003,539	9,277,609
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	206,809	0	206,809
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	287	0	287
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	616,869	60,213	556,656
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	20,710	0	20,710
T	Total fund needed	*(N+O+P+Q+R+S)*	11,125,823	1,063,751	10,062,072
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,063,751		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.76 %		

8. Injection Safety Support (INS)

Afghanistan is not reporting on Injection Safety Support (INS) in 2012

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2011**. All countries are expected to report on:

   a. Progress achieved in 2011

   b. HSS implementation during January – April 2012 (interim reporting)

   c. Plans for 2013

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2011, or experienced other delays that limited implementation in 2011, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2011 fiscal year starts in January 2011 and ends in December 2011, HSS reports should be received by the GAVI Alliance before **15th May 2012**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2012, the HSS reports are expected by GAVI Alliance by September 2012.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved activities and budget (reprogramming) please explain these changes in this report (Table/Section 9.5, 9.6 and 9.7) and provide explanations for each change so that the IRC can approve the revised budget and activities.**Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval. The changes must have been discussed and documented in the HSCC minutes (or equivalent).**

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2011

   b. Minutes of the HSCC meeting in 2012 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2011 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

9.1. Report on the use of HSS funds in 2011 and request of a new tranche

9.1.1. Report on the use of HSS funds in **2011**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.

9.1.2. Please indicate if you are requesting a new tranche of funding **No**

If yes, please indicate the amount of funding requested: US$

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	6700000	8950000	7200000	6600000	4650000	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	2500000	10091209	8157346	10634411	11050232	
Total funds received from GAVI during the calendar year (*A*)	6699975	4594975	7318000	7977346	2999975	
Remaining funds (carry over) from previous year (*B*)		6556888	5544305	3316412	5114945	3464052
Total Funds available during the calendar year (*C=A+B*)	6699975	11151863	12862305	11293758	8114920	
Total expenditure during the calendar year (*D*)	143087	5607558	9545893	6178813	7650867	
Balance carried forward to next calendar year (*E=C-D*)	6556888	5544305	3316412	5114945	3464052	
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	335000000	447500000	374400000	320100000	218550000	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	125000000	504560450	424181992	515768933	519360904	
Total funds received from GAVI during the calendar year (*A*)						

Remaining funds (carry over) from previous year (*B*)						
Total Funds available during the calendar year (*C=A+B*)						
Total expenditure during the calendar year (*D*)	7211256	290077528	465476843	283706371	224678757	
Balance carried forward to next calendar year (*E=C-D*)						
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

Report of Exchange Rate Fluctuation

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January	50.3977	51.7298	48.762	45.916	48.309	
Closing on 31 December						

Detailed expenditure of HSS funds during the 2011 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2011 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number:)**

If any expenditures for the January April 2012 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number:)**

Financial management of HSS funds

Briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the HSCC in this process.

The financialmanagement of the HSS funds follows the similar financial procedures asother donors such as World Bank, Global Fund, Government of Afghanistan, andUSAID. All developmental budgets currently being channeled through Ministry ofFinance. First of all work plans are made at the departmental level and followthe normal procedures for approval. This includes approval from the donors; incase of GAVI-HSS, the approval is being received from the the HSS-SC. Later on allof the departments' plans are shared with The Finance Directorate of The MoPH.According to Chart of Accounts of The Ministry of Finance; the developmentbudget unit of finance directorate categorizes the expenditures and all relevant forms are being completed. At thisstage the finance directorate makes requests for allotments of required budgeton the basis of approved work-plans received the various departments of the MoPH from The Ministry of Finance. The requests ofallotments are signed by the finance director and the leadership of MOPH. Oncethe allotments are approved the relevant departments areaccountable for the implementation of the approved work plans. In order tostart the implementation of the work plans by the relevant department, onceagain the approval obtains from the leadership of MoPH. In case the activities reflected in theworkplans are complemented or adjustments are needed to request more funds ,the leadership of MoPH (The Ministers or Deputy Ministers) approve it and forward it to FinanceDirectorate of MoPH for processing. Inorder to ensure transparency and , the head of departments are signing accountability the relevantfinancial documents and once again the signatures of the leadership of MoPH areobtained. The documents are being sent to the teams controllers seconded by theMinistry of Finance to The Ministry of Public Health for further scrutiny inorder to make sure that the documents are properly processed in accordance tothe defined rules and regulations; Once the relevant documents are beingcleared up by the team of controllers , the controllers singed the relevantdocuments and forward them to Ministry of Finance.

At the provinciallevel, once the financial allotments arereceived , the provincial health officesliquidate the budgets in line with the approved rule and regulations of AfghanGovernment under the oversight of Mustufiates, (The Ministry Financial set upat provincial level) the provincial Ministry of Finance structures). It is worth mentioning that the HSS is theonly source which transfers the funds to all 34 provinces. The rest of MOPHdevelopment budget is either sent through a parallel structure, or not sent tothe provinces.

The HSS fundsare fully reflected in the national health plan according to the agreedframework of HSS proposal. The accounts where the HSS funds are kept, are theGovernment current accounts and no commercial bank account is used, therefore,no interests are generated. This is the case for all health sector donors inAfghanistan who uses Government channels.

Financialreporting system is is user friendly at central level. At provinciallevel, the financial reports are provided by the Ministry of FinanceMustufiates. On one hand, there is limited capacity in most of MOPHprovincial offices and on the other hand, the same is with most of Mutufiates.Experiences in the past years show that by approaching the new fiscal year which coincides with the 20th of March, The Mustufiates provide mixed reports which putsup the MOPH to a challenge. Clearing up the financial accounts takes two to three more months atprovincial level and this can cause slight changes in the financial statementsprovided because the statements are provided by 15th of May while clearing up all the relevant accounts with provinciallevel reaches normally at the end Juneevery year. In some instances, the other donor’s money comes to the account orvice versa which requires more time to fix the problem.

It looks thatthis problem may resolve over the passage of years while the system getsmatured enough. Although there were some suggestions appreciated by MOPH totransfer the funds through a commercial bank and a letter was provided by GAVIto support this suggestion. But after consultation and thoroughly studying theissue, it was found that it might create room for corruption because theGovernment procedures although very complicated and bureaucratic, are good toprevent corruption. That is why MOPH never used this mechanism for HSS funds.

The ICC does notplay any major role in the management of HSS funds since there is theHSS-Steering Committee involved in the process of approval of HSS plans,allocation of funds, modifications of budget, and recommendations forprocurement decisions and so on. The HSS steering committee consists of USAID,EU, WB, WHO, UNICEF, MOF, CSOs and MOPH representatives. This committee is setof the key partners of the Consultative Group for Health and Nutrition which isthe high level health sector coordination forum. The support of this committeehas been tremendously important and instrumental in implementation of HSS fundsto date.

Has an external audit been conducted? Yes

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number:)

9.2. Progress on HSS activities in the 2011 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2011 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2011**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Objective 1: Improved access to quality health car			
Activity 1.1-1.2: Establishing Sub-Centers and d	• Continuation of SHC&MHTs project contract management for the year of 2011 • Provide technical support to the implementers based on SHC and MHT concept note and receipt, analysis, and provision of feedback , and channeling the fund to implementing organization (NGOs) • Archive of the documents in regards to contract management including, budget revisions and contracts amendments • External Evaluation of MHT project evaluation by UNICFE fund through IIHMR and ACTD Consulting research organizations • Procurement of External Audit for audit of GAVI-HSS program and C-IMCI second project • Preparation for proper close out and hand over of SHC&MHT projects to other BPHS grants financed by EU,USAID, and WB	100	Grant and Contract Management Department based on NGOs quarterly reports, HMIS and MHT evaluation report. (100% for SC and MHTs continuation means that they are established and functioning but also need continuation)

Activity 1,3:Expanding integrated management of ch	• Monitor the implementation of the C-IMCI project , conducting training site visits , baseline survey and monitor CHWs' C-IMCI training. • Make preparation to start up the 2nd round of C-IMCI project • Provide technical assistance to the implementers. • Review the progress of narrative reports on quarterly basis and provide feedback to implementers through MOPH official channels or face to face meetings • Preparation for evaluation and close out the project "Which Project?.	89	• IMCI department of Child and adolescent directorate of MoPH reports • NGOs quarterly reports, • Monitoring Reports,
Activity 1,4: Develop an in-service training progr	• Project's closure report will be compiled as part of overall HSS report		
Objective 2: Increased Demand for and Utilization			
Activity 2.1: Implementing a nationwide Informati	• Develop Health promotion policy and strategy • Establishment of telecommunication information center (health information via cell phone) • Broadcasting key IEC messages through media • Follow ups with Ministry of Education and relevant partners related to IEC activities in schools • Conduct IEC / BCC and IPCC workshops • Production of Radio and TV spots • Supply and distribution of IEC materials		Health Promotion Department reports
Activity 2.2: Pilot a model of demand side finan	• Monitor the process of end of project survey. • Assist implementing NGOs to conduct GAVI supported end of project's surveys, data collection, analysis and final report of the project and Monitor the process of end line survey. • Conduct end of project household survey, as part of the internal project evaluation • Dissemination of the final reports and sharing program recommendations to MOPH and Key stakeholders • Collaborate with key stakeholders including HS20/20 in conducting a qualitative study to document the findings, conclusions and recommendations. • Smooth close out of the project	100	- Health Economic and Financing Department reports - End line survey report - Final report of the project

Objective 3: Improve the ability of the MOPH, at a			
Activity 3.1: Up-grade the physical, information /	• Conduct household survey to measure the progress made with regard to GAVI/HHS and MoPH's Programm's key indicators • Make sure that BPHS and EPHS Strategic interventions are timely and properly monitored • Improve the use of NMC at provincial level • Training of DHOs in NMC Data base. • Generate and compile all evidences relevant to HSS interventions for program and policy practices s • Provide support to relevant department's MOPH at central and provincial levels particularly to fulfill its stewardship act		M&E directorate reports - NMC data base
Activity 3.2: Launch a community demographic surv	Not applicable		
Activity 3.3: Expanding capacity building program	• Monitor the implementation of the QPHC round 2ndproject. • Provide technical assistance to GAVI supported Project implementers .Review the progress of narrative reports on quarterly basis and provide feedback to implementers (written or face to face) • Explore new initiatives Evaluation and final report of the project	60	- Afghan National Public Health Institute / Training department reports - NGO quarterly Reports, and monitoring reports
Activity 3.4: Developing a communications and inte	• Arranging press related trips in order t o reflect success stories of MoPH • Organizing PR Conferences • Conducting PR Trainings for MoPH Program Managers • Provide support Publication made on monthly basis in MoPH • Support developing documentary films		Public Relation department reports

Activity 3.5: Launching an initial cadre of Distri	• Provide assistance to Launch DHO Initiative - Assist to conduct supportive supervision of DPHO Initiative. - Assist in developing mental health, health care improvement, and CDC guidelines to for train DPHOs. - Preparation for conduction of national district health coordination workshop - Follow up of DHO Initiative evaluation with the relevant partners - Make follow up of District Delivery Program of Independent Directorate of Local Governance of Afghanistan for the payment of hazard allowance for those DHOs who are working in very remote and in secure districts.	90	- District Health System Strengthening department of MoPH, - DPHOs third party evaluation report

