



Health System Strengthening (HSS) Cash Support

Application Package –Proposal Form

This proposal form is for use by applicants seeking to request Health Systems Strengthening (HSS) cash support from the GAVI Alliance. Countries are encouraged to participate in an iterative process with GAVI Alliance partners, including civil society organisations, in the development of HSS proposals prior to submission of this application for funding.

TABLE OF CONTENTS

TABLE OF CONTENTS	1
PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION	5
PART B – EXECUTIVE SUMMARY	8
PART C– SITUATION ANALYSIS	10
1. Key relevant health and health system statistics.....	10
2. Description of the National Health Sector.....	11
3. National Health Strategy and Joint Assessment of National Health Strategy (JANS).....	14
4. Monitoring and Evaluation Plan for the National Health Plan.....	14
5. Health System Bottlenecks to Achieving Immunisation Outcomes	15
6. Lessons Learned and Past Experience.....	19
PART D - PROPOSAL DETAILS	21
7. Objectives of the Proposal.....	21
8. Results Chain	24
9. Monitoring & Evaluation Framework.....	26
10. The Proposal Development Process.....	27
PART E – BUDGET, GAP ANALYSIS AND WORKPLAN	29
11. Detailed Budget and Workplan Narrative	29
12. Gap Analysis & Complementarity.....	30
13. Sustainability	31
PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION	33
14. Implementation Arrangements	33
15. Involvement of CSOs.....	33
16. Technical Assistance.....	34
17. Risks and Mitigation Measures.....	35
18. Financial Management and Procurement Arrangements	37
SUMMARY OF A COMPLETE APPLICATION	41

A completed application comprises the following documents. Countries may wish to attach additional national documents as necessary (see list at the end of this form).

HSS Proposal Forms and Mandatory GAVI attachments		
→ Please place an 'X' in the box when the attachment is included		
No.	Attachment	X
1.	HSS Proposal Form	X
2.	Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members	X
3.	HSS Monitoring & Evaluation Framework	X
4.	Detailed work plan and detailed budget	X

Existing National Documents - Mandatory Attachments		
Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.		
→ Please place an 'X' in the box when the attachment is included		
No.	Attachment	X
5.	National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions	X
6.	National M&E Plan (for the health sector/strategy)	X
7.	National Immunisation Plan	X
8.	Country cMYP	X
9.	Vaccine assessments (EVM, PIE, EPI reviews), if available	X
10.	Terms of Reference of Health Sector Coordinating Committee (HSCC)	X

All applicants are encouraged to read and follow the accompanying guidelines in order to correctly fill out this form. Each corresponding section within the Guidelines provides more detailed instructions and illustrative instructions on how to fill out the proposal form.

GAVI's Approach to Health System Strengthening

The following bullets outline GAVI's approach to health system strengthening and should be reflected in an HSS grant:

- One of GAVI's strategic goals is to *"contribute to strengthening the capacity of integrated health systems to deliver immunisation"*. The objective of GAVI HSS support is to address system bottlenecks to achieve better immunisation outcomes, including coverage and equity. As such, it is necessary for the application to be based on a strong bottleneck and gap analysis, and present a clear results chain demonstrating the link between proposed activities and improved immunisation outcomes.
- GAVI's approach intends to deliver and document results. The performance of the HSS grant will be measured through intermediate results as well as immunisation outcomes such as diphtheria-tetanus-pertussis (DTP3) coverage, measles coverage, and percent of districts reporting at least 80% coverage. Therefore the application must include a strong Monitoring & Evaluation (M&E) framework aligned with the national M&E plan or national M&E processes.
- Performance based funding is a core approach of GAVI HSS support. All applications must align with the new GAVI performance based funding (PBF) approach introduced in 2012. Countries' performance will be measured based on a predefined set of PBF indicators against which additional payments will be made to reward good performance in improving immunisation outcomes.
- GAVI supports the principles of alignment and harmonization (in keeping with Paris, Accra and Busan declarations and the International Health Partnership, IHP+). The application must demonstrate how GAVI support is aligned with country health plans and processes, complementary to other donor funding, and uses existing country systems, such as for financial

management and M&E. The IHP+ Common Monitoring and Evaluation Framework is used as a reference framework in these guidelines.

- GAVI supports the use of Joint Assessment of National Strategies (JANS). A JANS assessment is not a requirement for a GAVI HSS application. If a country has conducted a JANS assessment the findings can be included in the HSS application. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.
- GAVI encourages a consultative and participatory approach for developing this HSS proposal, particularly across relevant departments in the Ministry of Health (including Planning, EPI, HMIS, M&E), across development partners, and civil society. While the HSCC (or equivalent) is required to sign off on this application, the ICC (or equivalent) also needs to be consulted and involved in the proposal development process.
- GAVI encourages countries to request funding for technical support in their HSS application for grant implementation, monitoring and capacity building.
- GAVI encourages countries to identify and build linkages between HSS support and new vaccine introduction support (as GAVI New Vaccines Support). These linkages must be demonstrated in the application. Countries will need to demonstrate systems readiness¹ for new vaccine introductions in the context of routine immunisation services. GAVI HSS support will be for strengthening these routine immunisation services.
- GAVI's approach to HSS includes support for strengthening information systems and improving data quality. Strong information systems are of fundamental importance both to countries and to GAVI. Countries are strongly encouraged to include in their proposals actions to strengthen data systems, including surveys and the institutionalization of routine mechanisms to track data quality improvements over time.
- GAVI supports innovation. Countries are encouraged to be innovative in their identification of activities which will have a catalytic effect on addressing HSS bottlenecks to improving immunisation outcomes.
- GAVI encourages applicants to include funding for Civil Society Organisations (CSOs) in implementation of HSS support to improve immunisation outcomes. CSOs can receive GAVI funding through two channels: (i) funding from GAVI to MOH and then transferred to CSO, or (ii) direct from GAVI to CSO. Please refer to Annex 4 of the guidelines for further details.
- Applications must include details on lessons learned from previous HSS grants from GAVI or support from other sources.
- Applications must include information on how sustainability and equity (including geographic, socio-economic, and gender equity) will be addressed.
- Applications will need to show the additionality of GAVI support to reducing bottlenecks and strengthening the health system, relative to support from other partners and funding sources.
- Cash disbursed for HSS support must be used solely to fund HSS activities. These funds may not be used to purchase vaccines or meet GAVI's requirements to co-finance vaccine purchases, and shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies.

¹ For a definition of 'systems readiness' see: http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/

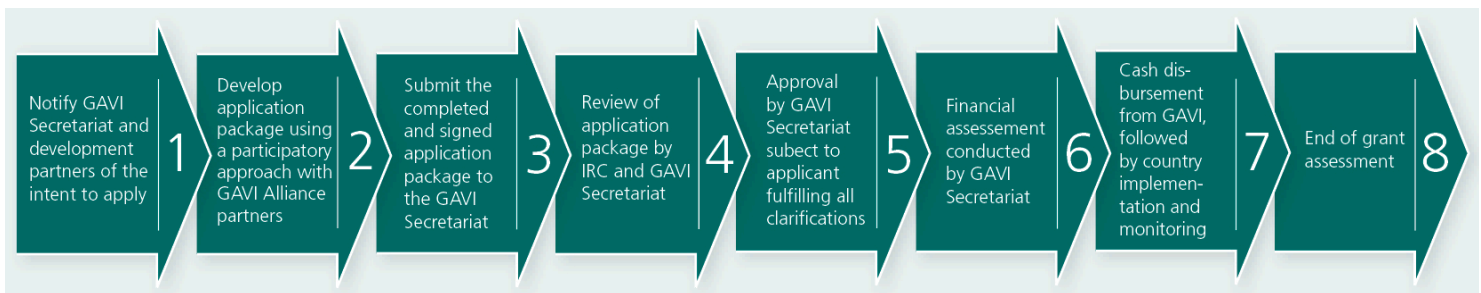
Application and Implementation Process

This application form has key instructions, but for more detailed information please see the attached guidelines for completing a GAVI HSS proposal. The application process for GAVI HSS proposals is similar to the process of applying for new and underused vaccines. The process of taking a decision to apply for GAVI funding and work with GAVI Alliance partners to develop a proposal (Steps 1 and 2 in Figure 1 below) will require adequate time; as much as possible, it should be planned to link with existing country planning processes.

Countries are encouraged to participate in an iterative process with GAVI Alliance partners, CSOs and development partners in the development of HSS proposals prior to submission of this application for funding. Steps 1-7 indicate the standard steps for GAVI HSS application process. Countries should allow 9-12 months for these steps. Steps 1-3 are expected to take 3-4 months, while steps 4-7 typically take 6-9 months.

Please note that if approved your application for HSS support will be made available on the GAVI website and may be shared at workshops and training sessions. Applications may also be shared with GAVI Alliance partners and GAVI's civil society constituency for post-submission assessment, review and evaluation.

Figure 1: Application and Implementation Process



PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION**For further instructions, please refer to the Guidelines for Completing the HSS Application**

Applicant:	<i>The Ministry of Health, Republic of Uzbekistan</i>
Country:	<i>Uzbekistan</i>
Proposal title:	<i>Health System Strengthening for Immunization</i>
Proposed start date:	<i>July 1, 2014</i>
Duration of support requested:	<i>4.5</i>
Total funding requested from GAVI:	<i>USD17,218,480</i>

Contact Details

Name	<i>Dr Dilorom Tursunova</i>
Organisation and title	<i>Deputy Head of Department, Ministry of Health</i>
Mailing address	<i>12 Navoi St., Tashkent, Uzbekistan</i>
Telephone	<i>+998 71 2441603</i>
Fax	<i>+998 71 2394721</i>
E-mail addresses	<i>dilorom.tursunova@minzdrav.uz</i>

Signatures: Government endorsement

Please note that this application will not be reviewed or approved by GAVI without the signatures of both the Ministers of Health & Finance and their delegated authority.

Minister of Health

Name: Prof. Anvar Alimov

Signature: (signed)

Date: 13 September 2013

Minister of Finance (Head of Finance Department, MOH)

Name: Mr. Bakhtiyor Khashimov

Signature: (signed)

Date: 13 September 2013

HSCC SIGNATURE PAGE
For submission with GAVI HSS application

Health Sector Coordination Committee

Country: UZBEKISTAN

Date of HSS application: SEPTEMBER 2013

We the members of the HSCC, or equivalent committee [1] met on 13.09.2013 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

[1] Health Sector Coordination Committee or equivalent committee which has the authority to endorse this application in the country in question.

Name of the HSCC in country: Inter-Agency Coordination Committee expanded with the Working Group on Health Systems Strengthening

Health Sector Coordination Committee			
Name/Title	Agency/Organisation	Signature	Date
Saidmurad Saidaliev, Deputy Minister	MOH		
Bakhtiyor Khashimov, Head of Department	MOH		
Kamil Mukhamedov, Head of Department	MOH		
Bakhrom Almatov, Chief Doctor	RCSSES		
Dilorom Tursunova, Deputy Head of Dept, SSES	MOH		
Shahin Huseynov, Technical Officer	WHO		
Kamola Safaeva, Health Officer	UNICEF		
Sevil Abdurakhimova, Project Manager	JPIB		
Abdukhalil Kamalov, Manager	JPIB		
Lyutsia Kim, Head of Department	RCSSES		
Dildora Adilova, Accountant	RCSSES		
Gafur Tajibaev, Deputy Chief Doctor	RCSSES		
Dilbar Makhmudova, Adviser	Institute of Pediatrics		
Erkim Musabaev, Director	Institute of Virology		
L. Ambartsumova, Head of Department	Ministry of Finance		
R. Zadorozhnaya, Head of Department	Ministry of Economy		
Kh. Fayzullaev, Deputy Head of Fin Department	MOH		
Rafael Klivleev, Head of Acc Department	MOH		
B. Odilova, Lead Specialist, PHC Department	MOH		
Z. Mukahmedov, Head of Department	MOH		

Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes No

Individual members of the HSCC may wish to send informal comments to: gavihss@gavialliance.org
 All comments will be treated confidentially.

