Evaluation of Gavi's contribution to reaching ZD and missed communities

Country Case Study: Afghanistan

February 2024

Gavi The Vaccine Alliance

Ipsos

Contents

List of figures

List of tables

List of acronyms

ARTF	Afghanistan Reconstruction Trust Fund
BCC	Behaviour change communication
BPHS	Basic Package of Health Services
CCEOP	Cold-Chain Equipment Operations Platform
CSO	Civil society organisation
DHO	District health officers
DTP	Diphtheria, tetanus and pertussis
EAF	Equity Accelerator Fund
EPHS	Essential Package of Hospital Services
EPI	Expanded Programme on Immunisation
FED	Fragility, Emergencies and Displaced Populations Policy
FPP	Full Portfolio Planning
GDP	Gross domestic product
GLM	Geolocation monitoring
HR	Human Resources
HSS	Health Systems Strengthening
ICC	Independent Coordinating Committee
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
IPC	Interpersonal communication
IPCC	International Panel on Climate Change
IRC	Independent Review Committee
IRMMA	Identifying, reaching, monitoring and measuring, or advocating (framework)
ICT	Information, communication technologies
JICA	Japan International Cooperation Agency
KAP	Knowledge, attitudes and practices
M&E	Monitoring and evaluation
MoPH	Ministry of Public Health
MPM	Multidimensional poverty measure
NGO	Non-governmental organisation
NIS	National Immunisation Strategy
RSSH	Resilient and Sustainable Systems for Health
SCM	Senior country manager
ToC	Theory of change
UHC	Universal Health Coverage
UNICEF	United Nations Children’s Fund
WHO	World Health Organization
ZD	Zero-dose

1 Context

Health system context

As a low-income country with a gross domestic product (GDP) per capita of USD 363.7 (2021)[1], the second lowest globally, Afghanistan faces numerous challenges. With an estimated population of about 39 million (2020), the nation's life expectancy at birth is 10% lower than the global average. In 2020, Afghanistan's national budget was predominantly funded by development partners, accounting for about 70% of the total budget. The country's health expenditure was 13% of GDP in 2019.[2]

Afghanistan's health system is among the bottom five of the Universal Health Coverage (UHC) index. This low ranking drives many patients towards private healthcare providers, leading to a high out-of-pocket health expenditure of 75.5%, and frequent instances of catastrophic health expenditure.[3]

In 2017, the last year for which National Health Accounts data is available, the government accounted for 5.1% of total health expenditure, donors for 19.4%, and out-of-pocket expenditure made up 75.5%. However, with declining budget allocations for health, the government's share of health expenditure had likely reduced to around 2% by 2021.[4]

The situation in Afghanistan changed dramatically on 15 August 2021, when the government of the Republic collapsed, and the Taliban assumed control as the Islamic Emirate of Afghanistan. This political shift led to the swift suspension of donor funding due to the Taliban movement's ongoing UN sanctions, dating back decades. As a result, the annual USD 8 billion of reconstruction and development assistance, including almost all health sector funding both on and off-budget, disappeared overnight, and Afghanistan was cut off from the global banking systems.[5]

The health and immunisation systems in Afghanistan have suffered a significant brain drain, particularly depleting senior management and technical capacities. The system is currently overwhelmed with near-permanent campaigns for severe measles outbreaks, mass COVID-19 immunisation, and the endgame of polio eradication, as Afghanistan is one of the last two countries still battling the disease. These circumstances continue to absorb most of the weakened system's capacity, posing significant challenges to the country's healthcare landscape.[6]

Gavi support

Afghanistan's Health Systems Strengthening 3 (HSS3) grant was approved in 2016, for the period 2016–2020. The proposal was tailored to address key health and immunisation system bottlenecks that were impeding the country's ability to overcome socioeconomic and geographical inequities in immunisation outcomes. The objective was also to bolster the performance of the health system related to immunisation.[7]

---

[1] World Bank. (2023). GDP (current US$) | data. Retrieved from The World Bank website: https://data.worldbank.org/indicator/NY.GDP.MKTP.CD
[2] World Health Organization. (2023). Global health expenditure database. Retrieved from apps.who.int website: https://apps.who.int/nha/database
[3] Ibid
[4] Gavi. (2022). Supporting Narrative for Theory of Change for Gavi Support Request. ***Gavi internal documentation.***
[5] Ibid.
[6] Ibid.
[7]

The strategic focus of the HSS3 support was centred on enhancing equitable access and effective coverage of immunisation services through several strategies, including training female vaccinators, providing cold-chain equipment to unserved health sub-centres, and training vaccinators for community-based outreach in underserved villages. Moreover, the HSS3 support facilitated the delivery of basic health services through public-private partnerships (civil society organisation (CSO) type B) and the continuation of mobile health teams for the Kuchi population. [8]

By 2019, according to the latest Joint Appraisal available Gavi had approved the full committed amount of USD 47.5 million, of which USD 28.9 million had been disbursed, resulting in a 61% utilisation rate. An additional USD 2.3 million was approved for data quality improvement, with USD 1.3 million disbursed (57% utilisation).[9]

However, in 2020, the focus shifted to the COVID-19 pandemic, and Afghanistan's Full Portfolio Planning (FPP) began with the aim of submitting the proposal by June 2021. For the 5.0 strategic period, Afghanistan's HSS Core Approval Cap (2021–2025) was set at USD 39,323,663, with an Equity Accelerator Fund (EAF) core ceiling of USD 17,747,501[10]. Progress was being made and domestic financing was identified, but the application process was stalled due to a severe second wave of COVID-19 in May/June 2021, followed by the Taliban takeover in August 2021. In total, the latest internal documentation shows Gavi provided USD 67,310,024 total during HSS 3 including the contingency grant between 2016-2022.[11]

When the government of the Republic collapsed on 15 August 2021, and the Taliban formed the Islamic Emirate of Afghanistan, external funding was suspended due to UN sanctions on the Taliban movement, and Afghanistan was disconnected from the global banking system. By October 2021, the international community had started providing humanitarian assistance to health, under a sanction's exemption, channelling aid through the UN and non-governmental organisations (NGOs). However, two essential components of the immunisation system were governmental and could not be funded under this humanitarian umbrella.

In response, Gavi stepped in with a 'Contingency grant' in November 2021. The country developed an emergency HSS Plan of USD 7,925,110 to bridge programme support and to ensure the maintenance and restoration of essential national immunisation systems between 1 January and 30 September 2022. FPP planning resumed in March 2022, and by November 2022 the Independent Review Committee (IRC) final report approved a partial amount of USD 16,213,574 for 18 months (instead of the 3 years requested timing and amount). However, Afghanistan's EAF application was delayed until 2023 given the overwhelming priorities in terms of HSS implementation, Covid 19 vaccine deployment and campaigns, MR and polio nationwide campaigns as well as earthquakes.[12]

Key stakeholders

Since 2003, primary healthcare in Afghanistan, including a basic package of health services (BPHS), has been provided free of charge. The BPHS was funded by the World Bank, United States Agency for International Development (USAID) and the European Union (EU), and largely contracted out by province to 16 NGO service providers. This service was financed through the Afghanistan

[8] Gavi. Afghanistan HSS 3 proposal and IRC report. ***Gavi internal documentation.***
[9] Gavi. (2019). Afghanistan Joint Appraisal 2019. ***Gavi internal documentation.***
[10] Gavi (unsp.) Summary of 5.0 country allocations for Gavi-eligible countries. https://www.gavi.org/sites/default/files/support/Gavi-5_0-Ceilings-by-country-and-support-type.pdf. ***Gavi internal documentation.***
[11] Gavi. (2023). Overview of Gavi support October 2023 – Quarter 3 catch up and monitoring. ***Gavi internal documentation.***
[12] Gavi. Afghanistan HSS 4 proposal and IRC report. ***Gavi internal documentation.***

Reconstruction Trust Fund (ARTF), a pooled fund managed by the World Bank, under the name of Sehatmandi, and overseen by the Ministry of Public Health (MoPH).[13]

However, the political shift in August 2021 led to the suspension of the Sehatmandi mechanism through the MOH and was redirected to be managed by UNICEF (until summer 2022). It was replaced by the Health Emergency Response (HER) in late 2022 under various emergency funding mechanisms. There was a delay in the start of HER because of divergences in the selection of NGOs service providers between Unicef/World Bank and the MoH. The new HER programming is an enhanced model of Sehatmandi with BPHS contractors and indicators which include the last mile immunisation delivery, which involves transporting vaccines from the refrigerator at the health facility to the child. The ain difference to note is the modality of contracting and fiduciary arrangements which changed from the MoPH to UNICEF. The BPHS/Essential Package of Hospital Services (EPHS) service provider still covers the costs of the vaccinators' salaries, direct supervision and refresher training, outreach, facility rent, and all other costs associated with the last mile. The funding for this still comes from the ARTF, at roughly the same per capita cost.[14]

The National Expanded Programme on Immunisation (EPI) department of the MoPH manages the higher parts of the system, including the import of vaccines, managing the cold stores, data systems, coordination, quality assurance, training, demand generation, and all else. This is largely funded by Gavi, with contributions from the Japan International Cooperation Agency (JICA) for funding for payment of traditional vaccines and cofinancing, and UNICEF. Meanwhile, immunisation delivery is largely contracted out to NGOs under BPHS.[15]

Under the 5.0 strategic period, and in HSS 4, Gavi's support will be distributed through five entities, namely UNICEF, World Health Organization (WHO), Acasus, International Federation of Red Cross and Red Crescent (IFRC) and International Organization for Migration (IOM)[16]. However, contracts with IFRC and IOM will only last for one year due to cost considerations. Other key public health actors and donors in Afghanistan include the World Bank, USAID, the Asian Development Bank (ADB), the Global Fund and the International Monetary Fund (IMF).

Country ZD theory of change (ToC)

The root cause of limited immunisation in Afghanistan can be traced back to 42 years of conflict, which underlies most other causes for the high prevalence of zero-dose (ZD), under-immunised children and missed communities. Factors such as illiteracy, low demand, vaccine hesitancy, poverty, displacement, under-investment, mal-distribution of facilities, and gender discrimination, both in service delivery and barriers for women and girls accessing services, are all exacerbating the issue. There is a high correlation between the severity of conflict and the prevalence of ZD.[17]

However, the cessation of fighting in 2021 has created an opportunity for change. Areas and populations that were inaccessible for decades due to conflict suddenly became reachable, opening the door to increase coverage. Despite years of conflict, natural disasters, a pandemic, regime change in 2021 with economic collapse and a brain drain, the immunisation system of Afghanistan has proven remarkably

[13] Gavi. (2022). Supporting Narrative for Theory of Change for Gavi Support Request. ***Gavi internal documentation.***
[14] Ibid.
[15] Ibid.
[16] Gavi. Gavi HSS4 application materials. ***Gavi internal documentation.***
[17] Gavi. (2022). Supporting Narrative for Theory of Change for Gavi Support Request. ***Gavi internal documentation.***

resilient. It is stabilising again, with some system strengthening planned and renewed expansion to previously hard-to-reach populations.

