COUNTRY EVALUATION REPORT

EVALUATION OF THE GAVI ALLIANCE FUNDED HEALTH SYSTEM STRENGTHENING PROGRAM

AFGHANISTAN

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Conducted by:
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I. EXECUTIVE SUMMARY

Introduction

This report transmits the results of evaluation of GAVI Funded Health System Strengthening program from 2008 to 2013 and is prepared by Governance Institute-Afghanistan (G-IA).

The application for HSS program was submitted in May 2007, the program started -in December 2007, and it was successfully completed in December 2012 with a total fund amounting to US$34,100,000. The main objectives of HSS Program in Afghanistan were: 1) to improve access to quality healthcare services, 2) to increase demand for and utilization of mother and child healthcare services and 3) to advance the ability of the MoPH to fulfill its stewardship responsibilities at various levels.

Methodology

This evaluation relied on a combination of qualitative and quantitative approaches through applying the following methods: desk review of country level documents, cross sectional survey in HSS program areas, in-depth interviews with various stakeholders, and a SWOT analysis. The evaluation scope was widened to collect inforamtion from six provinces of Afghanistan namely Kabul, Lghman, Panjshir, Badakhshan, Ghzni and Kandahar between August 11 and October 31, 2014. The selection criteria was developed in close consultation with MoPH relevant department given the field realities and density of GAVI funded HSS program interventions operationalized. List of all provinces where GAVI funded HSS program was implemented has been developed, it was made sure that provinces selected would ensure different geographic represenation including, central region, eastern region, northern region, south and southwestern region. Provinces selected include urban, semi urban and remote and deep remote provinces with relatively secure, none secure and highly none secure provinces to ensure representativeness of the sample. Data collection teams received comprehensive training on data colletion, editing and recording. Data collection teams include data collecter, moderator and supervisor. Quality assurance measures including on the spot and post spot monitoring was conducted. Post spot monitoring was conducted through key evaluaiton team members.

Qualitative data were analysed using thematic content analysis approach where themes and subthemes were defined and then inductive and deductive analysis techniques were applied. Qualitative data were summarized , similarity and contrast check was made. Theny synchronization of data were conducted applying claustering and skimming approaches to enable the reseachers to figure out similaries and contrast in each thematic areas. Summaries of qualitative analysis were produced and shared among evaluation experts to be reviewed seperately and final analysis reflected in the report.

Quantative data was analysed with the support of Statistical Package for the Social sciences (SPSS) software.

Results

To accomplish the objective 1 “improving access to quality healthcare particularly maternal and child health” the following interventions have been planned and successfully operationalized:

1. 120 sub-health centers have been established in underserved communities in Afghanistan to improve access to and utilization of maternal, child health care including EPI services. At present the sub-health centers received support from the EU and World Bank, providing Basic Package of Health Services to the most vulnerable population throughout the Afghanistan.
2. 26 mobile health outreach teams were established to visit isolated villages that are too far (in excess of 20 km) from existing health facilities and are un-served by the existing healthcare system. These mobile outreach teams provided, as an interim measure until the facility-based healthcare system is adequately expanded, a wide range of health services including health education, immunization, TB case detection and basic curative care including treatment of Diarrhea and Pneumonia, referral, family planning, antenatal and post natal care services have been provided. 26 mobile health outreach teams have been providing lifesaving maternal and child health services including EPI services for the most isolated and vulnerable populations in Afghanistan.
3. A pilot Integrated Management of Childhood Illnesses (IMCI) Project have been expanded to improve access to antenatal care; appropriate care seeking behavior; promotion of immunizations; exclusive breastfeeding during first six months; complementary feeding and appropriate treatment for diarrhea, Acute Respiratory Infection (ARI) and fever at first-level facilities; personal hygiene; and micronutrient supplementation. This program has been rolled out incrementally over three years to train at least 80% of entire cadre of 15,000 Community Health Workers (CHWs) in Afghanistan. As a result, 12392 CHWs and 530 community health supervisors meeting a target of (86%) received training on IMCI.

4. Conducted in-service training program for basic package of health services (BPHS) primary healthcare providers in 13 provinces of Afghanistan. The training was planned to be offered to at least 3,500 healthcare providers focusing on the seven primary components of the BPHS which are: i) maternal and newborn heath; ii) child health and immunizations; iii) nutrition; iv) communicable disease treatment and control; v) mental health; vi) disability and physical rehabilitation; and vii) regular supply of essential drugs. In total 804 doctors, nurses, midwives, pharmacists, and community health supervisors (CHS) have received training on the above mentioned topics. Given the fact that similar training was supported by other donors, therefore, reprograming was made for this activity.

To accomplish the second objective "increasing demand for and utilization of mother and child healthcare services" the following interventions have been planned and successfully operationalized:

1. Implement a nationwide strategic Information, Education and Communication (IEC) initiative. Mass media campaigns (especially though local radio stations) as well as set of key messages regarding the dangers signs and appropriate responses to ARI and diarrhea, uptake of immunization among children and pregnant women, and promotion of Antenatal Care and skilled birth attendance, have been used. This was complemented by involving BPHS staff, community leaders, teacher and Mullahs focusing on awareness raising and educating communities.
2. Pilot the effectiveness of a model of demand side financing and providing monetary performance incentives to CHWs. GAVI fund was utilized in response to persistently low service utilization, the MoPH launched a two-year conditional cash transfer project (from 2009 to 2011) that provides monetary incentives to households when the woman gives birth at a government facility, and when a child receives the third dose of Diphtheria-Pertussis-

Tetanus (DPT3) vaccination at the facility. In addition, the program provides monetary incentives to CHWs to increase referrals for institutional delivery and DPT3.

A multi factorial operational study was designed and conducted to seek the association between monetary incentive schemes and utilization of maternal and child health service and address the following questions:

- Are monetary incentive schemes associated with increase in institutional delivery?
- What types of incentive scheme (e.g., household, community health worker, both household and community health worker) appear to be more effective in increasing institutional delivery (and in terms of increasing DPT3 vaccination)?
- What are the socio-demographic factors associated with uptake of cash incentive?

The results across the three intervention arms that provided monetary incentives (Household Arm, CHW Arm, Household and CHW Arm) showed that the uptake of Conditional Cash Transfer (CCT) for both institutional delivery and DPT3 were highest among women who are between the ages of 20 – 30, who have some level of education, and who live closer to a health care facility (within 1 hour from a health care facility).

To accomplish the third objective ***"improve the ability of the MOPH, at various levels, to fulfill its stewardship responsibilities"*** the following interventions have been planned and successfully operationalized:

1. The physical, information/communication technology infrastructure and means of transportation of the M&E Directorate of the MoPH adequately upgraded at the central, provincial and district levels. GAVI fund was utilized to strengthen the stewardship function of MoPH at different level. This is accomplished through recruiting one senior advisor and four consultants to provide technical backstopping to M and E Directorate of MoPH and assist in capacity building of M and E Directorate's staffs. Through the support of GAVI fund 25 staffs of M and E Directorate have completed one year diploma course training where their skill improved in report writing, Biostatistics, Health System Research, Applied epidemiology, health survey and HMIS. M and E Directorate staff equipped with transportation, infrastructure and communication facilities to monitor the progress Basic Package of Health Services and Essential Package of Health Services at national level. As a result, the stewardship functions of MoPH at different level have improved and proportion of provinces visited at least four times per year using national monitoring checklist increased from 29% in 2007 to 85% in 2012.
2. Expanding the capacity building program for MoPH managers at the central and provincial levels. With the assistance received from GAVI funded HSS program, in total 1287 managers at central and provincial MoPH including 759 Provincial Health Officers (PHO) working at provincial level, 328 staff working in central MOPH , and 200 District Health Officers appointed at the district level have received training on polices and strategies of MoPH, supportive supervision, monitoring and evaluation, financial management; planning and budgeting; English language and computer competency based training out of which 72 staff at different level were female staff.
3. Developing a communications and internal advocacy program to seek increased funding from the GOA and the international community for the MoPH. GAVI funded was utilized to produce tangible results to advance a communication and internal advocacy program. Public Relation Strategy was developed and launched to promote MoPH and its partners' achievements and transformation changes produce in the health sector of Afghanistan.

GAVI fund utilized to develop electronic Website of MoPH where all policies, strategies, and success stories are launched and being access at national and international level. Press travelers of MoPH to share the success stories and lessons learned at the provincial level have been conducted. Documentary films produced to record innovations supported by GAVI funded HSS program. Such innovations include launching midwifery program, mobile health teams, and vaccination interventions to improve the coverage of vaccination in Afghanistan.

4. Launching an initial cadre of District Health Officers (DHOs) who extended the MoPH's reach into more remote areas of the country. GAVI fund was utilized to strengthen the stewardship function of MoPH at district level where more collaboration and coordination was needed between different partners and stakeholders. Out of 250 DHOs, 152 of them have been recruited through the support received from GAVI. At present all DHOs are absorbed within the formal structure of MoPH.
5. Launching a community demographic surveillance system to provide valid and timely information on trends in births, deaths and coverage of healthcare services. This activity was reprogramed; given the fact that such capacity was not existed to launch a community demographic surveillance system. This decision was unanimously made by the HSS steering committee which represents the donor decision at the country level.

The two major interventions that contributed towards improving the equity have been establishment of SHCs/MHTs and partnership with private service providers. Establishing SHCs and Mobile Health Teams improved access to maternal and child health services in the remote and undeserved areas of Afghanistan in 23 provinces and establishing private public partnership model improved this access in insecure districts of Kandahar, Helmand, Nuristan, Pakya, Urozgan and Farah Provinces. In total, 121 SHCs and 26 MHTs were established through the support of GAVI HSS funds although the original proposal planned to establish 120 SHCs and 80 MHTs. The target number of MHTs was not met because the fund allocated in the proposal was not sufficient to establish 80 MHTs. The HMIS data shows that at GAVI HSS supported health facilities outpatient concentration index is tending towards female, as 63% of OPD clients are female.

The HMIS data shows that percentage of districts that achieved coverage of Penta 3 vaccination greater than 80% has increased from 49% in 2007 to 61% in 2012.

According to EPI reports 11% of districts have Penta3 coverage of less than 50%. In addition, 61% have > 80% of Penta3 coverage which shows visible geographic inequity in immunization coverage. On the other hand, no specific data is available to examine the depth of inequities in relation to gender disparities in all districts and no proper information is available to comment of immunization coverage in different socio economic groups' i.e. children in different wealth quintile groups.

For the first time, it was made possible to monitor every province on a quarterly basis within the framework of GAVI funded HSS Program in Afghanistan. About 85% of provinces have been visited using national monitoring checklist in 2012.

All key stakeholders in the health sector including EPI programs, government entities, NGO partners, civil society organizations, and the private sector, have been well informed and especially involved in the implementation phase of HSS program. Over 14 directorates of MoPH at central level and 34 directorates at provincial level were involved in implementation of the HSS. In addition, over 25 NGOs/CSOs were involved in HSS implementation. Further for profit private sector was involved in delivery of immunization and basic MCH services in insecure areas of the country. *One of respondent from HSS-SC said that "One of the success stories was the development of HSS proposal to GAVI.*

First the process was entirely inclusive and almost all relevant departments and strategic partners been involved. Second, feasible and supplementary interventions to the BPHS been introduced such as building capacity at community level by CHWs training, establishment of mobile and sub health center, establishment of district health officers."

Conclusion

The results indicate that HSS program has been successfully implemented and has produced tangible results. In addition the program has generated other positive externalities. However, there have been some challenges and weaknesses within the program and the outsider context. These challenges are related to coordination, communication, equity gaps, gender disparities, lack of qualified staff especially female, and insecurity, and low payment levels, lack of clear sustainability strategy, staff turnover, and weaknesses in regulatory frameworks where most of them are not under direct control of MoPH. The work done in HSS program in Afghanistan is commendable, however, rebuilding Afghan health system will require sustained support and commitment of all partners and donors and strengthening inter-sectorial coordinated efforts of Government of Afghanistan.

The Big Idea

GAVI HSS funded program has contributed to strengtheing the health system of Afghanistan and produced tangible results through applying innovative and multifaceted approaches to improved access to quality health care services, increasing demand for and utilization of maternal and child health care services including EPI, and Strengthening the the stewardship functions of the MoPH at different level. The health system strengthening component of GAVI funded HSS program was crucially important. Input and capacity development interventions contributed to the institutional development of MoPH and its partners, where such approach enable MoPH to envision and produce health sector outputs, outcomes and impacts.

GAVI funded HSS program has focussed on strengthening and improving internal and external dimesion of health system of Afghanistan.

The internal functional dimension of GAVI funded HSS program focused on improving MoPH strategies; system values and power distribution; structures; work processes; coordination and collaboration; material and non-material incentives; and operational relations to partners, various departments and civil society organizations.
The external functional dimension of GAVI funded HSS program focused on producing resources, results-based performance, targets, timeliness and adequacy of resources, oversight bodies (e.g HSS Steering Committee) and formal accountability requirements.

Tangible Results Produces:

- Proportion of provinces visited at least four times per year using national monitoring checklist has increased from 29% in 2007 to 85% in 2012.
- Proportion of CHWs trained on C-IMCI has increased from 2% in 2007 to 62% in 2012.
- Proportion of children who received treatment for diarrhea at community level has increased from 30% in 2007 to 57% in 2012.
- Average number of persons referred by CHWs per quarter has increased from 14.8 in 2007 to 34.4 in 2012.
- Number of contacts made per person per year has increased from 0.6 in 2007 to 1.8 in 2012.
- Proportion of deliveries attended by skilled birth attendants has increased from 19% in 2007 to 46% in 2012.

