

## Joint appraisal report

<b>Country</b>	Tajikistan
<b>Reporting period</b>	Previous appraisal: <i>Internal Appraisal 2014</i> Current appraisal: <i>Joint Appraisal August 2015</i>
<b>cMYP period</b>	2011-2015
<b>Fiscal period</b>	January - December
<b>Graduation date</b>	N/A

### 1. EXECUTIVE SUMMARY

#### 1.1. Gavi grant portfolio overview

Starting from 2001,<sup>1</sup> GAVI initiated its support to Republic of Tajikistan by providing various grants such as Immunization System Support (ISS from 2001-2005, 2008, 2010, 2012-2013), Health System Strengthening Support (HSS – 2010, 2012, 2014), New Vaccines Support (NVS) for HebB (2001, 2004-2009), Pentavalent (2008-2015), Rotavirus (2014-2015), IPV to be introduced by January 2016, accompanied by Vaccine Introduction Grants (VIG) (2008, 2014) and Injection Safety Support (2004-2007). In total, up to June 15, Gavi investments to Tajikistan amounted to 22,835.033 USD.

Tajikistan relies on donor support for immunization program. There are problems with planning, budgeting, and budget execution. Although, MOH provides full funding of allocated budget for the National Immunization Program (NIP), the funds do not cover all the needs of the program for reasons which will be further elaborated in this report, which results in shortages and ad-hoc requests to donors for contributions.

Gavi has been a major contributor to the immunization program since its beginning. In 2014, Gavi provided support for Pentavalent vaccine, as well as the vaccine and introduction support for Rotavirus Vaccine totaling 2,601,642 USD. In early 2014, the country also received the last tranche of HSS funding of 334,000 USD. During 2015, the country applied for new HSS, and the IRC in its July meeting reviewed the proposal and recommended for approval.

All cash support from Gavi is reflected in the national health sector budget but goes through a parallel account.

The country moved to pre-transition category as per July 2015 GNI figures announced by the World bank.

#### 1.2. Summary of grant performance, challenges and key recommendations

##### Grant performance (programmatic and financial management of NVS and HSS grants)

Tajikistan has achieved a high level of coverage rates (over 90%) for immunization service provision in the country. 96% of the cities and regions of the country met > 90% coverage of DTP3 (Pentavalent) compared with 94% of the 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 2014.

According the WHO/UNICEF official estimates vaccination coverage of children under 1 year old in 2014 for BCG was 98% and 94% for OPV3. DTP3 is indicated at 97%. The dropout rate between the first and third doses of DTP is 5%. Less than 1% of children aged 18-29 months have not received any vaccinations (DHS 2012).

During 2014, no outbreaks were detected which serves as additional indication of the strengths of National Immunization Program (NIP).

The Government of Tajikistan recognizes NIP as one of the priority national public health programs. This was confirmed by the efforts of the Government to develop an efficient legislative framework for implementation of NIP in the country, declared responsibilities of the Government to ensure access for

<sup>1</sup> All-countries-Commitments-and-Disbursements

free immunization services to the population, commitment of the Government to provide financing for fulfilling co-financing commitments for vaccine procurement and 100% execution of approved budgets.

Despite the Government's efforts to provide free basic services including immunization services to the population and to maintain achievements of NIP; the financial allocation for the NIP implementation is insufficient. Financing to the health sector from the budget is low in general which could be regarded as an alarming problem faced by the NIP and by the country as a whole. Economic crisis and local currency depreciation further aggravate existing funding problems, jeopardizing availability of resources for vaccine procurement and for delivery of immunization services, which calls for immediate attention.

In Tajikistan, gender disparity is not an issue in immunization coverage and in access to health care for immunization services as it was confirmed by the number of studies and surveys carried out in the country.<sup>2</sup>

During the Joint Appraisal, the mission members identified strengths, successes and major challenges of Tajikistan NIP through the extensive consultations with the key stakeholders of the health care sector. High level political commitment to the immunization program and support from development partners country achieved high coverage rates for all antigens. The country introduced the Rotavirus vaccine in January 2015. Availability of an up-to-standard SOP Manual on vaccine management and development of communication and crisis communication strategies were named among successes of the immunization program. Lastly, the country is following the recommendations provided by WHO for realization of the Global Polio Eradication End Game Strategy.

Despite of all these achievements, there are variety of challenges faced by the NIP, which have to be addressed for ensuring sustainability of program achievements:

- As Tajikistan is the poorest country in the region, financing to health sector is not sufficient leading to inadequate fiscal space for NIP.
- In addition to the fiscal space limitations, the country has insufficient capacity to plan and coordinate effectively mobilizing financial resources to fill existing funding gaps for immunization program and vaccine procurement
- The country has on-going health reforms which includes integration various services at the primary healthcare (PHC) levels. It would be essential to analyze of potential implications of integration of immunization services into the broader health care system both from programmatic and financial aspects to determine the long term needs.
- Difficult economic situation triggering currency depreciation and jeopardizing immunization services and vaccine procurement, which may lead to the stock outs of vaccines in February 2016 (MR, Hepatitis B, bOPV);
- RCI requests for vaccine procurement funds from MOHSPP however, do not consider requesting funds for critical expenditures of the program such as fuel, maintenance of cold chain, etc. IN addition, in 2015, RCI did not request for funds co-financing of rotavirus vaccine and local currency depreciation.
- RCI needs long term in-country technical and programmatic support to improve program planning, management and related capacity.

**Key recommended actions to achieve sustained coverage and equity** (list the most important 3-5 actions)

Following key priority areas were identified for achieving sustainable coverage in Tajikistan:

- Maintain immunization as a priority
- Build RCI's and MOH finance department's capacity for resource mobilization efforts for vaccines by better integrating into the existing coordination platforms such as ICC, Donor Coordination Committee etc.
- Advocate for immunization financing to the Government and the MoF through preparing rationale on value and benefits of immunization
- Assess long term financial and programmatic implications of integration of services at PHC level (under the health reforms) to immunization outcomes

<sup>2</sup> UNDP Human Development Report 2013; DHS and MICS

- Need for long term human resource capacity at WHO country office to support program for effective management and planning of activities of the RCI

### 1.3. Requests to Gavi's High Level Review Panel

#### Grant Renewals

##### New and underused vaccine support

In 2016 Tajikistan requested renewal of Gavi support for Pentavalent vaccine and Rotavirus vaccine.

##### Health systems strengthening support

In 2015 Tajikistan submitted a stand-alone Gavi HSS2 proposal for approval and funding. Approval of the HSS2 grant is pending.

Details on HSS2 grant status and conditions for approval are presented in the 3.2.1. Section of this report - "Grant performance and challenges".

### 1.4. Brief description of joint appraisal process

The Joint Appraisal was conducted during the period of August 24 - 29 2015 in Dushanbe by the Joint Appraisal Mission composed by the representatives of Gavi Secretariat and WHO Regional office for Europe. The mission participants met with the Deputy Minister of Health and Social Protection of Population (MOHSPP), Heads of Departments of Maternal and Child Health, Economics and Finances and Budget Planning of the MOHSPP, as well as HSS Focal Point at the MOHSPP. The Mission participants also met with the Senior Management team of the Republican Center of Immunoprophylaxis (RCI), Health Policy Analysis Unit of the Scientific Research Institute for Preventive Medicine, Center of Family Medicine, Health care and Labor Budget Planning Unit of the Ministry of Finances (MoF), the World Bank Country Office Representatives, as well as the representatives of the UNICEF and WHO country offices.

This report was drafted by the independent consultant in close cooperation with Gavi SCM, and is based on the desk review of the relevant background documents, and extensive discussions during the mission. The report was shared for feedback with the mission members, regional offices of WHO and EURO for technical components and country counterparts. The Minister of Health and ICC members discussed (August 29<sup>th</sup>) and endorsed final findings and recommendations of the report on September 16<sup>th</sup> 2015.

## 2. COUNTRY CONTEXT

### 2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants

#### 2.1.1. Leadership, governance and program management

**The Immunization Program of Tajikistan benefits from effective communication and collaboration with Gavi, WHO, UNICEF and from the strong political commitment of the Government to reform and increase efficiency of the health care sector.**

##### Health Sector

Tajikistan inherited the Soviet health care model, which is structured around a network of in-patient health facilities. The financing of hospital services on the basis of beds has encouraged superfluous capacity. Since independence, the system has remained virtually unchanged, burdened by large and crumbling infrastructure, scarce funding, weak governance structures, high turn-over of the staff, and a lack of human resources. Currently Tajikistan is *experiencing a shortage of both doctors and nurses* with imbalanced distribution of human resources across the regions. However, due to the ongoing health care system reforms, the profile of the health workforce is significantly changing from being dominated by specialists to family doctors and family medicine nurses. While allocations to the health sector as % of total government budget have increased in recent years they are still among the lowest in the region or in the range of 6-7% representing a major underlying challenge for the sector. Health care reforms are ongoing to try to improve efficiency and equity in the use of resources including piloting of output based payment systems and performance based funding.

##### Political Support

The Government of Tajikistan recognizes National Immunization Program (NIP) as one of the priority national public health programs, which is confirmed by the legislation of the Government for immunization program and however short, the commitment to provide financing to the NIP.

The Deputy Minister of Health chairs the Inter Agency Coordination Committee (ICC). The senior representatives from the MOHSPP and representatives of the major international organizations, such as UNICEF, WHO and JICA are among the ICC members.

In 2011, by the special Decree of the Ministry of Health, the Government of Tajikistan approved The National Immunization Program of Republic of Tajikistan for 2011-2015, which is fully in line with the WHO Global Immunization Vision and Strategy. Currently the Government is working on developing the new cMYP for the period 2016-2020.

As part of the public immunization policy the government guarantees free preventive vaccination to Tajik citizens included in the national immunization calendar,<sup>3</sup> which was confirmed in the “National Health Strategy of the Republic of Tajikistan for 2010-2020”, underlining responsibility of the Government to provide free immunization services against maternal tetanus and to all newborns in the absence of contraindications according to the National Immunization Schedule.

Finally, political support of the immunization program is confirmed by the ongoing health care system reform, which considers immunization program as an integral part of the broader health care system of the country.