By 2023, the systems showed encouraging signs of stabilisation, and some donor support has resurfaced as humanitarian aid. However, the main problems remain far from being resolved. The BPHS, despite its success in reducing maternal and child mortality, is rather narrow and geared towards disease patterns of the turn of the century. The quality of care is modest, and the system does not have the capacity to reach the whole population though now accessible (which was not the case under the previous regime), partly due to underfunding.[18]

Last mile immunisation delivery, from the refrigerator at the health facility to where it is administered to the child, continues to be included in the BPHS contracts. However, no detailed costing of this component has been done, nor is a precise estimate available of how many vaccinators are needed in a context like Afghanistan. Immunisation is not ring-fenced in the contracts.[19]

The BPHS/EPHS system covers all 34 provinces, but funding gaps exist. The 2023 HER provides for 27.4 million people, while the Urban Health Initiative, funded by the USAID, catered for about 7 million population in the five big cities. After transition, these Urban Health Initiative contracts were cancelled and rechannelled to support only the private sector, which only provides a very small proportion of immunisation. This leaves a considerable funding gap in last mile immunisation delivery.[20]

The National EPI department of the MoPH operates the higher parts of the system, largely funded by Gavi, with contributions by JICA and UNICEF. Afghanistan's HSS4 three-year funding proposal (2023–2025), which was only approved for 18 months initially, aims to further stabilise the system, with some system strengthening and a modest expansion of coverage. The 2023 application to the EAF will be a major coverage expansion drive. HSS4 proposes increasing outreach by deploying more vaccinators with their transport, linking with the mobile health and nutrition teams that are combatting the food security crisis, and aligning with the polio eradication initiative. This investment, primarily consisting of human resource (HR) costs, builds on the HER programming, and will hopefully further build a foundation for increased core (non-Gavi) funding for the BPHS from 2024 onwards, as the HER is far from being enough.[21]

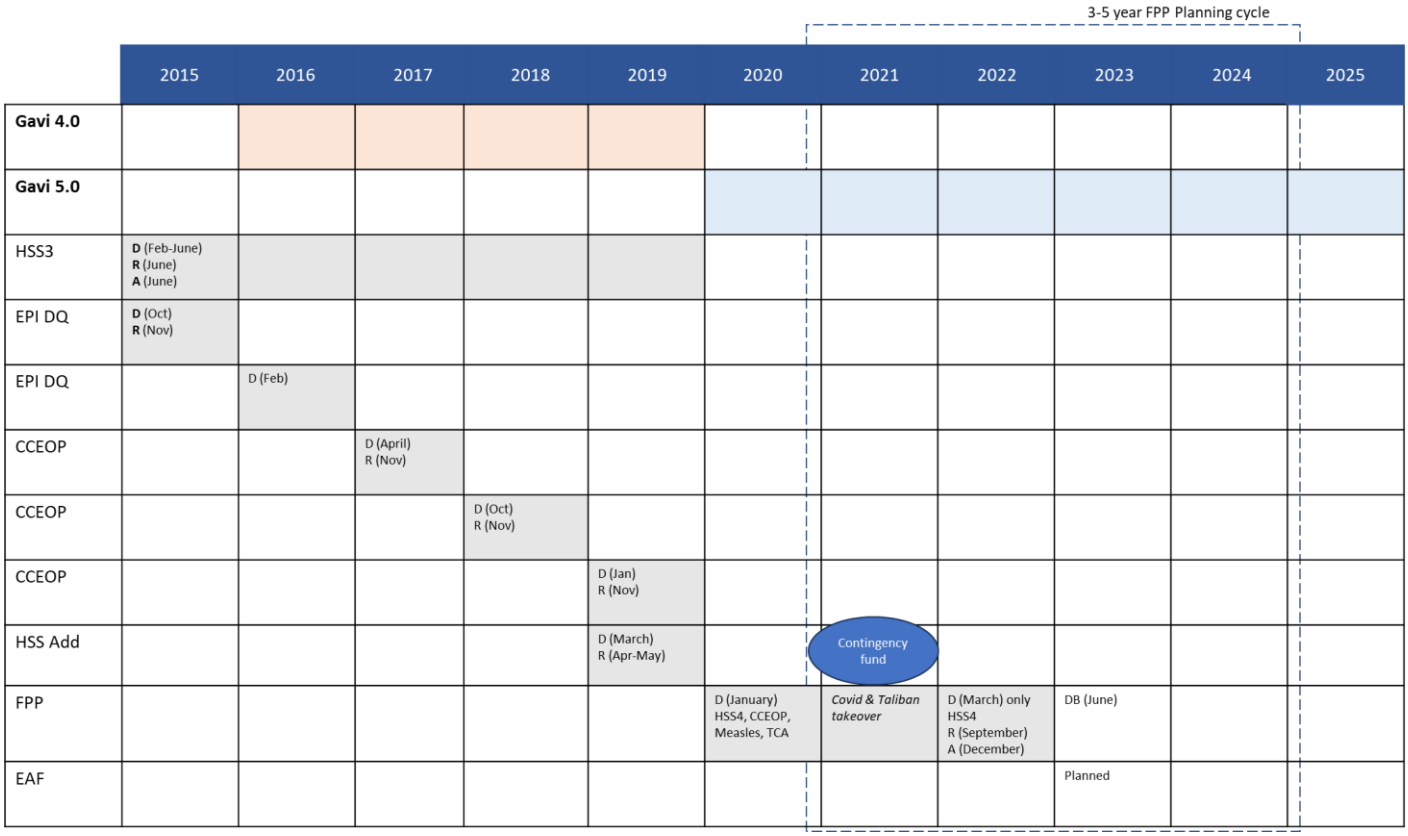
Data collection timeline

Data collection activities included the following:

- **Introductory call** with the Gavi Afghanistan Senior Country Manager (SCM) and Programme Manager (May 2023)
- **Document review** (June – September 2023) (list of documents in Annex)
- **Semi-structured interviews** with key operational stakeholders (July – August 2023)
- **Validation call** with the Afghanistan SCM and project manager (October 2023)

[18] Ibid
[19] Ibid
[20] Ibid
[21] Ibid

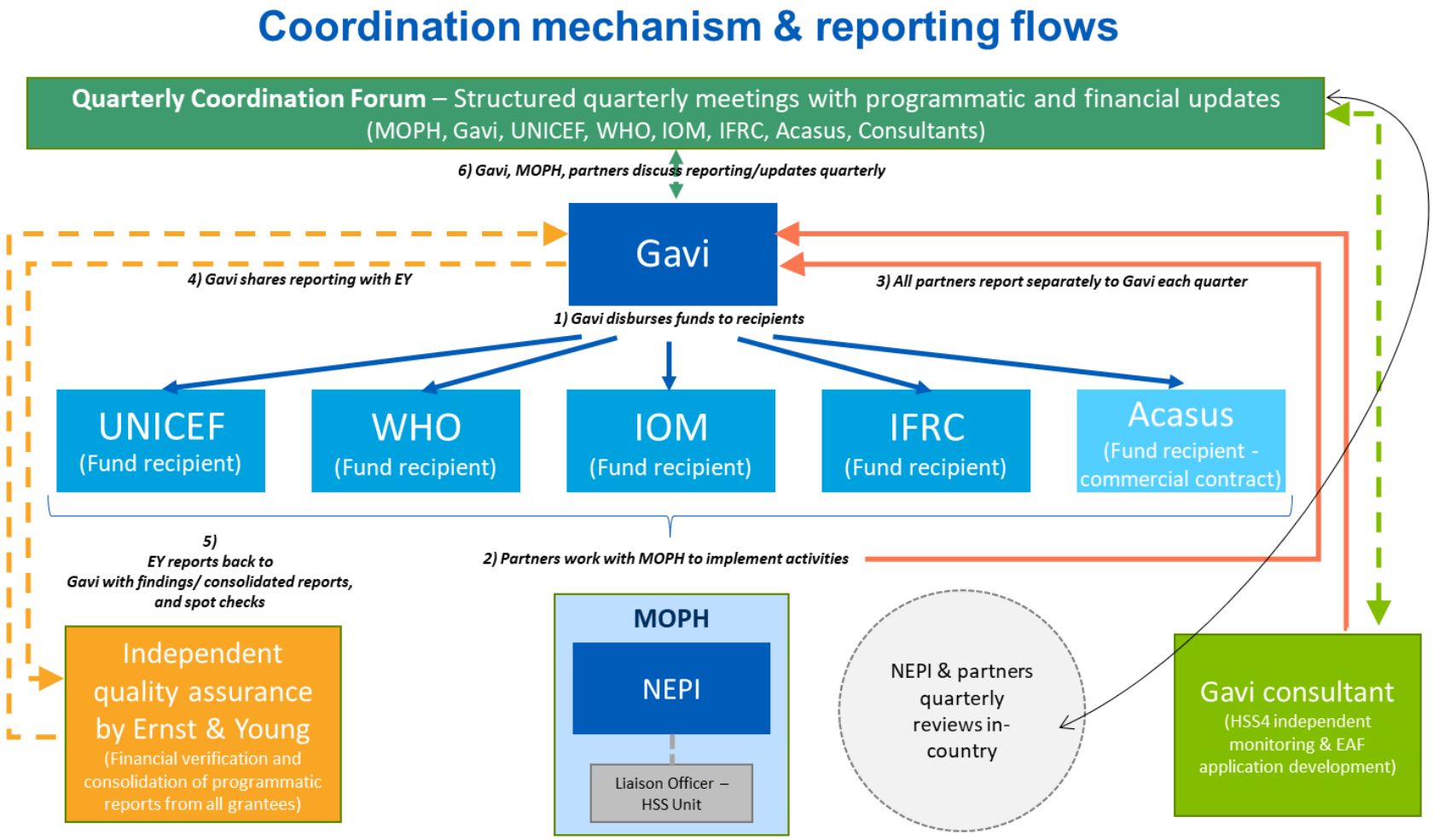
Figure 1.1: Timeline of Gavi 4.0 and 5.0 grants in Afghanistan (excluding Vaccine Introduction Grants)[22]



D: design; R: review; A: approval; DB: disbursement; I: implementation; C: closure

