Global Alliance for Vaccines and Immunization (GAVI)

PROPOSAL

for Support to

Health System Strengthening (HSS)

Republic of Tajikistan

March 7, 2008

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Abbreviations and Acronyms

ADB	Asian Development Bank
AEFI	Adverse Events Following Immunization
AKDN	Aga Khan Development Network
ANC	Antenatal Care
APR	Annual Progress Reports
BBP	Basic Benefits Package
BCG	Bacillus Calmette-Guerin (tuberculosis vaccine)
CBHP	Community and Basic Health Project
CCT	Conditional Cash Transfers
CDC US	Centers for Disease Control and Prevention
cMYP	Comprehensive Multi Year Plan
DPT or DTP	Diphtheria-Tetanus-Pertussis Vaccine
EmOC	Emergency Obstetrics Care
ENbC	Emergency Newborn Care
EPI	Expanded Programme on Immunization
FM	Family Medicine
GAVI	Global Alliance for Vaccines and Immunization
GBAO	Gorno – Badakhshan Autonomous Oblast
GHE	Government Health Expenditure
HH	Health Houses
HIV	Human Immunodeficiency Syndrome
HPAU	Health Policy Analysis Unit
HSCC	Health Sector Coordination Committee
ICC	Inter-Agency Coordinating Committee
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MLM	Mid Level Management Training
MoE&T	Ministry of Economic Development and Trade
MoH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NDS	National Development Strategy
NGO	Non Governmental Organization
NIP	National Immunization Programme
PAD	Project Appraisal Document
PH	Public Health
PHC	Primary Health Care
PIU	Project Implementation Unit
RCIP	Republican Center for Immunoprophylaxis
RED	Reach Every District
RHC	Rural Health Centers
RRS	Rayon of Republican Subordination
SDC	Swiss Development Agency
SIDA	Swedish International Development Agency
SSA	State Statistics Agency
SWAp	Sector Wide Approach
TB	Tuberculosis
U5MR	Under-five Mortality Rate
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VPD	Vaccine Preventable Disease
WB	World Bank
WG	Working Group
WHO	World Health Organization

Executive Summary

The goal of the current Proposal is to improve access to and demand for basic health services in poor hard-to-reach areas through increased financial commitment of the government at all levels, creation of outreach services, and improvements in the quality of physical and human resources.

The proposal has five objectives leading towards the achieving the above goal:

- Objective 1. Strengthen evidence-based decision making at central and local government levels in order to build financial commitment for PHC and public health services
- Objective 2. Increase access to PHC services in remote hard-to-reach areas
- Objective 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance
- Objective 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers
- Objective 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning

The Proposal is tailored in such as way as to compliment the existing government and donor activities through the following two types of activities:

⇒ Scaling up and harmonizing traditional interventions with developed implementation mechanisms and proven effectiveness in the context of Tajikistan or other countries in the region,

⇒ Providing **seed funds** to trying **innovative approaches** where traditional interventions have not been fully successful.

Traditional interventions with known effectiveness in the HSS Proposal include refurbishment of PHC facilities in rural areas, development of unified training guidelines for supportive supervision, operational support to PHC staff for outreach activities and for public health services staff for VPD surveillance, establishment of village health committees, and training of village health promoters.

The policy innovation in the GAVI HSS Proposal is the development and introduction of a system of demand-side incentives using the international experience with Conditional Cash Transfers (CCT). Programs on CCT are increasingly recognized as effective mechanisms for increasing the demand for and use of health services by the poorest population groups living in the most remote under-developed areas. Given the success of the experience in Latin America, a number of countries in Sub-Saharan Africa, East Asia and Middle East (Turkey) are starting to implement similar programs. However, they are still treated with caution as the traditional approaches have focused on addressing the supply-side constraints. This is particularly the case in countries of ex-Soviet Union where governments focus almost exclusively on improving service delivery system through increased infrastructure or outreach activities.

While in recent years activities based on community involvement have gained in popularity, these have focused more on communication and social mobilization strategies than on overcoming the social and economic constraints to use of basic health services, including immunization. The problem is that simply accepting the importance of immunization does not guarantee that a household will access available services. Factors which increase the opportunity cost of seeking services, such as travel and waiting time costs and missing time from work, particularly for self-employed women are deterrents to demand for immunization services.

Under the proposed Program in Tajikistan health conditionalities will include but not restricted to the following: (a) enrollment of an infant in a PHC facility; (b) completion of vaccines according to the recommended schedule and regular health check-ups and growth monitoring for infants under 24 months; (c) pre- and post-natal checkups for pregnant women. Considering the innovativeness of the CCT program for the region, the Proposal envisages significant technical and financial resources for the Program evaluation. The main outcome measures of the study will focus on changes in program and non-program districts in the following three aspects:

- ⇒ Utilization of PHC services,
- ⇒ Share of fully immunized infants under 24 months, and
- ⇒ Nutritional outcomes for infants under 24 months.

It will also assess program impact and operational performance by examining: (1) the adequacy of CCT programs' administrative processes; and (2) the extent to which CCT programs reach poor areas and poor households.

The GAVI HSS Proposal combines activities that will be implemented at the national as well as the district level. The list of activities by level of implementation is provided in Table 1. Most of the district level activities will be implemented in 6 priority districts marked in red on the map below (Figure 2). These districts were selected according to seven criteria on IMR, share of home deliveries, DTP-3 coverage rate, distance from the regional center, level of infrastructure, district poverty rate, and presence of other donors. The program on CCT will be piloted in two out of the six priority districts due to the budget constraints and the highly innovative nature of the activity.

Figure 1. Map of the Republic of Tajikistan

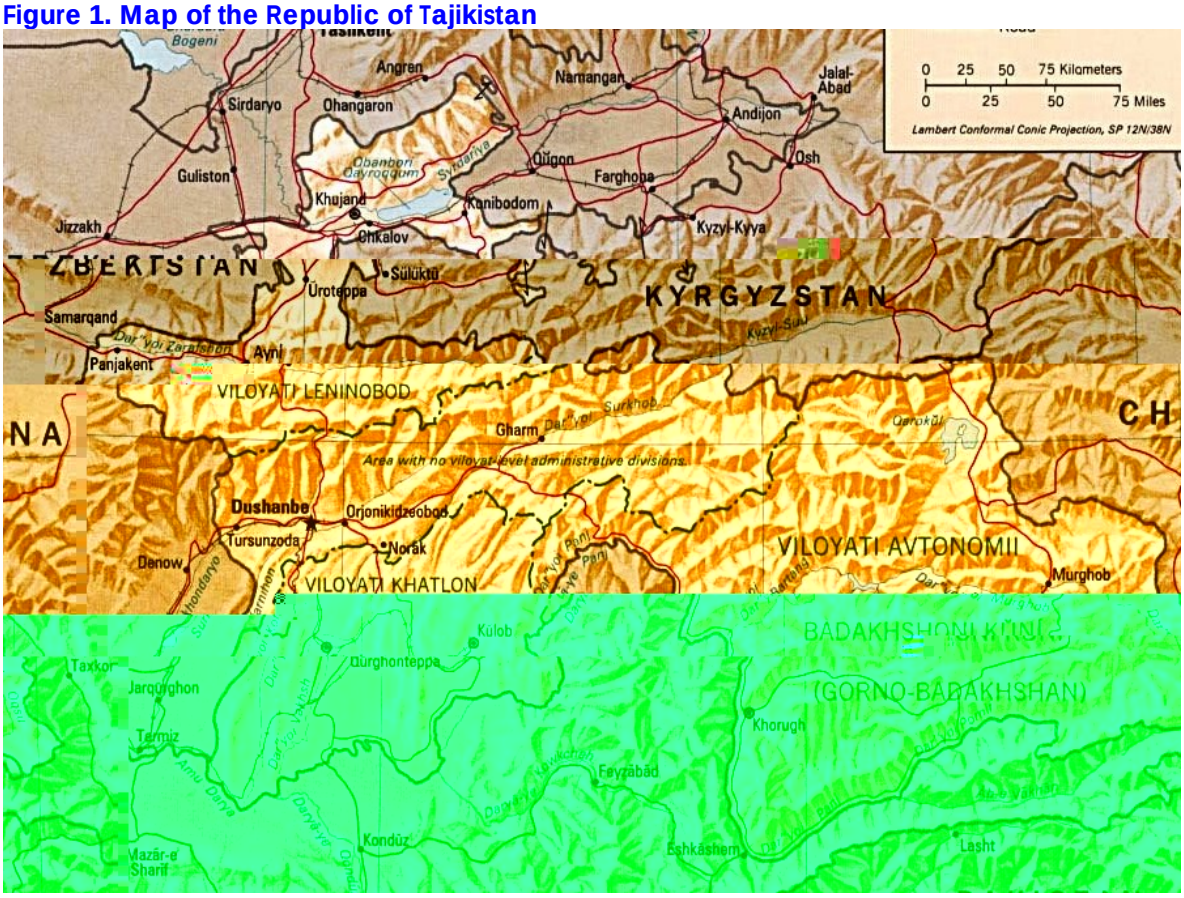
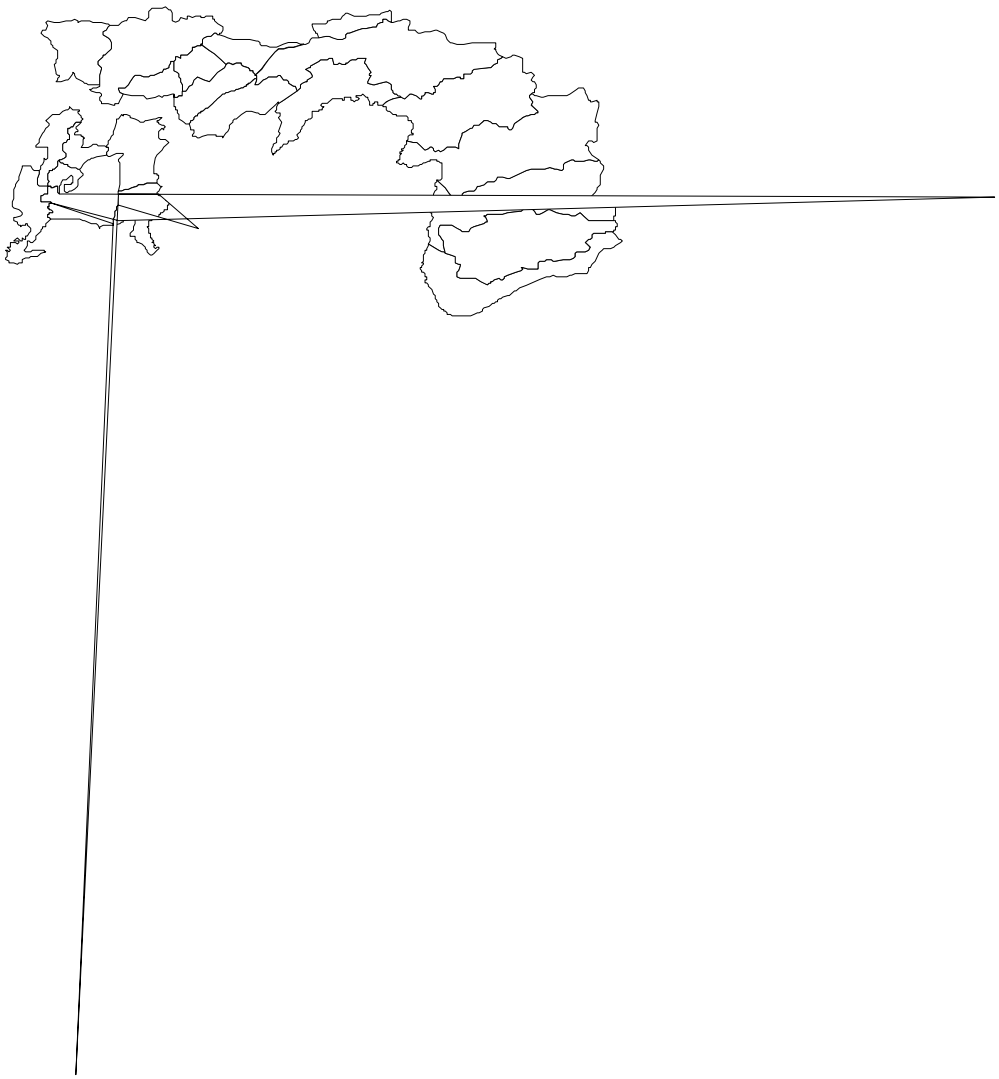


Figure 2. Map of the selected districts for the GAVI HSS, Republic of Tajikistan



Objectives	Main strategies/activities and expected results	Duration and level of support	Total amount of requested funds
	and brief language regarding the impact of their policies on the population health, linkages between health and economic development of the country etc. ***Main output indicator:*** Number of annual policy briefs based on impact analysis developed with focus on progress towards achieving MDGs #4 and #5		
Objective 2. Increase access to PHC services in remote hard-to-reach areas	2.1. Renovate rural health facilities (Health Houses) in remote villages with counterpart participation of the local governments and local communities on the basis of their applications to the MOH (according to PHC rationalization plan) 2.2.Provide basic equipment, including cold bags, medical supplies to PHC facilities in selected districts 2.3. Provide operational support to PHC staff for conducting outreach activities through covering their transportation expenditures and per diems 2.4. Establish mobile teams on the basis of the needs assessment for poor hard-to-reach areas that do not have medical staff or facility **Expected results**: **Barriers to physical and financial access to basic health services in poor hard-to-reach areas are removed, and medical staff has incentives and means to provide basic health services.** ***Main output indicators***: (i) # of RHFs in GAVI pilot districts that improved their physical infrastructure (renovated and equipped); (ii) # of remote villages in pilot districts that received outreach services at least 2 times per year.	**2008-2009** Rural health facilities level (for priority 6 districts) **2008-2009** Rural health facilities level (for priority 6 districts) **2008-2010** Rural health facilities level (for priority 6 districts) **2008-2010** Villages level (for 6 priority districts)	**Total amount $733,926** $216,746 $144,500 $ 162,000 $ 210,680
Objective 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance	3.1. Review existing training programs on IMCI, reproductive health, immunization conducted by different agencies and develop unified guidelines for PHC 3.2. Training on VPD and AEFI, IMCI, MCH for medical staff in PHC facilities in selected districts (not covered by current programs) 3.3. Conduct training for staff of public health services on VPD, AEFI surveillance	**2008-2009** Unified Guidelines for nation level **2008-2010** Train PHC staff in 6 priority districts **2008-2010** All districts (65)	**Total amount $ 250,554** $3,800 $165,720 $15,750