#### **National level program management**

The NIP in Tajikistan generally operates in isolation, with limited cooperation with other implementing departments or agencies of MOH, with its own funding stream, dedicated staff at national level, specific procurement and logistics systems, and separate planning and information system. This separation was determined by historical patterns of government funding and donors’ investments.

At the national level, the NIP is managed by the Republican Centre of Immunoprophylaxis (RCI), with 40 member staff and three structural units: Departments of Epidemiology, Organization and Statistics and Department of Vaccines. RCI is also responsible for the program management at the sub-national level, which is provided through the three oblast level branches in Dushanbe, Gorno-Badakhshan, and Sagdi oblasts, and zonal branches in of Kuliab, Kurgan-Tiube, and Rasht. The staff of the sub-national level centers is composed of 6 to 10 members. Some of the NIP program functions have been delegated to other structural units over past few years. This separate management descends to the district level through the District Centres for Immunoprophylaxis (CIPs) operating under the administrative and financial management of the District Central Hospitals, or District PHC Centers. In a few districts the NIP program is managed by the Independent CIPs, financed by the local administrations (Hukumats) and operating based on the approval of the CIP charter and budget by the local administrations.

At service delivery level, immunization services are mostly integrated with primary health care services and delivered by PHC health workers. There was also an additional element of service provision, where vaccinations had been provided through outreach services, but the service provision was suspended based on the decision of the National Health Coordination Committee due to the lack of required financing. In addition, there was problems identified by the Gavi HSS assessment about the data collection from these services and sustainability of the mobile teams.

#### **HSCC/ICC**

There are multiple committees, sub-committees, and committee working groups involved in coordination of GAVI grants. The **National Health Coordination Committee (NHSS)** was established by the Government of Tajikistan in 2010 and represents the main sector level coordination body in the country. The **Health Systems Coordination Committee (HSCC)** was established by the government in 2007 at times of accessing the GAVI HSS funds in 2007. The committee is formed by the heads of MCH,<sup>4</sup> Family Planning and Sanitary and Epidemiological Departments of the MOHSPP, as well as Republican Centers of Immunoprophylaxis and Family Medicine. As requested by Gavi, the HSCC along with government representatives included representatives of WHO and Unicef Country offices, as well as representatives of the WB and local Civil Society Organizations (CSOs). The Committee was charged with overall responsibility for the HSS program oversight and coordination, including coordination with other health programs implemented in the country. The HSCC and the Alliance partners played critical

<sup>3</sup> Law of RoT on Immunoprophylaxis of Infectious Diseases dated 21. 12. 2010, no 680, Dushanbe – 2011, p. 15

<sup>4</sup> Maternal and Child Care

role during the HSS proposal development and revision phases. *However, after receipt of the HSS grant, the HSCC mostly failed in its coordination and oversight functions.*<sup>5</sup> Throughout the program implementation the role of the HSCC was largely limited to reviewing and approving high-level annual program plans and budgets, without discussing the necessary details required for effective oversight and/or coordination.

The **Inter-Agency Coordination committee (ICC)** is composed of 10 members and is chaired by the Deputy Minister of Health, the Head State Sanitary Doctor. Initially the ICC was composed by the senior representatives of the Ministry of Health (Heads of the Maternal and Child Health, Sanitary, Epidemiology and Emergency Medical Care and Health Service Organization departments), State Medical Surveillance System, Republican Center for Healthy Lifestyle, RCI and representatives of implementing partner organizations, such as UNICEF, WHO, JICA and project HOPE. However, the current composition of ICC is unclear due to the frequent turnover of the ICC members.

In general, the roles, functions and accountability of both Gavi support coordination mechanisms (HSCC and ICC) are vague and require substantial revision of the relevant documents, such as TORs and SOPs related to the functions and accountability for ensuring effective linkages to the main implementing departments of MoHSPP.

It is noteworthy that the HSCC and the NHCC exist in parallel the former focusing on wider sector issues while the latter one is mostly focusing on health system support through GAVI.

### **NITAG**

Establishment of NITAG was discussed between the members of the WHO EURO mission and the Deputy Health Minister and Senior management of NIP in July 2014. During the meeting, the mission members discussed rationale for the establishment and added value of an independently standing advisory body on immunization. The discussion focused on how a NITAG can enable the Ministry of Health to optimize the current immunization program and make informed decisions on introduction of new vaccines and technologies. It was agreed that a well-balanced and institutionalized group could be instrumental in increasing credibility of the MOHSPP decisions on immunization policy and practice, as well as in empowering key policy- and decision-makers of the health sector to resist pressure from specific lobbying groups. It was decided that WHO EURO will provide technical support to the NIP in defining NITAG composition and Terms of Reference and development of NITAG Charter.

During the Joint Appraisal mission, the NIP Management confirmed their interest and readiness to establish NITAG and reported about the initial preparatory activities carried out by the country. The JA mission confirmed decision of the WHO to provide technical assistance for supporting NIP in development NITAG charter, selection of NITAG members and development of TORs for NITAG operations by the end of 2015.

### **Legislation framework**

The Government of Tajikistan elaborated and approved key policy documents regulating all activities in the country related to the immunization sector. The details of the existing legislative framework are represented in the Section 2.1.1. "Leadership, governance, and program management" of this report.

### **National Regulatory Authority (NRA)**

The State Service on Surveillance of Pharmaceutical Activities acts as the National Regulatory Authority, and is in charge of registration of pharmaceuticals in the country. However, functions of the National Regulatory Authority are not in place. The vaccines are not registered in the country and import is based on the individual waivers issued for importing a particular shipment. No expedited procedure for registration of WHO pre-qualified vaccines was adopted by the country. The NRA does not perform all the required functions such as licensing and post-marketing (AEFI surveillance). The AEFI surveillance function is partially performed by the EPI, receiving notifications and carrying out investigation of cases. No AEFI case has been detected during the last few years.

Considering the current state of the NRA functions, it is important that the NRA's critical regulatory functions for vaccines is assessed and strengthened.

<sup>5</sup> HSS Assessment (2014)

### **Gender and Equity**

According to the UNDP's Human Development report for 2014, Tajikistan's Human Development Index (HDI) for 2013 is 0.607— which is in the medium human development category—positioning the country at 134 out of 187 countries and territories. The Gender Development Index (GDI) based on the sex-disaggregated Human Development Index, defined as a ratio of the female to the male HDI. The 2013 female HDI value for Tajikistan is 0.591 in contrast with 0.621 for males, resulting in a GDI value of 0.952.

However, gender disparity is not an issue in health care, and the recent surveys including DHS and MICS confirmed almost no gender gap in immunization coverage and access to health care. There is also no ethnic disparity in access to immunization services. Geographic difficulties could be regarded as an important gap in terms of equity in immunization service provision of the country. There is also inbuilt inequity in the allocation of resources in the health sector, with allocation of funds being based more on inputs such as existing infrastructure that in many cases is outdated, rather than actual population numbers, needs and provider outputs.

#### **2.1.2. Costing and Financing**

##### **Fiscal space**

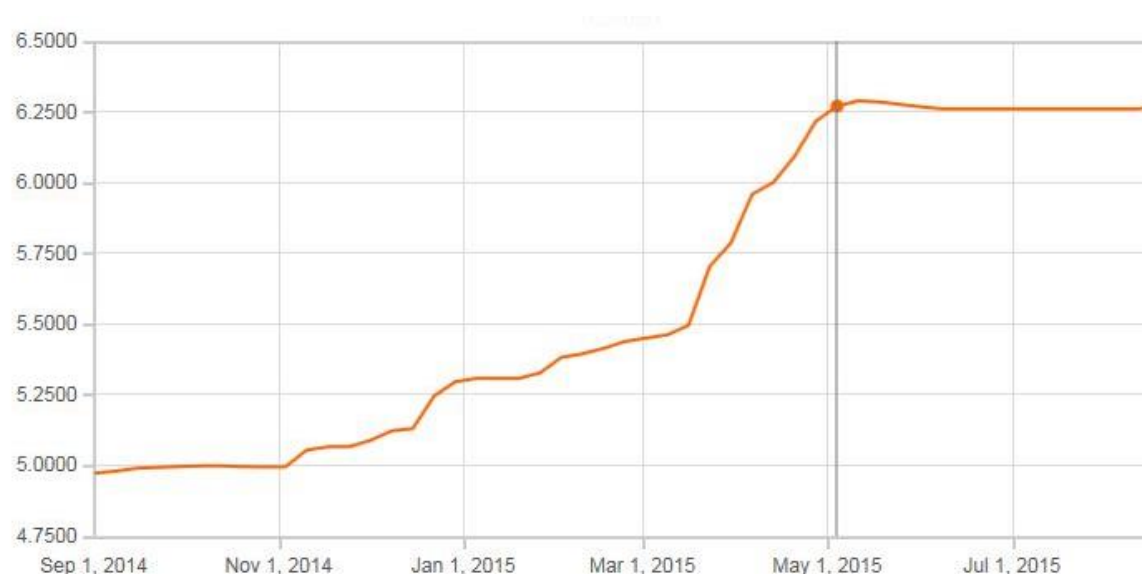
The health budget development cycle starts at the beginning of the year and consists of two development phases: phase I – development of the basic budget, and Phase II - development of the new budget (for the next year). The basic budget is developed by the MoF and submitted to the MOHSPP. Together with the basic budget, the MoF provides the Ministry of Health with the budget ceilings that are elaborated and approved by the special resolution of the Government. Based on the Basic Budget and the budget ceiling, the MOHSPP develops the budget for the following year, and returns the final draft budget to the Ministry of Finance by September 1st of each year. During the two week period after submission of the budget to the MoF, the new budget is intensively discussed and debated between the representatives of MoF and MOHSPP for finalization. The MoHSPP submits the final budget to the Government for approval by September 15, and the government approves the budget by the end of the year.

There is dedicated budget line for the immunization program but there is a separate line item within MOH budget for vaccine procurement including line item for co-financing. Approved funds are transferred to the MOHSPP account and further disbursed by the MOHSPP to all separate state programs and MOHSPP structural units.