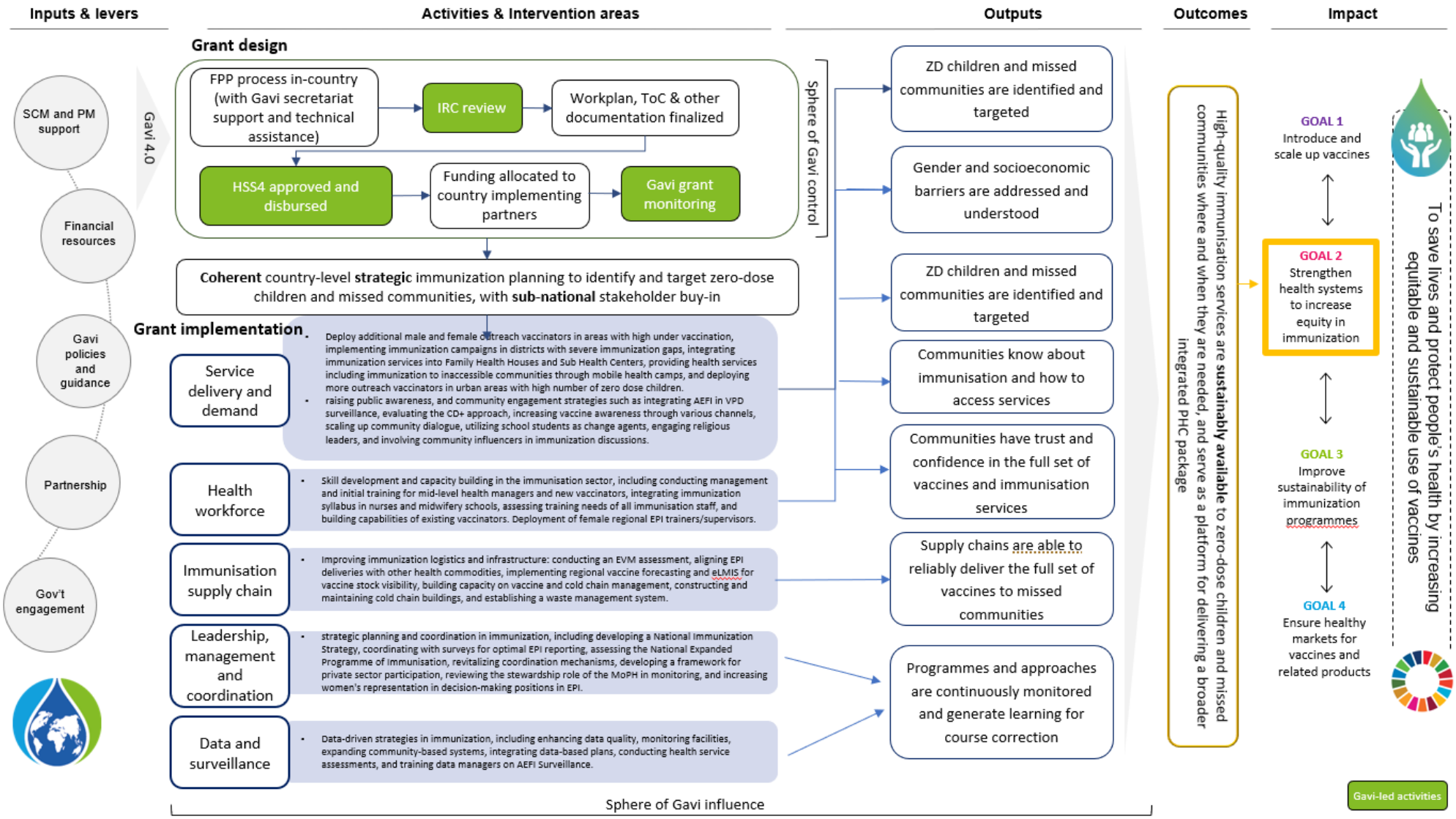
[22] Based on available documentation. Timeline to be validated by Gavi following review of the draft case study.

Figure 1.2: Key actors, coordination mechanisms & reporting flows in Afghanistan Gavi 5.0[23]



[23] Based on available documentation. To be validated by Gavi following review of the draft case study.

Figure 1.3: Afghanistan theory of change for Gavi 5.0



2 Findings

Objective 1: Relevance and coherence of Gavi's ZD agenda

EQ1. How relevant is Gavi 5.0/5.1's focus on ZD children and missed communities to countries' needs?

Summary of findings	• Gavi's targeted approach towards ZD children and missed communities in Afghanistan aligns with the health needs of the beneficiaries, and the country's priorities to overcome immunisation disparities. The intervention design responds to the complex socio-political and economic landscape and specific challenges of conflict-affected and rural regions. • However, the lack of robust population data and deeply rooted cultural and economic obstacles highlight the need for Gavi to adapt and reinforce its strategies, ensuring continuous relevance amid changing circumstances through data investment, cultural sensitivity, and broadened community engagement.
Strength of the evidence	**1** (2 / 3 / 4)
Rationale for this judgement	Evidence comprises multiple data sources of decent quality. This includes triangulation of informant views with factual quantitative data from secondary sources and objective reporting from desk review of activities undertaken.

Afghanistan's health system has been on the brink of collapse following the regime change in August 2021. The little funding from previous domestic resources is gone, and the primary healthcare services, once supported by the Sehatmandi programme, are under severe threat due to lack of funding, resulting in unpaid staff and shortages of essentials like medicines and food. This situation has been exacerbated by the COVID-19 pandemic, with only 11% of the population vaccinated as of 2021, and the ongoing drought leading to acute food insecurity. It is also difficult for the EPI preventative model to coexist with the polio eradication model. The pressure for eradications leads to constant campaigns, which is disruptive to routine immunisation. The existing healthcare challenges are amplified by an overconcentration of immunisation facilities in urban areas, neglecting rural communities, thus underscoring Gavi's relevance in focusing on zero-dose children and missed communities.

Afghanistan's immunisation priorities are striving to ensure all children complete the recommended immunisation schedule, including key vaccinations for diseases like diphtheria, tetanus, and pertussis (DTP), polio and measles. Importantly, Afghanistan is one of two countries left in the world with endemic polio. The challenge of dropouts – where children miss scheduled vaccinations due to limited healthcare access, vaccine hesitancy or lack of awareness – also remains a significant concern. Inequities in immunisation coverage also persist, with disparities in access between urban and rural areas, conflict-affected regions, and different ethnic groups, which necessitates efforts to ensure equitable immunisation access. The COVID-19 pandemic has further complicated these efforts, causing a temporary drop in immunisation doses delivered in 2020 due to lockdowns, but immunisation services have rebounded, and ongoing efforts are focused on maintaining these services amid the pandemic's challenges.

In Afghanistan, the identification and location of ZD children present a complex and challenging issue. Afghanistan has an estimated 321,000 ZD children and a DTP1 coverage rate of 77%[24]. **However, the precise locations of ZD populations remain largely undefined due to a lack of robust population data; the last complete census in Afghanistan was conducted in 1979, and it was not completed due to ongoing conflict[25].** Despite this, efforts are under way to identify underserved communities and ZD children. Techniques such as geospatial satellite population estimation are being used to assess population densities in certain provinces, and there is a recognised need for community micro-census and field verification to identify these populations.

Based on the limited information available, areas with higher percentages of ZD children are found particularly in the southern regions and north-central areas of Afghanistan. A prominent belt of concern extends from the south to the north-central, largely coinciding with the polio transmission belt. These areas are thinly populated, historically underserved with healthcare, education, and road infrastructure, and are heavily conflict-affected. The megacity of Kabul, despite having only 10.8% ZD children in the 2018 Afghanistan Health Survey, still represents a significant number of unvaccinated children due to its high population. Identifying these children among a relatively well-immunised majority poses a considerable challenge. In this context, Gavi's identify approach (which encourages identify strategies based on triangulation to establish the target population, uses a variety of sources to estimate the population, identify the main causes and target specific geographies) is highly relevant. However, the country first needs comprehensive data. Consequently, investment in data forms a crucial part of the country's health system strengthening application (HSS4)[26].

The drivers of ZD populations in Afghanistan are varied, and deeply rooted in the country's socio-political, economic and cultural fabric. The 42-year history of conflict has significantly hindered immunisation efforts, disrupting health services, restricting access to rural regions, and limiting essential service investments in conflict-affected areas. The limited access to immunisation services is exacerbated by harsh terrains, scattered populations, and inadequate roads, particularly in previously conflict-affected and remote rural regions.

Economic factors are equally influential, with poverty acting as a significant barrier despite immunisation services being free of charge. Indirect costs, such as transportation and opportunity costs, disproportionately affect poor households, further limiting access to immunisation. Vaccine hesitancy, fuelled by misconceptions, concerns about intelligence gathering and religious beliefs has also adversely affected immunisation rates in some communities. Gender discrimination and limited female autonomy, underpinned by strict cultural norms and restricted movement without a male chaperone, impede access to immunisation services for women and children. Internal displacement due to conflict and natural disasters, coupled with chronic underfunding and underspending on health services, further compound these challenges.[27]

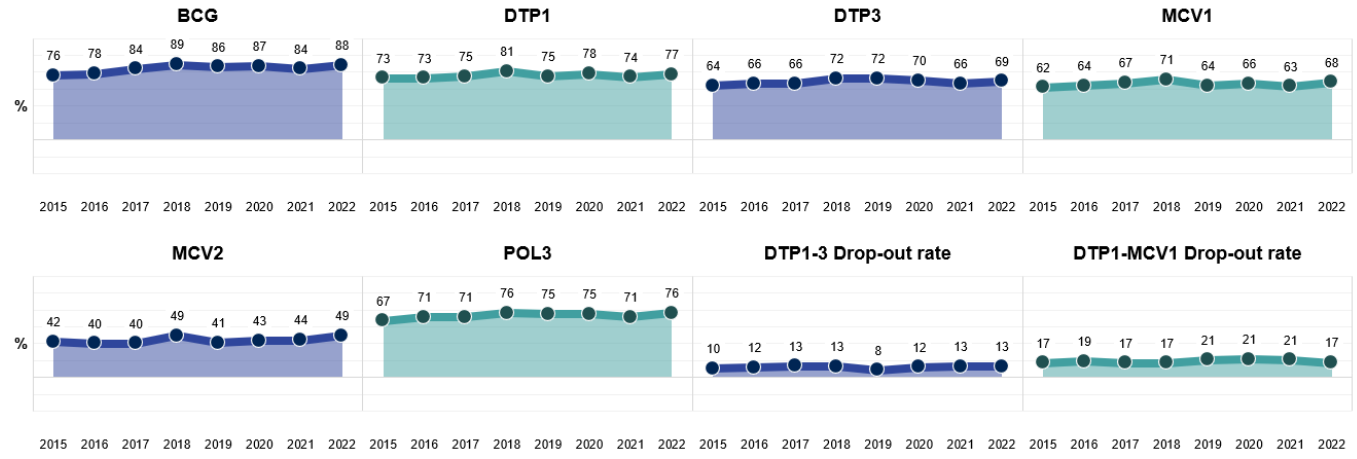
Afghanistan's classification in Gavi's fragile and conflict segment reflects the country's complex landscape. Gavi's principles address these barriers by focusing on gender, demand and differentiating support, which are highly pertinent to the Afghanistan context. However, in Afghanistan, indirect costs like transportation and lost labour, especially for the poor, are significant, and cultural factors often double these costs. In regions with low female autonomy, the decision to immunise children often lies with the male head of the household, necessitating social and behavioural change

[24] WEUNIC data
[25] Gavi. (2022). Supporting Narrative for Theory of Change for Gavi Support Request. ***Gavi internal documentation.***
[26] Gavi. Afghanistan HSS 4 application materials
[27] Gavi. (2022). Supporting Narrative for Theory of Change for Gavi Support Request. ***Gavi internal documentation.***

interventions that include a strongly male-oriented component. Maternal education also plays a critical role, with 30% of children remaining unvaccinated when their mothers have no education compared to 11% when their mothers have primary education. Therefore, community engagement and acceptance for new programmes are crucial, particularly in regions with strict tribal codes.

