Assessment of GAVI Support to Health System Strengthening in Tajikistan

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37d,I. Chavchavadze ave.,Tbilisi, 0162, Georgia; Phone: (+995 32) 225 31 04, 225 13 44, 2253196; Fax: (+995 32) 299 55 40
საქართველო, თბილისი, 0162, ი.ჭავჭავაძის გამზ. 37დ; ტელეფონი: (+995 32) 225 31 04, 225 13 44, 225 31 96; ფაქსი: (+995 32) 299 55 40
E-mail: cif@curatio.com www.curatiofoundation.org

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Acronyms

AEFI	Adverse Events Following Immunization
APR	Annual Progress Report
cMYP	Comprehensive Multi-year Plan
CDC	Center for Disease Control
CCT	Conditional Cash Transfer
DTP	Diphtheria, Tetanus, and Pertussis vaccine
EPI	Expanded Program on Immunization
FMA	Financial Management Assessment
GAVI	Global Alliance for Vaccines and Immunization
HRIRD	Department of Health Reforms and International Relations
HSS	Health System Strengthening
HSCC	Health Sector Coordinating Committee
IHP	International Health Partnership
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
INS	Injection Safety Support
IRC	Independent Review Committee
ISS	Immunization Service Support
JAR	Joint Annual Review
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MOU	Memorandum of Understanding
NVS	New Vaccine Support
NHS	National Health Strategy
OECD/DAC	Organization for Economic Cooperation and Development/Development Assistance Committee
PAU	Policy Analysis Unit
PHC	Primary Health Care
RRS	Rayon under the direct Republican Subordination
RCI	Rayon Center of Immunoprophylaxis
RCIP	Republican Center of Immunoprophylaxis
SGBP	State Guaranteed Benefit Package
TA	Technical Assistance
TAP	Transparence and Accountability Policy
UNICEF	The United Nations Children's Fund
VIG	Vaccine Introduction Grant
VPD	Vaccine Preventable Diseases
WB	The World Bank
WHO	World Health Organization

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Disclaimer

Although the GAVI secretariat commissioned this report, GAVI bears no responsibility for, and are in no way committed to, the views and recommendations expressed herein, which are the sole responsibility of the authors.

Executive Summary

The Republic of Tajikistan is a mountainous, landlocked country located in Central Asia (CA) and divided into 5 regions, which include 3 oblasts (GBAO, Khatlon and Sogd), Dushanbe City and 13 Rayons (districts) under the direct Republican Subordination (RRS). Tajikistan is known by high population growth rate, which reached rate of 2.5% in 2012. While Tajikistan is heading towards economic growth, at present it remains one of the poorest countries in the world with GDP per capita at 953 USD in 2012. According to the World Bank estimates, 80% of Tajikistan's population lives below the poverty line. Many people cannot afford costs of transportation, drugs, and other expenditures for health services. This leads to self-medication and home deliveries that in turn affect maternal and child health outcomes as well as the immunization coverage.

Starting from 2000, GAVI initiated its support to Tajikistan by introducing new vaccines and providing the Immunization System Support (ISS) and later on since 2008 the Health System Strengthening Support (HSS). The main goal of the Tajikistan HSS 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.

The overall objective of the assessment was to **provide solid evidence to what extent GAVI HSS support to Tajikistan achieved its objectives and contributed to strengthening the health system of the country.** Therefore the assessment aims to identify successes; key challenges and lessons learned that might help GAVI Alliance to improve the design and implementation of future HSS support to Tajikistan and to other countries. Consequently, the assessment covers the period of GAVI's HSS grant to Tajikistan 2008-2014 and focuses on the districts targeted by the HSS program.

The assessment focuses on the program **implementation effectiveness, efficiency and results** of the GAVI HSS support to Tajikistan and tries to answer five key questions posed by the GAVI secretariat in the RFP and described later.

The assessment is based on the framework developed by IHP+ and applied in the GAVI HSS tracking study. Therefore, the assessment looks at system inputs, processes, outputs and outcomes achieved by the program. Furthermore it uses the relevance, effectiveness, efficiency and the results from OECD/DAC evaluation criteria.

The country visit took place during August 5th - 15th and filed-work in targeted two districts out of six was conducted during August 10th – 12th by two separate teams, composed of international and a local consultant and interpreter. Mixed research methods including desk

review, in-depth interviews, group discussion, site observation and quantitative analysis were applied by the assessment team to validate the findings arising from a desk research.

Assessment Findings

The findings of the assessment were following:

Q.1 - To what extent the activities set out in the HSS application were implemented as planned (quality, quantity, ways and means)?

While overall design of the HSS program with its five key objectives being relevant to the country context was kept unchanged, the specific activities proposed in the original proposal underwent major revisions. Overall, program implementation faced significant delays due to numerous objective and subjective reasons. The most important factors were probably: a) a lack of clear and streamlined communication between GAVI secretariat, the country and in-country partners due to individual or organizational reasons; b) inadequate risk and process management on the part of all involved, but especially by the GAVI secretariat and c) a lack of transparent and all-engaging collaboration at a country level. Consequently delayed implementation called for adjustments in the activities and implementation schedule. 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 during implementation from its original design 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 quality of implemented activities also raises concerns. It is assumed that the quality would have been better had the program ensured sufficient transparency and the adequate and timely engagement of expertise required for the design of complex interventions, provided that such expertise was available within the country or from the Alliance's partners.

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

Q.2 - To what extent were activities, resources appropriately coordinated and assessed (given the pilot aspect of the program) and reported by the MOH to the GAVI Secretariat and Alliance partners?

The Health Sector Coordinating Committee (HSCC) established by the government at times of accessing the GAVI HSS funds in 2007 was charged with overall responsibility for the HSS

program coordination and oversight. As required by GAVI, the HSCC along with government representatives included WHO, UNICEF, the World Bank and other bi-lateral donor representatives. The HSCC and the Alliance's partners played active role during the HSS proposal development and revision phases. However, after receipt of the HSS grant and based on the presented evidence the HSCC mostly failed in its coordination and oversight function. Throughout 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 GAVI secretariat played an instrumental role in supporting the program implementation and triggering and facilitating the national processes. However, their engagement proved not sufficient to manage the complex program in a complex country environment, where the partnership model used by GAVI for hands off management, failed to deliver on its expectations. The assessment team thinks that more assertive and proactive engagement on the part of the GAVI secretariat could have been more helpful in a given context and could have assured better implementation outcomes.

Besides, the HSS program implementation was also hampered by other factors such as: *inadequate communication between GAVI and the Country, bureaucratic procedures* within the Government of Tajikistan as well as within WHO and GAVI and *institutional interests* of in-country partners struggling to emerge as GAVI HSS fund recipients.

Finally, the weakness of the monitoring and evaluation framework for the HSS program significantly impeded this assessment as well as management and oversight of the HSS program implementation. The Selection of inadequate (not sensitive) indicators and their use by the country, HSCC and GAVI most likely limited the ability of all involved to timely detect implementation challenges and to call for corrective measures. Also the opportunities were missed by not undertaking joint annual HSS program reviews, when most issues noted by the assessment team could have been captured, reported and acted on.

Q.3 - To what extent were the funds used efficiently and as planned?

Based on supplied information the funds were spent according to the approved budgets by the HSCC and within the agreed budgetary limits for the given objectives and obviously the program implementer- the Republican Center of Immunoprophylaxis (RCIP) deserves credit for this. Although, it has to be also noted that in many instances honoring budget limits occurred at the cost of reduced the program targets, which obviously negatively affected overall program outcomes.

This was compounded by the weaknesses in financial systems arising from institutional weaknesses of the RCIP, especially by the lack of experienced staff in the management of donor-funded programs, and by the lack of standard operational and financial management procedures that led to deficiencies in financial record keeping. Consequently, the lack of adequate financial and programmatic data together imposed significant limitations on the

assessment and constrained the team's ability to evaluate financial efficiency of the program and/or its activities.

Thus, the overall financial management of the program deserves attention. These weaknesses were well documented early on in the grant making process during 2008 and 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, which obviously increased financial risks for the HSS grant in a complex country environment such as Tajikistan. However, Tajikistan is not the only country where WHO tries to maintain good and long-term relationships with the government and where the organization is hesitant to assume policing role of a fiduciary agent. Similar findings emerged from HSS evaluation conducted during 2009 in other GAVI supported countries. Consequently it may be appropriate for GAVI to re-consider its current partnership model for financial risk management and seek for alternative solutions.

Q.4 - To what extent did the HSS program contribute to observed trends in the following indicators: a) Increasing basic vaccination (DPT-3, Hep B1) and what was the GAVI HSS program contribution? b) Increasing PHC utilization and what was the GAVI HSS program contribution?

In some pilot districts targeted by the HSS program the assessment team noted increasing immunization coverage and growth in PHC utilization rates. However, the assessment team could not establish plausible connection between the program interventions and the observed changes, because several factors may have influenced such developments. Firstly the data limitations due to weak M&E framework imposed significant constraint on the assessment team's ability to obtain more granular data and better assess the program outcomes in pilot districts. Secondly, the districts targeted by this program also received the assistance from other donors and observed changes may have been affected by other programs/projects. Finally very active polio campaigns in the aftermath of polio outbreak in 2010 may have also contributed to the observed trends.

Q.5 - To what extend has the MOH learnt from the pilot activities in the HSS program?

The assessment team concluded that limited documentation and learning occurred during the HSS implementation and believes that this assessment may provide some critical lessons to benefit national processes and the Ministry of Health (MoH), and if considered could help with future program design as well as with implementation.

Recommendations

Based on the assessment findings we formulated fiver recommendations, which may help GAVI improve/enhance its systems in a way that ensures improved implementation and better program outcomes. We also elaborated a set of country-specific comments to help the authorities in Tajikistan improve program design and implementation management, which are presented below:

RECOMMENDATIONS FOR THE GAVI SECRETARIAT

Recommendation 1: Enhance program management capabilities of the organization

- Either exploit full potential of the Alliance's current partnership model, where possible, or develop alternative mechanisms necessary to more proactively support country program implementation.
- In high-risk countries, such as Tajikistan, hands off management model, currently at work within the GAVI secretariat, may increase risk-exposure to programmatic and financial risks and may not provide adequate levers for risk management/mitigation, unless addressed through organizational re-thinking.

Recommendation 2: Improve/enhance communication between GAVI, the country and with in-country partners, which may entail:

- Formalizing communication timelines between GAVI and the country with the objective of shortening and clearly defining response timelines/deadlines for both parties;
- Improving the secretariat's communication (maybe even formalizing in the operational policies) with the country and involved partners in order to maintain frequent, transparent and all-inclusive communication with the HSCC members and to ensure that they are fully up-to-date and engage in a timely manner when necessary;
- Independent Review Committee (IRC) reports should include detailed comments on the progress and identify deviations from original plans, indicators and targets. However, remote review of documents, which may not hold quality and adequate information for the HSS program monitoring is expected to impose limitations, unless the format and content of Annual Progress Reports (APRs) are more adjusted to the HSS needs;
- Develop adequate in-country support with the help of partners to reduce language related barriers and accelerate information exchange between the secretariat and the country.

