GAVI ALLIANCE

EVALUATION OF GAVI SUPPORT TO CIVIL SOCIETY ORGANISATIONS

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COUNTRY EVALUATION REPORT - AFGHANISTAN

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CEPA

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ACRONYMS AND ABBREVIATIONS

Acronym	Full description
ANMEAB	Afghanistan Nursing and Midwifery Education Accreditation Board
APR	Annual Progress Report
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CHC	Comprehensive Health Centre
CEPA	Cambridge Economic Policy Associates
CGHN	Consultative Group for Health and Nutrition
CSOs	Civil Society Organisations
CSO	Central Statistics Office
DFID	Department for International Development
DH	District Hospital
EC	European Commission
EPI	Expanded Programme on Immunisation
EPHS	Essential Package of Hospital Services
GAVI	GAVI Alliance
GCMU	Grant and Contract Management Unit
GDP	Gross Domestic Product
HDI	Human Development Index
HP	Health Post
HSCC	Health Sector Coordination Committee
HSS	Health Systems Strengthening
HW	Health Worker
ICC	Inter-agency Coordination Committee
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOPH	Ministry of Public Health
MOU	Memorandum of Understanding
NGO	Non Governmental Organisation
NRVA	National Risk and Vulnerability Assessment
NTCC	National Technical Coordination Committee
NVS	New and underused Vaccines Support

Acronym	Full description
PEMT	Provincial EPI Management Team
PHCC	Provincial Health Coordination Committee
PPP	Public Private partnership
REMT	Regional EPI Management Team
SC/US	Save the Children US
SIDA	Swedish International Development Cooperation Agency
SRTRO	Silk Route Training and Research Organisation
UN	United Nations
UNICEF	The United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

EXECUTIVE SUMMARY

Afghanistan is one of the Asia's poorest and most unstable countries. It has suffered prolonged years of conflict since 1978, entirely disrupting social services including the health care delivery system.

To rapidly expand public health services during the early-2000s, the Ministry of Public Health (MOPH) assumed a stewardship role over the health sector and contracted out the delivery of some health services to CSOs, including a Basic Package of Health Services (BPHS) and Essential Package of Health Services (EPHS), both of which include immunisation services. Approximately 200 CSOs have signed MOUs with the MOPH and around 60 CSOs are directly involved in various capacities in delivering health services and conducting immunisation-related activities.

GAVI approved Type A and B CSO support for Afghanistan in February and May 2008 respectively. Although feedback regarding both types of support was positive, awareness regarding Type A was relatively low among the CSOs contacted. However, there was unanimous agreement regarding the need for the continuation of Type A support as the landscape of CSOs is rapidly changing. Type B support was perceived as a relevant pilot project that needs to be replicated in other parts of the country. The activities under Type B (community midwife education (CME) in four provinces and public-private partnerships (PPPs) for immunisation services in two provinces) were relevant and complementary to current CSO activities.

Although the officials who have interacted with the GAVI Secretariat viewed the support provided positively, they would appreciate further input from the Secretariat. GAVI Partners have had some involvement in the programme: WHO and UNICEF were involved in the development of Type A and B proposals as well as the selection of Type B CSOs. WHO has also played the role of the Financial Management Agent (FMA). The MOPH officials were in favour of stronger support from GAVI Partners and more clarity regarding their roles.

A number of issues with the implementation of the CSO programme in Afghanistan were identified; these include: (i) insufficient monitoring visits and technical input from the MOPH and GAVI Partners; (ii) delays in the disbursement of funds; (iii) lack of communication between the government and other stakeholders; and (iv) insecurity in project areas.

Type A support has resulted in a database of active CSOs and the nomination of CSOs to the CGHN, ICC and HSS steering committee. Type B support has resulted in the training of more than 80 community midwives in four underserved provinces. In addition, more than 50 private service providers were trained, supplied and technically assisted to deliver immunisation and reproductive health services.

In terms of sustainability, it is likely that the CME component will cease when GAVI funding expires. This represents a significant challenge for the health system in training and recruiting midwives in the targeted areas where the national CME programme does not reach. By contrast, the PPP component has been continued with World Bank funding, representing an important achievement.

To improve the effectiveness of the programme, the following recommendations were made: (i) clarify the programme objectives; (ii) improve disbursement procedures; (iii) clarify the roles and

responsibilities of GAVI Partners; (iv) strengthen the M&E and technical support available to CSOs; and (v) increase GAVI's country interaction with government and GAVI Partners.

1. INTRODUCTION

This report provides an evaluation of GAVI CSO support in Afghanistan and forms a part of CEPA's overall GAVI CSO evaluation report. The report has been prepared by CEPA country-level partners – Dr. Kayhan Natiq and Dr. Essa Tawfiq[1] with guidance from CEPA.

1.1. Objectives of the country study

Afghanistan is one of five country studies undertaken under this evaluation.[2] The specific objectives of the country study are as follows:

- to understand the relevance of GAVI CSO support in the country, including the alignment of country funded programmes with broader immunisation/ health sector plans and priorities, as well as the suitability of various aspects of the programme design;
- to document the country's experience in implementing the programme, including identifying factors that have promoted or impeded effectiveness;
- to collate information on the results achieved through the funding to date; and
- solicit feedback on the suggestions for improving the effectiveness of the programme going forward.

