

Tajikistan

Internal Appraisal 2014

1. Brief Description of Process

This Internal Appraisal was conducted for Gavi by independent technical expert Zaza Tsereteli, in close cooperation with Gavi senior program manager for the country Nilgun Aydogan, and is based on reports and documentation supplied to Gavi by the national authorities and institutions in the country for the year 2013. Some inputs and updates are provided by WHO EURO.

Immunisation decision support team drafted the dose calculations for 2015 for hib-pentavalent using the approved targets (numbers of infants & wastage). The number of doses to be allocated (and planned for shipment) for 2015 for hib-pentavalent are based on the approved targets (2015) as well reported opening stocks (Jan 2014), shipment plan (2014) and targets. Syringes and safety box calculations are derived from dose calculation. All this is done in consultation with the vaccine programme manager, and the country (re-checked the stocks), and are signed off by the senior program manager.

2. Achievements and Constraints

Tajikistan has achieved a high level of coverage rates (over 90%) for immunisation services being provided in the country. 96% of the cities and regions of the country met > 90% coverage of DTP3 (Pentavalent) compared with 94% of districts in 2012. All cities and regions of the country have reached > 90% coverage with the first dose of measles vaccine. Wastage of DTP3 reduced from 5% in 2012 to 4% in 2013. Access of health workers in remote and hard to reach areas is provided by the mobile units. Those teams are financially supported by Gavi Health System Strengthening (HSS) and Immunization Service Support (ISS) funds.

As per DHS 2013 (data dated 2012) the overall vaccination coverage is 89% for children aged 18-29 months. A slightly lower proportion of children (86%) received the entire course of MOH-recommended vaccinations, which includes hepatitis B at birth with 93% coverage. The proportions of children receiving the second and third doses of polio and DTP are slightly lower, as is the proportion receiving the measles or MR vaccine. DTP3 is indicated at 93%. Thus, the dropout rate¹ between the first and third doses of DTP is 5%. Less than 1% of children aged 18-29 months have not received any vaccinations.

Situation with cold-chain has also improved with 88% of health facilities adequately supplied with cold chain equipment, compared with 80% in 2011 and 86% in 2012. There are still areas of improvement needed as EVM recommendations are not fully completed. At the central level, there will be challenges when new vaccines are introduced (rota and IPV for 2015) and if number of shipments is reduced from four to two per year. Additional cold-rooms are required and generally the capacity of cold and dry stores needs to be expanded significantly. The country is due for new EVM in 2015 to review the status and future needs.

For the national immunisation program (NIP), there are a weak organization and management issues especially in hard to reach locations. Main issues are inadequate funding from the local authorities for recurrent operational and logistics costs such as fuel for vehicles and allowances for mobile teams which hinders the implementation.

Gavi approved original Tajikistan's HSS application in June 2008 with the implementation scheduled for 2008-2010. However, actual implementation only commenced in May 2011 with a significant delay and due to issues related to financial management assessment and fund channelling. Consequently, implementation was re-planned for 2011-2013 and eventually extended till December 2014.

HSS implementation activities took place as planned. However the recent Gavi HSS assessment conducted in July revealed that there are some deviations from the original proposal such as number of clinic refurbishments, or selection of locations, etc. The assessment report indicated that there are increasing immunisation coverage rates and Primary Health Care (PCH) utilisation rates in some pilot regions, however the assessment did not establish credible links between the HSS implementation and observed changes. Tajikistan submitted a new HSS application for November IRC round. Lessons learned and assessment information has been utilised for the new proposal development.

3. Governance

The National Immunisation Program (NIP) in Tajikistan generally operates as a vertical programme, with its own funding stream, dedicated staff at national level, specific procurement and logistics systems, and separate planning and information system. At service delivery level, vaccination services are mostly integrated with primary health care (PHC) services and delivered by PHC health workers; there is also a vertical element where vaccinations are offered through outreach services. Governance of the programme tends to be less integrated at higher levels, than at district level or below within the health system.