Recommendation 3: Enforce greater accountability and transparency requirements

- Ensure that GAVI operational policies clearly define accountability responsibilities for the secretariat as well as for the partner country and set clear rules based on principles of mutual accountability. Though current Transparence and Accountability Policy (TAP) includes such provisions, albeit they operate on much higher level and do not provide clear guidance on how to operationalize the policy elements in any given country.
- In the current system it is not clear how IRC approved programmatic targets can be enforced and/or how the country could be held accountable for achieving the objectives stated in the original proposal. Consequently, developing institutional assurance mechanisms/systems seems necessary if country accountability has to be enforced and program results achieved. However, this cannot be done without countries being able to revise the original targets in light of changes in the country context. Therefore, clearly defining and communicating the processes through which countries will be allowed to revise their original program targets seems necessary;

- As a signatory to the IHP+ initiative, GAVI should enforce and proactively facilitate joint annual program reviews with the active involvement of in-country partners. While such provisions were incorporated in the MOU with Tajikistan the reviews were never produced and consequently the enforceability mechanism seems to have failed.

Recommendation 4: Enhance country coordination arrangements (rules) by:

- Considering imposing a mandate for semi-annual (or annual) review of program progress against set targets, timelines and budgets;
- Considering tightening transparency requirements on HSCC meeting notes to be shared with all involved and, if possible, published on the internet;
- Considering tightening transparency requirement on GAVI-supported programs by imposing mandates for: a) placing GAVI -funded program description in a local language on governmental websites; b) translating and placing annual budgets and annual expenditure reports on publicly accessible internet sites; c) ensuring that program targets and monitoring and evaluation results are also publicly accessible.

Recommendation 5: Strengthen GAVI's Monitoring and Evaluation framework for HSS programs

- Current M&E guidance for GAVI HSS grants includes set of indicators (e.g. National level DPT3 coverage; number/share of districts achieving ≥ 80% DPT3 coverage; under five mortality rate) that are not relevant for monitoring HSS grants. The external HSS evaluation team arrived at similar conclusions in 2009. Consequently we repeat their suggestion and recommend GAVI to revise HSS M&E guidance and include appropriate set of indicators, which allow adequate measurement of outcomes resulting from HSS investments.

RECOMMENDATIONS FOR THE COUNTRY

Recommendation 1: Improve HSCC functionality by: a) ensuring that HSCC implements its coordination and oversight role effectively, through following up on program progress routinely, identifying shortfalls and deviations from the original plans and taking corrective measures and b) ensuring annual joint review of the program with the active engagement and participation of the partners;

Recommendation 2: Ensure engagement of adequate/experienced stakeholders and in-country partners by: a) encouraging active involvement of the partners and other stakeholders in program planning, monitoring and annual and mid-term evaluation; b) ensuring that HSS program activities have an integrated approach and different players of the health system are involved and c) soliciting technical assistance as needed from experienced consultants.

Recommendation 3: Improve management arrangements and enhance financial management systems: a) staff program implementation unit with adequate, experienced and qualified human resources in program management, M&E and financial management;

b) develop standard operating procedures for program management and necessary M&E tools and c) ensure a qualified external audit on an annual basis and compliance with the financial management requirements of GAVI.

Recommendation 4: Increase transparency of the program implementation: a) HSCC and program implementers have to ensure the transparency of programmatic and financial data; b) Ensure the transparency of the processes and accountability for program results.

1. Introduction

1.1. Objectives of the Assessment

The overall objective of the assessment is to **provide solid evidence of to what extent GAVI HSS support to Tajikistan achieved its objectives and contributed to strengthen the health system of the country.** The assessment aims to identify successes, key challenges and lessons learned that may help GAVI Alliance to improve the design and implementation of future HSS support to Tajikistan and other countries. The assessment covers the period of GAVI's HSS grant to Tajikistan from 2008-2014.

Specific questions of the assessment are:

1 To what extent were the activities set out in the HSS application implemented as planned (quality, quantity, ways and means)?
2 To what extent were the activities and resources appropriately coordinated, assessed (given the pilot aspect of the program) and reported by the MOH to the GAVI Secretariat and Alliance partners?
3 To what extent were the funds used efficiently and as planned?
4 To what extent did the HSS program contribute to observed trends in the following indicators:
  4.1 Increasing basic vaccination (DPT-3, Hep B1) and what was the GAVI HSS program contribution?
  4.2 Increasing PHC utilization and what was the GAVI HSS program contribution?
5 To what extent has the MOH learnt from the pilot activities in the HSS programme?

1.2. Country Context

The Republic of Tajikistan is a mountainous, landlocked country located in Central Asia (CA) that covers an area of 143,100 square kilometers, 93% of which is high mountains. Tajikistan is divided into 5 regions, which include 3 oblasts (GBAO, Khatlon and Sogd), Dushanbe City and 13 Rayons (districts) under the direct Republican Subordination (RRS). Tajikistan is known for its high

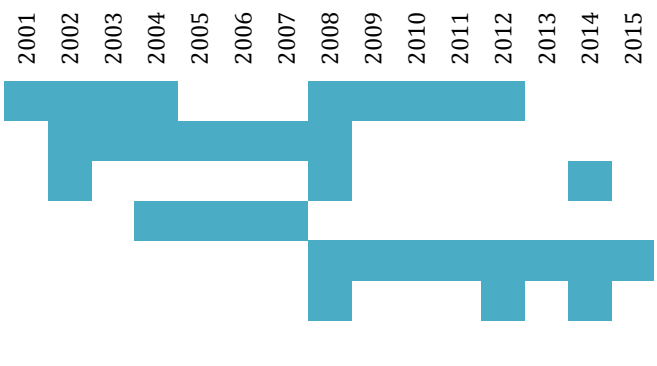
population growth rate, which reached annual rate of 2.5% in 2012.[1]

While Tajikistan is heading towards economic growth, at present it remains one of the poorest countries in the world, with GDP per capita at 953 USD in 2012.[2] According to World Bank estimates, 80% of Tajikistan's population lives below the poverty line. Many people cannot afford the costs of transportation, drugs, and other expenditures for health services. This leads to self-medication and home deliveries, which in turn negatively affect maternal and child health outcomes as well as immunization coverage rates.

GAVI provides support to the Republic of Tajikistan since 2001 through various grants such as Immunization Service Support (ISS), New Vaccines Support (NVS) for number of new and underused vaccines, accompanied by Vaccine Introduction Grants (VIG) and Injection Safety Support (INS). The HSS support has been provided by GAVI during 2008 -2014. See Table 1 for time frame of different grants. Since 2001 up to July 2014 total disbursements to Tajikistan amounted to 18,804.307 USD.[3]

Table 1: GAVI support to Tajikistan[4]

	Disbursements 2000-2014 (US$) (31 Jul 2014)
ISS	$2,386,980
NVS- HepB	$1,458,457
VIG	$403,000
INS	$348,745
NVS - Penta	$12,892,625
HSS-1	$1,314,500
Total	**$18,804,307**



1.3.Health Care System

Tajikistan inherited the Soviet health care model, which is structured around a network of health facilities with emphasis on in-patient care. The financing of hospital services on the basis of beds has encouraged superfluous capacity[5]. Since independence, the system has remained virtually unchanged, burdened by large and crumbling infrastructure, scarce funding, weak governance structures, migration and lack of human resources. Tajikistan is currently experiencing a shortage of both doctors and nurses with imbalance human

[1] http://data.worldbank.org/indicator/SP.POP.GROW
[2] http://data.worldbank.org/indicator/NY.GDP.PCAP.CD
[3] http://www.gavi.org/country/tajikistan/
[4] Lines indicate duration of support based on commitments
[5] European Observatory on Health Systems and Policies; Health System in Transition, Tajikistan Health System Review; Vol 12, N 2 2010.

resources across the regions. The profile of the health workforce is also changing from being dominated by specialists towards family doctors and family medicine nurses.[6]

During the last five years, general government expenditures on health have increased both in relative and absolute terms. The share of the health budget in the total public budget, as an indicator for the priority of health spending, shows positive trend growing from 5.6% in 2007 to 7.5% for the year 2013. The Absolute increase in health spending, which has increased five-fold in nominal terms since 2007, is even more impressive. Nevertheless, total health expenditure is still small and amounted to just $18 per capita in 2012. This is the lowest per capita public spending on health in the WHO European Region[7]. Expenditure on Hospital sector remains the largest component of the total health expenditure (56.1%), and expenditure on primary health care services is 32.4%[8].

The latest National Health Strategy (NHS) is based on the priorities of the National Development Strategy of the Republic for 2005-2015 and the Poverty Reduction Strategy in the republic of Tajikistan for 2005-2015. The NHS is now the common policy framework for cross-sectoral and interagency policy dialogue and serves as the major reference for all undertakings in the health sector. The NHS sets the following priorities for the period of 2010-2020[9]:

a) Health System Reform - strengthening and modernizing health system governance in order to create a results oriented, socially accepted, sustainable, transparent, accountable, and fair and equal access to health care services for the people of Tajikistan;
b) Improved accessibility, quality, and efficiency of individual and population focused health services; and
c) Development of health system resources.

The Introduction of mandatory health insurance, health purchasing, nationwide State Guaranteed Benefit Package (SGBP), Primary Health Care (PHC) oriented system, accreditation and licensing, are all parts of the ambitious reform package promoted by the NHS[10]. The reduction of infectious diseases and control of vaccine-preventable diseases (along with improved availability, access, quality and effectiveness of health services and improvement of maternal and child health) remains one of the main priorities of the NHS.

1.4.Immunization System

The Expanded Programme of Immunization (EPI) is one of the main preventive health care services in Tajikistan. It is performed by primary health care facilities (polyclinics, rural

[6] The European Union's DCI –ASIE program for Tajikistan, Health Sector Analysis, 2013
[7] Ibid6
[8] Joint Annual Review of Implementation of the National Health Strategy of the republic of Tajikistan for 2010-2020; The Ministry of health and Social Protection of population of the republic of Tajikistan; 2013
[9] National Health Strategy; Republic of Tajikistan 2010-2020
[10] MoH, GoT, National Health Strategy 2010 – 2020, Dushanbe 2010

health centres and health houses) as well as in maternity houses for new-borns. The EPI Programme in Tajikistan generally operates as a vertical programme, with its own funding stream, dedicated staff at national and sub-national level, specific procurement and logistics systems, and separate planning and information system[11]. The EPI functions that are most integrated into health systems are service delivery and surveillance of vaccine-preventable diseases. At the service delivery level, vaccination services are mostly integrated with primary health care services and delivered by PHC workers.