PART B – EXECUTIVE SUMMARY

For further instructions, please refer to the Guidelines for Completing the HSS Application

→ Please provide an executive summary of the proposal, of no more than 2 pages, with reference to the items listed below:

1. The main bottlenecks for achieving immunisation outcomes addressed within this proposal and how proposed objectives in this application will address these bottlenecks and improve immunisation outcomes.
2. Objectives and the related budget for each objective.
3. The proposed implementation arrangements including the role of government departments and civil society organisations. Please include a summary of financial management, procurement and M&E arrangements.

The Government of Uzbekistan is applying for GAVI support in Health System Strengthening (HSS) for immunization; the total requested funding is US\$17,218,480.

The national Immunization Programme in Uzbekistan is traditionally robust as proven by high immunization coverage against major antigens during past years.

However, some health system bottlenecks still affect the performance the immunization system. Achievements of the immunization system cannot be sustained if the following bottlenecks are not addressed in next 5 years:

- 1) Obsolete and insufficient **infrastructure** of the State Sanitary Epidemiologic Services
- 2) Weaknesses in the **legal environment** that regulates procurement and distribution of injection supplies, institutionalization of supportive supervision of immunization and other preventive services
- 3) Weaknesses related to **workforce**: Insufficient skills (due to high turnover rate) among vaccinators/nurses health care professionals to manage vaccines and deliver immunization services; improper immunization related medical practices as the PHC care level (in some facilities) due to the lack of knowledge and clinical oversight on quality of care
- 4) Weak **management** of PHC care facilities as autonomous entities, including financial management and planning of resource requirements (including vaccines and injection supplies)
- 5) Lack of modern **information management** practices, that affects efficiency and effectiveness of decision making in areas of communicable disease prevention and mother and child health

If problems with infrastructure and legal environment directly affect achievement of immunization outcomes in long run (thus can be considered as “immunization system specific”) then scope of issues on workforce, management and information is much broader and if addressed can benefit substantially service delivery and management practices.

The following objectives are proposed to address health system bottlenecks affecting achieving immunization outcomes:

Objective #1: Increase performance and sustainability of immunization services, objective budget \$11,084,930

Objective #2: Improve management of PHC services, objective budget \$1,873,900

Objective #3: Increase demand on preventive and MCH services, objective budget \$911,000

Objective #4: Strengthen data collection and reporting for MCH services, objective budget is \$2,423,160

The Grant implementation will be managed by Implementation Unit (IU) established in the Ministry of Health. The Ministry of Health assumes full responsibility for the implementation of the HSS grant in front of the GAVI Alliance and development partners. The Minister of Health will delegate the grant administration powers to deputy ministers: the Implementation Unit will be supervised by the First Deputy Minister (also in charge of PHC, inpatient care, diagnostic and treatment standards and regulations) and will be subordinated to the Deputy Minister, Chief Sanitary Inspector. The head of “Main Economic and Financing Department” will provide oversight on budget planning and execution.

The expanded ICC will assume the role of health sector coordination committee for the provision of oversight in HSS grant implementation: it will include review and endorsement of HSS implementation progress reports (at

least twice a year), review and endorsement of annual work plans and budgets, coordination with other health sector strengthening undertakings supported by the development partners.

Monitoring and evaluation of the grant will be carried out the Implementation Unit on a regular basis in accordance with the M&E Framework attached to the application Form. Monitoring and Evaluation specialist will be responsible for data collection, data validation, measurement of implementation progress (in addition to calculating achievements for output/intermediate result indicators) and preparation of M&E reports. Financial and managerial accounting will be carried out by a financial officer. The following specialists will be directly responsible for the implementation: Immunization and health system specialists, Procurement specialist and IT and management information system specialist and logistician. Monitoring and evaluation specialist will be in charge of collecting information, assessing progress in accordance with the M&E plan and production of reports. The program management is estimated to cost 877 thousand US\$, that is 5% of the HSS proposal's total budget.

TWO PAGES MAXIMUM

PART C– SITUATION ANALYSIS

For further instructions, please refer to the Guidelines for Completing the HSS Application

1. Key relevant health and health system statistics

→ Please complete the table below providing the most recent statistics for the key health, immunisation, and health system indicators listed.

→ Where possible, data on the key statistics should be presented showing wealth quintile differences, and disaggregated by sex.

→ If available disaggregated data for the key statistics indicators showing differences by geographic location (region / province) and urban / rural should be included in the space provided after the table.

*Where possible, GAVI asks for both country administrative data as well as from 'other' data sources. Please state the source of 'other' data in brackets after entering the value. 'Other' recommended data sources are DHS/MICS or recent coverage estimates from WHO/UNICEF. If the difference between these reported data are more than 5% points, the country should include an explanation as to how they plan to strengthen data quality as part of the HSS grant.

Key Statistics

Indicator	Source	National Average	Percentage difference between highest & lowest quintiles	Sex (Please provide disaggregated data where available)			Year
				M	F	Total	
DTP3 coverage	Administrative Data	99%	n/a	n/a	n/a	598360	2012
	Other* (state source)	n/a					
Measles 1 st dose coverage	Administrative Data	99.7%	n/a	n/a	n/a	606318	2012
	Other* (state source)	n/a					
Drop-out rate between DTP1 & DTP3	Administrative Data	0.3%	n/a	n/a	n/a	1619	2012
	Other* (state source)	n/a					
Percent of districts with DTP3 coverage ≥80%	Administrative Data	96%	n/a	n/a	n/a	190	2012
	Other* (state source)	n/a					
DTP3 coverage in the lowest wealth quintile is +/- X% points of the coverage in the highest wealth quintile	Administrative Data	n/a	n/a	n/a	n/a		
	Other* (state source)	n/a					
Fully immunised child coverage (%)	Administrative Data	96%	n/a	n/a	n/a	579502	2012
	Other* (state source)	n/a					

Additional Health System Statistics

Indicator	Source	Value	Year
Under Five Mortality	Administrative Data	20.8	2010
	Other*	49, WHO	2011

	(state source)		
Total Expenditure on Health (THE) as percentage of GDP	Administrative Data	5.4%	2011
	Other* (state source)	n/a	
Per capita expenditure on health	Administrative Data	\$80	2011
	Other* (state source)	n/a	
Total health sector budget for the year of application	Administrative Data	\$2,760,088,266	2011
	Other* (state source)	n/a	
Percent of the health sector budget funded by the government from domestic sources	Administrative Data	92.8%	2013
	Other* (state source)	n/a	
Budget of EPI programme for the year of application	Administrative Data	\$2,575,000	2013
	Other* (state source)	n/a	
Percent of subnational level facilities with cold chain capacities fit for purpose (based on WHO definition "fit for purpose")	Administrative Data	100%	2012
	Other* (state source)	n/a	
Timeliness and completeness of facility and district (or equivalent) reporting	Administrative Data	100%	2012
	Other* (state source)	n/a	

Please use the space below to provide:

- **Explanation of any disparities between administrative statistics and 'other' statistics and details of any plans to improve data quality to address these disparities.**
- **Further disaggregation of the Key Statistics Indicators (if available). This data will be used to illustrate equity differences by geographic location and urban/rural.**

THREE PAGES MAXIMUM

2. Description of the National Health Sector

This section will provide GAVI with the country context which will serve as background information during the review of the HSS proposal.

→ *Please provide a concise overview of the national health sector, covering both the public and private sectors, including CSOs, at national, sub-national and community levels, with reference to NHP or other key documents.*

→ *Please include a copy of the National Health Strategy/Plan as Attachment 5. If the NHP is in draft format please provide details of the process and timeline for finalising it. If there is not an NHP, or if other documents are referenced in this section, please provide these other relevant documents.*

It is recommended that applicants refer to GAVI's health system strengthening grant categories detailed in the Application Guidelines (Table 1, Under 'Key Terms'). For each of the categories listed in the Guidelines (2.1-2.7) please provide a short commentary. In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, and provide reference to the relevant section in the National Health Plan for further detail.

Service delivery:

Uzbekistan's health services organization and delivery is based on rayon and oblast administrative areas. Responsibility for primary and secondary care rests with rayons and cities within rayons (districts). There are 1,132 hospitals and 4,310 outpatient facilities. There are 159 rayon-level hospitals and 847 city hospitals in oblasts (264 of which are private) and 107 in Tashkent.

In Uzbekistan, preventive services in the area of maternal and child health care are provided at the level of general

practice. Maternal and child health care is provided strictly within the public health system and is included in the program of state guarantees.

Routine immunization delivery in Uzbekistan is based on fixed immunization point strategies – vaccines are administered through the network of **5,000 sites**. BCG1 and OPV0 are administered in maternity hospitals. In rural areas, at SVPs, vaccination is carried out on specific days in order to decrease vaccine wastage when using multi-dose vials.

Since the mid-1990s, Uzbekistan has undergone major reforms, with a health sector that has focused on restructuring Primary Health Care (PHC) in rural areas and establishing an emergency medical care network. In PHC, the country has implemented a standard approach to the training of general practitioners (GP), upgrading the rural PHC infrastructure³ and the allocation of equipment for GP rural clinics. According to the Analytical Review of PHC Development in Uzbekistan (2011), 3,195 autonomous Rural Medical Facilities (SVPs) outfitted with modern equipment for preventive and medical services operate in Uzbekistan.

Total population receiving preventing and health care at rural PHC facilities exceeds 17 million people. Average number of catchment area patients is 1,500-2,500 per GP (considered as 1 and 1.5 working shifts respectively). In 2010, visits of rural residents to outpatient health facilities amounted to 9.3 (per one rural resident), which is by an order of magnitude greater than figures from 2006 or 7.5 throughout Uzbekistan (6). The percentage of rural patient visits to general practitioners increased from 22.2 % 2003 to 58.8 % in 2010 (Statistical Report from the Institute of Health 2010).

The Ministry of Health has been implementing the urban PHC reform since 2006. The urban PHC model is being piloted at 25 polyclinics of Tashkent, Gulistan, Samarkand, and Margilan cities under World Bank-supported “Health-2” project. New urban FP and Central Counseling and Diagnostic Polyclinics (CCDP) have been established within the current reforms (renamed later into “Central Multi-Profile Polyclinics”). Teams of GPs and patronage nurses have been created at the former type of health facilities, while the latter are staffed with a team of narrow specialists, where patients are referred as necessary to receive advice from doctors with particular specialties.

Workforce/human resources:

In 2010, the health care system in Uzbekistan employed 72,522 physicians and 299,186 midlevel staff as compared to 2006, when 70,564 physicians and 261,901 midlevel staff worked for the system. This indicator of physician availability per 10,000 people for the same year of 2010 decreased and amounted to 25.7 (15) as compared to 2005 indicator of 26.9. Midlevel health staff availability increased to 105.97 as compared to 2006 indicator of 99.5 (15). Staffing of PHC facilities and distribution of health professionals by districts is described in 4.1 “Accessibility of Services”, page 64 of Attachment #10).

Currently, there are three ways of training general practitioners: first, there is pre-service training of certified specialists at medical universities; second, working medical specialists are retrained at ten-month courses on the premises of newly created and equipped training centers at medical universities; and, third, they are trained under a system of continuous education recently introduced in Uzbekistan. Training centers provided with necessary equipment (training dummies, models, and computers) have been set up to upgrade clinical knowledge and skills of senior medical students. Central District Hospitals have set up and equipped training classes for GPs to ensure their continuous professional development (see details in Section 2, page 25, Attachment #10).

Up to 3770 doctors working in SVPs in rural areas had underwent 10-month retraining program under the WB supported Health2 project built upon the success of the training program piloted in Health 1 project (with the WB and DfID support) (see Attachment #11).

Family polyclinics in urban areas are legally autonomous, equipped with state-of-the-art technology, and their staff was trained in the same manner as general practitioners at rural PHC facilities. As of 2011, 700 physicians from urban family polyclinics have received training under the ten-month program, while the parallel continuous professional development program provides training doctors in various areas of health care and more than 3,000 nurses have been trained in different fields of medicine.