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
Improved access to quality health care particularl	
	• 120 out of 121 SHCs and 26 MHTs have been actively operating during the reporting period. The project contracted to 8 national, 7 international NGOs in 24 provinces of Afghanistan while 8 SHCs and 4 MHTs are managed by strengthening mechanism of MoPH in the 5 provinces; providing health services to population of 1,123,513. The services include Maternal and Newborn Care, Child Health Care and Immunization, Assessment of Nutrition and Treatment and Control of Communicable Diseases in accordance to country's basic package of health services policy. Last year one SHC was integrated within USAID BPHS supported PCH grant in Ghazni province (The facility has been upgraded to a Basic Health Center). On first of November 2011 following bidding process in European Union supported provinces of Ghor under PGC grant, the former BPHS implementer (CHA) has been replaced and new BPHS implementers (ACTD) took over, GAVI supported 11 SHC and 1MHT has been handed over to ACTD under the same agreed term and conditions . During reporting period in the GAVI-HSS supported health facilities in total there are 1,330,549 OPD (on average of 32 consultation per clinic per day) conducted , in total 18,281 Penta3and 23,817 TT2+ vaccines were administered. In addition, there are 4,429 deliveries, 3 1,416 ANC visits and 14,936 PNC visits and 28,764 FP clients received services. 54% of sub centers and mobile health facilities have been staffed with at least one female health worker. • Assisting (NGOs) implementing the SHCs & MHTs to provide regular feedback with regard to their progress reports, review and analysis of HMIS data and findings of monitoring missions in order to take remedial action and take programmatic decisions through various mechanisms including arranging coordination meeting, face to face and soft communication; as well as assisting them in proper contract management • All procurement documents, correspondence, minutes of the meetings, feedbacks, budget revisions, contracts amendments,

Activity1.1-1.2 :Establishing Sub-Centers and D	project close out instruction notice and instructions, for the inventory of the assets and hand over phase and other important documents are archived in hard and soft versions and regular backup of the data are obtained. • The results of mobile health team evaluation presented a wonderful picture of service delivery in far remote areas of the country. In other words the evidences found during the evaluation have been very impressive resulted in proving effectiveness of this intervention. Therefore it has been recommended to continue this intervention with the support of all donors. • Preventive focused nature of services provided by MHT is the most robust public health practice. MHT made it possible to provide life saving health care services to the most marginalized and vulnerable pockets of people in very far flung areas in Afghanistan. Most of MHTs are staffed with qualified doctors or female healt workers that are added initiative in Afghanistan. This contribute to equity in service provision. (MHT evaluation report, Annex 5) • GCMU as prime procurement body of MoPH for consultancy services completed the procurement of C-IMCI project under open call for bidding process for northeast zone covering provinces of Baghlan, Ghazni, Paktika, Khost, and signed the contract with MMRCA in partnership with ACTD and for Southeast zone covering the provinces of Kundoz, Badakhshan, Paktya, Takhar and signed the contract with HNTPO in partnership with HADAAF and AADA. • Negotiations with EU reached to a meaningful end resulting absorbing all 43 SHCs and 7 MHTs by related BPHS implementers in provinces under the EU coverage for health services. However, the fate of 72 facilities in USAID supported provinces are under discussion and MoPH advocates for their inclusion under the current PCH grant in 13 USAID supported provinces. Recently as per the requirements of USAID a group comprised of representatives grant management and finance units finalized their report and sent to USAID for perusal indicating that GAVI funded sub centers are in high priority areas. The six mobile health team contracts in World Bank supported provinces-PPA have also been communicated with related section in GCMU to be proposed for further discussions and their inclusion in SHARP contracts. The six contracts will be for a period 6-12 months until absorbed under WB grants.

Activity 1.3: Expanding integrated management of c	• In the first round of C-IMCI project, it was planned to train 9225 CHWs and CHSs for the duration of three years. But at the end of project (14/02/2012) totally 8245 (89.3%) including 4020 female and 3826 male CHW and 38 female and 361 male CHSs were trained in both module of ARI and treatment of Diarrheal diseases. The reasons why the target has not been met 100% by the implementer NGOs vary from region to region, however, commonly it was the insecurity and drop out of CHWs. • The second project of C-IMCI focusing on northeast and southeast zones covering 8 provinces was announced twice since less than threshold qualified consulting organizations was short listed. Considering the geographical difficulties of 8 provinces located in two different zones, MOPH recognized that, CIMIC training needs to be re-announced under two lots to find qualified interested consulting organizations. This approaches enabled the organizations to properly design the project plan and schedule a feasible implementation plan, therefore by splitting in two lost, enough number of applications were received. Meanwhile the focal point of C-IMIC joined other organization and project remained without technical support for a while until he was replaced. Finally the procurement of C-IMCI project under open call for bidding process was completed on 1 March 2012 in two zone division: for northeast zone covering provinces of Baghlan, Ghazni, Paktika, Khost, and the contract signed with MMRCA in partnership with ACTD and for Southeast zone covering the provinces of Kundoz, Badakhshan, Paktya, Takhar signed with HNTPO in partnership with HADAF and AADA. Through these contracts, 4991 CHWs and CHSs will receive the CIMCI trainings. • The monitoring teams form MoPH visited C-IMCI ongoing training sessions in Jawzjan, Kapisa, Panjshir, Badghees, Daikundi, Paktia, Herat, Parwan, Laghman, Nangarhar, Kunar, Nooristan, Samangan, Balkh, Faryab and Sarepul provinces , meanwhile 30 CHWs during their daily work in the health posts were monitored. (M&E dept. monitoring reports). • The implementing NGOs have received regular technical assistance and guidance on the basis of request or reviewing quarterly reports and recommendations of monitoring missions. Face to face, meetings have also been arranged with NGOs whenever needed • NGOs reported their activities using the standard activity-reporting format on quarterly basis which is followed by the reviewing the process and provision of feedbacks to NGOs through email and face to face meeting. • Contract expiration notice sent to the NGOs to prepare for properly close out of the projects and hand over of the assets to MoPH.
Activity 1.4:Develop an in-service training progra	NA
Objective 2: Increased demand for and utilization	

Activity 2.1: Implementing a nationwide Informat	• The health promotion policy and strategy was not developed due to lack of technical assistance within MoPH in year 2011. The USAID funded project,; the Health Service Support Project (HSSP) as result of coordinating the activities had agreed to provide the TA from their own fund and from GAVI funds to support translation and printing of the policy. As a result of HSS problems, this activity will be accomplished in the year 2012. • Since this is a new initiative in the country, and needed number of meetings and consultations with the relevant stakeholders especially with Ministry of Information Technology (MoIT) and lack of capacity with MoIT and Health Promotion Department of MoPH, the development of the design and establishment of this call center postponed for 2012. • Given the tedious procurement procedures, the contract was signed at end of the year with 4 TV and five Radio channels. The broadcasting is being started at the beginning of 2012. Which contains, 178 minutes of TV and 1487of Radio health messages mainly focusing on Maternal and child health. • Since the child and adolescent department of MoPH is working closely with Ministry of Education, based on the decision made by the leadership of MOPH this activity become an integral part of the child and adolescent health department. • 3 separate capacity building IPCC workshops for 150 staff working in central and provincial hospital, teachers of GAZANFAR institute of health science were conducted. • The procurement process of this activity started at end of third quarter of year, since none of the production companies met the requirements it was decided by the procurement committee to be re announce in 2012. • Based on NGOs requests and through HP department, totally 358,259 posters and 281,763 brochures distributed to health facilities all over the country. • IEC packages (banner, invitation card, posters for different events, ROGHTIA magazine, Newsletter, Certificates, Calendars and Report for the MoPH designed during the reporting period.
	The DSF project was piloted in sixteen districts of four provinces of Badakhshan, Kapisa, Faryab, and Wardak from December 2008 to May 2011 by HOPE worldwide. The aim of the project was to assess the impact of providing incentive to improve maternal and immunization services. It was a quasi-experimental study with four arms 1) Providing Incentive to families to utilize maternal health and vaccination; families were given $6 for each delivery at a public health facility and $3 for bringing a child to the health facility for DPT3 vaccination. 2) Providing incentive to community health workers; $3 for the referral of a pregnant woman in order to promote institutional delivery at the public health facilities as well as referral of a child to receive DPT3 vaccination. 3) In the combined arm, both household and CHWs are provided incentive and 4) in the control arm, no incentive were provided. • MoPH monitored almost all the process of end of project's survey at the field level, although the end line survey was conducted by the implementing agency, HWW, but the technical assistance was provided by Health Systems 20/20, USAID funded health strengthening project focusing more on designing survey methods, developing instrument, and analyzing findings. • According to the end of project survey the findings suggest that cash incentive is an effective mechanism to increase demand. However, progress varied from districts to districts. For example: □ Based on descriptive analysis comparing baseline and end-line surveys, Kapisa reported the highest change in percentage of women who delivered at a health care facility followed by Wardak. □ Increase in the percentage of children immunized for DPT3 was greater in Kapisa than other provinces – followed by intervention districts in Badakhshan. □ Across the three intervention arms that provided monetary

Pilot a model of demand side financing (DSF).	incentives , uptake of CCT for both institutional delivery and DPT3 were highest among women who were between the ages of 20 – 30, who have some level of education, and who lived closer to a health care facility.
	  Differences were not observed among women of different ethnic groups and among those who resided in larger or smaller households
	  Women who were in the middle and upper quintiles of wealth were more likely to deliver at a health care facility compare to women who were in the lower wealth quintiles (OR: 2.4 p<0.04).
	  Women who had a history of delivering at a health care facility were significantly more likely to participate in the cash incentive program compare to women who previously delivered at home (OR: 3.2 p<0.01) .
	The findings suggest that more can be done to reach women who have never delivered at a health facility and to communicate the program to the disadvantaged women.
	Conclusion: Cash incentives – when provided to both community health workers and households, are associated with an increase in institutional delivery and DPT3 vaccination.
	Recommendations: In future, points that should be taken into account during design and implementation:
	• Varying incentive amounts to account for transportation
	• Supply side factors such as number of female health service providers, quality of care, hours of operation, availability of drugs and supplies affect demand for services
	• Some differences among provinces that are contracted-in vs. contacted out
	• Security (DSF end of project report Annex 6)
	• The final report approval from formal and informal channels shared with the relevant department of MoPH and key stakeholders
	
	• Health systems 20/20 (USAID funded project) provided technical assistance in designing survey methods, developing instrument, and analyzing findings further to that conducting qualitative assessment with HEFD team.
	
	• The inventory lists have already been submitted to MoPH and the project will be closed formally following CCT presentation was made to CGHN on 25th April, 2012.