At the national level, the NIP is managed by the Republican Centre of Immunoprophylaxis (RCIP¹). Some of the programme functions have been delegated to other departments over the past few years. This separate management structure descends to the district level through the regional and district branches of CIP and State Epidemiology and Surveillance (SES). Regional CIPs are administratively under Regional Health Managements but continue to receive separate funding from the RCIP, whereas District CIPs are both administratively under District Health Management and receive their funding from local district government. There are approximately 2,500 fixed and mobile vaccination points in the country. At the PHC facilities, routine immunisation services are provided by paediatricians, family doctors and nurses in maternity houses, urban polyclinics, village health centres and rural health houses. Hard-to-reach and understaffed areas are served by mobile teams travelling quarterly from district level. However, some areas are geographically inaccessible for up to five or six months in winter.

4. Programme Management

RCIP is directly accountable to the Ministry of Health, has a separate budget which is formed from the central health budget, is responsible for overall planning, evaluation and monitoring of NIP, the provision of vaccines and cold chain equipment, data collection and analysis, guidance and control for the safety of vaccination cities and districts of the country.

Universal immunisation of children under age 1 against major vaccine-preventable diseases is one of the most cost-effective of all programs to reduce infant and child morbidity and mortality. Ministry of Health has adopted the World Health Organization (WHO) guidelines for childhood immunisations that call for all children to receive the following: a BCG vaccination against tuberculosis; three doses of DPT to prevent diphtheria, pertussis, and tetanus (hib-Pentavalent); three doses of polio vaccine (OPV); and a measles vaccine during the first year of life. In addition to these standard vaccinations, hepatitis B vaccine for birth dose and MR (at age 12 months). Tajikistan is already approved for Rota and IPV introductions for 2015 which will be added to the national immunisation schedule in 2015.

5. Programme Delivery

The National Immunisation Program has several key priorities:

- Provision of achievements (poliomyelitis eradication, measles elimination, rubella and CRS, maintenance of low level of disease by a diphtheria, the control over other diseases,

¹ Equivalent of an EPI department

prevented by immunization), received due to primary vaccination against 7 infections prevented by immunization, four types of vaccines (BCG, Polio, pentavalent, (DPT, Hib, Hepatitis B and rubella) and additional actions for immunization (mass and mop up campaigns).

- Decrease inequalities in coverage between regions (utilisation of mobile teams for hard to reach areas)
- Introduction of new vaccines such as Rotavirus Vaccine
- Improve and strengthen the management of the program as a whole by implementing vaccine management training for the staff, Mid-level management trainings, Reach Every District (RED), surveillance training and operational management trainings
- Strengthen effective surveillance on the vaccine preventable diseases, and laboratory capacity.

Immunisation services are provided in about 3,000 various medical institutions (city polyclinics, maternity hospitals and branches, the health centres, etc). The medical personnel of various qualifications are involved in them: staff nurses, midwives, family doctors.

However, there are significant problems for health work force as the qualified staff migrate to other countries for better pays. The shortage of the health personnel in some remote areas, insufficient maintenance of mobile units are some of the obstacles for full implementation of the NIP plans.

Due to high turn-over of health staff, keeping timely vaccination schedules is an issue. In addition, there are issues around having combined vaccines, multiple injection schedules, and misinformation on immunisation contra-indications among the health staff.

According to the current legislation, vaccination services are given free of charge; however there is a problem of informal payment for immunisation services.

Surveillance is conducted, but limited (for AFP, the measles, rubella and CRS). The country has no other laboratory capability for surveillance and investigations. Needed tests are conducted with support from WHO in Moscow or other countries.

The last EVM took place in October 2012. The assessment shown that, vaccines and diluents stored at the correct temperatures, and cold and dry storage and transport capacities are sufficient. Buildings and cold chain equipment are adequate. However, the assessment has revealed systemic weakness in vaccine stock management and the preventive maintenance of cold chain equipment.

The EVM developed 72 recommendations for implementation plan. According to the APR only 14 out of 41 recommendations were fully implemented. Recommendations such as lack of refrigerator in the airport, lack of electronical equipment to control the temperature in cold rooms at regional levels, and registration of incoming vaccines still need to be addressed.

Although the country maintains high coverage, due to the obstacles in critical areas as well as financial constraints, the NIP is one of the most fragile in the region.