The Identifying, reaching, monitoring and measuring, or advocating (IRMMA)[28] framework provided by Gavi, while not found universally useful in Afghanistan, did aid some country stakeholders in planning grant-related activities. Gavi's IRMMA approach to using its funding levers have successfully focused Afghanistan's stakeholders on investing in neglected areas, highlighting the need to address under-investment in previously conflict-affected areas for not just health, but also education and other essential services. The case study data suggests a need for Gavi's strategy to more explicitly focus on the integration of services in Afghanistan, such as nutrition, within primary healthcare interventions, and frameworks like IRMMA could more explicitly acknowledge this.

Figure 2.1: Zero-dose and immunisation indicators[29]



[28] Identify, reach, monitor, measure, advocate framework
[29] WEUNIC data

EQ2. How relevant are the Gavi funding levers to the needs of countries with regard to reaching ZD children and missed communities?

Summary of findings	• Gavi's financial support is crucial in maintaining Afghanistan's immunisation services amid limited domestic financing and suspended development cooperation. • However, the dependency on Gavi's support for professional staffing since 2004 and lengthy processes to apply for the funding levers pose substantial risks, highlighting the need for a balanced approach between sustaining the health system and locating and reaching ZD children.
Strength of the evidence	**1** (circled) | **2** | **3** | **4**
Rationale for this judgement	Evidence comprises multiple data sources of decent quality. This includes triangulation of informant views with factual quantitative data from secondary sources and objective reporting from desk review of activities undertaken.

The Health Emergency Response, the replacement of Sehatmandi, currently contributes USD 169 million for just over 2 years, or around USD 6.8 million a month[30]. Gavi's ceilings & approval cap for ongoing grants or those starting within Gavi 5.0 (2021-2025) for Afghanistan total just under USD 108 million until 2025.[31]

Gavi's funding levers play a critical role in addressing the needs of countries like Afghanistan, particularly in reaching ZD children and missed communities. At present, domestic financing of immunisation in Afghanistan is non-existent, with all development cooperation suspended and all health emergency interventions off-budget due to sanctions. The current financing of routine immunisation depends almost exclusively on the ARTF HER project, and HSS4, now that the Gavi contingency grant has expired[32]

Preserving the functionality of service delivery processes is crucial for maintaining current reach and enabling future expansion. However, budget constraints, particularly for central staffing, limit resources available for health sector strengthening and targeted zero-dose efforts. The cost input for human resources for Afghanistan under the Gavi 5.0 strategy is higher than desirable due to Gavi's long-standing commitment to funding professional EPI-related staff at the national level since 2004. While discussions between Gavi and the ministry have begun, transitioning away from this dependency will take time, particularly given the current crisis.

Data underscores the necessity of maintaining the immunisation health system while targeting ZD children, suggesting a need for balance between these two objectives. Afghanistan's funding crisis, as discussed earlier, has left the country reliant on insufficient current humanitarian and emergency funding, with Gavi's support crucial to maintaining core immunisation functions. The reduction in immunisation funding to two main actors, the ARTF/World Bank/UNICEF complex and Gavi, has further placed strain on the system, as has the shift in the Urban Health Initiative's funding focus to

[30] UNICEF. (2022). Afghanistan health emergency response (HER) project | UNICEF afghanistan. Retrieved November 2, 2023, from www.unicef.org website: https://www.unicef.org/afghanistan/documents/afghanistan-health-emergency-response-her-project
[31] Gavi (unsp.) Summary of 5.0 country allocations for Gavi-eligible countries. https://www.gavi.org/sites/default/files/support/Gavi-5_0-Ceilings-by-country-and-support-type.pdf
[32] It is worth noting that the contingency grant was a limited budget to sustain basic functions.

the private sector and the drying up of other small immunisation donors. It is important to note that the Islamic Emirate of Afghanistan has expressed its commitment to development based on domestic resources. However, due to the current economic crisis and international sanctions, the government is currently unable to fulfil this commitment. As such, Gavi fundingand the ARTF remain criticial to keeping the immunisation system functional amidst these challenges.

The IRC gave a partial approval for Afghanistan's HSS4, providing approval for 18 months of the three-year proposal submitted, and impacting future planning. The internal review process which started in mid-September 2022 took an extended period of 2.5 months, during which the proposal was granted only a partial approval for 18 months in December 2022, with funds not disbursed until June 2023. Respondents for this case study highlighted delays as a major risk to crucial and predictable funding for Afghanistan. This has also meant that the country needs to resubmit an application for the remaining three months, which will impose high transaction costs for both the country and Gavi Secretariat, and impact medium term planning.

Due to delays in starting, the requested support for Afghanistan's immunisation programme covered a three-year period from January 2023 to December 2025, amounting to USD 27,630,999. The funding request was aimed at addressing the multifaceted drivers of ZD populations and rebuilding the National EPI. The proposal targeted barriers to ZD immunisation, such as gender discrimination, geographic disparities, and ethnic differences, and planned to mobilise women using a gender-driven approach. The programme's success is highly dependent on collaboration with other donors, particularly the HER programme.

The challenges faced by the immunisation programme in Afghanistan, including the loss of experienced staff due to the country's political situation, economic challenges and reduced external donor funding, were recognised by the IRC. To overcome these challenges, the adoption of flexible and innovative approaches, such as a phased approach and continuous cycles of implementation, monitoring and learning, were recommended it its report. Given the complexities in the country's governance mechanisms, the proposal emphasises the need for coordination, transparency, and alignment, and recommends revitalising governance bodies, including the Health Sector Coordination Committee. The IRCs partial approval was a total amount of USD 16,213,574, with a requirement to address outstanding issues and ensure the continuity and improvement of EPI activities.

Apart from using BPHS NGOs to deliver services, Afghanistan's HSS proposal does not provide specific information on how CSOs will be involved in the proposed activities. However, civil society involvement is mentioned as an important aspect of demand generation and community engagement in the overall strategy. It is stated that civil society initiatives have reduced recently due to funding and regulatory challenges, but the Afghan Red Crescent Society is mentioned as a "strong friend" of immunisation efforts. The proposal also includes activities related to community engagement and demand generation, which may involve partnerships with CSOs[33].

[33] Gavi financing will rest on the contracted NGOs for BPHS

Table 2.1: Funding levers and ceilings

Funding lever	Grant ceilings ($)[34]	Main aims of funds in-country
HSS	27,738,251	Stabilisation of the immunisation system with system strengthening. Increased identification and modest expansion of reach towards zero-dose.
EAF	17,747,501	TBC at the time of writing.
CCEOP	9,219,611	Restore and strengthen vaccine supply chains and achieve better immunisation equity and coverage.
TCA	12,938,235	Sustain existing and additional capacities that enable the provision of the most specific/critical inputs such as cold-chain, demand, data, surveillance, leadership and programme management.
Vaccines	IPV: $317,500 (cash) Measles: $5,251,627 (cash)	As stated.

EQ3. How coherent is Gavi's ZD agenda with other international and national actors' focus?

Summary of findings	• Health donors in Afghanistan coordinate regularly. However, in the absence of a concrete vaccination strategy from the current regime, Gavi's ZD agenda, while aligned with the efforts of international partners, faces uncertainty regarding its compatibility with national priorities. • The synergies between Gavi's agenda and other health and humanitarian interventions, including initiatives addressing food insecurity and the polio eradication efforts, demonstrate a level of coherence at the sectoral level. • However, so far, there is limited evidence on the outcome of the alignment of Gavi's investments with other major health investments in Afghanistan as funding flows under the new regime are nascent., although new HSS, CCEOP, and EAF were designed involving all the other health donors, aligned with the Afghanistan joint framework the Health Transition Strategy.			
Strength of the evidence	**1**	**2**	**3**	**4**

[34] Gavi (unsp.) Summary of 5.0 country allocations for Gavi-eligible countries. https://www.gavi.org/sites/default/files/support/Gavi-5_0-Ceilings-by-country-and-support-type.pdf

Rationale for this judgement	Evidence comprises few data sources (limited triangulation). Due to the decision to limit Afghanistan to a desk-based study with targeted interviews, no interviews were carried out with actors outside of Gavi's direct investments.

At the time of writing, no national immunisation strategy existed outlining the current regime's strategy. No interviews could be held with government representatives for this case study. Therefore, no assessment can be made on the coherence of Gavi's ZD agenda with the government's focus. Of note, the government's health budget has not allocated substantial funding specifically for immunisation, relying on external sources for vaccine supplies and other support.

Request for Gavi support in HSS4 includes developing a national immunisation strategy (NIS), improving coordination between stakeholders, and advocating for increased domestic and international funding for health and immunisation.

In Afghanistan, Gavi's ZD agenda is one of many health and humanitarian interventions entwined with the efforts of other international and national actors and the country stakeholders have recognised this need in the design of how Gavi funding gets used. Amid a multitude of challenges including the pandemic, an earthquake, food insecurity and economic instability, there is a critical need for donor coordination. In this context, Afghanistan's HSS4 aligns with other efforts by seeking to increase outreach, link with mobile health and nutrition teams addressing food insecurity, and align with the polio eradication initiative.

Apart from WHO and UNICEF, Gavi's other main implementing partners are IFRC and IOM, whose 2021–2025 Strategic Plan for Afghanistan includes immunisation priorities and success indicators measuring providing immunisation in hard-to-reach/white areas. The government of Japan has been a large direct donor to Afghanistan, providing almost USD 45 million since 2019 to UNICEF for children's and mothers health, administration of essential vaccines, health systems strengthening and water, sanitation, and hygiene (WASH). Other actors with major health investments are outline in Table 2.1 below. However, as described in earlier sections, health programming in Afghanistan is still nascent following the regime change, and therefore there is a lack of evidence thus far, on the coherence with Gavi's investments. Due to the decision to limit Afghanistan to a desk-based study with targeted interviews, no interviews were carried out with actors outside of Gavi's direct investments (WHO, UNICEF, IFRC and Acasus). However, it should be noted from conversations with the country team, health donors work closely together in Afghanistan, trying to ensure alignment. For example, staff from the Global Polio Eradication Initiative Polio people were invited to the FPP workshop, there is a health donor group transitional health strategy that ensures alignment and coherence (that has been presented to the MoH), a monthly catch up of health donors and health donor partner meetings with the minister of health and his team every month. Despite all the odds therefore, there is clearly a process in place, even if the outcome of this coherence is not able to be evidenced yet.