The country study forms an important source of evidence for our evaluation of the policy rationale and programme design, implementation, and results of GAVI CSO support.

1.2. Methodology

The country study draws on information from: (i) country-level documentation; and (ii) interviews with local stakeholders held during October and November 2011.

1.3. Structure of the report

The report is structured as follows: Section 2 provides the country context and overview of GAVI support in Afghanistan. Sections 3, 4, and 5 respectively present an evaluation of the policy rationale and programme design, implementation, and results of GAVI CSO support in Afghanistan. Section 6 provides some recommendations on improving GAVI CSO support, based on country-specific experience and feedback.

The country report is supported by annexes on: bibliography (Annex 1); list of consultations (Annex 2); background statistics on the country health sector (Annex 3); summary results through Type B funding (Annex 4); and factors impacting effectiveness (Annex 5).

[1] Dr. Kayhan Natiq and Dr. Essa Tawfiq were employed through the Silk Route Training and Research Organisation for the purposes of this consultancy.

[2] The other country studies are being conducted in DRC, Ethiopia, Indonesia and Pakistan.

2. COUNTRY CONTEXT AND GAVI SUPPORT

2.1. Brief background on Afghanistan

Afghanistan is one of Asia's poorest and most unstable countries. It has suffered prolonged years of conflict since 1978 when the communist pro-Soviet party toppled the government. During the 10 years of Soviet invasion, the already sparse infrastructure in rural parts was entirely decimated. The collapse of the communist regime was followed by civil war among Mujahidin factions and the emergence of the Taliban in 1990s, entirely disrupting social services including the health care delivery system. Soon after 11 September 2011 (9/11), with the fall of the Taliban and presence of the international community, the road was opened for reconstruction and development. However, the Taliban remain a threat to the progress made over the last 10 years.

Afghanistan is divided into 34 administrative provinces with over 400 districts. Although the cities have grown rapidly in recent years, the majority of the population resides in rural parts of the country dominated by conservative Muslims, particularly in the south and southeast.

Table 2.1: Afghanistan – key statistics[3]

Indicator	Value (year)
Population size	~25 million (2010)
GDP per capita (current US$)	$457 (2010)
Human Development Index (HDI)	Ranked 155th (2010)

2.2. Health and immunisation sector

After the fall of the Taliban, Afghanistan had fragmented public health services, mostly delivered by CSOs who were generally uncoordinated and concentrated in accessible areas, leaving the majority of rural population without any basic services.[4] To rapidly expand public health services, the MOPH assumed a stewardship role and contracted out the delivery of health services to CSOs.[5]

To ensure services met the basic needs of the population and were delivered equitably, the MOPH defined the BPHS, incorporating: maternal and newborn care; child health and immunisation; communicable diseases; public nutrition; essential drugs; mental health; and disability.[6] In 2006, the MOPH also developed the Essential Package of Health Services (EPHS) defining the types of hospitals and their services from district to national levels. The BPHS and EPHS form the core MOPH interventions towards achieving its goals[7]: (1) making BPHS accessible to 90% of the population; (2) reducing maternal mortality by 15%; (3) reducing infant and under five mortality by 20%; and (4) increasing immunisation coverage to above 90%.[8]

[3] Central Statistics Office, UN Data, and Afghanistan Human Development Report

[4] Loevinsohn & Sayed (2008): 'Lessons from the health sector in Afghanistan: how progress can be made in challenging circumstances'

[5] Sondorp, Palmer, Strong, & Wali (2002): 'Paying NGOs for Performance in a Post-conflict Setting'

[6] Ministry Of Public Health (2005): 'Basic Package of Health Services'

[7] As stated in Afghanistan National Development Strategy 2007-2013.

[8] Afghanistan National Development Strategy (2007)

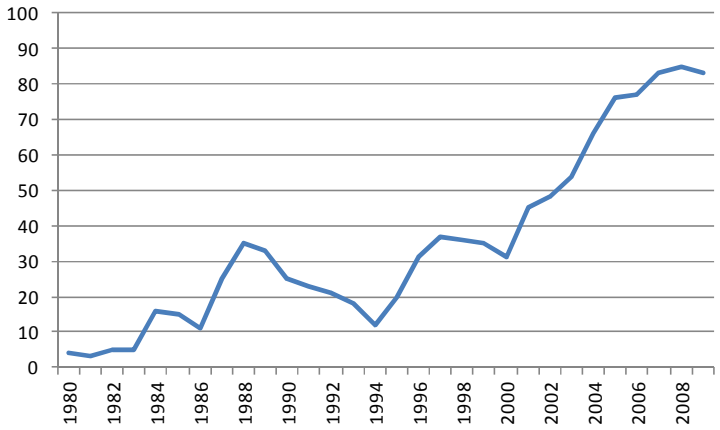
Health facilities at a range of levels deliver the BPHS nationwide, which are run by CSOs in 31 out of 34 provinces in Afghanistan.[9] CSOs are selected to deliver BPHS services through a competitive bidding process either led by the Grant and Contract Management Unit (CGMU) of the MOPH (but funded by USAID and the World Bank) or the European Commission (EC) who contract CSOs directly.[10] CSOs are required to submit quarterly technical and financial reports, comply with MOPH standards and document health services delivered.