- Proportion of children <1 who received one dose of Measles vaccine has increased from 68% in 2007 to 81% in 2012.
- Proportion of districts with more than 80% coverage of PENTA3 has increased from 49% in 2007 to 61% in 2012.
- Proportion of children less than one year who received three doses of PENTA3 vaccines has increased from 77% in 2007 to 87% in 2012.
- Under one year mortality rate has reduced from 129/1000 live births in 2006 to 77/1000 live births in 2010.
- Under five years mortality rate has reduced from 191/1000 live births in 2006 to 97/1000 live births in 2010.
- Maternal mortality ratio has reduced from 1600/100000 live births in 2002 to 327/100000 live births in 2010

Abbreviations and Acronyms

ADB	Asian Development Bank
AHS	Afghanistan Household Survey
ANDS	Afghan National Development Strategy (Interim Poverty Reduction Strategy Paper)
APHI	Afghan Public Health Institute
AREU	Afghanistan Research and Evaluation Unit (NGO)
ARI	Acute Respiratory Infection
ARDS	Afghanistan Reconstruction and Development Services
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BSC	Balanced Scorecard (Afghanistan Health-Sector Balanced Scorecard)
CCT	Conditional Cash Transfer
CGHN	Consultative Group on Health and Nutrition (HSCC equivalent in Afghanistan)
CHC	Comprehensive Health Center
CHS	Community Health Supervisor
CHW	Community Health Worker
cMYP	Comprehensive Multi-Year Plan for Immunization
CSO	Civil society organization
DH	District Hospital
DFID	Department for International Development (United Kingdom)
DHO	District Health Officer
DSF	Demand Side Financing
DSS	Demographic Surveillance System
EC	European Commission
EMRO	Eastern Mediterranean Regional Office (of the World Health Organization)
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
EU	European Union
FMA	Financial Management Assessment
FS	Financial Sustainability
GAVI	The GAVI Alliance (formally known as the Global Alliance for Vaccines and Immunizations)
GI-A	Governance Institute-Afghanistan
CBHC	Community Based Health Care
GCMU	Grants and Contracts Management Unit
GDP	Gross Domestic Product
GOA	Government of Afghanistan
HIS	Health Information System
HMIS	Health Management Information Systems
HSCC	Health Sector Coordination Committee
HSS	Health System Strengthening
HSS-SC	Health System Strengthening Steering Committee
ICC	Interagency Immunization Coordination Committee
IRC	Independent Review Committee
IEC	Information Education and Communication
INS	Injection Safety

IIHMR	Indian Institute of Health Management Research
IMCI	Integrated Management of Childhood Illnesses
C-IMCI	Community Integrated Management of Childhood Illnesses
ISS	Immunization Support Services
JHU	Johns Hopkins University
JICA	Japan International Cooperation Agency
JRF	Joint Reporting Format (UNICEF, WHO, MOPH annual Joint Reporting for EPI Coverage)
MICS	Multi-Indicator Cluster Survey
MOF	Ministry of Finance
NHP	National Health Policy
NIDs	National Immunization Days
NRVA	National Risk and Vulnerability Assessment
PEMT	Provincial EPI Management Team
PHCC	Provincial Health Coordinating Committee
PHD	Provincial Health Director
PHO	Provincial Health Office
PHSPs	Profit Health Service Providers
PPGs	Performance Based Partnership Grants
PPHD	Provincial Public Health Directorate
P/PPTF	Public/Private Partnership Taskforce
PRR	Priority Reform and Restructuring
REMT	Regional EPI Management Team
SPSS	Statistical Package for Social Sciences
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

II. INTRODUCTION

This report transmits the results of evaluation of GAVI Alliance funded health system strengthening (HSS) program in Afghanistan . This report has been prepared by Governance Institute-Afghanistan (GI-A).

A. Country Context and GAVI Alliance Support

Afghanistan is a land locked country which has been ranked 158 out of 172 countries in Human Development Index (HDI). Illiteracy is a major challenge for the country, especially the low literacy rate among women (12%) and the mean age for marriage at 17.9 years.

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

Trends of infant and child mortality, known to be among the highest in the world, were the first signals of success. Infant and child mortality rates were decreased from 165 and 257/1000 in 2002 to 129 and 191 respectively in 2008. Furthermore, the Afghanistan Mortality Survey 2010 (AMS) shows a further reduction to 77 and 97/1000 live births respectively.

WHO-UNICEF coverage estimates of immunization coverage shows considerable increase in the proportion of targeted children covered by the various antigens. EPI services cover the whole country including the remote areas. EPI services are available at various levels of health facilities. Vaccination efforts need to be reinforced among the currently marginalized populations like the nomads and Internally Displaced Peoples (IDPs) in the more peripheral health facilities like the health sub-centers (HSCs). All these gains are attributed to the support of all health sector partners including but not limited to donors, state and non-state organizations, UN agencies and dedicated health workers.

The implementation of GAVI funded HSS Program in Afghanistan started in 2008. This was a significant development and led to major important outcomes far exceeding the planned objectives. The HSS program introduced and implemented a number of innovative interventions to promote the coverage and performance of, in particular, EPI and basic MCH services. The training of community midwives in remote provinces through partnership with NGOs and the use of the private sector capacity in security compromised areas proved successful innovation in the health system of Afghanistan. In 2007, the DPT coverage was 77% and jumped to 87% in 2010[1] which is an example of great achievement.
GAVI-HSS funds have empowered the MoPH to fill the gaps in improving access to quality healthcare services; increasing demand for and utilization of maternal and child health care services; and improving the ability of the MoPH at various levels to get done its stewardship functions.

[1] Reports of Routine EPI, 2011 APR

Despite impressive gains, there are still myriad of challenges. There are, therefore, two important conclusions about the health sector in Afghanistan: first, it has made impressive progress since 2001; and second, there is still a long way to go until Afghanistan has acceptable health outcomes and an adequate health care system.

B. Objectives of Evaluation

Afghanistan is the first cournty being evaluated following a successful implementation of GAVI funded HSS Program from 2008 to 2013. The specific objectives of this contry level evaluation is as follows:

- To assess the relevance of GAVI HSS support to the contry needs and health system prioritties;
- To analyze concerns related to the sustainability of GAVI funded HSS programme;
- To identify the GAVI funded HSS Program contributions toward achieving national health goals and objectives;
- To assess GAVI funded HSS Program impact on improving the health equity concepts;
- To measure the performance of GAVI funded HSS Program against its stated objectives and benchmarks;
- To elicit HSS lessons learned including strenghts and weaknesses; and
- To provide program and policy recommendations for improving effectiveness and impact of GAVI support in Afghanistan.

C. Methodology

The external evaluation of GAVI funded HSS country level program utilizes a combination of qualitative and quantitative multifaceted and participatory approache in six provinces of Afghanistan: Kabul, Lghman, Panjshir, Badakhshan, Ghzni and Kandahar between August 11 and October 31, 2014. Specifically, this evaluation employed the followoing methods in evaluating HSS program:

(i) Desk review of country level documents
(ii) Field survey of operationalization of GAVI supported HSS Program activities
(iii) In-depth interviews with different stakeholders and
(iv) SWOT analysis to feed the overall findings and draw policy and program recommendations.

The desk review included a thorough reading of the following key documetns:

1. Afghanistan National Health Policy 2005-2009
2. County Multi Year Plan (EPI) 2006- 2010
3. Health Sector Strategy 2008-2012 (draft which was submitted along with proposal, meanwhile the final one).
4. GAVI HSS Application Guidelines March 2007
5. GAVI- HSS Proposal May 2007
6. Steering Committee meeting minutes (2008-2012)
7. GAVI Alliance Annual Progress Reports (2008-2012)
8. Afghanistan Mortality Survey Report (2010)
9. Afghanistan Household Survey Report (2006)
10. Balanced Score Card Report (2012)
11. Report on "Evaluation of Mobile Health Teams in Afghanistan", 2011

12. Impact Evaluation of the Decentralization of Health Services to District Health Officers in Afghanistan, May 2011
13. Study Report, Evaluation of Public Private Partnership, Urozgan Province
14. Progress Report on Demand Side Financing
15. Report on Reproductive Age Mortality Survey 2002
16. Application for GAVI funded HSS Program (2008-2013)
17. Other country level documents i.e. health sector review reports, WB reviews, and NRVA reports.

Field survey covered the following six provinces: Kabul, Ghazni, Kandahar, Laghman, Panjshir and Bakakhshan. The selection criteria was developed in close consultation with MoPH relevant department given the field realities and density of GAVI funded HSS program interventions operationalized. List of all provinces where GAVI funded HSS program was implemented has been developed, it was made sure that provinces selected would ensure different geographic represenation including, central region, eastern region, northern region, south and southwestern region. Provinces selected include urban, semi urban and remote and deep remote provinces with relatively secure, none secure and highly none secure provinces to ensure representativeness of the sample. The list of provinces where GAVI HSS program was implemented is presesented as annex one.

In-depth interviews were conducted with the following staff: HSS team at the central level, HSS Steering Committee Members, M&E Department staff, UN-WHO relevant staff, CBHC Department staff, healthcare promotion directorate staff, CHWs/CHSs, provincial health directorate staff, BPHS implemnting NGO staff, and district health offices. Interviwers were selected purposively based on the their level of involvemnt in health systems strenghteing, immunization programs, delivery of primary care especially BPHS, poliyc formulation and monitoring and evaluation. In total, 38 provincail helath officers, 25 district health officers, 13 M & E officers, and six HSS streeing committee members were interviewed. For provincial and district health officers structured and semi-structured questionnair were applied while for the rest two categories of reponded a specific tool mostely with open ended questionnaire have been applied. In each province, guidelines for C-IMCI, national monitoring checklist, filled form of monitoring checklist and feed back mechansim were observed. In additoin the TORs of provincial heatlh coordinaito committee, job descriptions and annual workplan of District Health Officers, Provincial Health Officers and BPHS providers have been reviewed at provincial and district levels. The administrative data (HMIS data) have been reviewed at both the central and provincial levels. Finally at central level of MoPH the inventory list of equipment provided through GAVI/HSS fund was observed.

Qualitative data were analysed using thematic content analysis approach where themes and subthemes were defined and then inductive and deductive analysis techniques were applied. Qualitative data were summarized , similarity and contrast check was made. Theny synchronization of data were conducted applying claustering and skimming approaches to enable the reseachers to figure out similaries and contrast in each thematic areas. Summaries of qualitative analysis were produced and shared among evaluation experts to be reviewed seperately and final analysis reflected in the report. Quantative data was analysed with the support of Statistical Package for the Social sciences (SPSS) software.

The data gathered from desk review, in-depth interviews and site visits were triangulated to draw overall findings and policy recommendations.

III. EVALUATION RESULTS

A. Relevance of GAVI Funded HSS Program to Afghanistan:

GAVI funds have been customized to the health priorities, goal and objectives of national health system of Afghanistan. GAVI funds have been utilized to boost access to immunization and quality maternal and child health care services, increasing demand for and utilization of maternal and child health care services, and improving the ability of the Ministry of Public Health at various levels to fulfill its stewardship function. It has created a unique fit between different health system gaps and health strategic objectives in Afghanistan. For instance, Public Private Partnership Model has been established in the provinces where the coverage of EPI was low. Mobile health teams and sub health centers have been established in underserved areas to provide services to the marginalized population where the sub health centers and mobile health teams become an integral part of BPHS. One of the main functions of MoPH is to steward the health sector. GAVI funded HSS program supported M & E Directorate staff of MoPH by providing training capacity building, transportation, internet facility and incentives to monitor the implementation of strategic interventions. District Health Officers have been recruited through the support of GAVI fund to improve coordination between MoPH and its partners at district level and monitor the performance of BPHS implementers.

GAVI HSS funds are indeed aligned with country context, health system needs and procedures as illustrated by the following evidence:

- **Country-driven**: The MoPH led the process of the proposal development and implementation. GAVI HSS has addressed the health system problems and bottlenecks identified by the country itself. In particular, the Ministry of Public Health developed GAVI funded HSS proposal on the basis of critical gap analysis of health system using recent data available. The main purpose of this analysis was to identify critical areas for GAVI HSS support and to target gaps in current funding for the health system of Afghanistan. The Working Group for the GAVI-HSS application development was delegated by the Consultative Group on Health and Nutrition at its January 31, 2007 meeting and consisted of representatives from MoPH, UNICEF, WHO, Ministry of Finance.

  During the process, other experts and stakeholders from NGOs, technical agencies, and CSOs were also invited to working group (WG) meetings and contributed to different segments of the application and reviewing the different drafts. The CGHN-designated WG for GAVI-HSS application development met on a weekly basis starting February 2007, and was supported by a number of international agencies, including the World Health Organization (WHO). The proposal was drafted in a participatory process. Further to the drafting GAVI application; the application was reviewed by staff of MoPH, technical experts from UNICEF, WHO, USAID, World Bank, Johns Hopkins University and representative from NGOs and ICC. After a comprehensive review of GAVI application, the application has been approved and endorsed by the CGHN members at the 2nd May 2007 meeting when the final draft was presented. The final draft was approved by the Deputy Minister Technical MoPH, and final approval for the application was given by the Minister of Public Health and Minister of Finance. The final version of application was submitted to GAVI secretariat.

The records available from proposal development process at country level as well proposal evaluation report by GAVI–IRC confirms this. In addition, all major decisions have been taken at the country level by the HSS steering committee members with regard to implementation of activities supported by GAVI/HSS fund. One of respondent concluded that *"this program designed in close consultation of different key player and finally we come up with feasible strategies. This diverse participation paves the way to attract donor attention and eventually accepted and awarded fund to proposed strategies by GAVI secretariat"*.

- **Health System-aligned**: GAVI HSS funds are consistent with health sector goals, objectives, and strategic interventions of the Ministry of Public Health. The proposal was developed in line with the priorities reflected in National Health policy 2002-2009, draft of Health and Nutrition Sector Strategy 2008-2012, Country Multiyear plan (cMYP) 2006-2010. HSS interventions are also in line with the Strategic Plan for the Ministry of Public Health (2011-2015).

- **Harmonized:** The GAVI HSS fund has been proved to be an added value to current or planned interventions by complementing rather than competing with existing donor support. One of respondent expressed that *"The HSS funds operate as a catalyst and tried to fill the gaps that left from other donors e.g. establishment of SHC, MHC particularly in remote area where BPHS does not exist geographically are hard to reach"*. The HSS support contributed significantly to extend BPHS reach at remote areas which is the country core service delivery strategy through establishment of SHCs and MHTs. The criteria used for establishing SHCs/MHTs have been Accessibility, Population per available HF(s) and Average Monthly Utilization of the closest HF (s) and evidence shows that sites have been proposed from provincial levels. For CSO type B only those private for profit health facilities have been selected where BPHS health facilities have been existed at the vicinity of 20 kilometer. The provinces and districts have been selected based on vaccination coverage, (districts with lowest vaccination coverage based on HMIS data), and districts where security is a major challenge. However monitoring of CSO support type B model is still a major challenge from the central level.