Objective 3: Improve the ability of the MOPH at v	

Activity 3.1: Up-grade the physical, information /	• Since Jonhs Hopkin's University (JHU) is planning to conduct Household survey in 2012, in order to avoid duplication and save resources, negotiation is going on with JHU to incorporate GAVI HSS indicators in their survey which will be conducted in June 2012. • During the reporting period, 47% of the provinces monitored once in each quarter and only one province due to insecurity and unavailability of air transportation facility was not monitored at all during reporting period. Staff of 80% of provinces trained to use National Monitoring Checklist (NMC) for monitoring purpose. The PHO staff of remaining provinces (Helmand, Uruzgan, Nuristan, Zabul, Paktika and Daikundi) did not receive training on NMC due to volatile security or shortage of enough staff at PHO; therefore the staff could not conduct monitoring visit to health facilities using NMC. The M&E officers during their visits to the provinces trained 2 PPHO staff on how to use NMC data base. This was exercised in 60% visited provinces. • The Balance Score Card (BSC), NMC and partly HMIS data is compiled. The Afghanistan house hold survey is underway, once the results are compiled, the findings will be disseminated. In addition, it is necessary to document the effectiveness of GAVI HSS support which is planned in the year 2012. • Minimal support was provided to central level, however, for the provinces, already mentioned above.
Activity 3.2:Launch a community demographic survei	N/A

Activity 3.3: Expanding capacity building program	The second round of the QPHMC project contracted through an open bidding with the winner NGO. The related assets from the former project were handed over to the new winner NGO; the process of hand over took place congruent with the availing rules and regulations by APHI/MoPH. This project initially agreed duration was from 1st May 2011- 30th April 2012, however, because of heavy winter and several health emergencies, since there was the need to have the provincial offices staff to be on service rather in trainings, based on MoPH leadership decision, the project received a no cost extension till 15 June 2012. The QPHMC round 2nd project objective is to strengthening the capacity of provincial health officers in fundamentals of leadership, principles of management, disaster management, proposal and report writing skills. According to the original plan , 266 PHO staff were planned to receive training in 34 provinces. Out of 266 trainee , 167 PHOs from 24 provinces was planned to be trained in all five modules while 99 PHOs from 10 European Union supported provinces will be trained in three modules (Fundamental /basic leader ship, Basic Management, Proposal writing ,Disaster Management ,Report writing). During the reporting period in total there are 40 people trained in 5 modules, 25 people trained in 4 modules, 40 people trained in 3 modules, 74 people trained in 2 modules and 168 people trained in one module. So far 701 out of 1231Provincial Health officers and District Health Officers received training on the training package. • In total there have been 4 monitoring visits conducted to monitor the trainings conducted in Kabul training center of implementing NGO. The overall management and the quality of training were found satisfactory, only lower % of participation by some Provincial Health Officers during the training have been reported. The issue was discussed with relevant the APHI and Provincial Liaison Department of MoPH to discuss the issue with provincial health director in order to resolve the issue. • Technical assistance provided on due time the implementing NGOs on the basis of their request , recommendation of monitoring missions and reviewing the technical reports. • The implementing NGO quarterly technical report has been regularly reviewed and regular feedback provided to them. • No initiatives explored, however, the capacity program also started for MoPH central level. In two rounds all provinces were covered. Based on TNA and criteria, the HSS-SC, recommended a group of 23 people to different courses of institution based or distance. • Since the close out phase of the project has been delayed till mid June 2012 and final project report and close- out will be reflected in the next APR.

Activity 3.4:Developing a communications and inter	• Press Travels for reflecting MoPH's Success Stories conducted in three provinces of Parwan , Kandahar and Khost . The objectives of these press travels were to oversee of health situation, the outbreak of Cholera disease and inauguration of District Hospital and Midwives Graduation Ceremony. • Over 130 Press conferences launched during reporting period. The press conferences covered different health events such as International and National Health Days, Contracts & MoUs signing and etc, and more than 420 Press and NEWS Releases, and Statement in Dari, Pashto and English were developed and also sent to the National and International media outlets for broadcasting. • The PR trainings were not conducted during this reporting period , since PR Staff happened to get caught up with lots of inevitable PR related activities. • The MoPH Four issue of Newsletter were published, each issues each contains 20 pages in Dari, Pashto and English languages reflecting important e events. Printing of advertising papers, (envelope, folder, calendar, and Dairy) were completed and distributed to different department of MoPH, The process of Year Calendar Designing was completed. • The production of documentary on vaccination, midwifery education program and mobile teams is still under procurement process. Although the procurement process started at the beginning of the year but due to lengthy procurement procedures in the MoPH, the contract has not been signed yet and the production has not started yet, therefore this activity is shifted in the year 2012.

Activity 3.5: Launching an initial cadre of Distr	1. Supportive supervision of 58 DHOs in 12 provinces were conducted during the reporting period. 2. Mental health, and health care improvement, guidelines are being distributed to DPHO in addition, CDC guidelines are under process of development which will be distributed later. 3. The coordination workshop for DPHOs was not conducted. Preparation to conduct district health coordination workshop completed. This workshop will be attended by PHDs and focal points of DPHO and other health sector partners to improve coordination at district level. 4. 34 DPHOs in north and north east regions trained on disability component of BPHS with the support from EU funds. 5. 152 DHOs are planned to receive training on four public health modules in second phase of QPHMC supported by GAVI –HSS. 6. DPHO Pilot Project funded by GAVI-HSS evaluated by third party (HPRO) with the financial support of USAID (tech-serve) in year 2011. The results of this evaluation recommended that this was an excellent initiative that GAVI funded within the health system of Afghanistan. Below are the findings of evaluation: • DPHO is a representative of the MoPHA bridge between the district and the province. • DPHO is a problem-solver; Able to see gaps in service provision and work with the stakeholders try to solve problems. • DPHO is a co-coordinator; Due to their attendance at health meetings and non-health sector meetings they are able to have a good relationship with all the key people in the district. • DPHO is a monitor; their presence ensures the health facilities and NGOs perform better and also reassures the community that the NGOs are performing well. It is worth mentioning that the DPHOs made positive impacts within their working districts and specific examples were given to show how they do this. Specifically the DPHOs impact on the services delivery at the district level are; • Improving the performance of clinics such as opening times and coverage of vaccine programs. • Monitoring environmental health such as promotion of used of clean water in the district, or monitoring shops and restaurants • Coordinating activity such as the building of a new health clinic • Monitoring private clinics and removing expired drugs These above mentioned points were directly link with the DPHOs performance which ultimately improved access, efficiency and quality of health services, as compared to the districts without -DHOs s. The finding of third party evaluation recommended that DHO initiative should be extended to other districts as well.. (for details please refer to DHO evaluation report annex (Annex 7) 7. District Delivery Program of Independent Directorate of Local Governance of Afghanistan has agreed to pay hazard allowance for 15 DPHOs who are working in very remote and insecure districts. 8. Based on this successful experience , 100 more DPHOs are added from the Government sources to the structure of DPHOs and plans are to cover all districts.

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Most of the activities were conducted as planned. The over 47 sub centers and 7 MHTs which wereplanned to be handed over to EU funded provinces, were handed over before theschedule because the EU generously agreed to take over GAVI-HSS funded subcenters based on their contract out plan with NGOs. The amounts planned weresaved. On the other, hand USAID did nottake over the HFs as planned and therefore, and extension is made under thosecontracts (72 Sub centers and over 5 MHTs). There were delays in C-IMCIcontracts because it was announced twice and in the first round qualifiedprovider could not be identified. Therefore, the contract will go for almostanother year. IEC activities were carried out as planned, however, someactivities were moved without changes to 2012. The DSF project completed,however, the last payment to NGO was not made because until final approval ofthe report and hand over of assets to MoPH , therefore, the payment is plannedfor the year 2012. The same is for in-service training program for BPHSimplementers. The planned household survey was cancelled because the WB isgoing to fund an household survey, therefore, it was coordinated to cover allaspects including some uncovered HSS indicators. The fund was shifted to otherM&E activities to 2102 including a thorough review of the effectiveness ofHSS support to Afghanistan.

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

Efforts are made to deny payment of irrelevantto HSS staff of MoPH. In Afghanistan, all other donors and technical partnersin a way contribute to payment of some MoPH essential staff. These include butnot limited to USAID, EU, WB, WHO, UNICEF, UNFPA, Global Fund and so on. From GAVI funds, one procurement officer, twoHR advisors, one legal advisor, and few staff of MoPH minister have been paid. The procurement has been challenge the personpaid works for all donors and Gov funds, the HR advisors work for MoPH and areleading the reform process which will significantly impact the all MoPHprograms, legal advisor checks all the contracts and MoUs signed with NGOsincluding GAVI funded contracts with NGOs. Only a group of six staff who arecleaners and guards of new MoPH Minister are paid with a small amount. It is worth mentioning that the payments toall this group are ceased and efforts are made to pay the HR advisors from WBwhich is already communicated (WB already pays 4 HR advisor) , legal advisorfrom some other source (maybe through Gov channel). Six staff of HE MoPHMinister will remain on the payroll until end 2012. The rest of HE staff arepaid from other sources such as WB or USAID. All these issues have been verytransparently decided by the HSS-SC.

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2010 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2011 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2007	2008	2009	2010	2011		
Objective 1 (Outcome)											
1.1: To increase National DTP3 coverage for the ch	77%	JFR/EPI ?	90%(2012)	87%	77%	85%	83%	87%	89%	JFR/EPI	
1.2: To increase the number/percent of districts a	49%	JFR/EPI ?	100% (2012)	58%	49%	58%	56%	58%	57%	JFR/EPI	Number of insecure districts increasing
1.3 To reduce under five mortality rate from 210/1	191/1000 live birth	AHS 2006	153/ 1000 (2012)	161/1000 LB	191/1000 live birth	191/1000 live birth	161/1000 LB	161/1000 LB	97	AMS	The target for 2012 was 153 but now it reached 97
1.4 To increase National Measles coverage (% of ch	68%	JFR/EPI	90%	79%	68%	75%	76%	79%	82%	JFR/EPI	
1.5 To increase skill birth attendance (% of deliv	19%	AHS/HHS	40% (2012)	35%	19%	30%	32%	35%	45 %	HMIS (AMS 2010 indicates a % of 34 for SBA)	

1.6 To increase treatment of diarrhea and ARI at c	30%	HMIS/IMCI	30% (2012)	34%	30%	30%	32%	34%	73%	HMIS	Significant increase. It might be attributed to GAVI support to community IMCI program which covered 25 out of 34 provinces
Objective 2: (Output)											
2.1: To increase contacts per person per year with	0.6%	HMIS	1 (2012)	1.3	0.6%	1.06%	1.16	1.3	1.5	HMIS	
2.2: To increase average number of persons referre	14.8	HMIS	20/ quarter 2012 achieve	22	14.8	24	20	22	23.3		
2.3: Provider knowledge score	67.8%	BSC	90% (2012)	70.6%	67.8%	82.7%	Not Measu red	70.6%	2011 Survey is under proces		
2.4: To increase the % of mothers in rural communi	?	AHS/HHS	40% (2012)	TBD	Not measu red	TBD	TBD	TBD	Not availab le (is include d in 2012 JHU survey)		Planned in 2012 survey
2.5: To increase % of CHWs trained in community IM	2%	HMIS/IMCI	80% (2012)	34.3%	56%	28%	20.3%	34.3%	56%		
2.6: To increase the % of provinces receiving moni	29%	M&E.Dep	100% (2012)	56.5%	47%	33%	47%	56.5%	47%	NMC data base	The Monitoring % has decreased. Mostly this is linked with security situation in provinces. However, all 34 provinces have been monitored but this % indicates only those provinces which are regularly monitored once per quarter

9.4. Programme implementation in 2011

9.4.1. Please provide a narrative on major accomplishments in 2011, especially impacts on health service programs, notably the organization program

TheGAVI – HSS funds as envisaged in the GAVI guidelines and reported in theprevious APRs have been indeed catalytic and instrumental for the health systemof Afghanistan.

A. Management

1. Six HSSsteering committee meetings were conducted during reporting period. The HealthSystem Strengthening Steering committee (HSS-SC) with the presence of key CGHNmembers within the health sector of Afghanistan is actively supporting thehealth sector for successful implementation of global health initiativesrelated to HSS especially the GAVI support. The HSS-SC as coordination andmonitoring body for HSS program is comprised of three MOPH voting members (keydepartments), representatives of UNICEF, WHO, World Bank, European Commission,USAID, Civil Society Organizations interim representative and Ministry ofFinance.

2.The bottom up annual plan of action (form 11 MOPH departments) was developed,approved by HSS-SC

and accepted by MoF.

3. GAVIsupport type B bridging endorsed and implementation started. Two new provinceswith lowest Penta 3 coverage included.

4.HSS components of Global Fund R8 funded projects are being implemented.

5.Timely support has been given to implementing departments of MOPH for planning,implementation and monitoring of the activities

6.The GF R10 proposals approved and after over one year, financial agreement was signed on March 2012.

7.Extension of CSO type A under a new proposal was endorsed by GAVI andimplementation initiated.