The large majority of funds received at the national and local levels are spent for covering costs of personnel. National level institutions spend approximately 90% of their budgets for salaries and 10% on other expenses, while on the regional level 40% of the budget goes into covering immunization services, and 60% - to cover other costs of the NIP.

Low allocation of finances to the health sector is the major challenge faced by the NIP Tajikistan. The overall context in terms of immunization was further complicated with the recent currency depreciation that significantly jeopardized availability of resources for vaccine procurement and for provision of immunization services. (see below figure on USD-TJK Somoni exchange rates)

Figure 1 Currency depreciation in Tajikistan (USD vs Tajik Somoni)



### **Financial Management:**

Financial management of the NIP deserves special attention taking into account the results of the HSS assessment carried out in 2014. The weaknesses in financial management were documented earlier at the proposal development stage, and were addressed through assignment of fiduciary and procurement responsibilities to WHO CO. However, during implementation, the fiduciary and procurement responsibilities given to WHO CO were not effectively exercised, increasing the risk for implementation of the HSS grant in a complex country environment such as Tajikistan. According to the assessment findings it was appropriate for Gavi to reconsider its current partnership model for financial risk management, and to look for alternative solutions. Similarly to the management of the HSS programmatic part, the financial management mechanisms, responsibilities and functions had transparency issues, and were completely unclear. No or incomplete bank statements and other requested financial documents were provided to Gavi despite of multiple requests, which raised major concerns in terms of capacity of the local management to meet the reporting and accountability procedures set for the program implementation.

### **cMYP**

Tajikistan's current cMYP covers 2011-2015. The country is currently working on the 2016-2020 cMYP, and expects to finalize it in Q4 of 2015.

### **Government and donor funding**

The estimated cost of NIP for 2014 is \$5.3 mln including the cost of vaccines and supplies (\$4.5 mln), operational costs (US\$ 0.47 M), and staff cost (US\$ 0.35 M).

In 2014, the government allocated \$1.4 mln for the NIP implementation, and donors provided \$3.91mln. In addition, the project HOPE provided one time financial support for procurement of Hepatitis B birth dose due to the shortage of vaccines in 2014.

Gavi has been one of the primary donors of the programme since its inception in 2000, and has provided ISS, HSS and NVS grants to Tajikistan. The country remains Gavi-eligible and qualified to receive all types of support. In 2014 the program was supported by the international implementing partners, such as UNICEF, WHO, JICA and KFW. The details of the financial support provided by these organizations are represented in the table below.

Table 1 The NIP funding in 2014 (source: RCI)

Source	Amount US Dollars
Government	\$1,402,547
GAVI	\$3,426,043
Unicef	\$89,805
WHO	\$135,891
JICA	\$203,027
KFW	\$395,446
<b>Total</b>	<b>\$5,318,759</b>

The NIP did not receive all requested funds for procurement of vaccines from Government in 2014 and in 2015 and will not receive in 2016. The RCI efforts to raise donors' funds to fill in the gap in financing procurement of vaccines are not well orchestrated with annual plans and communication. The donors are approached individually and on ad-hoc basis when there is a risk of vaccines stock outs. The NIP does not use existing mechanisms to raise additional funds in planned, transparent, and systematic way (through National Donors Coordination Committee).

### **Procurement mechanism**

Republic of Tajikistan procures all its non-Gavi traditional vaccines and the vaccines for SIAs exclusively through UNICEF SD. The procurement is based on the MoU signed between UNICEF and MOHSPP Tajikistan on 30 March 2004. The MoU is still valid, and thus, the procurement of newly introduced Rotavirus vaccine was carried out through the UNICEF SD. Country does not request alternative mechanisms for vaccine supply and procurement.

The funds required for procurement of new vaccines are directly transferred by RCI to the UNICEF Supply Division via UNICEF country office. The RCI and MOHSPP are responsible for all operations related to the transfers.

### **Human resources**

The immunization services in Tajikistan are provided through the PHC network. The country experiences shortages of health professionals in PHC facilities, and therefore, the immunization program experiences lack of skilled human resources trained in immunization at local levels.

HR development is one of the main component of the HSS Project, particularly, *Objective 1 of the project – "Capacity strengthening of PHC with focus on immunization service quality and safety"*, aiming at training of all staff of immunization services in EVM at the national, regional, and district levels.

The level of staff qualification at the primary health care level particularly related to the qualification of General Practitioners/Family Health Doctors, who were delegated with the responsibility to provide multiple medical services to the population, including immunization. There is a lack of funds at all levels for ensuring regular training of GPs and vaccinators on immunization. There is also the lack of training opportunities and knowledge about the new vaccines among medical specialists, which causes multiple concerns about the safety of vaccines, as well as wide range of contraindications given to the patients. Finally, there are concerns with regards to timeliness of the BCG and the birth dose of HepB vaccines in the regions with high proportion of home deliveries.

### **Cold chain and logistics**

The latest EVM assessment was carried out in Tajikistan in August 2015. The assessment report presented findings, and provided recommendations for improving vaccine management and cold chain to improve the program cold chain performance. In 2012, the total value of vaccines passing through the Central Vaccine Store was US\$ 2.6 million. With the introduction of Rotavirus vaccine (in 2015), one dose of IPV in 2016, and a plan to introduce PCV and HPV for girls in 2018 and 2020 into the routine schedule, the value will increase to US\$ 29 million, approximately 11 times.



EVM assessment report provided following programmatic recommendations:

- An appropriate stock management computer application should be installed at the central vaccine store and six provincial stores;
- Cold chain equipment preventive maintenance plans should be developed and shared with all vaccine stores and immunization facilities;
- Vaccine management training should be updated with particular emphasis on stock management and use of SOPs
- The vaccine management knowledge and understanding of all staff should be refreshed and updated on a regular basis;
- Freeze indicators should accompany all freeze-sensitive vaccines during transportation;
- Fridge tags should be used at all provincial and all 66 district stores and relevant training should be given to all staff at these two levels;

In addition to these programmatic recommendations EVM assessment team provided following strategic recommendations:

- Vaccine stock management should be computerized and integrated at central and provincial levels.
- An appropriate computer application such as the WHO/UNICEF recommended Vaccination Supplies Stock Management (VSSM stand-alone) should be used in 2015 and staff should be trained at these two levels. Particularly at the central level the staff are young and computer literate, and ready for gaining new experience. This will bring culture of accuracy and accountability to this level, and can be a good start for drawing the plan to expand the use of VSSM to district level in 2016. The adoption of such technology should alleviate many of the weaknesses in stock management identified by the assessment.
- The program should shift from the current district collection of vaccines from the province to a system in which provinces deliver vaccines to district stores. Currently, most of the 59 district stores collect vaccine from the six provincial stores.

The total costs for implementation of strategic recommendations is estimated to be US \$ 493,000, which includes US \$ 387,500 for equipment and infrastructure, and US \$ 105,500 for training and management development.

#### **Immunization service delivery**

As it was mentioned in section 2.1., the immunization services represented by national Republican, regional, and district immunization centers in Tajikistan generally operate in isolation with its own funding stream, dedicated staff at national and sub-national level, specific procurement and logistics systems, and separate planning and information system. The program functions that are most integrated into health systems are at the service delivery levels and surveillance of vaccine-preventable diseases. However, the NIP does not have the program management capacity that would ensure better coordination with other agencies for program implementation and vice versa.

The immunization services in Tajikistan are provided through the PHC network facilities. There are approximately 2,500 fixed and mobile vaccination points in the country. At the PHC facilities, routine immunization 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 have been served by mobile teams travelling quarterly from district level. However, the mobile and outreach service provision has been suspended based on the decision of HSCC due to the lack of financial resources.<sup>6</sup> HSCC recommended to reassess the need for mobile service provision within the framework of the new HSS program, and to present the assessment results to the Government of Tajikistan and the Ministry of Finances in order to secure additional funds for mobile strategy implementation.

#### **AEFI reporting disease surveillance**

NRA does not perform AEFI monitoring and related functions. AEFI surveillance is carried out by RCI staff that is limited to the receipt of notifications and for carrying out case investigations. As per RCI management, no cases have been reported during the last two years that makes quality of AEFI

<sup>6</sup> HSCC meeting notes, April 24, 2015

functions and related reporting systems questionable. Considering the low technical capacity, lack of experience, and limitations of the skills of the RCI staff, the AEFI system requires substantial revision.

More detailed information on AEFI and disease surveillance will be obtained during the Post-Introduction Evaluation of Rotavirus vaccine by the end of this year.

### **Communication**

In 2014 UNICEF provided technical assistance to NIP for development of immunization strategy and crisis communication strategies.

Through the technical assistance provided by UNICEF, the NIP developed immunization and crisis communication strategies. For realization of these strategies, action plans including capacity building and awareness raising at various levels targeting different health professionals, parents and public, has to be developed, elaborated and translated into the local language and implemented as per action plans.

### **Polio eradication**

Tajikistan, together with the rest of the WHO region, was certified as polio free in 2002. In 2010, the world's largest Polio outbreak in Tajikistan raised concerns about weaknesses in the routine immunization services and in the reliability of the reported coverage. Past immunity gaps in the population were also demonstrated by a sero-survey conducted by WHO and the Centers for Disease Control and Prevention (CDC) US. EPI review conducted in 2012 following the polio outbreak also indicated that immunization management information system is insufficient in Tajikistan.

The SIAs with OPV lasted through 2012, and there was no mass campaign in 2013 due to lack of funds to cover operation costs; the SIAs was conducted in February 2014. In addition, in 2014 due to the proximity of Tajikistan to Afghanistan, still polio endemic country, the MOHSPP conducted national immunization days against polio in two rounds (first round on 14-18 April 2014 and the second round on 19-23 May 2014) with the coverage exceeding 92%.

In 2014, Gavi approved the IPV introduction, initially scheduled for October 2015. However, due to the vaccine supply constraints, the introduction was postponed until the January 2015.

The IPV introduction is a part of the "Polio Eradication and End-game Strategy". According to the introduction plan, by the end of 2016 the introduction aims at reaching 95% coverage rate at the national and regional levels, and at least 90% coverage rate at the district level, at the same time maintaining OPV coverage rate above 95%.