- **Flexible:** The MoPH during implementation course was able to make significant adjustments in increasing, decreasing, modification or cancelation of some activities. Cancellation of Demographic Surveillance System (DHS) that was endorsed by HSS-SC and approved by GAVI; and partly implementation of In-service training programs are the examples. DHS was cancelled because of funding limitations while In-service trainings were ceased because of uptake of this intervention by USAID.

- **Inclusive and collaborative:** All key stakeholders in the health sector including EPI programs, government entities, NGO partners, civil society organizations, and the private sector, have been well informed and especially involved in the implementation phase of HSS program. Over 14 directorates of MoPH at central level and 34 directorates at provincial level were involved in implementation of the HSS. In addition, over 25 NGOs/CSOs were involved in HSS implementation. Further for profit private sector was involved in delivery of immunization and basic MCH services in insecure areas of the country. One of respondent from HSS-SC said that *"One of the success stories was the development of HSS proposal to GAVI. First the process was entirely inclusive and almost all relevant departments and strategic partners been involved. Second, feasible and supplementary interventions to the BPHS been introduced such as building*

capacity at community level by CHWs training, establishment of mobile and sub health center, establishment of district health officers."

- **Innovative**: GAVI funded HSS programshave encouraged the development of innovative models and approaches in Afghanistan. GAVI funds have sometimes been utilized to try something completely new, and pursue a different approach to strengthen the health system of Afghanistan. For example, through CSOs mediation, national immunization days (NIDs) have been conducted in the most insecure areas where it has never been conducted in the past Piloting Performance Based incentives and Conditional Cash Transfer schemes have been the other example. One of key informant in Kandahar provinces state that *"The vast majority of intervention proposed by GAVI HSS, were the new concept within and applied for the first time in the country for example recruitment of DHOs, community participation to solve problem even security situation, establishment a coordination mechanism between health facilities and community by enabling CHWs and Shura-i-sehi".* Establishing Public Private Partnership by contracting and training private for profit health providers in insecure provinces is another example. This model aims to provide vaccination, basic reproductive health services, treatment of common diseases and referral services in insecure and hard to reach provinces.

- **A medium for Technical Support**: GAVI HSS funds have been utilized in providing country driven technical support and capacity building. GAVI HSS has strategically positioned key experts in various departments of MoPH to provide technical assistance and enhance departmental capacity when needed. For instance, GAVI HSS Program has recruited one senior Monitoring and Evaluation advisor and four monitoring consultantsin the M&E Directorate of MoPH. In addition, HSS Steering Committee that has representative from all national and international key players has also extended their technical support to MoPH.

- **Results-oriented**: Afghanistan has linked its strategies for tackling "bottlenecks" or barriers in the health system with specific indicators that showed how the GAVI HSS fund has ultimately resulted in improved immunization coverage and other child and maternal health outcomes. The ultimate impact and results of GAVI funded HSS proposal is evidenced at the peripheral level (i.e. district and service delivery levels). GAVI funded HSS interventions have improved the coverage of immunization through involvement of private for profit health service providers (PHSPs) in insecure districts of Afghanistan. A study was conducted by HNI a CSO in March 2013 in three districts of Urozgan province (Trinkot, Dehrawod, and Chora). In this study, 510 households in 34 clusters were selected through a stratified cluster sampling. The study results showed that three important indicators on childhood vaccination are significantly higher in PHSPs villages than non PHSPs villages. Penta 3 coverage was 52.19% and 5.24% respectively, measles immunization coverage was 61.40% and 24.82% respectively and the mean number of vaccination per child was 5.55 and 2.47 respectively.[2]

[2] Dr. MartijnVink, Epidemiologist (2013) Study Report Evaluation Study Public Private Partnership Program Urozgan, HealthNet TPO Amsterdam.

B. Sustainability of GAVI Funded HSS Program in Afghanistan

The MoPH has tried to ensure the technical and financial sustainability of GAVI funded interventions beyond the life of GAVI funding. One of the major issues in Afghanistan has been low capacity. The MoPH has utilized GAVI fundsto advance its capacity mostly in expanding access to health services, and its stewardship functions.As stated above, technical experts have been recruited to different department of MoPH in order to assist in capacity building of staff of MoPH. Majority of GAVI funded HSS interventions have already been integrated into the current structures and national health strategic interventions. Sub Health Centers (SHCs) and Mobile Health Teams (MHTs) which were two major activities in HSS application have been absorbed through BPHS beyond 2013. However, this absorption is to shift the source of financial support from GAVI to mostly the EC, USAID and WB which are still external funding sources for the health sector. Activities such as launching the initial cadres of District Health Officers (DHOs) have been absorbed within Government systems and paid from MoPH regular budget which is laudable. However, the equipment provided to DHOs from GAVI funds, is unlikely to be replaced by the Government routine budget once they are torn out. These DHOs are responsible to implement the stewardship function of MoPH at district levels; therefore, their current level of effectiveness may not remain if they do not have access to other facilities in addition to merely salaries.

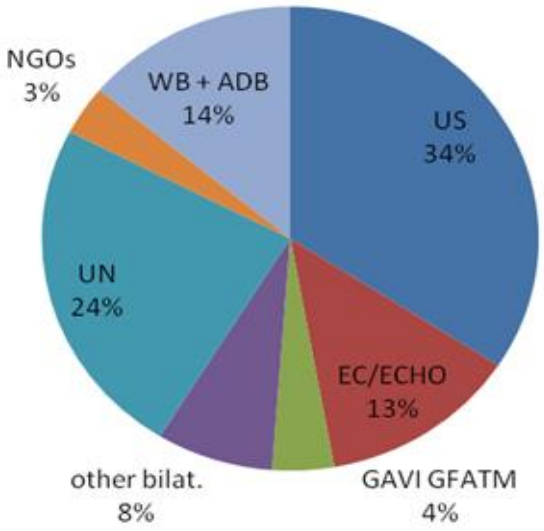
There has been no significant procurement involved from HSS funding in Afghanistan including immunization equipment. The major procurement has been the vehicles for mobile health teams which are now with either provincial public health directorate and they are paying the maintenance costs for these vehicles. The PHOs are utilizing them for monitoring and supervision purposes.

Activities that were in from of pilots such as Demand side financing and CHWs performance incentives have been completed and its future application will require additional resources, therefore, no concerns currently about their sustainability unless they are launched nationally. On the other hand, Demographic Surveillance System was not launched from initial stages. However, there are some concerns regarding sustainability of some other activities. For instance, the technical assistance (TA) that is provided to different departments of Ministry is not sustained yet. In addition, support to IEC approaches, M&E functions, planning and so on remains severely in need of continued support. In some cases operation costs are paid from HSS funds which in principle need to be paid from Government recurrent budget, however, for the moment it looks impossible to be paid by Government. This problem exists with almost all donor supported programs. .

Health sector funding and GAVI funding has been steadily increasing. GAVI total disbursed funding until 2013 has been over US$128 Million to Afghanistan out of which over 50% has been in form of vaccines. Over US$60 Million of this funding has been for CSO, HSS, injection safety (INS), and Immunization Support Services (ISS) and over US$66 Million has been for Tetra, Penta and Pnumo vaccines.

Health sector funding according to available analyzed data until 2008 has increased 2.4 times since 2003. However, information about out of pocket payment is only available for the years 2006-2008 which is way high at the level of 75%. In addition, in total contribution of GAVI and GFATM from 2003-2008 budget has been estimated only 4% of the total health sector budget.

Figure1: Percentage contribution of health sector financing by donors, years 2003-2008 (data is derived from the implemented budgets[3])



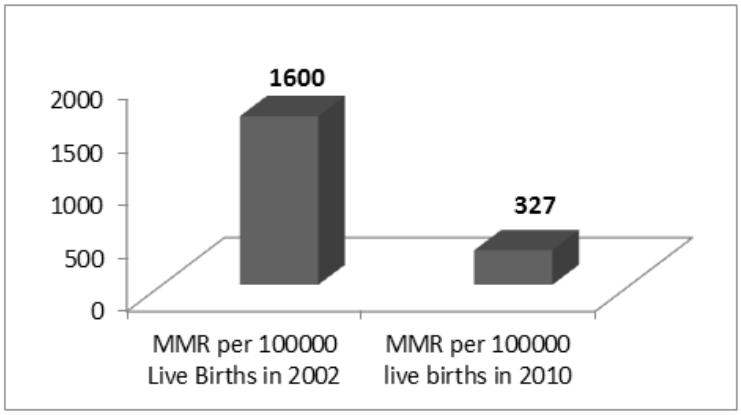
Total allocation of the health sector budget as of total of Government allocation has been ranging from 4-6%, however, government allocation to MoPH regular budget has more than doubled from US$25 Million in 2003 to over US$50 Million in 2012 which is an indication of Government commitment to health sector.

In HSS application, all interventions proposed are primary health care focused and deemed most cost effective, however, given the high level of poverty in Afghanistan and overall Government reliance on external funding sources, the country will be critically in need of support at least in near future which will require the support of health sector donors and partners including GAVI and those who are funding GAVI to maintain and expand where applicable these most cost effective live saving interventions until Afghanistan economy reaches to a responsive level.

C. HSS Program Contributions Toward National Health Goals and Objectives

Given the involvement of multiple donors in supporting the health system of Afghanistan, it is hard to disentangle the contributions of each donor towards achieving national health goals. All donors and partners have all together contributed enormously towards achieving national health goals. However, specific contribution of GAVI HSS funds are evident from the outputs generated from implementation of HSS planned activities presented in section E, annex two of this report and annual progress reports of 2007-2012. The table below shows reduction in maternal mortality ratio from 2002[4] to 2010.[5]

Figure 2: comparison of Maternal Mortality ratios from 2002-2010 in Afghanistan

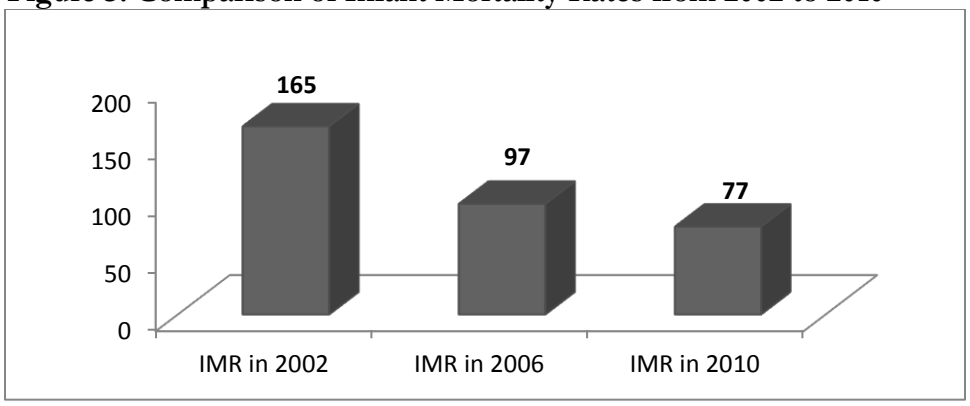


The data in Figure 2 shows that maternal mortality has declined

[3] Afghanistan Health Care financing study 2008
[4] Reproductive Age Mortality Survey, UNICEF Afghanistan (2002)
[5] Afghanistan Mortality Survey MACRO (2010)

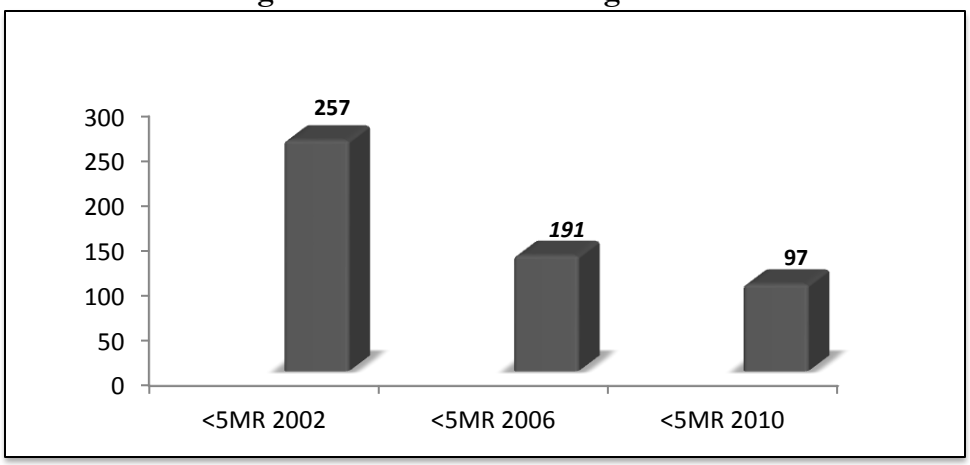
from 1600/100000 live births in 2002 to 327/100000 live births in 2010.

Figure 3: Comparison of Infant Mortality Rates from 2002 to 2010



The data in Figure 3 show that Infant Mortality has declined from 165/1000 live births in 2002[6] to 77/1000 live births in 2010[7].
The chart below depicts comparison of mortality among children less than 5 years of age from 2002 to 2010.

Figure 4: Comparison of Mortality (per 1,000 live births) among children less than 5 years of Age from 2002 to 2010 in Afghanistan



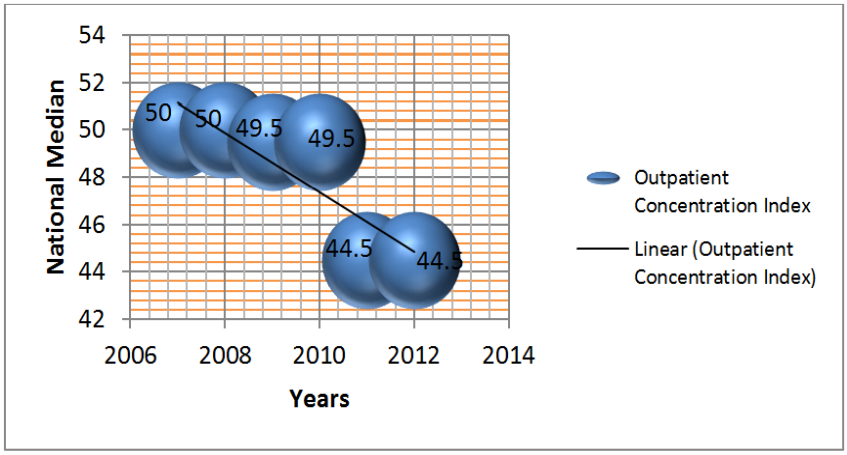
The data in Figure4 shows that mortality among children less than 5 years of age has declined from 257/1000 live births in 2002 to191/1000 live births in 2006[8] and to 97/1000 live births in 2010[9] in Afghanistan. The data on infant mortality, less than five years mortality and Maternal Mortality is not available at sub national level.