According to the BPHS guidelines, immunisation fixed centres, staffed by two vaccinators, must be available in all BPHS health facilities. Immunisations included in the BPHS are BCG, DTP-HepB-Hib2, OPV, and measles. Women of reproductive age also receive TT. All immunisations delivered at public health facilities are free of charge.

Finally, there is an unregulated, extensive and ever-expanding network of private health service providers including hospitals, clinics, pharmacies, etc. The potential of the private service providers to provide basic services, including immunisation, particularly in insecure areas where the capacity of CSOs is restricted has not been fully exploited – despite GAVI's current efforts as part of Type B support.

Substantial progress has been made in increasing the accessibility and coverage of the BPHS, as well as improving the quality of health services. Health metrics have also improved – a summary of which is provided in Annex 3. As indicated in Figure 2.1, there have been marked improvements in the DTP3 coverage rate.

Figure 2.1: Percentage of children aged 12-23 months immunised with DTP3 in Afghanistan (1980-2008)[11]



2.3. CSO context and role in immunisation

Since the 1980s, CSOs have gradually handed the management of the cold chain and vaccine logistics to the MOPH. By contrast, the delivery of immunisation has remained with CSOs, as part of the BPHS.

[9] This includes: health posts (HPs) staffed by 2 community health workers (CHWs) covering 1,000-1,500 people; 2) basic health centres (BHCs) covering 15,000-30,000 people; 3) comprehensive health centres (CHCs) covering 30,000-60,000 people; and 4) district hospitals (DHs) covering 100,000 people. As of 2010, this also includes mobile health teams and health sub-centres, covering 3,000-7,000 people.

[10] We note that the EC intends to hand over the management of the NGO contracts to the MOPH in the future.

[11] Data from http://databank.worldbank.org/

Currently, more than 2,000 CSOs, unions, associations and media organisations are registered with government departments in Afghanistan, of which approximately 200 have signed MOUs with the MOPH and around 60 are directly involved in delivering health services and conducting immunisation-related activities. 17 of these CSOs, of which nine are national, are contracted to deliver the BPHS – these CSOs are directly responsible for the planning, implementation and supervision of the EPI programme, including routine services and immunisation campaigns under the leadership of the MOPH. CSOs are also represented in all of the technical and coordination structures including the CGHN, ICC and all technical taskforces including the EPI taskforce, NTCC, and PHCC.

A number of CSOs, including associations of health professionals and academic institutions, are also expected to play a key role in advocacy, assessment of national health policies and in developing evidence for decision making.

Community health committees and other local structures are also viewed as key partners, responsible for providing local resources, including volunteers, community mobilisation, logistical support and a commitment to the utilisation of services.

2.4. Health sector coordination mechanisms

The MOPH leads several technical and coordination mechanisms involved in EPI, including the CGHN, ICC, National Technical Coordination Committee (NTCC), technical taskforces, and Provincial Health Coordination Committees (PHCCs).

Among the above-mentioned technical and coordination mechanisms, the CGHN, equivalent to HSCC, plays a central role (MOPH Afghanistan, 2008). Having been operational since late 2002, its meetings, chaired by the Deputy Minister for Policy and Planning, are held once or twice a month and the minutes are published and disseminated to all members and partners.

The CGHN has served as a forum for coordination among the MOPH, other line Ministries, and development partners including donors, UN agencies and NGOs for achieving the targets set in the national health policies and strategies. The NGOs can also suggest agenda items and attend the meetings for making presentations. The specific functions of the CGHN are as follows:

- Coordinate inter-ministerial activities through exchange of information;
- Develop policies and institutional benchmarks which enhance the effectiveness and efficiency of the delivery of the BPHS and other health services;
- Identify the strategic actions and programmes necessary to achieving the benchmarks, including the review of all projects with national policy implications;
- Ensure the provision of technical and investment resources to implement actions and programmes; and
- Review progress in achieving national health objectives.

Some CSO representatives stated that the CGHN, changed to a mere information sharing body, is not as vigorous as it used to be and attendance is relatively open to all institutions involved in

health. The meetings are usually conducted once or twice a month and the minutes are circulated to all invitees – around 60 individuals from the MOPH, donors, UN organisations, NGOs, etc.

2.5. Overview of CSO and other GAVI support in Afghanistan

GAVI approved both CSO Type A and B support for Afghanistan, in February and May 2008 respectively. Table 2.2 below provides information on the timing and amount of approval and disbursement of funds for both types of support.