In 2010, the world's largest Polio outbreak in Tajikistan raised concerns about weaknesses in the routine immunization services and 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.[12] An Inadequate immunization management information system was also identified as one of the weaknesses of the immunization system in Tajikistan by the National Immunization Program Review.

The major strategic document related to the provision of immunization services is a Comprehensive Multi-Year Plan on Immunization (cMYP) for 2011-2015 that was developed by the Republican Center of Immunoprophylaxia (RCIP) in 2010 and approved by the MoH[13]. The document was updated in 2013.

1.5.GAVI HSS Program in Tajikistan

In 2000, The GAVI Alliance initiated its support to Tajikistan by introducing new vaccines and providing the Immunization System Support (ISS) and later on the Health System Strengthening (HSS) during 2008-2014. The main goal of the Tajikistan HSS 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 services, and improvements in the quality of physical and human resources**[14]. The grant followed five objectives necessary for achieving its goal: 1) strengthening the evidence-base for decision making at central and local levels in order to build financial commitment for PHC and Public Health (PH) services; 2) increasing access to PHC services in remote hard-to-reach areas; 3) strengthening the capacity of PHC and public health (PH) staff using updated and harmonized guidelines for Integrated Management of Childhood Illnesses (IMCI), for Vaccine Preventable Disease (VPD) and for surveillance of Adverse Events Following Immunization (AEFI); 4) increasing the demand for timely immunization through increased awareness and development of a system of incentives for mothers using Conditional Cash Transfers (CCT); 5) increasing the capacity of PHC facilities in data collection and timely reporting with the objective of enhancing data-driven decisions and planning for immunization and other services [14].

[11] National Immunization Program Review, Tajikistan, MoH, UNICEF, WHO, JICA, USAID, AKHS, 2012
[12] Ibid11
[13] Comprehensive Multi-Year Plan of the Immunization Program of Tajikistan for 2011-2015
[14] GAVI Proposal for support to Health System Strengthening (HSS) Republic of Tajikistan; March 2008

Most activities supported by the GAVI HSS grant are implemented in six priority districts (Ganchi, Vose, Mastchoh, Farkhor, Kumsangir and Baljuvan), although some activities cover all 65 districts in the country. As per the proposal, the targeted six districts were selected using seven criteria: a) Infant Mortality Rate (IMR); b) share of home deliveries; c) DTP-3 coverage rate; d) distance from the regional center; e) level and quality of infrastructure; f) district poverty rate; and g) presence of other donors.

2. Assessment Methodology

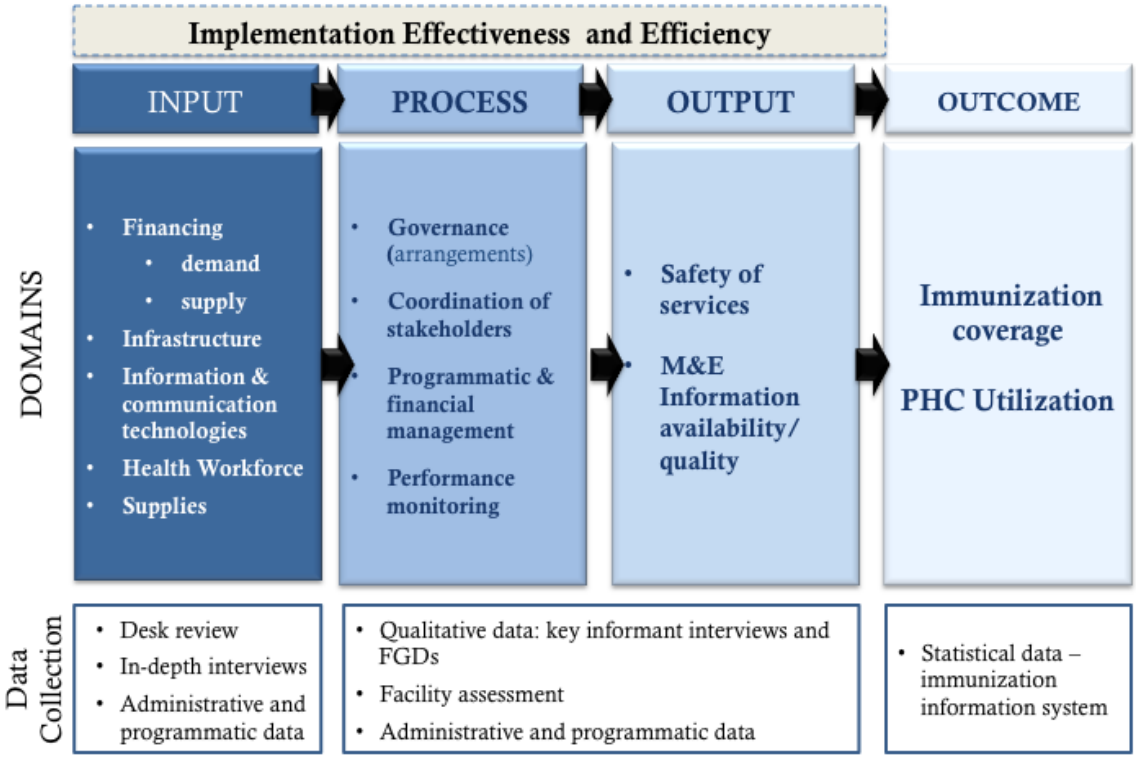
2.1 Assessment Framework and Matrix

As requested by the RFP, the assessment focused on program implementation, specifically looking at the implementation effectiveness, efficiency and results of GAVI HSS support to Tajikistan.

The Assessment framework for this assignment is described below in Figure 1 and is based on the health systems M&E framework developed by the IHP+[15] and used by GAVI in the HSS tracking study[16]. It focuses on following four domains: 1) system inputs, 2) processes, 3) outputs and 4) outcomes. This study did not evaluate the impact resulting from GAVI HSS funding, because determinants of child mortality are complex and involve different causes such as the length of breastfeeding, immunization coverage, access to care and also those beyond the control of the health sector (poverty, education, parent behavior, food insecurity, unsafe drinking water, etc.)

[15] WHO Geneva; Monitoring and evaluation of health systems strengthening; An operational framework; November 2009
[16] JSI Research and Training Institute Final Synthesis Report; Health Systems Strengthening Tracking Study, 2009

Figure 1: Assessment framework



Furthermore, the assessment team drew from Organization for Economic Cooperation and Development /Development Assistance Committee (OECD/DAC) evaluation criteria as requested in the RFP. Consequently GAVI's support to Tajikistan was evaluated along four criteria: relevance, efficiency, effectiveness and results.

Relevance was assessed by looking at the plans and respective interventions and indicators, and examining their relevance to achieve the planned outcomes.

Implementation effectiveness of the HSS program was measured by looking at whether the planned activities were carried out on time and on budget, and if key objectives/targets were achieved. While studying effectiveness, the major factors that may have influenced achievement or non-achievement of the objectives were documented as well.

Efficiency of the implementation was assessed using qualitative methods and looking at whether an integrated approach was applied when delivering program interventions. The team did not analyze the efficiency of the interventions due to lack of necessary data for such analysis, which is described later in the report.

The results were measured by looking at outcome level indicators (such as Penta3, Hep B-1 coverage and PHC utilization rate) and to what extent the GAVI HSS program may have contributed to achieving these results.

The relevance of the HSS program was assessed across all five objectives, while for implementation effectiveness and efficiency the study team looked separately at each of the

five objectives of the HSS application and applied the approaches presented in the assessment matrix in Annex 1. This matrix links inputs, targets and outputs for a given objective with the assessment criteria. Inputs are derived from the Annual Progress Reviews (APRs) while source for the targets is the original proposal and revised implementation plan. To measure progress of the objectives almost all indicators from the original proposal were taken, with exception of impact indicators on infant and under-five mortality due to reasons explained above. Assessment team also developed criteria to measure relevance, implementation effectiveness and efficiency where possible. Each assessment criterion has its measurement methodology with the data sources used by the assessment team to arrive at quantitative and/or qualitative judgment. The assessment matrix also suggests criteria for outcome measurement (immunization coverage and PHC utilization). In the original proposal these indicators are given as national level indicators, which are not relevant to the district level activities of the HSS project. Therefore, to assure relevance, the assessment team looks at Immunization coverage and PHC utilization indicators at the district level and compares with other districts of the same oblasts, where the project was not active. This allows capturing of GAVI contribution to improved outcomes.

The weakness of the M&E framework of the HSS program is described later in the respective section of the document. Nevertheless it is worth to mention here, that this limitation significantly challenged data collection as well as the assessment itself.

2.2 Geographical scope of the assessment

In accordance with the RFP requirements, the scope of the assessment was program-wide, however the data collection was limited to the sub-set of districts covered under HSS project. The district selection was also informed by the RFP requirements and included: a) type of activities supported by the HSS program and b) the volume of allocated resources. Consequently, the HSS program design guided the district selection. Namely: the program was implemented in six districts, out of which four (Farkhor, Kumsangir, Vose and Baldjuin) are in Khatlon oblast and two (Matcha and Ganchi) in Sogd oblast. The HSS proposal (2008) stipulated that planned interventions were similar in all targeted six districts with the exception of the *Conditional Cash Transfer* (CCT) component (demand side incentives for poorest mothers in hard-to-reach areas), which was only planned to be piloted in two districts of Khatlon – Farkhor and Kumsangir. Consequently, it was decided to select one district from Khatlon with CCT component – Farkhor– and one from Sogd oblast that is most remote and mountainous among the targeted six– Matcha. This selection was made in close consultation with GAVI and it meets the selection criteria suggested in the RFP.

2.3 Assessment Methods

A Mixed method approach was used for this assignment and included a desk review, qualitative methods and quantitative data analysis.

The desk review was essential to provide an independent assessment and verification of project plans, implementation processes and achieved results. The desk review utilized available key project documents (such as agreements, Annual Progress Reports (APRs), GAVI alliance decision letters, IRC reports, Health System Coordinating Committee (HSCC) meeting minutes, etc.), policy documents, survey and study reports, financial and monitoring reports. The majority of the key documents were provided by GAVI Alliance, although the list was expanded through an Internet search and with the help of in-country stakeholders, including the Government. The list of the documents reviewed is provided in Annex 2.

Face-to-Face interviews were carried out to collect qualitative information on a specific set of issues per each assessment criterion. In-depth interviews were conducted using semi-structured interview guides, with questions tailored to interviewed individuals. Government representatives (national and district level), facility and program managers, and development partner representatives who were involved in the design, implementation oversight and coordination of the program, informed this work. Participants were assured of their privacy and protection of their confidentiality. The list of the organizations whose representatives were interviewed is provided in Annex 3.

Field/site visits were conducted in Farkhor district (Khatlon oblast) and Matcha (Sogd oblast). The assessment team visited Facilities that were renovated under HSS grant, were provided with refrigerator and had relatively remote locations. In total, 6 facilities in Farkhor and 4 in Matcha were visited to validate the assessment findings arising from a document review and in-depth interviews.