Objectives	Main strategies/activities and expected results	Duration and level of support	Total amount of requested funds
	3.4. Conduct timely investigation and undertake preventive measures to halt the spread of VPDs	**2008-2010** All districts (65)	$38,250
	3.5. Develop mechanisms and procedures for joint supervision (district health centers, district reproductive health centers, district centers for IMCI, centers for immunprofylaxis etc.)	**2008-2010** 6 priority districts	$18,684
	3.6. Conduct training of PHC management on data use, monitoring and planning to improve effectiveness of PHC services building on the training program developed under the WB/SIDA financed CBHP	**2008, 2010** 6 priority districts	$8,350
	Expected results: **Quality of MCH services, including immunization, and timeliness of surveillance activities are improved.** ***Main output indicators***: (i) # of medical staff trained in integrated and standardized programs related to VPD, AEFI, IMCI, MCH at the PHC level (Including trainers, doctors, nurses); (ii) % of reported VPD that received timely investigation.		
Objective 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	4.1. Increase public awareness on importance of timely immunization and steps to be followed in case of home deliveries	**2008-2010** Nation and districts' levels	**Total amount $153,495** $4,900
	4.2.Broaden the existing mobilization programs on the basis of an integrated approach and scale up to the selected districts	**2009-2010** 6 priority districts	$13,350
	4.3. Harmonize activities of existing community health committees and NGOs working in the area of MCH, conduct short TOT workshops, and provide necessary methodological guidelines	**2009-2010** 6 priority districts	$5,440
	4.4. Develop and pilot a system of incentives for poorest mothers in hard-to-reach areas with high share of home deliveries based on international experience on conditional cash transfers	**2008-2010** 2 priority districts	$104,005
	4.5. Operational research on the effectiveness and financial sustainability of the pilot (4.4) to evaluate the possibility for the scale up	**2008, 2010** Districts level	$25,800

Objectives	Main strategies/activities and expected results	Duration and level of support	Total amount of requested funds
	Expected results: Demand for ANC and immunization services are expected to increase, while the share of deliveries without a professional birth attendant are expected to decrease in particularly poor hard-to-reach areas with high share of home deliveries. ***Indicator:*** **#** of women benefiting from the conditional cash transfer program.		
Objective 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning	5.1. Improve the systems for collection of data at primary level 5.2. Build capacity for timely processing and exchange of data at district level **Expected results: Good quality health information data is the basis for new Health Information System helping improve data management at district and national level. This will contribute to building the culture of evidence-based decision-making and allow MOH and donors to better plan their programs/interventions.** ***Indicator:*** **#** of PHC facilities submitting simplified reporting forms on time specified by the MOH HRIR Department.	**2008-2010** National and districts' levels	**Total amount $ 114,500**

The Republic of Tajikistan is submitting the HSS Proposal for the third time. Following the conditional approval in December 2007 (GAVI/07/431/cb/at), the Proposal has been revised according to the IRC comments. The revision of the Proposal was led by the MOH working group in close and constant consultation with MOF and key international partners, including Asian Development Bank, SIDA, SDC, UNICEF, UNFPA, World Bank and WHO. Technical input and advice was provided by the World Bank, UNICEF, and WHO. At each stage of development the Working Group presented the Proposal to the Health Sector Coordinating Committee (HSCC) for comments and feedback. WHO provided technical support to the HSS Working Group in revision of the proposal based on the IRC comments. Overall, the Working Group met in full twice, but its individual members and small teams have been working continuously, consulting with different partners in the Government and the donor community. Following each Working group meeting the proposal was shared with partners for comments and feedback. Finally, the proposal was discussed and approved by the HSCC. Further details are provided in Section 1.2.

The proposed interventions under this HSS application are in harmony with the existing Government policies and strategies, contribute into the health care reform initiatives and support the improvements in the health care system that will lead to better coverage and improved quality of services.

GAVI HSS Plan implementation will start following approval of the proposal (2008) and will continue till the end of 2010. The total amount requested from GAVI is USD 1,485,458.45, including support for country activities – USD 1,314,565.00

Section 1: Application Development Process

1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):

Health Sector Coordination Committee of the MoH, Tajikistan

HSCC is operational since March 2007. The HSCC of the MoH, is chaired by the Minister of Health, established for policy-level coordination of initiatives and projects related to health sector reform and health system strengthening. This committee is not limited only to the coordination of GAVI HSS, but aims to enhance coordination and synergies between different HSS interventions in the longer term through prioritization, focusing on, and coordination of the HSS activities (including PHC reforms, immunization, MCH, and other relevant interventions), implemented by the Ministry of Health, donors, and other implementing partners.
The HSCC has not replaced any existing body, but aims to upgrade the level of dialogue between all interested parties as well as the integration of previously vertically implemented programs.

Organizational structure (e.g., sub-committee, stand-alone):

The HSCC is a stand alone committee that works to coordinate the health system strengthening activities in the country.

The Project Management Unit under the Health Reform and International Relations Department of the MoH will be the leading unit for coordination between MoH and other stakeholders, including all other HSS related partners, the Ministry of Finance and the Ministry of Economic Development and Trade.

Frequency of meetings:[1]

According to the HSCC regulations, HSCC meetings will be convened twice in a year. However, in 2007 the HSCC conducted 4 meetings to discuss major health sector issues. Furthermore, following the conditional approval of the GAVI HSS Proposal, the HSCC met in order to discuss the proposed conditions and make the required changes. The minutes of the HSCC meeting held on March 4, 2008 are attached to the application as Annex E.

Overall role and function:

The functions of the HSCC include:
Coordination of all activities and projects in the health field, arriving at recommendations through joint decision making processes. Particularly, the HSCC is seen as a body is to oversee all health system strengthening related projects that are underway/will be implemented in the country. In this context the HSCC specifically will:

a. Coordinate preparation, review, approval and submission of proposals on HSS including the GAVI HSS application
b. Supervise the implementation and monitor the progress of HSS activities being implemented
c. Recommend corrective measures
d. Assess the impact of HSS activities,
e. Ensure regular information sharing and communication between all partners involved
f. Influence the health-related legislation in order to support improvement of access and quality of health care.

[1] Minutes from HSCC meetings related to HSS should be attached as supporting documentation, together with the minutes of the HSCC meeting when the application was endorsed. The minutes should be signed by the HSCC Chair. The minutes of the meeting endorsing this GAVI HSS application should be signed by all members of the HSCC.

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

MoH coordinated and provided oversight to the application process through an advisory group consisting of MoH senior officials and major in-country partners (which are WHO, WB, UNICEF COs, and MoF) and the Working Group (consisting of all relevant unites of MoH, MoF, and MoE&T) established within MoH. Since July 2007 the process of preparing and drafting the application has become increasingly dynamic and productive, gaining in efficiency and transparency (by involving additional partners, MoH Units, etc to collect and analyze the necessary data and information) and intense (regular, two-three WG meetings a week conducted), and efficient (involvement of MoH units and partners inputs to collect and analyze the data needed).

Who led the drafting of the application and was any technical assistance provided?

MoH led the drafting of the application through a Working Group established within MoH receiving technical assistance mainly from WHO and as well as other in-country partners. Apart from WHO Country Office staff support, WHO recruited three consultants for the process who provided technical assistance to address the IRC comments. The Working Group also benefited from the technical assistance provided by a workshop on application development in August in Kyrgyzstan as well as the joint (UNICEF, WB, and WHO) EPI mission, August – September 2007.

In December 10 2007, the Ministry of Health received the IRC Recommendations and "Conditional Approval" to country HSS Application submitted on October 5 2007 (Letter # GAVI/07/431/cb/at). In order to provide sound response, the HSS Working Group met to work on the revision of the budget and work plan according to the 2006 World Bank GNI per capita and at the same time reflect other GAVI IRC recommendations. To achieve the objectives reflected in the GAVI HSS Proposal of the Republic of Tajikistan (submitted on October 5, 2007) using the new budget ceiling, the Working Group worked on the changes, namely revision of the budget and Plan of Actions. The Working group presented the results of the revision and response to the members of the Health Sector Coordination Committee. The presented response was endorsed by the HSCC (minutes attached). WHO provided technical input during the revision process.

Describe a brief time line of activities, meetings and reviews that led to the proposal submission.

The initial discussions with MoH took place in early March 2007. The National level Working Group was established in mid-March and met 2 or 3 times a week to review the process, discuss the content and provide insight into the problems and impediments to improved immunization services. The first application submitted to GAVI in May, 2007 was rejected by IRC. The IRC comments were carefully reviewed by WG and while working on a new version the Working Group took great pains/put all efforts to address the issues identified by IRC. In this context the WG furthermore pursued following activities:

- Participation of the key Working Group' members in the GAVI HSS Proposal Preparation Workshop (Issyk-Kul, July 2007)
- Strengthening the WG through involvement of additional members (July-September, 2007)
- Multi- and bilateral consultations with the development partners (September 2007)
- Synchronization and harmonization of the activities proposed under the HSS proposal with other existing projects (September 2007)
- Harmonization with the comprehensive Multi-Year Plan for immunization (September 2007)
- Regular WG meetings (July -September 2007)
- Videoconference calls (WB HQ, WHO HQ, WHO EURO, UNICEF CEE/CIS, Local WHO, WB, UNICEF) and online support from the reviewers. (September 2007)

External TA (in-country and online) has been provided by the WHO consultants: Pim De Graaf, Elina Mandjieva, and Ninel Kadyrova. (September 2007, February 2008)

To illustrate the above, specifically

- The Working Group members in September 2007 met with the following donor/implementing agencies to obtain additional information on their activities aimed at health systems strengthening or other components of the proposal:
- SDC funded Sino project
- SIDA
- UNICEF
- UNFPA
- PIU for the ADB funded health reform project
- Aga-Khan Foundation
- PIU for the WB funded Community and Basic Health project
- CARE International
- EPI Mission (David Gzirishvili and Shahin Huseinov)
- Ministry of Finance, Budget Department
- USAID funded ZdravPlus Project
- ADB

That resulted in:

- A further revision of the barriers in light of the documented evidences, and it also had been suggested by the IRC and the WB,
- Developing evidence-based selection criteria and decreasing number of pilot rayons
- Harmonization of the Action Plan with the activities of other existing projects (per GAVI' recommendations)
- Consistency with the comprehensive Multi-Year Plan for immunization
- Inclusion of the Operational Research
- Estimation of potential contributions from counterparts:
    - Government of Tajikistan (state budget)
    - Donor
    - Community participation
- Including activities for the Ministry of Health' capacity development in project implementation to ensure institutionalization of the project

Who was involved in reviewing the application, and what was the process that was adopted?

The review process has been conducted under coordination of the HSCC. Partners involved in the review of the application were:

- Members of the WG (including MoF)
- Aga Khan Development Network/Health Services (AKHS)
- Asian Development Bank
- Project Sino
- SDC
- SIDA
- UNICEF
- ZdravPlus/USAID
- WHO
- World Bank

The Needs Assessment and Plan of Work were discussed on 6 of September by the HSCC and sent for the review to all interested parties on 9th of September. Following the comments from partners, the proposal was edited/elaborated and sent for the peer review on 21 of September. The final comments and suggestions received by 27 of September have been incorporated into the final version, discussed by the HSCC on 1st of October. Both, in-country peer review and regional peer review (Issuk-kul, July-August; September) allowed to significantly improve the proposal and identify sound interventions to be proposed to GAVI.

Major partners involved were UNICEF, WHO and the World Bank. The WG strongly benefited from the comments and suggestions of the major partners, namely UNICEF and the World Bank.

Who approved and endorsed the application before submission to the GAVI Secretariat?

The application was approved and endorsed by the Health System Coordination Committee at the Ministry of Health (see Annex E).

1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organi-sation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Minister	MoH	yes	o Overall responsibility for the development of the application o Review and approval of the application
Dr Salimov First Deputy Minister of Health	MoH	yes	o Technical and managerial advice o Coordination of the MoH WG activities. o Chair of the WG
Dr Miraliev Head of Health Reform and International Relations Department	MoH	yes	o Advice on current health reform interventions and linking those to the HSS planning o Member of the WG
Dr Mirzoev Deputy Minister of Health	MoH	yes	o Distribution of tasks among the MoH staff involved into the preparation of the HSS application o Member of the WG
Dr Kurbanov Head of MCH Department	MoH	yes	o Advice on maternal and child health services o Provision of information on MCH o Linking of HSS planning with the current MCH projects o Member of the WG
Dr Saifutdinov Head of Health Services Organization Department	MoH	yes	o Advice on current state of services o Linking of HSS plans with other existing plans and interventions o Member of the WG
Dr Azimov Head of Sanitarian and Epidemiology Services	MoH	yes	o Working with other departments to ensure co-ordination and harmonization of the future HSS activities o Member of the WG
Dr Jobirov Director, Head of Republican Immunoprophylaxis Center	RCIP/ MoH	yes	o Technical advice on the immunization related issues o Linking of the HSS plans with immunization related activities o Support in identification of barriers impeding immunization coverage o Member of the WG
Naimi Alamkhon – Head of Department	MoF	yes	o Review and advise on the proposed costing of the HSS plans o Member of the WG
Country Representative/ Head of Office	WHO office in Tajikistan	yes	o Coordination with MoH and major partner on HSS preparation o Overall leadership in the process of application preparation

Title / Post	Organi-sation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
National Professional Officer	WHO	no	o Facilitation of the WG meetings o Secretarial support to WG o technical advise o Member of the WG
Country Representative	UNICEF	yes	o Coordination with MoH and WHO o Provision of advice on current UNICEF agenda in the country o Review of the draft application o The UNICEF NPO is the member of the WG
National Health Officer	SDC	yes	o Provision of information on on-going activities in health sector under SDC programmes o Member of the WG
Deputy Country Director	ZdravPlus/ USAID	yes	o Provision of information on on-going activities in health sector under USAID funded health reform program
National Officer on Social Sector	SIDA	yes	o Provision of information on on-going activities in health sector under SIDA programmes o Member of the WG
Executive Director	Tajik Family Planning Alliance	yes	o Provision of information o Liason between local NGOs and the HSCC o member of the WG
Project Manager, Social Sector Programs	CARE International	no	o Provision of information on on-going activities in health sector o Information on incentives program for MCH, antenatal and postnatal care, immunization, and breastfeding
Head, Community Health Programme	AKHS	no	o Provision of information on on-going activities in health sector o Technical advice o Member of the WG
International and local Consultants	WHO	no	o Technical support in preparation of the application o Coordination and technical discussions with partners o Costing of the proposed activities; o Conducting of analysis, barriers and selected goal and objectives
National Officer	WB	yes	o Technical advice and consultations o Member of the WG
National Officer	ADB	yes	o Coordination and technical discussions
Assistant Country Representative	UNFPA	no	o Coordination and technical discussions
Core group	WB PIU	no	o Coordination and technical discussions
Core group	ADB PIU	no	o Coordination and technical discussions
Deputy Chairperson	ICC	no	o Coordination with the cMYP, technical discussions

1.4: Additional comments on the GAVI HSS application development process:

The private sector is underdeveloped in the country. There are only few strong private enterprises in Tajikistan. So far there are not any examples of public-private partnership to address public health needs. That might happen in future, when Tajikistan economy does serious progress.

