Uzbekistan
NEW VACCINE SUPPORT

This Decision Letter sets out the Programme Terms of a Programme.

1. **Country:** Uzbekistan

2. **Grant Number:** 15-UZB-19b-X / 15-UZB-08f-Y

3. **Date of Decision Letter:** 29 April 2014

4. **Date of the Partnership Framework Agreement:** 07/02/2014

5. **Programme Title:** New Vaccine Support

6. **Vaccine type:** HPV

7. **Requested product presentation and formulation of vaccine:** HPV Quadrivalent, 1 dose(s) per vial, LIQUID

8. **Programme Duration**[1]**:** 2015

9. **Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement):**

	2015	Total[2]
Programme Budget (US$)	US$4,193,500	US$4,193,500

10. **Vaccine Introduction Grant:** US$560,500 payable minimum of 6 months prior to introduction.

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[1] This is the entire duration of the programme.
[2] This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table.

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11. Indicative Annual Amounts (subject to the terms of the Partnership Framework Agreement):[3]

Type of supplies to be purchased with GAVI funds in each year	2015
Number of HPV vaccines doses	880,800
Number of AD syringes	932,000
Number of re-constitution syringes	0
Number of safety boxes	10,350
Annual Amounts (US$)	US$4,193,500

12. Procurement agency: UNICEF Supply Division

13. Self-procurement: Not applicable.

14. Co-financing obligations: Reference code: 15-UZB-19b-X-C According to the Co-Financing Policy, the Country falls within the Intermediate group. The following table summarises the Co-Financing Payment(s) and quantity of supply that will be procured with such funds in the relevant year.

Type of supplies to be purchased with Country funds in each year	2015
Number of vaccine doses	38,700
Number of AD syringes	40,900
Number of re-constitution syringes	
Number of safety boxes	475
Value of vaccine doses (US$)	US$174,919
Total Co-Financing Payments (US$) (including freight)	US$184,000

15. Operational support for campaigns: Not applicable

[3] This is the amount that GAVI has approved.

16. Additional documents to be delivered for future disbursements: The Country shall deliver the following documents by the specified due dates as part of the conditions to the approval and disbursements of the future Annual Amounts.

Reports, documents and other deliverables	Due dates
Annual Progress Report or other reporting formats as requested by the GAVI secretariat	15 May 2015 or as agreed with GAVI Secretariat

17. Financial Clarifications: The Country shall provide the following clarifications to GAVI*: **Not applicable.**

**Failure to provide the financial clarifications requested may result in GAVI withholding further disbursements*

18. Other conditions: Not applicable.

Signed by,

for [signature]

On behalf of the GAVI Alliance
Hind Khatib-Othman
Managing Director, Country Programmes
29 April 2014

Uzbekistan
Health Systems Strenthenging (HSS) Cash Support
This Decision Letter sets out the Programme Terms of a Programme.

1. **Country:** Uzbekistan

2. **Grant number:** 1418-UZB-10a-Y

3. **Date of Decision Letter:** 29/04/2014

4. **Date of the Partnership Framework Agreement:** 07/02/2014

5. **Programme Title:** Health Systems Strengthening (HSS)

6. **HSS terms:**

The ultimate aim of HSS support is to ensure increased and sustained immunisation coverage through addressing health systems barriers in Country, as specified in:

- The relevant GAVI HSS guidelines – please contact your CRO at naydogan@gavialliance.org for the guidelines.
- The relevant GAVI HSS application form - please contact your CRO at naydogan@gavialliance.org for the form.
- Country's approved grant proposal and any responses to the HSS IRC's request for clarifications.

The HSS cash support shall be subject to GAVI's performance-based funding (PBF). Under this, the HSS support will be split into two payments: the programmed payment (based on implementation of the approved HSS grant) and the performance-based payment (based on improvements in immunisation outcomes). This means that in the first year, Country will receive 100% of the approved ceiling, or programme budget if different (the initial Annual Amount), as an upfront investment. After the first year, countries will receive 80% of the ceiling, or programme budget if different, based on implementation of the grant, and additional payments will be based on performance on immunisation outcome indicators. Note that countries whose total grant budget would fall below US$3 million are exempt from this 80% rule.