[6]Multi Cluster Indicator Survey (MICS), UNICEF Afghanistan (2002)
[7] Afghanistan Mortality Survey (AMS), MACRO, (2010)
[8]Afghanistan Household Survey (AHS) , Johns Hopkins University , 2006
[9]Afghanistan Mortality Survey (AMS), MACRO, 2010

D. HSS Program Impact on Health Equity

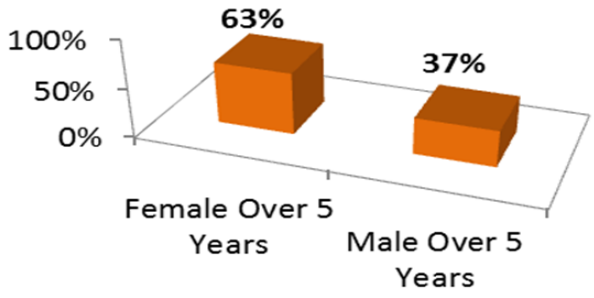
Ensuring equity in health care distribution has been a global and country level focus. GAVI HSS fund has encouraged innovative approaches to achieve equitable coverage of services. This included identification of underserved and hard to reach groups, marginalized populations, and in turn addressing inequities to certain extent. The two major interventions that contributed towards improving the equity have been establishment of SHCs/MHTs and partnership with private service providers. Establishing SHCs and Mobile Health Teams improved access to maternal and child health services in the remote and undeserved areas of Afghanistan in 23 provinces and establishing private public partnership model improved this access in insecure districts of Kandahar, Helmand, Nuristan, Pakya, Urozgan and Farah Provinces.

Figure 5: National Median: Outpatient Concentration Index[10]



The data in Figure 5 Outpatient Concentration Index showsthat half of the populations utilizing health services from the year 2007 to 2010are women. While in the years 2011 and 2012 outpatient concentration index is tending toward males; only 44.5% of outpatient department (OPD) clients are female at national level.

Figure 6: Concentration of Utilization of Services among clients/patients over5 years of age at GAVI HSS Supported SHCs and MHTs (2010-2012)



The data in the above chart shows that 63% of clients who have benefited from Out Patient Services at GAVI HSS supported SHCs and MHTs are female.

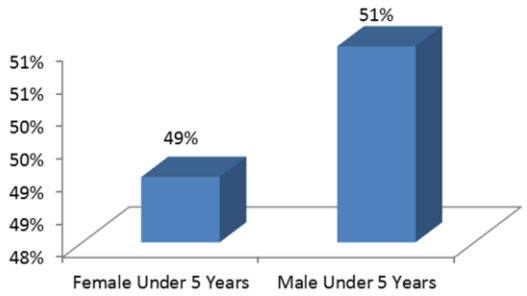
The HMIS data shows that at GAVI HSS supported health facilities outpatient concentration index is tending towards female, as 63% of OPD clients are female, while this proportion at national level is 44.5%. This difference may be attributed to the fact that GAVI HSS SHCs and MHTs are operating at gross route levels in more remote areas with the concentrated focus on immunization and basic MCH services where the primary care takers of the children are the women.

The data on concentration of utilization of services at SHCs and MHTs show that 49% of girls and 51 % of boys < 5 years of age are seeking care from GAVI HSS supported SHCs and Mobile Health Teams during the years 2010-2012 which is commendable.

Despite these facts, according to EPI reports 11% of districts have Penta3 coverage of less than 50%. In addition, 61% have > 80% of Penta3 coverage which shows visible geographic inequity in

immunization coverage. In addition, DPT3 coverage in Kochi population was recorded at <15% in 2008 but the Government is trying to address the Kochi's problems in second HSS application being implemented. On the other hand, no specific data is available to examine the depth of inequities in relation to gender disparities in all districts and no proper information is available to comment of immunization coverage in different socio economic groups' i.e. children in different wealth quintile groups.

Figure 7: Concentration of Utilization of Services among children under 5 years of age at GAVI HSS Supported SHCs and MHTs (2010-2012)



This indicates the need to adopt tailored approaches to specific geographic areas of the country which needs continued commitment of MoPH and sustained support of partners and donors.

Finally, interviews with key informants also highlight limited female involvement in management of HSS funds, however, this problems seems to be the result of limited number of female candidates applying for concerned positions, since all the announcements are opened both for male and female. Some positions for example M&E officers are never of interest for women. One of SC members related to gender involvement stressed that *"I don't know what is the problem that women do not applying for the positions announced by MoPH or other institutions. For the time being, in central level among 46 positions we have only two female staff. This challenged us for program implementation and we felt that in each intervention there is a concern on availability of midwife and female nurse. Most of DHOs are operating in insecure areas and even we cannot find male MD easily. Women participation in public health training was extremely low and I think that families still do not allow women to travel. There might be some other reason, I don't know."*

E. HSS Program Performance Againts its Stated Objectives and Benchmarks

GAVI funded HSS program in Afghanistan has achieved its stated objectives and indicators successfully, as detailed in the matrix of indicators in Table 1.GAVI funded HSS program has focussed on the following objectives to improve from 2008 to 2013. Under each objective and interventions, we discuss their current status.

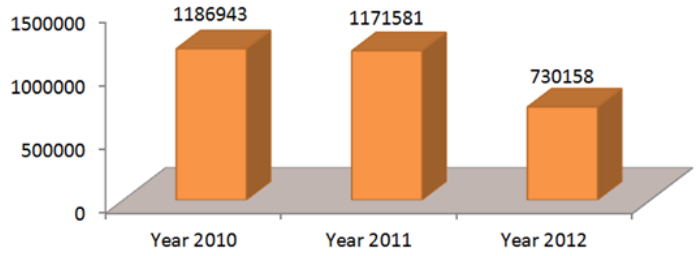
Objective 1: Improved Access to Quality Healthcare

1.1 Establishing Sub-Health Centers (SHCs) and Mobile Health Teams (MHTs)

In total, 121 SHCs and 26 MHTs were established through the support of GAVI HSS funds although the original proposal planned to establish 120 SHCs and 80 MHTs. The target number of MHTs was not met because the fund allocated in the proposal was not sufficient to establish 80 MHTs. This indicates poor budget estimation for this activity in initial stages which might be because of limited country experience for costing the new approaches. It is worth mentioning that out of the 26 MHTs, only 13 were absorbed by the BPHS program. In addition to these centers, MoPH should explore funding sources from other donors to support 13 mobile health facilities that have not been absorbed. The implication of this is that on average 130,000 people (average of 10,000 people coverage for each MHT) have lost their access to the services delivered through these MHTs. 114 private for profit health service providers have been contracted through establishment

of public-private partnership model in insecure and underserved areas of Afghanistan to provide quality EPI, RH, referral and health education services. Establishment of public-private partnership has significantly contributed towards improving access to the marginalized and vulnerable population in insecure areas given the fact that public private partnership is the sole means of access to life saving services in insecure areas of Afghanistan.

Figure 8: Utilization of Services in GAVI Supported HSS SHCs and MHTs: the number of patients treated



The data in Figure 8 show that about 3,088,682 marginalized and underserved patients have benefited from GAVI HSS funded SHCs and MHTs from 2010 to 2012.

The data in the Figure 9 shows that percentage of districts that achieved coverage of Penta 3 vaccination greater than 80% has increased from 49% in 2007 to 61% in 2012. This confirms that GAVI HSS along with World Bank, USAID, EU and CIDA contributed towards improving access to and utilization of EPI services in Afghanistan.

In addition, the public-private partnership program was initiated in Urozgan and Farah provinces with the support of GAVI. This model was further expanded to two more insecure provinces (Nuristan and Paktia) to strengthen the capacity of private for profit practitioners to provide quality health, concentrating on reproductive health, childhood vaccination referral, health education and basic health services. The program involved training, equipping, and supplying essential drugs and vaccines to 114 private for profit health services.

Figure 9: Trend of Percentage of Districts >80% coverage of Penta3 Vaccination 2007-2013

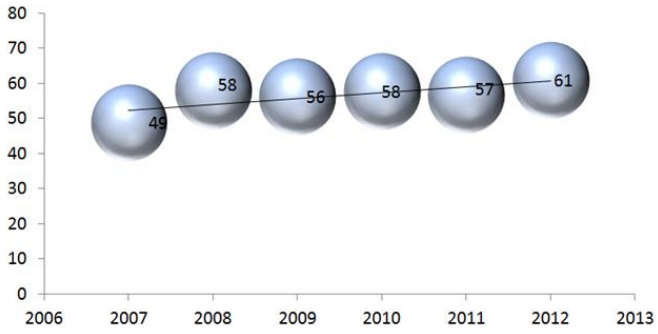
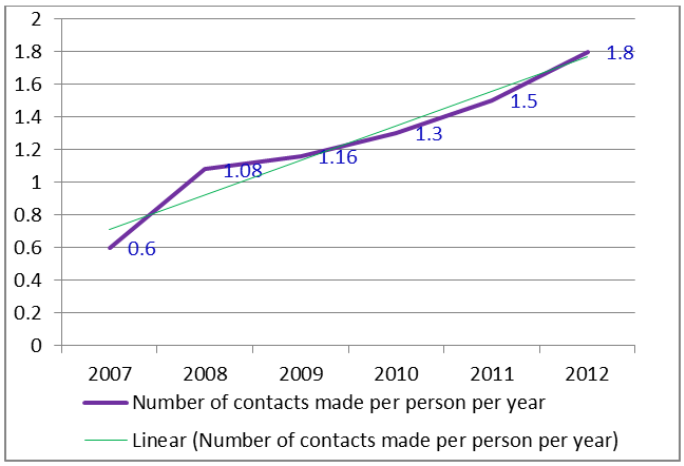


Figure 10: Trend of contacts per person national level



Given the hard to reach geography and scattered population, the establishment of SHCs and MHTs has contributed to improving access and availability of quality health care services in Afghanistan. Particularly this strategy is very appropriate to embark on providing services for internally displaced peoples (IDPs), Nomad (Khochis) and scattered pocketsof population. On the other hand, the major challenges remaining include recruiting female staff, rehabilitation of vehicles for

mobile health teams, and monitoring of SCHs and MHTs. Additionally, given the volatile security, sometimes MHTs are not able to travel according to their schedules.

According to annex two of this report, the target for output indicator "Number of Contacts Made Per Person/year " which could be closely attributed to the establishment of SHCs and MHTs has exceeded its target of 1 for 2012 significantly:

1.2 Expanding and building upon a pilot Integrated Management of Childhood Illness (IMCI) Project

HSS Program has focused on expanding and building upon a pilot Integrated Management of Child Illnesses (IMCI) project. Under this project, 12,884 CHWs have been received training on C-IMCI to improve access and quality of health care services in Afghanistan. The descriptive statistics show that in 2010 on average of 31260 children, aged less than one year, received Penta 3 vaccination in provinces where CHWs received C-IMCI training as compared to 21577 children less than one year of age in provinces where CHWs did not receive C-IMCI training. In 2011, on average 32820 children less than one year of age received Penta 3 vaccination in provinces where CHWs received C-IMCI training as compared to 24517 children less than one year of age in provinces where as CHWs did not receive C-IMCI training. In 2012 on average 35832 children less than one year of age received Penta 3 vaccination in provinces where CHWs received C-IMCI training as compared to 29189 children less than one year of age in provinces where CHWs did not receive C-IMCI training.

Table 1: Mean Number of Children < 1 years of age who Received Penta 3 Vaccination (2010-2012)

	2010	2011	2012
Provinces CHWs Received C-IMCI Training	31260	32820	35832
Provinces CHWs Did not Receive C-IMCI Training	21577	24517	29189

The data in Table 1 show that the mean number of children less than one year of age, who have received vaccination for Penta3, is greater in provinces where CHWs have received C-IMCI training as compared to provinces where CHWs did not receive C-IMCI trainings. The results indicate that training CHWs on C-IMCI has increased access to and utilization of EPI services, given the fact that CHWs refer more children to health facilities in order to receive Penta 3 vaccination. The data indicated that C-IMCI training resulted in improving referral of children for vaccination where more children have received vaccination.

Table 2: Mean Number of Pregnant Women who Received Ante-natal Care (2010-2012)

	2010	2011	2012
Provinces CHWs Received C-IMCI Training	28548	31242	35677
Provinces CHWs Did not Receive C-IMCI Training	19981	23616	26369

The data in Table 2 show that the mean number of pregnant women, who have received ante-natal care, is greater in provinces where CHWs have received C-IMCI training as compared to provinces where CHWs have not received C-IMCI trainings.

Table 3: Mean Number of Pregnant Women who received Post-natal Care (2010-2012)

	2010	2011	2012
Provinces CHWs Received C-IMCI Training	16016	20179	23827
Provinces CHWs Did not Receive C-IMCI Training	10307	11656	14250

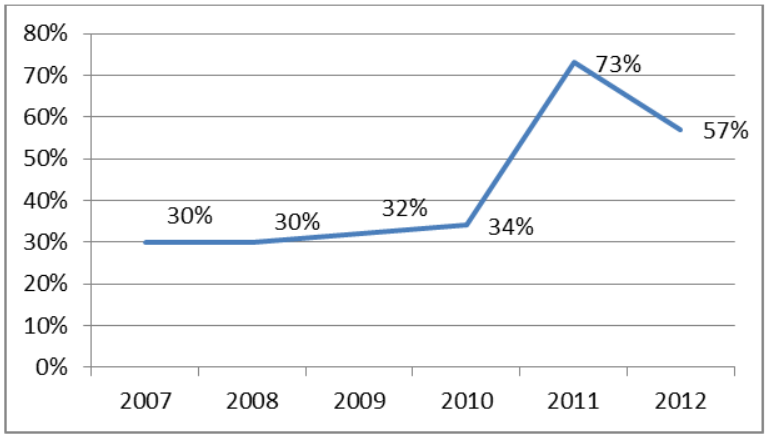
The data in Table 3 show that the mean number of pregnant women, who have received post-natal care, is greater in provinces where CHWs have received C-IMCI training as compared to provinces where CHWs have not received C-IMCI trainings.