B. Improved access to quality health care:

B.1: Establishment of sub centres and Mobile Health teams in remote andunderserved areas of the country**:**

Activities wererunning smoothly as planned. 120 out of 121 SHCs and 26 MHTs have been activelyoperating during the reporting period by 8 national, 7 international NGOsin 24 provinces of Afghanistan while 8SHCs and 4 MHTs were managed by strengthening mechanism of MoPH in the 5 provinces; providing health services to population of 1,123,513.The services include Maternal and NewbornCare, Child Health Care and Immunization, Assessment of Nutrition andTreatment and Control of Communicable Diseases in accordance to country's basicpackage of health services policy.

During reporting period in theGAVI-HSS supported health facilities intotal there are 1,330,549 OPD (on average of 32 consultationper clinic per day) conducted , in total18,281 Penta3and 23,817 TT2+ vaccines were administered. In addition, there are4,429 deliveries, 3 1,416 ANC visits and 14,936 PNC visits and 28,764 FPclients received services. 54% of sub centers and mobile health facilities havebeen staffed with at least one female health worker.

The results of mobile health team evaluation presented awonderful picture of service delivery in far remote areas of the country. In other words the evidences found during theevaluation have been very impressive resulted in proving effectiveness of thisintervention. Therefore it has been recommended to continue this interventionwith the support of all donors. Preventive focused nature of services providedby MHT is the most robust public health practice. MHT made it possible toprovide life saving health care services to the most marginalized andvulnerable pockets of people in very far flung areas in Afghanistan. Most ofMHTs are staffed with qualified doctors or female health workers that are addedinitiative in Afghanistan. This contributes to equity in service provision. (MHT evaluation report)

GCMU as prime procurement body ofMoPH for consultancy services completed the procurement of C-IMCI project underopen call for bidding process for northeast zone covering provinces of Baghlan, Ghazni, Paktika, Khost, and signedthe contract with MMRCA in partnership with ACTD and for Southeast zone covering the provincesof Kundoz, Badakhshan, Paktya, Takharand signed the contract with HNTPO in partnership with HADAAF and AADA.

Negotiations with EU reached to ameaningful end resulting absorbing all 43 SHCs and 7 MHTs by related BPHSimplementers in provinces under the EU coverage for health services. However,the fate of 72 facilities in USAID supported provinces are under discussion andMoPH advocates for their inclusion under the current PCH grant in 13 USAIDsupported provinces. The six mobile health team contracts in World Banksupported provinces-PPA will be absorbed by WB.

B.2: Implementation of community basedIntegrated – Management of Childhood Illnesses:

Inthe first round of C-IMCI project, it was planned to train 9225 CHWs and CHSs forthe duration of three years. But at theend of project (14/02/2012) totally **8245** (89.3%) including 4020 female and 3826 male CHW and 38 femaleand 361 male CHSs were trained. Thereasons why the target has not been met 100% by the implementer NGOs vary fromregion to region, however, commonly it was the insecurity and drop out of CHWs.

The second project of C-IMCI focusing on northeast andsoutheast zones covering 8 provinces was sucessfuly contracted are in the inititalstages of implementation. For northeast zone covering provinces of Baghlan, Ghazni, Paktika, Khost, and thecontract signed with MMRCA inpartnership with ACTD and for Southeastzone covering the provinces of Kundoz, Badakhshan, Paktya, Takhar signed withHNTPO in partnership with HADAF and AADA. Through these contracts, 4991 CHWsand CHSs will receive the CIMCI

trainings.

The monitoring teams form MoPH visited C-IMCI ongoing training sessions in Jawzjan, Kapisa, Panjshir, Badghees,Daikundi, Paktia, Herat, Parwan, Laghman, Nangarhar, Kunar, Nooristan,Samangan, Balkh, Faryab and Sarepul provinces , meanwhile 30 CHWs during their daily work in the health posts were monitored. (M&E dept. monitoringreports). The projects are running smoothly and not major problem have beenencountered.

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

As reported last year, this activity is handed over toUSAID. Only the last payment is pending.

C. Increases demand for and utilization of health care services

HP policy and strategy anddesigning a m-health is postponed to the year 2012.Given the tediousprocurement procedures, the contract was signed at end of the year with 4 TVand five Radio channels. The broadcasting is being started at the beginning of2012. Which contains, 178 minutes of TV and 1487of Radio health messages mainlyfocusing on Maternal and child health. IECactivities are well coordinated with others.

3 separate capacity building IPCCworkshops for 150 staff working in central and provincial hospital, teachers ofGAZANFAR institute of health science were conducted. Based on NGOs requests and through HPdepartment, totally 358,259 posters and 281,763 brochures distributed to healthfacilities all over the country. Inaddition, IEC packages (banner, invitation card, posters for different events,ROGHTIA magazine, Newsletter, Certificates, Calendars and Report for the MoPHdesigned during the reporting period.

C.2: Pilot the effectiveness of a model of demand sidefinancing and Provide monetary performance incentives to Community HealthWorkers:

The DSF project was piloted insixteen districts of four provinces of Badakhshan, Kapisa, Faryab, and Wardakfrom December 2008 to May 2011 by HOPE worldwide. The aim of the project was toassess the impact of providing incentive to improve maternal and immunizationservices. It was a quasi-experimental study with four arms 1) Providing Incentive to families to utilizematernal health and vaccination; families were given $6 for each delivery at a public health facility and $3 for bringing a child to the health facility forDPT3 vaccination. 2) Providing incentive to community health workers; $3 forthe referral of a pregnant woman in order to promote institutional delivery atthe public health facilities as well as referral of a child to receive DPT3vaccination. 3) In the combined arm, both household and CHWs are providedincentive and 4) in the control arm, no incentive were provided.

MoPH monitored almost all theprocess of end of project's survey atthe field level, although the end line survey was conducted by the implementingagency, HWW, but the technical assistance was provided by Health Systems 20/20,USAID funded health strengthening project focusing more on designing surveymethods, developing instrument, and analyzing findings.

According to the end of projectsurvey the findings suggest that cash incentive is an effective mechanism toincrease demand. However, with variant degrees of progress and concluded withthe following conclusions and recommendations:

Conclusion: *Cashincentives – when provided to both community health workers and households, areassociated with an increase in institutional delivery and DPT3 vaccination.*

Recommendations: *Infuture, points that should be taken into account during design andimplementation:*

- *Varying incentive amounts to account for transportation*
- *Supply side factors such as number of female health service providers, quality of care, hours of operation, availability of drugs and supplies affect demand for services*
- *Some differences among provinces that are contracted-in vs. contacted out*
- *Security: where security is better, it better works*

The project is being closed andone installment of NGOs is pending.

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

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

During the reporting period, 47%of the provinces monitored once in each quarter and only one province provinces due toinsecurity and unavailability of air transportation facility was not physicallymonitored at all during reporting period. Staff of 80% of provinces trained touse National Monitoring Checklist (NMC) for monitoring purpose. The PHO staffof remaining provinces (Helmand, Uruzgan, Nuristan, Zabul, Paktika and Daikundi)did not receive training on NMC due to volatile security or shortage of enoughstaff at PHO; therefore the staff could not conduct monitoring visit to healthfacilities using NMC. The M&E officers during their visits to the provincestrained 2 PPHO staff on how to use NMC data base. This was exercised in 60% visitedprovinces.

M&E team assisted the thirdparty (JHU/IIHMR) in conducting of BSC 2001. As usual Balanced Score Card is contracted out to the third party(JHU) and financed by the World Bank. Results will be announced soon. Also JHUwill conduct HHS in 2012.

The GAVI has contributedsignificantly to improve M&E especially the routine, however, furtherintensive support is required to reach to a desired system for M&E.

D.2: Launch a community demographic surveillance system

This activity already cancelled from GAVI funds in 2008.

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

The second round of the QPHMCproject contracted through open bidding. This project initially agreed durationwas from 1st May 2011- 30th April 2012, however, becauseof heavy winter and several health emergencies, the project received a no costextension till 15 June 2012. The QPHMC round 2nd project objectiveis to strengthening the capacity of provincial health officers in fundamentalsof leadership, principles of management, disaster management, proposal andreport writing skills. According to the original plan , 266 PHO staff wereplanned to receive training in 34 provinces. Out of 266 trainee, 167 PHOs from 24 provinces was planned to be trained in all five modules while 99 PHOs from 10 European Union supported provinces will be trained in three modules (Fundamental /basic leader ship,Basic Management, Proposal writing ,Disaster Management ,Report writing). During the reporting period in total thereare 40 people trained in 5 modules, 25 people trained in 4 modules, 40 peopletrained in 3 modules, 74 people trained in 2 modules and 168 people trained inone module. So far 701 out of 1231Provincial Health officers and DistrictHealth Officers received training on the training package.

In total there have been 4monitoring visits conducted to monitor the trainings conducted in Kabultraining center of implementing NGO. The overall management and the quality oftraining were found satisfactory, only lower % of participation by some ProvincialHealth Officers during the training have been reported. The issue was discussedwith relevant the APHI and Provincial Liaison Department of MoPH to discuss the issue with provincial health director in order toresolve the issue. Technical assistance provided on due time the implementing NGOs on the basis of their request ,recommendation of monitoring missions and reviewing the technical reports.

No initiatives explored, however,the capacity program also started for MoPH central level. In two rounds allprovinces were covered. Based on TNA and criteria, the HSS-SC, recommended agroup of 23 people to different courses of institution based or distance.

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

Press Travels for reflecting MoPH'sSuccess Stories conducted in three provinces of Parwan , Kandahar and Khost . Theobjectives of these press travels were to oversee of health situation, theoutbreak of Cholera disease and inauguration of District Hospital and MidwivesGraduation Ceremony. In addition, over 130 Press conferences launched duringreporting period. The press conferences covered different health events such as Internationaland National Health Days, Contracts & MoUs signing and etc, and more than420 Press and NEWS Releases, andStatement in Dari, Pashto and English weredeveloped and also sent to the National and International media outlets for broadcasting. Furthermore, four issue of MoPH Newsletter was published.

The production of documentary onvaccination, midwifery education program and mobile teams is still underprocurement process. Although the procurement process started at the beginningof the year but due to lengthy procurement procedures in the MoPH, the contracthas not been signed yet and the production has not

started yet, therefore thisactivity is shifted in the year 2012.

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

Supportive supervision of 58 DHOs in 12 provinces was conducted duringthe reporting period. In addition, mental health, and health care improvement,guidelines are being distributed to DPHOs. The CDC guidelines are under processof development which will be distributed later.

The coordination workshop for DPHOs was not conducted. Preparation toconduct district health coordination workshop completed. This workshop will beattended by PHDs and focal points of DPHO and other health sector partners toimprove coordination at district level.

34 DPHOs in north and north east regions trained on disability componentof BPHS with the support from EU funds and 152 DHOs are planned to receivetraining on four public health modules in second phase of QPHMC supported byGAVI –HSS.

DPHO Pilot Project funded by GAVI-HSS evaluated by third party (HPRO) withthe financial support of USAID (tech-serve) in year 2011. The results of thisevaluation recommended that this was an excellent initiative that GAVI fundedwithin the health system of Afghanistan.

It is worth mentioning thatthe DPHOs made positive impacts within their working districts and specific examples were given toshow how they do this.

Specificallythe DPHOs impact on the services delivery at the district level are;

- *Improvingthe performance of clinics such as opening times and coverage of vaccineprograms.*
- *Monitoring environmental health such as promotionof used of clean water in the district, or monitoring shops and restaurants*
- *Coordinating activity such as the building of anew health clinic*
- *Monitoring private clinics and removing expireddrugs*

These above mentionedpoints were directly link with the DPHOs performance which ultimately improved access, efficiency and quality ofhealth services, as compared to the districtswithout -DHOs s. The finding of thirdparty evaluation recommended that DHOinitiative should be extended to other districts as well..