Country will have the opportunity to receive payments beyond the programme budget amount, for exceptional performance on the same immunisation outcomes. The maximum programmed payment plus performance payment may be up to 150% of the country ceiling.

Given that Uzbekistan's DTP3 coverage was **at or above 90%** in 2012 based on WHO/UNICEF estimates, Country will be rewarded for sustaining high coverage with:

- 20% of programme budget for maintaining DTP3 coverage at or above 90% and
- 20% of programme budget ensuring that 90% of districts have at or above 80% DTP3 coverage.

The performance payments under the performance-based funding shall be used solely for activities to be implemented in the country's health sector.

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7. Programme Duration[4]**:** 2014 to 2018

8. Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement): Note that with PBF, annual disbursements may be more or less than these endorsed amounts after the first year (see section 6 above).

	2014	2015	2016	2017	2018	Total[5]
Programme Budget (US$)	4,099,880	3,279,830	3,279,390	3,279,480	3,279,900	17,218,480

9. Indicative Annual Amounts (indicative) (subject to the terms of the Partnership Framework Agreement):

The following disbursements are subject to the conditions set out in sections 6, 10, 11 and 12:

Programme Year	**2014**	**2015**	**Total**[6]
Annual Amount ($US)	4,099,880	3,279,830	7,379,710

10. Financial Clarifications: The Country shall provide the following clarifications to GAVI[7]:

If the bank account information most recently provided to GAVI has changed or changes prior to disbursement, the country will need to complete a bank account information form. Please contact gavihss@gavialliance.org for the form.

11. Documents to be delivered for future HSS cash disbursements:

The Country shall deliver the following documents by the specified due dates as part of the conditions for approval and disbursements of the future Annual Amounts.

Reports, documents and other deliverables	Due dates
Annual Progress Reports (APRs), or equivalent. The APRs, or equivalent, shall provide detail on the progress against milestones and targets against baseline data for indicators identified in the proposal, as well as the PBF indicators as listed in section 6 above. The APRs, or equivalent, should also include a financial report on the use of GAVI support for HSS and use of performance payments, which have been endorsed by the Health Sector Coordination Committee (HSCC) or its equivalent.	15 May 2014 or as negotiated with Secretariat
Interim unaudited financial reports. Unless stated otherwise in the existing Aide Memoire between GAVI and the Country, the Country shall deliver interim unaudited financial reports on the HSS cash support no later than 45 days after the end of each 6-month reporting period (15 February for the period covering 1 July – 31 December and 15 August for the period covering 1 January – 30 June). Failure to submit timely reports may affect future funding.	15 February and 15 August
In order to receive a disbursement for the second approved year of the HSS grant	As necessary

[4] This is the entire duration of the programme.
[5] This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table.
[6] This is the amount approved by GAVI.
[7] Failure to provide the financial clarifications requested may result in GAVI withholding further disbursements

(2014), Country shall provide GAVI with a request for disbursement, which shall include the most recent interim unaudited financial report.	

12. Other conditions: The following terms and conditions shall apply to HSS support.

Cash disbursed under HSS support may not be used to meet GAVI's requirements to co-finance vaccine purchases.

In case the Country wishes to alter the disbursement schedule over the course of the HSS programme, this must be highlighted and justified in the APR, or equivalent, and will be subject to GAVI approval. It is essential that Country's Health Sector Coordination Committee (or its equivalent) be involved with this process both in its technical process function and its support during implementation and monitoring of the HSS programme proposal. Utilisation of GAVI support stated in this letter will be subject to performance monitoring.