Table 4: Mean Number of Institutional Deliveries (2010-2012

	2010	2011	2012
Provinces CHWs Received C-IMCI Training	13122	15761	17763
Provinces CHWs Did not Receive C-IMCI Training	7569	9937	11094

The data in table 4 show that the mean number of institutional deliveries is higher in provinces where CHWs have received C-IMCI training as compared to provinces where CHWs have not received C-IMCI trainings. The data conclude that training CHWs on C-IMCI have significantly contributed to improving access to and utilization of health care services in Afghanistan.

Figure 11: Trend of Proportion of children who received treatment for diarrhea at communitv level 2007-2012



The effectiveness of C-IMCI can also be clearly seen in the progress made on the indicator "Proportion of children who received treatment for diarrhea at community level" which has increased significantly over years from 30% in 2007 to 57% in 2012, however, during implementation course, there has been change in source of data from surveys to HMIS:

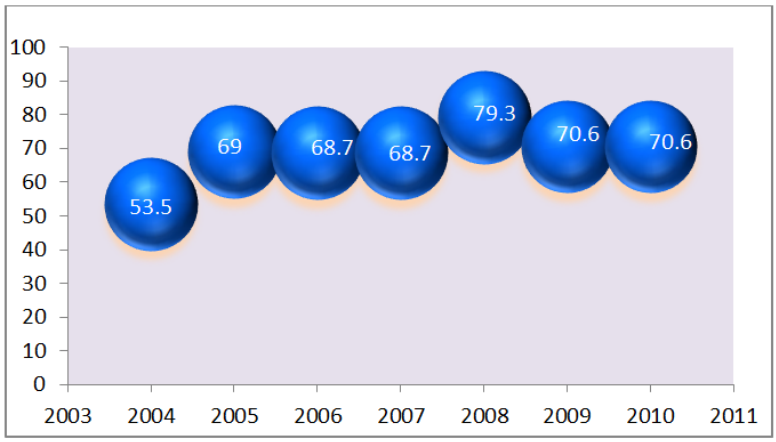
1.3 Developing an in-service training program to be implemented for BPHS primary healthcare providers

HSS Program has contributed towards advancing the capacity of health professionals working with non-state entities in Afghanistan. Through GAVI fund, around 741 health professionals including doctors, nurses, midwives, and pharmacist, have received a total of 57 training course around the country on the following topics: IMCI, Public Nutrition, Family Planning, Management of Essential Drug, Continuum of Care (CoC), Basic and Advanced Emergency Obstetric Care (EOC). These trainings were provided for BPHS providers, therefore, the target groups were in line with those initially proposed in HSS application or in other words, the front line primary health care service providers. Some of the training components for instance, IMCI contained immunization specific relevancy while the rest have been related mostly to other components of primary health care including maternal health.

The MoPH at the middle of 1388 (2009) noticed that Health Services Support Project (HSSP) funded by USAID planned trainings of health providers in 13 USAID supported provinces which was covered already by GAVI-HSS. In order to avoid duplication and fill other critical gaps existed in the planned HSS interventions, re-allocated the funds to C-IMCI activity to cover two more zones. Required approvals were obtained timely.

Figure 12 show the trend of knowledge of doctors, nurses, midwives operating in the BPHS health facilities. During the Annual Health Facility Assessment, the knowledge tests conducted for doctors, nurses and midwives. The knowlged of doctors , nureses and midwives mesusred through questinnaires designed for doctors, nurses and midwives.Doctors, nurses and midwives have been asked certain questions on IMCI, management of pregnancy and pregnacy complications and common diseases and their answeres have been recorded. This way health workers knowledge have been assessed to measure the imact of training on improving health workers knowledge from 2004-2011.

Figure 12: Knowledge score of Doctors, Midwives and Nurses Working in BPHS Health Facilities



The results of third patry evalution Balance Score Card (BSC)[10] show that GAVI funded capacity building programs became visible since 2008 just at the time that HSS Program was operationalized in Afghanistan. As illustrated in Figure 12, national median score on Health Worker Knowledge has increased from 68.7 in 2007 to 79.3 in 2008 and was maintained at 71 until 2010.

Objective 2: Increased Demand for and Utilization of Mother and Child Health Care Services

2.1 Implementing a Nationwide strategic Information, Education and Communication (IEC) Initiative

With the assistance of GAVI HSS fund, the Health Promotion Directorate of MoPH has embarked on a series of awareness raising initiatives including, development and dissemination of Information Education Communication (IEC) Materials at national level, broadcast of spots conveying key health messages through radios and televisions, development of Health Promotion Strategy, and nationwide Inter Personal Change Communication (IPCC) workshop. Call centers have been established to improve awareness of people through mobile phone messages in Afghanistan. In addition, nationwide distribution of IEC materials was systematized through establishment of stock and computerized systems. Finally, a Knowledge Attitude and Practice (KAP) survey was conducted at national level based on which a national Communication Strategy was developed.

2.2 Piloting the Effectiveness of a Model of Demand Side Financing in Afghanistan,and Providing Monetary Performance Incentives to Community Health Workers

This experimental research sought to describe the association between monetary incentive schemes and utilization of maternal and child health service, while addressing the following questions:

1. Are monetary incentive schemes associated with increase in institutional delivery?

[10] Health Worker Knowledge Index (Balanced Score Card 2011)

2. What types of incentive schemes (e.g., household, CHW, both household and CHW) appear to be more effective in increasing utilization of services including deliveries and Penta 3?
3. What are the socio-demographic factors associated with uptake of cash incentive?

According to the final report of demand side financing project, based on descriptive analysis comparing baseline and end line survey, there were substantial differences in uptake of Conditional Cash Transfer (CCT) pilot project at the district level. The results indicate that when incentives are given to households, the impact is the greatest[11], i.e. the proportion of women who delivered at BPHS facility increased from 33.74 in the baseline to 39.66 in the end line (follow up survey), increasing at a percentage rate of 5.92 with a p-value of less than 0.05. Similarly, the proportion of children who received DPT3 vaccination increased from 33.63 in the baseline to 36.93 in end line (follow up survey), increasing at a percentage of 3.3 with a p-value of less than 0.05. Overall, variations in service utilization at the provincial level were greater than at the district level (within the same intervention arm). Among the four provinces, Kapisa reported the highest change in percentage of women who delivered at health facilities, followed by Wardak. Similarly, increase in the percentage of children immunized for DPT3 was greater in Kapisa than other provinces – followed by intervention districts in Badakshan.

The design for the Demand Side Financing (DSF) model was multi-factorial with four arms of control, household, CHWs and combined (household + CHW) conducted in 16 districts of 4 provinces. Provinces were selected were based on clear and sound criteria and many appropriate relevant factors have been considered, however, despite efforts and establishing criteria, districts in control and intervention sites were not comparable in all aspects other than treatment. Districts were selected in consultation with Provincial Health Directorate Staff where matching of districts (Intervention vs.Control) was not made in term of type of health facilities and availability of trained female staff in the health facilities. Such confounding factors could significantly affect the results of the study, in case there were district hospitals in control districts, and female staff absence in intervention districts. In such case, paying incentive would play little role in increasing utilization of services particularly institutional deliveries.[12]

Objectives 3: Improve the ability of the MOPH to fulfill its stewardship responsibilities

3.1 Up-grading the physical, information/communication technology infrastructure and means of transportation of the M&E department

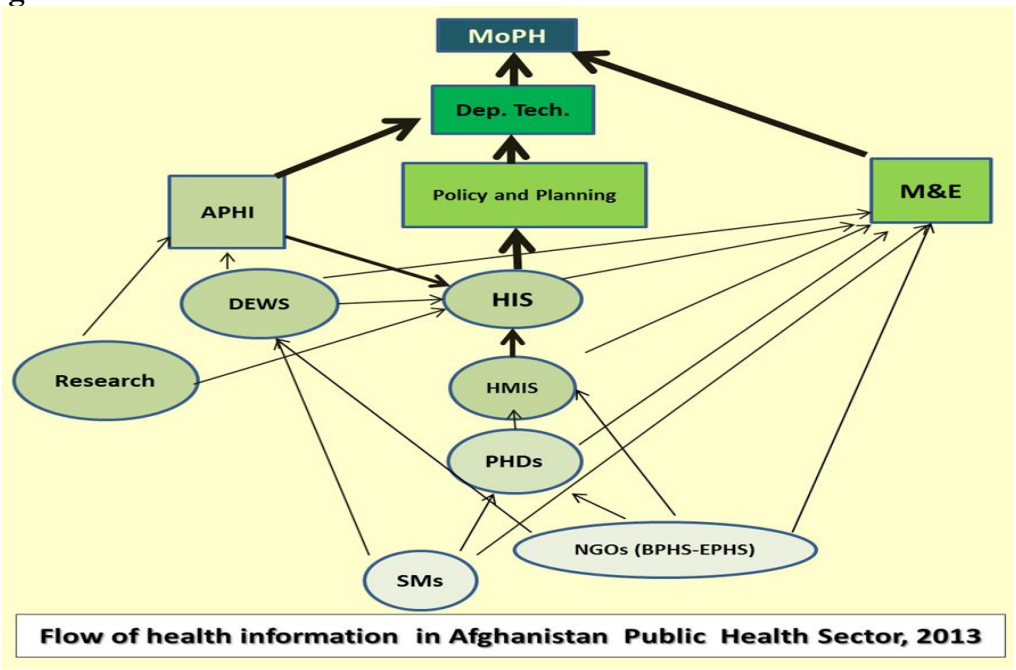
HSS Program has provided monetary (incentives and salaries) and non-monetary support including training, and technical assistance to M&E Directorate. Support also included transportation facilities, communication technology and infrastructure. The technical assistance included recruiting experts to the M&E Directorate. Since 2003, the MoPH has outsourced BPHS and has adopted a stewardship function at the health sector, thus requiring a more robust M&E system in the context of contractual obligations with NGOs.

[11]Demand Side Financing Final Report: An Assessment of the pilot study on the effect of cash incentives on increasing maternal and child health service utilization in rural Afghanistan, August 2011

[12]Demand Side Financing Final Report: An Assessment of the pilot study on the effect of cash incentives on increasing maternal and child health service utilization in rural Afghanistan, August 2011

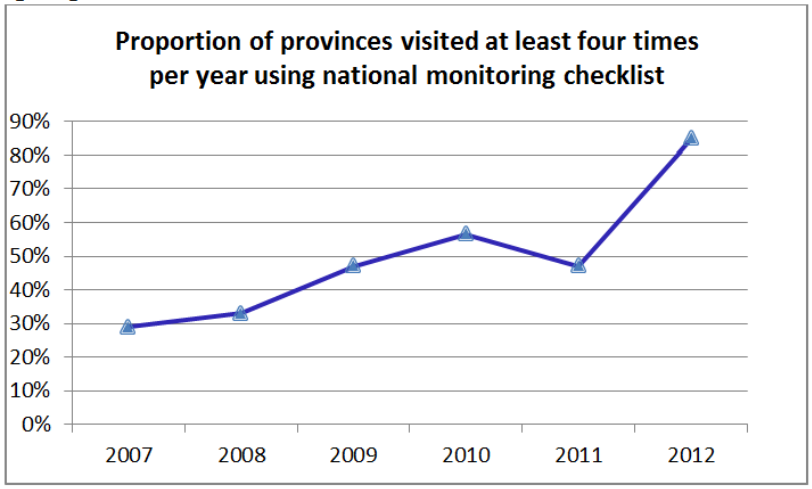
Below is the schematic presentation of flow of information among different departments in the MoPH.

Figure 13: Schematic information flow of MoPH



As part of HSS support, percent of provinces regularly monitored from central level has increased from 25% in 2007 to 85% in 2012.

Figure 14: Trend of number of provinces monitored at least once per quarter 2007-2012



For better M&E functions, a number of areas of development must be brought to light. There is a need to update the M&E strategy. At present, different departments are heavily involved in data management such as HMIM, DEWS, Research department and M&E Directorate. It might be efficient if they operate under one umbrella. It is important to agree on a set of indicators, adjust annual targets and follow on quarterly or annually based on the nature of indicator with stronger feedback mechanisms between the central and provincial levels. In 2010, several surveys were

conducted, e.g., Afghanistan Mortality Survey (AMS), National Risk and Vulnerability Assessment (NRVA), Multi Indicators Cluster Survey (MICS). Better leveraging partners for coordination of survey programs will ensure added value for money and improve efficiency.

Decentralization of routine M&E functions is critically important. This evaluation revealed that provinces are more monitored from central level. As part of this decentralization process, the quantity and quality of M&E activities should be improved at periphery levels. Moreover, for community level activities in addition to implementers and MoPH, options should be explored to more systematically use communities for monitoring the health activities. In the concept paper, for MHTs under GAVI HSS, community monitoring role was assigned also to people at community level through signing the log books of MHTs vehicles which is commendable. Such initiatives can be further explored and widely applied.

3.2 Expanding capacity building program for MOPH managers at the Central and Provincial levels

Quality Public Health Trainings namely principles of leadership, strategic management, disaster management, report and proposal writing have been conducted for the Provincial Health Directorate Staff operating in at national level. The objectives of training were to improve the performance of Provincial Health Directorate staff to fulfill their stewardship functions properly.