Table 2.2: Summary of Type A and B support

Type of support	Type A	Type B
Date of proposal submission	10 January 2008	10 January 2008
Date of approval	9 February 2008	1 June 2008
Date of disbursement	3 November 2008	5 May 2009
Total funds approved	$100,000	$2,425,998
Amount disbursed (as on July 2011)	$100,000	$2,425,998
Destination of funds	WHO	WHO

Source: GAVI finance data, as of 22 July 2011

3. EVALUATION OF POLICY RATIONALE AND PROGRAMME DESIGN

3.1. Relevance of GAVI CSO support in Afghanistan

Relevance of supporting CSOs in Afghanistan

Given the enormity of CSOs involvement in the health sector, huge gaps in health services delivery, and shortage of resources, all types of support to CSOs to improve coordination and health services are appreciated. Most of the stakeholders emphasised that the funding needs to be increased to cover other types of CSOs and expand services to the other remote and insecure areas. While some of the stakeholders were not fully informed about GAVI CSO support, the project was generally perceived as relevant to the context in Afghanistan.

Relevance of Type A and B support

Although overall feedback on both Type A and B support was positive, awareness regarding Type A was relatively low among the CSOs contacted. However, there was unanimous agreement on the need for the continuation of Type A support, as the landscape of CSOs is rapidly changing (with the emergence of new types of CSOs) and there is a strong need for better coordination and capacity building. Some government officials emphasised that the mapping exercise had helped the Ministry identify relevant CSOs, what they are doing, what capacity they have, what type of programmes they are running, and where they are located.

Overall, Type B support was perceived as a relevant pilot project that needs to be replicated in other parts of the country. However, some MOPH officials questioned its relevance, particularly as donor and government funding is already given to CSOs for delivering immunisations as part of the BPHS. The activities under Type B support (training of community midwives in four provinces and PPPs for immunisation services in two provinces) were seen as complementary to the ongoing work of the CSOs, and particularly relevant given their focus in relatively insecure provinces. The training of community midwives is filling a serious gap in human resources in four remote and relatively insecure provinces, whereas the PPP is ensuring the availability of EPI and reproductive health services in insecure and hard-to-reach areas.

Alignment of Type B activities funded with health/ immunisation plans

The Type B funded activities are closely aligned with the national health sector priorities. For example, community midwives have been trained in most parts of the country, mostly by CSOs with funding from the government or donors, which has been designed to specifically address the shortage of qualified female health professionals. Type B support was used in provinces where funding for the training of the community midwives was either not available or additional funds were required. The PPPs on EPI and reproductive health services made available those services to pockets of the population living in remote and insecure areas where they cannot be reached by conventional types of health facilities included within the BPHS. Both activities were perceived as successful pilot projects that require more funding for their continuation and expansion.

3.2. Programme design

A key issue for the evaluation is the assessment of the suitability of GAVI's approach of channelling funds for the CSO programme, which in Afghanistan's case have been made through WHO. WHO has acted as a Financial Management Agent (FMA) for both Type A and B support, as selected by the CGHN and the MOPH.[12] The MOPH and CGHN have overseen Type B activities through the HSS Unit – this is separate from the Grant and Contract Management Unit which handles funding from other major donors. Some MOPH officials were critical of the presence of this separate unit for the management of the GAVI's support while there is a full-fledged department carrying out the same tasks managing funds from other donors.

While some CSO representatives suggested that GAVI, like the Global Fund, should channel the funds through a CSO, some interviewees (including CSOs and the MOPH officials) were in favour of channelling the funds through the GCMU of the MOPH. Other interviewees were content with the current arrangements. However, a number of government officials and CSOs indicated that more funds should be more flexible – for example, a World Bank project with lump-sum contracts allows CSO significantly more room to re-programme budget-lines and use the resources as the project managers deem appropriate.

[12] Initially, the CGHN requested UNICEF, MSH, SCA and IMC to act as the FMA, but they refused. HNTPO offered to do so, but given the potential for conflict of interest the offer was declined. Finally, the WHO was approached and assigned as the FMA. The MOPH was not selected due to concerns regarding government bureaucratic procedures and possibility of delays in operations.

4. EVALUATION OF PROGRAMME IMPLEMENTATION

4.1. Role of GAVI institutions

4.1.1. GAVI Secretariat

Although the officials who have interacted with the GAVI Secretariat viewed their inputs positively, they suggested that the Secretariat should take more active role in the programme through: regularly reviewing progress; having closer collaboration with the country officials and CSOs to explain procedures; providing technical support; undertaking the M&E aspects of programmes through country visits; and clarifying GAVI's expectations from CSOs and the roles and responsibilities of GAVI Partners. Both the MOPH and CSO officials suggested that GAVI, like several other donors, should have an increased in-country presence in Afghanistan for better advocacy, communication, supervision, monitoring, collaboration and support on decision making on key policy and programmatic priorities.

Some CSO representatives complained about the sluggish proposal review period and delays in fund disbursements. For example, the approval of the proposed one-year extension of Type B took more than six months. WHO in particular noted that the GAVI approval process had taken much longer than that for other donor programmes.

4.1.2. GAVI Partners

WHO and UNICEF were involved in the development of the country proposals and the selection of CSOs for Type B support. As noted above, WHO has also played the role of the FMA, however, there is some confusion among MOPH officials over whether UN bodies are mandated to manage funds and contracts in this manner. GAVI's expectations from GAVI Partners is not clear and MOPH officials would appreciate stronger support from them and more clarity on their role.