Immunization training is included in curriculum of Doctors Post-Graduate Training Institute as a module in a mandatory re-certification course for managers, epidemiologist, and GPs. Vaccination nurses undergo an annual re-certification process on vaccination practices.

Procurement & supply chain management:

Procurement and supply of medicines and disposals are decentralized: beginning in 2010, medications are delivered to SVP in a centralized manner through pooled procurement at the level of regional (oblast) departments of health, which enables purchasing medications in bulk at a cheaper price and free SVPs from the need to prepare a set of bidding documents. (see details in Assessment of the National Immunization Programme, section “Procurement and funding”, page 16, Attachment #12)

Since 2012, all EPI vaccines for children up to and including 2 years of age and for re-vaccination of adolescents

at 7 and 16 years of age are procured through the State budget and supplied to the national program twice a year through UNICEF Procurement Services. Domestic vaccine supply chain has four levels. National store distributes vaccines four times a year to all subnational stores (R. Karakalpakstan, Navoi Mining Company, all oblasts and Tashkent city). Centrally procured immunization supplies are distributed once or twice a year. Once every month, rayon stores using their own vehicles travel to oblast stores to pick up vaccines and supplies. Health centres, using the same requisition system, collect vaccines from the rayon cold stores using public transportation (see details in Section 4 “Supply chain overview”, EVM Assessment 2012 Report, Attachment #13). The rest of vaccines for children above 2 years of age are procured by Oblast level health authorities (see details in cMYP, pages 13-, Attachment #01)

Vaccines for routine immunization are procured at the national level but separately from injection supplies.

Health information system

Routine data on PHC reforms offered by traditional systems of health information, currently, fail to meet the needs of numerous stakeholders. Regrettably, present day information systems in Uzbekistan are isolated, different ministries and agencies accumulate data individually, the data are not always integrateable across sectors, and most indicators related to social factors and people’s health are insufficient and need to be updated. (see section 1.5.1 “The use of Information Systems for Interests of the PHC Reform”).

Uzbekistan strengthened a management information system in MoH under Health 2 project by: a) procuring hardware and software and training designated personnel; b) equipping 1,536 rayon ICT centers with computer equipment, diesel-generators and air-conditioners.

Most importantly, an integrated electronic database for surveillance of communicable diseases (IS IDES) was introduced. Development of HMIS under the project resulted in the creation of the Data Processing Centre under the Ministry of Health. This Centre promotes the information system for monitoring communicable diseases throughout the country and supports the creation of an IS for monitoring non-communicable diseases. In the future, the Centre shall become a major tool supporting justified decisions related to healthcare system management. Namely, under the Health III project, the Centre shall support implementation of HMIS at RMUs, thus accelerating the reforms of management and funding nationwide. Uzbekistan intends under Health 3 project to develop a health information system for the hospital financing pilot in preparation for potential national level rollout.

Community and other local actors:

Community level actors involvement in PHC support and strengthening is limited, although traditional community based organizations – Mahalla committees are important actors in the provision of social and other public services.

Legal, policy and regulatory environment

The legal framework for public health in Uzbekistan is, in the first place, the Constitution of the Republic of Uzbekistan declaring every citizen’s right to health care and the law of the Republic of Uzbekistan “On Protection of Citizens’ Health” (1996) aimed at guaranteeing the rights of citizens to health care from the government, healthy lifestyle promotion, legal regulation of activities of state agencies, enterprises, institutions, organizations, public associations in the field of public health protection.

There is a wide array of laws and by-laws that regulates various aspects of the healthcare system including organization, governance, financing and delivery of health care services (see details in sub-section 1.1 Policy Development, page 15 of the Analytical Review, Attachment #10).

Presidential Decree UP-2107 as of November 28, 1998 adopted the first national program, which identified a phased approach to developing the national model of health care. Together with the Presidential Decree No. UP-3923 (as of 19 September 2007 On Main Areas of Further Deepening of Reforms and the Implementation of the State Program of Health Care Development, see Attachment #22) it represents the major health sector development roadmap.

Financing of health system

The state system of health care financing in the Republic of Uzbekistan has been historically set up on the basis of the Soviet model of health care, where free-of-charge health care services to population by state owned health facilities with the objective to ensure equal access to the health care of all categories/groups of population formed the core of the system.

After successful piloting of a model of per capita financing of rural PHC facilities (under Health 1 and 2 projects), this approach was adopted by the Cabinet of Ministers in 2005 (Resolution No. 217). According to the resolution, more legal and financial autonomy was granted to PHC facilities. As of now, all PHC facilities are financed on a per capita basis.

Although case-based financing of inpatient care was piloted under USAID-funded Zdrav-plus project, resource

allocation to hospitals is still input based (reflecting nominal capacity, e.g. the number of beds and not the volume of services provided).

According to the World Bank data, Uzbekistan's GNI in 2012 was \$1720 per capita, and thus Uzbekistan is entering the group of countries graduating from GAVI's support. The upcoming graduation poses significant challenges to sustainability of the immunization financing. A multi-agency WHO/UNICEF/GAVI assessment mission will be visiting Uzbekistan on 23-27 September 2013 to discuss implications of the graduation with the government of the country and advocate for sustainable financing. The results of the mission will be communicated to GAVI and the IRC.

TWO PAGES MAXIMUM

3. National Health Strategy and Joint Assessment of National Health Strategy (JANS)

This section will be used to determine how immunisation is addressed in the national health plan, and what the key findings of an independent JANS assessment of the strategy were. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.

- *Please provide a reference to the relevant sections and pages in the NHP which outline immunisation policies, objectives, and activities.*
- *If a Joint Assessment of the National Health Strategy (JANS) has been conducted, please provide the JANS report as an attachment.*
- *Please provide a summary of how the government and partners have addressed the weaknesses and recommendations identified in the JANS or attach the country's response.*

ONE PAGE MAXIMUM

4. Monitoring and Evaluation Plan for the National Health Plan

This section will provide background information on how the country organises M&E arrangements and whether this proposal is aligned and complementary to national M&E plans.

- *Please attach a copy of the M&E Plan for the national health plan.*
- *Please provide a summary of how the National M&E Plan is implemented in practice. In your answer refer to relevant sections of the M&E Plan in the national health plan for further details.*
- *Please provide a description of how development partners are involved in the M&E of the national health plan implementation and financing. Is there a Joint Annual Health Sector Review (JAR) and if so how and when are they are conducted? Please outline the extent of GAVI involvement in the JAR process.*
- *Is the immunisation programme review linked to the Joint Annual Review (JAR)? Please state Yes/No.*

There is no standalone national health plan in Uzbekistan. Health sector reform plans consist of a set of legal documents (such as Presidential decrees ##3923 dated 19.09.2007 and #PP-700 dated 02.10.2007) and programs such as State Program on Healthcare Reform (1998); Health reform projects (Health-1, Health-2 and Health-3) implemented by the Ministry of Health with the support from the World Bank; Welfare Improvement Strategy of Uzbekistan (2008 – 2015, see 5.6.5 Healthcare on page 92-96) that is equivalent to Poverty Reductions Strategy Paper.

The latter strategy sets a monitoring and evaluation framework that includes health related indicators (such as indicators of life expectancy, maternal and child mortality rates, prevalence of socially significant diseases) along with other social and economic indicators. An Inter-Agency Council (IAC) was charged with the responsibility for oversight, coordination of implementation, monitoring, assessment and annual adjustment of the strategy. Representatives of the development partners, namely the World Bank, UNDP and Asian Development Bank are members of IAC (see Annex 4, page 25, Attachment #15).

As stated in the Strategy (section 7.5 Institutional capacity for Monitoring, page 124), "The monitoring of the Strategy implementation process and its impact on living standards will be conducted by the Ministry of the Economy. These functions will be delegated to one of the existing departments of the Ministry, or with external technical support to a special Department for Monitoring and Evaluation of the WIS implementation (DME)."

Involvement of development partners in M&E is reflected in a Memorandum of Understanding (MoU) signed between the Government of the Republic of Uzbekistan, the Asian Development Bank, the United Development Program (UNDP and the World Bank. According Article C. "Strengthening of the Monitoring and Evaluation Capacity" partners committed to assist in strengthening institutional capacity and M&E practices in addition to the support for the elaboration of the M&E Framework (see Annex 5, page 27, attachment #15).

Annex 3 of the Strategy, "Matrix of Indicators for monitoring the Welfare Improvement Strategy of the Republic of Uzbekistan for 2007 - 2010 and for the period up to 2015" provides a set of healthcare related indicators with targets (up to year 2015) and responsible agencies (see attachment #15 pages 16-20).

In addition, the Ministry of Health together with development partners drafted Mother and Child Health National Strategy (2014 – 2018) that contains more detailed set of M&E indicators and plan; it is expected the strategy to be endorsed by 2014.

ONE PAGE MAXIMUM

5. Health System Bottlenecks to Achieving Immunisation Outcomes

This section will be used to understand the main bottlenecks affecting the health system performance. The analysis here underpins the application, ensuring the proposed activities are designed to address the bottlenecks.

→ *Please describe key health and immunisation system bottlenecks at national, sub-national and community levels preventing your country from improving immunisation outcomes. Consider bottlenecks to providing services to specific population groups, such as the under reached, marginalized or otherwise disadvantaged populations. The country is also asked to consider gender related barriers to accessing quality services.*

In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, providing a reference to the relevant section in the National Health Plan for further detail.

→ *Please refer to bottlenecks which impact on gender and equity-related access to immunisation.*

→ *Please reference the analytical work that led to identification of the bottlenecks.*

→ *Describe the bottlenecks identified in any new vaccine proposals submitted to GAVI, the National Health Plan, and any recent health sector assessments such as the Effective Vaccine Management (EVM) assessment or Post Introduction Evaluation (PIE).*

→ *Which of the above specified bottlenecks will be addressed by the current proposal? Which bottlenecks are addressed by other national or externally supported programmes?*

In order to keep this section concise, please summarise the key bottlenecks and provide references to the relevant sections in existing bottleneck analyses. Please ensure the referenced analyses are provided as attachments.

The National Immunization Program has been performing well in Uzbekistan if measured by coverage rates for all vaccines administered under the age of 2 – coverage rates have been maintained above 95% through the country. However, weaknesses of the healthcare system or of certain components of the immunization system identified in recent years through different assessment will undermine the performance and it will not be possible to sustain achievements in long run if not addressed adequately now. Therefore, key health and immunization system bottlenecks at all levels are presented and discussed below in the light of health system strengthening interventions carried out by the Government with the support of development partners.

Prevention of communicable and socially dangerous diseases

The State Sanitary and Epidemiological Surveillance (SSES) is responsible not only for routine immunization, but also for immunization by epidemiologic indications and emergency prophylaxis of certain infections (such as hepatitis A, rabies, tick-borne encephalitis, etc.), as well as for control of dangerous pathogens (including border control).

23 laboratories of SSES Centers were outfitted with modern equipment, consumables, and vehicles (worth of 2,380,290 USD) under Health 2 Project. However, premises of 75 state border sanitary control offices under the auspices of SSES are not suitable for operation and lack basic communication.

SSES possesses and maintains most of cold chain transportation capacity critical for the immunization system performance. Weaknesses of cold chain and transportation are discussed separately in detail below.

SSES's capacity to manage the prevention of communicable diseases had been partially strengthened under Health 1 and Health 2 projects (see details on information management practices below). However, compared to other public institutions, it has received less support because organizational development and capacity

strengthening interventions have been focused on primary and secondary health care delivery in rural and urban areas including professional education and training institutions.

Cold chain

At the present, cold chain storage volume is adequate to accommodate vaccines and injections supplies (including Rota) at all levels (except 14 districts having no freezers and storing OPV in refrigerators). However, according to the EVM assessment 2012 the main problem that may affect immunization service delivery if not addressed timely is related to poor working condition of cold chain equipment (due to aging and/or improper maintenance). It is common to use domestic refrigerators including small bar/dormitory type coolers at this level. Considering frequent power outages in rural areas, these refrigerators either should be backed up alternative electric power supply or should be replaced with reliable ice-lined refrigerators.