Table 5: Impact of Quality Public Health Training on Improving Performance of Provincial Health Directorate Staff (n=6)

Variable	Response	proportion
1. How do you assess the quality of training?	Excellent and good	100
2. Did your performance improve after receiving quality public health training?	Yes	100
3. How did quality public health training improve your performance?	I can better coordinate with partners	100
	I can better develop EPI report	100
	I can better supervise and monitor the health facility	83
	I can better provide feedback to health facility staff	83
	I can better record the information that I received	33
4. Have you received any refresher training on quality public health management?	Yes	33

However, the sample was small and only 6 (16%) of them responded, but it may suggest that there is high turnover among provincial health directorate staff. Yet there is absence of effective strategy to prevent high turnover of staff particularly at the provinces. Qualified staffs are attracted by NGOs given the fact that NGOs offers good salaries as compared to Government. The results in table 5 may also suggests that Public Health Management trainings have significantly contributed toward improving basic management and stewardship functions of PHOs further receiving quality public health trainings. However, there will be focused to strengthen the followings:

- Establish award and reward system on the basis of proper appraisal system for health workers functioning at different level in health sector.

- Planning and conducting joint monitoring with BPHS implementing partners on regular basis. Provincial Health Directorate staff and BPHS implementing partners will conduct a workshop to develop joint operating plan to implement.
- Conducting quality supportive supervision including on the job training, filling monitoring checklist and provision of recommendations, follows up recommendations and holding meeting to share the findings of supportive supervision with health facility staff.
- Review of health sector indicator and regular feedback to implementing partners in order to enable them to make remedial actions.
- Ensure effective coordination and communication with all stakeholders at various levels.

3.3 Developing a Communications and Internal Advocacy Program to Seek Increased Funding

The MoPH has conducted series of advocacy interventions. The MoPH conducted a press tour to 8 provinces to share the MoPH success stories and lessons learned. Series of press release and press conferences have been conducted and launched advocacy of health sector initiatives. Documentary films on vaccination and midwifery program has been developed after over 3 years of repeated planning.

However, the advocacy unit of MoPH was not proactive in fund raising. The MoPH needs to update its PR strategy, develop a PR plan including more systematic targeting the parliament, donors, MoF and through media, the communities in order to further funding opportunities and attract more non-monetary support. Lastly, despite HSS support to PR department, still the web site is not up to date with all updated MoPH documents.

3.4 Launching an Initial Cadre of District Health Officers

GAVI funded HSS Program has launched a District Health System Support Project where 152 District Health Officers have been recruited equipped and trained in order to strengthen the stewardship functions (Monitoring and Supportive Supervision) of health sector; improve coordination and reporting, improve quality and service delivery mechanisms and control outbreaks at district level. In addition to 152 DHOs supported by HSS Program, 50 more DHOs have been recruited by the Ministry of Public Health.

The District Health Officers are particularly important and effective for the following reasons:

- A representative of the government at the district level – therefore it is a bridge between the district and the province.
- A problem-solver – able to see gaps in the service provision and work with the stakeholders in the district and province to try to solve any problems.
- A 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.
- A monitor – their presence ensures the health facilities and NGOs perform better and also reassures the community that the NGOs are performing well.

Table six described variables related to ToR. All respondents expressed that they have job description and 96% believed that their responsibilities have been reflected appropriately. In respect to having operational plan, 96% of respondents said that there is an annual operation plan in place and 80% expressed that most of plan have been implemented. On the other hand, 84% of respondent replied that due to lack of financial support the annual operational plan was not

implemented while 48% of respondents mentioned lack of support from PPHD and lack of support from BPHS implementer NGO as bottlenecks to operate effectively.

Table 6: DHO Operational information, n = 25

Variables	Response	Proportion
1. Do you have job description?	Yes	100
2. Does your role appropriately reflected in the ToR	the role has appropriately reflected	96
3. Do you have annual operational plan	Yes	96
4. To what extent did you implemented operational plan	Most of the plan implemented	80
5. If the annual plan was not fully implemented? what are the main reason	lack of financial resources	84
	Lack of support form PHHD	48
	Lack of support from NGOs	48

From all respondents, 44% received training on national monitoring checklist. 52 percent of DHO staff managed to conduct at least 1-3 times monitoring from health facilities. However all respondents conducted at least one monitoring visits during last quarter, only 64% of them provided feedback to health facilities. As concerned with some challenges to successful conduction of monitoring visits; lack of financial resources (96%), lack of PPHD support (52%), lack of support from BPHS implementers (52%), security (68%), geographical barrier (28%) and not receiving training (36%) are identified as some of challenges.

Table 7: DHO monitoring system information, n = 25

Variables	Response	Proportion
1. Did you receive training on National Monitoring checklist during last year?	Yes	44
2. How many health facilities did you monitored at least one time during last quarter using national monitoring checklist	1-3 monitoring conducted	52
	> 3 monitoring visits conducted	48
3. Number of written feedbacks provided to the health facilities	at least one feedback provided	64
4. What challenges do you face to fulfill monitoring functions	lack of financial resources	96
	Lack of support form PHHD	52
	Lack of support from BPHS NGOs	52
	Security	68
	Geographical barrier	28
	did not receive training	36

Among all 38 PHOs, interviewed for this evaluation, 70.3% of them have supervised DHOs. Replying the challenges in daily work, 97.4% of respondents, had challenges. Lack of training and technical knowledge are the top of challenges , with security, inadequate salary and DSA, inadequate transport, lack of motivation and staff shortage each, lack of feedback on performance, lack of supervision were some challenges that commonly faced program in trouble. (Detail information provided in table four of annexes three.) Of all 38 respondents, 71.1% of them had done DHO assessment. In response to the role of DHO, 27 respondents (100%) replied that the DHO

program is effective and 37 respondents (97.4%) think that, the establishment of DHO had positive impact.

Table 8: DHOs supervised by PPHO, n = 38

Variable		Response	proportion
1.	DHOs supervised by PPHO	Yes	70.3
2.	Are there any challenges/difficulties that you are facing in your daily work?	Yes	97.4
3.	Did you conduct DHO assessment?	Yes	71.1
4.	Was the DHOs program effective?	Yes	100
5.	Do you think that the establishment of DHO had positive impact?	Yes	97.4

According to the final report of "Impact Evaluation of the District Health Officers" in Afghanistan conducted by Health Protection and Research Organization (HPRO) in May 2011 the following results were found which was already shared with HSS-SC and GAVI through APRs.

The District Health System Support Initiative has positively impact on:

- Improving the coverage of vaccine programs.
- Improving the performance of clinics such as opening times.
- Monitoring environmental health such as 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. [13]

However the followings are the bottlenecks with regard to District Health System Support Project:

- Challenges with transportation in remote districts – a motorbike may not be sufficient.
- Low salary and not paid on time
- Lack of resources for monitoring and coordinating e.g. per diems for field visits, transport costs for travel to provincial level
- Interaction with provincial-level – more support needed and there is no designated person to support DPHOs in provincial team
- No office – this is also likely to affect how DPHOs are perceived in the community
- Not part of the civil service – DPHOs lack authority
- More training needed on skills to fulfill their TOR

The DHO have been selected based on relevant criteria, however, before national application of this program uniformly, it might be helpful to relook at the program design. This initiative is supposed to be rolled out to all districts; however, the size and geographic characteristics of the districts are widely variable in some cases.

[13]Impact Evaluation of the Decentralization of Health Services to District Health Officers in Afghanistan conducted by Health Protection and Research Organization (HPRO) in May 2011

IV. HSS PROGRAM LESSONS LEARNED

A. Lessons Learned

Afghanistan submitted its GAVI HSS Program support proposal in 2007 and the grant was approved in 2008. The total fund to support HSS program in Afghanistan was US$34,100,000. The GAVI HSS grant has offered a new platform of funding for the MoPH. This funding has helped the MoPH focus on the real needs for health systems strengthening in Afghanistan. The first lesson learned is that robust country driven initiatives results into better identification of the needs and proper programing.

HSS program in Afghanistan has also strengthened the health sector coordination where HSS Steering Committee (HSS-SC) as a sub group of Consultative Group for Health and Nutrition (CGHN) improves this aspect reciprocally. The HSS program has succeeded in attracting considerable attention among all stakeholders including donors, civil society organizations and line ministries in Afghanistan to focus on strengthening the health system in a more harmonized and coordinated manner. It gives a good lesson that establishment of Governance and coordination mechanisms at initial stages of rolling out HSS support contributes significantly to achieve better outcomes. The other lesson learned is that HSS support has contributed to enhance EPI agenda at different levels of the system because of HSS management close relationship with higher management inside and outside of MoPH.

HSS-SC is represented by the MoPH, three major donors (USAID, EU, WB), WHO, UNICEF, Ministry of Finance and Representatives from civil society organization and few key relevant departments led by leadership of MoPH. This committee is part of the transparent allocation and utilization of funds according to the country needs which indicates some degrees of flexibility. However, minimum Governance benchmarks to be better defined by GAVI/MoPH to HSS-SC. The evaluation team found only one TOR of support attached with the APRs issued by GAVI where countries are required to utilize support in line with their approved proposals.

To a large extent, the HSS support of GAVI shows elements of harmonization and alignment with country plans as well as being result oriented which corresponds with Paris Declaration principles. This lesson learned indicates that country systems if programs are well defined and aligned; better outcomes can be achieved even if the country context is very challenging like Afghanistan.
HSS Program in Afghanistan, from the initial stages designated a HSS coordinator with a small team to oversee the support and streamline the implementation of the activities across Ministry while the HSS support was implemented by relevant departments. In other words, in addition to NGOs/CSOs, HSS is being implemented by almost 14 directorates of central and 34 directorates of provincial MoPH. This indicates that HSShas promoted the realization of effective health system through integration of HSS support within Afghan health system without creating parallel structures. One of the lessons learned from this approach is that such strategy results into wider capacity building of different MoPH departments compare to project based approaches. This capacity building is evident in relation to departmental planning capacities, improved departmental coordination and communication within departments as well as outside, reporting capacities and so on.

B. Weaknesses and Caveats

Having discussed the numerous strengths that the HSS program entailed, we now turn to discussing areas of improvemnet. HSS application was developed thorugh an inclusive process and for the Governance and coordination of effrots, HSS-SC was established. Though at initial stages, particcipation level was very high, after 2010 there have been some sings of fatigue in participation. In addition, the minimum Governance benchmarks and expectations from committee should be updated by GAVI and MoPH.

The MoPH contracts services as overall and majority of HSS interventions were contracted out. Since the MoPH encourages low cost proposals, some NGOs in order to get the contract try to under estimate costs of the interventions which affect quality of services provided during implementaiton phase. This is not only the case with HSS but all projects suffer from this problem.

Coordination mechanisms needs further strenfthening in general but between HSS and EPI in particular. This coordination should properly cover exchange of inforamtion, timely responding to program needs, joint plans development and so on.

Some tragets set in HSS application were ambitious such as % of provinces with more than 80% of DTP3 coverage to 100% in 2012. This targets were originated from Comprehensive Multi-Year Plan for Immunization (cMYP) 2006-2010 and inserted into HSS application, therefore, tragets set in cMYP should be realistic since most will be reflected in HSS applications. There is also a visible discrepancy between cMYP baselines and targets and National Health Startegy of the country. In latter the basline and targest relies on survey findings. High discreapancy between data sources for EPI coverage is another weakness including differences in denominators. This has affected the HSS program to certain extent but EPI program apprently has lost significant monetary bonuses of ISS in the past years. HSS program in second round will be significantly affected if the country does not pay attention to this problem. Or GAVI will need to change its approach from routine data estaimates to other mechanims for determinng awards to HSS second phase bounuses.

GAVI HSS Program funds were so tiny as compare to over all health sector funding needs, therefore, in the context of high number of prorities, HSS support could not focus on strengthening the national planing processes financial management, and procurement of goods of MoPH. The HSS program, however, supported procurement of goods department with one jounior and one senior procurement advisors. The recentlly Financial Management Assessment (FMA) report proposes interventions to fix problems and steps have been taken.

There is need for developing a comperhensive M&E strategy. Third party evaluation of BPHS which was contracted to a joint consortium of Johns Hopkins and IIHMR which is already completed. Currently, efforts are going on to identify the new evaluator. There has been no systematic study of the capcity transfer to MoPH as well as future clarity for this process continuation or sustainability. The M&E missions are more centrally managed and this system is not effecient because of high costs and the need for huge number of human resources. Such missions cannot timely respond to provincial needs and properly trace improvements at field level. Despite some efforts, M&E is not also providing regular summary of progress againsts indicators to leadership of MoPH to enable them take more evidence based decisions.

The MHTs were supposed to be monitored also by communities. There is limited evidence to support M&E of MHTs have been conducted by communities. In addition, the second objective for establishing the MHTs were to identify candidates during visists to remote villages and introduce them to CHW training programs which has not been implemented by many NGOs.

Public-private partnershipsat gross route levels in hard to reach and insecure provinces to provide EPI and MCH services has been one of the innovative mechanisms as a result of HSS support. However, this approach needs more regulation and needs further replication.

The EPI and human resources (HR) departments need up to date information about number of vaccinators available and number needed, though high turn over may affect the longer accuracy of estimates. Strategic saturation of the market with sufficient number of vaccinators especailly female remains unaddressed . HSFP proposal tends to train 300 new vaccinators but this number is unknown to be sufficient.

Information, education and communication strategies and materials could be more carefully customized to the cultural norms of communities. For example, in some cases, Dari messages were designed for Pashto sepaking regions or written messages were provided for illterate segmetns of populations, who could have benefitd more pictorial messages.

There have been some confusions in relation to use of DHOs. Some DHOs even have directly reported to central level. More strategic thinking is required in relation to use of DHOs.

Sustainability of health care services including HSS is an issue which requires a comprehensive sustaibility strategy. In addtion, sustaining the incentives and payments made from HSS funds needs more objective criteria.
Lastly, the Annual Progress Reporting (APR) could benefit from a more simplified format and increased involvement of various MoPH departments.

C. SUCCESS STORY

GAVI-HSS CSO Type B in Afghanistan: Public Privat Partnership Save lives and Promote Health

In a rural area of Farah province a girl was born her name was Najiba, she was from a poor and extended family. Her mother was a house wife and father was a farmer. The situation was not going well with the family, she was always facing family and financial problem. When she was 15 years old her family decided that she gets married. Her family and herself thought that if she get marry they will have a supporter and better future, but unfortunately everything got upside down.