District Delivery Program of Independent Directorate of Local Governanceof Afghanistan has agreed to pay hazard allowance for 15 DPHOs who are workingin very remote and insecure districts.

Based on this successful experience, 100 more DPHOs are added from theGovernment sources to the structure of DPHOs and plans are to cover alldistricts.

Although very challengingcontext, with the support of all health sector partners, the MOPH succeeded to implementthe planned activities to certain extent. Indicators as stated in the relevanttables shows satisfactory progress during the year 2011, however, twoindicators as a result of security has not been improved and even reduced.

[1]Included in “means of transportation” are:per diems, fuel, and provision of motorcycles and bicycles at the Provinciallevel.

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

- **Insecurity** in some parts of the country: o cope with insecurity problem the MOPH has piloted the partnership with for profit health service provider to provide reproductive health, child health and immunization services in insecure and underserved areas under CSO type B Project .
- **Long and tedious administrative procedures** inside and outside of the MOHP: reforming is under way . However, the proposed reforms are not effective to the extent where pragmatic changes take place.
- **Suboptimal capacity and commitment of** MOPH authorities at provincial level to fullfil the stewardship act of MoPH and effectively monitor NGOs implementing health related interventions .
- **Lack of qualified health workers** particularly female health workers in remote and underserved areas . Various initiatives are underway to train and recruit more female health workers in insecure and underserved areas.
- **Geographical constraints**, prolonged and harsh winter in certain parts of the country, and bad road conditions.

The new HSFP application willcontribute to ease some of these challenges especially the administrativeprocess related to procurement which is next to the insecurity challenge. Inaddition, volunteer health workers will be trained mostly female in Kochipopulation through HSFP which will produce evidence based results and furtherensure equity.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

HSS has been providing support to improve thecapacity of M and E Directorate thorough assigning national consultant and Mand E officer as well as providing regular backstopping and training toM and E set up in MoPH.. Therefore, the budget allocated to support M and Eactivities was reallocated to the M and E workplan.. In addition, theAfghanistan the current GAVI/HSSproposal has a specific activity called "upgrading the physical technologyinfrastructure of the M&E department". Therefore, the M&E departmentreceives its prime source of supportfrom GAVI– HSS funds. It includes supporting salaries of M and E Directorate staff , provision of, equipment,vehicles andA technical assitace and backstopping at central and provincial levels. In addition,M&E directorate is assisted to expand their role in the process of designingM and E tools and checklists for monitoring the HSS supported initiatives.

In addition;,the Balanced Score Card, a national evaluation tool aiming at evaluating the MoPHstrategies on an annual basis implemented by The Third Party Evaluation (The Johns Hopkins University) funded by the World Bank, has alsocaptures important information for someof the GAVI/HSS Program indicators . HMIS department of MoPH has been collecting information from the BPHShealth facilities on a quarterly basis where information from MHT and SHC arealso collected , processed and analyzedto assist program and policy people to take evidence based policy decisionsDuring the year 2011 USAID/Tech serve supported the evaluation of "launching a new cadre ofDistrict Health Officers". UNICEF has supported the MHT initiatives. Inaddition, The different department of MoPH are involve in implementingdifferent activities and their staff receive support from GAVI/HSS Program areinvolve in monitoring of HSS supported activities.. HSS initiativehas promoted in incorporation of in-built monitoring mechanism with theprojects/interventions being supported by GAVI fund, for instance, C-IMCIproject has a baseline and follow up evaluation in built within the scope ofC-IMCI Project.The Mid term evaluation of GAVI/HSS suppoted interventions hasbeen conducted and recommendation has been provided to take remedial actions. Itis also planned to conduct external evaluation of GAVI/HSS program during theyear 2012 in order to measure the impact of GAVI/HSS initative; this documentwill serve as a good lessons learned not only in Afghanistan but also for othercountries receiving GAVI funds.

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

GAVI/HSS avail the opportunity to integrate the M and Eactivities with the country system; HSS provide technical support toconduct annual health sector review socalled results conference and health sector retreat where the progress in thehealth sector has been reviewed and the gap analysis exercise has beenconducted and policy and program recommendations proposed. HSS support the Mand E directorate to collect information on GAVI/HSS indicators as well ashealth sector indicators and review those indicators on regular basis; infuture , GAVI HSS support will be usedto strengthen the reporting and stewardship act of MoPH at Provincial level aswell. GAVI/HSS supported initiative is the sole added initiative to assist MoPHto integrate and support M and E activities on a regular basis in Afghanistan.

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including Civil Society Organisations). This should include organization type, name and implementation function.

At the oversight level, the HSS-SCprovides a significant level of support to GAVI HSS supported initiatives in theprocess of design and implementation.Other stakeholders such as the world bank, USAID, WHO, UNICEF , and EU play an important role in the process ofoversight and provison of technical input andbackstopping of GAVI HSS supported activities. The MOPH Afghanistan and itspartners believe that the use of Civil Society Organizations (CSOs) will helpthe health sector of Afghanistan to timely and efficiently achieve its nationaland, consequently the international, health targets. Therefore, the MOPHAfghanistan has adopted the stewardship role and contracted out most healthservice delivery to NGOs. Form HSS support, over 65% of activities is beingimplemented by NGOs.

The CSO type B initial phase wasimplemented by the six national and International NGOs. Four CommunityMidwifery Education (CME) programs were implemented in four provinces ofGhazni, Nimroz, Kunar and Zabul provinnces and completed last year. Two pilot public-privatefor profit partnership projects are running in the two insecure provinces ofUruzgan and Farah and two more are added in CSO bridging in Nooristan andPaktya provinces.

The achievements so far inAfghanistan can be attributed to the significant involvement of CSOs in thehealth sector. In 31 out of 34 provinces NGOs are implementing a Basic Packageof Health Services (BPHS) in Basic Health Centres, Comprehensive HealthCentres, and District Hospitals. NGOsare also involved in the implementation of Essential Package of HospitalServices (EPHS). Other CSOs are involvedin training programs and in monitoring and evaluation.

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

The majority of the HSS activities are being implemented bythe National and International NGOs since beginning of the HSS program, some projects being implement by one NGO andsome of the in consortium with one or two NGOs

The Sub centers and MHT implemented by 7 International NGOslike Swedish Committee for Afghanistan (SCA), Aid Medical International (AMI) ,BRAC , HNTPO, Aga Khan Health System (AKHS), Merlin and MARCA and 7 NationalNGOs like Bakhter Development Network(BDN), Care of Afghan Families (CAF),Ibnsina, STEP Health and developmentOrganization (STEP), Solidarity forAfghan Family (SAF), Humanitarian Assistance Development of Afghanistan (HADAF) and Coordination forHumanitarian Assistant throughout thecountry.

The C-IMCI projects are also running by two International ofSave children / US, HNTO and Agency forAssistance and Development of Afghanistan (AADA) a National NGO covering 25provinces.

The Quality Public Health Management courses for thecapacity building of health managers at the central and provincial level alsoimplementing with a consortium by HADAF and IIHMR (both National andInternational NGOs) throughout the country.

M&E diploma course for training of 27 M&E officersconducted by Ibnsina , meanwhile the KAP survey conducted under healthpromotion activity conducted by IIHMR.

The Demand Side Financing project was implemented by HopeWorld Wide an International organization.

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

As stated in several parts of the report, the GAVIHSS support has been very instrumental to address the challenges andbottlenecks of existed in the healthsystem of Afghanistan.. There have been no changes in the management of HSSfunds. The overall management is overseen by the deputy Minister Health Care services provision and coordinatedby HSS Unit, being implemented by different departments of MoPH aswell as CSOs and NGOs. Given the natureof activity, the HSS funds are managed by different departments of MOPH. Thefinance directorate development budget unite is responsible for the financial management, M&E for monitoring and evaluation and the procurement directorate is responsible forprocurement.

The GAVI HSS Program oversight by Health SystemStrengthening Steering Committee. The Health System Strengthening Steeringcommittee (HSS-SC) consist of representative from the WB, USAID, EU, Ministryof Finance, WHO, UNICEF and CSOs as wellas presence of key CGHN members withinthe health sector of Afghanistan is actively supporting the implementation of GAVI HSS supportedinitiatives and promote the implementation of global health initiatives relatedto GAVI/HSS The HSS-SC as coordinatingand monitoring body for HSS program is comprised of three MOPH voting members(key departments), representatives of UNICEF, WHO, World Bank, EuropeanCommission, USAID, Civil Society Organization representatives and Ministry ofFinance. The bottom up annual plan of action (form 11 MOPH departments) aredeveloped, approved by HSS-SC and MoPH Minister and accepted by MoF. Eachrelevant MOPH department has at least one designated staff for HSS and eachdepartment plans and implements its relevant activities. The relevant runningcosts of each department are covered from HSS support and other costs arecovered by either the Government of Afghanistan or other donor's support. Todate, the HSS support has been very helpful to strengthen the health system;for example, some of the departments severely lacked the capacity of planning,reporting, or following up the issues. Now all of the relevant departments knowthe concepts of planning, coordination, implementation, and are activelyinvolved in management and implementation of their plans whether it is GAVI orother donors or Government resources.

9.5. Planned HSS activities for 2012

Please use **Table 9.5** to provide information on progress on activities in 2012. If you are proposing changes to your activities and budget in 2012 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2012

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Original budget for 2012** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2012 actual expenditure** (as at April 2012)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2012** (if relevant)

Activity1.1-1.2 :Establishing Sub-Centers and	• Contract management and continuation of SHC&MHT projects until absorbed by main BPHS donors (USAID and World Bank) • Smooth hand over and absorption of all health facilities to PCH and PPA grants • Close out of SHC&MHT • Archive of all documents • Collection and entry of all assets of project in a adapt base such as inventory of assets, hand over documents, softwares, whole project data and analysis, pictures, clips). • Conduct monitoring from grant management perspectives and conduct external audit	3512716			No activity is changed. Only EU absorbed HF before schedule but USAID has not yet taken over. Extension budget is under process. The exact amount cannot be given since, the extension budget will come from NGOs, and processed under Gov rules and regulations also there will be negotiation stage as well. MHTs and SC in PCH Provinces: First 6 months extension of PCH provinces: 572933 USD (Unspent has been deducted) Second 6 months of PCH provinces: 1384056 USD Total: SC&MHT of PCH provinces: 1956989 USD MHT cost in PPA provinces: 12 months extension for 6 MHTs: 270000 USD SHC&MHT of PGC provinces under EU Fund: since the project are absorbed by the PGC Grant, the cost will be will be determined soon the final reports received from organization	3647034

Activity 1.3: Expanding integrated management of c	• Start the process of proper close out and hand over of the first round of C-IMCI project. • Monitor the implementation of the second round of project by conducting visits from training sites, pre project survey and monitor CHWs who received C-IMCI training. • Provide technical assistance to the new implementers. • Review of progress of narrative reports in quarterly bases and provide feedback to implementers through MOPH official channels or face to face meetings • To assist implementer NGOs to conduct post project survey • Start the process of proper close out and hand over of the first round of C-IMCI project.	1043216			Not any major difference. It is worth mentioning that for all contracts, this takes at least 3-6 months to clear the accounts with NGOs including finalization of the reports and properly take over the assets	1096847
Activity 1.4:Develop an in-service training progra	0					

Activity 2.1: Implementing a nationwide Informat	• Print of IEC materials • Print and providing of flip charts • Preparing of TV spots about different health issues • Printing of books about different health issues • Airing of TV spots • Airing of Radio spots • National Monitoring of IEC materials • Conduct of IPCC workshops for 170 persons for 34 provinces • Translation and printing of HPD policy and strategy • Establishing of call center (Giving information about health issues through mobile phones)	407317			No major difference	473619
Activity 2.2-2.3: Pilot a model of demand side f	The project has already completed by June 2011.	330757			The NGO completed the project with less amount then approved in the bidding process. Saved funding were shifted to other HSS proposal activities where fund was needed	60000