Small group discussions were organized in two selected districts with the facility level staff represented by primary care doctors and nurses. In total 17 primary care health providers participated in these discussions in both districts.

In addition, **small group discussions** with the program beneficiaries (mothers / caregivers of children under 6 years who received incentives) in villages in each district were conducted. Beneficiary selection was done through the list of beneficiaries that was provided by managers of the Rayon Center for Immuniprophylaxis (RCI). Discussions were held in a neutral place, although interpreters were used as most of the conversations took place in the Tajik language. See for In-depth interview and small group discussion guides (Annex 4).

Quantitative data was gathered from secondary sources through document review as well as field visits. The assessment team collected available data on outputs and outcome indicators selected by the country as part of its HSS program. District level data on immunization coverage rates, PHC utilization and other indicators was collected from the Center for Medical Statistics and Information and RCIP. GAVI HSS program budget expenditure data by program objectives and activities by years was supplied by local

counterparts. The list of collected quantitative information used in the analysis is provided in Annex 5.

2.4 Assessment team and implementation

The assessment team consisted of an international team leader and two international researchers. A local consultant used for data collection and for meeting arrangements also supported the international team. All researchers were fluent in Russian, although interpreters were used when field visits were conducted and when interviews were held in the local language.

The country visit took place during August 5th – 15th and field-work in targeted districts was conducted during August 10th – 12th by two separate teams, composed of an international researcher and a local consultant and interpreter.

2.5 The Assessment limitations

The assessment faced the limitations listed below, which have to be considered when reading this report:

- Due to desire of Tajikistan to apply to new HSS grant during September 2014, GAVI had to impose extremely tight timelines (one month) for this assessment, which constrained team's ability to collect more in-depth information and data, which could have made the findings even richer;
- The actual timing of the country visit during the month of August coincided with the summer holiday season and some key informants were not in the country for interviews;
- Due to length of HSS program implementation (almost six years), some key individuals involved in the program design and GAVI application preparation in 2008 have moved to different offices and/or countries and were not readily available for interviews. Nevertheless the assessment team used various means (Skype calls, network references, etc.) to access these individuals and obtain their informed feedback. Another limitation emerged due to long recall periods, with some individuals facing challenges remembering the events that took place several years earlier;
- Furthermore, the reorganization at the MoH that occurred in December 2013 moved some key stakeholders out of the Ministry, which meant that current officials were less informed about the past of the HSS program and the decisions made. To address this shortcoming, the assessment team communicated with those individuals who held the positions prior to the MoH reorganization, which helped to increase number of interviews as well as breadth and depth of information. Even so, not all respondents were accessible and/or willing to be interviewed.

- Limited sample of two districts out of six targeted by the HSS program imposed further limitations, and therefore generalization of the assessment findings should be done with caution;
- Data limitations, caused by weak health management information system in the country, poor documentation of government decision making, weaknesses in record keeping, especially for financial expenditure, etc., imposed additional complexity. Where possible, the assessment team worked hard to obtain and validate the data.
- However, the greatest limitation was imposed by the weak monitoring and evaluation framework of the HSS program, which had inadequate set of indicators (on an outcome/impact as well as input/output level) limiting establishment of plausible causal linkages between HSS interventions and program outcomes. And the weak monitoring and evaluation framework was further layered by lack of data even for those process and output indicators, which could have been helpful for this task.

3. Assessment Results

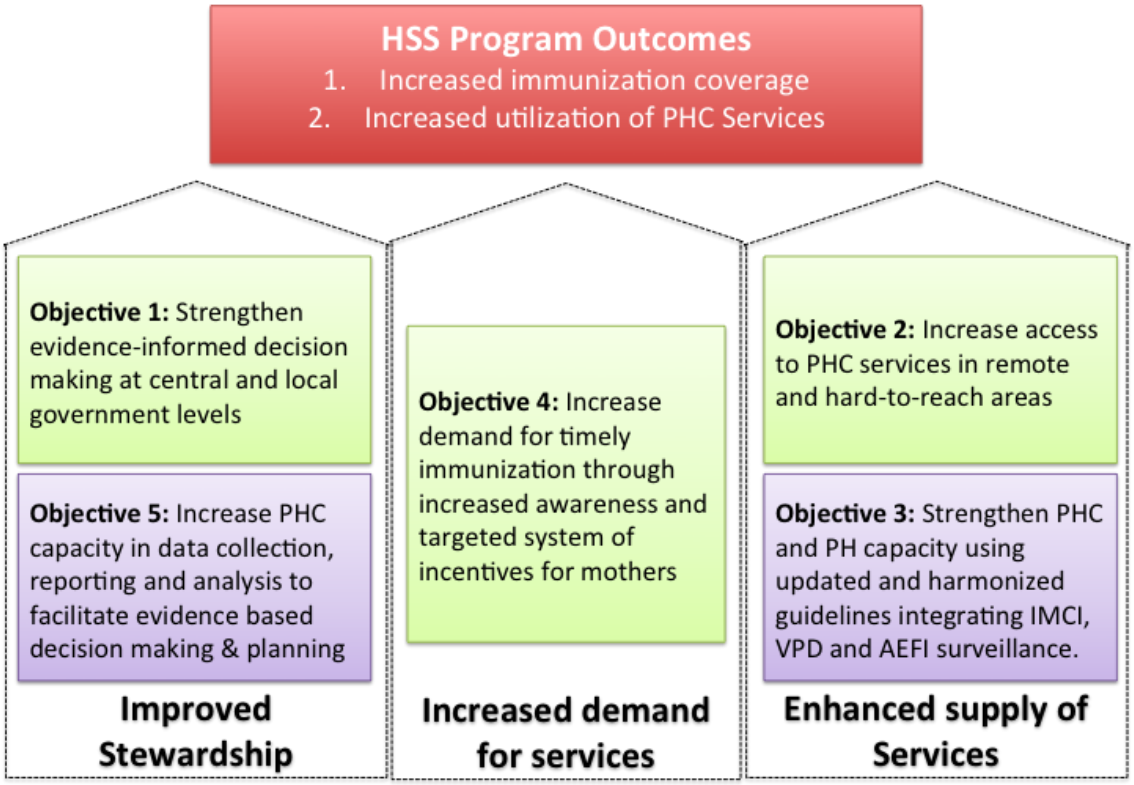
In this section of the report we first present the overall logic of the HSS program design, which helps to understand the program components and their relevance to achieving the planned results. Then we provide information about national planning, implementation management, coordination and oversight, which explains successes as well as delays in the program implementation and allows lessons to be derived for further consideration. Thereafter we move onto describing each HSS program objective separately, with a particular focus on the relevance and effectiveness of their implementation and their possible contribution to achieving overall results. Finally we discuss the program outcomes and the possible GAVI HSS contribution.

3.1 Overall logic of the HSS program design in Tajikistan

Based on the document review, we have constructed the overall logic (for visualization purposes only) of the interventions planned under the Tajikistan HSS program, which is schematically presented in Figure 2 and include a set of supply, demand and stewardship enhancement activities. The program intended to enhance the stewardship function of the central and local government a) by strengthening evidence-based decision making with the help of policy briefs; and b) by improving PHC capacity in data collection, reporting and analysis with the help of modified recording and reporting forms and trainings. In terms of supply,, the program planned significant investments in a) PHC infrastructure and equipment in hard to reach and remote areas; and b) updating and harmonizing guidelines for IMCI, VPD and AEFI surveillance, and training facility staff in these guidelines. On the demand side, the program focused on a) population awareness increasing activities about VPDs and immunization; and b) in two pilot districts testing conditional cash transfers (CCT) for the poor and underprivileged mothers to facilitate timely utilization of

immunization and PHC services. More details about these activities are provided later in the report. Based on this description, on the available global evidence and IRC review, the overall program design was relevant to the objectives that the HSS program set out to achieve.

Figure 2: Overall logic of the HSS program interventions in Tajikistan



3.2 Planning, Management, Coordination and Oversight of Implementation

3.2.1. Implementation Delays and Major Determinants

This section of the report discusses factors affecting implementation timelines, and the findings presented are based on a thorough review of the documents/letters/correspondence between the GAVI Alliance and Government of Tajikistan (GoT) supplied by GAVI and/or the MoH. Details of the communication in chronological order are presented in Annex 6. The findings of the document review were validated through in-depth interviews and are presented below.

The GAVI Alliance approved original Tajikistan's HSS application in June 2008, with implementation scheduled for 2008-2010. However, actual implementation only commenced in May 2011, with a significant delay due to circumstances described below.

Consequently, implementation was re-planned for 2011-2013 and eventually extended until December 2014.

The initial delay in the program start occurred during 2008-2009, caused by delayed execution of the Memorandum of Understanding (MOU) between the GAVI Alliance and the WHO CO, which was prime recipient of the HSS grants. The WHO CO was assigned this role during the proposal development stage. This decision was made jointly by the MoH and partners, based on various assessments that identified MoH's limited capacity to implement donor-funded projects. However, following the grant approval this decision was subject to renewed discussion, and agreement was not reached for several months because other in-country partners expressed an interest to become recipients of GAVI HSS funds. Based on a document review in September 2009, GAVI notified the MoH and WHO CO about the urgency of signing the MoU[17]. Finally the MoH made a decision in favor of the WHO CO, and the MoU between GAVI Alliance and WHO CO was signed in spring 2010. While these discussions were taking place between the GAVI secretariat and MoH, another factor emerged that delayed the program start further. Tajikistan was expected to submit an external audit report for its ISS grant for the year of 2008 towards the end of September 2009. However, delays in submitting this audit report "forced" GAVI to introduce a condition in the HSS grant, which required timely provision of the audit report prior to HSS fund disbursement[18]. The GoT was late in its fulfillment of this precondition and consequently the external audit report for ISS grant was only submitted to GAVI in August 2010. Subsequently, the first disbursement under the HSS grant in the amount of 282,235 USD only occurred in August 2010 and these funds were credited to WHO CO bank account.

While RCIP was the recipient of the Immunization services support (ISS) grant, WHO CO was designated as the funding channel for the HSS grant due to the findings of the Financial Management Assessment (FMA) commissioned by GAVI in 2010. The GAVI Alliance reserves the right to perform FMA in order to ensure the accountability and transparency of funds disbursed to a country. This assessment enables GAVI to have a better understanding of the financial management arrangements in any given country and permits better fiduciary risk management. The FMA in Tajikistan implemented during August 2010 identified numerous weaknesses in the public financial management system of the country. Serious deficiencies were noted in budget execution, in accounting, in internal financial controls, external scrutiny and audit. Weaknesses in financial planning as well as in tax compliance and inadequate transparency were also noted by the FMA. Consequently the FMA recommended retaining RCIP for the ISS grant and using WHO CO for the HSS program support. Furthermore, the report suggested specific measures aimed at improving the existing financial management arrangements in place for ISS grant.[19] Thus, in 2010 findings

[17] GAVI IRC Report on APR 2008, September 2009
[18] GAVI Alliance decision letter, GAVI/09/305/ir, 14 January, 2010
[19] Financial Management Assessment, 15-27 August 2010

of the FMA assessment once again reaffirmed the need for an adequate financial risk management and suggested external fiduciary agent to the government, i.e. WHO.