Section 2: Country Background Information

The Republic of Tajikistan is a mountainous country located in the Central Asia covering an area of 143,100 square kilometers, 93% of the country is high mountains. Tajikistan is sharing borders with Afghanistan, China, Kyrgyzstan and Uzbekistan. Communication among regions is difficult especially during the winter because of high mountain ranges. The population is about 6,920,000, with 70 percent living in rural areas.

Administratively, Tajikistan is divided into 5 regions, which include 3 oblasts (GBAO, Khatlon and Sogd), Dushanbe City and 13 Rayons (districts) of the Republican Subordination (RRS).

The population growth rate is as high as 3.5%; fertility is also quite high, with a TFR of 4.9 in 1998, e.g. If the current population growth rate and fertility rate continue, the population would double every 20-22 years. Forty-two-point-five percent of the population is below 15 years of age and only 6.1 % are 60 years and older (cMYP document).

While Tajikistan is heading towards economic growth, at present it remains one of the poorest countries in the world[2]. According to World Bank estimates, 80% of Tajikistan's population live below the poverty line. Many people cannot afford the costs of transportation, drugs, and other expenditures for health services. This leads to self-medication and home deliveries that in turn affect the immunization coverage.

According to the 2003 Tajikistan Living Standards Survey (TLSS) conducted by the State Statistical Commission with assistance from the World Bank most of the population (even those with relatively higher incomes) faces significant difficulties in meeting their basic daily needs. The costs of illness or injury are seen as additional burden on the modest budgets of the families. At the same time the TLSS report states that health is one of the greatest concerns of people in Tajikistan.

2.1: Current socio-demographic and economic country information3

Information	Value	Information	Value
Population	6,999 661 (mid 2006, SSA)	GNI per capita	US$390 (WB, 2006)
Annual Birth Cohort	188.991 (2006 cMYP)	Under five mortality rate	79 /1000 (in 2005, UNICEF MICS)
Surviving Infants*	176.706 (in 2006, cMYP)	Infant mortality rate	65/1000 (in 2005, UNICEF, MICS)
Percentage of GNI allocated to Health	1.3 (in 2004, PRSP)	Percentage of Government expenditure on health	22.9 (in 2005, NDS)

* Surviving infants = Infants surviving the first 12 months of life

The initial phases of health sector reform have paved the way for introduction of new concepts and approaches in the health system.

The 2008 state budget is foreseen to be U$ 1.15 billion and 137 million, or 30.2% of the GDP. Compared to the 2007 state budget, it is increase of U$ 348 million, or 63%. It should be emphasized that in 2008, ~U $459 million from the state budget will be allocated for social sector, comparing to 2007, where the increase was about U$ 134.5 million or 45%. Out of this money, ~U$ 200 million will be allocated for education and ~U$ 74 million – for the health sector. There will

[2] Tajikistan Health Sector note. World Bank. June 2004

[3] If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested.

be also be ~U$ 136 million for population social protection. At the same time, in comparison with the 2007 state budget, financing of education and health sectors will be increased by 44 to 47% accordingly[4].

Health expenditures

According to the MoH source, the total budget of the health sector for 2008 will be ~ U$ 74 million), which is ~U$ 10.6 per capita. The total budget for health sector is 1.7% of the GDP and 5.7% of the 2008 state budget[5].

Reforms in health care financing include introduction of a Basic Benefit Package, introduction of capitation payment for primary health care, an increased budget share for primary health care and a commitment to further rationalize the hospital sector in order to balance hospital and PHC expenditures.

Reforms in service delivery include strengthening of primary health care. Delivery of primary health care services is being consolidated and provided at policlinics and medical posts by general practitioners (family doctors). Rural outpatient ambulatories and rural hospitals would be combined into new Rural Medical Centers. At the district level, the newly created position of Primary Health Care Network Managers will combine budgetary and managerial authority for management of the primary health care network as a whole. Communities will be involved in planning and management of health care at the community level.

Reforms in resource generation include development of a human resource strategy and reforming medical education in order to train and attract highly qualified personnel to the health system in general and particularly to PHC level.

Reforms in stewardship include strengthening the role of the Ministry of Health (MoH) in policy development, policy analysis and donor coordination. Country (with the external support) makes steps to the introduction of a health-sector Medium Term Expenditure Framework (MTEF) and Sector-wide Approach (SWAp). This transition is envisioned over the next five years.

2.2: Overview of the National Health Sector Strategic Plan

The Government of Tajikistan has been supported by international partners such as ADB, SDC, SIDA, UNICEF, USAID, WHO, the World Bank and others in developing of a number of key policy and strategic documents that define directions of health care reforms and priorities for the country. The different strategy documents appropriately identify major health problems and major directions for health system development and health sector reform, but do not present a unified strategic vision of the totality of health sector goals and objectives. The MoH is therefore, with CBHP support, about to start a technically guided process for the elaboration of a comprehensive health sector strategy. It is expected that this will improve the coherence of sector policies, while also providing a basis for better co-ordination of donor-financed activities and be a step towards the transition to a Sector-Wide Approach (SWAp) in the health sector.

A brief summary of the existing health sector strategy documents is provided below:

A. **National Development Strategy of the Republic of Tajikistan for the period to 2015 (NDS. Dushanbe, August 2005).** This important strategic document recognizes that the proportion of the budget spent on health care is insufficient to provide sustainable health care financing and develop the system. It also accepts that the proportions of funding allocated to primary and secondary health care are imbalanced and that there is a shortage of medical personnel in the system.

[4] Press Office of President/ www.president.tj
[5] TJK MoH annual report, 2007

The NDS names the following main priorities for health care development in Tajikistan:

a. Reform of the health care system, including development of the private sector and attraction of investment;
b. Improvement *of maternal and child health.*
c. A significant slowdown in the spread of HIV/AIDS, *a reduction in infectious diseases and the eradication of certain infections that can be controlled by vaccination;*
d. *Improved availability, quality and effectiveness of medical services*.

B. Poverty Reduction Strategy (PRS). This document represents the mid-term social and economical development programme of Tajikistan for 2007-2009. It recognizes the problems and re-enforces the priorities and direction of development in all sectors outlined in the NDS and other documents. It represents a programme of actions to achieve the mid-term goals for the country.
It is specifically underlined in the PRSP document that "one of the main measures for reduction of infant and child mortality is to ensure sustainable high coverage of vaccination for all vaccine-preventable diseases (VPDs). The priority is to gradually move towards *financing of vaccines by the Government* and the integration of immunization into maternal and child health services.
The PRSP is positive that realization of these measures in the health sector will lead to reductions in maternal and child mortality, infectious diseases and vaccine-preventable diseases.

C. The Strategy of the Republic of Tajikistan on the Health of the Population to 2010. The problems and priorities described in this document are in line with those identified in other strategic documents described above. It aims at overcoming problems in public health protection and health care within the conditions, requirements and capacities of Tajikistan. It intends to introduce new approaches, coordinate activities, mobilize resources of all sectors, elaborate multi-sectoral approaches, increase sector responsibility and intensify collaboration with the international community in protection and strengthening of health.

Expected results of the strategy are improved access to quality medical care, reduction of maternal mortality by 25-30%, reduction in the number of abortions by 30%, reduction of infant mortality to 20 per 1,000 live births, and improved protection of children and adolescents.

a. **D. Concept of Health Care Reform of the Republic of Tajikistan** was developed and approved by the Government of Tajikistan in 2002. It provides a general framework for health reform directions and supports the strategies and interventions outlined in other strategy and policy documents. The main developmental strategies for the health care reform defined in this Concept paper.

E. The Immunization Programme of the Republic of Tajikistan in 2003 – 2010. This document has been developed in close cooperation with all partners and members of the Interagency Coordination Committee (ICC). The programme has been framed within the policy framework for National Health Reform, in which decentralization and local development are fundamental policies to allow improved and enhanced access of the population to PHC services. The plan addresses improvement of immunization services management, capacity building, safety of injections, and ensuring of financial sustainability of immunizations services. The plan targets VPD morbidity and mortality, and aims at high immunization coverage at the national level (>95%), with particular attention to polio-free status and elimination of measles.

F. Comprehensive Multi-Year Immunization Plan

In September 2007 WHO/EURO initiated the joint mission of WHO, UNICEF and World Bank to support the Ministry of Health to review the

vaccines by the Government of Tajikistan was noted. The budget is yet to get finalized and may see further increases in state financing.

Potential complementarities between immunizaiton system components (cMYP) and HSS components

(source: cMYP, with extra inputs from the HSS WG).

		Strengthen evidence-based decision making at central and local government levels in order to build financial commitment for PHC and public health services	Increase access to PHC services in remote hard-to-reach areas	Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance	Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning
Immunization system components	Service delivery		x	x	x	
	Advocacy and communication	x			x	
	Vaccine supply, quality and logistics		x	x		x
	Surveillance		x	x		x
	Programme management	x				

In addition to the documents above, several secondary documents were used to assess the current situation. These include The strategy of the Republic of Tajikistan for Improvement of Reproductive Health Care developed by MoH, The Strategy of the MoH of Republic of Tajikistan on Human Resource Development developed by MoH/ADB project on health sector reform and the report on findings of MICS Survey conducted by UNICEF in 2005 and the Tajikistan Health Sector Note of the WB published in 2004.

Section 3: Situation Analysis/Needs Assessment[6]

3.1: Recent health system assessments

Title of the Assessment	Participating Agencies	Areas/Themes covered	Dates
Poverty Reduction Strategy of the Republic of Tajikistan to 2015	Government of Tajikistan; All ministries of the Government; WB UN (all relevant agencies)	Mid-term social and economical development programme of Tajikistan for 2007-2009	2007
National Development Strategy of the Republic of Tajikistan	Government of Tajikistan; All ministries of the Government;	National strategies in all sectors including health sector.	2007

6 Within the last 3 years

for the period to 2015	WB UN (all relevant agencies)		
Tajikistan Health Sector Note	WB Government of Tajikistan	Overview of the trends in the health sector, an analysis of the Government's proposed health reform policies and programs, a synthesis of the findings and recommendations for the medium-term strategy for achieving the Government's objectives outlined in the Tajikistan Poverty Reduction Strategy including (i) Health Care Finance; (ii) Nutrition; (iii) Community Health and Public Health; and (iv) Community Health Surveys.	2004
MICS 2005. Preliminary Report	Tajikistan State Commission on Statistics UNICEF	Child health and nutrition, their household-level determinants health and trends 2000 to 2005	2006
MDG National Assessment	UNDP Government of Tajikistan	Overview of the policy reforms and financial resources required to meet key human development targets in Tajikistan within the framework of the eight Millennium Development Goals (MDGs).	2005
The Immunization Programme of the Republic of Tajikistan in 2003 – 2010	MoH ICC partners	Improvement of immunization services management, capacity building, safety of injections, ensuring of financial sustainability of immunization services.	2003

3.2: Major barriers to improving immunization coverage identified in recent assessments

1. <u>Weak financial commitment of the government to the health sector, particularly at local levels,</u> is a main barrier in improving PHC and public health services and worsens regional inequalities in health care utilization rates. Currently, 80% of public health expenditures are financed by local governments while the republican budget covers only 20% (PEIR, WB 2005). Given differences among regions in their revenue raising capacity, reliance on local budgets to finance most of the health expenditures leads to worsening of inequalities in financial access and utilization of health services. For example, according to the MOH finance department, in Khatlon oblast per capita public spending on health is approximately 8 Somoni ($2.4) whereas in Sogd, it is 11 Somoni ($3.2) and outpatient visits per year per capita in Khatlon are 0.44 whereas in Sogd, they are 0.79. Moreover, Khatlon that has the second highest poverty rate (78%) after GBAO also has the lowest use of prenatal care (74%) and highest rate of stunting among children (41%) (RT Health Sector Note, WB 2005). Also, Khatlon oblast has a much higher rate of home deliveries than Sogd (37% vs. 4%, Annual Medical Statistical Information Book). It should be noted that these regional averages hide further differences in per capita spending, poverty, use of health services and health outcomes among districts within a region.

2. <u>Low salaries</u> lead to shortages and high turnover of qualified medical staff in rural areas. According to the MOH Finance Department report, the average salary of a PHC doctor is $17 per month and $11 per month for mid-level medical personnel, including nurses, while the average wage in the economy is $53 (182.2 Somoni) per month. This clearly creates problems with attracting new and retaining the existing staff. It also has a negative impact on performance motivation. Thus, according to the WHO Health for All Database, Tajikistan has only 192 physicians per 100 000 population as compared to EU, which has about 317 and CIS average of 371. The situation is worse when it comes to nurses: In Tajikistan, the number of nurses per 100 000 population has been steadily declining since 1991 and is now much less than the EU or CIS averages (RT Health Sector Note, World Bank 2005; Project Appraisal Document KfW/GOPA, July 2007). The problem is more acute in rural areas where due to widespread poverty medical workers are not able to supplement their salaries by charging patients formal and informal fees. Thus, in Kukhistoni Mastchoh district of Sogd region there are 6.6 doctors per 10 000 population as compared to Dushanbe that has 68.2 doctors per 10 000 population. Several agencies working in the health sector in different districts

across the country noted in interviews that many PHC health facilities are not functioning due to lack of medical workers. Unfortunately, MOH at centralized level does not have the precise figure of the country's need in doctors and nurses because it has not conducted such survey. However, separate projects conducted detailed surveys in their own districts and have noted this issue during the discussions leading to the preparation of this Proposal.

3. Lack of systematic training and weak supportive supervision of PHC and public health service providers contribute to weak capacity in VPD and AEFI surveillance, IMCI, and immunization. Tajikistan has high indicators for IMR, U5MR, and MMR. While there are many factors outside of the health system such as widespread and deep poverty and poor infrastructure that impact these indicators, some of the barriers lie within the health system itself and weak capacity of PHC and public health service providers in EmOC, ENbC, IMCI, immunization and reproductive health issues is one such barrier (UNICEF Report on Progress and Results in Country Program Components). With regard to surveillance of VPDs and AEFI, due to lack of resources the PHC staff have not received training in new surveillance concepts, case definitions, reporting methodology, use of surveillance indicators, active surveillance, specimen collection and transportation, and case investigation (cMYP).

Apart from the short training courses, supportive supervision is an effective tool for increasing capacity as it should be used by supervisors as an opportunity to provide on-the-job training. Current supervisory practices are neither supportive nor carried out in a structured and information-based manner. The regularity of supervisions is under threat due to inadequate operational support. This affects the health system performance, especially at PHC level, where the staff has limited opportunities to update their skills and knowledge. In addition, the Soviet style of supervision where staff were blamed for problems and not supported in their work leads to under-reporting of disease and adverse events, thus making it difficult to generate reliable information as a basis for quality-of-care improvements.

