Joint appraisal report

Country	Tajikistan
Reporting period	*January – December 2015*
Fiscal period	*January – December*
If the country reporting period deviates from the fiscal period, please provide a short explanation	*N/A*
Comprehensive Multi Year Plan (cMYP) duration	*2016 - 2020*
National Health Strategic Plan (NHSP) duration	*2010 - 2020*

1. SUMMARY OF RENEWAL REQUESTS

Programme (NVS)	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
Pentavalent	*Extension*	*2017*	*859,900*	*US$ 224,000*	*US$ 1,403,500*
Rotavirus	*Extension*	*2017*	*597,000*	*US$ 155,500*	*US$ 1,187,500*

Indicate interest to introduce new vaccines with Gavi support	Programme	Expected application year	Expected introduction year
	PCV	*2018*	*2019*
	CCEOP	*2017*	*2017-2018*

2. COUNTRY CONTEXT

Starting from 2001,1 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).

Tajikistan relies on donor support for immunization program. There are problems with planning, budgeting, and budget execution. Although the allocated funds do not cover all the needs of the program, the MOH fully disburses of allocated budget for the National Immunization Program (NIP). Gavi has been a major contributor to the immunization program for new vaccine introductions. In 2016, Japanese Government agreed to provide support to procure the traditional vaccines for the next 4 years.

Tajikistan moved to pre-transition category and current GNI reported on July 2016 is US$ 1,240.

3. GRANT PERFORMANCE AND CHALLENGES

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

Tajikistan National Immunization Programme (NIP) continues to be a strong performer in the EURO region, with coverage against most antigens above 95%, with the exception of MCV2 (94%) and recently introduced rotavirus vaccine (85% for the last dose), as confirmed by WHO/UNICEF coverage estimates, disease surveillance and epidemiology.

Vaccine coverage in Tajikistan has been gradually increasing since 2007, before dropping slightly in 2015 (by 1 percentage point for DTP 1 and 3, HepB birth dose, Hib 3 and MCV1, and by 4 percentage points – for MCV2). In 2015, DTP3 coverage in all 66 districts and capital city Dushanbe in the country was above 80%, and in 55 of them (83%) it exceeded 95%. 58 districts (88% of the total) had measles coverage above 95%. This is a decrease from 65 districts a year ago and is consistent with the overall reduction in measles coverage in 2015. The dropout and

wastage rates remained in accordance with the UNICEF and WHO-suggested targets and showed improvement compared to previous years (from 2% to 1% for DTP1-DTP3 dropout).

Rotavirus vaccine introduced in January 2015 and the post introduction evaluation (PIE) took place in June 2016. Data on the number of vaccine doses administered are reported on a monthly basis by all health facilities to the district centers of immunoprophylaxis, where those data are compiled and submitted to the regional and national level. The reported national rotavirus vaccine coverage for 2015 was 94% for dose one and 85% for dose two. The data and methods used by health facilities to determine the rotavirus vaccine target group (denominator) are variable. National guidelines for standardization of coverage calculation are lacking. Currently, only infants registered in health facilities are included in the denominator, which may underestimate the true target population size. Some key findings of the PIE are as follows:

- Develop a comprehensive set of national guidelines covering the following immunization program topics (which are supported fully or partially by Gavi HSS, CCEOP and PEF TCA):
    - Unified methodology for enumeration of target population, with periodic adjustments and accounting for population mobility
    - Vaccine management and wastage
    - AEFI reporting, investigation, and response
    - Vaccines administration techniques
- To address possible underestimation of the target population caused by limiting inclusion in the denominator to only those infants who are registered in health facilities, we recommend validating the target group size (number of children under 1 year of age) by utilizing different sources of data (maternity hospital reports, vital registration data).
- With partners' support, evaluate the reasons for low vaccines uptake among Roma populations and develop tailored strategies to increase vaccination coverage, including rotavirus vaccine (Gavi HSS)
- In light of challenges associated with an aging infrastructure in local level health facilities and planned introduction of new vaccines in the coming years, we recommend continuing engagement with partners and stakeholders to identify funding opportunities to implement a vaccine management improvement plan, including upgrades to the cold chain equipment (Gavi HSS and CCEOP)
- Conduct enhanced training, orientation, and refresher courses for GPs and newly appointed staff to address knowledge gaps observed mainly in the following areas (PEF TCA):
    - Benefits of rotavirus vaccination
    - Evidence-based contraindications
    - Essential information provided to mothers before and after vaccination, including serious AEFIs that require immediate medical attention
- In collaboration with Family Medicine Center and Medical Schools, we suggest incorporation of immunization training modules in GPs' pre- and in-service training (PEF TCA)
- Utilize the WHO training materials on vaccine safety and contraindications to educate GPs, neurologists and other medical specialists on the benefits of vaccines and on evidence-based contraindications (PEF TCA)

Table 1. Reported Vaccination Coverage, 2010-2015.