The next set of challenges further delaying HSS program implementation emerged after initial tranche was credited to WHO's account, when funds transferred during August 2010 reached WHO CO bank account on 25 January 2011[20]. According to stakeholders, these delays were due to changes in WHO's internal financial management system. Therefore, HSS grant funds appeared on the RCIP's special account only end of March 2011, and not in USD but in the local currency[21], which resulted in further exchange rate losses. Consequently due to exchange rate losses and WHO's commission, RCIP received almost 19,000 USD less than expected. This triggered another set of events that negatively affected pace of implementation. Local stakeholders, especially RCIP, became vocal about these challenges. Importance of direct transfer of funds to RCIP bank account was raised several times with the WHO and GAVI, although it was well documented on several occasions that financial management capacity of the Government was quite weak. Nevertheless, the GoT officially requested from GAVI Secretariat changes in the funding mechanism to avoid further delays in funds transfer and also to minimize transaction/currency related losses. The request was made to transfer funds directly to the GoT's special bank account for HSS at the RCIP in May 2011[22] .

According to the GAVI Transparency and Accountability Policy (TAP), changes in funding mechanism had implications for programmatic and financial management, and required review and endorsement by the Health System Coordinating Committee (HSCC), which was communicated to the country in writing[23]. The issue of the funds transfer change was discussed at the HSCC meeting on October 5th 2011.[24] The WHO did not object this decision, although stressed importance of the HSCC involvement in the funds management/oversight. The GAVI representative, who attended the HSCC meeting underlined that the change will strengthen local capacity, also clarifying that although funds would be directly credited to the RCIP special account, this decision would not free the WHO CO from the responsibility of monitoring the financial management of the grant. Consequently, the government's proposal was endorsed by the HSCC on October 5th 2011. Although in its letter[25] GAVI required the country to reflect the changes in the 2011 annual progress report (APR), a review of the document and its attachments did not reveal any evidence of these changes being well reflected in the APR.

Following the country's request, the Aide Memoire enacted by the GAVI Alliance and the GoT on 29 November 2011 defined the programmatic and financial management

[20] Independent audit report of RCIP financial reporting of GAVI HSS funds in 2011, April 2012
[21] APR 2011
[22] MoH Letter to the GAVI Alliance (ref 116,2011), 6 May, 2011
[23] GAVI Alliance letter to the Minister of Health, GAVI/11/174/NA, 10 June, 2011
[24] The HSCC Meeting Minutes No2, 5 October, 2011
[25] GAVI Alliance letter to the Minister of Health, GAVI/11/174/NA, 10 June, 2011

requirements under HSS grant. The document mandated that the GAVI HSS support was to be disbursed to and managed by the RCIP, while the WHO CO should ensure close monitoring of the budget; provide technical assistance and programmatic oversight of the HSS program. Furthermore, the document required the HSCC to undertake a joint annual review of the HSS program in close cooperation with WHO and UNICEF to ensure that the objectives of the program are on track and will be met[26]. The Aide Memoire is part of the Partnership Framework Agreement (PFA), which sets out all general terms and conditions governing current and future programs between GAVI Alliance and the GoT. It took one year for the GoT to fully enact the PFA, which entered into full force only on November 2012. Signing the PFA was a prerequisite for the program to be effective and for the second tranche to be transferred. Consequently, the second tranche (in the amount of 698,530 USD) was received only in January 2013.

The issues related to the delays with the second tranche of funds were discussed and noted by the HSCC twice (January 27 and April 12, 2012). The delayed approval of the APR for 2011 by GAVI, which was due on May 15th 2012, was reported as one of the reasons for the delayed transfer of funds. However, HSCC members were not aware that the signature of PFA was an important precondition for the HSS grant to proceed. This misunderstanding might have been caused by weaknesses in communication between the MoH and GAVI and in-country partners. The assessment team was not able to obtain the IRC report or other communication from 2012 that reflected the dates and times when GAVI alerted the MoH about the need to sign the PFA. As reported by the key informants, another obstacle that contributed to weak communication was that letters arriving at the MoH only reached the addressee with a 2-3 month delay.

Due to these delays in delivering the second tranche of funds, all program activities planned for 2012 were rescheduled for 2013 and the GoT requested a no-cost extension until end of 2014. The request for a no cost extension was endorsed by the IRC[27] and the country received the third tranche (in the amount of 334,000 USD) in January 2014.

In light of presented sequence of events it is obvious that several factors were at play that delayed the HSS program start and its implementation. Namely:

- Institutional/partner competition within the country, most likely also affecting unity of partners and consequently the support they were expected to provide to the government seems to have caused initial delays. These findings are similar to the ones detected by the GAVI HSS support evaluation[28] in other countries, when

[26] Aide Memoire Governing the Financial Management of GAVI Health Systems Strengthening (HSS) and Immunization Services Support (ISS) Cash Grants in Tajikistan, November 29, 2011

[27] IRC 2013 on APR 2012

[28] HLSP 2009. GAVI Health System Strengthening Support Evaluation 2009. http://www.gavi.org/results/evaluations/hss-review/

lack of partner support during program start was as well noted and caused delays in implementation.

- Inadequate and/or miscommunication between the GAVI secretariat, the country and in-country partners has also emerged as an important reason affecting implementation pace. Especially lack of knowledge of GAVI policies and procedures related to HSS grants and its disbursements seems to have negatively affected program start as well as pace of implementation;
- Slowness of institutional bureaucracies of the country, WHO and GAVI were as well at fault. Namely, document flow within the government/public entities in Tajikistan delayed communications. The weaknesses in planning and management within RCIP resulted in delays with audit report submission for 2009. Some unknown WHO bureaucracies/procedures significantly affected pace of funds flow from WHO HQ to WHO CO and thereafter to RCIP also resulting in fund loss due to currency exchange rates. Operational policies of GAVI imposed emerging requirements on the country like conditionality for audit report submission, the FMA assessment, PFA approval, procedurals steps necessary for modification of funds flow from WHO CO to RCIP, etc.

All of these leads to the opinion that at minimum adequate risk assessment as well as risk-management is needed along with adequate management capacity within the GAVI secretariat to manage grants with the help of complex partnerships and in a complex country setting and to deal with the complexities described above.

3.1.2. Program Governance and Coordination Arrangements

In this section we discuss the planned program governance and coordination arrangements, and what changes, if any, occurred. We try to highlight the strengths and weaknesses captured during the assessment.

According to the original HSS proposal, HSCC was established in 2007 to coordinate all health sector reform and health system strengthening efforts, including reforms of the PHC, immunization, MCH and other interventions implemented by the government and development partners. The HSCC was also envisioned as a mechanism for coordinating the GAVI HSS program activities with other health programs. However, the assessment team was not able to obtain any governmental document that legally established HSCC in 2007 and defined its roles and responsibilities. The only ministerial decree regulating HSCC emerged on April 30th 2014[29] and endorses the renewed composition of the HSCC following the major reorganization of the MoH, which took place in November-December 2013. Consequently the membership in the HSCC was as follows: heads of MCH, Family Planning

[29] MoH decree N255 April 30, 2014

and Sanitary and Epidemiological Departments of the MoH, RCIP, representatives of MoF, WHO CO, UNICEF, the WB health program.

Furthermore, according to the GAVI HSS proposal the HSCC had the following functions:

- Monitoring implementation of the planned GAVI HSS activities and taking high level policy decisions, where necessary, to resolve any issues impeding implementation;
- Ensuring coordination between GAVI HSS activities and other activities for harmonizing implementation of country -wide HSS activities;
- Reviewing and approving changes considered in the GAVI HSS plans and budget(s);
- Providing a mechanism to coordinate activities and disseminate information among stakeholders supporting Tajikistan in its HSS efforts.

In 2007 and 2008 the HSCC met several times to discuss the GAVI HSS application, to review IRC comments and approve the revised proposal. Thereafter HSCC met on average twice per year to approve APRs (starting from 2011), audit reports, annual plans and budgets and discuss high level issues related to HSS program implementation and make any necessary decisions. Based on the reviewed documents, HSCC meetings were participatory, always attended by representatives from the MCH department, WHO and UNICEF, as well as other health project officers from other entities. However, HSCC members felt that the frequency of meetings was insufficient as they were unable to discuss the details of program implementation, such as assessing progress against set indicators. As a result, HSCC members were not adequately informed about the details of the program performance. Participants also faced challenges recalling any debates addressing the HSS program implementation problems other than transferring funds from WHO CO directly to RCIP bank account. The review of the meeting minutes also did not reveal any discussions about HSS program progress. Most respondents agreed that critical issues were not raised during HSCC meetings, with the exception of one case when one of the participants questioned the effectiveness of the use of mobile teams supported by the HSS grant.

> "*HSCC meetings were useful to solve operational issues; it was not a venue for program implementation discussions …..*"
>
> Quote from a key informant

Interviewed stakeholders all agree that HSCC provided space to communicate information about the GAVI HSS program implementation to the stakeholders working on health systems issues, but this space was not used effectively by the authorities. While almost all interviewed stakeholders recalled their active involvement in the HSS program

> "*GAVI HSS program has inadequate visibility….*"
>
> *"GAVI is only associated with Immunization and information about HSS program has not been well disseminated….*"
>
> Quotes from key informants

elaboration and design, they noted very limited engagement and awareness about the implementation stages. Some in -country partners only recently learned about program components, such as CCTs for poor mothers, when the new GAVI HSS proposal was developed in July-August 2014. Stakeholders also agree that GAVI HSS program had low visibility, which was also evidenced by the absence of GAVI HSS in the 2013 Joint Annual Review of the National Health Strategy. While the Aide Memoire mandated HSCC to conduct annual joint reviews of the HSS program with active involvement of WHO and UNICEF[30], in reality such reviews never took place.

All of this indicates that while HSCC probably had the potential to ensure effective coordination and oversight of the program, however the weaknesses noted above meant that it failed to deliver on expectations. **We noted that during the HSS proposal preparation there was regular and active engagement of stakeholders and the Alliance's partners. However, HSCC engagement became marginal or non-existent during program start[31] and during actual implementation**. Consequently ensuring continuous HSCC oversight during grant application as well as during implementation seems absolutely necessary to create a common information space, which in turn would ensure better oversight, coordination and effective program implementation, including from the Alliance's partners.