When she got married she started to face different kinds of problems. The worst was her inability to get pregnant. Ten years passed since she got married. Her husband and in-lows started to insult her and accuse her of being infertile. Life was getting so stressful and full of misery. Her husband started to threaten her that she either gets pregnant or another wife will join the family. Najiba thought should rather die before that happens.

So, ten years of Najeba's life passed in real agony. She tried her best to tolerate her miserable life and to feel thankful that her husband was still hers alone while hoping that a miracle will unfold one day. Her family was aware about their daughter's suffering but was unable to do anything as, according to the culture; she belongs to her husband's family. If they interfere, they were afraid; this will cause more trouble to their daughter.

Fortunately one day, the long awaited miracle started to unfold. Najiba had good news. She thought she was pregnant. Her husband and his family were skeptical and didn't believe it in the beginning. But after day, Najiba was getting sure she was pregnant. She was hoping that this is her hope to have a son, to end her agony and to restore her husband.

Few weeks later her growing belly became an undeniable evidence of her pregnancy. Her husband and his family started to believe her. Things started to change.

Throughout the pregnancy months everyone was happy; her family, her in-laws and first and foremost her husband. Preparations went underway to receive the new child and Najiba was excited with the happy atmosphere around her.

Child birth was expected to happen at home and, according to the culture, attended by her mother in-law. According to her in-laws, females were not allowed to go to out of house for any reason and child birth, in particular was a family business.

Najiba was pregnant for seven months when, all of a sudden, she started to feel severe pain in her abdomen. As it was a pit early, her mother in-law judgment was this was not labor pain and some herbal medicines will help her to feel better. The pain did not subside. However, her mother in-law kept telling her that a pain like this is normal during pregnancy and she must be patient. And there was nothing to worry about. One thing was out of question, to seek medical advice.

Najiba was getting weaker as the pain continued for three days. On the third day, Najiba was really struggling for her life and the life of her baby. Everybody, including her mother in-law, started to get worried that they might lose Najiba and, of course, her precious baby. As the news about her situation spread around in the village, it reached to the knowledge of wise elderly man. The early man, in a firm, voice, instructed that Najiba has to be taken immediately to the nearest private clinic for medical advice. The elderly told them that he heard about a clinic in Parchamn village in which a nurse midwife called Gulsoma is said to be very good in women and children health.

People from the surrounding villages take their wives and children to benefit from her services when needed. A relative of Najiba argued that he heard that Gulsoma was fired from her job in a public health facility but the old man told the group listening to him that this was not true. Gulsoma, like many other female health workers, left the public health center for security reasons and went back to her village where she is running a successful practice.

For many years, Gulsoma was working in public health center owned by the government and run by one of the famous NGOs. One day, Gulsoma started to get threatening messages from unknown source; she had to leave her job. There was no choice, Gulsoma took her family and went back to her native village, Parchamn. There she started to practice and to help women and children as there were no other health facilities in the area. Very soon, she became known for her skills, for the many mothers she helped during labor and for the many children born by skillful hands. In recognition to her good work, the village donated heraplace to be used as a clinic. Over time, her reputation travelled to the surrounding villages and the number of patients, all women and children grew rapidly. Gulsoma started to face problems of poor supplies, lack of equipment and absence of any kind of support. She was looking for someone to help but in those remote security compromised areas, the government health system was too far to expect its help.

One day, two of her an NGO supervisors visited the village. They have heard about Gulsoma and the services she provides to her people. They went directly to her clinic and informed her that now, thanks to GAVI funded Public Private Partnership Program, their NGO is extending support to private clinics like hers as part of a wider support initiative o the Health System. They explained that the program includes a number of districts in the province; it is owned by the Ministry of Public Health (MoPH) and is implemented by their NGO with technical support from World Health Organization (WHO). The program will link her to the health system, provide her with the support she needs, including training, to deliver more and to deliver better and will maintain timely and regular supplies to her clinic. They added that as maternal, newborn and maternal health care services as well as the immunization coverage are not adequate in many areas of Afghanistan, this program is part of GAVI's contribution to strengthen the health system in Afghanistan in order to promote access to maternal and child care and to increase the coverage of the EPI program.

Since then, Gulsoma felt more capable to respond to the needs of her people. She provides them more services with strong back up from the project management. For the first time, immunization services became available for the women and children of her village and the surrounding villages who come for medical consultations and get free immunizations on top. She has better equipment and strong back up from the program supervisors who visit her village frequently.

The travel to Gulsoma clinic added much to Najeba's fatigue. Nevertheless, she was happy as the trip was increasing her hopes that her baby will be saved at the end. Her marriage, her future and possibly her life will depend on the outcome of this visit. She heard before about Gulsoma and her successful practice. She never thought that one day she will see it. Now, she is making her way slowly on the back of an old donkey and surrounded by her husband, her in-laws and her own family together with a number of female neighbors and friend with their children. Destination is Gulsoma clinic Parchamn.

Gulsoma was ready as usual when they arrived to her clinic. She immediately examined Najiba, listened to the heart sounds of her baby and made the diagnosis. Gulsoma was in labor but the baby

was breech presentation but they shouldn't worry as she will help the mother. Gulsoma went on immediately to help Najiba.

One hour later, Najiba was very happy when she hugged her baby boy. Now, her baby is saved, her life is saved and her future was saved and her own life was saved. Although she was very tired, she was able to smile to Gulsoma with her eyes full of tears. Everybody was exited and Najeba's husband shot a number of rounds from his rifle to express his joy.

After the deliver, Gulsoma talked to the ladies who came along Najeba's convoy. They were all eager to listen to her as she told them about maternal care, child health and immunization. She offered the free immunization for the accompanying children and explained the routine schedule and encouraged them to come for next vaccinations. Najeba's husband promised to talk to the fathers back in the village and ensure that all the children of his village will not miss any vaccination dose in the future.
Few weeks later, the happy couple, Najiba and her husband, went to themountain to collect honey. It was their gift to Gulsoma. The gift was given to Gulsoma on their next trip to her clinic, this time to immunize their child.

Basic Idea
The basic idea of this "Partnership with Private for Profit Health Service Providers Project" *supported by GAVI is to lay the foundation of improving coverage of vaccination in Afghanistan particularly at the provinces where the coverage of vaccination is low. This is done through equipping and training PHSPs (doctors, nurses/midwives and midlevel health workers operate in insecure provinces, it will be potential to incorporate public nutrition, follow up of DOTS, identification and referrals of mental health and disability cases. this could be done thorough arrangement of regular and on the job training and strengthening good public/private for profit partnership management to bring PPHSPs to a level where they can manage EPI, basic reproductive health , public nutrition interventions, follow up of DOTs, and identification and referrals of mental health and disability cases in insecure areas .This model could be further expanded into other insecure provinces in future.*

V. CONCLUSIOINS:

HSS program in Afghanistan has been very successful and produced tangible results. During the course of implementation, once it was recognized by Independent Review Committee in Geneva to be successful model which GAVI should use to further strengthen its HSS program. In addition, this support has contributed to strengthen other areas of the health system which were not part of the activities or in other words has had extensive positive externalities.

The HSS Program has achieved majority of its set benchmarks and targets successfully. The benchmark and indicators consist of impact indicators, outcome indicators and output indicators. Only few indicators are border line or slightly behind the target, while the majority of them have overachieved their targets. For example, the proportion of children under one year of age who have received three doses of Penta3 is 87% against its target of 90% coverage. The proportion of districts with more than 80% coverage of Penta 3 has reached 61% against its target of 100%. The proportion of children under one year of age who have received one dose of measles vaccine has reached 81% of its 90% target. There is a slight drop in health care provider knowledge score in 2012. Among the list of indicators, there is no data available only on one indicator namely "proportion of mothers in rural communities knowledgeable about prioritized health messages".

For the first time, it was made possible to monitor every province on a quarterly basis within the framework of GAVI funded HSS Program in Afghanistan. About 85% of provinces have been visited using national monitoring checklist in 2012. HSS Program has contributed to improving health sector coordination mechanisms and has involved all key stakeholders including relevant departments of MoPH, partner NGOs, civil society organizations, and the private sector collaboratively in the process of implementation of HSS supported programs. Establishment of public-private partnership, with the private sector has been made it possible to extend EPI and basic MCH reach to some insecure areas.

One example of other wider positive externalities is the contribution to certification of MoPH to procure services over US$200,000. According to Afghan law, all the services over US$200,000 should be procured by Afghanistan Reconstruction and Development Services (ARDS). HSS program for the first time developed all service procurement tools in line with Afghan procurement law with translations to local language. This facilitated the successful certification of MoPH which is considered vitally important for timely procurement and consequently delivery of health services.

There have been some challenges and weaknesses within the program and the outsider context. These challenges are related to coordination, communication, equity gaps, gender disparities, lack of qualified staff especially female, and insecurity, and low payment levels particularly for vaccinators, lack of clear sustainability strategy, staff turnover, and weaknesses in regulatory frameworks where most of them are not under direct control of MoPH.

The work done in HSS program in Afghanistan is commendable, however, rebuilding Afghan health system will require sustained support and commitment of all partners and donors and strengthening inter-sectorial coordinated efforts of Government of Afghanistan.

VI. LIMITATION OF THE EVALUATION

The GAVI funded HSS program evaluation mostly relied on desk analysis of country reports and utilized the routine reporting system. Utilizing published report of surveys conducted may not always be reliable as well as valid.However, data generated by the routine system considered to be good but they are often incomplete and inaccurate, prone to be biased, and may be subjected to manipulation.

VII. POLICY RECOMMENDATIONS

- Improve the operations of future HSS program.
  - Develop strategies for relevant MoPH programs with reflected relevant program gaps preferably in the context of health system building blocks. Use these strategies to support HSS applications rather than conducting general ad hoc gap analysis workshops. Use such workshops in some cases where needed i.e. particular program strategy is outdated.
- Improve country coordination mechanisms at different levels.
  - Provide information in form of capacity building for HSS-SC members especially for those members who are less familiar with GAVI and HSS concepts.
  - Budget for missions of HSS-SC to monitor and guide HSS interventions at field level.
  - There are two main coordination mechanisms between HSS and EPI that are the ICC and HSS-SC. Though there are discussions to merge both ICC and HSS-SC which is a good move, it will require better defining the mechanisms of support from this joint committee to both programs.
- Strengthen the MoPH stewardship functions at the central and provincial levels.
  - Further strengthen the information flow mechanismsamong M&E, HMIS and DEWS. In particular, analyze the feasibility of unifying the line of reporting of these departments to a single line of authority.
  - Focus on better defining the program and policy indicators and institutionalizing regular reviews and feedback mechanism for decision makers to assist them with making informed decisions.
  - Update the M&E strategy and revitalize the M&E advisory board. Decentralize routine M&E functions.
  - Institutionalize more direct feedback mechanisms between the central and provincial level officials. For example, the central and provincial level staff could be more directly connected through audio and video communication technologies.
  - Develop a joint supervision plan with BPHS implementers, focusing on quality rather than quantity. Prior to conducting any supervision, relevant health sector indicators should be reviewed, on the job training plan should be developed and regular follow up on the translation of recommendations into actions should be made.
  - Develop especial monitoring, supporting supervision mechanisms for insecure areas of the country. This could be done through recruiting and training local staff from the insecure areas.
  - Strengthen coordination mechanisms at provincial level through supporting PHCCs with updated guidelines, tools, and funding of its secretariats.
- Enhance EPI performance.
  - Further strengthen the capacity of EPI department and PEMTs. Develop training and deployment plan for more vaccinators based on a comprehensive gap analysis to identify the number of vaccinators needed. The newly trained vaccinators should be selected at the community level where commitment will be made to deploy them at their villages.
  - Reduce the number of missed opportunities for vaccinations at BPHS health facilities. For example, when children under the age of one visit the health facilities for other medical care, their vaccination status should be verified.
  - Context specific health education materials on EPI should be developed and health education sessions should be conducted at least on a weekly basis in each BPHS health

facility in order to raise mothers' awareness about vaccinations and increase demand for and coverage of vaccination.
  - Make outreach vaccination program more regular through well defining this function in BPHS implementer's contracts. In addition, put efforts to improve coordination between EPI program and NGOs.
  - Make systematic monitoring of BPHS implementer to improve their overall performances in general and performance related to EPI in particular.
  - Mobile teams' schedules should be synchronized with vaccination scheduling. For example, knowing that Penta3 is administered within 4 weeks interval, mobile teams' visits should be scheduled at the same frequency for the same villages.
  - Improve EPI micro planning, set realistic targets, identify and target those pockets of populations that do not fall within the catchment areas of BPHS facilities.
  - Strongly work to reduce the significant gaps between the estimates of different data sources for immunization coverage. Improve data quality through conducting more robust data audits; providing capacity building, supplying tools, using IT, imposing sanctions and provide incentives.
- Further focus on advancing the capacity of planning, procurement, and finance departments of MoPH.
- Strengthen and expand public-private partnership model through developing a strategic framework, guielines and clear regularatory framework.
- Explore new funding opportunities, for example with the International Health Partnership Plus.
- Ensure that communication strategies and materials are fully customized to the needs, cultural sensitivities and language requirements of the target communities.
- Further work on better utilization of DHOs to ensure efficiency and use of their expertise. This can be done through revisiting lessons learned, revisiting selection and recruitment criteria, categorization of the districts and so on. Where necessary DHOs can be deployed within PHOs, used on cluster bases to supervise more than one district or remain for one district depending on the size and characteristics of the districts.
- Think of other strategies for selection of NGOs in relation to the cost of their projects to ensure quality of service delivery. This could be done on fixed costs basis where historical records and lessons learned could as benchmarks. In addition, proactively plan for systematic costing of new interventions. Lastly, defining guidelines and robust blacklisting of NGOs who underperform is essential to improve quality of the contracted services.
- Sustainability of health care services including HSS interventions and its affiliated payments is an issue which requires development of a comprehensive sustainability strategy.
- Conduct an in-depth study of isolated pockets of population who do not have access to immunization and other health care services. Develop a national equity strategy.
- Institutionalize gender reporting in all levels of HIS and commence collection of sex disaggregated data for EPI coverage.
- Reconsider developing Demographic Surveillance System to replace surveys and ensure timely access to realistic coverage data for primary health services as well as mortality estimates.