Vaccine/coverage	2015 (%)	2014 (%)	2013 (%)	2012 (%)	2011 (%)	2000 (%)
BCG	98	98	98	97	97	98
HepB (birth dose)	96	97	96	94	96	-
DTP1 (pentavalent 1)	97	98	98	96	98	88
DTP3 (pentavalent 3)	96	97	96	94	96	83
Polio3	96	94	97	96	97	86
MCV2	94	98	92	97	96	59
Rota2	85	-	-	-	-	-

Source: WHO-UNICEF estimates

During 2015, no outbreaks were detected, however, there has been measles cases in 2016. Since May 2016, the measles cases are being identified and the country applied for follow up campaign support to Gavi in September 2016 and Tajikistan's proposal was recommended for approval with comments by the IRC.

Table 2. Reported Confirmed Cases of Vaccine-preventable Diseases

	2015	2014	2013	2012	2011	2010	2000	1990
Diphtheria	-	0	0	0	0	0	11	11
Japanese Encephalitis	0	0	0	0	0	0	-	-
Measles	3	0	1	16	1	0	192	6,897
Mumps	-	-	1'530	1'518	1'441	1'558	428	-
Pertussis	-	6	2	5	56	12	13	935
Polio	-	0	0	0	0	457	0	-
Rubella	1	0	0	1	0	6	111	-
Tetanus (neonatal)	-	-	0	0	0	0	0	-
Tetanus (total)	-	-	0	0	3	4	-	-

Source: WHO

No polio cases have been registered in the country since 2010. However, as Tajikistan is bordering Afghanistan, where polio remains endemic, a risk of wild polio virus cases emerging in Tajikistan remains. The country successfully switched from tOPV to bOPV in 2016. Introduction of IPV vaccine, initially scheduled for October 2015, was delayed first to January 2016, and now to Q4 of 2017 due to issues with IPV supply availability. The initial preparatory work and medical staff training have already been carried out in the countries, with 100% of the disbursed IPV VIG (US$ 222,000) spent. Refresher trainings will be required in 2017 prior to IPV introduction, and a mechanism to fund such needs, which are not limited to Tajikistan, will need to be discussed at Gavi Secretariat level in order to identify an appropriate solution. It should be noted that IPV supply constraints are expected to remain uncertain until 2018 and a global risk management strategy has been put in place using a criteria to determine the classification of each country, and therefore its prioritization for the allocation of IPV. All Central Asia countries, including Tajikistan are classified as T3/4, with the lowest priority to allocate the available IPV supply.

The country reported short-term stock-outs of BCG and DPT in 2016 due to the delay in the release of the funds for those vaccines to UNICEF Supply Division. To avoid such situations in the future, the country started working with UNICEF Supply Division on the Vaccine Independence Initiative (VII), which would allow vaccines to be delivered to Tajikistan without a pre-payment. The initial assessment for VII took place as per TA under the PEF supported by Gavi in 2016.

Tajikistan has consistently complied with its co-financing obligations and has never defaulted on its co-payments despite a recent challenging economic situation. 2016 co-financing obligations have already been fulfilled. However, health sector financing remains to be a challenge in the country. Despite the recent year improvement for overall economic indicators, this is not reflected with improvements in the social sector budgets such as health.

In 2016, the country received support from UNICEF SD support on vaccine and related supply financing. It was assessed and agreed that Tajikistan can subscribe to Vaccine Independence Initiative (VII), as the country buys all its vaccine via UNICEF SD. Using VII, the vaccine procurement can start before money arrives, country pays 60 days upon arrival. UNICEF SD will work on subscription document (VII plan). It is planned that VII will be in place by Q2 2017 for Tajikistan (subject to Government's submission of plan and signature of requisite documents) which will provide better predictability and uninterrupted immunization supply for the program.

3.1.2. NVS future plans and priorities

Tajikistan plans to introduce PCV vaccine in 2018, and HPV vaccine potentially in 2020. Respective applications are expected to be submitted in late 2017 and 2018. The country is also planning to apply for CCEOP in May 2017.

3.2. Health systems strengthening (HSS) support

The HSS2 proposal approved in late 2015 in the total amount of 9,659,748 USD for five years with major the focus on increasing the coverage in the areas where coverage is low, including some urban populations.