Table 2.2: Total financial resources for immunisation by source[35]

Donor/ source	Main aims of health spending
Government	In 2017, the last year that National Health Accounts are available, the government paid for 5.1% of total health expenditure, donors for 19.4%, and out-of-pocket expenditure was 75.5%. With the declining budget allocations for health the share had likely reduced to around 2% by 2021. This paid mainly for the MoPH's own administrative structure
World Bank	As of February 2021, the World Bank had $813,400,000 of finance committed across three health projects in Afghanistan through the International Development Association, two of those being COVID-19 health projects worth $213,400,000
Asian Development Bank	The ADB has $100,000,000 of PHC-related commitments. Afghanistan has loans or grants for PHC-related commitments
Global Fund	In addition to funding disease-specific service delivery (for AIDS, tuberculosis and malaria), the Global Fund also finances Resilient and Sustainable Systems for Health (RSSH) investments that strengthen system components for health in an integrated manner. Afghanistan has a committed $54,192,116 multicomponent grant with a direct RSSH component
International Monetary Fund (IMF)	Poverty Reduction and Growth Trust Eligibility agreement in place
Global Polio Eradication Initiative	$36,289,684 committed through the Global Polio Eradication Initiative

Harmonising the efforts of various stakeholders, especially the EPI and the Global Polio Eradication Initiative, is crucial for effective operations and this is still emerging. Following the regime change and the resultant restricted donor funding environment, related interventions in Afghanistan are still taking shape and it is too early to effectively analyse how coherent Gavi's interventions are, which have only just started themselves. However, in Afghanistan there seem to be challenges in donor coordination, arising from different stakeholders controlling various financing mechanisms. Afghanistan is eligible for financing from different organisations (see Table 2.1) and fund mechanisms offering public health support alone that often fund the same interventions, and this leads to potential conflicts and inefficiencies. For example, during 4.0, the World Bank's "pay-for-performance" scheme for managing the BPHS NGO providers was found to conflict with Gavi's intentions of reaching remote areas, as the scheme incentivised NGOs to go for the 'low hanging fruit" and immunise more easily accessible populations.

[35]Tougher, S., Mandalia, N., & Griffiths, U. K. (2023). Recovery of Routine Immunisation: Mapping External Financing Opportunities for Reaching Zero-Dose Children. Vaccines, 11(7), 1159–1159. https://doi.org/10.3390/vaccines11071159

Objective 2: Operationalisation of the ZD agenda

EQ4. To what extent have Gavi 5.0/5.1 funding levers, processes and guidance enabled countries to focus their Gavi support towards reaching ZD children and missed communities?

Summary of findings	• Afghanistan's funding application process and grant design was deemed lengthy and complex, especially in the context of Afghanistan's instability. Interviewees suggested streamlining Gavi's application process and shifting towards more efficient and agile methods. • Despite these challenges, progress was made, however, criticisms were made about Gavi's bureaucracy causing delays, the partial approval contradicting the full approval initially granted, and the lack of predictability in the approval process disrupting financial planning and ongoing programmes
Strength of the evidence	**1** (selected) / 2 / 3 / 4
Rationale for this judgement	Evidence comprises multiple data sources of decent quality. This includes triangulation of informant views with factual quantitative data from secondary sources and objective reporting from desk review of activities undertaken.

Summary of the application process

The Afghanistan FPP started in 2020 with the aim of submitting the proposal in June 2021. Although much progress was made, the application was stalled due to a severe second wave of COVID-19 in May/June 2021, followed by the Taliban takeover in August 2021. In November 2021, the country developed the emergency HSS/Contingency Plan.

In Q2 2022, the FPP process was relaunched in a 'fast-track' manner. It was decided to only pursue an HSS4 application rather than the full FPP package. The proposal was submitted in September 2022. The CCEOP proposal came six weeks after and was reviewed after HSS as a stand alone.

The internal pre-review of the proposal started mid-September 2022 and the final report of 25 November 2022 was ready to be shared with the country. That internal review process took 2.5 months with two rounds of responses from the country. The proposal was then granted the partial approval for 18 months ('phase 1'). The IRC clarifications for 'phase 1' of the HSS4 grant were shared to Gavi country team late November 2022, which were then shared immediately with the country. These clarifications had to be responded by the country by early January 2023. Funds were finally disbursed in June 2023.

Gavi's Monitoring and Performance Management (MPM) data shows the time taken from FPP kick-off to IRC decision was seven months, and the time taken from IRC approval to disbursement was 6 months.

The extent to which ZD intended shifts are happening in Afghanistan varies[36]. Since implementation has only begun, in phase 1 of the evaluation, this is judged by the extent to which shifts are appearing in grant design.

Findings that correspond to the IRMMA approach are as follows:

- **Identify:** As noted in earlier sections, robust population data are lacking in Afghanistan. The last (and first) census was in 1979, and even this was not completed because conflict broke out. In Afghanistan's HSS application, to identify ZD, an effort was made to triangulate data from United Nations Population Division (UNPD), administrative and polio data. The percentage of ZD children is not reported, but this is likely because there are data concerns with the denominator regarding the target population distribution. There are highly uncertain estimates due to data availability and quality. There is a plan to address data concerns in the implementation period. Despite concerns raised about data quality, there is a clearly constructed process for a targeting assessment given available indicators. In the context, Afghanistan is considered to have done a comprehensive job in developing an identify strategy.

- **Reach:** supply and demand-side barriers are highlighted with clearly outlined response activities in Afghanistan's FPP. However, the proposed interventions are not deemed to thoroughly identify demand and supply immunisation constraints in disadvantaged and low-coverage areas. The approach was deemed by the IRC to be unfit for specific communities, but the country is planning to improve data and better identifying in the first 6 months and apply for EAF with better targeted reach activities mid-2023.

- **Monitor:** specific learning questions are not outlined but data strengthening activities are planned and included in the workplan to support reaching ZD through crossover of performance data and ZD location data and expanding ZD monitoring through 'effective tools and methods' with Acasus; a monthly provincial EPI performance review; and expanding geospatial dashboard to identify missed communities with Acasus support.

- **Measure:** the FPP narrative indicates a plan to follow the Gavi monitoring and evaluation (M&E) framework, but there is no further elaboration. The application does however identify different points of integration of digital health activities, including a geospatial dashboard with provincial microplanning.

- **Advocate:** Afghanistan's NIS is planned for 2024 with HSS support as outlined in the application. However, social accountability is not highlighted in application. There are limited other donor resources with the regime change, and the application indicates no capacity for investment of domestic resources at present. There is also a reduction of engagement with CSOs under the new regime and there are difficulties in the contracting of CSOs in the current political environment.

Regarding other key shifts, review of the FPP documentation shows[37]:

- **Gender:** Proposed interventions clearly address health worker barriers, such as deploying additional female vaccinators as well as pre and in-service training for more female vaccinators and the deployment of 14 female regional EPI trainers/supervisors. However, there are some

[36] Gavi. (2023). HSS Shifts Tracker. ***Gavi internal documentation***
[37] Ibid.

gaps. There are no interventions specifically addressed to barriers of adolescent mothers, and while planning to use school clubs will be used to sensitise secondary students as change agents on immunisation, secondary education for girls has been suspended and there is no mention of reaching these out-of-school girls.

- **Demand:** No BeSD (behavioural, emotional and social difficulties) assessment has been conducted in Afghanistan. There are, however, some activities related to demand, such as interventions tied to the behavioural determinants and identification of key influencing groups with activities included to reach them with demand interventions. The frequency and reach of interpersonal (face-to-face) communication for vaccination promotion to caregivers is also high. Yet at the moment, there is little or no engagement or leveraging of CSOs planned for vaccination demand promotion.

- **Sub-national targeting:** significant amount of sub-national planning is present in the application.

- **Single ToC:** there is a single ToC.

- **CSO engagement:** There is a budget for CSO activities, although it is not very clear how much will go towards CSOs as other amounts are allocated through UNICEF and WHO. The CSO allocation is estimated to be about 17%,[38] which is allocated to IFRC and the 16 BPHS NGOs. Afghanistan's CSO engagement is extremely high due to the BPHS, and CSOs are expected to implement demand generation and advocacy activities. They are also expected to identify ZD children, do community monitoring, and link community data to the health information system.

Although it is not specified which CSOs will be contracted, the country already has identified CSOs that they will work with and clearly discussed their added advantages. In a few sections, there is reference to local CSOs and it is indicated that it was difficult for international NGOs to work in the country. Thus it is assumed that they mainly utilise the local CSOs. It is not clear how much is allocated towards local CSOs, however, it is assumed that the majority of the CSO allocation will be towards local CSOs given the complex nature of civil society.

Extent to which Gavi 5.0/5.1 funding levers, processes and guidance enabled countries to focus the support to ZD and missed communities

Gavi's FPP process played an important role in enabling Afghanistan to focus on reaching ZD children and missed communities by fostering an environment of collaboration and shared knowledge. In Afghanistan, the initial pilot process was marked by a comprehensive immunisation gap analysis workshop that brought together local and national stakeholders. This was subsequently followed by a workshop in Kabul in March 2020 that had broad representation, including government, BPHS implementers, UN, and donors. Respondents affirmed the inclusive and participatory nature of the process, highlighting particular benefits to be involving a variety of partners, assigning decision-making leadership to the Ministry of Health, and ensuring the availability of technical support. The process in Afghanistan required a systematic approach, underpinned by intensive in-country work with small teams and significant time investment. This comprehensive and inclusive approach ultimately helped Afghanistan develop a robust strategy, providing clear direction for immunisation efforts.

FPP in Afghanistan was helped by strong local representation, which brought in-depth understanding of the context. However, the decision-making process within technical working groups

[38] The HSS shifts tracker produced by Gavi states that in the FPP strategic narrative, it was indicated that the majority of the vaccinators are from NGOs hence the amounts allocated towards vaccination were pulled out to come up with this estimate CSO allocation figure.

during HSS4 planning was found by some to be swayed by individuals and their level of influence. Local counterparts were integral to the effective implementation of the FPP process in Afghanistan where local WHO and UNICEF representatives played a strong role in driving the process, and on-ground presence and strong focal points were important in sustaining momentum and enthusiasm in the initiative. Initially, there were regular visits to Afghanistan, complemented with ongoing remote work, which served to maintain enthusiasm and keep up the momentum.

The fragile, emergencies and displaced populations (FED) policy, designed to alleviate administrative burdens and provide a flexible, context-based approach, is yet to be fully operationalised. This lapse has resulted in ongoing management inefficiencies and a lack of clear processes, particularly for countries like Afghanistan dealing with complexity, capacity, and administration challenges.