6. Data Quality

There are issues related to immunisation data and data quality. There are two sources of the data on target groups: the State Statistical Committee and the Republican Center of Medical Statistics and Information at the Ministry of Health. There are differences in data between the institutions on denominator as well as other variables used. Ministry of Health considers that the data on targets and coverage provided by the Republican Center of Medical Statistics and the Information, as more reliable.

According to the HSS assessment report, in general, medical workers at sub-national and health facility levels perform their assigned tasks of recording and reporting immunisation-related

information at the satisfactory levels. The report also indicates that, monitoring and analysis of the reported data is weak, especially at the district and PHC levels. Routine reports are compiled and sent to the upper level, but without proper validation and any analysis.

With the exception of AFP, the national surveillance system does not routinely analyse timely investigation of Vaccine Preventable Diseases (VPD) cases, although relevant data is collected by case examination card.

Although there is not much information within the APR, Tajikistan plans to expand the introduction of a computerised database for immunisation coverage at the PHC level, with the aim of moving towards full computerisation of data entry and processing. Trainings of the staff involved in this process is planned to be carried out.

7. Global Polio Eradication Initiative, if relevant

The first importation of wild poliovirus into the WHO European Region since its certification in 2002 was reported in Tajikistan in 2010. This outbreak spread rapidly affected three nearby countries.

The Government of Tajikistan responded effectively when the cases were detected through close cooperation with WHO, USAID, UNICEF, Rotary International, the Global Polio Eradication Initiative (GPEI) and other partners. In responding to the outbreak, six nationwide immunisation rounds and one subnational mop-up campaign were implemented in the country; as a result of these campaigns, the outbreak was stopped in Tajikistan. However, the outbreak caused more than 457 cases of polio in both children and adults, resulting in 29 deaths.

Rapid AFP surveillance reviews conducted in 2011 and 2012 demonstrated certain improvements in surveillance. The SIAs with OPV lasted through 2012, and there was no mass campaign in 2013. However in 2014, because of proximity of Tajikistan to Afghanistan, still polio endemic country, the Ministry of Health and Social Welfare conducted national immunisation days against polio in two rounds (first round on 14-18 April 2014 and the second round on 19-23 May 2014) with coverage exceeding 92%.

In line with Global Polio end game strategy, Tajikistan applied and approved in 2014 for IPV introduction in 2015.

8. Health System Strengthening

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

The programme has five major objectives:

- Strengthening the decision-making at the central and local government level in order to create a sustainable funding mechanism PHC and public health services.
- Increase access to primary health care in remote and inaccessible locations.
- Strengthen the capacity of health workers and health facilities at the PHC level
- Increased demand for timely immunisation by increasing awareness and creating a system of incentives for mothers.
- Strengthening the hospital information system of primary health care

Due to delays (re-visiting FMA and finalising Aide Memoire) in delivering the second tranche of funds during 2012, all program activities planned for this year were rescheduled for 2013 and the MOH requested no-cost extension till end of 2014. The request for a no cost extension was endorsed by the IRC², and the country received the third instalment (in the amount of 334,000

² IRC 2013 on APR 2012

USD in January 2014. Out of US\$334,000 US\$181,000 were spent during the first four months of 2014.

In July – August 2014, “Curatio International Foundation” carried out the assessment of Gavi support to HSS programme in Tajikistan. The assessment revealed that HSS funds were spent according to the approved budgets by the HSCC and within the agreed budgetary limits for the given objectives. Although, it has to be also noted that in many instances due to budget limits some of the program targets were reduced, which obviously affected overall program outcomes.

According to the assessment in the approved HSS proposal improvement of 36 health care facilities was planned; however, according to the APR for 2013 only 23 facilities were renovated resulting in 64% achievement on this indicator, as supposed to the original proposal. This is partially due to the increased average cost of renovation per facility (by 83% compared to original proposal estimates).