In addition, the storage capacity at the central level is not enough if the country switches to central procurement of all injection supplies. The major issue revealed during EVM is also related to the lack of application of modern information management solutions for vaccine management at any level.

According to the EVM assessment 2012, the following steps should be taken to ensure smooth operation of the cold chain in the future:

- All cold rooms at central store should have continuous electronic temperature monitoring devices and temperature alarm systems. Refrigeration equipment at Oblast and Rayon stores should also be equipped with temperature data loggers.
- Current net capacity of the cold and freezer rooms at central store should be improved with additional shelves
- Additional cold rooms and freezers are needed to accommodate peak vaccine volumes of single dose vials, and new vaccine introductions
- Current dry store should be refurbished to improve storage space and occupational safety.
- Dry store capacity at central store should be increased to cover current and future immunization program needs. Additional 330m³ net storage volume is needed if all syringes and safety boxes will be procured and stored centrally
- All cold rooms should have functioning dual refrigeration units
- Old cold and dry stores should be refurbished at central level
- Only WHO prequalified cold chain equipment should be procured for all levels in the future cold chain equipment renewals
- All freeze-sensitive vaccine shipments packed with conditioned icepacks should include Freeze-tags
- A standard Operating Procedures Manual (for main vaccine management activities) should be prepared according to WHO's recommendation
- Using a cold chain inventory data base should be taken into consideration. Cold Chain Equipment Manager (CCEM) might be a good option.

Uzbekistan succeeded to implement some but not all activities outlines in the EVM Improvement Plan (see attachment #16) mostly due to budgetary constraints.

Demand on immunization and other preventive MCH services

Strict regulatory environment compels target population to avail themselves of free-of-charge immunization and other preventive MCH services, and the population is used to utilize these services as a legacy of the soviet times. However, there are serious concerns that the demand on immunization and preventive MCH services could decrease from generation to generation without consistent and effective information and education interventions.

The Analytical Review of PHC Development in Uzbekistan noted that "Demand of the population [is], primarily, for diagnostic and therapeutic services rather than preventive ones", and considered "inadequate awareness of the population about the scope of health services available at PHC facilities" as one of the weaknesses.

The recent assessment of the Immunization National Program revealed the following weaknesses in this regard:

- Present communication plan for immunization needs strengthening
- Existing communication is information-based and one-way
- Limited number and coverage of mass media
- Limited research to define KAPB among general public and medical professionals, and to monitor impact
- Weak design of messages and materials

As stated in the cMYP, there is a funding gap for knowledge, attitude and practice (KAP) surveys envisaged by the

national immunization program.

Human resources/workforce

The government made significant investment in PHC professional resources with the support of development partners (such as „Health-2“ and 'Women and Children Health Development' Projects). With the support from the European Commission and Unicef, over 16,000 health professionals from maternity hospitals and primary health care facilities were trained in newborn and child survival techniques

An Independent evaluation (conducted in 2011) of Health-2 project proved that training of GPs and SVP personnel improved their knowledge and skills, particularly in area of mother and child health. As a result, the quality of antenatal care provided by SVPs has improved. However, the same study identified several weaknesses in professional training of key medical personnel:

- “18% of doctors have not attended training in reproductive health. In 35% of cases, pregnant women’s charts lacked gravidograms; some, – although not so many, – GPs did not know the signs of threatening miscarriage, abortion in progress, ectopic pregnancy and threatening eclampsia”.
- In addition, a “tendency of nurses” high rotation was observed: the experienced or trained under Health 2 Project nurses were being replaced by young nurses having graduated from colleges, whose knowledge and skills were evaluated by GPs as inadequate, resulting in inferior quality of services provided to the population, women and children”.

Turnover rate of vaccinators and nurses involved in immunization varies between 30%-40% per annum that requires regular investment in the staff directly responsible for the delivery of immunization services. This is particularly relevant to young staff, and high coverage with immunization services is mostly based on elderly staff approaching and exceeding the retirement age.

The Analytical Review of PHC Development in Uzbekistan also identified “Inadequate training and lack of public health professionals for inter-sector collaboration” as one of threats for the PHC development in the country.

Assessment of National Immunization (2010) found that:

- "Low knowledge and interest of GPs on immunization
- Some new staff lack key management and technical knowledge and skills
- Insufficient understanding of GPs of case definitions, including AFP and AEFI”

Management of public and PHC services

The Analytical Review of PHC Development in Uzbekistan revealed the following weaknesses:

- “Somewhat slow and ineffective transition from inspections of PHC performance to supportive supervision/monitoring on a regular basis;
- Lack of effective planning and financing mechanisms for supervision, evaluation and monitoring systems as an important part of expenses in the budgets;
- Health personnel at PHC facilities in insufficiently motivated to engage into inter-sector coordination of healthy lifestyle promotion and disease prevention among the population;
- PHC facility heads/managers are insufficiently knowledgeable about modern management methods.
- Lack of earmarked financing for provision of training, methodological, and informative materials to improve the process of managing health services at PHC level to district and regional PHC managers may slow down the introduction of modern management mechanisms”
- Underreporting of vaccine preventable disease due to the following factors “the lack of knowledge of standard case definitions among health professionals, low awareness about the surveillance system, incomplete, late and inaccurate reporting, lack of incentives for reporting”
- “Inadequate control over preventive and curative activities, hence the risk of development of complications and irrational prescription of medications”
- “Results of preventive measures carried out by general practitioners are not analyzed”

Data management practices for decision making

Uzbekistan strengthened data management capacities within the Ministry of Health under Health 2 Project:

- “536 sets of computer equipment for rayon ICT centres under the RMUs were procured, training of RMU staff on using the computer equipment in healthcare sector management conducted”
- 74 sets of computer equipment for GP training centres at medical institutions and 13 sets for regional training centres for SVP laboratory assistants were procured

- 1. 536 kits of computer equipment were procured for rayon ICT centers, including head-end, diesel generator equipment and precision air conditioner”
- All necessary hardware (servers) for the data center, up to 241 personal computers (including 223 for SSES offices) and 16 notebooks were procured and installed to operate IS IDES

Under the current World Bank supported Health 3 Project it is intended to strengthen health surveillance system (subcomponent 3.2) with a focus on non-communicable diseases.

However, most of these data management capacity-strengthening interventions have bypassed the State Sanitary and Epidemiologic Services (SSES): key actor at all levels in the control and prevention of communicable services.,

Despite several attempts to introduce various pieces of software to manage data related to immunization or other preventive and infectious control activities within the SSES almost all information collection, exchange and/or storage is still done manually in 216 offices of SSES throughout the country. “Information System for Infectious Diseases Electronic Surveillance” introduced recently under Health 2 project (including server infrastructure and computers for end users) is the only exception.

Immunization data in Uzbekistan lacks quality and accuracy and requires strengthening capacities in the field of proper target population estimates for immunization and investing in information systems and introduction of electronic immunization registries.

Regulatory framework

As described in the previous section, an extensive legal framework regulates organization and delivery of PHC services including immunization. However, there are some gaps in the regulatory framework that impede effective functioning of the healthcare system (concerning MCH and preventive service):

- The Regulation on the Material Incentives for Health Care Facility Staff sets forth a set of indicators for performance assessment of outpatient facilities to award bonuses or impose penalties. However, there is no evidence that this or other regulations directly affecting MCH and preventive service delivery are enforced effectively or that effective reporting and supervision mechanisms are in place ensuring adherence to these regulations. Sub-national authorities are not obliged to provide necessary resources for supportive supervision and oversight over the application of the regulations.
- There is no rule that obliges health authorities a) to procure injection supplies together with vaccines (exception is only Pentavalent, that is supplied via Unicef together with AD syringes) and b) to use auto-destructive syringes for vaccination (at least). As a result, vaccination can be interrupted and/or safety suffers due to “insufficient syringes and Safety Boxes for all injectable vaccines” (Assessment of National Immunization (2010))

Summary of Health System Bottlenecks to Achieving Immunization Outcomes

Despite apparent success of the EPI in Uzbekistan, a few health system bottlenecks can still affect the performance the immunization system. Achievements of the immunization system cannot be sustained if the following bottlenecks are not addressed in next 5 years:

1. Obsolete and insufficient **infrastructure** of the State Sanitary Epidemiologic Services
2. Weaknesses in the **legal environment** that regulates procurement and distribution of injection supplies, institutionalization of supportive supervision of immunization and other preventive services
3. Weaknesses related to **workforce**: Insufficient skills (due to high turnover rate) among vaccinators/nurses health care professionals to manage vaccines and deliver immunization services; improper immunization related medical practices as the PHC care level (in some facilities) due to the lack of knowledge and clinical oversight on quality of care
4. Weak **management** of PHC care facilities as autonomous entities, including financial management and planning of resource requirements (including vaccines and injection supplies)
5. Lack of modern **information management** practices, that affects efficiency and effectiveness of decision making in areas of communicable disease prevention and mother and child health

If the #1 and #2 problems directly affects achievement of immunization outcomes in long run (thus can be considered as “immunization system specific”) then scope of issues 3, 4 and 5 is much broader and if addressed can benefit substantially service delivery and management practices.

FOUR PAGES MAXIMUM

6. Lessons Learned and Past Experience

This description will highlight to GAVI how lesson-learning has been incorporated into the design of the activities. It will provide the evidence base that demonstrates that the proposed activities will be effective, and that implementing them will achieve the desired intermediate results and immunisation outcomes.

→ Please use the table in the proposal form to summarise the evidence base and/or lessons learned related to each of the objectives in the proposal. Applicants are asked to provide examples specific to their country of relevant interventions that were successful.

→ In addition please provide examples illustrating the challenges to successful implementation. If no evidence base exists within the country of question, please note 'not applicable'.

**Where possible, please provide evidence of this learning by providing a reference or a web-link to a published document related to each example.*

Objective	Example(s) of lessons learned, highlighting both successes and challenges
Increase performance and sustainability of prevention of communicable diseases	The Ministry of Health has conducted a series of trainings of health care professionals throughout the country since 1998 under Health-1 and Health-2 projects or other projects supported by development partners. Furthermore, investment has been made in professional training capacity under Health-2 project. Duration of trainings varies from 1, 3 and 5 days for short-term course up to 10 months for long term courses (for general practitioners). Therefore, there is sufficient hands-on experience in organizing and conducting trainings nationwide.
Increase performance and sustainability of prevention of communicable diseases	Cold chain equipment substantially upgraded 10 years ago but many of them do not function properly or have to be replaced due to poor maintenance practices as detected by the EVM Assessment 2012. The country will contract out cold chain equipment maintenance services to prolong actual life of cold chain equipment procured under HSS grant as well as will introduce proper oversight on adherence to operational procedures as recommended in the EVM "Improvement Plan".
Improvement of management of public health and PHC services	The Ministry of Health conducted successfully training of financial managers of hospitals in pilot areas under Health-2 project. It is planned (under Health-3 project) to expand the training of financial managers of other health facilities at rayon (district) level and urban polyclinics based on the accumulated experience. Organizational and methodological aspects of the proposed trainings of health care managers (deputy chief doctor and financial manager) under HSS project will be also based on this positive experience.
Increase demand on MCH services	<p>The Institute of Health and Medical Statistics (IHMS) conducts regularly small scale (localized) public surveys on different public health topics through its network of national and oblast level Social Research Monitoring Departments (see for more details "B. Sectoral and Institutional Context" of PAD of Health-3 Project, attachment #17).</p> <p>Therefore, there is enough institutional capacity for and experience in conducting household surveys combining different modules and approaches such as Lot Quality Assurance (LQA) techniques for sampling blended with country tailored instruments for MICS and/or HUES.</p>
Strengthen data collection and reporting for MCH services	<p>Standalone applications (IT solution) and off-shelf products introduced several years ago for vaccine management or temperature monitoring had not been used as intended:</p> <ul style="list-style-type: none"> • "WHO introduced StockCards, an Excel based simple stock management software in 2006 and VSSM Software in 2009. Neither of these softwares were found to be in use in the central store." • "All oblast cold stores have 8 channel computerized temperature recorders procured and installed by UNICEF in 2008. As there are more than 8 refrigerators/freezers in an average oblast store, these recorders are not capable to monitor the whole cold storage. Reportedly none of them are in