Activity 3.1: Up-grade the physical, information	• HHS with JHU on measuring impact of HHS indicators (13) • Train PPHOs in NMC database • Design vital registration system • Conduct result conference • Conduct M/E advisory board meeting • Conduct mini results workshop for MoPH leadership • Review GAVI indicators on quarterly basis	1226716			Major part of this fund was utilized in 2011, however, the remaining carry forwarded to 2011	755786
Activity 3.2:Launch a community demographic survei						
Activity 3.3:Expanding capacity building program f	• Continue monitoring the implementation of the QPHC round 2ndproject. • Provide technical assistance to the implementer. • Review the progress of narrative reports on quarterly basis and provide regular feedback to implementers through MOPH official channels or face to face meetings • Evaluation and final report of the project • Preparation for the evaluation and close out the project	462239			The first phased of planned capacity building for provinces completed and or being completed. As a third phase under this object a group of MoPH central staff will receive required trainings	750625

Activity 3.5: Launching an initial cadre of Distr	• Coordinating technical issues of the DPHOs with the provincial and central level departments • Revision of DPHOs TOR • Conduct DPHOs coordination workshop • Develop Non communicable diseases control and communicable diseases control guideline. • Follow up of implementation of the MoPH policies and strategies at the district level. • Conduct monitoring visit	71479			No major diffirences	83651
Management cost		258312			General audit of the entire MoPH and NGOs planned. Finance monitors recruited to do Financial Monitoring including all travel costs, perdiems and so on. The auditor the last year is not paid and the funds carry forwarded to 2012. The staff payment will be the same	534745

Activity 3.4:Developing a communications and inter	• Organizing PR Conference • Follow up of production of three documentary films on Vaccination, Mobile Teams, and Midwifery Education Programs which remained from past years. • Contract with different TV channels for the broadcasting produced films. • Develop and publish the MoPH Monthly Newsletter. • Print the advertising papers, (envelope, folder, calendar, and Dairy). • Further development of MoPH web-site	104657			Activities remain the same. The Procurement of documentary film production completed at early 2012. More funds needed in the year 2012	196585
		7417409	0			7598892

9.6. Planned HSS activities for 2013

Please use **Table 9.6** to outline planned activities for 2013. If you are proposing changes to your activities and budget (reprogramming) please explain these changes in the table below and provide explanations for each change so that the IRC can approve the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 9.6: Planned HSS Activities for 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)
		0			

9.6.1. If you are reprogramming, please justify why you are doing so.

Only for the first threemonths of 2013 activities are planned and accommodated in 2012 work plansbecause of the calendar difference (March to March). Unless there are delaysin 2012 plans implementation because insecurity and political changes areunpredictable in Afghanistan. On theother hand, experience shows that clearing the accounts with NGOs includingfinalization of the final report and taking over the assets of NGOs, may take3-6 months. This may cause some management extensions to 2013.

9.6.2. If you are reprogramming, please outline the decision making process for any proposed changes

9.6.3. Did you propose changes to your planned activities and/or budget for 2013 in **Table 9.6** ? **No**

9.7. Revised indicators in case of reprogramming

If the proposed changes to your activities and budget for 2013 affect the indicators used to measure progress, please use **Table 9.7** to propose revised indicators for the remainder of your HSS grant for IRC approval.

Table 9.7: Revised indicators for HSS grant in case of reprogramming

Name of Objective or Indicator (Insert as many rows as necessary)	Numerator	Denominator	Data Source	Baseline value and date	Baseline Source	Agreed target till end of support in original HSS application	2013 Target

9.7.1. Please provide justification for proposed changes in the **definition, denominator and data source of the indicators** proposed in Table 9.6

No changes

9.7.2. Please explain how the changes in indicators outlined in Table 9.7 will allow you to achieve your targets

Not applicable

9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
Global Fund (Rond10)	11418816	3 year (March 2012 - Feb. 2015)	Improve the coverage and quality of health services delivered to and within communities by critical assessments and improving the recruitment and supervision of CHW (training of 250 female CHS and training of 510 community nurses) Strengthen the quality of peripheral laboratory performance through the creation of a regional reference laboratory system (establishment 3 reference laboratory at regions and providing equipment in given hospitals and health facilities; 13 provinces, 20 districts, 160 CHC/BHC).
Global Fund (Rond8)	10499699	5 year (Feb. 2010- January 2015)	Improvement of health management information system and Field Epidemiology Training Program at the level of Master degree Strengthening the performance and services of laboratory through establishment lab services at BHC levels Strengthening the community health services through establishment of community nursing education program (training of 300 community nurses)
There are many other sources of funding by WB , USAID, WB and other donors/partners. The following table only outlines the funds that are labeled HSS and provided by the GAVI and GFATM			

9.8.1. Is GAVI's HSS support reported on the national health sector budget? **Yes**

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Afghanistan Mortality Survey 2010	A huge nationwide survey	
HMIS 2011	Routine checks by HMIS department	
JRF 2011	EPI department , WHO, UNICEF	
National Monitoring Data base	Routine checks by M&E department	
NRVA 2008	Central Statistics office records	

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

The sections 9.4.5 and 9.4.6 should be refinedas one section to explain involvement in implementation and the other sectionother than implementation issues (i.e oversight, M&E, information sources so on) . Implementers canbe CSOs or non CSOs.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2010?? 5

Please attach:

1. The minutes from all the HSCC meetings held in 2010, including those of the meeting which discussed/endorsed this report **(Document Number: 23)**
2. The latest Health Sector Review report **(Document Number:)**

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

10.1. 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 1

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

CSO initial Type A supported was alreadycompleted and in due time reported to GAVI.

Since there in no place to download the CSO Type A support 2 , please find the complete report in the attachment list number 24 .

10.1.1. **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 describe the mapping exercises, the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed **(Document number)**

If the funds in its totality or partially utilized please explain the rational and how it relates to objectives stated in the original approved proposal.

Alreadycompleted and reported to GAVI

If there is still remaining balance of CSO type A funds in country, please describe how the funds will be utilised and contribute to immunisation objectives and outcomes as indicated in the original proposal.

NA

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.

NA

10.1.2. **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).

Already reported

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.

CSOs TOR development is under process.

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.

Although already reported, but we are gettingmore systematic inputs from CSOs. We see positive changes around working withCSOs as well within CSOs interactions.

Please provide the list of CSOs, name of the representatives to HSCC or ICC and their contact information

Full name	Position	Telephone	Email
Dr.Yasin Rahimyar / CSOs representative	CAF	0093(0)700709317	yasinrahimyar@gmail.com

10.1.3. **Receipt and expenditure of CSO Type A funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type A funds for the 2011

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	215,800	10,052,379
Remaining funds (carry over) from 2010 *(B)*	0	0
Total funds available in 2011 *(C=A+B)*	215,800	10,052,379
Total Expenditures in 2011 *(D)*	7,370	351,781
Balance carried over to 2012 *(E=C-D)*	208,430	9,700,598

Is GAVI's CSO Type A support reported on the national health sector budget? **No**

10.2. 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 support1

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

ANMEAB Afghanistan Nursing and Midwifery Education Accreditation Board<?xml:namespace prefix = o />

BCC	Behaviour Change Communication
BDN	Bakhtar DevelopmentNetwork (NGO)
BPHS	Basic Package of Health Services
BRAC	Building Resources Across the Community
CGHN	Consultative Group on Health and Nutrition (HSCC equivalent)
CH	Child Health
CHA	Coordination of Humanitarian Assistance (NGO)
CME	Community Midwifery Education
CMW	Community Midwife
cMYP	Comprehensive Multi-Year Plan for National EPI
CSO	Civil Society Organisation
EPI	Expanded Program on Immunization
FMA	Financial Management Agency
GAVI	Global Alliance for Vaccination and Immunization

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10.2.1. **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.

The project implementation has been continuing during the year 2011. CSOs have received their quarterly installments in return for successful submission of quarterly technical and financial reports. Asteering committee has been established/ and organized its meeting on regular basis for providing technical assistance for successful implementation of CSO Support Type B project. Meanwhile, it is responsible for recommending major changes to the project's activities, timelines and other key attributes.

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<!--[if !supportLists]-->•□ □ □□<!--[endif]-->Four community mid-wifery schools achieved progress in teaching their relevant curriculum in four insecure provinces of Kunar, Ghazni, Zabul and Nimroz. All four schoolscompleted their taught program at the end of 2010 and students started theirpractical work in the BPHS healthfacilities (HFs).

<!--[if !supportLists]-->o <!--[endif]-->25 Students continued their study of community midwiferycurriculum in Kunar province. In addition to, they had practical work atschool's skill lab, provincial hospital and BPHS health facilities. The schoolis evaluated by Afghanistan Nursing and Midwifery Education Accreditation Board(ANMEAB) two times in 2010. The school was successfully accredited by ANMEAB inFeb 2011. The implementation is contracted out to Norwegian AfghanistanCommittee (NAC). Last year 23 students were reported that have been successfullypassed all the requirements for enrolment in the program. Considering the needand some districts uncovered, two more students were given chance to beenrolled in the program. No dropout of students is reported in 2010. 25 out 25students graduated and received their diplomas. Graduated community midwivesare deployed at HFs in their respective districts. The project ended on April12, 2011.

<!--[if !supportLists]-->o <!--[endif]-->25 Students continued their study of community midwiferycurriculum in Ghazni province. In addition to, they had practical work atschool's skill lab, provincial hospital and BPHS health facilities. The schoolis evaluated by Afghanistan Nursing and Midwifery Education Accreditation Board(ANMEAB) two times in 2010. The school was successfully accredited by ANMEAB inMarch 2011. The implementation is contracted out to Bakhtar Development Network(BDN). No dropout of students is reported in 2010. 25 out 25 students graduatedand received their diplomas. Graduated community midwives are deployed at HFsin their respective districts. The project has successfully completed on 12thApril , 2011.

<!--[if !supportLists]-->o <!--[endif]-->21 Students continued their study of community midwiferycurriculum in Zabul province. In addition to, they had practical work atschool's skill lab, provincial hospital and BPHS health facilities. The schoolis evaluated by Afghanistan Nursing and Midwifery Education Accreditation Board(ANMEAB) two times in 2010. The school was successfully accredited by ANMEAB inMarch 2011. The implementation is contracted out to IBNSINA Public HealthProgram for Afghanistan (IBNSINA). No student dropout is reported in 2010. 21out 21 students graduated and received their diplomas. Graduated communitymidwives are deployed at HFs in their respective districts. The project hassuccessfully completed on 12th April , 2011.

<!--[if !supportLists]-->o <!--[endif]-->20 Students continued their study of community midwiferycurriculum in Nimroz province. In addition to, they had practical work atschool's skill lab, provincial hospital and BPHS health facilities. The schoolis evaluated by Afghanistan Nursing and Midwifery Education Accreditation Board(ANMEAB) one time in 2010. The implementation is contracted out to BRAC. Onestudent dropout has been reported in 2010. Nimroz is one of the large and lesspopulated provinces of Afghanistan. Population are living in dispersed pockets.On the other hand, the province is highly insecure. Therefore, the selectionprocess took much time and resulted in late start of the course. The NGOrequested a no cost extension with strong justification. Based on their strongjustification, WHO granted a no cost extension until June 12, 2011. Thegraduation of students is expected in June 2011. The graduated CMWs will bedeployed in BPHS health facilities in their respective districts from wherethey are introduced.The project has successfully completed on 12th June 2011.