Signed by,

On behalf of the GAVI Alliance
Hind Khatib-Othman
Managing Director, Country Programmes
29 April 2014

GAVI
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NEW PROPOSALS IRC COUNTRY REPORT
GAVI Secretariat, Geneva, 7 – 22 November 2013
Country: Uzbekistan

1. Type of support requested

Type of support requested	Planned start date *(Month, Year)*	Duration of support	Vaccine presentation(s) *(1st and 2nd choice, if applicable)*
PCV	July 2014	1.5 years	1st: PCV13, 1 dose/vial 2nd: PCV10, 2 doses/vial
HPV	January 2015	1 year	1st: HPV quadrivalent, 1 dose/vial 2nd: HPV bivalent, 2 doses/vial
HSS	January 2014	4.5 years	n/a

2. In-country governance mechanisms (ICC/HSCC)

An ICC meets regularly. Minutes of three of five meetings held in 2103 were provided with terms of reference. Participation appears limited to mainly MoH staff working at the central level but also involved staff of the Ministry of Finance, WHO, UNICEF and World Bank. It is clearly a functional coordination mechanism. Most attendees come from the MoH with a representative of WHO and UNICEF. There is no CSO representation and no evidence of social sciences capacity. Technical staff of WHO, UNICEF and UNICEF were involved in development of the HPV proposal and the Ministry of Education endorsed the strategy. Technical support was provided by WHO. The proposal was discussed at the meeting of the NITAG and approved by the ICC. There is also a HSCC (the Inter-Agency Council).

3. Situation analysis (burden of disease)

The NVS proposal is justified by the epidemiological data presented. While the pneumococcal disease burden has not been formally assessed, WHO estimates suggest a high disease burden. Sentinel surveillance in two urban sites indicates that 51% of purulent meningitis and 33% of community-acquired pneumonia cases are pneumococcal. WHO estimates that cervical cancer is the second most common cancer among women and the second most common cause of death in women aged 15-44 years. Uzbekistan has consistently achieved very high levels of DTP3 vaccine coverage (in the high 90s). Administrative coverage data correlate with WHO and UNICEF estimates. DHS data in 2005 indicated 93% DPT3 coverage. Only 2% of districts reported DTP3 coverage below 90% in 2012. Immunisation is obligatory although it is possible to opt out. School-based immunisation has traditionally achieved over 95% coverage. Immunisation data quality is acknowledged as a concern, with infrequent use of confirmatory surveys and data quality audits. A focus of the HSS proposal is improved data management of data for MCH services, including immunisation.

A comprehensive mix of immunisation specific and other health system bottlenecks are described, mostly based on experience in implementing World Bank credits for HSS. The four objectives in the HSS proposal address these issues. Lessons documented from introduction of pentavalent vaccine in 2009 and the HPV pilot project have informed the PCV/HPV proposal. While the lessons learned are grouped by the four objectives of the HSS proposal, the link between some of the lessons learned and HSS programme implementation is weak.

4. Overview of national health documents

It is difficult to readily make a judgment on the coherence of national health documentation in the absence of a comprehensive strategic health plan. The strategic objectives for health are defined by the Law on Health Protection of 1996, and a number of Presidential Decrees.

There is no standalone national health plan. The Welfare Improvement Strategy of Uzbekistan (2008 – 2015) sets a monitoring and evaluation framework that includes indicators of life expectancy, mortality rates, and prevalence of significant diseases but immunisation is mentioned only once in the text and in an indicator table. Immunisation is not one of the six objectives in the public health strategy. The cMYP (2011- 2015), revised in 2013, provides a clear situational analysis of the immunisation programme and indicates the intent to introduce PCV and HPV vaccines. The time frame of the cMYP is in line with the NVS application but not for HSS implementation. It makes no reference to HSS, nor does the Welfare Improvement Strategy or the Public Health Strategy. Complementary materials include the EVM (2012) and EVM improvement plan, specific introduction plans for PCV and HPV and the 2010 Comprehensive EPI Review. There are no apparent or perceived linkages between the cMYP and broader health sector planning documentation.