	<p>use now”(EVM Assessment Report).</p> <p>EVM Report suggested introduction of Cold Chain Equipment Manager (CEM) MS Access based tool but the recommendation had not been implemented.</p> <p>The NIP assessment 2010 found that the software for coverage reporting “Vacinfo” was not up to date for newly introduced vaccines and notes some software related problems. It was recommended to “Explore improving electronic data management at the oblast level ideally using software that can be update”.</p> <p>According to cMYP, measles and rubella surveillance module (MRSM) software had been in pipeline but there is no evidence of its use.</p> <p>The computerized software for PHC financial reporting was developed and implemented by “Zdravplus” project for pilot regions. With the introduction of the Treasury system in 2007, the developed software did not meet the requirements for a functioning financial management system and had not been extended.</p> <p>No overt resistance to application of IT solutions in routine work had been noted. However, it uptake of available IT products is lower than expected. At the same time, Information System for Infectious Diseases Electronic Surveillance (IS IDES) introduced under Health 2 Project can be considered as a success story.</p> <p>Based on the aforementioned experience, the following lessons can be drawn:</p> <ul style="list-style-type: none"> • a success with the institutionalization (and not just development) of a modern HMIS solution increases substantially if the product is well tailored to local needs and a thorough understanding of business processes precedes introduction of off-shelf or even custom IT products • In addition to personnel training and demonstration of apparent benefits to end-users, a regulatory framework should be updated correspondingly that designates a government entity in charge of its operation • Whenever possible, new solutions should be integrated with ones that are operational instead of introducing standalone products. <p>Therefore, the country decided to build new IT solutions upon the existing IS IDES expanding its scope to meet new functional and user requirements and using local capacity for software development and support generated during Health 2 Project implementation.</p>
<p>TWO PAGES MAXIMUM</p>	

PART D - PROPOSAL DETAILS

For further instructions, please refer to the Guidelines for Completing the HSS Application

7. Objectives of the Proposal

This section will be used to assess whether the proposed objectives are relevant, appropriate and aligned with the National Health Plan and cMYP, and contribute to improving immunisation outcomes. It will also ensure alignment with the bottleneck analysis above.

→ *Please succinctly describe the immunisation and HSS objectives to be addressed in this proposal and explain how they relate to, and contribute to, reducing HSS and immunisation bottlenecks (identified in section C.5 above) and strengthening of the health system. Please describe how these objectives are aligned with those in the national health plan and cMYP.*

The objectives need to be aligned to and numbered in the same way in the HSS M&E Framework (Attachment 3) and also in the detailed Budget, Gap Analysis and Workplan Template (Attachment 4).

For each objective, please describe:

- a) *Which immunisation outcomes will be improved by implementing the activities, and how will the activities contribute to their improvement? Please focus on the key activities related to each objective rather than every single activity. Please demonstrate this link in the next section on the results chain.*
- b) *Whether and how the proposed objectives relate to the equity and gender related barriers to access as identified in the bottleneck analysis, and how the objectives will result in narrowing the equity gap in immunisation coverage and contribute to reaching the under reached, underserved and marginalised populations. Countries are requested to consider gender related and geographic barriers to access of immunisation and other health services.*

→ *Please list and describe all of the proposed activities in the Budget, Gap Analysis and Workplan Template. If GAVI funding is requested to go into pooled funds, please attach the Annual Work Plan and Budget for the pooled fund and related TORs.*

This description will be used to assess if the proposed key activities will be sufficient to achieve the identified immunisation outcomes.

The following objectives are proposed to address health system bottlenecks affecting achieving immunization outcomes:

Objective #1: Increase performance and sustainability of immunization services

Objective #2: Improve management of PHC services

Objective #3: Increase demand on preventive and MCH services

Objective #4: Strengthen data collection and reporting for MCH services

Efforts under Objective #1 are focused on addressing immunization specific problems in the area of service delivery, vaccine supply, quality and logistics. Interventions under the objectives 2, 3 and 4 deal with a broader health system issues both on supply and demand sides of primary health care and public health.

Objective #1: Increase performance and sustainability of immunization services

There are 2 groups of activities:

- Activities that aligned with the EVM Assessment Improvement Plan and addressing most of critical issues highlighted in EVM Assessment (except vaccine data management that is undressed under Objective #4) related to obsolete or insufficient infrastructure of the State Sanitary Epidemiologic Service (stores, cold chain equipment, transportation)
- Activities addressing problems related to vaccination practices via training of the dedicated healthcare personnel (general practitioners, pediatricians and 10,000 thousand vaccinators/nurses) and supportive supervision.

The proposed Investment in vaccine logistics infrastructure serves two purposes:

- Increase reliability of cold chain equipment and transportation mainly by replacing obsolete devices and following the recommendations of EVM Assessment (2012)
- Install adequate storage capacity in the light of introduction of 2 new vaccines (PCV and HPV) as well as desired centralized procurement of AD syringes; therefore, the country can allocate new vaccine introduction

support to other areas such as training of PHC doctors and nurses, surveillance and social mobilization (particularly concerning HPV) while addressing logistical bottlenecks via HSS support

A detailed investment plan will be developed based on a thorough needs assessment which will be conducted with WHO support prior to launching HSS implementation.

As to another group of activities, they address human resource/workforce related problems applying to approaches:

- Investment in professional resources via modifying pre and in-service training of GPs and conducting 1 day pre-certification trainings of up-to 4,000 of nurses/vaccinators every year
- Conducting regular supportive supervision visits to health facilities to ensure that acquired skills are applied properly in practice

The proposed Investment in both physical infrastructure and human resources is expected to address to a certain extent existing inequities across oblasts and rayons revealed by the EVM Assessment (2012).

This objective contributes directly to the achievement of most of immunization outcomes such as coverage (DTP3 coverage, Measles coverage, Fully immunized child), equity (geographical) and drop-out rates (wherever related to stock-outs).

Outcomes of GAVI graduation mission in September 2013 will be used to adjust recommendations for programme sustainability under HSS.

Objective #2: Improve management of PHC services

Three types of interventions are proposed under this objective:

- Investment in human resources in charge of management of health facility (SVPs in rural areas): financial managers, deputy head doctors (in charge of medical practices) and chief nurses in charge of medical practices of nurses and forecasting requirements in vaccines and injection supplies)
- Supportive supervision ensuring that acquired managerial skills are applied correctly as well as managerial and clinical practices are consistent with regulatory requirements
- Information sharing and experience learning through organizing annual national conference on immunization and MCH services and study tours of PHC and SSES managers

This objective is expected to contribute primarily to reduction in drop-out rates and geographic equity of DTP3 coverage.

Objective #3: Increase demand on preventive and MCH services

Two distinct interventions are proposed to increase demand of population on MCH services including immunization:

- Collection of evidence on actual immunization coverage and (healthcare seeking) behavior of families in certain groups of population with relatively lower utilization of MCH & preventive services
- Development and implementation of social mobilization interventions based on the collected evidence

These interventions are expected to give a better insight into gender issues and/or inequalities wherever they exist and to elaborate adequate strategies to address them.

If achieved this objective is expected to contribute primarily to the improvement of socio-economic equity in immunization coverage for selected population groups and to the decrease in drop-out rates.

Objective #4: Strengthen data collection and reporting for MCH and preventive services

The proposed interventions are supposed to substantially change information management practices in 3 areas (work flows):

- Vaccine (and other supply) stock management
- Delivery of preventive and curative MCH services
- Surveillance (case based) and reporting

A national computerized system of vaccine stock management will ensure automatic registration of in/outflow of vaccines from national, oblast and rayon level stores, monitoring of storage conditions, stock management: the hardware and software developed by local IT teams will be installed in all vaccine stocks. Considering an integrated approach to pharmaceutical and supply management, the system can benefit not only immunization system but also other delivery areas.

Another set of interventions are focused on creating a modern intranet for all SSES offices at all levels that creates a physical platform (infrastructure) to develop case based surveillance and reporting (as an extension of existing

infection disease monitoring) and personalized register of MCH services. It will allow to expand the scope of existing IS IDES to VPD surveillance and develop an electronic birth/children register and an electronic register of children vaccinated and/or receiving other preventive/MCH services.

Three types of activities envisaged under this objective:

- Procurement and installation of hardware
- Development of software after defining user and functional requirements
- Training of end users and regular data quality checks

This objective will contribute primarily to decreasing drop-out-rates and improved geographic coverage through better vaccine stock management practices.

Cross-cutting interventions

Revisions of the regulatory framework are envisaged under each objective except one (Objective #3). These interventions are intended to institutionalize new practices (e.g. application of modern data management IT solutions or more efficient procurement and supply procedures) or to ensure financial and operational sustainability obliging sub-national authorities to allocate financial resources for supportive supervision.

TWO PAGES MAXIMUM

8. Results Chain

This description will detail to GAVI how the proposed activities will result in improved immunisation outcomes.

→ Please present a Results Chain using the template provided in the application form for each objective. This diagram should demonstrate how activities contribute to achieving outputs / intermediate results and how outputs/intermediate results contribute to achieving immunisation outcomes. The outputs / intermediate results should link directly to the HSS bottlenecks identified in Section 5 and should address or contribute to addressing the selected bottlenecks for the GAVI HSS proposal.

(Please only include the key 4-5 activities for each objective that are central to delivery of intermediate results and immunisation outcomes. It is not necessary to list all activities for each objective. The full list of activities should be completed in the workplan and budget (see Section 10)).

→ The Results Chain should be consistent with the HSS M&E Framework. For every output / intermediate result and immunisation outcome listed in the Results Chain there should be corresponding indicator(s) in the HSS M&E Framework to measure achievement.

→ Please note that a GAVI HSS proposal must include the six immunisation outcome indicators listed in the Guidelines Key Terms Section. Applicants are encouraged to include other immunisation outcome indicators as well which relate specifically to the part of the health system where funds will be used.

→ Each result and outcome listed in the results chain should have a corresponding indicator in the Monitoring and Evaluation Framework.