4. Limited infrastructure of PHC and public health services in remote rural areas with highly dispersed population lead to poor physical availability of basic health services, including immunization. According to KfW draft feasibility study (July 2007), 65% of buildings in Khatlon oblast are from the period of 1938 to 1980 and they do not meet basic requirements. Many health facilities have no proper heating and water supply, or reliable electricity (PRSP to 2010). According to the Effective Vaccine Store Management Assessment(MOH/WHO Joint Report, 2006), maintenance/repair of cold chain equipment/vehicles need to be considered of high priority because any breakdown might put at risk a large quantity of vaccines, which can represent a large amount of funds as well as cause an interruption of the national immunization program for the time the replacement quantity of that vaccine is shipped in the country. The assessment identifies upgrades and replacement of cold chain equipment amounting 327 000 $USD. It includes procurement of cold chain equipment mainly for district level and vaccine carrier and cold box type of equipment for operational level below district level from 2008 till 2010 (cMYP). For effective surveillance of VPDs and AEFI, the availability of transportation appears to be a real problem in hard to reach areas because a health facility does not have a functioning vehicle and other transport means are too costly which make timely transportation of specimen difficult (National Workshop on Strengthening Surveillance of VPD and AEFI, WHO 2006).

Moreover, according to the MOH database, there are 198 rural communities that are more than 10 km away from the nearest PHC facility, a large share of these communities is located in Khatlon region. It should be noted also, that this is the oblast with the second highest share of home deliveries (37%, according to the Annual Medical Statistical Information Book). According to the results of the analysis of the WHO mission expert, the rate of home deliveries declines when the ratio of obstetricians and midwifes to population increases (WHO Mission Report, April 2005). At the same time, funding of the existing healthcare system is beyond the country's capacity. According to UNICEF Report on Progress and Results in Country Program Components, some health facilities have 5-10 infants per year in their catchment areas for immunization. There is no up to date needs assessment done in this area and analysis of the various options to address this issue. The problem of physical availability is furt

Currently, in Tajikistan home deliveries, particularly without qualified medical staff, result not only in high rates of maternal and infant mortality but also contribute to a high number of unregistered children. According to the GosKomStat/UNICEF MICS Survey 2005, only 88% of children 0-59 months of age are registered at birth. This national average hides large inter-regional and inter-district differences.
Currently, for deliveries, MoH promotes facility-based deliveries by trained obstetricians and midwifes. However, it is unclear whether this is a feasible strategy for the medium-term considering the extremely high share of home deliveries and the complexity of factors influencing it. There are four main causes of home deliveries in Tajikistan: (i) poor quality of care in maternity homes, (ii) socio-cultural practices and lack of awareness, (iii) costs such as transportation, food, payments to medical staff associated with deliveries, and (iv) physical barriers such as geographical and climatic conditions (Strategic Plan for Reproductive Health of the RT by 2014, MOH/UNFPA/USAID/WHO 2004; RT Health Sector Note, World Bank 2005; WHO Mission Repot, April 2005). Thus, there is a need to look at the root causes of the growing share of home deliveries and to design more appropriate strategies for each. For example, to address poor quality of care in maternity homes, there is a need to improve skills of medical staff as well as physical infrastructure. To address the third cause of home deliveries, the Government needs to find ways to reduce the financial burden, at least for the poorest families. The differentiated approach to home deliveries also leads to differentiated approach to addressing the issue of timely immunization coverage for children born outside of a health facility. For women who choose to deliver at home because of poor quality of maternity homes, there is a need to raise their awareness on the importance of *timely* registration and immunization of children. A different strategy to increase timeliness of immunization should be used for women for whom costs associated with accessing health services is the main barrier.

6. Weak capacity at facility and district levels to collect and manage data is a major barrier to the monitoring and planning of immunization. Unified and comprehensive HMIS development has generally been slow until the recent year due to the lack of realistic national plan for its development, the need to align a variety of interests and insufficient funding for purchase and maintenance of equipment and training and retaining of specialists. According to Programmatic Document on the Development of the Health Management Information System 2006-2010, the concept of utilization of data for planning purposes at district or facility level is non-existent (MOH 2006). For example, data are not used for identifying bottlenecks to priority services in the districts and data for disease surveillance is not available in a timely manner to be used for action. Data on service utilization and equity are not used to inform policy and make decisions on distribution of staff (WB/SIDA CBHP PAD). Private not-for-profit providers do not report into the national HMIS. Moreover, there is a large number of different forms that duplicate each other. At the same time, there is a real shortage of basic reporting forms at health facilities (WB/SIDA CBHP PAD, interviews with a number of project implementation agencies).

3.3: Barriers that are being adequately addressed with existing resources

1. Weak financial commitment of the government to the health sector, particularly at local levels, is a main barrier in improving PHC and public health services and worsens regional inequalities in health care utilization rates. This is a complex barrier that requires a multifaceted approach. Thus, the WB/SIDA financed Community and Basic Health Project (CBHP) is partially addressing this issue through the Component A on Strengthening Policy, Planning and Donor Coordination in the Ministry of Health and Component B on Implementing Organization and Financing Reforms in the Health Sector. Activities such as provision of evidence-based advice on policy development in response to MOH needs, building MOH's capacity in strategic and operational planning, implementation of the Public Expenditure Tracking Survey (PETS) aim at increasing financial commitment of the central government to the health sector.

Moreover, the Government's Health Financing Strategy (Prikaz #171, 15 May 2005) that is being implemented with financial and technical assistance of a number of donors, including USAID, SIDA, Asian Development Bank, SDC and the World Bank, envisions pooling of sources of public funds and output-based financing of PHC facilities which should contribute to a more equitable distribution of funds within the districts and regions. Per capita financing is being piloted in eight districts but will be gradually scaled up to the whole country following its evaluation. Moreover, the current simple per capita formula will be further refined to include coefficients that will account for higher costs of provision of services in remote mountainous areas with dispersed population (WB PAD).

The World Bank Programmatic Development Policy Grant also contains conditions that aim at improving the general levels, predictability and efficiency of financing of the health sector. It has conditions related to introduction of BBP, per capita financing for PHC and also wage increases for primary health care workers.

2. Low salaries lead to shortages and high turnover of qualified medical staff in rural areas. This barrier is closely related to the barrier described above on the weak financial commitment at central and local levels of government. However, this is a separate issue in that it is a barrier specifically related to service delivery. Moreover, the issue of wages in the public sector is difficult to address separately for each sector without raising question of financial sustainability, distortions, and oversized public sector. This barrier is not directly addressed by any of the donors. However, the Government is undertaking steps to improve salaries in education and health sectors. Thus, the salaries of doctors and nurses were increased on average by 50% (40% for the hospital level and 60% for the PHC) in 2006 and by 50% in 2007 (Interview with MOF, September 5, 2007). Moreover, it is expected that as the result of the current reforms in health financing, including formalization of informal payments at hospital level and re-direction of state budget funds to the PHC and public health services, salaries of the medical staff as these levels will be visibly increased (WB PAD).

3. Lack of systematic training and weak supportive supervision of PHC and public health service providers contribute to weak capacity in VPD and AEFI surveillance, IMCI, and immunization. There is a high number and a wide variety of training activities targeted at strengthening the capacity of PHC and public health service providers in EmOC, ENbC, IMCI, immunization and reproductive health issues. However, there is a fragmentation among these programs where a program covering reproductive health issues does not cover IMCI or safe immunization practices. The World Bank/SIDA financed CBHP and the ADB financed HSRP are supporting activities aimed at creating a systematic approach to training in family medicine. They are also supporting training of PHC management in planning and financing. However, there is a need to standardize more specialized training programs on IMCI, ENbc, EmOC, immunization and reproductive health issues.

WHO/EURO conducted three days training on integrated surveillance for VPDs and AEFI in May 2006 where approximately 50 participants from oblast and rayon levels participated, mostly epidemiologists in charge of surveillance. However, this knowledge has not been transferred to facility level staff (National Workshop on Strengthening Surveillance of VPD and AEFI, WHO 2006).

4. Limited infrastructure of PHC and public health services in remote rural areas with highly dispersed population lead to poor physical availability of basic health services, including immunization. This barrier is being addressed by several donors, including ADB, Aga Khan Foundation, SDC, SIDA, and USAID, UNFPA, UNICEF and the World Bank. The World Bank/SIDA financed Community and Basic Health Project under the Component on Strengthening PHC in Selected Rayons has allocated a total of 7.1 million USD for strengthening the PHC infrastructure. The component covers six districts in Khatlon and Sogd regions selected according to the current PHC rationalization plan. The ADB financed Health Sector Reform Project is also providing similar infrastructural rehabilitation, including civil works and basic equipment, to PHC facilities in five districts across all four regions (Rayons of Republican Subordination, Khatlon, Sogd and Gorniy Badakshan). In total, it will rehabilitate 54 PHC facilities for a total amount of about 1.3 million USD. It has also financed the purchase of PHC equipment and drugs in these five districts. The Aga Khan Foundation has been engaged in the region of Gorno Badakhshan (GBAO) since 1992 and has invested significant resources in physical rehabilitation and equipment of PHC facilities in this region. The total investment in infrastructural rehabilitation provided by AKF (with donor support) in four years (2001-2004) is about US$ 302000. According to its assessments, most of the need for continuous investment in infrastructural support in GBAO is usually met by donor resources and not by government.

UNICEF under the MCH Program continues to provide essential equipment PHC facilities and maternity hospitals in ten priority districts for the total sum of 400 000 USD in 2007 alone. In addition, it has provided similar support to five other districts over the past 3 years. It has also provided technical assistance to RCIP for inventory of cold chain equipment and replenishment plan for 2006-2010 but no procurement has been made under this plan. There is a large unmet need for cold chain equipment but the Government of Tajikistan plans to apply to the GAVI ISS window for the support. Thus, although none of the current donors are addressing the need for cold chain equipment on a large scale, this is not addressed through the current Proposal. UNFPA, within the Program on Family Planning has a component on procurement of equipment for PHC facilities and maternity homes. It covers four districts under this component, although occasionally it covers other districts as well if the MOH makes a special request, but these are one-off purchases. In addition to these long-term large assistance, after the war there have been other agencies supporting basic physical rehabilitation and equipment across the country, but most of these facilities now require refurbishment and new equipment.

5. A significant number of unregistered children as a result of home deliveries and fees for birth certificates affects quality of immunization service planning and delivery. There are many innovative social mobilization activities that aim at increasing awareness of women of the importance of use of ANC, deliveries assisted by the qualified medical staff, and timely immunization. The Aga Khan foundation has been active in supporting community mobilization program in GBAO since the early 1990s. It has a rich and positive experience of improving mother and child health through community mobilization. Thus, although GBAO has the highest poverty rate in the country, it has one of the highest rates of prenatal care services utilization (95%) and the lowest rate of stunting (32.5%). The case of GBAO that has well organized community-based organizations may point to ways of addressing the issue of access and health service utilization in resource poor environments such as Tajikistan. Currently, the World Bank/SIDA CBHP, sub-component on Strengthening PHC services and outreach is providing support to community mobilization programs in fifteen districts in Khatlon and Sogd regions. Although the Project uses three different international NGOs, including the AKF, that offer different approaches, they work towards the same four objectives of reducing (i) child mortality, (ii) maternal mortality, (iii) malnourishment among children, and (iv) cases of malaria. They also use similar training materials and methods. While improved registration of newborns is not part of their task, they provide training to community leaders and health promoters on importance of safe deliveries and immunization issues. They also provide small grants to communities for small projects that are aimed at improving mother and child health. The three NGOs have different implementation strategies and thus, will provide a good basis for future evaluation and scale up.

6. Weak capacity at facility and district levels to collect and manage data is a major barrier to the monitoring and planning of immunization. One of the most important steps in addressing this barrier was taken in 2006 when the Government with the assistance from the Asian Development Bank developed and adopted the Programmatic Document on the Development of the Health Management Information System 2006-2010 which provides a general analysis of key bottlenecks and principles for the development of the national HMIS. Importantly, it has an action plan that identifies key financing and implementing agencies as well as monitoring indicators for each activity. It builds on the present activities by donors and technical agencies such ADB, the World Bank, SDC supported Project SINO, and USAID ZdravPlus Program. Thus, the WB/SIDA CBHP Project provides financial and technical support to building a modest information system designed for key managerial tasks at district level (WB/SIDA CBHP PAD). Specifically, it finances the procurement of computers and basic training for PHC managers and accountants in 41 districts of Sogd and Khatlon regions. It also supports the development of a basic district-level PHC management information system for utilization tracking and basic disease surveillance. Similar activities are being conducted by the ADB financed Health Sector Reform Project in its in five districts across all four regions (Rayons of Republican Subordination, Khatlon, Sogd and Gorniy Badakshan). Project SINO has also provided a similar support in its four pilot districts. The CBHP PIU during the preparation of the HSS GAVI Proposal informed the Working Group on HSS Proposal that the MOH with assistance from the CBHP is revising the existing reporting forms, eliminating duplications, and designing a single unified reporting form which can be easily filled out at PHC facilities.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

1. Weak financial commitment of the government to the health sector, particularly at local levels, is a main barrier in improving PHC and public health services and worsens regional inequalities in health care utilization rates. In the Section 3.3 above, it is noted that this barrier is being addressed by several donors already. The Health Policy Analysis Unit that is being established with financial support of the WB and SIDA will focus on monitoring the effects of the introduction of the Basic Benefits Package and per capita financing in pilot districts. This work needs to be supplemented with a more targeted policy analysis to increase commitment of local governments to PHC services and immunization activities and strengthen their capacity for evidence-informed policies. In order to avoid building additional or parallel activities or structures, it is envisioned that these activities will be also conducted under the newly established HPAU.

3. Lack of systematic training and weak supportive supervision of PHC and public health service providers contribute to weak capacity in VPD and AEFI surveillance, IMCI, and immunization. There is a fragmentation among the existing programs where a program covering reproductive health issues does not cover IMCI or safe immunization practices. Thus, there is a need to standardize more specialized training programs on IMCI, ENbc, EmOC, immunization and reproductive health issues. Moreover, the MOH does not feel ownership of these programs and is often unaware of their exact content. The training on VPD and AEFI surveillance of PHC staff at facility level and district level epidemiologists is not yet addressed. As noted above, the previous training programs on integrated surveillance for VPDs and AEFI targeted only oblast and rayon level staff, mostly epidemiologists in charge of surveillance (National Workshop on Strengthening Surveillance of VPD and AEFI, WHO 2006). Operational and technical support for

development of regular supportive supervision is not provided by any of the current projects. This is to be addressed through the current Proposal.

4. Limited infrastructure of PHC and public health services in remote rural areas with highly dispersed population lead to poor physical availability of basic health services, including immunization. Recognizing the high density of donors providing infrastructural support to PHC facilities, during the preparation of the GAVI HSS Proposal there has been a careful analysis of the geographical coverage of current and planned donor activities. This analysis shows that there are pockets of under-coverage with certain remote poor districts that have high IMR and high share of home deliveries. Thus, there is a need for very selective investments in rehabilitation.

5. A significant number of unregistered children as a result of home deliveries and fees for birth certificates affects quality of immunization service planning and delivery. As described in the previous section, this barrier is partially addressed through the AKF activities in GBAO and the World Bank/SIDA financed CBHP in selected districts of Khatlon and Sogd regions. However, according to the implementing agencies working with the CBHP, currently there is no funding to scale up these activities beyond the already selected fifteen districts. Thus, there is a need for additional funding that will use the current best practices and structures and scale up these activities to other districts that face similar barriers.