Tajikistan started preparatory process for IPV introduction, and developed training and educational materials with the support provided by the implementing partners. WHO recommended to include physicians in the IPV introduction trainings, as well as to provide refreshment trainings on effective vaccine management and cold-chain at all levels of the system.

NIP is also preparing the plan to switch from tOPV to bOPV in April 2016. However, after obtaining the financial figures planned for 2016 for the NIP, the mission members identified potential crisis with bOPV procurement faced by Tajikistan due to the lack of program financing which should be addressed as soon as possible. Currently, there is no clear plan and/or options for addressing this problem, no plans made to approach donors to mobilize required resources, which calls for immediate action as Tajikistan is defined as high risk country for transmission because of the neighboring endemic countries.

#### **2.1.3. Other factors, events**

As Tajikistan's GNI per capita for 2014 is above the Gavi low-income country threshold, it will be considered as part of the preparatory transition co-financing grouping (formerly referred to as intermediate) as of 1 January 2016.

This will have the following implications for Tajikistan:

- As 2016 is the first year in this new grouping, Tajikistan will be required to continue its co-financing payments in accordance with its previous status, and consequently, to contribute US\$0.20 per dose of pentavalent and rotavirus vaccines.
- Starting from 2017, the co-financing rules of the preparatory transition phase will apply. Under the revised co-financing policy, Tajikistan will co-finance a share of the vaccine price. This co-financed share will increase by 15% annually.

This new status will put more stress on the financial situation and it is paramount to improve the financial planning and resource mobilization for immunization financing.

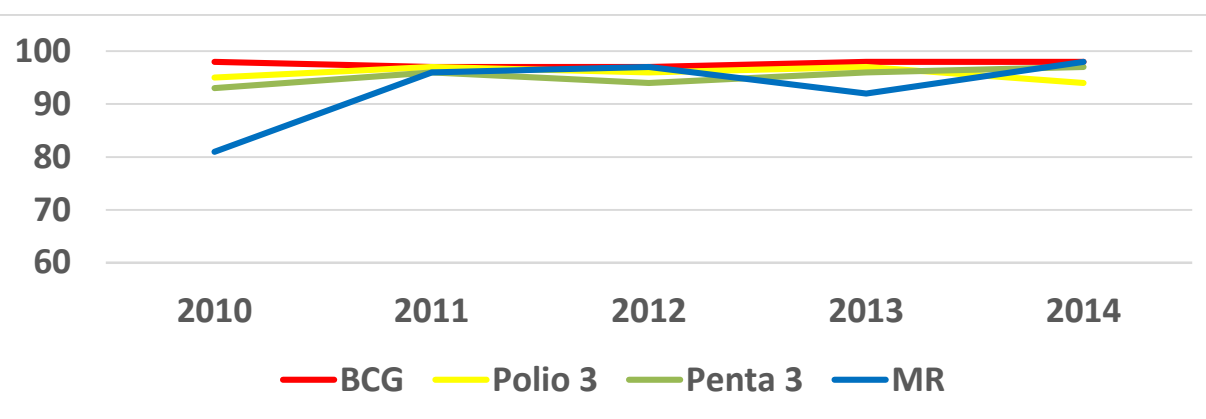
### 3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

#### 3.1. New and underused vaccine support

#### 3.2. Grant performance and challenges

In 2014, Gavi provided support for Pentavalent vaccine, as well as for vaccine and introduction support for Rotavirus Vaccine totaling 2,601,642 USD. In early 2014, the country also received the last tranche of HSS funding of 334,000 USD.

**Table. Routine immunization coverage rates**



**Rotavirus vaccine:** Rotavirus vaccine was added to Tajikistan's NIP in 2015. The vaccine is administered in two doses at age two and four months. With the technical assistance provided by the WHO, the training materials were developed and adopted to the national requirements. These materials included a Pocket Book for vaccinators, and training modules for administration of the Rotavirus vaccine (translation and custom-tailoring to the local context). Additional ToT trainings were delivered by the WHO and RCI at the national level. At the regional level, trainings for vaccinators were delivered. In result, 3003 vaccinators were trained in storage, transportation, and use of the Rotavirus vaccine.

In April 2015, seminars and trainings were delivered to the GPs. Trainings covered topics of the benefit, efficiency, and AEFI of immunization with the Rotavirus vaccine.

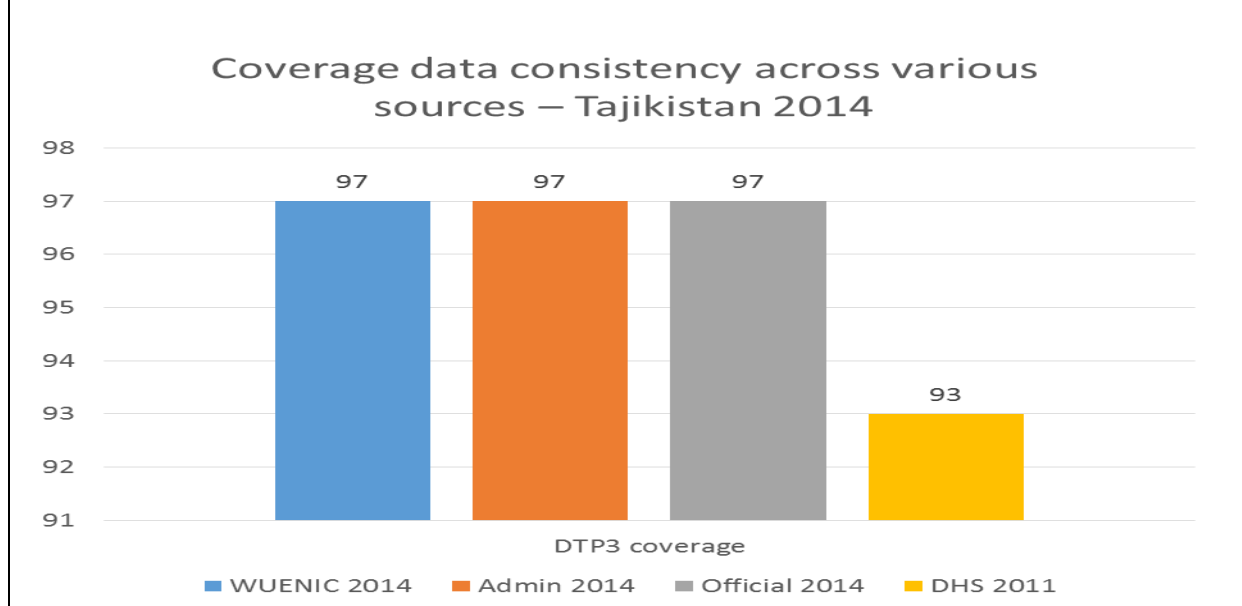
As of July 2015 coverage with the 1<sup>st</sup> dose reached 52%, and the coverage rate for the Rotavirus 2<sup>nd</sup> dose reached 41%. As per initial reports from the field the Rotavirus vaccine was well accepted by the medical workers and parents. There were some concerns with timeliness of vaccination due to the migration and false contraindications, as well as the confusion among vaccinators about the age restrictions related to the Rotavirus vaccine.

Since 2009, WHO supported implementation of the sentinel surveillance sites at the two major urban areas of the country. The surveillance results demonstrated high burden of rotavirus disease, where more than 35% of all hospitalizations for gastroenteritis among the children under 5 years are attributed to rotavirus. The highest burden of rotavirus diarrheas were observed among the children aged 6-23 months.

The Post Introduction Evaluation is planned in November 2015.

IPV: the detailed information on preparations and status of the IPV introduction is represented in the "[Polio eradication](#)" section of this report.

**Data Quality:** The estimates of immunization coverage from various sources are largely consistent. The figure below represents DTP3 coverage estimates from four different sources. The last national coverage survey was conducted as part of DHS in 2011 and the estimates were close to the administrative data.



### 3.1.2 NVS renewal request / Future plans and priorities

In 2016 Tajikistan requested renewal of Gavi support for Pentavalent vaccine and Rotavirus vaccine.

Depending on fiscal space for immunization financing there are plans for application in later in 2016 for PCV vaccine.

## 3.3. Health systems strengthening (HSS) support

### 3.3.1. Grant performance and challenges

The main goal of the Tajikistan HSS-1 program was to improve access to and demand for basic health services in poor hard-to-reach areas through increased financial commitment of the government at all levels, creation of outreach and demand for services, and improvements in the quality of physical and human resources. The program was planned to be implemented in six districts: Farkhor, Kumsangir, Vose and Baldjuin from Khatlon oblast and Gornaia Matcha and Ganchi in Sogd oblast during 2008-2010. However, delays in implementation shifted end date to 2014.

In July-August 2015, Gavi commissioned a HSS assessment to see the results of HSS implementation, and to inform the HSS -2 proposal development process.

The assessment findings indicate that while overall design of the HSS program with its key objectives being relevant to the country context was kept unchanged, the program and financial management of the program, as well as the specific activities proposed in the original proposal underwent major revisions.

Some changes in the activities were significant, and had major negative consequences for the program outcomes. In particular, piloting the conditional cash transfers (CCT) was completely changed from its original design during implementation, and instead, food parcels (food aid), not linked with improved health-seeking behavior, were implemented without adequate scale to achieve any tangible results.

Similarly, the scope of the Primary Health Care (PHC) information system enhancement was narrowed down to immunization information system only, and instead of integrated trainings, only the ones focused solely on immunization related issues were delivered. The assessment also stated that the quality of implemented activities is cause for concern.

Finally, responsibilities for program management were significantly altered from its original design, and instead the governmental entities with limited capacity in health system related issues were placed in charge of the program management. Obviously, this decision had negative impact on the program implementation and achieved results.

The National Health Sector Coordination Committee (HSCC) established by the government in 2007 was envisioned as the key coordinating body for the HSS program oversight and coordination, including coordination with other health programs implemented in the country. However, after the receipt of the HSS grant, the management and coordination responsibility the National Health Coordination Committee (HSCC) established by the Government of Tajikistan in 2010 and representing the main sector level coordination body in the country. Thus, the HSCC mostly failed in its coordination and oversight functions, and its role was largely limited to reviewing and approving GAVI HSS high-level annual program plans and budgets, without discussing the necessary health system context topics or details required for effective oversight and/or coordination.