In an attempt to introduce more flexibility for countries in conflict and fragile settings, the FED policy was launched 14 months before Gavi's FPP process was initiated. This policy led to the approval of three key flexibilities for Gavi. These included the waiving of the requirement for the signature of the Ministry of Finance and endorsement of ICC, enabling IRC review of application despite the human resource (HR) budget exceeding Gavi's threshold, and waiving the co-investment associated with the Cold-Chain Equipment Operations Platform (CCEOP) due to funding constraints. These changes were crucial, particularly given that Afghanistan's Minister of Finance is blacklisted and under the US/EU sanction lists, and domestic resources to pay for co-investment were non-existent. Support from a staff member seconded from the policy team was instrumental in identifying, documenting, tracking these flexibilities and negotiating them through Gavi's policies.

However, the late approval of the FED policy by the Gavi Board, after the relaunch of the FPP process for Afghanistan, meant the Gavi country team had to deal with unknown flexibility parameters and a lack of an implementation framework. This situation added uncertainty and unclarity to the application development process, as the team was unsure if the flexibilities would be granted until after the application was submitted. The internal review and approval process within Gavi was not differentiated and the country was the same as other countries without the context.

The operationalisation of Gavi's Fragility Policy, which has been pending implementation for over a year, is deemed critical. Interviewees have expressed concerns that Gavi appears more focused on fund retention rather than supporting countries and reaching ZD children. A shift in this mindset is seen as necessary to ensure Gavi's contributions are more effectively channelled towards its intended targets.

Interviewees have suggested that Gavi should consider simplifying the application process, as the current requirements consume excessive time that could be better spent on practical implementation. A proposed model involves embedding functional technical teams within country-facing teams to foster shared accountability and operational efficiency.

The FPP process, encompassing applications for various support modalities, was unrealistic due to the country's context. The FPP process was described as lengthy and intricate, necessitating numerous workshops and extensive planning to coordinate applications. This rendered the process quite resource intensive for all parties involved at the country level, including Gavi, particularly when all pillars of support were requested in a single application.

Due to initial delays in launching Afghanistan's FPP, the 'fast-track' relaunched involved a largely new Gavi and country team. Given the impending end of the current HSS/Contingency Plan funding by

30 September 2022 and the concern over potential funding gaps, the decision was made to pursue only an HSS4 application rather than the full FPP package. This decision was also influenced by the insufficient time and resources available to plan for TCA, EAF and CCEOP funding.

Despite the security constraints following the regime change in mid-2021, which prevented Gavi staff from travelling to the country, in-country workshops were conducted in April, May, and June 2022. These workshops, virtually attended by the Gavi team, served to build on the proposal and ensure buy-in from relevant country-level stakeholders. Additionally, in July/early August 2022, Gavi organised a large-scale workshop in Oman to consolidate findings and reach a consensus on relevant issues. This face-to-face workshop required significant preparation and on-the-ground facilitation efforts, with Gavi relying on two external consultants for programmatic and financial support, as well as numerous 'hybrid' workshops, teleconferences, and email exchanges.

The length of the process was not solely due to its complexity. The formation of technical working groups for gap analysis and prioritising activities in Afghanistan was protracted and disrupted due to COVID and the regime change. Face-to-face work was resumed in micro-workshops in March 2021 to limit infection risk, and by June 2021, Afghanistan had a mature draft HSS proposal almost ready.

The protracted nature of the FPP process, which necessitates the involvement of multiple stakeholders, renders it susceptible to disruptions caused by sudden changes in personnel, plans and strategies, especially in the context of fragile states. The lengthy duration required to complete the FPPs can potentially interrupt the continuation of certain necessary activities due to staff rotation or turnover. When the FPP was resumed in March 2022, only 24 of the original 51 members of the FPP thematic working groups were still available. Most senior staff had left due to the brain drain, and no female professional staff remained. The country also decided to postpone its application to the EAF until 2023 for two reasons: (1) The insufficient time post-conflict to fully identify underserved communities in former conflict areas and urban high-density areas, which prevented the formulation of a sufficiently targeted proposal; and; (2) The planned release of a new national budget in spring 2023 would provide clarity about funding availability for immunisation from the ARTF. Despite the challenges, progress was made over the summer of 2022 amid constant campaigns against measles, COVID-19, and polio. After an initial setback with the visa issuance for Afghan participants, a four-day consultative meeting was successfully held in August in Oman, involving 60 participants, including other donors and extended partners at the regional and global levels. However, there were concerns about Gavi's FPP approach, suggesting it seemed to operate as a one-size-fits-all process and that the funding levers were fragmented.

The application requirements for Gavi's funding levers are complex and resource intensive and there has not been enough time and resources for Afghanistan. The changing nature of Gavi's application templates proved to be a challenge for Afghanistan, complicating the process. Informants emphasised the need for Gavi to stabilise their template design for the sake of ease and efficiency.

The process of applying for Gavi's funding can be long and intricate, even when external consultants are brought in to manage it. An example is the extensive development process in Afghanistan's HSS4 and the complexity of the budget Excel spreadsheet required by Gavi. It became evident that a single consultant was insufficient, especially for addressing budgetary issues. Consequently, Gavi agreed with UNICEF country office to hire an additional resource to assist with budget preparation. For the budget, Gavi engaged Ernst & Young to verify the budget as it was being developed.

Interviewees suggested a reduction in complicated guidelines and a focus on the most critical needs of each country streamlined processes and a shift from high-demand procedures to more efficient and agile methods.

The capacity of Afghanistan to engage in the extensive FPP process was a significant challenge. The National EPI team consists of just 29 individuals, with only 15 technical staff members responsible for working on different aspects of proposals. This limited capacity was insufficient to handle all funding pillars under the FPP, leading to a looming funding gap. Consequently, the FPP application did not include several components, such as the M&E chapter of the HSS4, the New Vaccine Application, Targeted Country Assistance (TCA), CCEOP and the EAF.

One interviewee recommended conducting a total needs assessment before the official start of the FPP process to better understand the capacities of the MoPH. The interviewee stressed the importance of providing additional support to the ministry, given its leading role in decision-making, to ensure a smoother process.

The perception and understanding of Gavi's ZD agenda among country-level stakeholders were found to be unclear. A delay was noted in the dissemination of Gavi's ZD public relations between the in-country offices and the secretariat in Geneva, resulting in a several months' gap in understanding the agenda. Moreover, an observation was made that discussions about the ZD agenda rarely trickled down to the operational level.

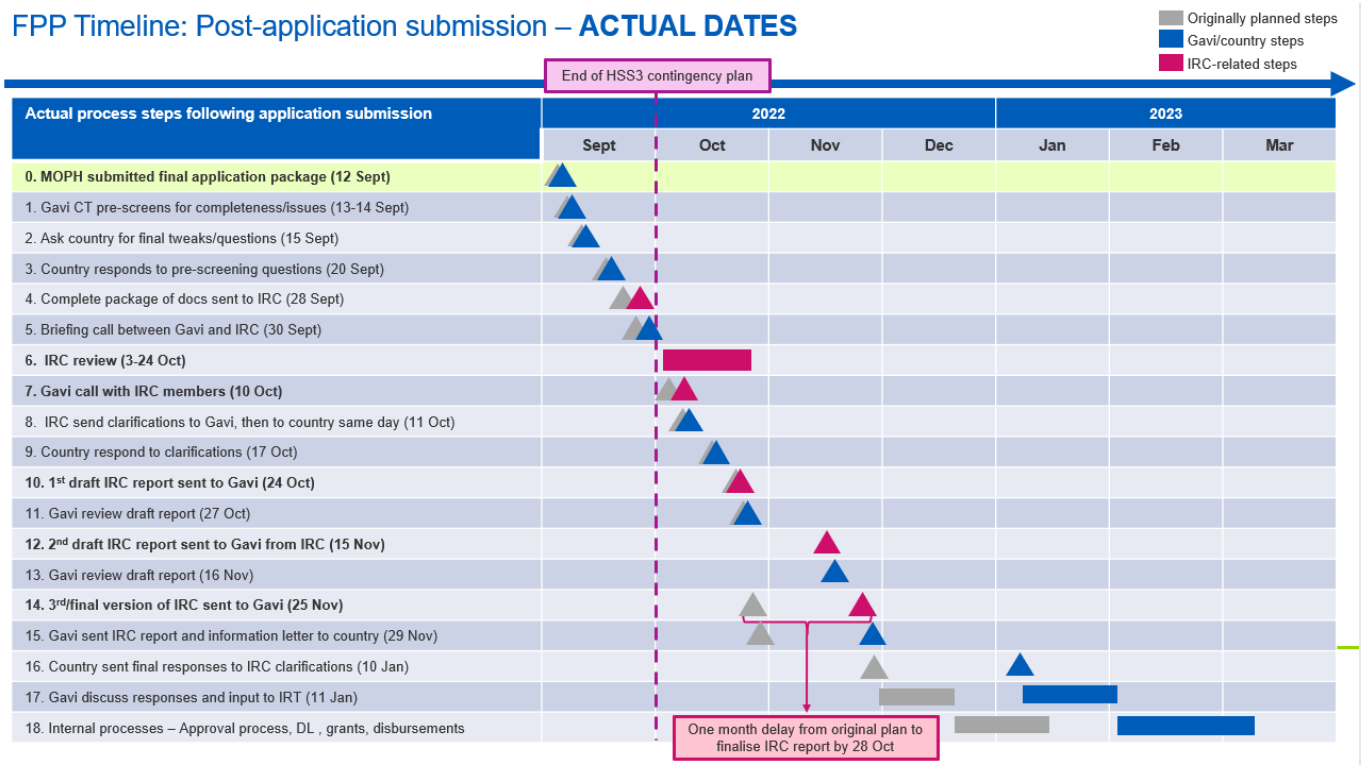
The ambiguity in the definition of zero-dose and the shift in priorities and expectations from Gavi were also highlighted as challenging. It was unclear to some stakeholders whether the focus on zero-dose implied prioritising the most underserved first or aiming to reach as many ZD children as quickly as possible. On the topic of partner expansion, the implementation of the programme in Afghanistan is planned to be carried out by five partners a significant shift from the previous single ministry approach. This broad partnership approach, despite being encouraged by Gavi, raised concerns about the predictability of financing, particularly as two partners could only be engaged for one year due to cost considerations. However, some interviewees expressed that extending partnerships beyond WHO and UNICEF could be beneficial in conflict states like Afghanistan, suggesting the involvement of a wider range of societal organisations with capacity.

The administration process of the Gavi secretariat was time-consuming and layered, adding significant time to the overall process. This raised concerns about the lack of predictability in the approval process, which disrupts financial planning and ongoing programmes. As mentioned above, following approval, the contracting process with the Gavi Secretariat took an additional six months, further extending the timeline (see Figure 2.2 below)

There are also concerns about Gavi's capacity to manage the demands of different countries and their specific challenges, particularly given its significant growth in a short timeframe. This rapid expansion has led to inefficient and time-consuming processes, affecting the country team in progressing with Afghanistan's application. There appears to have been imbalance in Gavi, with the secretariat having a larger proportion compared to the country team. This is seen as problematic considering Gavi's mandate to focus on country-specific needs and programmes.