5. Proposed activities, budgets, financial planning and financial sustainability

NVS

The proposed activity plans land budgets appear appropriate and realistic. Budgets have been defined and highlight substantial gaps. Request for US$ 12,043,000 (PCV) and US$ 4,144,500 (HPV). The proposal anticipates that much of the gap will be met through vaccine introduction grants and HSS funds from GAVI supplemented by 'other partners', but only WHO and government are specified. Should the HSS application be successful, the budget allocations of both PCV and HPV introduction grants which include cold chain support will be adjusted in favour of communication and training activities. The objectives and activities are an appropriate response to the analysis.

Health Systems Strengthening (HSS)

Request for support of US$ 17,218,480. This includes a substantial component (64%) to upgrade cold chain capacity and logistical infrastructure including transport, improved PHC management (11%), and data management (14%). The detail and description of the budget categories and justification for unit costs is useful and the country is commended. However the gap analysis provided in the HSS budget template does not correspond to that in the cMYP where the resource requirement is far less than the amount requested of GAVI. The proposed objectives and activities logically flow from the situation and bottleneck analysis. One of the 4 objectives is immunisation specific while the other 3 will benefit wider PHC and MCH services. Through the HSS grant, the country aims to rehabilitate cold chain and logistics infrastructure, improve skills of health workers, strengthen management of PHC care facilities and introduce modern information management. Training costs are included in 3 of the 4 objectives and total US$ 2,503,330. The largest component (50%) of the funding gap is for activities and recurrent costs.

It is proposed that an 'Implementation Unit' in the MoH will manage grant implementation. It is not clear if the unit is the same as the MoH Central Project Implementation Bureau (CPIB) that has oversight of a World Bank credit for HSS. Five per cent of the funding request (US$ 925,490) is earmarked for program management. There is no indication in the HSS that potential links to a World Bank credit for HSS of US$ 93 million agreed in 2011 or of Global Fund HSS support were explored.

Sustainability

Uzbekistan funds traditional vaccines and meets co-financing obligations. Co-financing of PCV from government funds will begin in June 2014 and HPV in October 2015 at the minimum requirement level. The country will graduate from 2014 and this poses significant challenges to sustainability of the immunisation financing. Government vaccine costs will rise from US$ 3.5m to US$ 20m over 4 years. If government fully finances the immunisation programme (assuming no donor support) the total cost of the programme will represent approximately 5.5-6.5% of the government health budget and 2.7-3.3% of total health expenditures.

6. Gender and Equity

No sex-disaggregated data is available nor are there plans to collect such data. The proposal states that there are no gender disparities in reaching children with immunisation and no significant differences in coverage between girls and boys nor between wealth quintiles (2002 DHS). Yet an objective of the Public Health Strategy (2010-2020) is to 'Increase equity in health regardless of differences in gender, socio-economic status, geographical location'. It is not clear how this will be measured as gender indicators are not included in the proposed HSS results chain.

Despite high coverage it may be anticipated that pockets of vulnerabilities exist in Uzbekistan, however, nothing is said on this issue. Tailored social mobilisation activities will address the urban population and nomadic populations and there are plans for audience segmentation of communication/awareness efforts, however, boys were not included. The planned collection of evidence on healthcare seeking behaviour of families with relatively lower utilisation of MCH & preventive services will provide better insight into gender issues and/or inequalities. Traditionally, CSOs have not been involved directly in the delivery of services in Uzbekistan. However there is positive experience of the engagement of traditional community-based organisations (known as Mahalla) in social mobilisation.

7. Specific comments related to requested support

NVS

PCV introduction plan

Selection of PCV13 is rational in offering protection against more serotypes and the single dose presentation will reduce wastage. Procurement will be carried out through UNICEF. PCV will be introduced country-wide from July 2014 and will aim to reach 50% of the target population in the first year (2014), and 100% in 2015. These targets seem reasonable given the very consistent high rates of vaccination coverage. 920,000 children will benefit from this support. The total support requested is US$ 12,043,000 over 18 months, and the country pledges co-financing in the amount of US$ 745,000, with the first co-finance payment in June 2014.

The detailed vaccine introduction plan is informed by lessons learned and experience of other countries. The plan provides detail of activities and budgets areas. There is an identified shortfall of US$ 950,246 (budget US$1,450,000, GAVI VIG US$ 499,754). Major budget lines include cold chain capacity, vehicles, survey and monitoring.