<!--[if !supportLists]-->o <!--[endif]-->Zabul, Kunar and Nimroz are the most insecure and underservedprovinces of the country. This is the first project of its kind in mentionedprovinces. Before this project, midwives were recruited from nearby provincesand country capital which had high turnover and absence rate. The students areselected from all districts of mentioned provinces based on predefined standardcriteria and consultations with local government authorities and community. Thegraduated students will be deployed in HFs of their relevant districts of residence.

<!--[if !supportLists]-->•□□□□□□□□<!--[endif]-->Two pilot models ofpartnerships with private health service providers (PPHSP) continued in twoinsecure and underserved provinces of Uruzgan and Farah Provinces; further tobaseline and follow up CSO support type B project evaluations; the findings ofthe end of project evaluation has found this project as the only vehicle toprovide life saving maternal and child health services in insecure provinceswhere government and NGOs have encountered major challenges to intervene.Therefore, the end of project evaluation recommended not only the extension ofthis model but also the expansion of such model in other insecure and underserved provinces inAfghanistan. Based on the recommendations of end of project evaluation, the CSO support Type B, with for profithealth care service providers project has been extended in Urozgan and FarahProvinces for the year 2012. In addition CSO support type B project proposalhas developed and submitted to GAVI, the project has been approved, currentlyCSO support type B project is currently being implemented in four provinces,Urozgan, Farah, and two new provinces (Nuristan and Paktya Provinces) wherecoverage of Penta-3 is low.The end of project evaluation report is attachedwith this report. The private health service providers are providingimmunization and basic reproductive and child health services in return forincentives. The private health service providers are trained for providingimmunization and basic reproductive and child health services.

<!--[if !supportLists]-->o <!--[endif]-->30 Private Health Facilities (PHF) were operational during 2011in Uruzgan province. The project contracted out to Health Net TPO, aninternational NGO. The private practitioners received trainings inimmunisation, IMCI, basic reproductive health services, reporting and basicmanagement. The PHFs received regular supplies of required medicines,equipments and supplies. The PHFs were also renovated for provision of requiredservices. The project facilitated establishment of Private Medical Association(PMA) in Uruzgan province. The PMA introduced a representative to ProvincialPublic Health Coordination Committee (PPHCC), a higher provincial decisionmaking body in the health sector. The private practitioners activelyparticipated in NIDs and through their assistance some

uncovered areas werecovered with NIDs. 17 out 30 PHFs are providing vaccination services and theremaining are providing health education for immunisation and referral. AllPHFs are providing basic RH services while four out of 30 are providing skilledbirth attendance. No dropout of private practitioners is reported.

<!--[if !supportLists]-->o <!--[endif]-->25 Private Health Facilities (PHF) were operational during 2011in Farah Province. The project is contracted out to Coordination ofHumanitarian Assistance (CHA), a national NGO. The private practitionersreceived trainings in immunisation, IMCI, basic reproductive health services,reporting and basic management. The PHFs received regular supplies of required medicines,equipments and supplies. The PHFs were also renovated for provision of requiredservices. The project facilitated establishment of Private Medical Association(PMA) in Uruzgan province. The PMA introduced a representative to ProvincialPublic Health Coordination Committee (PPHCC), a higher provincial decisionmaking body in the health sector. The private practitioners activelyparticipated in NIDs and through their assistance some uncovered areas werecovered with NIDs. 3 out 25 PHFs are providing vaccination services and theremaining is providing health education for immunisation and referral. It isplanned that the implementing NGO will increase the number of PHFs providingdirect vaccination. All PHFs areproviding basic RH services while two out of 25 are providing skilled birthattendance.

<!--[if !supportLists]-->o <!--[endif]-->20 Private Health Facilities (PHFs) will be operating during theyear 2012 (1st March 2012 to- 30th February 2013) in Nuristan province, toprovide basic reproductive health services and EPI services. The contract hasbeen signed with a national NGO called Humanitarian Assistance and DevelopmentAssociation for Afghanistan (HADAAF). Currently, the mapping activity of CSOsis going on in Nuristan Province.

<!--[if !supportLists]-->o <!--[endif]-->30 Private Health Facilities (PHFs) will be operating during theyear 2012 (1st March 2012 to- 30th February 2013) in Paktia province, toprovided basic reproductive health services and EPI services. The contract hasbeen signed with an international NGO called HNTPO, Currently; the mappingactivity of CSOs is going on in Paktia Province.

<!--[if !supportLists]-->o <!--[endif]-->The two PPHSP projects are evaluated at their mid-term. Thereport is finalized and the recommendations are implemented.(Annex 8) The key findings of the evaluationare summarized as following:

<!--[if !supportLists]-->o <!--[endif]-->No cost extensions have been offered to the CSO support type B Project's contracts for CHA (implementing CSOProject in Farah Province) and HNTPO (implementing CSO support type B inUrozgan Provinces) has been approved till 30 February 2012 in order to prevent occurrences of gap in providing maternal and child healthservices in Urozgan and Farah provinces.

<!--[if !supportLists]-->o <!--[endif]-->The new CSO support type B project contracts have been signed with NGOs in four provinces, (Farah, Urozgan, Nuristan and Farah) provinces.Currently maternal and child health services has been offered in Urozgan and Farah Provinces by Private for Profit Health Service Providers. Mapping exercisein going on in Nuristan and Paktia provinces to indentify the Private forprofit health service providers in these two in secure and hard to reachprovinces.

<!--[if !supportLists]-->o <!--[endif]--> The COS support Type B partnership with for profit health services providers have laid the foundation of a model in insecure areas in Afghanistan where private for profit and notprofit entities streamline their efforts to improve access to basicreproductive health and expanded services on immunization (EPI) services forthe most vulnerable group of people best suited for insecure and areas withtough terrain where primary health care delivery is challenging.

<!--[if !supportLists]-->o <!--[endif]-->The partnership with private for profit health service providers model has proven to be an added initiative and an innovative intervention where government and NGOs can not intervene in insecure provinces has been know the only means of providing maternal and child health services to contribute towardreducing maternal and child mortality in Afghanistan and accomplishing MGDs.

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).

Insecurity is a major challenge which hampers theproject activities. This problem is addressed through close cooperation withcommunity. Community health councils are established per each PHF. Commitmentof private practitioner for providing quality services is a challenge.Providing trainings, timely incentives, community health council and regularsupportive supervision and monitoring will be among the strategies to motivateprivate practitioners to deliver quality immunisation and basic RH and CHservices.

WHO is responsible for coordination, grant management, contract administration and monitoring and evaluation of the projects implemented by CSOs. The HSS Steering Committee revises and endorses all work plans, budgets, reports and amendments. It also provides technical support to the CSO type B project. Meanwhile, as PPHSP is a new intervention, a separate steering committee is established to provide technical support and review progress of the two projects of PPHSP. The ANMEAB, an independent body provides technical support to CME schools and carry out regular accreditation of the CME schools.

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- WHO serves as Management Agency for the CSO type B support. WHO releases funds to CSOs as quarterly installments, review financial reports of CSOs and financial audit at the end of the project. Also Grant Management and Contract Management are the tasks of WHO.
- WHO is responsible for coordination, and monitoring and evaluation of the projects implemented by CSOs. The HSS Steering Committee revises and endorses all work plans, budgets, reports and amendments. It also provides technical support to the CSO type B project. Meanwhile, as PPP is a new intervention, a separate steering committee is planned to provide technical support and review progress of the two projects of PPP. The NMEAB, an independent body provides technical support to CME schools and carry out regular accreditation of the CME schools.

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.

The CSOs submit regular technical and financial reports to WHO. Meanwhile, they participate in MOPH/PPP taskforce, ANMEAB meetings and workshops. A PPP coordination committee is established to coordinate technical issues between the CSOs implementing PPP projects. The CSOs also participate in PPHCC meetings at provincial level contributing to the provincial planning andcoordination. CSOs have introduced by free elections a representative to HSS Steering Committee. Recently, a coordination body has been establishedamong CSOs working in health sector.
The steering committee has been established representing CSOs, WHO and Ministry of Public Health staff in order interact with each others, in order to coordinate the issues relevant to the project, exchange technical views and lesson learned and review the progress and challenges encountered during the project implementation and constructive recommendations have been provided.
Data relevant to the project regularly reviewed and efforts are made to improve the culture of data among CSOs , private providers and different departments of MoPH.

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

The implementation of BPHS is contracted out to CSOs. Child health and immunisation is the second priority layer of the BPHS. The CSOs are already implementing BPHS in many provinces of Afghanistan.

CSO support type B project is implementing by 4 different CSOs and consortiums in some occasions. Under CSO type B support, and bridge fund under the four PPHSP projects, contracts are signed with 105 private health practitioners for providing immunisation and basic reproductive and child health services in return for incentives. They are provided trainings, vaccines, equipments and other necessary supplies.

There has been a large network of CSOs has been established representing wide range of CSOs in Afghanistan. Please refer to CSO type A report (Attachment 24)

Please outline any impact of the delayed disbursement of funds may have had on implementation and the need for any other support.

<!--[if !supportLists]-->o <!--[endif]-->No cost extension has been of the CSO support type B Project'scontracts for CHA (implementing CSOProject in Farah Province) and HNTPO (implementing CSO support type B inUrozgan Provinces) has been approved till 30 February 2012 in order to prevent occurrences of gap in providing maternal and child healthservices in Urozgan and Farah provinces.

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 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.

Table 10.2.1a: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2011	Outcomes achieved
Bakhtar Development Network, BDN	Implemented BPHS in Balkh, Daikundi and Baghlan provinces	25 students enrolled in CME training in Ghazni province	25 students graduated and deployed in HFs at their districts of residence
BRAC Bangladesh (International)	Implemented BPHS in Balkh, Nimroz, Kabul and Badghis provinces	20 students enrolled in CME training in Nimroz province	20 students graduated and deployed in HFs at their districts of residence
Coordination of Humanitarian Assistance, CHA (National)	Implemented BPHS in Farah and Herat provinces	Contracts signed with 25 private health practitioners for providing immunisation and basic reproductive and child health care	25 Private practitioners continue delivering immunisation and basic RH and CH services
Health Net TPO (International)	Implemented BPHS in Nangarhar, Paktya and Khost provinces.	Contracts signed with 30 private health practitioners for providing immunisation and basic reproductive and child health care	30 Private practitioners continue delivering immunisation and basic RH and CH services
IBNSINA Public Health Programme for Afghanistan, IBNSINA (National)	Implemented BPHS in Laghman, Zabul, Paktya, Hirat and Helmandprovinces	21 students enrolled in CME training in Zabul province	21 students graduated and deployed in HFs at their districts of residence
Norwegian Afghanistan Committee, NAC (international)	Implemented BPHS in Ghazni province	25 students enrolled in CME training in KunarProvince	25 students graduated and deployed in HFs at their districts of residence

Please list the CSOs that have not yet been funded, but are due to receive support in 2011/2012, 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.

Table 10.2.1b: Planned activities and expected outcomes for 2011/2012

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2011/2012	Expected outcomes
Health Net TPO (International)	Implemented BPHS in Nangarhar, Paktya and Khost provinces.	Contracts signed with 30 private health practitioners for providing immunisation and basic reproductive and child health care	30 Private practitioners continue delivering immunisation and basic RH and CH services
Humanitarian Assistance and Development Association for Afghanistan (HADAAF).	Implemented BPHS in Nooristan province	Contracts signed with 20 private health practitioners for providing immunisation and basic reproductive and child health care	20 Private practitioners continue delivering immunisation and basic RH and CH services

10.2.2. **Future of CSO involvement to health systems, health sector planning and immunisation**

Please describe CSO involvement to future health systems planning and implementation as well as CSO involvement to immunisation related activities. Provide rationale and summary of plans of CSO engagement to such processes including funding options and figures if available.