The rapid expansion of the secretariat that works on new topics has also led to a clash of priorities and a lack of a streamlined approach. An overabundance of guidelines from different teams within Gavi posed challenges for the frontline staff in prioritising and incorporating all demands into their work.

Figure 2.2: FPP timeline: post-application submission – actual dates



The IRC approval process for Gavi's funding proved to be a challenging experience for Afghanistan. The country encountered difficulties in handling an ad hoc IRC for its application due to a deviation from the usual intake cycle, leading to unmet deadlines.

The IRC process initially showed promise with the well-prepared country team providing clear briefings about their context and requirements however those involved in the application process experienced a number of issues. The proposal was initially approved by the IRC for three years, reflecting an understanding of Afghanistan's unique circumstances. However, the internal review process which started in mid-September 2022 took an extended period of 2.5 months, during which the proposal was granted only a partial approval for 18 months. This partial approval contradicted the earlier full approval for three years granted at the first IRC deliberations, causing confusion and frustration among the country team.

The IRC's report received some criticism from the country team for its lack of sensitivity in language use and clarity about the political circumstances in the region. The response to this, which typically takes three days, took a full month. This delay impaired the operational plan as the country was facing a funding deadline.

The IRC's decision to only provide 'partial approval' for 18 months, while only recommending a 12-month budget, led to intense discussions at the country level and complications in strategic planning. This constant application process was described as a "nightmare" by one interviewee, as it diverted focus away from the actual implementation of the programmes and threatened the predictability of funding.

The bureaucracy of Gavi was highlighted as a factor causing delays in implementation, with the final report issued around Christmas of 2022 and the new funding only starting in June 2023. The IRC requested an assessment and light evaluation of the first year, with additional documents to be provided before money for the second phase is released. This essentially means that the country team

had to start the approval process at the secretariat again, which typically takes three months and almost full-time attention of the country team.

Consequently, Afghanistan faces potential funding gaps and the risk of not having a fully-fledged HSS plan. The lack of predictability in the approval process disrupts financial planning and ongoing programmes.

Interviewees suggested that Gavi would need to accept higher delivery costs and risks if it focuses more on ZD children in remote areas, demand less formal accountability but greater commitment towards collaborations, accelerate grant money disbursement, and perhaps evaluate the proposals at the secretariat level rather than the IRC. Despite the challenges, one interviewee appreciated the IRC process for its ability to sharpen the proposal, and another acknowledged Gavi's need to enforce certain standards due to the size of the grants they offer.

Objective 3: Contribution of Gavi 4.0 pro-equity and ZD grants

EQ5. How have Gavi grants initiated under Gavi 4.0 with continued implementation in 5.0/5.1 contributed to the delivery of the ZD agenda at the country level?

Summary of findings	• No grants initiated under Gavi 4.0 are continued in 5.0. Given the context of this case study, it was also decided with the Gavi Evaluation and Learning Unit to not interview key informants associated with implementation of grants during the 4.0 strategy period, and pre-dating the current government. • As a result, a contribution analysis was not possible due to the fact there was no possibility to establish any analysis from key informants linked to quantitative results.
Strength of the evidence	*N/A*
Rationale for this judgement	*N/A*

No grants initiated under Gavi 4.0 are continued in 5.0. Given the context of this case study, it was also decided with the Gavi Evaluation and Learning Unit to not interview key informants associated with implementation of grants during the 4.0 strategy period, and pre-dating the current government.

This section therefore provides analysis of Gavi's achievements to equity from a desk review. Any qualitative analysis is derived from very limited interview data stemming from those carried out with informants knowledgeable of the 4.0 strategy period in Afghanistan.

The desk review has also proved challenging. The last joint appraisal for Afghanistan was carried out in 2019. Gavi's Grant Performance Framework also lacks data for key equity indicators. Those that are available are provided in the Table 2.2 below. As a result, a contribution analysis was not possible due to the fact there was no possibility to establish any analysis from key informants linked to quantitative results. Those knowledgeable of the strategy period of Gavi's funding and interventions felt that Gavi had a significant role in focusing governments' attention and actions towards resolving specific health issues.

For example, Gavi's funding serves as a strong motivator for the government to develop a strategic timeline of activities, and the organisation's advocacy efforts usually bear positive results.

However, the success of overall objectives remains a point of debate among those knowledgeable of the period, questioning whether the goals were fully achieved and arguing that success is dependent on its definition.

Gavi's specific contributions encompassed financial aid, vaccine supply assurance, warehouse equipment provisioning, and the introduction of new partners such as the IFRC. Despite these contributions, there were challenges in accurately gauging Gavi's impact due to issues with data clarity and accountability. A criticism levelled was the perceived Gavi-centric nature of their measurement system, which was seen as disconnected from the broader health landscape, thereby disconnecting it from the wider impacts seen by collaborating partners like WHO and UNICEF.

The HSS3 grant was noted for its contribution towards integrating primary healthcare in Afghanistan, but the complex ecosystem of NGOs involved in the process made assessing Gavi's specific contributions challenging. Despite ongoing civil conflict and the Taliban's takeover, Gavi's efforts helped stabilise the immunisation situation in Afghanistan, preventing a complete collapse.

Notwithstanding the aforementioned challenges, certain infrastructures and systems, like the supporting supervision and close monitoring system, have endured. Gavi's continued support has extended to various National EPI programmes, including microplanning, data quality improvement and vaccine provision. However, it's important to note that the effectiveness and impact of these efforts are contingent upon the shifting socio-political landscape and the challenges inherent in such a complex ecosystem.

The following narrative describes Gavi's performance in objectives of Afghanistan's HSS3 grant, as they related to expanding immunisation to underserved communities, and equity.

Objective 1 of Gavi's HSS grant support to Afghanistan was targeted at enhancing equitable access and effective coverage of immunisation services through initiatives such as upgrading health sub-centres to EPI service delivery points, establishing community-based outreach, and supporting microplanning. These efforts were aimed at serving a total population of 3.8 million people, with a focus on underserved populations and areas with difficult access to healthcare.

Activities under this objective include upgrading 310 existing health sub-centres, establishing community-based outreach to cover 2,878 villages, continuation of 15 mobile health teams for the Kuchi population, scaling up public-private partnerships for service delivery in remote areas, and supporting microplanning to improve immunisation services.

The grant also focused on training female vaccinators and providing cold-chain equipment to upgraded health centres, which significantly contributed to the immunisation coverage throughout Afghanistan. The interventions under this objective addressed gaps in routine availability of service to remote rural populations and improve both coverage and access to immunisation services.

However, despite significant progress, there were still challenges including security issues, low levels of education, and social conflicts among nomad tribes. A total of 208 out of 310 planned sub-health centres were upgraded to EPI fixed centres and 173 out of 316 community-based outreach vaccinator teams were established. Moreover, budget utilisation varied across different activities, with some exceeding 100% due to unspent amounts from previous years being carried forward.

Despite these challenges, the Gavi HSS support made significant strides in improving the equitable access and effective coverage of immunisation services in Afghanistan.

Objective 2 of Gavi's HSS grant support to Afghanistan focused on strengthening the cold-chain and vaccine logistics management system. This involved increasing the physical capacity with cold rooms and warehouses, improving the HR capacity for vaccine management, and minimising delays and wastage of vaccines.

Activities under this objective included the expansion of existing cold-chain capacity for the introduction of new vaccines and the opening of new service delivery facilities. This was achieved by equipping 208 out of 310 sub-centres that were upgraded to EPI centres with the required cold-chain.

Additionally, capacity building for cold-chain management was conducted through training of 141 regional and provincial-level officials on the installation of solar direct drives. Also, initial training was provided for 400 vaccinators, with a focus on gender balance (300 females and 100 males).

Progress was also made in the construction of vaccine and non-vaccine storage facilities. Out of 34 planned construction projects, seven were completed, and others were ongoing at the time of the last joint appraisal.

Budget utilisation varied across activities, with some exceeding 100% due to carrying forward unspent amounts from previous years. For instance, for activity 2.1, 100% of planned cold-chain equipment was procured and distributed to provinces, and the budget utilisation was 117%.

Despite these achievements, there were challenges such as obtaining approval for the designs of construction projects and frequent changes in project sites by provincial health departments and other sub-national authorities.

Moving forward, the plan was to install the remaining 108 solar direct drives, procure the remaining cold-chain equipment planned for 2019, complete the temperature monitoring study, and initiate the CCEOP project. There was also an ongoing request to Gavi to de-link the CCEOP in-country operational support and allow country partners to take over the responsibility.

Objective 3 of Gavi's grant support to Afghanistan focused on improving the demand for immunisation services through context-specific communication interventions. The activities included in this objective were: increasing awareness and promoting immunisation through the mobilisation of religious leaders, implementing behaviour change communication (BCC) activities through mass media, Information, communication technologies (ICT) and interpersonal communication (IPC), and generating evidence and knowledge through a knowledge, attitudes and practices (KAP) survey.

The demand generation activities were implemented in all 34 provinces of Afghanistan. The KAP survey was conducted in 420 villages of 84 districts in 21 randomly selected provinces. The training of religious leaders was planned to be conducted in 17 provinces, and the schoolteacher and frontline health worker training in 20 provinces. The Health Information Centre provided counselling to the public on health queries nationwide via a toll-free number.

In terms of budget utilisation, 100% of the activities for the mobilisation of religious leaders were completed, with actual fund utilisation exceeding the planned amount by 3%. For BCC activities, 30% of schoolteachers and frontline health workers were trained on International Panel on Climate Change (IPCC) and BCC-focused immunisation, with a budget utilisation of 71%. The procurement process of

the Health Information Centre was completed. For the KAP survey, 100% of planned activities were completed, with actual fund utilisation exceeding the planned amount by 11%.

Major activities included training religious leaders on the importance of vaccination, implementation of BCC activities through mass media, ICT and IPC, and conducting the KAP survey. There were some delays in the implementation of religious leader's training and outsourcing was suggested to speed up the process.

Future planned activities include increasing awareness and promoting immunisation through the mobilisation of religious leaders, implementing multi-pronged BCC activities through mass media, local media, ICT and IPCC/BCC, and providing counselling and information to the public on immunisation.

Objective 4 of Gavi's grant support to Afghanistan was focused on strengthening the management and leadership capacity of the decentralised health system at peripheral levels for effective and efficient implementation of integrated BPHS including EPI services.

The activities under this objective included improving supportive supervision and monitoring of BPHS health facilities at different levels, conducting periodic evaluations to ensure accountability for equity at district and provincial level, improving the data flow system and improvement of HR accountability at national and sub-national level, and strengthening the internal audit system, procurement and finance system based on Financial Management Assessment 2012 findings.

The monitoring of grant implementation and NGO performance at national level was the responsibility of the monitoring directorate and at the sub-national level it is the responsibility of Provincial Health Directorates. In addition, 250 district health officers (DHO) contribute to the monitoring of insecure districts where HSS grant is being implemented.

There were several constraints, including insecurity in some provinces hindering appropriate and effective monitoring visits of some health facilities, and lack of female staff within monitoring structure making it difficult for male monitors to oversee some services which are gender sensitive.