4.2. Country implementation

4.2.1. Type A support

The CSO mapping exercise was conducted by two consultants hired by the MOPH. The data collection was completed by the provincial health coordination committees at the provincial level and by the consultants in Kabul, focusing on mainly three domains: CSO profile, CSO programme contents, and CSO's involvement in research or surveys. A database of CSOs registered with the Ministry of Economy and Ministry of Justice was developed. According to the report, over 1,700 NGOs were registered with the Ministry of Economy and over 1,700 associations, political organisations and academic institutions (most of them inactive) were registered with the Ministry of Justice. More than 180 NGOs had signed MOUs with the Ministry of Public Health although many were inactive – only 57 NGOs, 33 national and 24 international were active in the health sector at the time.

The nomination process involved CSOs electing their representatives for the CGHN, ICC, and HSS steering committee during a workshop. For each forum, a number of CSOs announced their candidacy and the election was conducted by a vote. Three CSOs were nominated to the

CGHN and the ICC. One CSO was also nominated to the HSS Steering Committee and the Inter-ministerial Coordination committee (which is no longer functional). While CSOs were already represented on these bodies, it is thought that the Type A nomination process resulted in a much fairer and transparent selection of CSOs.

4.2.2. Type B support

CSOs were invited to submit proposals for Type B support which were reviewed by the CGHN, resulting in six CSOs being selected to implement two types of project, as noted below.

- Four CSOs were selected to establish community midwifery schools and train 80 community midwives in Nimroz, Zabul, Ghazni and Kunar provinces. The provinces were selected using a set of criteria which assessed the existence of prior CME programmes, security, feasibility, shortage of health professionals, etc. The selected provinces had no previous CME programmes and although they were insecure, it was still feasible to conduct the training.
- Two NGOs were selected to forge PPPs with private health service providers to deliver immunisation and reproductive health services in Farah and Uruzgan provinces. Again, these provinces were selected, using a set of criteria which included immunisation coverage, security, presence of private providers, etc.

All Type B activities were completed on time, except for midwifery training in one region which was delayed by three months.

The CSOs have been required to submit quarterly, mid-term and final technical and financial reports. The Monitoring and Evaluation Department of the MOPH are responsible for monitoring and evaluation in accordance with a set of performance indicators including DTP3 coverage, antenatal care visits, deliveries, quality of education programme, etc. In addition, the Afghanistan Nursing and Midwifery Education Accreditation Board (ANMEAB) is responsible for assessing the midwifery education programmes in the targeted provinces and has accredited the schools in three provinces. A mid-term evaluation of the project has been conducted.

Country implementation approach and issues

There have been a number of issues with the implementation of Type B support, which are summarised below.

- Insufficient monitoring visits and technical input from the MOPH and GAVI Partners has adversely impacted the programme in terms of setting targets, identifying programmatic gaps, developing strategies to overcome the hurdles, etc.
- Delays in the disbursement of funds by WHO have negatively impacted the implementation of Type B activities. According to one of the CSOs, its instalments had not been paid for 2011 at the time of writing. It is not clear why exactly these delays have happened. According to one of the MOPH officials, WHO has streamlined its operations as a FMA, significantly improving the disbursement process, and the CSOs have also been part of the problem by submitting their reports incomplete and after the deadlines.

- Insufficient communication between the institutions (WHO and HSS Unit) overseeing GAVI's support to CSOs, and the Grant and Contract Management Unit of the MOPH has multiplied the workload on the CSOs in terms of reporting and compliance with various sets of rules and regulations. It has also increased the risk of miscommunication and duplication of efforts between units at the MOPH.
- The short duration of the programme, as compared to other donors who usually implement five year programmes, made it difficult to obtain significant results.
- A shortage of female professionals including trained vaccinators in the targeted areas has increased the operational costs of the education programmes by forcing the NGOs to hire and relocate staff from other provinces.
- Despite the contracts and payments being managed centrally by WHO, the CSOs have had to interact with the provincial authorities to implement Type B activities. This relationship between the CSOs and provincial authorities has been difficult at times, although it has smoothed over time as roles and responsibilities have become clearer.

Exogenous factors, particularly insecurity in programme areas, have also negatively impacted the programme. This has imposed formidable challenges to implementation activities including communication, travel, supply, supervision, monitoring and evaluation. However, this should have been anticipated more readily in advance, given that Type B interventions have targeted some of the most insecure provinces in the country and those populations that are not reached by conventional BPHS health facilities.

5. EVALUATION OF PROGRAMME RESULTS

5.1. Type A support

Type A support has resulted in a database of CSOs which has been, to some extent, useful to MOPH officials in giving them a clear picture of the CSO landscape in Afghanistan. However this report has not been shared with other government departments so its use in practice has been limited. The exercise is, however, reported to have helped the CSOs to communicate and organise themselves through the establishment of a CSO forum with over thirty members. There is a recognised need to regularly conduct the mapping exercise to account for the rapidly changing landscape of CSOs in Afghanistan – this is proposed as part of the Type A extension fund.