One of the objectives of HSS programme was introduction of outreach activities carried out by doctors and mobile teams, in order to improve access to qualified health services in hard to reach and remote areas. A Comparison of the original budget with the revised 2011 budget shows that most changes in the objective-level budget are within an acceptable margin i.e. 11% or less. However, budgetary shifts within activities under the given objective are quite significant e.g. investment costs for PHC facilities have been increased by 41%, reducing support for outreach and mobile activities. In light of the HSS program objective, such shifts run the risk of having a significant negative impact on the program’s expected outcomes, unless budget changes are well justified and substantiated with adequate analysis. The assessment also revealed that much of the funding transaction for the mobile teams was done through cash based transactions without bank transfers. This is due to that fact that RCIP does not have bank accounts at the peripheral levels and PHC bank transactions are managed and used based on local priorities and needs.

The HSS assessment showed that outreach activities are routinely carried out in the target areas. On average about 6-7 mobile/outreach visits per year are conducted in each district. However, this information is not reflected in any facility records, because plans for mobile/outreach visits does not exist, and neither are there records of the number of such visits conducted, the list of villages visited and/or number of children vaccinated/seen during the visit, etc. The RCIP or MoH does not request this information and consequently the data on mobile team/outreach performance is not routinely available at district and/or at a national level and neither they were included as an output measure for mobile team performance in the program M&E framework.

The quality of implemented activities also raises concerns as per the assessment results. PHC facility investments, initially destined for hard to reach areas with the objective of improving access to disadvantaged groups of the population living in remote locations, did not materialise fully, and only part of these investments benefitted remote communities. It is assumed that quality would have been better had program assured sufficient transparency and adequate and timely engagement of expertise required for the design of such complex scheme, conditioned that such knowledge was available within the country or from partners.

The assessment also revealed the weaknesses in financial systems arising from institutional weaknesses of the RCIP, especially by the lack of experienced staff in the management of donor-funded programs, and by the lack of standard operational and financial management procedures that led to deficiencies in financial record keeping.

The assessment report indicated that HSCC had several weaknesses which impacted the functionality especially on oversight and performance of the implementation. The involvement of HSCC was more active during proposal development but failed to deliver in the implementation. The recommendations for HSCC improvement include:

- ensuring annual (or semi-annual) joint review of the program with the active engagement and participation of the partners;
- Ensure engagement of adequate/experienced stakeholders and in-country partners by:

- encouraging active involvement of the partners and other stakeholders in program planning, monitoring and annual and mid-term evaluation;
- ensuring that HSS program activities have an integrated approach and different players of the health system are involved, and;
- soliciting technical assistance as needed

Apart from the above, the assessment includes several key recommendations such as improvement of program and financial management and documentation of immunisation plans and progress.

The independent assessment report also indicated that current M&E guidance for GAVI HSS grants includes set of indicators (e.g. National level DPT3 coverage; number/share of districts achieving $\geq 80\%$ DPT3 coverage; under five mortality rate) that are not relevant for monitoring HSS grants. The external HSS evaluation team arrived at similar conclusions in 2009. The assessment team recommended GAVI to revise HSS M&E guidance and include appropriate set of indicators, which allow adequate measurement of outcomes resulting from HSS investments.

Since January 2014, Tajikistan HSS program has been implemented by the new Program Implementation Center (PIC) within the MOH specifically developed for the Gavi HSS grant by the Ministerial Decree from 31 December 2013. All functions related to Gavi HSS grant management and fulfilled by RCIP were handed over to this newly established centre, including Gavi HSS grant particular bank account. The country partners have been working on the new HSS application and the assessment findings are utilised for the new application which is to be reviewed in November 2014.

9. Use of non-HSS Cash Grants from Gavi

In 2013, Country has used the whole amount of funds allocated under the Immunisation Service Support (ISS) activities. The ISS funds are included in the national health sector plans and budget. The budget and expenses were discussed at the ICC meetings. The 330,980 US\$ allocated for the 2013 were spent as following: purchase of two vehicles and spare parts to support the mobile teams in two mountainous areas; acquisition of cold chain equipment and spare parts for refrigeration; acquisition of fuels and lubricants for monitoring and transport of vaccines and injection materials in regional centers and areas; training seminars on vaccine safety, improvement of cold chain, reporting, active surveillance; printing of reporting documentation of immunisation. The funds were also used for an independent audit of expenditure of funds of Gavi ISS.

10. Financial Management

Based on information available financial reports and audits are submitted on time, and there are no outstanding financial clarifications to be provided to Gavi.