In terms of budget utilisation, 36% of districts and 48% health facilities were monitored and 271 provincial staff received M&E decentralised system training; 69% of planned budget was utilised in the reporting period.

Several activities were not implemented or delayed. Data quality self-assessments were not conducted in 2018, the two databases for residency specialisation programme and students essay research of internship programme are still in progress, and the Internal Audit Policy and Strategy and Anti-Corruption mechanism has been finalised but is waiting for approval from the MoPH.

Future activities included 25 monitoring visits from BPHS, EPHS and HSS-relevant projects in each quarter, strengthening and continuing a geolocation monitoring (GLM) project in nine piloted provinces, evaluating the GLM piloted project, conducting decentralisation training for provincial public health officers, DHO and M&E officer/NGOs supervisors, convert and developing of GLM technology from windows to android system, expansion of GLM project, and developing and designing of a community-based monitoring system as piloted strategy for three insecure provinces.

Table 2.3: Mapping ZD-related outputs to pro-equity interventions implemented under Gavi 4.0 with continued implementation into Gavi 5.0/5.1

ZD-related outputs	Indicators	Pro-equity interventions programmed/ implemented	Plausible contribution of Gavi (insufficient evidence, partial, full)
ZD children and missed communities are identified and targeted	DTP drop-out in targeted areas[39] DTP1 coverage in targeted areas[40] DTP drop-out[41] Geographic equity (DTP3 coverage)[42] No. of ZD children[43] Percentage of districts or equivalent administrative area with Penta3 coverage greater than 80%: 65% in 2020, a 21% improvement from 2016 but below the target of 85% Difference in Penta3 coverage between the highest and lowest wealth quintiles: 26% in 2017, above 15% target. No data for other years Penta3 coverage difference between the children of educated and uneducated mothers/caretakers: 17% in 2017, above 13% target. No data for other years. Difference in Penta3 coverage between children of urban and rural residences: 10% in 2017, no target set. No data for other years	Objective 1: Enhance equitable access and effective coverage of immunisation services through integrated public healthcare system, private health sector-PPPs, and community participation with more focus on underserved population. *Activity 1.1: Upgrading the 310 existing health sub-centres to EPI service delivery points.* *Activity 1.2: Establishing community-based outreach by vaccinators to 2878 villages.* *Activity 1.3: Continuing the 15 mobile health teams for nomadic (Kuchi) population which are established under HSS2.* *Activity 1.4: Continuing, scaling up and revising the PHP (CSO type B) project focused on the delivery of EPI and other essential maternal and child health services in remote and insecure areas.* *Activity 1.5: Supporting microplanning through reaching every district strategy using community health workers and BASIC tools to improve the immunisation services.* Objective 2: Strengthen cold-chain and vaccine logistics management system by increasing the physical capacity, maintenance and effective vaccine management with provision of adequate infrastructure throughout the country.	*Insufficient evidence*

[39] No data in GPF 2016–20
[40] No data in GPF 2016–20
[41] No data in GPF 2016–20
[42] No data in GPF 2016–20
[43] No data in GPF 2016–20

ZD-related outputs	Indicators	Pro-equity interventions programmed/ implemented	Plausible contribution of Gavi (insufficient evidence, partial, full)
	Percent of districts with updated micro plans that include activities to raise immunisation coverage[44]	*Activity 2.1: Expansion of existing cold-chain capacity for the intro of new vaccines and opening of new service delivery facilities.* *Activity 2.2: Building capacity of the cold-chain and vaccine logistics managers and establishing ppm and supportive supervision system.* *Activity 2.3: Constructing vaccine and non-vaccine storage facilities.* Objective 3: Improve demand for immunisation services by implementing context-specific communication interventions to cover the disadvantaged population. *Activity 3.1: Increasing awareness and promoting immunisation through the mobilisation of religious leaders.* *Activity 3.2: Implementing BCC activities through mass media, ICT and IPC.* *Activity 3.3: Generating evidence and knowledge.* Objective 4: Strengthen management and leadership capacity of the decentralised health system at peripheral levels for an effective and efficient implementation of integrated BPHS including EPI services. *Activity 4.1: Improving supportive supervision and monitoring of BPHS HFs at different levels with more focus on decentralisation.* *Activity 4.2 Conducting periodic evaluations to ensure accountability for equity at district and provincial level.* *Activity 4.3 Improving the data flow system and improvement of HR accountability at national and sub-national level.*	

[44] No data in GPF 2016–20

ZD-related outputs	Indicators	Pro-equity interventions programmed/ implemented	Plausible contribution of Gavi (insufficient evidence, partial, full)
		Activity 4.4 Internal audit system strengthening, procurement and finance system strengthening based on Financial Management Assessment 2012 findings to ensure the accountability of NGOs' performance.	
Gender and socio-economic barriers are understood and addressed	Country addressing gender-related barriers support[45] Percent of gender work plan activities executed[46]		
Communities know about immunisation and how to access services	Percent of functional health facilities providing routine immunisation services[47] Percent of demand work plan activities executed[48] Country implementing tailored plans to overcome demand barriers[49]		
Supply chains are able to reliably deliver the full set of vaccines to missed communities	Closed Vial Wastage (DTPcv)[50] Stock availability at health facility levels[51] Effective Vaccine Management Score (composite score): 80 in 2018, below 85 target, no data for other years CCE expansion in existing equipped sites[52]		

[45] No data in GPF 2016–20
[46] No data in GPF 2016–20
[47] No data in GPF 2016–20
[48] No data in GPF 2016–20
[49] No data in GPF 2016–20
[50] No data in GPF 2016–20
[51] No data in GPF 2016–20
[52] No data in GPF 2016–20

ZD-related outputs	Indicators	Pro-equity interventions programmed/ implemented	Plausible contribution of Gavi (insufficient evidence, partial, full)
	CCE extension in unequipped existing and/or new sites[53]		
Programmes and approaches are continuously monitored and generate learning for course correction	EPI management capacity		

[53] No data in GPF 2016–20

3 Annex

Table 3.1: List of documents reviewed

Source	Document title	Year
Gavi	Afghanistan Overview of Gavi Support	2023
Gavi	Gavi 5.0 Strategy Briefing Full Portfolio Planning (FPP	2022
Health Sector Thematic Working Group	Health Sector Transition Strategy 2023 - 2025	2023
Gavi	Request for flexibilities from Gavi's FED Policy for the Afghanistan full portfolio planning submission to the IRC	2022
Gavi	Afghanistan's fast-track Full Portfolio Planning (FPP) process: Lessons Learned	2023
Gavi	Independent Review Committee (IRC) Country Report Afghanistan - remote review	2021
Gavi	Gavi HSS budget forecast 2020 & 2021	2020
Gavi	HSS Reallocation Request in Response to COVID-19 Approval Request Memo	2020
Gavi	REQUEST FOR ADDITIONAL HSS FUNDS	2019
WHO/UNICEF	Afghanistan: WHO and UNICEF estimates of immunization coverage: 2021 revision	2021
Gavi	June 2015 IRC Screening of New Health Systems Strengthening (HSS) Applications	2015
Gavi	Afghanistan A Country Tailored Approach	
Gavi	Independent Review Committee (IRC) Country Report	2016
Gavi	Capacity Assessment of NGOs Implementing Gavi HSS – Afghanistan Summary of Assessment Results	
Gavi	Independent Review Committee (IRC) Country Report	2017
Gavi	Supporting Narrative for Theory of Change for Gavi Support Request	2022

Table 3.2: List of academic sources

Source	Document title	Year
Tougher, S., Mandalia, N., & Griffiths, U. K.	Recovery of Routine Immunisation: Mapping External Financing Opportunities for Reaching Zero-Dose Children. Vaccines, 11(7), 1159–1159. https://doi.org/10.3390/vaccines11071159	2023
UNICEF	Afghanistan health emergency response (HER) project | UNICEF afghanistan. Retrieved November 2, 2023, from www.unicef.org website: https://www.unicef.org/afghanistan/documents/afghanistan-health-emergency-response-her-project	2022
World Bank	GDP (current US$) | data. Retrieved from The World Bank website: https://data.worldbank.org/indicator/NY.GDP.MKTP.CD	2023
World Health Organization	Global health expenditure database. Retrieved from apps.who.int website: https://apps.who.int/nha/database	2023

Table 3.3: List of stakeholders

ID	Position	Organisation	Categorisation	Remote vs in-person
1	Gavi Senior Country Manager	Gavi	Operational	Remote
2	Gavi Programme Manager	Gavi	Operational	Remote
3	Former SCM	Gavi	Operational	Remote
4	Former PM	Gavi	Operational	Remote
5	FPP Consultant	Independent	Operational	Remote
6	Partner focal point	WHO	Operational	Remote
7	Partner focal point	IFRC	Operational	Remote
8	Partner focal point	Acasus	Operational	Remote
9	EPI Manager	MoH	Operational	Remote

Our standards and accreditations

Ipsos' standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a 'right first time' approach throughout our organisation.

ISO 20252

This is the international market research specific standard that supersedes BS 7911/MRQSA and incorporates IQCS (Interviewer Quality Control Scheme). It covers the five stages of a Market Research project. Ipsos was the first company in the world to gain this accreditation.

Market Research Society (MRS) Company Partnership

By being an MRS Company Partner, Ipsos endorses and supports the core MRS brand values of professionalism, research excellence and business effectiveness, and commits to comply with the MRS Code of Conduct throughout the organisation. We were the first company to sign up to the requirements and self-regulation of the MRS Code. More than 350 companies have followed our lead.

ISO 9001

This is the international general company standard with a focus on continual improvement through quality management systems. In 1994, we became one of the early adopters of the ISO 9001 business standard.

ISO 27001

This is the international standard for information security, designed to ensure the selection of adequate and proportionate security controls. Ipsos was the first research company in the UK to be awarded this in August 2008.

The UK General Data Protection Regulation (GDPR) and the UK Data Protection Act (DPA) 2018

Ipsos is required to comply with the UK GDPR and the UK DPA. It covers the processing of personal data and the protection of privacy.

HMG Cyber Essentials

This is a government-backed scheme and a key deliverable of the UK's National Cyber Security Programme. Ipsos was assessment-validated for Cyber Essentials certification in 2016. Cyber Essentials defines a set of controls which, when properly implemented, provide organisations with basic protection from the most prevalent forms of threat coming from the internet.

Fair Data

Ipsos is signed up as a 'Fair Data' company, agreeing to adhere to 10 core principles. The principles support and complement other standards such as ISOs, and the requirements of Data Protection legislation.

For more information

3 Thomas More Square
London
E1W 1YW

t: +44 (0)20 3059 5000

www.ipsos.com/en-uk
http://twitter.com/IpsosUK

About Ipsos Public Affairs

Ipsos Public Affairs works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. Combined with our methods and communications expertise, this helps ensure that our research makes a difference for decision makers and communities.