Considering the growing evidence around the world about the importance of demand side incentives for use of health and education services, particularly in traditional areas with high poverty rates, and persistently high and growing share of home deliveries in Tajikistan with accompanying low registration of newborns it is important to look for creative approaches that are not only supply oriented but also work on the demand side. Experience in Latin America and now increasingly, the countries in sub-Saharan Africa with conditional cash transfers point to new ways of approaching this barrier in Tajikistan. Conditional cash transfers have been implemented in more than 20 countries. It is considered to be one of the most effective mechanisms for targeting the poor. Impact on utilization of preventive health services, health impact on child height is significant but on immunization rates is still unclear. However, Oportunidades Program in Mexico that covers 20% of population through bi-monthly transfers on several conditions, including immunization, has shown statistically significant coverage increases for measles vaccination in treatment areas. Moreover, children from households with less educated mothers and living more than 5.5 km away from a health facility show most significant results (Barham T., L. Brenzel and J. Maluccio. May 2007, draft. Beyond 80%: Are there new ways of increasing vaccination coverage?). The same results were achieved for Nicaragua.

6. Weak capacity at facility and district levels to collect and manage data is a major barrier to the monitoring and planning of immunization. As it has been noted by several agencies working on PHC system reforms, district level PHC managers are not and will not be able to collect reliable data on time if the frontline providers at lower levels do not have basic reporting forms and skills to collect and process these data. Often those who collect data at primary level do not even understand what they are collecting and why. Considering the ongoing and planned activities by other donors and technical agencies outlined in the Government Programmatic Document on HMIS, in order to effectively address this barrier, there is an immediate need to provide training in data collection and analysis. Moreover, there is a short-term need to finance printing and distribution of this new form (HSCC Meeting, September 6, 2007, cMYP).

Section 4: Goals and Objectives of GAVI HSS Support

4.1: Goals of GAVI HSS support

The goal of the current Proposal is to improve access to and demand for *basic* health services in poor hard-to-reach areas through increased financial commitment of the government at all levels, creation of outreach services, and improvements in the quality of physical and human resources.

4.2: Objectives of GAVI HSS Support

Objective 1. Strengthen evidence-based decision making at central and local government levels in order to build financial commitment for PHC and public health services

Objective 2. Increase access to PHC services in remote hard-to-reach areas

Objective 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance

Objective 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers

Objective 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning

BARRIERS	OBJECTIVES
Weak financial commitment of the government to the health sector, particularly at local levels, is a main barrier in improving PHC and public health services and worsens regional inequalities in health care utilization rates	Objective 1. Strengthen evidence-based decision making at central and local government levels in order to build financial commitment for PHC and public health services
Limited infrastructure of PHC and public health services in remote rural areas with highly dispersed population lead to poor physical availability of basic health services, including immunization.	Objective 2. Increase access to PHC services in remote hard-to-reach areas
Lack of systematic training and weak supportive supervision of PHC and public health service providers contribute to weak capacity in VPD and AEFI surveillance, IMCI, and immunization.	Objective 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance
A significant number of unregistered children as a result of home deliveries and fees for birth certificates affects quality of immunization service planning and delivery	Objective 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers
Weak capacity at facility and district levels to collect and manage data is a major barrier to the monitoring and planning of immunization	Objective 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning

The Proposal supports activities that are targeted at the national level and at the district level and below. All activities under Objective 1, most activities under Objective 3, and one activity under Objective 5 target the entire country. Activities under Objectives 2 and 4, some activities under Objectives 3 and 5 are targeted at 9 districts that were selected as GAVI HSS priority or target districts based on the following seven criteria:

1. Share of home deliveries
2. IMR
3. DTP-3 coverage rate
4. Remoteness and difficulty of access
5. Poor infrastructure and lack of medical staff
6. Poverty rate
7. Presence and the level of involvement of other donors.

The 6 selected districts are Ganchi, Matcha, Humsangir, Vose, Farhor, and Baldjuvon. It should be noted here that considering the innovativeness of the conditional cash transfers for this region, this activity under Objective 4 will be piloted only in 2 out of the 6 GAVI HSS priority districts. While it is considered to be one of the most effective methods for increasing demand for and use of preventive health services among the poor and has proven to be successful in many Latin American countries, there are many issues related to the administrative costs of such program as well as financial sustainability. Hence a small scale pilot is considered to be most appropriate here.

HSS GAVI OBJECTIVES	Activities and action point
Objective 1. Strengthen evidence-based decision making at central and local government levels in order to build financial commitment for PHC and public health services	**Component activities aim at strengthening the evidence-informed decision-making at central and local government levels in order to improve financial commitment of the government to PHC and public health services.** Specifically, the component will support the development, publication and dissemination of policy briefs focusing on the impact of government policies and PHC reforms on maternal and child health outcomes. The policy briefs will be based on analysis of key indicators and results of already conducted population, patient and health worker surveys, i.e. the component will not finance surveys or collection of new indicators since many have taken place in recent years by various organizations. ⇒ Unlike typical reports, policy briefs will be between 2 to 4 pages, written in clear non-academic language and focus on policy recommendations. The development of policy briefs will be based on the positive experience in the Kyrgyz Republic where they have proven to be important instruments in building strong political support for health sector reforms and increasing financial commitment of the government and international development agencies. ⇒ In order to ensure that these documents actually reach the decision-makers at all government levels they will be presented during the regional (oblast), district (rayon) and jamoat government meetings. The newly established Health Policy Analysis Unit in collaboration with the Maternal and Child Health Unit of the MOH will be responsible for preparing and presenting these documents. In addition to increasing awareness among decision-makers at central and local levels and strengthening their financial commitment to PHC and public health services this will further build the Ministry's capacity in policy analysis, communication and inter-sectoral cooperation.

Objective 2. Increase access to PHC services in remote hard-to-reach areas	**The main objective of the component is to increase physical access to PHC services in hard-to-reach poor areas.** The component will support the following activities: ⇒ Refurbishment or reconstruction – depending on their condition – of rural health facilities (Health houses) in hard-to-reach villages making them more attractive for patients and thus, contributing to increased utilization of PHC services in rural areas. The infrastructural upgrade of rural health facilities will be based on counterpart participation from local governments in order to build ownership for the facility, thus helping ensure its future maintenance. Local communities will be able to apply for a small grant if they are ready to contribute 30% of the total cost of reconstruction. The contribution can be in-kind, for example, through labor. These health facilities will also receive basic PHC equipment and cold bags. The basic equipment package will be similar to the packages procured under the WB and ADB financed projects in their target districts. In total, the component will support the refurbishment or renovation of approximately 36 health houses. This is a preliminary estimate according to the data provided by district level managers from the selected 6 GAVI HSS priority districts. ⇒ Operational support to PHC doctors for conducting outreach activities through financing their transportation expenditures and per diems. This will ensure that population groups served by rural health points have access to qualified medical services. As described in Section 3, small villages are served by rural health points (or health houses, HH) with a nurse or a midwife and do not have medical doctors on a permanent basis. According to current regulations, doctors from the nearest PHC facility are expected to make regular visits to HHs. However, lack of motivation and funds to cover operational expenditures result in extremely low and irregular coverage by these outreach activities. The component will provide financial support to the PHC doctors to conduct regular outreach activities through financing their transportation expenditures and per diems. It is expected that gradually the state budget will be able to take over the coverage of these expenditures, as it is already part of the budgetary planning. ⇒ based on the needs assessment to be conducted establishment of mobile teams to ensure regular coverage by basic health services of population groups living in areas without stationary health facilities or permanent health workers. In mountainous areas with a highly dispersed population there are communities that are too small to justify building a new facility but which are not covered by the existing network because of costs of transportation, difficult terrain, seasonal factors and lack of qualified medical staff willing to work in those areas. Thus, the component will support the following: (i) Purchase of 6 four-wheel drive vehicles (1 vehicle per GAVI HSS target district), (ii) Creation of teams at district/rayon level drawing on existing medical staff of rural health centers, IMCI centers, reproductive health centers and centers for immunoprophylaxis. The team will consist of one family doctor/pediatrician, a nurse, and a driver. (iii) Purchase of basic equipment, training and operational manuals for provision of basic health

	services, including immunization (iv) Operational support covering expenditures for fuel, maintenance of vehicles, and per diems.
Objective 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance	**The objective of this component is to strengthen the capacity of PHC and PH services staff through systematizing and building a more integrated approach to the content of already existing training programs.** To achieve this objective the component will support the following activities: ⇒ In cooperation with WHO and UNICEF, review existing training programs on IMCI, reproductive health, immunization etc. conducted by different agencies, broaden them to include VPD and AEFI surveillance and develop unified training guidelines that can be included into the basic training program for PHC staff. Using the newly developed guidelines, train PHC staff in the 6 GAVI HSS priority districts. The entire training program will consist of 3 cycles, 5 to 8 days each. ⇒ In cooperation with WHO and UNICEF, develop a 5-day training program in VPD and AEFI surveillance for public health services staff and conduct training of trainers. Based on this program conduct training for public health services staff at district level covering all districts using the newly trained trainers. ⇒ On-the-job training in Immunization in Practice for persons responsible for vaccination by national trainers that have been trained by UNICEF covering all districts. ⇒ Operational support (transportation expenditures and per diems) for case investigation and preventive measures for all district SES. ⇒ A multi-agency working group consisting of key specialists from district health centers, district centers for reproductive health, and district centers for IMCI will develop mechanisms and integrated guidelines for joint supportive supervision. Using these guidelines, the MOH will conduct training of trainers at national level who will then provide trainings at district level covering 6 districts. The component will also finance per diems and transportation expenditures for conducting supervisory visits for 6 selected districts. ⇒ Develop and conduct a 5-day training for PHC management from 6 GAVI HSS priority districts (5 persons per district) on data use, monitoring and planning to improve effectiveness of PHC services building on the training program developed under the WB/SIDA financed CBHP.
Objective 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	**The objective of this component is to increase demand for timely immunization, particularly in cases of home deliveries which in Tajikistan reach approximately 70% of all deliveries.** To achieve this it will support the following activities: ⇒ Increase awareness of the population on the importance of timely registration of children and immunization through TV and radio campaigns, information leaflets, and community-based organizations. This is mostly targeted at relatively wealthy women who choose to deliver at home because of cultural norms and perceived poor quality of maternity houses. Two points should be

noted here about the Tajik context: (a) there are no private maternity homes in districts outside the capital that would be able to offer significantly higher quality of services, (b) in a country with more than 50% general poverty rate, a relatively wealthy woman is not rich and cannot afford flying to the capital for delivery. The main issue with this group of women is to inform them about the importance of (a) ANC in order to detect any complications that might require a woman to be taken to the hospital for the delivery and (b) timely immunization of infants with emphasis on the fact that there are some vaccines like HepB that need to be injected within the first 24 hours.

While TV and radio campaigns are important for raising general population awareness, their effectiveness might be limited in rural traditional settings. Thus, community-based organizations that have become increasingly active in Tajikistan have a special role to play in raising awareness and promoting certain types of behavior. Building on the experience and methodology developed by existing agencies such as AKF, SIDA, and SDC that support community-based programs, the component will provide financial support to establishment of 15 village health committees in 2 GAVI HSS priority districts and training of about 15 health promoters (1 health promoters per local self-governance). In addition, it will support short trainings for already active village health committee members and NGOs to broaden their knowledge on mother and child health, including immunization issues.

⇒ Develop, approve and disseminate brief procedural guidelines for medical staff on steps to follow in case of home deliveries. These will be very simple and short guidelines that will help medical staff when mothers bring their infants for immunization but have delivered at home and do not possess registration documents such as birth and marriage certificates.

⇒ Develop and pilot a system of incentives using the international experience with Conditional Cash Transfers. The Program will have geographic targeting (poorest districts with the lowest immunization coverage rates and high share of home deliveries) as well as household level targeting. The household level targeting ideally should be based on proxy means testing. But considering that there is no system for income-testing and existing welfare benefits are based on social categories, eligibility for the program will be decided by village health committees. Eligibility will be based on the level of wealth of the household. Considering that there is no system for income-testing and existing welfare benefits are based on social categories, eligibility for the program will be decided by village health committees. However, to ensure transparency and wide community participation the selection criteria and other basic information on the program will be widely disseminated through leaflets in schools, announcement boards of local self-governments etc. The first 2 districts chosen for the pilot (Kumsngir, and Farkhor) have the highest poverty rates (according to the LSMS 2005) and the largest number of children that have not received DTP 3 vaccine. The program at its pilot stage will cover approximately 3400 women (rough estimate based on the number of births per year in the selected 2 districts and poverty rate). It should be noted that even when rolled out nationally, the program will not cover all districts but focus on the poorest districts with the lowest immunization coverage rates and other child health indicators.

While the exact content and mechanisms of the program will be developed as one of the GAVI HSS

	Grant sub-activities, based on the preliminary discussions with key stakeholders the proposed size of the incentive for 1 mother is 15 USD – 5 USD for transportation costs and 10 USD for infant clothes and food – plus, a birth certificate, which now costs about 33 cents, for free. Free birth certificates will come as the contribution from local governments. The payments will be hand delivered to beneficiaries through the village health committees. However, during the design stage of the program the exact size of the incentives will be determined in order to avoid distortions and resentment among other members of the community. Also, a monitoring and verification system to minimize any graft or misuse of the Program will be developed in further detail. In Mexico, for example, health workers recorded the dates when services needed to be obtained in the health cards and kept track of receipt of services separately. A system similar to it will be developed in Tajikistan. ⇒ The pilot will be carefully monitored and evaluated, particularly as questions being raised in the development community on the impact of such temporary incentives on permanent behavioral changes. This concern is partly mitigated by the fact that this activity is targeted at the poorest women and thus, decreasing financial burden associated with access to basic health services is equally important to changing certain behavior. However, the issues of cost effectiveness, financial sustainability and overall impact on mother and child health need to be evaluated. This is described in more detail in the Section on Operational Research.
Objective 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning	**The objective of this component is to increase capacity of PHC facilities in collection and reporting of data in a timely manner for decision-making and planning.** Under the World Bank Project the MOH has developed the software for collection, reporting, and analysis of data for PHC management. It is expected that this software will be adapted to new unified reporting forms by the end of 2007. To achieve its objective the Component will support: ⇒ Improving the systems for collection of data at primary level through printing of the new reporting forms for PHC facilities nationwide ⇒ Training in data source and collection and filling-in of the new simplified forms for PHC staff at district level for all districts ⇒ Purchase of computers, including printers and UPS devices, for PHC facilities for GAVI HSS priority districts (not covered by existing projects such as SINO, ADB and the WB) – a total number of 20 packages ⇒ Two-day training on computer-based processing of reporting forms for district level specialists in medical statistics of PHC facilities nationwide.