Currently, the roles, functions, and accountability of both Gavi support coordination mechanisms (HSCC and ICC) as well as other committees involved in the HSS coordination, such as National Health Coordination Committee, are unclear, and require substantial revision of the relevant formal documents such as ToRs and SOPs related to the functions and accountability.

The findings of the assessment were shared with the MOHSPP and Gavi partners, and it was expected that the new HSS2 proposal would take the issues raised in the assessment into consideration. The HSS2 proposal was recently reviewed by the IRC, and recommended approval due to the technical strengths of the proposal. However, several aspects of the proposal still require clarifications and revisions. Particularly, revision of distribution of roles, as well as the issue of accountability of Gavi support coordination mechanisms (ICC and HSCC), selection of ineligible CSO that does not meet the Gavi eligibility criteria, exclusion of WHO from leading implementing partners, lack of the financial implications of the EVM improvement activities recommended by the EVM assessment in the program budget.

The new HSS funding (HSS2) totals to 9,659,748 USD for five years (January 2016 to December 2020) with major the focus on increasing the coverage in the areas where coverage is low, including some urban populations. *(please see the next section for strategic focus of the new HSS2 proposal)*

The other key component is the improvement of cold chain and logistics, as well as improvement of services at primary health care (PHC) level.

All these challenges were discussed with the representatives of MOHSPP and HSCC, and identified and agreed on all necessary activities for implementation before disbursement of HSS2 funds:

- Address ambiguity of roles, functions, and accountability of Gavi support coordination mechanisms (ICC and HSCC);
- Review and revise coordination mechanisms including HSCC, CG, ICC, and ensure linkages to main implementing departments of MOHSPP
- Revise relevant documents such as TORs, SOPs on the functions and accountability
- Reselect CSO member for the HSCC considering that the current member does not meet the Gavi requirements
  - o GAVI SCM provide support in the selection process
- Develop CSO engagement strategy for implementation upon selection of the CSO
- Reinstate the role of WHO as a leading implementing partner, and revise the budget accordingly
- Revise the budget based on recommendations of recent EVM assessment
- Review and improve monitoring and evaluation framework
- Develop detailed annual plans of activities and annual procurement plans
- Conduct Financial Management Assessment (FMA) to review the program and financial issues, and follow up on the findings

In addition, Gavi secretariat will work closely with partners to ensure that there is appropriate program management and coordination structures in place for the governance of HSS funding as per recommendations of HSS assessment and IRC before any Gavi HSS funds can be disbursed to Tajikistan.

Tajikistan is eligible for Cold Chain Enhancement (CCE) Platform, the new Gavi opportunity, to support cold chain and vaccine management areas. The country is in need of support for development of CCE proposal that will be complimentary to the pending HSS-2 funding.

### 3.3.2. Strategic focus of HSS grant

The HSS2 proposal which is recommended for approval (with comments) by the IRC in its last review in July 2015, aims at the following four strategic objectives:

**Objective #1: Strengthen capacity of PHC with focus on immunization service quality and safety**

The objective contributes to maintaining high immunization coverage and equity in relatively well performing districts mainly through strengthening supply chain management and increasing the safety and quality of immunization services delivery.

The objective is fully aligned with of the National Health Strategy and contributes to the achievement of the following results:

- improved vaccine logistics and distribution
- Strengthening cold chain and logistics with upgrades at the central as well as sub-national level (the recent EVM Assessment results will guide this component)

**Objective #2: Improve equity in vaccination by increasing immunization coverage in low performing and hard-to-reach areas**

The objective contributes to the improvement of geographical equity through reaching children in hard-to-reach areas, as well as decreasing missed opportunities for vaccination related to home deliveries. Furthermore the objective is aligned with the health sector strategic priority of “Raising Quality and Accessibility of Health Services”, thus, will be to promote rural health posts in hard-to-reach areas.

**Objective #3: Improve implementation of the National Health Strategy “Population Health of Tajikistan 2010-2020” with focus on immunization**

The objective contributes to the improvement of drop-out rates, increasing the proportion of fully immunized children and increasing coverage in low coverage areas as well as urban areas where there are pockets of low immunization coverage.

**Objective #4: Improve readiness of population to immunization and MCH services**

The Objective #4 (as the demand side intervention) contributes directly to the improvement of all immunization outcomes. In addition, it is essential to tackle coverage inequity affecting children born to mothers with high education and/or living in urban settings.

The objective contributes to the implementation of the priority interventions of the National Health Strategy, namely to communication and social mobilization activities.

### 3.3.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

N/A

### 3.4. Graduation plan implementation (if relevant)

N/A

### 3.5. Financial management of all cash grants

There were major issues in terms of financial management of the cash grants related to the significant deviations from the initial financial management.

More specifically:

1. Financial Statements for HSS 2014 (post April'14) are not submitted. Despite a document having a heading of Financial Statements HSS, there is no actual statement providing details of spending of the last tranche of HSS of \$ 334,000 beyond April 2014.
2. Financial Statements for VIG IPV for \$222,000 received in 2014 are not submitted.
3. Audit report for HSS 2014 is not submitted. It is not clear if final tranche is fully spent.
4. Bank statement for HSS, VIG is not submitted.

Gavi requests clarifications from Tajikistan:

1. Country to submit HSS financial statement for the entire 2014 showing the remaining balance at 31 December 2014.
2. Country to submit VIG IPV financial statement for 2014.
3. Country to submit an audit report for HSS 2014 if US 334,000 is spent in 2014 (i.e. >\$250,000).
4. Country to submit bank statement as at 31.12.2014 for HSS and VIG.

The country provided clarifications which are being reviewed by the relevant Secretariat teams.

Prior to disbursement of any new HSS funding, the new Financial Management Assessment will be carried out to follow up on the findings. The FMA will be conducted in the Q1 of 2016. The FMA will also follow up on the findings and recommendations of the Gavi HSS assessment conducted in August 2014. The assessment raised concerns on delegation of authority, transparency in decision making processes and lack of financial documentation.

## 3.6. Recommended actions

Actions	Responsibility (government, WHO, UNICEF, civil society organizations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
1. Maintain immunization as a priority	Government (Alliance partners working with collaboration RCI, MOH and relevant government agencies)	continuous	Government/PEF
2. The country has insufficient capacity to plan and coordinate effectively mobilizing financial resources to fill existing funding gaps for immunization program and vaccine procurement	RCI and MOH, WHO, Gavi Secretariat	2016-17	PEF
3. Advocate for immunization financing to the Government and the MoF through preparing rationale on value and benefits of immunization	RCI and MOH, WHO, Gavi Secretariat	2016-17	PEF
4. Assess long term financial and programmatic implications of integration of services at PHC level (under the health reforms) to immunization outcomes	WHO, RCI and relevant departments of MOH	2016-17	PEF
5. Need for long term human resource capacity at WHO country office to support program for effective management and planning of activities of the RCI	WHO	2016-17	PEF
6. Address financial issues listed in above section 3.4. Financial management of all cash grants	MOH (country responded, Secretariat review is on-going)	ASAP	MOH



## 4. TECHNICAL ASSISTANCE

### 4.1. Current areas of activities and agency responsibilities

In 2014 Tajikistan received following technical support from the Gavi Alliance partners:

#### WHO EURO

- Mission on development of Roadmap to introduce Mandatory Health Insurance in Tajikistan, March 2014
- Policy dialogue on improvement of health service delivery system in Tajikistan, March 2014
- Flagship course on Health Systems Strengthening, Tajikistan, 31 March – 3 April 2014
- Senior Policy Dialogue on Health Financing Reforms, 4 April 2015
- EVIPNet pilot phase launch, Tajikistan, June 2014
- Introduction of Systems of Health Accounts, 2014
- Mission on Rational Use of Medicines, September 2014
- Joint Annual Review of the National Health Strategy 2010-2020, in 2014
- National Health Summit, December 2014
- Support in development and implementation of rotavirus vaccine and IPV introduction plans
- Support in conducting trainings for medical workers on introduction of rotavirus vaccine
- Support in conducting vaccine management assessment
- Support in vaccine stock management review

#### UNICEF

- Development of EPI communication strategy and crisis communication strategy and strategy materials, including a booklet and a poster on immunization, leaflets on rotavirus, and polio and TV and Radio spots
- Printing of materials for Rota introduction
- Cold chain management – provided support to the MoHSPP to reassess the capacity of the cold chain system as a part of the cold chain infrastructure preparedness for IPV introduction for informing cMYP 2016-2020, as well as a procurement plan for cold chain equipment under GAVIHSS grant
- Capacity development activities concerned with development of SOPs for effective vaccine management, trainings of national, regional, and district EPI managers, training of the family doctors on the rotavirus vaccine, and training of family doctors from 10 remote districts on immunization I practice
- Polio campaign – provided communication support as well as campaign monitoring for two-rounds of polio campaign.