Interviewed stakeholders perceive GAVI's role in program implementation as very positive and helpful in triggering and facilitating the national processes, although not to full extent. Routine and scheduled communication between country and GAVI (from submission of APR to IRC and Decision letter) provided the space for effective coordination and program oversight, when implemented effectively. However, noted weaknesses/delays in communication arising from language barriers as well as from lack of clear communication channels with the HSCC and involved partners could be seen as potential reasons for delayed implementation. Furthermore, beyond formal communication GAVI uses other channels such as meetings and informal e-mails to address important implementation issues. The assessment team did not have access to such communication and therefore was not able to judge its effectiveness. Since GAVI does not have presence in the country and relies on the Alliance's partners, their role is critical for successful program performance. This role could be enhanced through effective communication that informs partners about program implementation issues and empowers them to tackle these matters using the national coordination mechanisms established for such grants. Albeit, in Tajikistan neither partners engaged actively in the program oversight nor the GAVI secretariat sought their support proactively. Consequently actual implementation of the HSS program, with very

[30] Aide Memoire: Governing the Financial Management of GAVI Health Systems Strengthening (HSS) and Immunisation Services Support (ISS) Cash Grants in Tajikistan; November, 2011
[31] Also noted in other countries by the HSS support evaluation from 2009

limited oversight, was left in the hands of the Government, whose weaknesses were known well in advance.

Therefore, GAVI's current partnership model used in Tajikistan proved ineffective and thus GAVI needs to enhance its assurance mechanisms, which guarantee that mandates imposed on countries in an FPA and/or MoU are well recorded, monitored and reported. The case of Tajikistan suggests that such assurance mechanisms may need to be strengthened if the accountability of the recipient country, GAVI's partners and the GAVI secretariat is to improve.

3.1.3. Program Management Arrangements

Under the approved proposal (March 2008), the Health Reforms and International Relations Department (HRIRD) was designated entity to fully manage the GAVI HSS grant. Its responsibilities included: a) regular (at least twice a year) reporting to the HSCC on the progress of the program implementation; b) day-to-day management and monitoring of the implementation process for all activities under the HSS grant; c) compiling financial and programmatic reports and submission to the GAVI Secretariat and HSCC; d) managing communication with GAVI Secretariat on behalf of HSCC, MoH and other relevant departments; and e) cooperation and collaboration with the WHO CO and UNICEF on GAVI HSS program implementation and monitoring. According to the original design, implementation responsibilities were shared between two departments of the MoH: i) Department of Maternal and Child Health (MCH) and ii) Republican Center for Immunoprophylaxis (RCIP). While HRIRD had prime responsibility for HSS grant management, WHO CO was assigned responsibility for oversight of financial management and for undertaking procurement under the GAVI HSS program.

The assessment revealed significant deviations from the original management arrangements. Starting from early 2011 (after receipt of the first tranche of the HSS grant) and based on the MoH decision, the RCIP replaced HRIRD and became the only responsible entity for program implementation and financial management. Not only were HRIRD functions fully handed over to the RCIP, but the responsibilities of WHO CO for procurement and fiduciary control were fully subsumed by the RCIP. Finally, the MCH department under the MoH and district health departments were completely removed from program implementation responsibilities. Table 2 below compares the originally planned management arrangements and the *de facto* arrangements for the period 2011-2013 and thereafter.

The Introduced changes raise several concerns, which may have negatively affected the program implementation, including:

- Implementation of the HSS became the responsibility of a centralized vertical system – RCIP, which was responsible for the national immunization program and had no responsibilities for health system planning and management. **Consequently**

the entity charged with planning for and managing the HSS program had limited expertise in health systems area;

- The situation was further aggravated by the removal of the district health department, from program management and abolition of the MCH department's role. Both these entities are critical players that can ensure better planning of the health system at the district level and better integration of child health and immunization services;
- WHO's role for procurement and fiduciary control has been significantly reduced and was limited to approval of quarterly HSS program implementation plans and budgets submitted by the RCIP.[32] Such a decision was against the FMA recommendation that highlighted PFM fiduciary risks and called for risk mitigation strategies by actively involving WHO in a financial planning and management. Although, RCIP involved both UNICEF and WHO in the tender committee established under the HSS program for procurement purposes, actual engagement of both WHO CO and UNICEF was limited to approval of APRs, annual plans and budgets submitted to GAVI.

> *"… the RCIP director was capable of solving most problems himself without involving others….."*
>
> Quote from a key informant

> *"I wish the program implementation was more transparent ……"*
>
> *"The Program should have used external technical expertise….."*
>
> Quotes from key informants

Since January 2014 the HSS program has been implemented by a new Program Implementation Center (PIC) within the MOH specifically established for the GAVI HSS grant by the Ministerial Decree from 31 December 2013[33]. All functions related to GAVI HSS grant management and fulfilled by the RCIP were handed over to this newly established center, including a special bank account for the GAVI HSS grant. Finally the MoH decree from 9th January 2014[34] appointed a former RCIP director as an executive director of the new PIC. However, these changes were not communicated to the GAVI secretariat in a timely manner, even though the Aide Memoire requires the country to notify GAVI about such changes in program management arrangements.

On the other hand the RCIP simultaneously implemented GAVI HSS and National Program for Immunization in the period 2011-14, which ensured strong coordination and linkages

[32] Ibid 26
[33] MoH decree #801 31.12.2013
[34] MoH decree #10/a 09.01.2014

between these two programs. Although the RCIP director provided strong leadership, the overall resources available for HSS program management seemed limited. The program had only the program director (same as the RCIP director) and three consultants. The necessary additional technical and administrative resources were drawn from the RCIP office itself. While using the RCIP's qualified technical staff for trainings and implementation monitoring was a positive aspect of implementation arrangements, those staff members have routine responsibilities which mean that they may lack sufficient time for additional tasks. Such behavior was more noticeable on a district level, where the Rayon Center of Immunoprophilaxis (RCI), despite limited resources, implemented the HSS activities that were beyond the scope of its regular duties.

Table 2: Comparison of the proposed and Actual Program arrangements

Functions/Responsibilities	Proposed	Actual 2011- 2013	Actual since 2014
Oversight and overall coordination	HSCC	HSCC	HSCC
Overall program management	HRIRD	RCIP	PIC
Financial Management	WHO	RCIP	PIC
Procurement	WHO	RCIP	PIC
Monitoring and Evaluation	HRIRD	RCIP	PIC
APR preparation	HRIRD	RCIP	PIC
Communication with GAVI	HRIRD	RCIP	PIC
Implementing Agency at the national level	RCIP and MCH	RCIP	PIC
Implementing Agency at the district level	District Heath Departments and District Centers for Immunoprophylaxis	District Centers for Immunoprophylaxis	District Centers for Immunoprophylaxis

Finally the assessment also revealed that in-country partners had limited involvement, beyond those described above, in the HSS program implementation and TA provision. RCIP/MoH may not have adequately utilized external technical expertise for the CCT design and/or for training activities. Most stakeholders felt that the behavior of government entities, which had a reputation for lack of information sharing and limited transparency, was a determining factor for not requesting and receiving the needed technical assistance from the Alliance's partners.

3.1.4. Financial management

Human resource limitations, of the RCIP which were noted above, also affected the financial management of the program. Due to changes in management arrangements, the RCIP/PIC was responsible for financial management even though it lacked dedicated staff and the RCIP financial director was fulfilling this task in addition to his daily duties.

The assessment team noted that 12% of the total funds or 124,443 USD (which was spent up to April 2014 on operational support to the PHC staff and mobile teams to conduct outreach activities) flowed from the central level to the districts through cash-based transaction, without using the banking system. Consequently, on average twice per year cash was provided from a central level to the director of a RCI who confirmed receipt of funds through cash receipt. Transfers through the banking system are not used primarily because RCIs do not have separate bank accounts as they are under the rayon Primary Heath Care structure, and the odds that rayon PHC managers may use grant funds for other purposes are high. Moreover, based on anecdotal evidence, when funds appear in the bank accounts, even to meet RCI's needs, they attract the interest of the rayon authorities, which may prevent the timely and targeted use of these funds.

The Complexity of financial transactions between the center and the rayons is also exacerbated by significant deficiencies in financial record keeping. These include poor organization of the financial documentation at the central and rayon levels, lack of standardized financial reporting formats, poorly communicated reporting requirements to a lower level and consequently poor understanding how to record and report expenditures, etc. These shortcomings are most likely caused by the absence of standard operation procedures and the lack of experience in managing donor-funded projects, especially at a lower-district level. Difficulties in obtaining financial documentation at the district level mean that this assessment lacks factual evidence on programmatic expenditures at the lower-rayon level.

Finally, the RCIP contracts an external audit company through competitive tendering, which undertakes an annual audit of RCIP books and prepares audit findings and recommendations, which are presented and discussed at the HSCC meetings and submitted to GAVI. However, weaknesses in documenting and reporting financial information on a lower–district level to the center and cash-based transactions between these two raise serious concerns about the feasibility of a quality audit in this context.

The Assessment team analyzed changes in the program budget by objectives (see Annex 7). Budget revisions took place annually. A Comparison of the original budget with the revised 2011 budget shows that most changes in the objective-level budget are within an acceptable margin i.e. 11% or less. However, budgetary shifts within activities under the given objective are quite significant e.g. investment costs for PHC facilities have been increased by 41%, reducing support for outreach and mobile activities. In light of the HSS program objective, such shifts run the risk of having a significant negative impact on the program's expected outcomes, unless budget changes are well justified and substantiated with adequate analysis. Nevertheless, all changes in the budget reflected in Annex 7 were reviewed and approved by the HSCC, where key partners (UNICEF, WHO and WB) were present, although meeting minutes did not reveal hard evidence of thorough deliberation on these topics.

The assessment team also compiled annual expenditures for 2011 and 2013 presented in Annex 8 . The analysis reveals that since the start of implementation (after the release of funds), the RCIP has been absorbing funds according to the schedule, and reached an absorption rate of 99% and 97% in 2011 and 2013 respectively. Only expenditure item, which relates to the program management and administration, was overspent by 15% in 2011 and by 96% in 2013. For example, in 2013 the planned budget under the "management and administration" budget line included only salaries for the project consultants in the amount of 23, 412 US $. No other items were initially included. Assessment revealed that 35,714 US $ was spent on the salaries (for project staff and local consultants), 8,104 US $ on payroll taxes and 2,063 US $ on independent audit. Interestingly independent audit is not a new and unplanned activity, as it should be carried out on annual basis and was previously conducted during the first year of the project in 2011. All above once again indicates on weak financial planning capacity of the RCIP, which resulted in budget fluctuations.

3.3 Program Implementation Plan and M&E Framework

The M&E Framework that was a part of the approved original proposal included six impact/outcome and seven output indicators and targets for each year.