Section 5: GAVI HSS Activities and Implementation Schedule

5.1: Sustainability of GAVI HSS support

The health sector expenditures have been gradually increasing for the last 3 years, both in absolute terms and relative to government expenditures. Thus, in 2007 the total budget for health sector was 1.7% of the GDP, or 5.7% of the 2008 total state budget. According to the draft budget for 2010, the share of health expenditures in total government expenditures is projected to increase to 6,4 % or 78,013,283 USD. Also, structural credits and grants such as the World Bank Programmatic Development Policy Grant have conditions that are targeted at increasing the government spending on health.

As it is projected, the GDP will be steadily increased on the annual basis:

Year	(in ,000 somoni)
2007	12,200,000
2008	14,800,000
2009	17,420,000
2010	20,500,000

The state budget for health will also be increased:

Year	(in ,000 somoni)
2007	189,699
2008	255,759
2009	310,700
2010	311,300

In the Proposal itself, there are also mechanisms that promote financial commitment and sustainability. Thus, there is requirement for local government participation in refurbishment and reconstruction of PHC facilities (30% contribution to the total cost). This should increase ownership at the community (jamoat) level. Moreover, this activity is on refurbishment or reconstruction of existing facilities and not building new ones. The two activities that have implications for the recurrent costs of the health sector budget are maintenance of mobile teams and operational support (per diems and transportation costs) to outreach activities. However, it is estimated that the total cost of maintaining the mobile teams and providing operational support for outreach activities is only about 2,3% of the total state health sector budget.

Table: Recurrent costs of mobile teams and outreach activities, 2008 – 2010

	2008	**2009**	**2010**
projected Government Health Expenditures (GHE)	$69 499 728	$80 291 214	$78 013 283
population TJ	7 247 459	7 435 893	7 629 226
per capita on health from GHE	$9,6	$10,8	$10,2
population of 6 targeted GAVI districts	645 867	662 660	679 889
exp on outreach activities per year in 6 districts	**$36 000**	**$72 000**	**$72 000**
per capita on ouit-reach activities	**$0,06**	**$0,11**	**$0,11**
exp on mobile teams per year in 6 districts	**$29 520**	**$59 040**	**$59 040**
per capita on mobile teams	**$0,05**	**$0,09**	**$0,09**
additional exp. on out-reach activities per year for all districts (65)	$403 966,32	$807 932,64	$807 932,64

	2008	2009	2010
% GHE for out-reach activities	0,6%	1,0%	1,0%
additional exp. on mobile teams per year	$331 252,38	$662 504,77	$662 504,77
% GHE for mobile teams	0,5%	0,8%	0,8%
Total for out-reach activities and mobile teams	$735 218,71	$1 470 437,41	$1 470 437,41
% to annual GHE	1,1%	1,8%	1,9%

Source: GHE provided by the Ministry of Health, RT; population figures are from Goskomstat sbornik for 2007.

Most activities such as creating more systematic training programs and providing trainings do not have cost implications for the future.

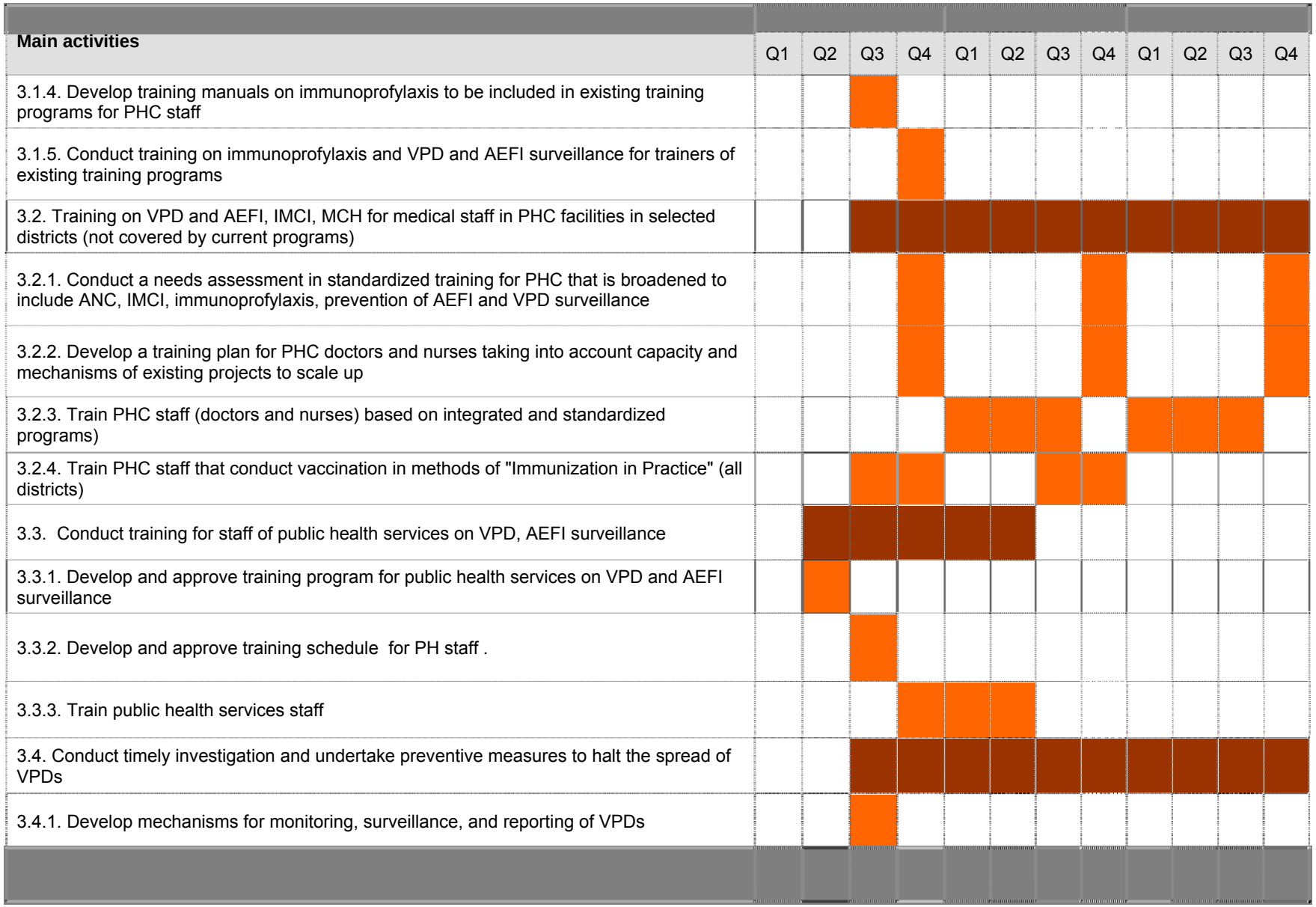
Overall, it is expected the GAVI project to play the catalyzing role in advocating and promoting some interventions, already implemented in Tajikistan and piloting new activities to be potentially (fully or partly) supported by the Government. Being implemented in the regions lacking so far donor support, the proposal will be reducing differences between other donors' pilots and non-supported regions, without competing with the ongoing projects

5.2: Major Activities and Implementation Schedule

Main activities	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.1.1. Evaluate the impact of activities under the PHC reforms on MDGs 4 and 5 on the basis of key monitoring indicators regularly collected and analyzed												
1.2.1. Prepare documents for the meetings and provide organizational support												
1.3. Review issues on immunization coverage and PHC services in general at regional, district and jamoat government meetings to lobby for appropriate financing based on evidence												
1.3.1. Prepare documents for the meetings and provide organizational support												
Objective # 2. Increase access to PHC services in remote and hard-to-reach areas												
2.1.Renovate rural health facilities (Health Houses) in remote villages with counterpart participation of the local governments and local communities on the basis of their applications to the MOH (according to PHC rationalization plan)												
2.1.2.Establish a committee to review applications for the rehabilitation and prepare application guidelines												

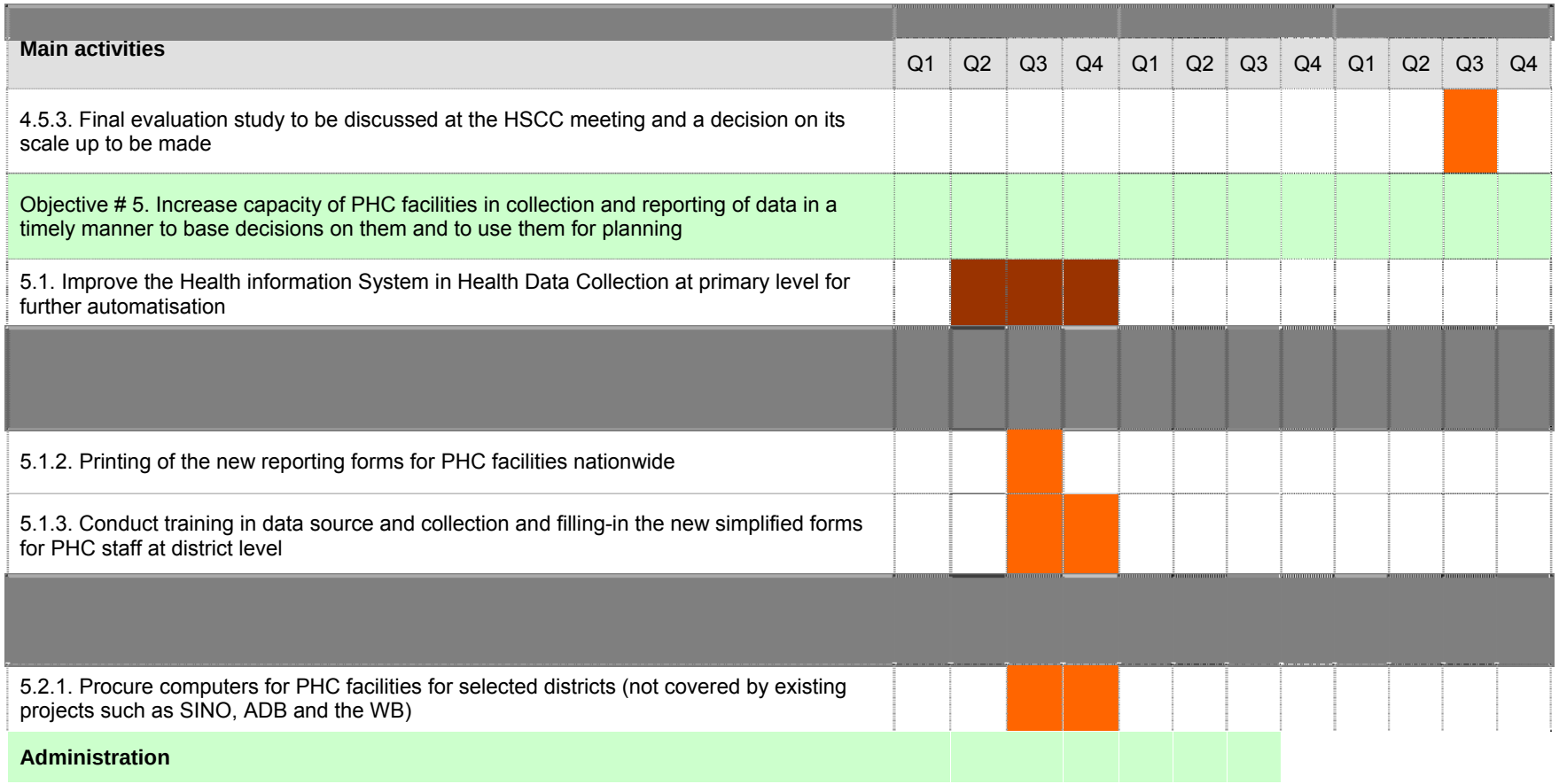
Main activities	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.1.3.Organize training activities for local self-governments and health facility management on the application process												
2.1.4. Provide small grants for the preparation of project documents, including the rehabilitation plan												
2.1.5. Select the communities for support (30% of project costs are to be covered by local governments, jamoats)												
2.1.6. Monitor the rehabilitation progress of facilities in selected communities 2.1.6. Провести мониторинг ремонтных работ домов здоровья, выигравших конкурс на основе поданных заявок												
2.2.Provide basic equipment, including cold bags, medical supplies and small parts to PHC facilities in selected districts												
2.2.1.On the basis of rapid assessment, procure basic equipment for facilities in selected districts												
2.2.2. Prepare specifications for the procurement												
2.2.3. Prepare technical documents for the bidding process												
2.2.4. Purchase and deliver the equipment												
2.3. Provide operational support to PHC staff for conducting outreach activities through covering their transportation expenditures and per diems												
2.3.2. Develop schedule of visits to the selected rural areas												
2.4.Establish mobile teams on the basis of the needs assessment for poor hard-to-reach areas that do not have medical staff or where there is only one medical worker if she is away on a training course												

Main activities	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2.4.1. Appoint persons in the MOH and oblast health departments responsible for supervision of mobile teams in hard-to-reach poor areas												
2.4.2. Conduct a needs assessment for mobile teams												
2.4.3. Develop and approve TOR, standard operating procedures, including reporting forms												
2.4.4. Define a list of equipment for mobile teams and prepare specifications for procurement												
2.4.5. Procure vehicles with four-wheel drive for mobile teams (6)												
2.4.8. Conduct training of mobile teams on provision of basic health services, including immunization												
2.4.9. Inform the target districts regarding the schedule of mobile team visits												
2.4.10. Provide operational support for the teams, including fuel costs, per diems and supplies												
Objective # 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc												
3.1.1. Establish a working group in the MOH to review the existing training programs supported by different agencies												
3.1.2. Review the existing programs, develop and approve standardized programs at the national level												


Main activities
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
3.1.4. Develop training manuals on immunoprofylaxis to be included in existing training programs for PHC staff
3.1.5. Conduct training on immunoprofylaxis and VPD and AEFI surveillance for trainers of existing training programs
3.2. Training on VPD and AEFI, IMCI, MCH for medical staff in PHC facilities in selected districts (not covered by current programs)
3.2.1. Conduct a needs assessment in standardized training for PHC that is broadened to include ANC, IMCI, immunoprofylaxis, prevention of AEFI and VPD surveillance
3.2.2. Develop a training plan for PHC doctors and nurses taking into account capacity and mechanisms of existing projects to scale up
3.2.3. Train PHC staff (doctors and nurses) based on integrated and standardized programs)
3.2.4. Train PHC staff that conduct vaccination in methods of "Immunization in Practice" (all districts)
3.3. Conduct training for staff of public health services on VPD, AEFI surveillance
3.3.1. Develop and approve training program for public health services on VPD and AEFI surveillance
3.3.2. Develop and approve training schedule for PH staff .
3.3.3. Train public health services staff
3.4. Conduct timely investigation and undertake preventive measures to halt the spread of VPDs
3.4.1. Develop mechanisms for monitoring, surveillance, and reporting of VPDs

Main activities	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
3.5. Develop mechanisms and procedures for joint supervision (district health centers, district reproductive health centers, district centers for IMCI, centers for immunprofylaxis etc.)												
3.5.1. Establish a working group and develop integrated guidelines for supportive supervision (district health centers, district centers for reproductive health, district centers for IMCI)												
3.5.2. Develop and approve schedules of joint supportive supervision visits												
3.5.3. Train trainers in principles of joint supportive supervision, provide operational support and monitor implementation of supervision visits according to approved indicators and milestones												
3.6.1. Develop guidelines for PHC management on methods of data use and analysis for management decisions, monitoring, and planning												
3.6.2. Train PHC managers in data use and analysis for management decisions, monitoring and planning in order to improve performance of their facilities and increase effectiveness of PHC services (Per diems, transportation and handouts).												
4.1. Increase public awareness on importance of timely immunization and steps to be followed in case of home deliveries												
4.1.3. Develop TV and radio programs promoting timely ANC and immunization of children, particularly in case of home deliveries												
4.1.4. Transmit or air TV and radio programs developed under 4.1.3.												