In addition the Gavi Alliance partners implement the following activities in 2015:

#### WHO

- Institutionalization of the Health Policy Analysis Unit, January 2015
- Joint mission on NCD and Health Service Delivery, June 2015
- Peer to peer training, sentinel surveillance for rotavirus, June 2015
- EVM Assessment (in collaboration with UNICEF) August 2015
- Joint Annual Review of NHS 2010-2020, Q4 2015
- Review of the National Family Medicine Programme, September-October 2015
- Mission on development of Public Health Concept and review of PH legislation, October 2015
- Civil Registration and Vital Statistics Rapid Assessment in Tajikistan, October 2015
- National Health Summit, in 2015
- Conduct trainings for medical workers on introduction of IPV vaccine, Q4 2015

- Establishment of NITAG in Q4 2015
- Rotavirus vaccine post-introduction evaluation November 2015
- cMYP development for 2016-2020, Q4 2015
- Data quality review, Q4 2015

**UNICEF**

- Finalization of the cold chain inventory
- Support for cMYP development in collaboration with the WHO
- Printing of SOPs for vaccine management and roll out
- Procurement of vaccines through the UNICEF SD

**4.2. Future needs**

The following are the most critical needs of Tajikistan in the future:

- Strengthening immunization financing and resource mobilization for immunization program
- Strengthening program management capacity of the RCI
- Positioning of the NIP, analysing impact of the reform on immunization outcomes.
- Implementation of the EVM assessment recommendations
- Development of proposal for Gavi's new of the cold-chain optimization platform
- Long term human resource capacity at WHO country office to support program

<i>Immunization financing &amp; resource mobilization</i>	<ul style="list-style-type: none"> <li>• Discuss mobilization of resources to fill financial gaps in procurement of vaccines and implementation of immunization programme at National Donors Coordination Committee</li> <li>• Support the MoH in raising additional financial resources through donors support to address possible stock outs of vaccines, including bOPV in Q1 2016 (GAVI, WHO, UNICEF)</li> <li>• Develop resource mobilization plan – (WHO TA)</li> <li>• Develop advocacy materials (for resource mobilization)– (WHO TA)</li> <li>• Train relevant staff for resource mobilization – (WHO TA)</li> <li>• Support high level visit to Tajikistan to advocate for increasing financing of immunization programme and health system in general (GAVI, WHO, UNICEF)</li> </ul>
<i>Vaccine procurement</i>	<ul style="list-style-type: none"> <li>• Assist country to develop plans for vaccine procurement and budgeting processes</li> <li>• Continue procurement of vaccines through UNICEF to ensure access to the most favorable prices (UNICEF)</li> <li>• Participate in procurement-related WHO training workshops – (WHO TA)</li> </ul>
<i>Evidence-based decision-making</i>	<ul style="list-style-type: none"> <li>• WHO support to the NITAG (building capacity through participation in Regional meetings and trainings, ETAGE meeting) (WHO TA)</li> <li>• Discuss introduction of new vaccines with GAVI support at future NITAG meeting and make recommendations for inclusion of new vaccines in cMYP for 2016-2020 (WHO TA)</li> <li>• Continued WHO support in implementation of rotavirus sentinel surveillance and documentation and utilization of findings as evidence for resource mobilization – (WHO TA)</li> <li>• Support in preparing applications to Gavi for the support with introduction of PCV and HPV demo project (WHO)</li> <li>• Costing HPV vaccine introduction and conducting cost-effectiveness evaluation (WHO)</li> <li>• Technical assistance in defining HPV delivery strategy and assessment of school readiness for HPV introduction; (WHO)</li> <li>• Support in development of national plan on comprehensive cervical cancer prevention and control (WHO)</li> </ul>

<i>Programme performance</i>	<ul style="list-style-type: none"> <li>• Implement recommendations of rotavirus post-introduction evaluation to be conducted in November 2015 – (WHO TA)</li> <li>• Continue trainings of medical workers on immunization (using MLM and IIP modules) at district and health facility levels – WHO TA</li> <li>• Further strengthening of supportive supervision through development of SOPs – WHO TA</li> <li>• Technical support in switching from tOPV to b-OPV - (WHO TA)</li> <li>• IPV vaccine post-introduction evaluation (WHO)</li> <li>• Support to prepare for introduction of PCV and HPV vaccines (WHO)</li> <li>• Develop and implement strategy to timely administer hepatitis B birth dose to infants born at home (WHO)</li> <li>• Improve coverage and services amongst urban areas and geographically hard to reach areas (Gavi HSS)</li> <li>• Provision of long term technical assistance to RCI by WHO country office to support and built capacity of staff of RCI to effectively manage the program (WHO)</li> </ul>
<i>Data quality</i>	<ul style="list-style-type: none"> <li>• Conduct coverage (sero) survey to validate administrative immunization coverage (WHO)</li> <li>• Revise immunization monitoring system to improve monitoring of timeliness of the first dose of hepatitis B vaccine (WHO)</li> <li>• Support in improvement of immunization coverage monitoring system based on the results of coverage survey (WHO)</li> <li>• Provide support on denominator issues to further strengthen the data quality (WHO)</li> </ul>
<i>Communication &amp; social mobilization</i>	<ul style="list-style-type: none"> <li>• Technical assistance in development and implementation of immunization communication action plans (WHO and Gavi HSS grant)</li> <li>• Educate health care professionals on vaccine safety and contraindications (WHO)</li> </ul>
<i>Vaccine management &amp; logistics</i>	<ul style="list-style-type: none"> <li>• Support implementation of recommendations of vaccine management assessment (WHO and UNICEF), including: <ul style="list-style-type: none"> <li>• cold chain equipment preventive maintenance plans</li> <li>• standard Operating Procedures (SOP) at all levels</li> <li>• update of training materials and regular trainings for immunization staff</li> <li>• appropriate stock management computer application at central and provincial levels</li> <li>• contingency plan for emergency situations during the transportation according to the corresponding</li> <li>• standard WHO Vaccine Management Training Courses</li> <li>• Development of supervisory check-list and a supervisory logbook</li> </ul> </li> <li>• Support for development of proposal for the new CCE Platform opportunity (WHO)</li> <li>• Upgrading cold chain storage needs for future new vaccine introductions (Gavi HSS and CCE Platform )</li> </ul>
<i>Vaccine regulations &amp; AEFI surveillance system</i>	<ul style="list-style-type: none"> <li>• NRA Assessment to identify TA needs to improve the functions of NRA including pharmacovigilance and market authorization (WHO)</li> <li>• Support AEFI surveillance system evaluation and implementation of its recommendations - (WHO TA)</li> <li>• Develop an AEFI monitoring and response guidelines in accordance to evaluation recommendations - (WHO TA)</li> <li>• Conduct trainings of medical workers on AEFI monitoring and response</li> <li>• Support introduction of collaborative procedure for registration of WHO pre-qualified vaccines – (WHO TA)</li> </ul>


## 5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

The findings of the Joint Appraisal have been presented to the Deputy Minister of Health and in-country partners (UNICEF, WHO, WB country offices) and selected members of HSCC on August 28, 2015, during a debriefing presentation. The findings and recommendations of the joint appraisal was agreed by the meeting participants and Deputy Minister. The full presentation of Joint Appraisal Mission is included in the Annex F of this report.

The country officials received the copy of the report and had a chance to review and officially endorse the document. The official endorsement is received from the MOHSPP on September 15<sup>th</sup> 2015.

### **Issues raised during debrief of joint appraisal findings to national coordination mechanism:**

The HSCC members paid special attention to the immunization financing related issues, and need for increased funding to maintain immunization achievements and introduction of new vaccines in the near future.



**Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
<p>Improve program management by introducing standard operating procedures</p> <p>Improve documentation of meetings, progress made in each area</p>	<p>Implementation planned within the new HSS governance review and FMA</p>
<p>Define technical assistance needs for ICC</p>	<p>Implementation planned within the new HSS governance review and FMA</p>
<p>Strengthen the capacity and increase the financial support of the mobile units working in the hard to reach areas</p>	<p>Government is planning to carry out re-assessment of effectiveness of outreach and mobile services</p>
<p>Implementation of EVM recommendations should speed up and improve the situation at central and regional levels in light of the new vaccine introductions.</p> <p>VIGs for IPV and Rota should be used efficiently to maximize benefits for the cold chain improvement</p>	<p>New EVM assessment has been conducted and new HSS will be revised and will take into the consideration EVM assessment results.</p> <p>The program management capacity is insufficient to optimize use of funds</p>
<p>To bring the estimation methodology of the target population (denominator) for calculating coverage towards WHO recommendations</p>	<p>Considered under WHO TA for 2016-2017</p>
<p>Develop plans to improve:</p> <ul style="list-style-type: none"> <li>• HSCC role and oversight including technical assistance</li> <li>• Program management and documentation (introduce standard operating procedures)</li> <li>• Utilise the findings in the new HSS implementation when approved</li> <li>• Provide Gavi with end of grant detailed report with financial documentation</li> </ul>	<p>Implementation planned within the new HSS governance review and FMA</p>

## Annex C. Description of joint appraisal process

### Main institutions and persons visited:

Joint Appraisal was conducted from August 24 to August 29 in 2015, and was built upon information submitted in 2014 APR, HSS assessment, and financial and other background documentation. In this perspective, the main objective of the mission was to assess the conditions of continuous performance of the Tajikistan immunization program, which up to now has been one of the most stable programs among the WHO EURO region.

### Organizations met during the JA mission:

- **Ministry of Health and Social Protection of Population of Tajikistan**
  - Deputy Minister
  - EPI/RCIP Manager
  - Head of Maternal and Child Health Department;
  - Head of Department of Economics and Finances;
  - Focal point of HSS program
- **UNICEF Country Office**
- **WHO Country Office**

Discussions and technical meeting with individuals and organisations listed above took place during the Joint Appraisal mission. The findings of these discussions, as well as the recommendations and proposed activities to be implemented in addition to the activities included in the framework of ongoing programs as additional technical assistance, have been presented to the MoHSPP, WHO, and UNICEF country representatives.