The Assessment team evaluated the relevance of original set of indicators to the program activities using SMART criteria, which included following impact and outcome Indicators

1. National DTP3 coverage
2. Number / % of districts achieving $\geq$ 80% DTP3 coverage
3. Under five mortality rate (per 1000)
4. Infant mortality rate (per 1000)
5. Hepatitis B1 coverage in pilot districts and national
6. Number of annual average PHC contact / visits per person in pilot districts

According to the GAVI HSS guidelines[35], the first three indicators must be used to evaluate GAVI HSS investment and all countries are required to include these indicators in the application. The country selected additional three indicators presented above. The Assessment team thinks that only two indicators (#5 - HepB1 coverage in pilot districts and #6 PHC contact/visits per person) were relevant and appropriate for the activities included in the HSS proposal. Activities that may affect immunization coverage were planned only in 6 districts, and so this could not have led to an increase in national coverage rates (DPT3 and HepB1). Similarly, the pilot approach could not improve the performance of other districts; consequently indicator #2 also does not seem to be relevant to the Tajikistan HSS

[35] GAVI HSS Guideline March 2007

program. The Child and Infant mortality indicators are also not attainable with the scale and scope of the interventions under HSS and without addressing factors beyond the control of health sector. These findings indicate that outcome/impact indicators suggested by GAVI HSS guidelines (DPT3 coverage rate; number/percent of districts reporting ≥80% DPT3 coverage rate and child mortality related indicators) were not relevant and appropriate to measure HSS grant performance and its achievements. HLSP team that conducted HSS support evaluation in 2009, also arrived to similar conclusion[36], albeit these learnings did not reach Tajikistan project which started its implementation in 2011.

Output indicators were selected for each program objective and, according to the HSS proposal, were supposed to be used for monitoring and reporting on an annual basis. However, the assessment revealed that most of these indicators were not monitored. Instead, the routine monitoring followed mainly input/process and some output indicators elaborated in early 2011 along with the revised action plan, instead of the original ones included in the proposal. The changes in indicators and implementation plan were discussed at the HSCC meeting and were approved by all committee members[37]. Consequently, in the APRs Tajikistan HSS grant reported its achievements against these revised set of indicators that were not SMART enough to measure the HSS program results. Annex 9 presents the comparison of the original and revised indicators by objectives.

As per GAVI regulations[38], any changes to the activities and M&E framework should be highlighted and justified in the APRs, which will be reviewed by the IRC. Obviously, in this case the responsibility for selecting / revising appropriate set of indicators was left with the HSCC, which includes the Alliance's partners and was not fully able to ensure the selection and use of sensitive indicators that would permit appropriate program monitoring. Furthermore, although these indicators were reported annually in the APRs, neither the GAVI secretariat nor IRC commented on the appropriateness of these indicators for the HSS program, which prevented timely implementation of corrective measures. These findings resonate with the ones already reported in 2010 in the Review of GAVI Independent Review Committees[39].

3.4 Implementation of Program Objectives

In this section we focus on describing activities that were planned and implemented under each objective. we also present any modifications made to the implementation plan and outputs achieved. Strengths and weaknesses/gaps identified during implementation are

[36] HLSP 2009. GAVI Health System Strengthening Support Evaluation 2009. http://www.gavi.org/results/evaluations/hss-review/
[37] HSCC meeting minutes N1, April 5, 2011
[38] Ibid 35
[39] HLSP 2010. The Review of GAVI Independent Review Committees. http://www.gavi.org/results/evaluations/irc-review/

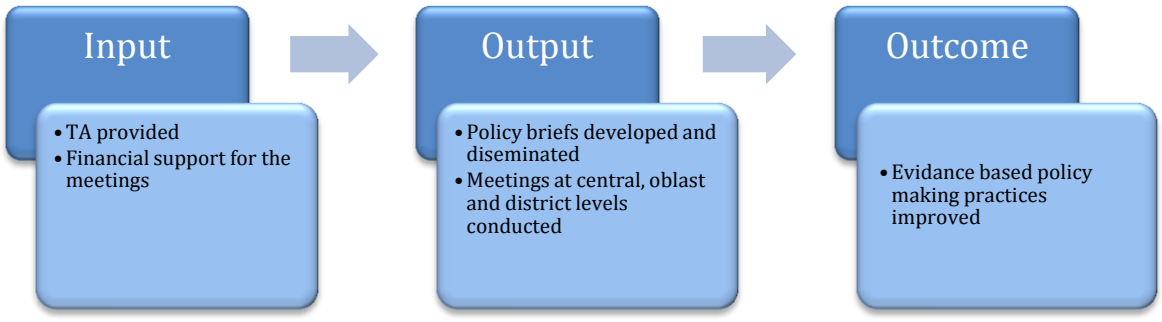
also noted. We do not provide details related to the sub-activities included in each objective, with the exception of Objective 2.

3.4.1. Objective 1

Strengthen evidence-informed decision making at central and local government levels in order to build financial commitment for PHC services, focusing on immunization

Figure 3 below presents a chain of inputs to outcomes for the given program objective. The logical chain was developed by the assessment team for visualisation purposes and to facilitate understaning of the logic of a given Objective. All inputs, outputs and outcomes listed in the figure below and thereafter are based on the original proposal and it revisions introduced by the country during implemenattion.

Figure 3: Chain of Inputs to outcome for objective 1



This component aimed to support the strengthening of evidence -based policy-making practices at the national and sub -national levels. As per the country application, the development, publication and broader dissemination of policy briefs focusing on the impact of government policies and PHC reforms on maternal and child health outcomes was planned. The Health Policy Analysis Unit (PAU) and MCH department under the MoH were supposed to produce and communicate the documents to the different stakeholders.

Three policy briefs, content of which was not specified, were planned annually in the original proposal. However, targets set in the revised implementation plan were reduced to three policy briefs in total over the program life-cycle. In order to ensure that the documents actually reach the decision-makers, several meetings were planned at the national oblast and district levels. Meetings to discuss issues related to immunization coverage and PHC services were considered at all administrative levels. It was expected that such discussions would lead to increasing central and local governments' financing of immunization services.

The Policy Analysis Unit (PAU) of the MoH representative reported that their routine work is policy analysis and MoH capacity building in data analysis and data use. In 2013 the PAU developed a series of the policy briefs that were distributed among policy makers at the

national level. A Review of the policy briefs showed that the topics are broad, ranging from health care financing to the health education issues. One policy brief reviews the process of Monitoring and Evaluation of the National Health Strategy (NHS)(2010-2020) implementation. The policy brief describes a) the process of developing the indicator package for tracking progress and evaluating the impact of activities of the NHS; and b) the process of developing the NHS Joint Annual Review (JAR), while highlighting its importance and application. The JAR for 2013 provides a comprehensive analysis of the NSH impact and outcome indicators, among which are infant and under-five mortality rates and % of fully immunized children under one, according to the national vaccination plan. Albeit JAR does not reflect on the HSS program implementation, although it was mandated by GAVI and the Alliance's partners (UNICEF, WHO and WB) were expected to contribute. Based on discussion with the national level stakeholders, the assessment team is of the opinion that policy briefs produced by PAU could be partially attributed to the HSS program output. However, the outcome of the activity remains marginal, as only the national level stakeholders knew the content of the policy briefs and sub-national stakeholders did not reveal good knowledge of these documents. Nevertheless, the potential for this objective to increase its contribution to HSS program seem greater, because recently the MoH requested the PAU to conduct a household survey and identify the main barriers to immunization. At the time of writing of this assessment report, the study is in the final stage of data analysis, and the results are expected to emerge in nearest future.

Consequently the effectiveness of this objective based on the assessment criteria developed by the assessment team was rated *as marginally effective*, although it has potential for improvement.

Table 3: Objective 1 Assessment Rating

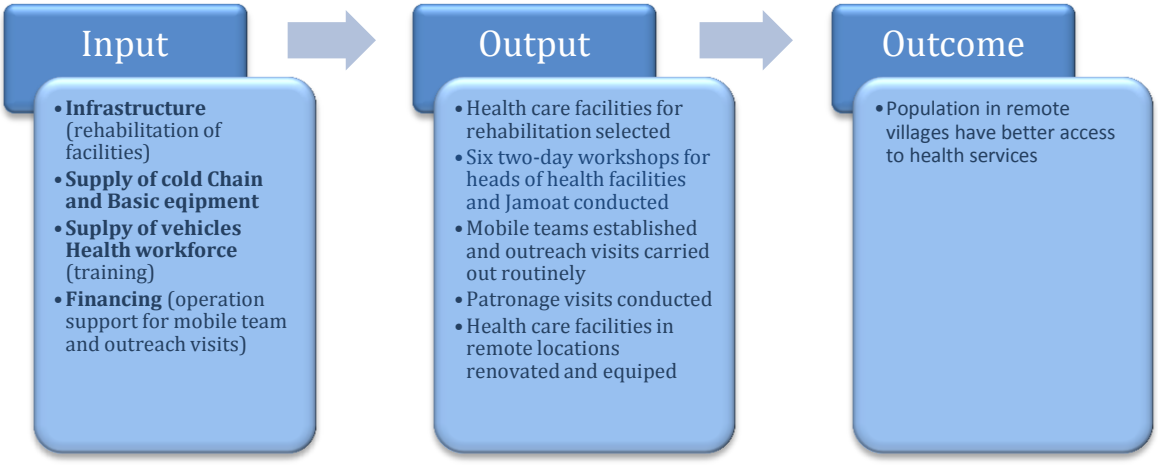
Description	Original target	Revised target	Results & Rating	Comments
Develop and disseminate Policy Briefs	–Three policy brief annually, total nine	–Only three policy brief over program cycle	Y1&Y3 - 1 **Marginally Effective**	33% of the revised target was reached and the policy brief was accessible only to the national level stakeholders

3.4.2. Objective 2

Increase access to PHC services in remote and hard-to-reach areas

The figure below presents a chain of inputs to outcomes for the given program objective, which covers 4 activities that aim at increasing physical access to better-equipped PHC services in hard-to reach areas, as well as improving the quality of health services.

Figure 4: Chain of Inputs to outcome for objective 2



2.1 Using the PHC rationalization plan and based on local government and/or community applications to the MoH, renovate rural health facilities in remote locations using principles of counterpart participation.

As indicated in the APR 2011, the facilities to be refurbished in six program-targeted districts were selected based on a rapid assessment carried out in the first year (2011) of the HSS program implementation. This assessment was conducted in close cooperation with the heads of the district health administration, health facility managers, RCI directors and

documented conditions of the PHC facilities in all pilot districts. Although, the assessment report was not produced, raw data in excel format that lists all PHC facilities, their construction date and condition was created.

In 2013 the MoH of the GoT issued a tender to select a construction company for rehabilitation of the facilities. Ministerial decree # 75 from 7 January 2013 established a tender committee consisting of one representative of the procurement department under the MoH, one from UNICEF and six people from the RCPI[40]. The Tender committee identified the winner among the bidders[41]. As per the 2013 annual report[42], the decision made by the tender committee was discussed and approved by the HSCC on April 19, 2013. However, after reviewing the HSCC meeting minutes # 2 from April 19th 2013, the assessment team found that this document is silent on the tender. According to the APR 2013, the renovation of all 23 facilities was conducted during the period 15 May- 30 November 2013. Although the project proposal envisioned the renovation of rural health facilities/Health Houses (HH) located in remote villages, the list of selected facilities include some that were located close to the district centers in visited districts. This indicates that facility selection was not performed as planned and/or was not carried out transparently and according to the original criteria established by the government.