Main activities	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
4.2. Broaden the existing mobilization programs on the basis of an integrated approach and scale up to the selected districts												
4.3.1. Conduct a round table with the most active NGOs (local and international) working on reproductive health issues and develop joint activity plans for increasing the population awareness about the importance of timely immunization and steps to follow in case of home deliveries												
4.3.2. Conduct training of trainers for all NGOs that have agreed for the joint activity plans and common approaches to community mobilization that focus on improving ANC rates, timely registration of infants and immunization, particularly in cases of home deliveries												
4.4.2. Pilot the system in selected districts (the number to be defined and the districts to be selected)												
4.5. Operational research on effectiveness and financial sustainability of the pilot (4.4) to evaluate the possibility for the scale up отдаленных селах												
4.5.1. Collect the baseline data and conduct a follow up survey												


Main activities
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
4.5.3. Final evaluation study to be discussed at the HSCC meeting and a decision on its scale up to be made
Objective # 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning
5.1. Improve the Health information System in Health Data Collection at primary level for further automatisation
5.1.2. Printing of the new reporting forms for PHC facilities nationwide
5.1.3. Conduct training in data source and collection and filling-in the new simplified forms for PHC staff at district level
5.2.1. Procure computers for PHC facilities for selected districts (not covered by existing projects such as SINO, ADB and the WB)
Administration

Section 6: Monitoring, Evaluation and Operational Research

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value[7]	Source[8]	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)	MoH, RCIP	80.6	MoH, RCIP	2006	95 %	2010
2. Number / % of districts achieving ≥80% DTP3 coverage	MoH, RCIP	52	MoH, RCIP	2006	100 %	2010
3. Under five mortality rate (per 1000)	MICS, UNICEF	93	MICS, UNICEF	2005	55	2010
4. Infant mortality rate (per 1000)[9]	MICS, UNICEF	65	MICS, UNICEF	2005	45	2010
5. HepB1 coverage (%)[10] – pilots and national	MoH, RCIP	80	MoH, RCIP	2006	90 %	2010
6. Number of annual average PHC contacts/visits per person in pilot districts	MoH, MCH	1.9	MoH, RMSC	2006	4.0[11]	2010

[7] If baseline data is not available indicate whether baseline data collection is planned and when
[8] Important for easy accessing and cross referencing
[9] Demonstrates quality of the antenatal and postnatal care, as well as behaviors/attitudes of caregivers
[10] Since the HepB vaccination is provided at the hospital level and PHC level in the first 24 hours after a delivery, the proposed indicator demonstrates project effectiveness in providing access to health services.
[11] The project targets the national annual average for PHC visits per person in pilot districts

6.2: Output Indicators

Main activities	OUTPUT INDICATOR/ MILESTONE	Data sources	Baseline	2008	2009	2010
Objective #1. Strengthen evidence-informed decision making at central and local government levels in order to build financial commitment for PHC services, focusing on immunization	Annual policy briefs based on impact analysis developed with focus on progress towards achieving MDGs #4 and #5	MOH/HRIR Dept	0	3 policy briefs distributed to stakeholders	3 policy briefs distributed to stakeholders	3 policy briefs distributed to stakeholders
Objective # 2. Increase access to PHC services in remote and hard-to-reach areas	# of RHFs in GAVI pilot districts that improved their physical infrastructure (renovated and equipped) under GAVI HSS	MOH/MCH Unit RHDs	0	0	36	0
	# of remote villages in pilot districts that received outreach services at least 2 times per year	MOH/MCH Unit RHDs	0	60	72	86
Objective # 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc	# of medical staff trained in integrated and standardized programs related to VPD, AEFI, IMCI, MCH at the PHC level (Including trainers, doctors, nurses)	MOH/MCH Dept and RCI	40	157	214	112
	% of reported VPD that received timely investigation	RCI Disaggregated data by rayons	50%	80%	90%	100%

Objective # 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	# of women benefiting of the conditional cash transfer program	MOH/MCH Dept/RHDs Disaggregated data by districts	0	0	3400	3400
Objective # 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning	# of PHC facilities submitting simplified reporting forms on time specified by the MOH HRIR Department	MOH/HRIR Dept	0	30	60	80

6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	Through existing monthly routine reporting system. No additional measures needed to collect required data.	Monthly at district level Quarterly at regional level and national coverage / drop out rates are calculated at all levels based on predetermined denominators. Performance is assessed according to preset coverage / drop out rate targets.	Quarterly feedback provided to sub-national levels RIC and low performing ones will be requested to respond, together with actions taken for improvement and/or additional inputs needed. Analyzed data will be presented at semi annual HSCC meetings and recommendations of HSCC will be forwarded to MoH to take/implement necessary actions. Annual progress reports will present analyzed data and recommendations to share the implementation progress with all stakeholders. The Project Unit will obtain data from RIC for the policy briefs
2. % of districts achieving ≥80% DTP3 coverage			

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		denominators. Performance is assessed according to pre-set coverage / drop out rate targets.	Analyzed data will be presented at semi annual HSCC meetings and recommendations of HSCC will be forwarded to MoH to take/implement necessary actions. The Project Unit will obtain data from RIC for the policy briefs
6. Number of annual average PHC contact per person	Data needed for this indicator is collected on annual basis No additional measures needed to collect required data.	Number of annual average PHC contact per person reflects utilization rate at PHC level. Rate is expected to increase gradually and achieve average National level by the end of the project. Utilization trend at PHC level will be analyzed on annual basis.	Annual average PHC contact per person will be presented at annual HSCC meetings to assess utilization trend of PHC services. Assessment of HSCC will be forwarded to MoH to take/implement necessary actions, if needed. Annual progress reports will present analyzed data and recommendations to share the implementation progress with all stakeholders. The Project Unit will use the data for the policy briefs
Output	**Data collection**	**Data analysis**	**Use of data**
Annual policy briefs based on impact analysis developed with focus on progress towards achieving MDGs #4 and #5	Health Reform and International Relations Department that supervises the activities of the Health Policy Analysis Unit responsible for the briefs.	Annually, at national level	Information will be used for planning, advocacy at the national level as well as locally, for assessment of intervention effectiveness and improving of PHC financing.
# of RHFs in GAVI pilot districts that improved their physical infrastructure (renovated and equipped)	Reports of Heads of RHFs in the pilot districts submitted to the MCH Department specialist hired under the GAVI HSS Grant	Semi-annually at district level, submitted to the national level for review and further integrated analysis	For rapid decision making, planning and review of plans, assessment of the effectiveness of interventions
# of remote villages in pilot districts that received outreach services at least 2 times per year	Administrative reports of the rayon health departments submitted to the	Semi-annually at district level submitted to the national level for	For rapid decision making, planning and review of plans, assessment of the

	MCH department with cross-checking through the regular field visits by the MCH Department specialist hired under the GAVI HSS Grant.	review and further integrated analysis	effectiveness of interventions
# of medical staff trained in integrated and standardized programs related to VPD, AEFI, IMCI, MCH at the PHC level (Including trainers, doctors, nurses)	MCH and RCI specialists hired under the GAVI HSS Grant using course participant lists and programs submitted by individual agencies/units conducting such training	Quarterly, at national level	For planning and assessment of the effectiveness of interventions интервенции
% of reported VPD that received timely investigation	Administrative reporting forms of the Heads of PHC facilities and Centers of Immunoprophylaxis submitted to the RCI	Data analysis will be done at the National level by the Republican Center of Immunoprophylaxis	For rapid decision making, planning and review of plans, assessment of the effectiveness of interventions
# of women benefiting from the conditional cash transfer program	Sources of data are health cards, household surveys (baseline and follow up), administrative reports of PHC facilities and rayon hospitals. Data will be collected by the Health Policy Analysis Unit as part of the Operational research. The MCH Department and RCI will be responsible for more regular data collection using administrative and financial reports.	Data analysis will be done at the district level as part of the baseline and follow up surveys.	For rapid decision making, planning and review of plans, assessment of the effectiveness of interventions
# of PHC facilities submitting simplified reporting forms on time specified by the MOH HRIR Department	Reports from the Centre on Medical Statistics and Information	Data analysis will be done at the National level by the Center of Medical Statistics and information of MoH and HRIR Department.	For rapid decision making, planning and review of plans, assessment of the effectiveness of interventions

6.4: Strengthening M&E system

The monitoring and evaluation for this project will require the combination of routine, survey and administrative data. However, weaknesses at facility and district levels to collect and manage data and limited surveillance capacity are considered to be key health system barriers in improving immunization coverage (Section 3.2). Thus, the Proposal incorporates several activities that have a specific aim of strengthening the country's M&E system. Specifically, activities under Objectives # 1, 3, and 5 will directly impact the quality, reliability, and timeliness of data collection, analysis and use. It is important to note here that the process of strengthening the monitoring capacity of the Tajik health system has already started through the support of a number of different donors. Thus, the Proposal is designed in such a way as to compliment the activities done by ADB, the World Bank, SDC, and USAID ZdravPlus Program (Section 3.4). Also, the operational research that will be managed by the Health Policy Analysis Unit of the MOH will serve to strengthen the MOH capacity to design, conduct and analyze surveys, and then use those results for further policy decisions.

6.5: Operational Research

Tajikistan is proposing developing and piloting a system of incentives using the international experience with Conditional Cash Transfers (CCT). Programs on conditional cash transfers (CCT) are increasingly recognized as effective mechanisms for increasing the demand for and use of health services by the poorest population groups living in the most remote under-developed areas. Given the success of the experience in Latin America, a number of countries in Sub-Saharan Africa, East Asia and Middle East (Turkey) are starting to implement similar programs. However, they are still treated with caution as the traditional approaches have focused on addressing the supply-side constraints. This is particularly the case in countries of ex-Soviet Union where governments focus almost exclusively on improving service delivery system through increased infrastructure or outreach activities.

While in recent years activities based on community involvement have gained in popularity, these have focused more on communication and social mobilization strategies than on overcoming the social and economic constraints to use of basic health services, including immunization. The problem is that simply accepting the importance of immunization does not guarantee that a household will access available services. Factors which increase the opportunity cost of seeking services, such as travel and waiting time costs and missing time from work, particularly for self-employed women are deterrents to demand for immunization services.

Under the proposed Program in Tajikistan health conditionalities will include but not restricted to the following: (a) enrollment of an infant in a PHC facility; (b) completion of vaccines according to the recommended schedule and regular health check-ups and growth monitoring for infants under 24 months; (c) pre- and post-natal checkups for pregnant women.

Targeting will be at geogrpaphic as well as household level. Eligibility for the CCT will be decided by village health committees based on the level of wealth of the household. The first 2 districts chosen for the pilot (Humsongir and Farhor) have some of the highest poverty rates (according to the LSMS 2005) and the largest number of children that have not received DTP 3 vaccine.

The main outcome measures of the study will focus on changes in program and non-program districts in the following three aspects:

1. Utilization of PHC services,
2. Share of fully immunized infants under 24 months, and
3. Nutritional outcomes for infants under 24 months.

The evaluation will also aim at assessing program impact and operational performance by examining: (1) the adequacy of CCT programs' administrative processes; and (2) the extent to which CCT programs reach poor areas and poor households.

To facilitate the monitoring process, for beneficiaries as well as for local health providers, each member of the family enrolled in the Program (infants under 24 months, pregnant and lactating women) will be provided with a health card. The health card will contain basic information on beneficiaries' health condition, history and a schedule of future health visits/required actions for the child/mother. This information will be recorded by the health agents for their record which will facilitate the monitoring process.

Prior to start of the Program there will be a baseline survey conducted in 2 pilot and 2 control districts. Control districts will be selected according to health utilization, immunization coverage and socio-economic indicators to match most closely to the pilot districts. A follow up survey will be conducted one year later in the same 4 districts. The data from these 2 surveys will allow difference-in-differences estimators to be applied to measure program impact.

As in most CCT evaluations, the evaluation of the Program in Tajikistan will rely on household surveys as the main data collection instrument. The questionnaire will contain a core set of questions about the demographic composition of the household, household expenditures, the socio-economic status, education, and health of household members. These will be supplemented by focus group discussions with beneficiaries focusing on perceptions of the program's social impact.

The research design will be modified as needed during the first quarter of the implementation of the Grant together with the exact set of conditionalities. The study will be carried out in collaboration with the Health Policy Analysis Unit that has been established in the Ministry of Health with the support of the CBHP financed by SIDA and the World Bank. The Unit already has experience in designing and managing large survey-based studies. The research design will be modified as needed during the first quarter of the implementation of the Grant together with the exact set of conditionalities. The study will be carried out in collaboration with the Health Policy Analysis Unit that has been established in the Ministry of Health with the support of the CBHP financed by SIDA and the World Bank. The Unit already has experience in designing and managing large survey-based studies.