11. NVS Targets

Penta vaccine

According the APR, in 2014, country is requesting 758,600 doses of vaccine, for 2015 the estimation is 762,300 doses. At the same based on UNICEF shipment report, the delivery plan for 2014, is 969,000 doses.

Rotavirus Vaccine and IPV (not for HLRP recommendation –but information only)

The rota vaccine introduction to Tajikistan has been approved and the decision Letter from Gavi was sent in April.

Last week of September the IPV introduction grant was also sent to the country. WHO and UNICEF are working closely with the Ministry of Health for preparation. Tajikistan is advised to utilise the VIG funds for both vaccines in synergy and develop efficiencies.

12. EPI Financing and Sustainability

Tajikistan is classified as low-income country. Tajikistan started mandatory co-financing of Penta vaccine in 2008. The country has been a good performer with timely payment of the co-financing obligations. In previous years the country paid .30cent per dose for pentavalent vaccine. The APR indicates that the co-financing for pentavelent will decrease to minimum payment of .20 cents in 2015 along with rotavirus vaccine introduction (also at the minimum co-financing). The government share in the total expenditures for immunisation was 12% in 2013, which is a decrease compared to previous years, as it was 35% in 2012, and 41% in 2011.

The country paid for only 5% of its traditional vaccines in 2013 (the majority was paid by Project HOPE and a small part by JICA), while this was 36% in 2012, and 41% in 2011. The APR indicates that for 2014, and 2015, the government will be funding the purchase of traditional vaccines. However, the country requests technical assistance to mobilise resources for the immunisation services.

13. Renewal Recommendations

Topic	Recommendation
NVS	<u>Penta vaccine</u> - Approve 2015 NVS support based on country request target.

14. Other Recommended Actions

Topic	Action Point	Responsible	Timeline
<i>Immunisation programme management</i>	<p>Improve program management by introducing standard operating procedures</p> <p>Improve documentation of meetings, progress made in each area</p> <p>Define technical assistance needs for ICC</p>		
<i>Immunisation services</i>	Strengthen the capacity and increase the financial support of the mobile units working in the hard to reach areas		
<i>Cold Chain</i>	Implementation of EVM recommendations should speed up and improve the situation at central and regional levels in light of the new vaccine introductions. VIGs for IPV and Rota should be used efficiently to maximize benefits for the cold chain improvement.		
<i>Data quality</i>	To bring the estimation methodology of the target population (denominator) for calculating coverage towards WHO recommendations.		
<i>HSS</i>	<p>Develop plans to improve:</p> <ul style="list-style-type: none"> - HSCC role and oversight including technical assistance - Program management and documentation (introduce standard operating procedures) - Utilise the findings in the new HSS implementation when approved - Provide Gavi with end of grant detailed report with financial documentation 		

Annex 1

ICC and HSCC

The membership of Inter-Agency Coordination Committee (ICC) and Health System Coordination Committee (HSCC) includes mostly representatives of the governmental institutions. In addition to the national representatives, representative from the UNICEF, WHO and two NGOs– "Project Hope" and "Aga Khan Foundation" are represented in the committees. The Minister of Health is the chair of the both committees.

The ICC took place on April 29. There were 14 members present at this meeting, however there are 21 signatures on the document approving the APR for 2013. Among the issues discussed at the meeting were the results of European Immunisation week, the status of implementation of National Immunisation Days (NIDs) and the proposal to Gavi for IPV vaccine.

The HSS meeting endorsing the APR for 2013, took place on April 13. 12 persons, including one representative from CSO were presented at the meeting. Meeting discussed the implementation of the Gavi supported activities in 2013, and audit report. There are inconsistencies between documents, dates and signatures which are in line with the assessment findings of HSS. The assessment revealed that there are weaknesses around the HSCC, their roles and responsibilities, particularly on program oversight issues.

The HSS assessment report indicated that HSCC has potential to assure effective coordination and oversight of the HSS program, due to weaknesses in functionality it failed to deliver on expectations. Stakeholder and HSCC engagement in coordinating Gavi HSS reveals being regular, however more concentrated, all-inclusive and engaging during the access to funding periods and marginal or no engagement during actual program implementation. This issue will be discussed further in the HSS section of this appraisal.