Vaccine management and cold chain capacity

The EVM assessment (May 2012) indicated overall effective vaccine management practices with the exception of the central store. No progress report of the EVM improvement plan was provided. The EVM highlights the poor working condition of much cold chain equipment and inadequate storage capacity at the central level if the country switches to central procurement, and lack of modern information management for vaccine management at all levels. The country is requested to clarify the additional storage capacity throughout the supply chain when PCV13 and HPV are introduced. The 2012 EVM projection for CC equipment does not consider the capacity needs related to introduction of HPV and PCV. The unit costs of cold chain equipment are provided but the link between recent assessments and the stated equipment needs of US$ 9,463,800 of the HSS budget need to be better defined.

AEFI surveillance

An AEFI system has been in place since 2008 and includes an expert review committee, a national vaccine safety plan and dedicated capacity. The AEFI guidelines will be updated to include information on PCV and HPV.

Waste management
Immunisation waste management is based on centralised collection in urban areas and incineration at available facilities (large hospitals) and local open-air burning in ovens or in pits in the rural areas. A Health Care Waste Management strategy is being developed within the health reform project funded by World Bank.

HPV introduction plan
Uzbekistan plans nationwide introduction of HPV vaccine in January 2015, building on past experience through a pilot project implemented in 2009-2011. Selection of the quadrivalent vaccine that offers protection against more serotypes is a rational choice and the single dose presentation will reduce wastage. HPV will be introduced through the existing school immunisation programme that achieves high coverage (over 95%) in all groups. The programme will vaccinate all girls who reach their 12th birthday in the calendar year. HPV vaccination will require arranging only one additional vaccination session to administer the second dose although the proposed schedule of 0, 1 and 6 months differs from that recommended 0, 2, 6 months. Targeting 12-year old girls relates to age of sexual debut and will benefit 233,500 girls. Teenagers who are absent on the day of vaccination will be followed up by school nurses or immunisation teams. Only 0.4% of all girls 9-13 were estimated to be out of school in 2006. MoH highlights experience in delivering immunisation successfully to nomadic populations.

The total support requested is US$ 4,144,500 for one year, with country co-financing of US$ 745,000. There is a substantial shortfall in budget for HPV introduction of US$ 1,433,618 (budget US$ 2,040,000, GAVI grant US$ 606,382).

Training, Community Sensitisation & Mobilisation Plans and Evaluation:
Social mobilisation and communication is identified as the most critical activity and almost one third of the introduction grant will be allocated for this component. It will be informed by behavioural analysis and targeted messaging to target parents, health workers and journalists but there is no mention of including boys.

Assessment of adolescent health interventions
Immunisation is the only health service provided to school children up to age fourteen, and is mandatory, although there is provision for formal refusal. School nurses deliver health educational messages during parent-teacher meetings and class meetings for children. No evaluation of school based health education has been conducted.

Development of cervical cancer prevention and control strategy
The process is underway with technical assistance from UNFPA.

<u>HSS</u>

Results chain and Monitoring & Evaluation Framework
The link between most intermediate indicators and immunisation outcomes, as measured by the six mandatory GAVI indicators is tenuous, especially for the outcome of reduction of dropout rates. The intermediate results in the results chain (qualitative) in section 8 of the proposal document, and the seven intermediate indicators in section 9 (quantitative) are not the same. Intermediate results are included in the results chain but not in the M&E framework. The M&E framework includes the six mandatory indicators, in addition to intermediate results and relevant data sources. There is no plan detailing data collection, analysis and use but objective 4 of the proposal focuses on this issue. There is no mention of a national M&E framework although the Welfare Improvement Strategy has a monitoring and evaluation framework that includes a few health related indicators. US$ 185,090 of the proposed costs is directly related to M&E (US$ 108,000 for the salary of an M&E specialist, US$ 27,090 for monitoring visits and US$ 50,000 for an end of grant evaluation). In addition, some other

activities share costs with M&E, such as US$ 288,000 for population surveys and for supervision visits (US $50,400).