In addition, the nomination process has resulted in three CSOs being elected to represent the CSOs at the CGHN – several CSOs have also been elected to other forums, including the HSS steering committee and many technical working groups. CSOs have been included more regularly in the CGHN and attend all meetings. However, the general feeling was that the CSOs are still not fully represented at the CGHN as it has many members from various Directorates of the MOPH, UN agencies, donors, etc. We also note that a number of CSOs and MOPH officials were not aware of the nomination process – this indicates that the process was not inclusive of all stakeholders and that the nominated CSOs may not be representative of other CSOs.

5.2. Type B support

Results framework – outputs, outcomes and impacts

Type B support appears to have worked well and considerable progress against achieving proposed outputs has been made.

- More than 80 community midwives successfully completed the community midwifery education programme in areas where there is serious shortage of female health workers. A majority of them were deployed in public health facilities run by the CSO providing maternal, reproductive health and immunisation services.
- The PPPs, as a natural extension of the BPHS public facilities, have emerged as a viable solution to the problem of a lack of access to services in insecure and remote areas. More than 50 public health service providers have received training, supplies and technical support to deliver immunisation and reproductive health services. Interviews suggest that all the supported health service providers deliver reproductive health and 30 of them deliver immunisation services, in some instances for the first time, in the selected provinces. In Farah province, the contracted private providers carried out 67,700 out-patient department (OPD) consultations, 2,801 antenatal visits, 4,798 referrals for immunisation, and distribution of family planning commodities to 5,701 new users. In Uruzgan, the PPPs have administered close to 24,000 doses of various vaccines to children and women.
- There is also some evidence that Type B support has led to improvements in immunisation coverage. According to the CSO Type B report 2010, the coverage of

pentavalent vaccine increased from 30 and 70% in targeted districts in Uruzgan and Farah provinces in 2007 to 65 and 80% in 2010. We note that this data comes from the routine reporting system which is known to have questionable accuracy and quality – it is also difficult to attribute this change to the CSO programme at this stage and in the absence of a rigorous study design.

To measure the actual impact of the project, the CSOs involved suggested that a final evaluation, qualitative and quantitative, needs to be conducted.

Sustainability

While some outputs from CSO support will have short to medium term benefits, particularly if the trained community midwives are retained in the public health system, there was general agreement that without the continuation and increase of GAVI funding the CME component of Type B support will cease. This could have a significant impact on the availability of midwives at health facilities in the targeted areas – where the activities were in response to a lack of the government CME programme. The effect of this may be emphasised if trained midwives continue to leave the areas most in need.

At present, the PPPs component has been continued after GAVI support with World Bank funding. This indicates that this element of the programme was valued highly in the country and its continued funding is an important achievement.

6. RECOMMENDATIONS

This section presents a summary of recommendations to improve GAVI's support to CSOs in Afghanistan.

6.1. Recommendations to improve effectiveness of the programme

Key suggestions to address some of identified issues in the CSO programme design and implementation include:

- *Improving the clarity of programme objectives.* GAVI should clarify the objectives of CSO support and better define the activities and types of CSOs it wishes to fund. The objectives of the programme should reflect the role that CSOs can play in country including direct implementation, advocacy, M&E, etc.
- *Improve disbursement procedures.* Given that the CSO support was a 'pilot', it should not have been delayed on account of the FMA requirements. Channelling funds through CSOs or the GCMU should be explored. Further, integrating GAVI's CSO funding with funding from other donors under one MOPH management team would bring efficiencies in operations as well as reducing administrative and reporting burden on CSOs.
- *Improve clarity of roles and responsibilities of various stakeholders.* The need to improve clarity in the roles and responsibilities of the various stakeholders involved in the CSO programme was emphasised. This refers to clearly defining the role of the Secretariat and GAVI Partners – including the expectations from Partners and whether these are realistic to achieve.
- *Strengthen the M&E and technical support.* Many stakeholders commented that the M&E could be strengthened, probably through a third party to act as a neutral reviewer of CSO performance. In addition, GAVI's support needs to include technical support to improve the capacity of the CSOs, particularly the national ones.
- *Increase GAVI's country interaction.* It was commented that if GAVI were to have more of a country presence, it would increase their ability to efficiently support and supervise the programme.
- *Increase the duration of the programme.* It was recommended by WHO representatives in country that GAVI increase the duration of the programme to a five year programme. This would be in line with other donor approaches in Afghanistan and would allow greater time to demonstrate results.

6.2. Channelling of funds

The majority of stakeholders favoured funding through the GCMU of the MOPH which is recognised by CSOs and government officials to have enough capacity to manage the funds and contracts, as evidenced by successful management of funds and contracts with large donors, including the World Bank and USAID. The management of CSO support through a separate unit is no longer warranted and has caused a lack of coordination and duplication of efforts between government departments. Channelling the funds through the GCMU will eventually

improve coordination, sense of ownership, accountability and capacity of the MOPH in managing funds more efficiently.

An alternative method of channelling funds among CSOs was to fund a large CSO or an umbrella organisation who would sub-contract local CSOs, similar to the Global Fund's approach. This approach would reduce the bureaucratic burden and increase the efficiency of operations.