Objective 1: Increase performance and sustainability of immunization services

Key Activities: <ul style="list-style-type: none"> ▪ Develop storage and cold chain upgrade (investment plan) ▪ Reconstruct and equip vaccine stores ▪ Procure and install cold chain equipment ▪ Train regularly vaccinators/nurses of vaccine delivery sites 	→	Outputs / Intermediate Results: <ul style="list-style-type: none"> ▪ Vaccine stores and facilities at all levels meeting EVM requirements ▪ Cold chain storage capacity is adequate to countries long term needs and functions properly 	→	Immunisation Outcomes: <ul style="list-style-type: none"> ▪ Improved immunization coverage: <ul style="list-style-type: none"> ○ DTP3 coverage, ○ Measles coverage ○ Fully immunized child ▪ Improved equity (geographical coverage) ▪ Reduced drop-out rates (wherever related to stock-outs)
---	---	--	---	--

Objective 2: Improve management of PHC services

Key Activities: <ul style="list-style-type: none"> ▪ Conduct training of health facility financial managers, deputy head doctors and chief nurses ▪ Conduct supportive supervision of chief nurses and execution of regulations ▪ Organize annual national conference on immunization and MCH services ▪ Organize study tours for experience sharing 	→	Outputs / Intermediate Results: <ul style="list-style-type: none"> ▪ Facilities forecasting properly requirements in vaccines and injection supplies increased ▪ Improved managerial and immunization related clinical practices 	→	Immunisation Outcomes: <ul style="list-style-type: none"> ▪ Improved coverage due to: <ul style="list-style-type: none"> ○ reduction of drop-out rates ○ increased geographic equity of DTP3 coverage
---	---	---	---	--

Objective 3: Increase demand on preventive and MCH services

Key Activities: <ul style="list-style-type: none"> ▪ Conduct household surveys ▪ Develop IEC strategies/plans and implement 	→	Outputs / Intermediate Results: <ul style="list-style-type: none"> ▪ Knowledge of and attitude toward immunization and other preventive services in selected communities improved 	→	Immunisation Outcomes: <ul style="list-style-type: none"> ▪ Improved socio-economic equity in immunization coverage ▪ Decrease in drop-out rates
--	---	---	---	---

Objective 4: Strengthen data collection and reporting for MCH and preventive services

Key Activities: <ul style="list-style-type: none"> ▪ Develop and deploy a software for effective vaccine management ▪ Procure and install PC and networking equipment in vaccine stores ▪ Develop and install intranet for SSES ▪ Conduct data quality monitoring site visits 	→	Outputs / Intermediate Results: <ul style="list-style-type: none"> ▪ Vaccine stores are integrated into and use fully computerized modern effective vaccine management system ▪ All branched/offices of the SSES demonstrate better data management and reporting practices 	→	Immunisation Outcomes: <ul style="list-style-type: none"> ▪ Improved coverage due to: <ul style="list-style-type: none"> ○ reduction of drop-out rates ○ increased geographic equity of DTP3 coverage
--	---	--	---	--

IMPACT: Improved child health due to effective prevention of vaccine preventable disease among children

- Under 5 mortality rate

ASSUMPTIONS:

- Supply of vaccines to Uzbekistan is adequate and is not interrupted
- Retention of qualified health care personnel remains high
- Socio-economic conditions of population, especially in rural areas improves

THREE PAGES MAXIMUM

For further instructions, please refer to the Guidelines for Completing the HSS Application

9. Monitoring & Evaluation Framework

This description will enable GAVI to assess how programme performance will be monitored and to ensure alignment with National M&E arrangements. The proposed M&E framework for the HSS grant should link to the proposed results chain. While the Results Chain provides the rationale for how the proposed activities will result in improved immunisation outcomes, this section provides details of how the monitoring and evaluation will be undertaken.

→ Please provide an HSS grant Monitoring & Evaluation Framework as Attachment 3 (please complete the GAVI template).

→ Please provide a description of how the monitoring and evaluation will be carried out for the grant, indicating how M&E is aligned with the national health plan results framework.

→ Which sources of data will be used?

→ How much budget will be allocated to M&E of this grant?

→ Please describe the M&E system strengthening activities to be funded through this proposal.

→ Please identify one or more immunisation outcomes for each objective. These will be used for PBF's performance payment (see Figure 1 on page 7 of the Guidelines)

→ Please identify a number of intermediate results indicators related to each objective of the grant that shall be used for tracking the overall progress of the grant implementation (these will be used for PBF's programmable section (see Figure 1 on page 7). These are the same intermediate results indicators that are included in the Monitoring & Evaluation Framework, and will be used to measure the outputs/intermediate results that are included in the results chain in Section D.8.

Please note that GAVI strongly recommends that each proposal includes an end of grant assessment in their M&E Framework.

Monitoring and evaluation of the grant will be carried out the Implementation Unit on a regular basis in accordance with the M&E Framework attached to the application Form. Monitoring and Evaluation specialist will be responsible for data collection, data validation, measurement of implementation progress (in addition to calculating achievements for output/intermediate result indicators) and preparation of M&E reports.

The following sources of data will be used for monitoring and evaluation:

- HSS grant implementation (programmatic and procurement) reports/documents – it will allow to track a pace of implementation assessing actual inputs against planned/budgeted. Data for 4 indicators “Net volume of cold chain storage upgraded by levels”, “Percent of SVPs which received supportive supervision”, “Percentage of districts submitting timely, complete and accurate health information reports to the oblast level” and “Percentage of districts EPI offices integrated into and reporting via MIS” will be collected from this sources
- Data obtained via observation and inspection during monitoring visits will supplement data from programmatic reports for indicators “Percentage of districts submitting timely, complete and accurate health information reports to the oblast level” and “Percentage of districts EPI offices integrated into and reporting via MIS”
- External assessments:
 - EVM Assessments (planned in 2015 and 2018) will provide quantitative data for indicators 2 indicators “Proportion of Vaccine stores and facilities with EVM criteria E2-E6 scores at or above 80% (national average | national | oblast | rayon | facility levels)” and “Proportion of Vaccine stores and facilities with EVM criteria E7-E8 scores at or above 80% (national average | national | oblast | rayon | facility levels)”. EVM Assessment scores will be entered in the indicator calculation tool (see Attachment #18) to measure achievements at all levels
 - Grant Implementation external assessment (planned in 2018) will validate reported achievements as well as provide insight into qualitative aspects of grant implementation
- EPI administrative reporting will serve as the main source of data for calculating almost all immunization outcome indicators
- Population surveys (including immunization coverage survey) planned annually under the HSS grant will serve as:
 - the main source of data for indicator “Proportion of target population demonstrating readiness for vaccinating children”
 - the main source of data for socio-economic equity indicator of immunization outcomes

- the alternative source of data for the rest of immunization outcome indicators
- MICS will serve as an alternative source of data for immunization coverage and equity indicators (immunization outcomes) as well as for validation of some output/intermediate result indicators
- Vaccine stock management software at SSES will serve as an additional data source to monitor net volume of cold chain storage upgrade by levels (after it becomes fully functional in Y3)

The following budget line items correspond to direct allocation of funds to M&E: 108,000\$ as salary of M&E specialist, 27,090\$ for monitoring visits and 50,000\$ for “end of grant assessment”, in total 185,090\$. In addition to direct expenditures, some other activities share costs with M&E such as:

- 288,000\$ is allocated to population surveys that will supply data for measuring objective #3 related indicator
- Supportive supervision visits (under activity #2.4 with the of 50,400\$) will also supply data for indicator “Percentage of districts submitting timely, complete and accurate health information reports to the oblast level”

M&E system strengthening is envisaged under objective 3 and 4:

- Developing in-country capacity for regular population surveys for immunization coverage and other MCH preventive services and supporting the practice of generating evidence to monitor the effectiveness of social mobilization (as well as actual performance of EPI among the certain population groups) strengthens the Ministry of Health capacity for M&E eventually
- Developing vaccine stock management information system will allow to assess on a regular basis performance of vaccine supply and logistic component of the immunization system
- Further expansion of infectious disease monitoring information system and introduction of case based reporting on vaccination and other preventive MCH services would increase the Ministry of Health’s ability to monitor performance of crucial public health interventions

The following intermediate result/output level indicators are proposed for tracking the overall progress of the grant implementation:

- 1) Proportion of Vaccine stores and facilities with EVM criteria E2-E6 scores at or above 80% (national average | national | oblast | rayon | facility levels) (linked to Objective 1)
- 2) Net volume of cold chain storage upgraded by levels (linked to Objective 1)
- 3) Proportion of Vaccine stores and facilities with EVM criteria E7-E8 scores at or above 80% (national average | national | oblast | rayon | facility levels) (linked to Objective 2)
- 4) Percent of SVPs which received supportive supervision (linked to Objective 2)
- 5) Proportion of target population demonstrating readiness for vaccinating children (linked to Objective 3)
- 6) Percentage of districts submitting timely, complete and accurate health information reports to the oblast level (linked to Objective 4)
- 7) Percentage of districts EPI offices integrated into and reporting via MIS (linked to Objective 4)

In addition to six mandatory immunization outcome indicators, one more indicator is proposed: “Geographic equity of DTP 3 coverage - % of districts that have **at or above 95%** DTP3 coverage”. DTP3 coverage threshold at 95% is more relevant to Uzbekistan considering more than 95% national coverage and has been included in the cMYP as one of the NIP objective for routine immunization.

TWO PAGES MAXIMUM

10. The Proposal Development Process

This section will give an overview of the process of proposal development, outlining contributions from key stakeholders.

→ Address all the items listed below. Indicate if any of these are not applicable and explain why:

- a. *The main entity which led the proposal development and coordination of inputs. It is possible to have multiple lead implementers, however the country must decide which department will lead the proposal development process.*
- b. *The roles of HSCC and ICC.*
- c. *Cooperation between EPI programme and the other departments of MOH involved in the proposal development.*
- d. *Involvement of subnational level (provincial, district, etc.) entities.*

- e. *The role of CSOs in the proposal development. Applicants must describe whether the HSCC/ICC worked with any CSO platforms/coalitions, or just with individual organisations. Please provide the names of the specific CSOs or of the CSO platforms involved.*
- f. *The names and roles of other specific development partners/donors.*
- g. *The role of the private sector, if applicable.*
- h. *Description of technical assistance received during the proposal development. Include the source of technical assistance and a comment on the quality and usefulness of that technical assistance.*
- i. *Description of the overall process of proposal development: duration, main steps of the proposal development, analytical work involved in the proposal development, links between the proposal development and national health sector planning/budgeting, links between the proposal development and JANS (if applicable).*
- j. *Description of the most challenging elements during the proposal development and how they were resolved.*

The proposal development and coordination of inputs was done by the Task Force on HSS proposal development established by the Minister of Health Order #1057 dated 17 July 2013. The Task Force was composed of senior staff of the MOH representing all involved departments. Overall responsibility was assigned to the Deputy Head of SSES Department and NIP Manager, Dr. Tursunova, and Head of Finance Department, Mr. Khashimov. Technical inputs on Health Systems were led by Manager of Joint Project Implementation Bureau of the MOH, Ms. Abdurakhimova.

The technical assistance to the proposal development was provided by WHO European Regional Bureau. The proposal was discussed at all stages with all involved stakeholders, including MOH, MOF, WB, WHO, UNICEF, and the WHO consultant was working closely with the Task Force members on development of the proposal. The draft proposal was reviewed at the ICC meeting in July 2013 and endorsed by ICC expanded by HSS TF.

EPI programme worked closely with other departments of the MOH, namely MCH, SSES, Finance, JPIB. The professional associations (Societies of epidemiologists and paediatricians) and academia (Post-graduate Medical Training Institute) were consulted during proposal development although not involved themselves substantially. Private sector was not involved.

The entire proposal development process took three months, starting in early June with collection of required background documentation.

TWO PAGES MAXIMUM

11. Detailed Budget and Workplan Narrative

This description will be used to assess if the proposed budget shows sufficient justification for the proposed activities and activity costs within the HSS grant.

→ Please provide a detailed budget and workplan as Attachment 4 to this proposal. Please refer to the Guidelines for the list of items required from the budget and workplan. It is highly recommended that applicants use the GAVI HSS Budget, Gap Analysis and Workplan template as Attachment 4. However, countries can also provide this information in the format of an existing national Annual Operational Plan or equivalent document.

→ Please include additional information on the assumptions within the budget and justification of unit costs to demonstrate that they are reasonable and supported by in-country planning. These assumptions and unit cost justifications may be inserted here or attached as separate documentation.

General assumptions

- It was assumed that major investment in infrastructure to take place in HSS project Y1 (including renovation and construction of vaccine stores, upgrade and expansion of cold chain equipment). However, investments in physical infrastructure have been stretched over the entire project life in order not to exceed annual ceilings.
- Infrastructure investment expenditures will be re-fined in immunization infrastructure upgrade plan (see activity #1.1). The plan will be based on the findings of a thorough inventory conducted with WHO support: specifications and quantities of cold-chain equipment will be specified and corresponding unit costs defined.
- HSS is expected to co-finance variable portion of supportive supervision costs: travel and per diems while salaries of personnel is paid from the core budget of SSES.
- The Ministry of Health intends to purchase most of cold chain equipment via Unicef that requires special decision to be made by the Government with corresponding legal act (allowing the Ministry of Health to bypass public procurement rules for this particular project). If that happens, unit costs for some cold chain commodities will be adjusted to Unicef's prices during the development the investment plan and savings could be reallocated to upgrade more SVPs with ice-line refrigerators.