## Annex D: Future technical assistance needs

Technical assistance for 2016 - 2017					
Programme component (or strategy)	Activity (that requires TA)	Intended outcome/s	Provider (potential)	Modality	Source of funding
<b>Immunization financing &amp; resource mobilization</b>	<ul style="list-style-type: none"> <li>Discuss mobilization of resources to fill financial gaps in procurement of vaccines and implementation of immunization programme at National Donors Coordination Committee</li> <li>Support the MoH in raising additional financial resources through donors support to address possible stock outs of vaccines, including bOPV in Q1 2016</li> </ul>	Increased in-country capacity on immunization financing	WHO, UNICEF & Gavi Secretariat	Sub-regional workshop and in-country TA	PEF
	<ul style="list-style-type: none"> <li>Develop resource mobilization plan</li> <li>Develop advocacy materials (for resource mobilization)–</li> <li>Train relevant staff for resource mobilization</li> </ul>	<ul style="list-style-type: none"> <li>-Road map for targeted resource mobilization efforts</li> <li>-Assessed and documented performance in mobilizing resources</li> </ul>	WHO	<ul style="list-style-type: none"> <li>Sub-regional workshop and in-country TA</li> <li>In-country work with external technical assistance</li> </ul>	PEF
	<ul style="list-style-type: none"> <li>Support high level visit to Tajikistan to advocate for increasing financing of immunization programme and health system in general</li> </ul>	Increased awareness and involvement of stakeholders	WHO, UNICEF and Gavi Secretariat	In country TA with external assistance	PEF
<b>Vaccine procurement</b>	<ul style="list-style-type: none"> <li>Assist country to develop plans for vaccine procurement and budgeting processes</li> </ul>	Efficient use of available resources and ensured timely access to quality-assured vaccines	UNICEF & WHO	In-country TA	PEF
	Continue procurement of vaccines through UNICEF to ensure access to the most favorable prices	Sustained procurement modality	UNICEF	Financial analysis of procurement modalities	PEF



	<ul style="list-style-type: none"> <li>Participate in procurement-related WHO training workshops</li> <li>Train key staff on procurement to improve knowledge on the vaccine market, vaccine procurement and supply</li> </ul>	Increased in-country capacity on procurement	WHO & UNICEF	Sub-regional workshop and in country TA	PEF
<b>Evidence-based decision-making</b>	<ul style="list-style-type: none"> <li>WHO support to the NITAG (building capacity through participation in Regional meetings and trainings, ETAGE meeting)</li> <li>Discuss introduction of new vaccines with GAVI support at future NITAG meeting and make recommendations for inclusion of new vaccines in cMYP for 2016-2020</li> </ul>	Improved strategic guidance to the Programme	WHO	Sub-regional workshop, study tours, in-country TA	PE
	<ul style="list-style-type: none"> <li>Continued WHO support in implementation of rotavirus sentinel surveillance and documentation and utilization of findings as evidence for resource mobilization –</li> </ul>	Improved strategic guidance to the Programme	WHO	In-country TA	PEF
	<ul style="list-style-type: none"> <li>Costing HPV vaccine introduction and conducting cost-effectiveness evaluation</li> <li>Technical assistance in defining HPV delivery strategy and assessment of school readiness for HPV introduction</li> <li>Support in development of national plan on comprehensive cervical cancer prevention and control</li> <li>Support in preparing applications to Gavi for the support with introduction of PCV and HPV demo project</li> </ul>	<p>Evidence on readiness for HPV vaccination</p> <p>Comprehensive approach for cervical cancer prevention</p> <p>Successful Gavi applications</p>	WHO	In-country TA	PEF
<b>Programme performance</b>	<ul style="list-style-type: none"> <li>Implement recommendations of rotavirus post-introduction evaluation to be conducted in November 2015</li> </ul>	Improvements in coverage and service delivery	WHO	in-country TA	PEF

	<ul style="list-style-type: none"> <li>Continue trainings of medical workers on immunization (using MLM and IIP modules) at district and health facility levels</li> <li>Further strengthening of supportive supervision through development of SOPs</li> </ul>	<p>Improvements in coverage and service delivery</p> <p>Improvement in service delivery and information related to implementation</p>			
	<ul style="list-style-type: none"> <li>Technical support in switching from tOPV to bOPV - (WHO TA)</li> <li>IPV vaccine post-introduction evaluation (WHO)</li> </ul>	<p>Smooth transition from tOPV to bOPV</p> <p>Recommendations to be used for further improvement of NIP implementation</p>	WHO	In-country TA and training	PEF
	<ul style="list-style-type: none"> <li>Support to prepare for introduction of PCV and HPV vaccines (WHO)</li> </ul>	Successful vaccine introductions	WHO & UNICEF	In-country TA and training	PEF
	<ul style="list-style-type: none"> <li>Develop and implement strategy to timely administer hepatitis B birth dose to infants born at home</li> <li>Improve coverage and services amongst urban areas and geographically hard to reach areas</li> </ul>	Increased vaccination coverage in identified target groups.	WHO	In-country TA and financial support	PEF and Gavi HSS grant
	<ul style="list-style-type: none"> <li>Provision of long term technical assistance to RCI by WHO country office to support and built capacity of staff of RCI to effectively manage the program (WHO)</li> </ul>	Improved program management by the RCI	WHO	In country TA	PEF
<b>Data quality</b>	<ul style="list-style-type: none"> <li>Conduct coverage (sero) survey to validate administrative immunization coverage (WHO)</li> <li>Revise immunization monitoring system to improve monitoring of timeliness of the first dose of hepatitis B vaccine (WHO)</li> </ul>	<p>Data quality improvement plan developed to address weaknesses</p> <p>Improved timeliness of birth dose implementation</p> <p>Built capacity of the RCI and key sub-national staff</p>	WHO	In-country TA	PEF

	<ul style="list-style-type: none"> <li>Support in improvement of immunization coverage monitoring system based on the results of coverage survey (WHO)</li> <li>Provide support on denominator issues to further strengthen the data quality</li> </ul>	Improved target population estimates for improved programme planning and reporting			
<b>Communication &amp; social mobilization</b>	<ul style="list-style-type: none"> <li>Technical assistance in development and implementation of immunization communication action plans</li> </ul>	Improved communication on immunization to parents and health care professionals	UNICEF & WHO	In-country training and TA	PEF and Gavi HSS grant
	<ul style="list-style-type: none"> <li>Educate health care professionals on vaccine safety and contraindications</li> </ul>	Improved knowledge on vaccine safety and reduced false contraindications amongst the healthcare staff	WHO	In-country TA and training	PEF
<b>Vaccine management &amp; logistics</b>	<ul style="list-style-type: none"> <li>Support implementation of recommendations of vaccine management assessment including: <ul style="list-style-type: none"> <li>cold chain equipment preventive maintenance plans</li> <li>standard Operating Procedures (SOP) at all levels</li> <li>update of training materials and regular trainings for immunization staff</li> <li>appropriate stock management computer application at central and provincial levels</li> <li>contingency plan for emergency situations during the transportation according to the corresponding</li> </ul> </li> </ul>	Improved supply chain	WHO & UNICEF	In-country TA, sub-regional workshop, in-country training	PEF

	<ul style="list-style-type: none"> <li>• standard WHO Vaccine Management Training Courses</li> <li>• Development of supervisory check-list and a supervisory logbook</li> <li>• Support for proposal development for the new CCE Platform that will be complementary to HSS-2 funding which is pending approval.</li> <li>• Upgrading cold chain storage needs for future new vaccine introductions</li> </ul>		WHO WHO and UNICEF	In-country TA  In country TA	PEF Gavi HSS and CCE Platform grants
<b>Vaccine regulations &amp; AEFI surveillance system</b>	NRA Assessment to identify TA needs to improve the functions of NRA including pharmacovigilance and market authorization	Plan to improve the NRA functions and access to quality assured vaccines	WHO	In-country TA	PEF
	Support AEFI surveillance system evaluation and implementation of its recommendations	Improved vaccine safety procedures and AEFI systems	WHO	In-country TA, Regional level training	PEF
	Develop an AEFI monitoring and response guidelines in accordance to evaluation recommendations	Improved AEFI system and built capacity in country	WHO	In-country TA	PEF
	Conduct trainings of medical workers on AEFI monitoring and response	Improved management of AEFIs and reporting of cases	WHO	In-country TA, Regional level training	PEF
	Support introduction of collaborative procedure for registration of WHO pre-qualified vaccines	Improved vaccine safety and registration of vaccines	WHO	In-country TA, Regional level training	PEF


## Annex E. HSS grant overview

General information on the HSS grant – Tajikistan							
1.1 HSS grant approval date		24/04/2008					
1.2 Date of reprogramming approved by IRC, if any		n/a					
1.3 Total grant amount (US\$)		\$1,314,500					
1.4 Grant duration		2008-2014 (HSS-1) concluded					
1.5 Implementation year		month/year – month/year					
(US\$ in million)	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
1.6 Grant approved as per Decision Letter	282.000				698.500	0	334.000
1.7 Disbursement of tranches			282.000		698.500		334.000
1.8 Annual expenditure				328.235		698.530	181.815
1.9 Delays in implementation (yes/no), with reasons							
1.10 Previous HSS grants (duration and amount approved)							
1.11 List HSS grant objectives		<p><b>Objective 1:</b> To strengthen political commitment and ensure financial sustainability of immunization and other priority PHC services, through advocacy activities targeting national-level decision-makers and improving planning capacity at sub-national levels;</p> <p><b>Objective 2:</b> To improve the access to and quality of services through strengthening the technical capacity and motivation of health staff, improving infrastructure at PHC level and mobilizing PHC services;</p> <p><b>Objective 3:</b> To enhance communicable disease surveillance (with emphasis on vaccine preventable diseases) and to improve the monitoring system for immunization and MCH services through staff training and provision of operational support;</p> <p><b>Objective 4:</b> To increase demand for health services through social mobilization and community involvement and advocacy activities to promote public awareness</p>					
1.12 Amount and scope of reprogramming (if relevant)							

**Annex F. Presentation delivered at the de-briefing of the Deputy Minister of Health and ICC members**

**Joint Appraisal  
of Gavi vaccine and cash support to  
the Republic of Tajikistan**

Dushanbe, Tajikistan  
24-29 August 2015

 **Gavi**  
The Vaccine Alliance

GAVI Secretariat  
WHO Regional Office for Europe

[www.gavi.org](http://www.gavi.org)

**MISSION MEMBERS**

- Nilgun Aydogan (GAVI Secretariat)
- Liudmila Mosina (WHO Regional Office for Europe)
- Maria Skarphedinsdottir (WHO Regional Office for Europe)
- David Sulaberidze (Consultant, WHO Europe)

2

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### MEETINGS HELD

- Republican Center for Immunoprophylaxis (RCI)
- Department of Maternal Child Health, MOHSP
- Department of Economics and Finance, MoHSP
- Scientific Research Institute for Preventive Medicine, Health Policy Analysis Unit
- Center for Family Medicine
- HSS Focal Point , MOHSP
- Department of Economic and Budget Planning, MoHSP
- Leading Specialist for Healthcare and Labour Budget Planning, MOF
- The World Bank Country Office
- » WHO and UNICEF Country Offices



### STRENGTHS AND SUCCESSES (1/3)

- Comprehensive Health Sector Strategy
- On-going efforts to reform the health sector in order to increase efficiency
- MTEF is operational and includes immunisation which provides predictability
- National Immunisation Plan in addition to cMYP
- Good collaboration with WHO, UNICEF and development partners



### **STRENGTHS AND SUCCESSES (2/3)**

- Immunization program is a priority, government commitments consistently fulfilled
- Devoted and motivated staff at the national level
- Good performing immunisation program demonstrated by consistently high coverage for all antigens and absence of outbreaks
- According to the initial data, smooth introduction of rotavirus vaccine and achieving of high coverage
- On-going planning for tOPV/bOPV switch

5

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### **STRENGTHS AND SUCCESSES (3/3)**

- Development of Communication Strategy and Crisis Communication Strategy (with support of UNICEF)
- Availability of an up-to-date Standard Operating Procedures (SOP) Manual on vaccine management.