A number of issues were highlighted with channelling funds through UN organisations, including: (i) there are conflicting views about their capacity to manage funds and contracts – some stakeholders see this as a strong point of routing funds via WHO or UNICEF[13] while others view it as a weak point; and (ii) they are seen as bureaucratic organisations which would impose rigorous restrictions on fund use.

6.3. Alignment with the HSS programme

Approximately 70% of the resources for the HSS programme are routed to CSOs for various activities, including: running mobile health teams and health sub-centres; implementing demand-side financing; and improving the capacity of the MOPH officials. GAVI's CSO support opened another window of funding for CSOs to train community midwives in four provinces for the first time and pilot-test PPPs in two insecure provinces where some pockets of the population could not be reached by conventional approach. These activities are complementary to the HSS programme and should be integrated into one programme.

[13] We note that some of these comments came from WHO and UNICEF staff.

ANNEX 1: LIST OF REFERENCES

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ANNEX 2: LIST OF CONSULTATIONS

Individual	Organisation	Position
Government and Ministry of Health		
Dr. Ahmad Jan Naeem	Ministry of Public Health	General Director of Policy and Planning
Dr. Ghulam Sarwar Hemati	Ministry of Public Health	Director of Grant and Contract Management Unit
Dr. Ahmad Shah Salehi	Ministry of Public Health	Director of Health Economics and Financing Department
Dr. Abdul Wali Ghayur	Ministry of Public Health	HSS Coordinator
Dr. Gula Khan Ayoub	Ministry of Public Health	EPI Communication Officer
GAVI Partners		
Dr. Najibullah Safi	Ministry of Public Health	PHC Advisor, WHO
Dr. Tahir Khan	WHO	Previously responsible for Type B support within WHO
Type B implementing CSOs		
Dr. Abdul Majeed Sediqi	HNTPO	Country Director
Dr. Ghulam Haidar Rafiqi	MSH	Senior Advisor
Dr. Habib Sahak	IbnSina	Country Director
Dr. Abdul Malook	Move	Country Director
Dr. Hamayon Safi	BDN	Programme Advisor
Dr. Abdul Rahman Shahab	ACTD	Programme Director/General Director
Dr. Najibullah Baleegh	AADA	Implementation Director
Dr. Mirza Khan	BRAC	Programme Coordinator
Dr. Khalil	CAF	Country Director
Dr. Hamid Saljuqi	CHA	Country Director
Dr. Shams	SCA	Health Programme Director

ANNEX 3: KEY STATISTICS ON THE HEALTH SECTOR

A summary of key statistics on the health sector in Afghanistan is presented below:

- A household survey conducted in 2006 found decreases in the infant mortality rate (to 129 deaths per 1,000 live births) and the under five mortality rate (to 191 deaths per 1,000 live births).[14]
- The number of functioning health facilities increased from 496 in 2002 to 1,169 in 2007 and currently the national health management information system reports the number to be 1,739.
- The Balanced Scorecard 2010 report indicates that the proportion of health facilities meeting minimum staffing guidelines increased from 39.3% to 90.2%, family planning availability index increased from 61.4% to 89.0%, and the mean quality score across comparable indicators increased from 50.4 to 70.4, between 2004 and 2010[15].
- The National Risk and Vulnerability Survey (NRVA)[16] conducted in 2008 found a DPT3 coverage of 43%, skilled birth attendance rate of 24%, contraceptive prevalence of 21%, and prenatal visit coverage of 36% .
- The MICS 2003[17] estimates of DPT3 coverage, skilled birth attendance rate, contraceptive prevalence and prenatal visit were 19.5%, 6%, 4.6% and 5.1%.

[14] Afghanistan Health Survey 2007 conducted by Johns Hopkins School of Public Health and Indian Institute of Health Management Research

[15] Afghanistan Basic Package of Health Services Balanced Scorecard National Report 2009/10, published by Johns Hopkins School of Public Health and Indian Institute of Health Management Research

[16] Conducted by the Central Statistics Office - Afghanistan

[17] Conducted by UNICEF

ANNEX 4: DESK REVIEW OF RESULTS OF TYPE B FUNDING

This annex provides a summary of the progress reported in the APRs against the activities and expected results detailed in the Afghanistan country proposal for Type B support. It is entirely desk-based, although the results were largely reinforced by our in-country consultations.

It should be noted that this draft analysis is based entirely on reported progress on indicators by countries, and CEPA has not sought to verify/ validate any of these (and indeed this is not possible given the mandate and timelines of our evaluation). We have however used our judgement, based on the information provided, to present a summary status on the progress achieved.

Structure of analysis

We have structured our analysis as follows:

- We present two tables – the first focusing on activities and outputs, and the second on outcomes and impacts. We have tried to construct these in a consistent manner following CEPA's results hierarchy, given the varying presentations across countries.
- These tables do not intend to map the progress against *all* activities undertaken, but rather, provide an overview of the *main* country level activities and progress achieved.
- We have tried to map both activities that can be assessed quantitatively (e.g. number of trained health workers) as well as activities that can be assessed based on whether they have been completed or not (e.g. conducting a baseline survey).
- We have attempted to summarise the extent of progress achieved by the following categories: "Considerable progress", "Some progress" and "Unknown"[18] – however this represents CEPA's subjective opinion based on the information in the proposal and APR documents available, and may not be completely accurate given the poor quality of information contained in these documents (see limitations below).