Unit cost specific assumptions

Unit costs	Description and assumptions
Per diem (76\$ per night) and travel (50\$ per visit/trip)	Proposed unit costs are based on the historic costs of field missions supported by development partners Per diem includes accommodations, meals and incidentals. Travel implies average cost of air and ground transportation.
Training costs per person: 63\$ for one-day training, 240\$ for three-day training	Proposed unit cost has been used by the Ministry of Health during the implementation of Health-1 and Health-2 projects. The cost is calculated for a training course with 25 participant and 2 teachers. It covers all fixed and variable costs such as honorarium of trainers, transportation and accommodation of participants, meals, accommodations and training materials
Consultancy fees: FTA – 1200\$ per day, LTA – 1,800\$ per month	Foreign technical assistance (FTA) – it reflect an average cost of FTA including fees, per diem and travel local technical assistance (LTA) – the proposed unit cost is widely accepted rate for remuneration of local consultants
Event costs: 50,000\$ per annual national conference	The proposed amount is based on historic costs of similar events organized by development partners. In includes travel and accommodation costs of participants (up to 500, considering 2 persons from each out of 200 districts, oblast and national level officials and healthcare professionals), rent of premises, lunch, etc. It is assumed that the events will be co-financed by the government and development partners (including in-kind contribution such as assistance in organization, deployment of international experts or academia representatives, etc.)
Study tours: 5,000\$ per	The unit cost comprises the following components: average cost of travel (1,200\$

travel (tour) per person	round-trip airfare from Uzbekistan to Europe), per diems and accommodation for 10 days of stay (250-300\$ per day), ground transportation (e.g. airport transfers), cost of interpreters, insurance, etc.
Face-to-face structured interview: 40\$ per person	The unit cost represents an average market price for a 60-90 minute face-to-face interview conducted by a trained interviewer; it includes all costs related to salaries, travel, data entry, field quality control, admin costs.
Service, lump sum 100,000\$ for developing and implementing IEC strategy	It is a rough estimate of the total cost of a package of services to be contracted out: elaboration of IEC strategy and its implementation (e.g. preparation of social advertisement, educational video clips, other educational materials, cost of air at national or regional TV and radio broadcasters, etc.); the estimate is based on historic costs of similar small and middle-range IEC activities supported by the development partners
PC – 250,000\$ per unit	Estimated costs of multi-processor modern (mid-range) server hardware (with RAID) plus software licenses (for MS Windows Server, MS SLQ Server); the estimate is based on similar expenditures on establishing MIS data center in the Ministry of Health
Device – 2000\$ per unit for creating SSES intranet	It includes average costs of personal computer (with software license) and networking equipment connecting an user to local area network (LAN) and then to wide area network (WAN)
Cold chain device unit costs (activity 1.5)	All proposed unit costs are based average market prices. Costs for refrigerators and cold rooms are higher than Unicef prices and will be adjusted accordingly if the equipment is purchased via Unicef. The unit costs will be re-visited and updated in the immunization infrastructure investment plan (see activity #1.1)
Vehicle unit cost: 15,000\$ for Damas and 20,000\$ for Lacceti, 100,000\$ for a truck with refrigerator	GM vehicles (Chevrolet Damas and Lacceti) are produced in Uzbekistan and the prices are substantially lower than for imported analogues (because of high custom taxes). Refrigerator trucks are also produced (assembled) in Uzbekistan and the proposed unit cost reflects the average market price for this type of vehicle
Civil works: 350\$/m ² and 100,000\$ per store (building)	The unit cost estimates are based on the experience of similar civil work procured under the World Ban supported Health-1 and Health-2 projects. Unit cost 350\$/m2 is average cost of construction (enlargement of existing store) and renovation (of existing and new space). Unit cost – 100,000\$ per building is also average cost of construction of vaccine stores in 4 oblasts and renovation of existing stores in 11 oblasts. The unit costs will be revisited and finalized in the immunization infrastructure investment plan (see activity #1.1)
Furniture: 1,500\$ per set	Includes office furniture and accessories per work place and is based on historical cost of similar procurement

TWO PAGES MAXIMUM

12. Gap Analysis & Complementarity

This description will ensure GAVI is aware of support provided by other donors, thereby avoiding overlap or duplication, and highlighting the value-added of the requested GAVI support.

→ *Please complete a gap analysis that is related to each of the GAVI HSS proposal objectives. The gap analysis should use information as available in National Health Sector Strategy/Plan, cMYP, or other gap analysis conducted, to show the total resource requirements for health systems strengthening related to each of the proposal objectives. Applicants are encouraged to use the GAVI HSS Budget, Gap Analysis and Workplan Template but can chose an existing country template.*

→ For each of the objectives, applicants should list different resources for HSS financing already in place that contribute to the proposal objective, including government and external donor contributions, the project name if applicable (or indicate budget support), duration of support, funding amount provided (in US\$), and geographic location covered by the support. The guidelines provide more detail on the key required elements of the gap analysis.

→ In the box below, please provide a narrative description of other efforts by the Government or development partners that focus on the bottlenecks that are addressed by the proposal objectives, including the timeframe and the geographic location of this support, thereby highlighting the value-added of GAVI support and how the current proposal complements those efforts.

GAVI encourages the use of data from existing gap analyses, rather than undertaking a new gap analysis.

The gap analysis was based on updated cMYP resource requirements and financing projections for 2014 and 2015. Scenario A was used for the gap analysis and it envisages introduction of Rota and PCV in 2014 and HPV in 2015.

If only secure financing of the national immunization program is considered funding gap for routine immunization amounts to 27,409,695 US\$ (in 2014 and 2015). Objective "1. Increase performance and sustainability of immunization services" accounts for 96% of the funding gap (\$26,411,881). It is mainly due to physical infrastructure (vaccines stores, cold chain, vehicles) interventions under this component.

Only a small portion of the gap is expected to be filled in with probable financing from UNICEF and WHO (190,285 US\$ in total).

As shown in "Gap Analysis Summary" table, the GAVI HSS is expected to cover less than half of the funding gap for objective 1 (11,084,930 US\$ vs. 26,341,596 US\$). As to remaining objectives, HSS budget exceeds the funding gap substantially, that can be explained by two reasons:

1. Funding gap covers only 2 calendar years while the HSS is budgeted for 5 years.
2. cMYP estimates funding gap from a standpoint of EPI only while HSS address health system needs beyond EPI boundaries particularly under objectives 2 and 4

Ongoing Health 3 Project's programmatic focus differs substantially from the HSS project:

- Health service delivery component of Health 3 covers central rayon hospitals and construction of RMUs based on new standards while HSS project while the focus of HSS project is public health institutions and PHC providers
- Under sub-component 3.2 it intends to strengthen the surveillance of non-communicable diseases and to develop a health information system for the hospital financing while HSS project deals with data collection related to vaccine-preventable communicable diseases and MCH services at the PHC level
- Training component of Health 3 project (under component 2) targets health facilities at district level and urban polyclinics but does not cover PHC providers at lower levels addressed by the HSS project
- HSS project aims at increasing demand on MCH related preventive services while Health 3 project (under the component 3.1 intends to increase public awareness and change behavior related to with increased risks of major non-communicable diseases (hypertension, diabetes and other chronic diseases)

Therefore, the HSS project complements the major health reform initiatives under Health 3 project and there is no overlapping programmatic area.

TWO PAGES MAXIMUM

13. Sustainability

This description will enable GAVI to assess whether issues of sustainability have been adequately addressed.

→ Please describe how the government is going to ensure sustainability of the results achieved by the GAVI grant after its completion. This should encompass sustainability of financing for immunisation services and health system strengthening, as well as programmatic sustainability of results.

→ If there are other recurrent costs included in this proposal please describe how the country will cover these costs after the funding finishes.

Daily subsistence allowance (DSA) paid to specialists conducting supportive supervision is the major recurrent cost in the budget. It is proposed to direct efforts on earmarking funds for supportive supervision in sub-national

budgets through corresponding changes in the legal framework (see activity #2.3) – if the law obliges oblast and national level local authorities to allocate sufficient funds on conducting regular supportive supervision visits then travel related recurrent costs will be fully financed by the government.

Most of requested HSS funding constitutes investments in physical infrastructure, technology (MIS) and human resources. Such investment is not subject to sustainability concerns as usual. However, based on the experience of investments in the past, the country recognizes that additional efforts are needed to sustain investment related benefits. Namely, service contracts will be concluded for the maintenance and repair of cold chain equipment and vehicles to prolong their useful life (some of these costs are already factored under activity #1.5). Regulations will be revised to ensure that modern data management practices are institutionalized, so that the investment in technology (hardware and software) is used properly for vaccine stock management, surveillance, and production of evidence for planning and decision-making.

Retention of qualified (trained) healthcare professionals (vaccinators/nurses particularly) is the weakest point from a programmatic sustainability point of view. The current proposal already envisages 30-40% turnover of professional resources involved in immunization service delivery. Human resource policy interventions (linked with the new schemes of reimbursement of healthcare providers and corresponding financial incentives) fall beyond the scope of the present proposal and are addressed through ongoing health sector reforms.

TWO PAGES MAXIMUM

PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

For further instructions, please refer to the Guidelines for Completing the HSS Application

14. Implementation Arrangements

This section will be used to determine if the necessary arrangements and responsibilities for management, coordination, and technical assistance inputs of the implementing parties have been put in place to ensure that programme activities will be implemented.

Please describe:

→ *How the grant implementation will be managed. Identify key implementing entities and their responsibilities with regard to specific grant activities.*

→ *Mechanisms which will ensure coordination among the implementing entities.*

→ *Financial resources from the grant proceeds that will be allocated to grant management and implementation.*

→ *The role of development partners in supporting the country in grant implementation.*

The Grant implementation will be managed by an Implementation Unit (IU) established in the Ministry of Health. The unit will be established based on a Ministerial order that will define scope of work of the unit, its structure and composition (staffing), administrative and functional subordination to the corresponding divisions of the Ministry, programmatic and financial accountability, supervision mechanisms, etc.

The implementation unit will be managed by the head of the unit. Financial and managerial accounting will be carried out by a financial officer. The following specialists will be directly responsible for the implementation: Immunization and health system specialists, Procurement specialist and IT and management information system specialist and logistician. Monitoring and evaluation specialist will be in charge of collecting information, assessing progress in accordance with the M&E plan and production of reports. The program management is estimated to cost 877 thousand US\$, that is 5% of the HSS proposal's total budget.

The Ministry of Health assumes full responsibility for the implementation of the HSS grant in front of the GAVI Alliance and development partners. The Minister of Health will delegate the grant administration powers to deputy ministers: the Implementation Unit will be supervised by the First Deputy Minister (also in charge of PHC, inpatient care, diagnostic and treatment standards and regulations) and will be subordinated to the Deputy Minister, Chief Sanitary Inspector. The head of "Main Economic and Financing Department" will provide oversight on budget planning and execution (please see organizational structure of the Ministry of Health in Attachement #19, Appendix 2 to the Resolution of the President of Uzbekistan #700).

The expanded ICC will assume the role of health sector coordination committee for the provision of oversight in HSS grant implementation: it will include review and endorsement of HSS implementation progress reports (at least twice a year), review and endorsement of annual work plans and budgets, coordination with other health sector strengthening undertakings supported by the development partners.

TWO PAGES MAXIMUM

15. Involvement of CSOs

This description will be used to assess the involvement of CSOs in implementation of the proposed activities. CSOs can receive GAVI funding through GAVI HSS grants going to the MoH and then transferred to the CSO².

→ *Please describe how CSOs will be involved in the implementation of the grant activities, indicating the approximate budget allocated to CSOs.*

→ *Please ensure that any CSO implementation details are reflected within the detailed budget and workplan.*

Traditionally, CSOs have not been involved directly in the delivery of immunization service or other preventive MCH services in Uzbekistan. However, there is positive experience of the engagement of traditional community based organizations (known as Mahalla) in social mobilization. It is likely them to get involved in the current project implementation under activity #3.2 "Develop IEC strategies/plans and implement"

² In special circumstances grant funds can go directly from GAVI to a CSO, please refer to the Application Guidelines for further information.