Linkages to immunisation outcomes, results and added value
The proposal demonstrates an understanding of health system constraints for immunisation outcomes. The key activities will support immunisation outcomes. The intermediate indicators in the results chain link inputs with outcomes clearly. The added value of possible funding from GAVI is that the funding is complementary to domestic and external resources.

Technical assistance needs
TA needs are identified and relevant. However, while the list of TA needs does include some deliverables, there is nothing on the process to identify the TA needs or how the TA will strengthen the institutional capacity of the MoH and contribute to systems sustainability.

8. Country document quality, completeness, consistency and data accuracy

A high quality PCV/HPV proposal with consistency between the proposal and the cMYP and EVM. However, immunisation barely features in national development and health documentation. The HSS proposal has a clear problem diagnosis, country documents have very broad statements but are complete.

9. Overview of the proposal

<u>**NVS**</u>

Strengths: Clear feasible plans that will build upon a high performing immunisation system.
Weaknesses: Data quality and transparency and lack of integration of immunisation programme with wider PHC.
Risks: Inefficient procurement (stockouts, lack VFM) and sustaining gains.
Mitigating strategies: HSS support

<u>**HSS**</u>

Strengths:
- Highlights underlying systemic challenges that if not addressed soon could have a negative impact on coverage rates.
- One of the four objectives is directly related to strengthening the immunisation system, although it does consume 64% of the costs. The other three objectives aim to strengthen the wider framework of PHC and MCH.

Weaknesses:
- Inconsistency between intermediate indicators in the results chain and those listed in the proposal but which are not in the M&E framework.
- Mandatory equity indicators are not included in the proposed results chain.
- A vertical implementation unit is proposed. This could duplicate the unit/ bureau for the World Bank HSS credit and further add to fragmentation. Health system strengthening should encourage and facilitate the use of existing systems.
- No mention of that possible complementary links between the proposed GAVI HSS and World Bank HSS credit have been explored.

Risks:
- Slow bureaucracy around decisions about procurement.

Mitigating strategies:
- Government to consider procurement through UNICEF rather than through government systems to reduce both costs and the time needed for procurement.

- The HSS investment will support perceived or upcoming challenges in the immunisation system.

10. Conclusions

NVS

Plans to introduce PCV and HPV are clearly justified and well planned. The proposals and supporting documents are adequate and realistic. The high performance of the immunisation system over many years provides confidence that the country is likely to achieve its objectives.

HSS

An adequate proposal that will enable a high performing immunisation programme to sustain the gains and ensure maximum benefits from new vaccine introduction. There is no plan to describe and detail of implementation. Support for HSS should not contribute to fragmentation and it is suggested that the planned vertical implementation unit and separate M&E functions be integrated as one system in one location in the ministry.

11. Recommendations

NVS (PCV and HPV):

Recommendation: Approval with clarifications

Clarifications:

1. Clarify the additional storage capacity required throughout the supply chain to accommodate introduction of PCV and HPV.

HSS:

Recommendation: Approval with clarifications Level 1

Clarifications:

1. Agree a list of intermediate indicators that link with planned outcomes, include the equity indicators and adjust both the M&E framework to include intermediate results and the results chain to ensure the same results as those in the M&E framework.
2. Provide a recent cold chain inventory to clarify the identified cold chain and transport needs with the HSS budget US$ 9,463,800.

Table 1: Approved budget for HSS

	Jan – Dec 2014	Jan –Dec 2015	Jan – Dec 2016	Jan – Dec 2017	Jan – Dec 2018	**TOTAL**
	Year 1	*Year 2*	*Year 3*	*Year 4*	*Year 5*	
5-year annual ceilings provided by GAVI (US$)	4,100,000	3,280,000	3,280,000	3,280,000	3,280,000	17,220,000
Budget request from Country Proposal (US$)	4,099,880	3,279,830	3,279,390	3,279,480	3,279,900	17,218,480
Budget approved by IRC - if different from proposal budget (US$)						