If the country is planning for HSFP, please describe CSO engagement to the process.

The implementation of the GAVI funded CSOType B project in two security compromised provinces was very successful inproviding the populations there with EPI and basic reproductive and childhealth services and in building an effective public private partnership. Theexperiences gained and lessons learnt encourage the MoPH to repeat the sameapproach in two more provinces in CSO type B bridge funding opportunity. This intervention will ensure continuation ofCSO support when the bridge funding forCSO support is completed while furtherexpanding the support to sixmore provinces.<?xml:namespace prefix = o />

In addition, there are several buildingsconstructed by various donor's support to establish new HFs mainly hospitals. The MOPH and the donors are not inthe position to fund operationalization of these hospitals. However, these HFswill be able to cover significant number of population and ensure delivery ofcare including EPI and other maternal and child essential services. At thisstage, this is very critical for the health sector in Afghanistan to explorepartnership opportunities with for profit National or International partnersfor operationalization of these hospitals.

Afghanistan has already developed and send HSFP proposal to GAVI which include of an activity (To continue and scale up the CSO type B project focused on the delivery of EPI and other essential maternal and child health services in remote and insecure areas of the country). up on approval of HSFP, the MoPH will contract the BPHS implementingNGOs to identify the private facilities, train the private practitioners,support them and monitor and report their performance. The planned interventionincludes strengthening the cold chain to accommodate the private facilitynetwork.

The training of the private practitionerswill focus on EPI, basic reproductive and child health services. Each privatefacility will be linked to the nearest public health facility which provides thesupervisory support and the regular EPI and other supplies.

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

The HSFP has been developed widely with the CGHN sub group for all HSS iniitiatives is HSS steering committee which is consists of the members from WB, USAID, EU, WHO , UNICEF , Ministry of FInance, NGOS elected representative.

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

<!--[endif]-->

10.2.3. Please provide names, representatives and contact information of the CSOs involved to the implementation.

Dr. Ismail Hail HADAAF General Director hadaaf_2005af@yahoo.com, 0093(0) 773333606
Dr. A.Majeed Sediqi HNTPO Head of Mission majeed@healthnettpoaf.org 0093(0) 700294627 . HNTPO is the implementer in two provinces of Paktia and Urozgan.
Eng. Yahya Abasi Country director of CHA abbasy@cha-net.org 0093(0)799446055

10.2.4. **Receipt and expenditure of CSO Type B funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type B funds for the 2011 year

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	242,731	12,158,396
Remaining funds (carry over) from 2010 *(B)*	455,464	21,304,980
Total funds available in 2011 *(C=A+B)*	698,195	33,463,376
Total Expenditures in 2011 *(D)*	511,333	25,612,670
Balance carried over to 2012 *(E=C-D)*	186,862	7,850,706

Is GAVI's CSO Type B support reported on the national health sector budget? **No**

Briefly describe the financial management arrangements and process used for your CSO Type B funds. Indicate whether CSO Type B funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of CSO Type B funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the HSCC in this process.

World HealthOrganisation (WHO) serves as the FMA of the CSO Type B project. Funds aretransferred from GAVI to WHO. WHO releases funds to CSOs as quarterlyinstalments, review financial reports of CSOs and financial audit at the end ofthe project. The CSOs submits financial reports on quarterly basis to WHO. Astandard financial reporting format is developed for this purpose. Financialinformation is collected from the field by CSOs and sent to CSO country office.The CSO country office aggregates and compiles the information and prepares thequarterly report. The quarterly financial reports are reviewed by MOPH/WHO andapproved. The quarterly instalments to CSOs are subject to successfulsubmission of quarterly technical and financial reports.

The CSOs preparesdetailed budget for running the projects and the budgets are approved byMOPH/WHO. <?xml:namespace prefix = o />

Detailed expenditure of CSO Type B funds during the 2011 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2011 calendar year **(Document Number)**. Financial statements should be signed by the principal officer in charge of the management of CSO type B funds.

Has an external audit been conducted? Yes

External audit reports for CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number).

10.2.5. **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.

Table 10.2.5: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target
Four CME training programmes in Kunar, Ghazni, Zab	Percentage of BPHS health facilities with at least	Health Management Information Syste	56% in 2007	82.5	May 2012	80	June 2011
Four CME training programmes in Kunar, Ghazni, Zab	No. of new CME programs in Kunar, Nimroz, Zabul an	ANMEAB accreditation report	NA	4	March 2011	4	First quarter of 2011
Four CME training programmes in Kunar, Ghazni, Zab	No. of skilled CMWs graduated from the four CME pr	CSOs CME completion repor	NA	91	March 2011	91	April 2011 and June 2011
Four CME training programmes in Kunar, Ghazni, Zab	No. of graduated CMWs deployed in the BPHS health	CSOs and BPHS joint report on deployment of newly	NA	85	July 2011	91	April 2011 and June 2011
Two pilot models of partnerships with private heal	PENTA 3 coverage in targeted districts of Uruzgan	Monthly EPI coverage reports	70% Farah , 30% Urozgan end of 2007	80% in Farah 65% in Urozgab	January 2011	80	August 2011
Two pilot models of partnerships with private heal	No. of private sector service providers from Farah	CSO activity report/monitoring visits report	0	55	February 2010	55	August 2011

Two pilot models of partnerships with private heal	No. of private sector service provision outlets of	Baseline assessment report of the CSO/ monitoring	0	4	February 2010	10	August 2011
Two pilot models of partnerships with private heal	No. of private sector service provision outlets of	CSO activity report/monitoring visits report/end p	0	55	February 2010	55	August 2011

Planned activities :

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.

Sofar, CSO support Type B are only reporting based on their own format on aquarterly basis. Given the fact that CSO support type B is being implemented inmost insecure and underserved areas. It was not possible to conduct householdsurvey to estimate the baseline value in these provinces. The CSO are onlyreporting through health management information system .It is possible tofollow the trend of the data on quarterly and annual basis.

TheCSO support type B project has been monitored from central level, WHO/MoPH. Atthe provincial level implementing NGOs and medical association monitors CSOsupport type B projects.The relevant information on certain indicators aregathered through regular reporting system, this project made the private forprofit health service providers for the first time accountable to report to WHOand MoPH.<?xml:namespace prefix = o />

Theproject has been evaluated at the middle of the project and end of projectevaluation conducted by the third party evaluation. The report of evaluationare attached

11. Comments from ICC/HSCC Chairs

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. These could be in addition to the approved minutes, which should be included in the attachments

No comments.

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2011 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2011 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2011 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2011 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2011 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2011 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Cover Letter0001.pdf File desc: File description... Date/time: 5/19/2012 12:16:09 AM Size: 375182
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature-Minister0001.pdf File desc: File description...Signatures of ICC members Date/time: 5/19/2012 12:17:23 AM Size: 768719
3	Signatures of members of ICC	2.2	✓	ICC signatures.jpg File desc: File description... Date/time: 5/22/2012 12:31:59 AM Size: 306130
4	Signatures of members of HSCC	2.3	✗	Participant list GAVI-HSS & CSO0001.pdf File desc: File description... Date/time: 5/19/2012 12:20:12 AM Size: 1465295
5	Minutes of ICC meetings in 2011	2.2	✓	ICC Min Jan11.doc File desc: File description...ICC minute Date/time: 5/15/2012 11:21:25 PM Size: 80896
6	Minutes of ICC meeting in 2012 endorsing APR 2011	2.2	✓	Min+ICC_May12.doc File desc: File description...Minute of ICC endorsed APR2011 Date/time: 5/15/2012 5:35:13 AM Size: 59904
7	Minutes of HSCC meetings in 2011	2.3	✗	HSS_Steering_Committee_Meeting_August_14__2011_(1).doc File desc: File description... Date/time: 5/22/2012 2:43:38 AM Size: 236032
8	Minutes of HSCC meeting in 2012 endorsing APR 2011	9.9.3	✗	_25th_SC_meeting_13May.doc 1.doc File desc: File description... Since all five steering committee mtg minute did not up load I attached only one you will get the rest through email Date/time: 5/19/2012 12:21:47 AM Size: 209920
9	Financial Statement for HSS grant APR 2011	9.1.3	✗	Finacial Statement GAVI-HSS 20110001.pdf File desc: File description... Date/time: 7/3/2012 3:47:51 AM Size: 6527628
				AfgcMYP11-15- updated March12.docx

10	new cMYP APR 2011	7.7	✓	File desc: File description...updated cMYP 2011-2015 Date/time: 5/15/2012 11:28:32 PM Size: 1019515
11	new cMYP costing tool APR 2011	7.8	✓	AFG cMYP_Costing_PneumoRota (19 Apr 11) F.xls File desc: File description...cMYP costing tool 2011 Date/time: 5/15/2012 11:40:47 PM Size: 3575808
12	Financial Statement for CSO Type B grant APR 2011	10.2.4	✗	Financial Statement 2011 CSO B0001.pdf File desc: File description... Date/time: 5/19/2012 12:42:06 AM Size: 3068558
13	Financial Statement for ISS grant APR 2011	6.2.1	✗	Financial Satement of GAVI ISS fund.doc File desc: File description...Financial statement for GAVI ISS grant, APR2011 Date/time: 5/15/2012 5:43:23 AM Size: 41472
14	Financial Statement for NVS introduction grant in 2011 APR 2011	7.3.1	✓	ICC_May_11.doc File desc: File description...May 11 ICC minute Date/time: 5/15/2012 11:24:04 PM Size: 86016
15	EVSM/VMA/EVM report APR 2011	7.5	✓	AFG EVM_report_Final.doc File desc: File description... EVMA 2011 Report Date/time: 5/15/2012 5:50:17 AM Size: 2215936
16	EVSM/VMA/EVM improvement plan APR 2011	7.5	✓	CC DevPlan.doc File desc: File description... Date/time: 5/22/2012 6:32:50 AM Size: 22016
17	EVSM/VMA/EVM improvement implementation status APR 2011	7.5	✓	EVMA implementation.doc File desc: File description...EVMA activity plan Date/time: 5/15/2012 11:30:20 PM Size: 32256
19	External Audit Report (Fiscal Year 2011) for ISS grant	6.2.3	✗	External audit.doc File desc: (Prop_ATTACH_00170) Date/time: 5/22/2012 6:34:42 AM Size: 22016
20	Post Introduction Evaluation Report	7.2.2	✓	ReportPieAfghanistanNov2011.docx File desc: File description...PIE Report 2011 Date/time: 5/15/2012 11:08:27 PM Size: 277824
				Min+ICC_May12.doc

21	Minutes ICC meeting endorsing extension of vaccine support	7.8	✓	File desc: File description...Minute of ICC endorsing extension of vaccine support Date/time: 5/15/2012 11:15:04 PM Size: 60928
22	External Audit Report (Fiscal Year 2011) for HSS grant	9.1.3	✗	The GAVI HSS audit is under process..docx File desc: File description... Date/time: 5/22/2012 6:15:28 AM Size: 12596
23	HSS Health Sector review report	9.9.3	✗	2012 Strategic Health Retreat Report (Final March 2012).pdf File desc: File description... Date/time: 5/19/2012 12:34:21 AM Size: 1315203
24	Report for Mapping Exercise CSO Type A	10.1.1	✗	CSO Type A support 2 Report.doc File desc: since there was no space in the format to up load the CSO type A support 2 Date/time: 5/21/2012 7:33:53 AM Size: 53760
25	External Audit Report (Fiscal Year 2011) for CSO Type B	10.2.4	✗	The CSO type B audit has been done in WHO but the report not ready yet..docx File desc: File description... Date/time: 5/22/2012 6:15:44 AM Size: 12594