[18] Our categories for summary progress are self-explanatory, however please note that where it is not clear either (i) what progress has been achieved; and / or (ii) the context for the progress (i.e. where targets or milestones are not noted), we have marked the progress as "unknown", despite APRs reporting on the progression of activities.

Limitations

There are a number of limitations to our analysis, as detailed below:

- The latest APRs we have been able to analyse was the 2010 APR. It is likely that further progress will be reported in future APRs (especially 2011, given ongoing funding support in the countries).
- Activities, outputs, outcomes and impacts (baselines and targets) are generally not clearly laid out in the country proposal and APRs. For example, sometimes these are noted on a general basis rather than defined by specific targets and timelines. Also, the context for some of these results is not clear – i.e. what part of the problem are these activities and their results aiming to solve?
- It is often unclear how the results hierarchy, or logical framework, has been constructed. For example, activities proposed do not always match outputs or outcomes proposed/ reported.
- As timelines and other factors have changed during the implementation of activities, target timelines, and sometimes the targets themselves, have changed.
- It is difficult to track progress along the results hierarchy as the information in the APRs does not always relate directly to the proposals (including inconsistencies between subsequent APRs).
- While we recognise that outcome and impact indicators may not be possible to measure as part of this evaluation, often they are not reported in the APRs. Where this is the case, we have inserted the summary status 'unknown' into the tables.
- The categorisation of summary progress is based on our subjective opinion – and is not directly comparable across countries, as the level and quality of information varies considerably across countries.

Country level summary

The tables below provide a work-in-progress summary for Afghanistan:

Table A4.1: Progress on outputs

Proposed activities		Progress against outputs	Summary status
Training of Community Midwives (CMWs) in four underserved provinces	• Training of 88 Community Midwives (CMWs) in four underserved provinces	• In 2009, training had commenced in all four provinces. • By 2011, training was completed in all 4 provinces and over 70 trained CMWs were deployed to BPHS health facilities.	Considerable progress
	• At least 80 trained CMWs deployed to BPHS health facilities in four provinces	• 71 trained CMWs were deployed as of May 2011. The remaining CMWs were due to be deployed in June 2011.	Considerable progress
	• 4 new CME programmes in selected provinces to be established and accredited by ANMEAB[19]	• The four programmes were accredited by ANMEAB as of December 2009.	Considerable progress
	• About 40 private sector providers (PSPs) from Farah and Uruzgan provinces trained	• At February 2010, 55 PSPs had been trained.	Considerable progress
Establish a replicable model of partnership with PSPs to provide access to EPI and basic RH services	• Develop about 50 formal partnership agreements with PSPs to provide access to EPI and basic RH services in insecure and underserved areas and establish a replicable model of partnership	• In 2010, 55 contracts were signed with PSPs to provide EPI and basic RH services in Farah and Uruzgan provinces.	Considerable progress
	• At least 10 PSP outlets in Farah and Uruzgan provinces upgraded	• The 2010 APR text states that all 55 PSP outlets have been 'renovated', however, the M&E section of the APR states that none have been upgraded.	Unknown

Table A4.2: Progress on outcomes and impacts

Proposed outcomes and impacts	Reported progress	Summary status
Percentage of BPHS health facilities with at least one female health worker in Faryab, Nimroz, Zabul and Ghazni provinces to rise from 56% to 80%	• Progress on the percentage of BPHS health facilities with at least one female health worker is not reported.	Unknown
DPT-3 coverage in the targeted areas of Uruzgan and Farah to rise from 30% and 70% to 80% and 80% respectively	• At January 2011, Farah had reached 80% coverage, while Uruzgan had reached 65%.	Some progress

19 Afghanistan Nursing and Midwifery Education Accreditation Board.

ANNEX 5: FACTORS IMPACTING EFFECTIVENESS

There are a number of factors (both positive and negative) which have affected the effectiveness of the CSO programme in Afghanistan. These factors are summarised in the table below. Positive factors are indicated by '+' while negative factors are indicated by '-' and factors which have been viewed differently by different stakeholders are indicated by '±'.

Table A5.1: Summary of factors affecting effectiveness

Type	Factors
GAVI-specific factors	± Limited funding and payment (of Type B) delays – GAVI Secretariat technical support to government has been timely and efficient – Demand for greater GAVI participation at the country level
Country-specific factors	± Insecurity – Government/ CSO relationship has been strong for a number of years
Programme-specific: Type A	± Rapidly changing landscape ± CSO mapping and nomination process were unclear to many stakeholders
Programme-specific: Type B	– Transparent selection of the CSOs – Lack of communication between the GAVI related partners and MOPH units and the GCMU – Channelling money via the FMA – Exclusion of community-based CSOs has not helped the mobilisation of communities ± Unclear role of GAVI Partners ± Unclear objectives of GAVI CSO support