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	

7.2: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organi-sation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Dr Salimov, Minister	MoH	yes	o Overall coordination and supervision of HSS implementation o Chairing of HSCC meetings, signing of all official reports and documents
	MoH	yes	o Co chair of the HSCC o Supporting the Minister in overall coordination and supervision of the proposal development process o Guidance to the technical units on managerial issues
Dr. Jobirova, First Deputy Minister of Health	MoH	yes	o Co-chair person of the HSCC o Supporting the Minister in overall coordination and supervision of the proposal development process o Guidance to the technical units on managerial issues
Dr Mirzoev Deputy Minister of Health	MoH	yes	o Co-chair person of the HSCC o Coordination of issues related to immunization and surveillance with HSS related projects
Dr Miraliev Advisor	MoH	yes	o Secretary to the HSCC o General communications among MoH departments, MoF, MoE&T and partners (local and international)
Dr Kurbanov Head of MCH Department	MoH	yes	o Coordination of all MCH-related activities under this project o Linking of HSS support with other MCH-related strategies and activities
Dr Bobokhojaev Head of Health Services Organization Department	MoH	yes	o Coordination with other health services and advice on implementation
Dr Azimov Head of Sanitary and Epidemiological Services	MoH	Yes	o Ensuring timely and adequate surveillance and monitoring of VPDs o Ensuring information sharing on surveillance activities for communicable diseases other than VPD
Dr Jobirov Director of Republican Center of Immunoprophylaxis	MoH	Yes	o Provision of information on immunization services o Monitoring of the influence of the HSS interventions on immunization services
Alamhon Naimi Head of Department	MoF	Yes	o Ensuring financial sustainability through timely and adequate fund allocation and transfer
Rahmonov A.A Deputy Minister	MoE&T	Yes	o Ensuring financial sustainability through evidence-based decision making and adequate resource allocation

Title / Post	Organi-sation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Country Office and Regional Office for Europe	WHO	Yes	o Transfer and disbursement of funds o Providing technical assistance to MoH in overall management of HSS Plan implementation (i.e., follow up of timely implementation, subcontracting, evaluation, reporting) o Provision of specific technical assistance in fields of: - Planning and budgeting - Training materials and guideline development - Supportive supervision - Performance-based payment system - Surveillance and reporting
Country Office	UNICEF	Yes	Provision of specific technical assistance in fields of: - Advocacy, - Training in immunization practices - Infrastructure development (procurement of basic equipments and cold chain materials) - Social mobilization and community involvement
Country Office	AKDN	Yes	Provision of specific technical assistance in fields of social mobilization and community involvement and training of PHC staff
Country Office	SIDA	Yes	Provision of specific technical assistance in fields of social mobilization and community involvement & PHC services.
Country Office	WB	Yes	Provision of specific technical assistance in field of - Training of health managers in pilot districts
Country Office	ADB	yes	Provision of specific technical assistance in fields of: - Performance-based payment system - Social mobilization and community involvement
Country Office	USAID	yes	Provision of specific technical assistance in fields of - health financing - Family Medicine
Country Office	SDC	yes	Provision of specific technical assistance in the fields of - Performance-based payment system - Social mobilization and community involvement - training in Family Medicine - clinical guidelines and protocols for PHC services - health management training, including training on developing of business plans in pilot areas

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channeling GAVI HSS funds into the country	GAVI HSS funds will be channeled into the country through a WHO trust fund
Mechanism for channeling GAVI HSS funds from central level to the periphery	GAVI HSS funds from central level to the periphery will be channeled through the subcontracted implementing agency for a given activity, such as a technical unit of the MoH or an in-country partner or an NGO.
Mechanism for budget approval	HSCC to approve budget for the main activities semiannually

Responsibility for budget use	WHO budget use procedures will be applied; WHO CO will be responsible for the financial reporting with the overall guidance. WHO Country Offcie will meet on a regular basis with the Ministry of Health to follow up on financial and logistical arrangements.
Mechanism for disbursement of GAVI HSS funds	WHO disbursement procedures will be applied.
Auditing procedures	Auditing procedures applied to WHO will be applicable for the GAVI HSS funds.

7.4: Procurement mechanisms

WHO procurement procures will be applied. Procurement procedures of other international partner organizations will be applied if they will be subcontractors and/or direct recipient of GAVI HSS funds for procurement of goods.

7.5: Reporting arrangements

The major reporting arrangement will be submission of annual progress reports (APR) to the GAVI Secretariat and sharing it with all relevant stakeholders. Health Reform and International Relations Department (HRIRD) at the MoH will be responsible for compiling and ensuring the quality of the APR, based on the relevant inputs provided by the MCH Department, RCI and WHO CO (responsible for financial management). Prepared APRs will be reviewed by HSCC and finalized according to HSCC evaluation and comments.
The HRIRD together with Health Policy and Analysis Unit will be preparing regular policy briefs, focused on analysis and police recommendation for the decision makers and stakeholders to build understanding and political support for health sector reforms.
HSCC evaluation, comments, recommendations and decisions will serve as a reporting mechanism for HSS-related stakeholders, through widely distribution of HSCC minutes of meetings which will take place twice a year.
Besides above arrangements, quarterly feedback will be issued by implementing units, based on received reports. These feedback reports will be open to all interested stakeholders.

7.6: Technical assistance requirements (*)

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Preparation of the policy briefs	2 months	1-2Q 2009, 2010	GAVI
2. Conduct needs assessment in selected districts and define a list of facilities that need to be renovated, needs in basic medical equipment and medical workforce	3 month	3Q 2008	GAVI
3. Conduct trainings to VHC on apply to MOH for support on renovation or refurbishment of HHs	2-3 months	4Q 2008	GAVI
4. Develop specifications on medical equipment and commodities for procurement for rural health facilities	3 weeks	3Q 2008	GAVI
5. Develop Job description, standard operating procedures and reporting for mobile teams	4 week	3Q2008	GAVI

6. Review the existing programs, develop and standardized programs at the national level	4 week 1week	3Q 2008	GAVI WHO
7. Develop training manuals on immunoprofylaxis to be included in existing training programs for PHC staff	1 month	3Q 2008	UNICEF
8. Reviewing surveillance system and reporting and developing training materials	1 month 1 week	2Q 2008 2Q 2008	UNICEF WHO
9. Develop mechanisms for monitoring, surveillance, and reporting of VPDs	1 week	3Q 2008 3Q 2008	UNICEF WHO
10. Develop mechanisms and procedures for joint supervision	1 month 1 week	3-4Q 2008 3 Q 2008	UNICEF WHO
11. Develop guidelines for PHC management on methods of data use and analysis for management decisions, monitoring, and planning	6 weeks 1 week	3 Q 2008 3Q 2008	GAVI WHO
12. Develop a system of incentives for mothers in close coordination with local self-governments (jamoats) and Rural health committees (CCTs)	10 weeks 2 weeks	3Q 208-1Q2009 4Q 2008	GAVI WHO
13. Operational research on effectiveness and financial sustainability of the pilot (4.4) to evaluate the possibility for the scale up	3 months 3 months 1 week 1 week	3-4 Q 2008 1Q 2010 4Q 2008 2Q 2010	GAVI GAVI WHO WHO

Section 8: Costs and Funding for GAVI HSS

8.1: Cost of implementing GAVI HSS activities

(a) Budget allocation for country activities

Area of support	*Cost per year in US $*			
	2008	2009	2010	GAVI TOTAL
TOTAL COSTS	**$282 235**	**$698 530**	**$333 800**	**$1 314 565**
Objective #1. Strengthen evidence-informed decision making at central and local government levels in order to build financial commitment for PHC services, focusing on immunization	**$0**	**$5 350**	**$5 350**	**$10 700**
1.1. Develop, publish and distribute policy briefs on impact of government policies and PHC reforms on MDGs #4 and #5 using the key monitoring indicators and results of different surveys		$2 250	$2 250	$4 500
1.2. Review issues on immunization coverage and PHC services in general at inter-sectoral government meetings, HSCC and Ministerial meetings during the budget formulation process to lobby for appropriate financing		$2 800	$2 800	$5 600
1.3. Review issues on immunization coverage and PHC services in general at regional, district and jamoat government meetings to lobby for appropriate financing based on evidence		$300	$300	$600
Objective # 2. Increase access to PHC services in remote and hard-to-reach areas	$136 846	$466 040	$131 040	$733 926
2.1.Renovate rural health facilities (Health Houses) in remote villages with counterpart participation of the local governments and local communities on the basis of their applications to the MOH (according to PHC rationalization plan)	$25 746	$191 000		$216 746
2.2.Provide basic equipment, including cold bags, medical supplies and small parts to PHC facilities in selected districts	$500	$144 000		$144 500
2.3. Provide operational support to PHC staff for conducting outreach activities through covering their transportation expenditures and per diems	$18 000	$72 000	$72 000	$162 000
2.4.Establish mobile teams on the basis of the needs assessment for poor hard-to-reach areas that do not have medical staff or where there is only one medical worker if she is away on a training course	$92 600	$59 040	$59 040	$210 680
Objective # 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc	**$47 691**	**$116 119**	**$86 744**	**$250 554**
3.1. Review existing training programs on IMCI, reproductive health, immunization conducted by different agencies and develop unified guidelines for PHC	$3 800			$3 800
3.2. Training on VPD and AEFI, IMCI, MCH for medical staff in PHC facilities in selected districts (not covered by current programs)	$19 500	$82 860	$63 360	$165 720
3.3. Conduct training for staff of public health services on VPD, AEFI surveillance	$7 875	$7 875		$15 750

Area of support	*Cost per year in US $*			
	2008	2009	2010	GAVI TOTAL
3.6. Conduct training of PHC management on data use, monitoring and planning to improve effectiveness of PHC services building on the training program developed under the WB/SIDA financed CBHP	$6 350	$2 000		$8 350
Objective # 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	**$15 500**	**$69 175**	**$68 820**	**$153 495**
4.1. Increase public awareness on importance of timely immunization and steps to be followed in case of home deliveries	$3 300	$800	$800	$4 900
4.2. Broaden the existing mobilization programs on the basis of an integrated approach and scale up to the selected districts		$13 350		$13 350
4.3. Harmonize activities of existing community health committees and NGOs working in the area of MCH, conduct short TOT workshops, and provide necessary methodological guidelines		$2 720	$2 720	$5 440
4.4. Develop and pilot a system of incentives for poorest mothers in hard-to-reach areas with high share of home deliveries based on international experience on conditional cash transfers	$700	$52 305	$51 000	$104 005
4.5. Operational research on effectiveness and financial sustainability of the pilot (4.4) to evaluate the possibility for the scale up	$11 500		$14 300	$25 800
Objective # 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning	**$66 400**	**$24 000**	**$24 000**	**$114 400**
5.1. Improve the Health information System in Health Data Collection at primary level for further automatisation	$38 400	$24 000	$24 000	$86 400
5.2. Build capacity for timely processing and exchange of data at district level	$28 000	$0	$0	$28 000
Management&Administration	**$15 798**	**$17 846**	**$17 846**	**$51 490**

(b) Total support costs for implementation of the GAVI HSS, extract from table (a)

Support costs	2008	2009	2010	Total GAVI HSS Reviewed Budget, Feb 2008	% to total GAVI HSS
GAVI HSS proposal	**$282 235**	**$698 530**	**$333 800**	**$1 314 565**	
Included:					
Management	$15 798	$17 846	$17 846	$51 490	3,9%
M&E	$11 500	$2 000	$11 500	$25 000	1,9%
Technical support (IOC)	$7 070	$6 790	$6 790	$20 650	1,6%
Total support costs	**$34 368**	**$26 636**	**$36 136**	**$97 140**	**7,4%**

8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation (GNI < $365 per capita)	Allocation per year (US$)				
	Year of GAVI application	Year 1 of implement-tation	Year 2 of implement-tation	Year 3 of implement-tation	TOTAL FUNDS
	2007	2008	2009	2010	
Birth cohort	193,054	197,205	201,445	205,776	
Allocation per newborn		$2,5	$2,5	$2,5	
Annual allocation		**$493 013**	**$503 613**	**$514 440**	**$1 511 065**

Source and date of GNI and birth cohort information:

GNI: $ 390 as of 2006 (World Bank)

Birth cohort: Tajikistan State Commission on Statistics and UN population estimations

8.3: Sources of all expected funding for health systems strengthening activities

Total estimated GAVI support for 2008-2010 is:
$1,485,469.75- 13% (WHO) = $1,314,575.00

Funding sources	2008	2009	2010	TOTAL FUNDS
Total GAVI support	**$318 926**	**$789 339**	**$377 194**	**$1 485 458**
GAVI support for country activities	$282 235	$698 530	$333 800	$1 314 565
Government	$3 400	$83 822	$2 822	$90 044
World Bank	$300	$7 000	$0	$7 300
WHO	$63 000	$0	$7 000	$70 000
UNICEF	$25 550	$6 000	$0	$31 550
Total Other	$92 250	$96 822	$9 822	$198 894
TOTAL FUNDING	**$374 485**	**$795 352**	**$343 622**	**$1 513 459**

Source of information on funding sources:

GAVI: .....
.....

Government: Local Budget (Ministry of Finance) .....

World Bank : International Development Association/SIDA.....
.....

UNICEF: UNICEF, JICA, TICA .....
.....

WHO : WHO regular budget .....
.....

Total other:.....
.....

Section 9: Endorsement of the Application

9.1: Government endorsement

The Government of Tajikistan commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Health:

Name: Dr. Nusratullo Salimov

Title / Post: Minister of Health

Signature:

Date:

Ministry of Finance:

Name:

Title / Post:

Signature:

Date:

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on March 4, 2008The signed minutes are attached as Annex 1.

Chair of HSCC (or equivalent):

Name: Dr Jobirova

Post / Organisation: Deputy Minister of Health

Signature:

Date:

Annex 1. Documents Submitted in Support of the GAVI HSS Application

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
National Health Sector Strategic Plan (or equivalent) Relevant Pages of the National Strategic Documents are attached: - National Development Strategy of the Republic of Tajikistan for the period to 2015 (Dushanbe, August 2005)	Yes	2015	1
- Poverty Reduction Strategy Paper. **(**Стратегия Снижения Бедности Республики Таджикистан на 2007-2009 Годы. Душанбе – 2006)		2009	2
- Conception of Health Care Reform of the Republic of Tajikistan			3
cMYP[13]	Yes	Till 2010	4
MTEF[14]	No		Not applicable

[13] If available – and if not, the National Immunization Plan plus Financial Sustainability Plan
[14] if available please forward the pages relevant to Health Systems Strengthening and this GAVI HSS application

Recent Health Sector Assessment documents: - The strategy of the Republic of Tajikistan for Improvement of Reproductive Health Care, MoH - The Strategy of the Republic of Tajikistan on Human Resource Development developed by MoH/ADB Project on Health Sector Reform - Preliminary Report on Findings of 2005 MICS Survey, State Committee on Statistics and UNICEF - Tajikistan Health Sector Note of the WB published in 2004. - The Strategy of the Republic of Tajikistan on the Health of the Population to 2010 - MDG National Assessment 2005	Yes		Not attached
HSCC minutes, signed by Chair of HSCC	Yes		5
Letter of MoH to GAVI on WHO assistance for fund – holding and technical support	Yes		6

ANNEX 2 Banking Form

GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION	Banking Form

SECTION 1 ***(To be completed by payee)***

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunization dated . . . . . , the Government of . . . . . hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: ***(Account Holder)***		
Address:		
City – Country:		
Telephone No.:	**Fax No.:**	
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**
For credit to: ***Bank account's title***		
Bank account No.:		
At: ***Bank's name***		

Is the bank account exclusively to be used by this program? **YES ( ) NO ( )**

By whom is the account audited? ----------

Signature of Government's authorizing official:

Name: ----------	**Seal:**
Title: ----------	
Signature: ----------	
Date: ----------	

SECTION 2 *(To be completed by the Bank)*

FINANCIAL INSTITUTION	**CORRESPONDENT BANK (*In the United States)***
Bank Name:	
Branch Name:	
Address:	

City –

COVERING LETTER

(To be completed by UNICEF representative on letter-headed paper)

TO: GAVI – Secretariat
Att. Dr Julian Lob-Levyt
Executive Secretary
C/o UNICEF
Palais de Nations
CH 1211 Geneva 10
Switzerland

On the ……. I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	.....	.....
Bank's authorizing official	.....	.....

Signature of UNICEF Representative:

Name .....

Signature .....

Date .....