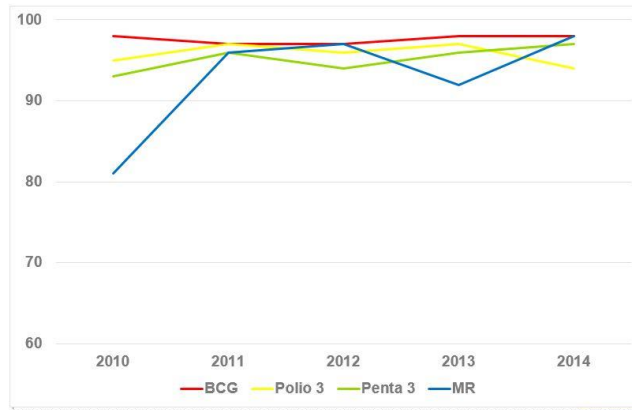
6

#add your hashtag





### Immunization coverage, WHO/UNICEF estimate, 2010-2014



7

#add your hashtag



### CHALLENGES (1/3)

- Low allocation of financing to health sector compared to neighbouring countries in the region
- Insufficient capacity for resource mobilisation to fill financial gaps for immunisation program and vaccine procurement
- Need for further analysis of implications of integration of services at PHC for immunisation program and outcomes.

8

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### CHALLENGES (2/3)

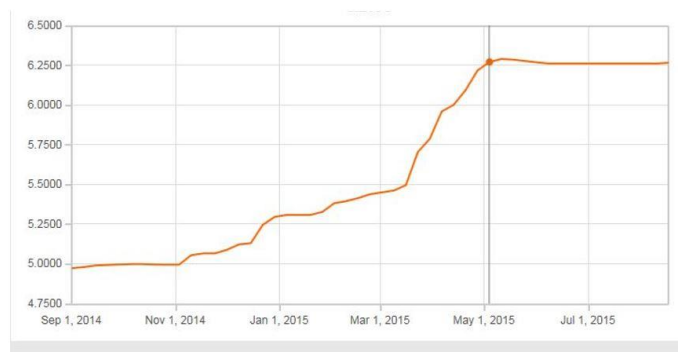
- Difficult economic situation/currency depreciation jeopardizing immunisation services and vaccine procurement
- Expected stock outs of vaccines in February 2016 (MR, hepatitis B, bi-OPV) due to lack of funds
- RCI request for vaccine procurement funds in 2015 did not reflect increased expenditures due to
  - introduction of rotavirus vaccine
  - local currency depreciation
- MoH did not allocate requested funds for 2014-2016

	2014	2015	2016
Requested by RCI	9 mil	9 mil	9.9 mil
Allocated by MoH	5 mil	5 mil	5 mil

9



### Currency depreciation in Tajikistan, September 2014 – July 2015



10



### CHALLENGES (3/3)

- Staff shortage and high turnover
- Lack of funds for regular training on immunisation for GPs and vaccinators
- Lack of training and knowledge about new vaccines among medical specialists:
  - concern about vaccine safety
  - false contraindications
- Lack of regular supportive supervision from national level
- Concerns about timeliness of BCG and HepB vaccination at birth in regions with high proportion of home deliveries

11



### CHALLENGES (3/3)

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- Concerns about timeliness of BCG and HepB vaccination at birth in regions with high proportion of home deliveries

11



## Cold Chain and Vaccine Management challenges

- No funding to maintain and repair cold chain equipment
- EVM assessment findings:
  - progress achieved since previous assessment particularly at central level
  - further improvements needed in light of new vaccine introductions
- EVM assessment recommendations:
  - cold chain equipment preventive maintenance plans
  - standard Operating Procedures (SOP) at all levels
  - update of training materials and regular trainings for immunization staff
  - usage of freeze indicators for transportation and storage of vaccines

12



## Rotavirus Vaccine Introduction

- Introduced in Jan 2015
- Comprehensive trainings medical workers were conducted
- Education materials were provided
- Coverage as of July 2015
  - 52% first dose
  - 41% 2<sup>nd</sup> dose
- Well accepted by medical workers and parents
- Concerns with timeliness of vaccination due to migration and false contraindications
- Confusion among vaccinators about the age restrictions related to rota virus vaccine

13



## GAVI HSS-2

- Strong technical proposal
- For fund disbursement to take place, following should be implemented:
  - Address ambiguity of roles, functions and accountability of Gavi support coordination mechanisms (ICC and NHCC)
  - Review and revise coordination mechanisms including NHCC, CG, ICC and ensure linkages to main implementing departments of MOH
  - Revise relevant documents such as TORs, SOPs about the functions and accountability
  - Reselect CSO member for the NHCC because the current member does not meet the Gavi requirements
    - GAVI SCM provide support in the selection process
  - After CSO is selected, develop CSO engagement strategy for implementation

14



## Gavi HSS-2 (Cont'd)

- Reinststate the role of WHO as leading implementer and revise the budget accordingly
- Revise the budget based on recommendations of recent EVM assessment
- Review and improve monitoring and evaluation framework
- Develop detailed annual plans of activities and annual procurement plans
- Conduct financial management assessment and follow up on the findings

15



### KEY PRIORITY AREAS (1/2)

- Maintaining immunization as a priority
- Within efforts to increase efficiency in the sector, ensure immunization is well prioritized and funded as cost effective intervention
- Reduce fragmentation of current resource mobilization efforts for vaccines by better integration into the existing coordination platforms
- Prepare rationale on value and benefits of immunisation to advocate for immunisation financing to Government and MOF
- Assess implication of integration of services at PHC level to immunization outcomes

16

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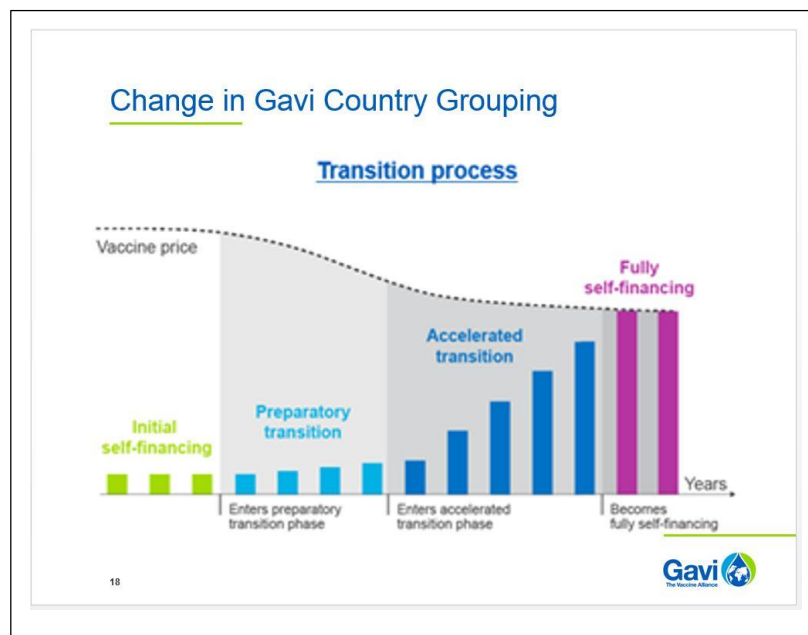
### KEY PRIORITY AREAS (2/2)

- Provide regular trainings for PHC staff, including PHC managers on immunization
- Improve and maintain strong linkages between the RCI and Family Medicine Center
  - Involve PHC staff in immunization training activities
  - Provide the center with the most updated information on immunization including new vaccines
- Strengthen supportive supervision of Immunization program performance
- Conduct the Rotavirus Vaccine Post Introduction Evaluation (PIE)
- Develop and implement strategy to ensure timely vaccination of infants born at home (BCG & Hepatitis B)

17

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### Change in Gavi Country Grouping

As Tajikistan's GNI per capita for 2014 is above the Gavi low-income country threshold, it will be considered as part of the preparatory transition co-financing grouping (formerly referred to as intermediate) as of 1 January 2016.

This will have the following implications for Tajikistan:

- As 2016 is the first year in this new grouping, Tajikistan will be required to continue its co-financing payments in accordance with its previous status and consequently contribute US\$0.20 per dose of pentavalent and rotavirus vaccines.
- Starting from 2017, the co-financing rules of the preparatory transition phase will apply. Under the revised co-financing policy, Tajikistan will co-finance a share of the vaccine price. This co-financed share will increase by 15% annually. (approx. US\$0.23 per dose in 2017; US\$0.26 per dose in 2018)

This new status will put more stress on the financial situation and it is paramount to improve the financial planning and resource mobilisation for immunisation financing

19

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**NEXT STEPS**

Step	Timelines
Joint Appraisal report to be finalized and circulated for comments	By 10 September
Findings and recommendations of the JA report to be endorsed by the NHCC and Minister	By 14 September
JA report submitted to the High Level Review Panel	15 September 2015
HLRP review and decision on renewal of support for 2016	October 2015
Implementation of support approved through the JA	2016



**THANK YOU!**

We would like to extend our appreciation and gratitude to all those who have dedicated their time to meet and work with us.

The discussions we had have been very informative and we hope to have reflected today the views and opinions expressed by your colleagues.

We all look forward to working with you in the future to achieving our mutual goals.