TWO PAGES MAXIMUM

16. Technical Assistance

This description will outline to GAVI how technical assistance will support implementation of the proposed activities.

→ Please describe technical assistance (consultancy services) included in the grant activities. Please describe how this technical assistance will improve the way health systems and immunisation programme function.

→ Please outline how technical assistance will improve institutional capacities of government agencies and CSOs and contribute to sustainability.

Technical assistance (foreign and local) is envisaged under the following grant activities:

#1.1 Develop a detailed plan of upgrading infrastructure (10 days FTA and 1 month LTA) – an expert in logistics will help to define needs and prepare technical specifications for the procurement

#1.11 Change legislation concerning injection supplies (10 days FTA and 2 months LTA) – international expert in injection safety will help in advocacy efforts while the national law expert will produce corresponding legislation amendments

#2.3 Introduce a rule binding local authorities to finance supportive supervision (3 months LTA) – national consultant will assist the Ministry of Health and the project implementation team in advocacy efforts

#3.1 Conduct household surveys (20 days FTA and 50 months LTA) – an international expert will help to develop a standard methodology and analytical tools and will transfer knowledge to 2 national experts in Y1; afterwards, national expert(s) will work with the Ministry of Health to supervise field study, analyze data and produce reports

#4.1 Develop functional and user requirements (LTA one time lump sum) – a team of national experts will be hired to produce a business requirement document (BRD) that defines user and functional requirements for the management information system to be developed for vaccine stock management and health information management in SSES

#4.2 Develop and deploy software (LTA one time lump sum) – a team of local software developers will be hired to script an application in accordance with the BRD, install, test and develop training documentation/multimedia tools

ONE PAGE MAXIMUM

17. Risks and Mitigation Measures

This information reflects the risk of a country not being able to implement the proposed activities within this grant proposal and/or spend the funds as approved by GAVI. It is expected that the Lead Implementer will be responsible for assessing and ensuring that risk mitigation measures are actually implemented.

→ If the country has existing health sector risk analysis please attach these assessments and provide here a brief reference to the relevant sections.

→ If the country does not have existing health sector risk analysis, please complete the table below for each of the proposed objectives. Please refer to the Guidelines for Completing the HSS Application for a description of the various types of risk. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.

Description of risk	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	Mitigation Measures
Objective 1:			
<i>Fiduciary Risks: No specific risk</i>			
<i>Institutional Risks: (external) Government internal review and approval procedures (specifically related to procurement) could cause delays for project implementation</i>	High	High	<i>The Ministry of Health will consider a possibility of procurement of cold chain equipment via UNICEF and ask the Government to allow exemption from the rule</i>
<i>Operational Risks: Investment is stretched over the entire project duration (instead of upgrading physical infrastructure in Y1) not to exceed annual ceilings</i>	High	Medium	<i>It increases substantially transaction costs (e.g. running tenders several times instead of one-time purchase) and increases impact of the previous risk. The HSCC/ICC may negotiate with the GAVI secretariat to reallocate investments in Y1 and Y2; Procurement via Unicef can minimize the impact</i>
Overall Risk Rating for Objective 1	High	Medium	
Objective 2:			
<i>Fiduciary Risks: No specific risk</i>			
<i>Institutional Risks: Capacity of SSES staff to conduct supportive supervision</i>	Low	Low	<i>The Ministry of Health will conduct special training in supportive supervision</i>

			<i>of designated personnel of SSES if the risk materializes</i>
<i>Operational Risks: No specific risk</i>			
Overall Risk Rating for Objective 2	Low	Low	
Objective 3:			
<i>Fiduciary Risks: No specific risk</i>			
<i>Institutional Risks: No specific risk</i>			
<i>Operational Risks: No specific risk</i>			
Overall Risk Rating for Objective 3			
Objective 4:			
<i>Fiduciary Risks: No specific risk</i>			
<i>Institutional Risks: No specific risk</i>			
<i>Operational Risks: No specific risk</i>			
Overall Risk Rating for Objective 4			
<p>The health sector risk analysis was conducted by the World Bank for the “HEALTH SYSTEM IMPROVEMENT PROJECT” and is included in project paper (dated 2013) – see attachment #20.</p> <p>The HSS grant specific risks and mitigation measures for objective 1 and 2 are discussed above.</p> <p>The both risks for objective 1 are considered to have high probability because described conditions exist (“long procurement and approval procedures”, “fragmented investment budget”) and there is the high likelihood that they affect the grant implementation unless mitigation measures are applied.</p>			
TWO PAGES MAXIMUM			

18. Financial Management and Procurement Arrangements

In this section applicants are requested to describe:

→ a) The proposed financial management mechanism for this proposal

→b) *Financial Management Arrangements Data Sheet: The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for oversight, planning and budgeting, budget execution (incl. treasury management and funds flow), procurement, accounting and financial reporting (incl. fixed asset management), internal control and internal audit, and external audit. CSOs can receive GAVI funding through two channels: (i) funding from GAVI to MOH and then transferred to CSO, or (ii) direct from GAVI to CSO. Please refer to Annex 4 of the Guidelines for further details*

→ c) *The main constraints in the (health sector's) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfil the above functions.*

4 pages (more pages necessary if more than one lead implementer)

Question (a): applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one. A rationale for this choice should be provided.

The grant will be managed by the Ministry of Health through existing financial management mechanism – similar to the funding from the state budget of health care sector via the Ministry of Health.

The grant money will be considered as

Question (b): Financial Management Arrangements Data Sheet

Any recipient organization/country proposed to receive direct funding from GAVI must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).

1. Name and contact information of Focal Point at the Finance Department of the recipient organization	Mr. Bakhtiyor Khashimov, Head of Finance and Forecast Department, MOH
2. Does the recipient organization have experience with GAVI, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
<p>3. If YES</p> <ul style="list-style-type: none"> • Please state the name of the grant, years and grant amount. • For completed or closed Grants of GAVI and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • For on-going Grants of GAVI and other Development Partners: Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, misprocurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion). 	<p>The World Bank supported “Health II Project” (2004 – 2011) – 40 million US\$</p> <p>The World Bank supported “Health System Improvement Project” (2012-2017) – 101 million US\$</p> <p>The GFATM grant UZB-304-G01-H 20.5 million US\$ implemented by National AID Center, Ministry of Health (2004 – 2010)</p> <p>The GFATM grant UZB-809-G05-T 12.8 million US\$ implemented by the Republic DOTS Center (under the Ministry of Health) (2009 – 2013)</p> <p>The GFATM grant UZB-809-G04-M 2.3 million US\$ implemented by the Republican Center of State Sanitary Epidemiological Surveillance (SSES) (under the Ministry of Health) (2010 – 2014)</p> <p>No issues related to financial or overall management were highlighted in the GFATM grant closer/performance assessment reports.</p> <p>Financial performance issues were not mentioned in the</p>

	completion report of Health II Project (see attachment #21)
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	The Task Force on HSS established at the Ministry of Health on 17 July 2013 jointly with the existing ICC will be responsible for the in-country oversight of the program. The joint committee will be meeting quarterly on regular basis and ad hoc when required.
5. Who will be responsible for the annual planning and budgeting in relation to GAVI HSS?	The Implementation Unit under the direct supervision of the Main Economics and Financing Department of the Ministry of Health will develop annual work plans and budgets. The budget will be reviewed and will be endorsed after being integrated into the annual Ministry of Health budget
6. What is the planning & budgeting process and who has the responsibility to approve GAVI HSS annual work plan and budget?	The Implementation Unit will draft the annual work plan and budget. Main Economics and Financing Department of the Ministry of Health will review it through internal Ministry of Health budget review procedures. Finally, the Ministry of Health will present the annual plan and budget to the ICC for review and endorsement before submitting it to GAVI
7. Will the GAVI HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	The Ministry of Health will open bank account (in US\$) based on ministerial order if the HSS grant is approved by GAVI. Correspondingly, all details (including titles of authorized signatories) will be provided in accordance with the ministerial order.
9. Will GAVI HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	In accordance with existing practices on implementation of donor-funded projects, a special account will be opened in a state or commercial bank in the name of the the Ministry of Health
10. Would this bank account hold only GAVI funds or also funds from other sources (government and/or donors- "pooled account")?	Only GAVI funds
11. Within the HSS programme, are funds planned to be transferred from central to decentralized levels (provinces, districts etc.)? If YES , please describe how fund transfers will be executed and controlled.	NO
Procurement	
12. What procurement system will be used for the GAVI HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	National procurement procedures will be used for the GAVI HSS programme. However, the Ministry of Health considers procurement of cold chain equipment via Unicef if the Government makes exemption from common rules and allows direct purchase of goods (without tender) from Unicef

13. Are all or certain items planned to be procured through the systems of GAVI's in-country partners (UNICEF, WHO)?	Yes, most of cold chain equipment is planned to be procured via Unicef if the Government issues corresponding decree
14. What is the staffing arrangement of the organization in procurement?	One procurement specialist in the Implementation Unit (in addition to the Ministry of Health agencies in charge of procurement and supply of medicines and medical equipment)
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES
16. Is there a functioning complaint mechanism? Please provide a brief description.	NO (If YES, please describe)
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES The legal framework for contractual disputes (within public procurement practices) is provided by corresponding legislation and is specified in procurement/tender documents and contracts whenever necessary. Unresolved contractual disputes are taken to court.
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organization in accounting, and reporting?	One financial officer will be in charge of recording all financial transactions and preparation of financial reports in the Implementation Unit. The Main Economics and Financing Department will supervise and ensure that financial accounting and reporting practices meet the Ministry of Health procedures and requirements.
19. What accounting system is used or will be used for the GAVI HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?)	Manual accounting
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Monthly and submits to the Main Economics and Financing Department
Internal control and internal audit	
21. Does the recipient organization have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES
22. Does an internal audit department exist within recipient organization? If yes, please describe how the internal audit will be involved in relation to GAVI HSS.	YES "Division for control over targeted used of budgetary funds"
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	NO
External audit	
24. Are the annual financial statements planned to be audited by a private	YES

external audit firm or a Government audit institution (e.g. Auditor General)? ³	Government Audit by the MOF
25. Who is responsible for the implementation of audit recommendations?	The Minister of Health
THREE PAGES MAXIMUM	
<p><i>Question (c): Please indicate the main constraints in the (health sector's) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfil the above functions</i></p> <p>There is no financial management constraint.</p>	
HALF PAGE MAXIMUM	

³ If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.

SUMMARY OF A COMPLETE APPLICATION

HSS Proposal Forms and Mandatory GAVI attachments

→ Please place an 'X' in the box when the attachment is included

No.	Attachment	X
1.	HSS Proposal Form	X
2.	Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members	X
3.	HSS Monitoring & Evaluation Framework	X
4.	Detailed work plan and detailed budget	X

Existing National Documents - Mandatory Attachments

Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.

→ Please place an 'X' in the box when the attachment is included

No.	Attachment	X
5.	National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions	X
6.	National M&E Plan (for the health sector/strategy)	X
7.	National Immunisation Plan	
8.	Country cMYP	X
9.	Vaccine assessments (EVM, PIE, EPI reviews), if available	X
10.	Terms of Reference of Health Sector Coordinating Committee (HSCC)	X

Existing National Documents - Additional Attachments

Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.

→ Please place an 'X' in the box when the attachment is included

No.	Attachment	X
11.	Joint Assessment of National Health Strategy (if available)	
12.	Response to Joint Assessment of National Health Strategy (if available)	
13.	If funds transfers are to go directly to a CSO or CSO Network, please provide the 3 most recent years of published financial statements of the lead CSO, audited by a qualified independent external auditor	
...		

Applicants are strongly encouraged to carefully read the instructions provided within the relevant sections of the guidelines before completing the application form.