In 2016, Gavi revised the scope of its Financial Management Assessment (FMA) of recipient countries to include a more in-depth review of both programme and vaccine management capacities. The new Programme Capacity Assessment's (PCA) aimed to assess the (current or proposed) financing modality and other structures for use of Gavi support provided in the form of cash grants, vaccines and vaccine related devices..

The Secretariat contracted Finconsult Ltd to carry out the Programme Capacity Assessment (PCA) for Tajikistan in light of the new HSS proposal. The assessment team, led by Mr Alan Nabiev, Project Manager, Finconsult Tajikistan, conducted the PCA from February - March, 2016. The findings of the PCA indicate that the proposed fund management arrangement for the Gavi Health System Strengthening (HSS) support under the Ministry of Health and Social Protection, does not meet Gavi minimum requirements, in particular in terms of financial systems, procedures, management and reporting. The findings included:

- The Project Implementation Unit (PIU), originally planned in the HSS proposal and to be created specifically for Gavi HSS with direct management by the MoHSP, as the main institutional setting and recipient of grant funding does not meet the minimum requirements of Gavi, the Vaccine Alliance.
- The draft standard operation procedures manual (SOPs) has weaknesses and gaps in key functional areas exposing Gavi funds to operational and fiduciary risks
- The internal controls indicated in the draft SOPs are weak and reporting lines not clear.
- Staff recruitment processes stated in the draft SOP are not clear and transparent.
- The coordination and linkages to the immunization program and other MoHSP departments from the proposed PIU are also not clear.

To further explore the alternative options, the secretariat conducted a visit in July 2016. Following the discussions with stakeholders in the country as well as other donor projects, it was proposed that HSS-2 will be implemented through existing WB PIU following similar fiduciary and implementation arrangements to those employed for the WB's HSIP with certain distinctions, particularly in regards to coordination, UNICEF and WHO. These agencies will administer the funds and support implementation of the Gavi HSS activities by the MoH and EPI agencies the Republican Center of Immunoprophylaxis (RCI) and Department of State Sanitary-Epidemiology and Surveillance.

A significant component of the HSS activities are oriented on capacity strengthening of PHC with a focus on immunization service quality and safety; and concurrent activities such as that of the World Bank Health Services Improvement Project are also PHC-driven, aiming to increase the coverage and quality of basic PHC services by piloting a performance-based financing scheme. The PIU is created under the MoH specifically to assist project implementation and has no separate legal status. In accordance to the WB model and procedures, the CO ensures fiduciary and programmatic oversight over PIU activities. WB CO has agreed to take on the responsibility for Gavi programmes in Tajikistan (subject to formal request from the Ministry of Health and finalizing the preparation work – estimated 3-4 months). The role of the CO is to oversee the implementation carried out by the PIU, using standard WB modalities, rules and regulations.

The decision to channel funds using WB, UNICEF and WHO was communicated to the country and partners in September 2016, which would initiate the approval processes. However, to date, MOF and MOH have not provided approval for WB component which is the significant portion of the HSS proposal. It is planned that upon approval, there will be budget revision process to determine exact amounts to be contracted for each agency as well as outlining of roles and responsibilities of each agency for objectives and activities. The discussion and close follow up with Alliance partners is required to fast track the processes (budget revision, roles and responsibilities etc.) and expedite the disbursement is required for Tajikistan HSS.

The coordination group (CG) for the PIU is established at the MoH. The CG is responsible for project preparation and implementation. The CG is headed by the Minister of Health and the First Deputy Minister of Health as the Project Coordinator. The CG consists of 29 members who are technical experts and heads of departments/units in the MoH. The CG is supported by international and local consultants

in technical, fiduciary and administrative functions carried out by the PIU. Members of CG also include PIU specialists on legal, procurement, civil works, verification matters.

For the Gavi HSS2, as UNICEF and WHO will be involved in the implementation, it was agreed that there will be a coordination will be between partners (MOH, WB, UNICEF and WHO) to harmonize the efforts for HSS and immunization related activities (including PEF TA). However there is a need to broader coordination committee , and it was discussed with all partners and key members of MoH that National Health Coordinating Committee (NHCC) should remain however, terms of reference for NHCC will have to be revised so that it works well with the MoH/PIU to oversee the implementation. As Interagency Coordinating Committee (ICC) has been functioning relatively well and has a specific function and members, gives good guidance to RCIP/EPI, it has been agreed to keep the ICC as it is. It is planned that under the LMC efforts, Tajikistan NHCC to get technical assistance to reformulate the NHCC membership and TORs as well as subsequent support on development of transparency for decision making processes.