ANNEXES:

Annex one: GAVI- HSS Projects Location

No	**Provinces**	**Sub-center / MHT**	**C-IMCI**	**In-service training**	**Health Promotion**	**DSF**	**M&E**	**Public Relation**	**Capacity building of MoPH managers at Central and provincial level**	**District Health officers**
1	Badakhshan	MHT/ SC	C-IMCI	In-service	All	DSF	All		QPHC	DHO
2	Takhar	MHT/ SC	C-IMCI	In-service	All		All		QPHC	
3	Kunduz	MHT/ SC	C-IMCI		All		All		QPHC	
4	Baghlan	MHT/ SC	C-IMCI	In-service	All		All		QPHC	DHO
5	Balkh	MHT	C-IMCI		All		All		QPHC	DHO
6	Juzjan	MHT/ SC	C-IMCI	In-service	All		All		QPHC	DHO
7	Sar-i-Pul	MHT	C-IMCI		All		All		QPHC	DHO
8	Faryab	MHT/ SC	C-IMCI	In-service	All	DSF	All		QPHC	DHO
9	Samangan	MHT/ SC	C-IMCI		All		All		QPHC	DHO
10	Kabul	SC	C-IMCI		All		All	MoPH/ center	QPHC	DHO
11	Bamyan	MHT/ SC	C-IMCI	In-service	All		All		QPHC	DHO
12	Logar	MHT/ SC	C-IMCI		All		All		QPHC	DHO
13	Parwan		C-IMCI		All		All		QPHC	DHO
14	Kapisa		C-IMCI		All	DSF	All		QPHC	DHO
15	Panjsheer	MHT	C-IMCI		All		All		QPHC	DHO
16	Maidanwardak	MHT	C-IMCI		All	DSF	All		QPHC	DHO

17	Dikundi	MHT/ SC	C-IMCI		All		All		X	DHO
18	Hirat	MHT/ SC	HSFP	In-service	All		All		QPHC	
19	Badghis	X			All		All		QPHC	DHO
20	Farah	X	HSFP		All		All		QPHC	DHO
21	Nimroz	X			All		All		QPHC	DHO
22	Urozgan	X	PRT		All		All		X	DHO
23	Ghor	MHT/ SC	HSFP		All		All		X	DHO
24	Zabul	MHT/SC	HSFP		All		All		QPHC	DHO
25	Helmand	X	PRT		All		All		QPHC	DHO
26	Kandahaar	MHT/ SC	HSFP	In-service	All		All		QPHC	DHO
27	Paktia	SC	C-IMCI	In-service	All		All		QPHC	DHO
28	Paktika	SC	C-IMCI	In-service	All		All		QPHC	DHO
29	Khost	SC	C-IMCI	In-service	All		All		QPHC	DHO
30	Ghazni	MHT/ SC	C-IMCI	In-service	All		All		QPHC	DHO
31	Laghaman	MHT/ SC	C-IMCI		All		All		X	DHO
32	Nangarhar	MHT	C-IMCI		All		All		X	DHO
33	Nooristan	MHT	C-IMCI		All		All		X	DHO
34	Kunar	MHT	C-IMCI		All		All		X	DHO

Annex two. Measuring GAVI Funded HSS Program Benchmarks and Indicators

Indicator(s)	2012 Target	Trends of Data from 2007 to 2012						
		2007	2008	2009	2010	2011	2012	Data source
Impact Indicators								
1.1 Maternal mortality ratio per 100,000 live births	533	1600	1600	1600	1600	327	327	AMS/Bartlet
1.2 Under five years mortality rate, per 1,000 live births	153	191	191	161	97	97	97	AHS/AMS
1.3 Under one year mortality rate, per 1,000 live births	96	129	129	129	77	77	77	AHS/AMS
Outcome Indicators								
2.1 Proportion of children <1 who received three doses of PENTA3 vaccines	90%	77%	85%	83%	87%	89%	87%	HMIS
2.2 Proportion of districts with coverage of PENTA3 >80%	100%	49%	58%	56%	58%	57%	61%	HMIS
2.3 Proportion of children <1 who received one dose of Measles vaccine	90%	68%	75%	76%	79%	82%	81%	HMIS
2.4 Proportion of deliveries attended by skilled birth attendants	40%	19%	32%	35%	35%	45%	46%	HMIS
2.5 Health Care Providers' Knowledge Index	90	68.7	79.3	70.6	70.60	64.60	64.4	BSC
2.6 Proportion of mothers in rural communities knowledgeable about prioritized health messages	40%	No data is available on this indicator						
Output Indicators								
3.1 Number of contacts made per person per year	1.0	0.6	1.08	1.16	1.30	1.5	1.8	HMIS
3.1 Average number of persons referred by CHWs per quarter	20	14.8	24	20	22	23.3	34.4	HMIS
3.2 Proportion of children who received treatment for diarrhea at community level	30%	30%	30%	32%	34%	73%	57%	HMIS
3.3 Proportion of CHWs trained on C-IMCI	80%	2%	28%	20.3%	34.3%	56%	62%	APR
3.4 Proportion of provinces visited at least four times per year using national monitoring checklist	100%	29%	33%	47%	56.5%	47%	85%	M&E Data base

Annex three: PPHOs and DHOs Quantitative Results

PPHOsResults

GI-A interviewed 38 PHOs across six provinces i. e. Badakhshan, Panjshir, Laghman, Kabul, Ghazni and Kandahar.

Table 1 describes information related to Quality Public Health Management Training.

Among 38 PPHOs interviewed for this evaluation, only 6 of them (15.8%) received the Quality Public Health (QPHM) Training. All participants of the training evaluated the quality of that training good and excellent. Those who attended the QPHM training (15.8%), got improvement in their performance, through better coordination with partners and reporting (100%).

Table 1: PPHO training on Quality Public Health Management training information

Variable	Response	number	proportion
Training on quality public health management received	Yes	6	15.8
Quality of public health management training	Excellent and good	6	100
Did your performance improved after receiving quality public health training?	Yes	6	100
How did quality public health training improved your performance	I can better coordinate with partners	6	100
	I can better develop report	6	100
	I can better supervise and monitor the health facility	5	83
	I can better provide feedback to health facility staff	5	83
	I can better record the information that I received	2	33

The training participants also expressed their performance improvement in better supervision and monitoring of HFs (83%), provision of feedback to HFs staff (83%), and better recording of received information (83%).

For evaluating the supervision activity of PHDs, 68.4% of them were supervised at least 1-2 times, 10.5% of them were supervised 3-6 times, and 7.9% of them were supervised more than six visits. Only 13.2% of them (5 person) were not supervised at all. Only 42.9% of PHOs were provided written recommendations.

Table 1.2 describes the supervision of PHOs by higher authoritative bodies.

Among 38 respondents, 87.9 % of them were checked for their office records, 51.5% of them were given on job training, 48.5% for technical knowledge, 81.8 % were provided management instructions and 84.8% were provided administrative instructions. All 38 PHOs(100%) had job description. More than 90% of these PHOs, replied that their main task is coordination, developing plans, monitoring, provision of feedback, reporting and on job training.

Table 2, Supervision of PHOs by higher authorities

Variable	Response	number	proportion
Number of times PPHO supervised in last six month by PHD.	No Supervisory visits	5	13.2
	1-2 supervisory visits	26	68.4
	3-6 supervisory visits	4	10.5
	more than six visits	3	7.9
Supervisor provided written recommendations	Yes	15	42.9
What did the supervisor do when s/he came on the last visit?	Checked office records	29	87.9
	provide on job training	17	51.5
	Assessed technical knowledge	16	48.5
	provide management instruction	27	81.8
	Provide instruction on administration	28	84.8
Availability of job description with PPHO	Yes	38	100
Can you tell me your main tasks that you are doing?	Developing plan	35	92
	Mentoring	0	0
	Monitoring	34	90.0
	Coordination	38	100.0
	Feedback provision	37	97.0
	Reporting	35	92.0
	On job training	32	84.0
	Bench mark setting for indicator	22	58.0

In response to having operational plan, all 38 interviewed PHOs, had operational plan (100%). 87% of them (33 PHOs) replied that most part of the operation plan is implemented. 95% of these PHOs were apprised by PPHD or central MoPH. Table 3 describes the operation of PHOs

Table 3, PHO Operation

Variable	Response	number	proportion
Do you have operational plan?	Yes	38	100.0
To what extent do you implement the program according to operation plan?	Most of plan has been implemented	33	87.0
Have you been appraised by PPHD or central MoPH?	Yes	36	95.0

Among all 38 PHOs, interviewed for this evaluation, 70.3% of them have supervised DHOs. The frequency of monitoring was usually 38.5%, normally 19.2%, frequently 30.8%, and sometimes 11.5%. It was found that 92% of interviewees had copies of reports and feedbacks. 95% of them

had different coordination mechanism in place, as mainly meetings (95%), formal letters (79%), feedback (76%)), IT(74%), field visit(71%). Table 4 describes the information on DHO supervision by PHO.

Table 4 DHOs supervision by PPHO

Variable	Response	number	proportion
DHOs supervised by PPHO	Yes	26	70.3
How frequent those monitoring sessions happened?	Usually	10	38.5
	Normally	5	19.2
	Frequently	8	30.8
	Sometimes	3	11.5
Can you show me the copy of monitoring report and or feedback?	Yes	24	92
Is there any coordination mechanism in place among different key players?	Yes	36	95
How do you coordinate health related activities with DHO?	Formal letter	30	79
	Meeting with stakeholders	36	95
	mobile phone	28	74
	field visit	27	71
	Feedback reports	29	76
Are there any challenges/difficulties that you are facing in your daily work?	Yes	37	97.4
Can you name some of challenges?	Security	26	70.3
	Lack of training and knowledge	27	73
	Lack of feedback of performance	13	35.1
	Inadequate transportation	20	54.1
	Lack of motivation	16	43.2
	staff shortage	16	43.2
	lack of supplies and drug	7	18.9
	lack of equipment	9	24.3
	lack of supervision	13	35.1
	Inadequate remuneration	25	67.6
	Lack of communication with health facility	11	29.7
	Lack of coordination with health facility	6	16.2
Did you conduct DHO assessment?	Yes	27	71.1
DHOs program is effective	Yes	27	100
Do you think that the establishment of DHO had positive impact?	Yes	37	97.4

Replying the challenges in daily work, 97.4% of respondents, had challenges. Lack of training and technical knowledge are the top of challenges (73%), with security(70%), inadequate salary and DSA(67%), inadequate transport (54.1%), lack of motivation and staff shortage each(43.2%), lack of feedback on performance (35.1%).lack of supervision(35%), and some other challenges with smaller percentages as seen in the table 1.4. Of these respondents, 71.1% of them had done DHO assessment.

In response to the role of DHO, 27 respondents (100%) replied that the DHO program is effective and 37 respondents (97.4%) think that, the establishment of DHO had positive impact.

DHO qualitative results

District health officer's (DHO) questionnaire applied in six selected provinces. A total number of 25 DHO have been interviewed.

Table below described variables related to ToR. All respondents expressed that they have job description and 96% believed that their responsibilities have been reflected appropriately. In respect to having operational plan, 96% said that there is an annual operation plan in place and 80% expressed that most of plan have been implemented. From other hand 84% of respondent replied that due to lack of financial support the annual operational plan was not conducted while 48% of respondents identified the lack of support from PPHD and lack of support from BPHS implementer NGO.

Table 5: DHO Operational information

Variables	Response	Number	Proportion
Do you have job description?	Yes	25	100
Does your role appropriately reflected in the ToR	the role has appropriately reflected	24	96
Do you have annual operational plan	Yes	24	96
To what extent did you implemented operational plan	Most of the plan implemented	20	80
If the annual plan was not fully implemented? what are the main reason	lack of financial resources	21	84
	Lack of support form PHHD	12	48
	Lack of support from NGOs	12	48

From all respondents, 44% received training on national monitoring checklist. 52 percent of DHO staff managed to conduct at least 1-3 times monitoring from health facilities. However all respondents conducted at least one monitoring visits during last quarter, only 64% of them provided feedback to health facilities. As concerned with some challenges to successful conduction of monitoring visits; lack of financial resources (96%), lack of PPHD support (52%), lack of support from BPHS implementers (52%), security (68%), geographical barrier (28%) and not receiving training (36%) are identified as some of challenges.

Table 6, DHO monitoring system information

Variables	Response	Number	Proportion

Did you receive training on National Monitoring checklist during last year?	Yes	11	44
How many health facilities did you monitored at least one time during last quarter using national monitoring checklist	1-3 monitoring conducted	13	52
	More than 3 monitoring conducted	12	48
Number of written feedbacks provided to the health facilities	at least one feedback provided	16	64
What challenges do you face to fulfill monitoring functions	lack of financial resources	24	96
	Lack of support form PHHD	13	52
	Lack of support from BPHS NGOs	13	52
	Security	17	68
	Geographical	7	28
	did not receive training	9	36

As it concern for coordination, among all respondent who replied to question on coordination mechanism at district level, 88% responded that the district health coordination committee (DHCC) has been established and 84% responded that district health Shura was established. 92% of DHCC managed to conduct at least one meeting in last quarter. With respect to supervision from provincial and central level, only 28% of respondent supervised by central MoPH while 84% of them supervised by provincial public health directorate.
Only 76% of responds had space to work. With respect to having functional computer and access to internet, 28% of them had functional computer and only 8% had access to internet.

Table 7, DHO Coordination information

Variables	Response	Number	Proportion
What are the coordination mechanisms at district level	DH Coordination committee established	22	88
	DH Shuras established	21	84
How many DHCC meetings were held during last quarter?	at least one meeting conducted	23	92
How many times have you been supervised during last six months	MoPH at least one supervision	7	28
	PHD at least one supervision	21	84
Do you have office space to work	Yes	19	76
Do you have official computer?	Yes, functional	7	28
Do you have internet facilities in the office	Yes	2	8

VIII. LIST OF FIGURES:

IX. LIST OF TABLES:

Table 8: DHO supervised by PPHO

X. REFERENCES

a. Annual Progress Report (2008-20013)
b. Afghanistan Mortality Survey Report (2010)
c. Afghanistan Household Survey Report (2006)
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