3.3. Transition planning

Not applicable. Tajikistan has entered the preparatory transition phase in 2016, and no change in the country's transition status is expected in the next several years. However, there is a need to work closely with the country and Alliance partners on immunization financing, resource mobilization for the immunization program and advocate with the Government to improve the state resourcing for vaccine procurement and critical operation costs of the immunization program.

3.4. Financial management of all cash grants

In October 2014, Tajikistan received a cash grant for IPV vaccine introduction in the amount of US$ 222,000. Funds are utilized as per plans of introduction in 2015. As indicated in the previous section of this report, that the country will need top up for the introduction activities prior to the vaccine availability in the country.

HSS-2 grant has not yet began due to significant delays in conducting the Programme Capacity Assessment and agreeing on implementation arrangements.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

The table below presents a list of high-level findings from 2015 Joint Appraisal.

Prioritized strategic actions from previous joint appraisal / HLRP process	Current status
1. Maintain immunization as a priority	Government (Alliance partners working with collaboration RCI, MOH and relevant government agencies). On-going effort. UNICEF secured funding from Japanese Government for the traditional vaccines and a few cold chain equipment to bring stability to the program and avoid stock outs which would hinder the program, while working to ensure financial sustainability beyond the grant duration.
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	VII assessment by UNICEF is concluded. The efforts on building the capacity for the vaccine management and procurement will continue in the 2017. WHO supported the country on resource mobilization by provision of training and tools to effectively advocate and work with the officials for the program. This work will continue in the 2017.
3. Advocate for immunization financing to the Government and the MoF	Not completed, this work will be closely followed up and supported with PEF TCA.

Prioritized strategic actions from previous joint appraisal / HLRP process	Current status
through preparing rationale on value and benefits of immunization	
4. Need for long term human resource capacity at WHO country office to support program for effective management and planning of activities of the RCI	TOR were developed in 2016- recruitment to be completed in 2017 (WHO PEF).

5. PRIORITISED COUNTRY NEEDS

Prioritized needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?* *(yes/no)* If yes, indicate type of assistance needed
Support to programme management capacity	**2017**	**PEF WHO (staff support)**
Support in decision-making for PCV and HPV vaccines introduction	**2017**	**In country and regional support - PEF TCA**
Support to development of new vaccine introduction applications	**2017**	**In country and regional support - PEF TCA**
NITAG Strengthening	**2017**	**In country support WHO. PEF TCA**
Support to development of CCEOP application	**Q2 2017**	**In country support WHO, PEF TCA**
Technical assistance to develop CC equipment deployment plan	**Q2 2017**	**In country support WHO, PEF TCA**
Support to adopt vaccine management SOPs	**2017**	**In country support WHO, PEF TCA**
Support to finalise and operationalise SOPs on vaccine logistics management (incl. cold chain) and supply chain data management	**2017**	**In country support UNICEF, Regular Resource, PEF TCA**
Support to update AEFI guidelines	**2017**	**PEF TCA WHO and HSS**
Support to conduct ToT training on updated AEFI guidelines	**2017**	**In country support, PEF TCA WHO**
Provide continued TA and supply support for rotavirus sentinel surveillance and support to conduct case-control study for rotavirus disease	**2017**	**In country support, WHO**
Advocacy to create common understanding about immunisation financing / budgeting among all stakeholders involved in the budget development (EPI) and approval (MoH and MoF) activities.	**2017**	**In country support, UNICEF (PEF TCA)**

Strengthening vaccine stock management system through capacity building on the use of supply data	**2017**	**In country support UNICEF, (PEF TCA)**
Capacity building of primary health care workers on forecasting and micro-planning for routine immunisation programme	**2017**	**In country support UNICEF (PEF TCA)**

6. ENDORSEMENT BY ICC AND ADDITIONAL COMMENTS

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	Not applicable as this is a JA update report. However, SCM visited the country in April 2016 to have discussions with partners and country stakeholders including training the EPI and SES departments on Performance Framework Platform. SCM had follow up discussions during July 2016 country visit. JA update meeting conducted in Copenhagen in September 2016 with participation of country offices as well as focal persons of EPI and HSS of the MOH to review and agree on prioritization of TCA and alignment of the HSS and other Gavi support. Finally the JA update report was endorsed by the EPI manager on May 29, 2017.
Issues raised during debrief of joint appraisal findings to national coordination mechanism	TBC
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	TBC