In the approved HSS proposal, the renovation of 36 health care facilities was planned. However, according to the APR for 2013, only 23 facilities were renovated resulting in 64% achievement on this indicator. The initial planning and budgeting was done in 2008 and 191,000 USD was estimated to be sufficient for 36 facilities. At the beginning of 2013 the program budget for 2013 was revised, and the budget allocated for the refurbishment was increased up to 280,000 USD. However only 223,120 USD was spent on renovation of 23 facilities. Consequently, the average cost of renovation per facility increased by 83% compared to original amount. Although stakeholders named inflation for labor and building material costs as a primary reason for increased costs and for not fully achieving targets, it should be noted that the cumulative inflation in Tajikistan for 2008-2012 only amounted to 62.5%. (The Assessment team calculated that cumulative inflation based on the inflation rates for 2008, 2009, 2010, 2011, 2012[43] .)

Further concerns arise from possible inaccuracies in reporting and accounting for investments made in PHC renovation. The assessment team noted that the report produced in 2013 in Russian[44] indicates that three facilities in Farkhor and four facilities in Matcha were renovated. However, during the field visits, the assessment team visited all renovated facilities in both districts and local stakeholders reported that only two facilities in Farkhor and two facilities in Matcha were renovated using the GAVI HSS program. The reasons for

[40] Ministerial decree # 75; 7 January 2013
[41] Tender committee meeting minute #3 dated 11 March, 2013
[42] The Report is in Russian, and. Report was provided by the Project Implementation Center
[43] http://www.imf.org/ (for 2012 IMF estimation)
[44] Министерство здравоохранения и социальной защиты; Годовой прогресивный отч. # 2. Январь-Декабрь 2013

such a discrepancy could be manifold, including inaccuracy of reporting in an environment where many donors provide financial support for facility renovation, a lack of stakeholder's awareness about which grants maybe funding the facility renovation in their districts, etc.

All above mentioned lead to the following conclusions:

1. The Facilities for refurbishment were not selected in the way in which it was planned, and not according to the original criteria agreed for the facility selection.
2. Although consultations were carried with local government for the facility selection and initial assessments were conducted, it appears that investment decisions were largely made by the center without clear evidence of the assessment data used in the decision -making process;
3. Management of investments and contractors for the facility renovation seemed inadequate, including financial management of investments and financial accounting;
4. Finally, reported cost increases in labor and building materials, the lack of appropriate financial management and inadequate coordination with key stakeholders seem to have led to missing the program target and making some less relevant investments in infrastructure rehabilitation.

In conclusion, all of these weaknesses could be attributable to the institutional capacity of the RCIP. Especially when planned investment activities are looked through the institutional appropriateness/capacity lens, it becomes obvious that RCIP may not be capable of planning and negotiating infrastructure investments with the district health departments and/or communities, and manage construction/renovation tendering, contracting and implementation process. almost all these activities fell well beyond its institutional mandate and abilities, and the institution does not seem to be well set up to undertake management responsibilities of such a program.

2.2. Provide basic equipment, including cold bags, medical supplies and small parts to PHC facilities in selected districts

Cold chain equipment (refrigerators cold boxes, ice-packs and thermometers) was purchased and distributed not only to the 6 districts targeted by the program, but also to other districts. The Cold chain equipment was procured twice in 2011 and 2013, amounting to a total of 120 refrigerators, 120 cold boxes, 480 ice packs and 120 thermometers, along with office furniture. The tendering committee handled the tendering process.[45]

The Cold chain equipment was distributed to the facilities with the help of oblast and district centers of immunoprophylaxis, based on the MoH decree[46]. The Facility selection was made based on the needs identified in the Effective Vaccine Store Management

[45] Ministerial decree # 75; 7 January 2013
[46] MoH Decree# 587, 19.10.2011

Assessment and Effective Vaccine Management Assessment conducted in 2010 and 2012 respectively.[47;48] While a consolidated cold chain distribution plan was not available at the national level for review by the assessment team, district-level plans were presented at both visited districts.

In total 7 refrigerators were supplied to the Farkhor district and 6 refrigerators to Matcha district. At present only 2 out of 18 facilities in Machta and 17 out of 52 facilities in Farkhor are not equipped with the refrigerators, but all of them have cold boxes and a sufficient supply of ice-packs. According to the last Effective Vaccine Management Assessment report, refrigerators need to be replaced in some facilities. Replacement plans were available in both visited districts, and facility visits confirmed that the distribution of the refrigerators was consistent with these plans.

2.3. Provide operational support to PHC staff for conducting outreach activities through covering their transportation expenditures and per diems; and *2.4. Establish mobile teams on the basis of the needs assessment for poor hard-to-reach areas that do not have medical staff*

These two activities are presented together as they are closely linked and are challenging to assess separately. These activities envisioned:

- Provision of operational support to doctors from nearest PHC facility to conduct regular visits to rural HHs staffed only by nurses;
- Establishment of mobile teams at district level, drawing on existing medical staff of the rural health centers, IMCI centers, reproductive health and centers for immunoprophylaxis in all districts targeted by the program. The procurement of vehicles and provision of financial support to cover transportation expenses (fuel and per-diem) of the mobile teams was also planned.

It was envisioned that the planned outreach activities carried out by doctors and mobile teams would improve access to qualified health services in hard to reach and remote areas .

Consequently, six mobile teams were established in all targeted districts (one per district), and six vehicles were purchased in May 2011 to facilitate the delivery of services in hard-to reach areas. Guidelines for mobile teams were developed and staffs were trained in the provision of basic health care services including immunization.

During the field visits in Matcha and Farkhor, the assessment team found that in both districts mobile teams were established in 2011 by a decree of the district hospital manager. In both districts, these teams consisted of an RCI director, a vaccinator and a driver.

According to the interviewed RCI directors, monitoring visits under the routine immunization program are usually combined with mobile and outreach visits to save on

[47] Effective Vaccine Store Management Assessment of the National Cold Store, Jurijs Perevoscikovs, 05-10 April, 2010
[48] Tajikistan Effective Vaccine Management Assessment, 8-25 October, 2012

operational expenses. Discussions with health care providers and the district health administration also confirmed that, in general, outreach activities are routinely carried out in the visited districts. These activities are routinely funded out of the district health administration budget and/ or from community contributions. Sometimes outreach visits are carried out using the HSS funded vehicles. Most district level staff confirmed that a family doctor, and sometimes the IMCI manager and obstetricians join these mobile teams and conduct outreach visits. On average about 6-7 mobile/outreach visits per year are conducted in each district. However, this information is not reflected in any facility records, because plans for mobile/outreach visits does not exist, and neither are there records of the number of such visits conducted, the list of villages visited and/or number of children vaccinated/seen during the visit, etc. The RCIP or MoH does not request this information and consequently the data on mobile team/outreach performance is not routinely available at district and/or at a national level and neither they were included as an output measure for mobile team performance in the program M&E framework.

With regards to immunization monitoring, comprehensive information was available in Matcha district, where the RCI director properly records plans and actual performance reports for such monitoring visits. For example, in 2014 he conducted 19 monitoring visits (i.e. one visit per facility during first 6 months), and he adequately documented the deficiencies found. One copy of the report was given to the facility in question, and all findings were reported to the district health administration and oblast Center of Immunoprophilaxis. However the report does not contain information on mobile team and outreach visits. In Farkhor the RCI director also reported joint visits to the facilities, although plans or reports for such visits were not in existence. The fact that the central level was also not engaged in monitoring mobile/outreach service delivery provided further room for concern. While RCIP staff regularly visited the targeted districts to supervise immunization services, they did not take the opportunity to conduct monitoring of the mobile/outreach team services (the task that most likely falls under the jurisdiction/competency of district health authorities). While effective monitoring of mobile/outreach activities was lacking in the program, during 2011-2013 the HSS program spent 13% more (227,943 USD) than the planned 201,301 USD for the purchase of vehicles and to support of mobile teams with per-diems. The assessment team was not provided with the financial documentation on per-diems or transportation expenses for these mobile and outreach teams, because such records were lacking at a district level. At the national level, documentation only recorded the amounts transferred in cash to RCI directors.

In light of this evidence, it is obvious that vehicles were purchased and the necessary staff resources were trained to conduct outreach services in hard -to -reach areas and improve the supply of quality services to children. Obviously, district health managers embraced this activity and not only decreed that such teams should be established, but also provided financial support from local budgets. However, the value of HSS program investments in attaining actual outcomes – i.e. increasing access to services in hard to reach areas – cannot

be fully established due to following weaknesses: a) outreach service provision was not adequately monitored, and so determining the volume of actual services delivered to the population in remote villages is not possible due to the unavailability of data; and b) the lack of data about service provision also raises concerns about the costs borne by the program in support of these services and how the actual expenditures are accounted for. Consequently, the limitations of the program M&E framework imposed constraints on the assessment team's ability to evaluate efficiency of the resource use.

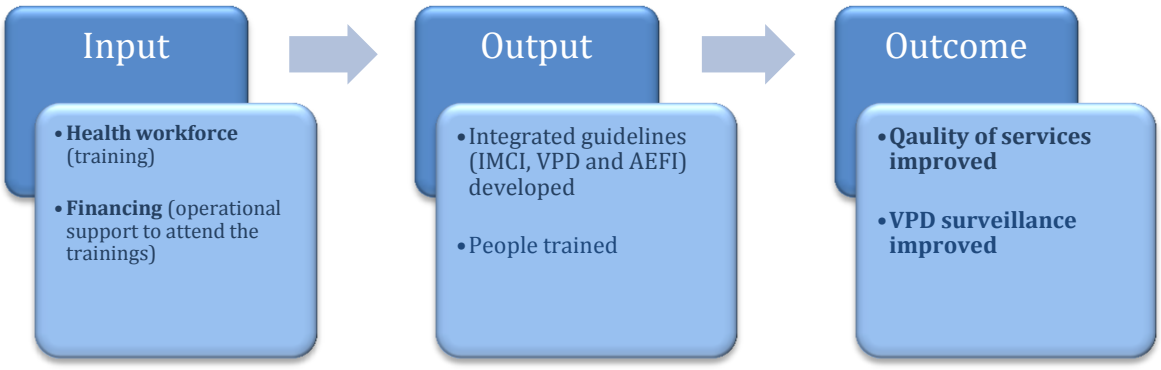
Table 4: Objective 2 Assessment Rating

Description	Targets*	Results & Rating	Comments
Renovated/reconstructed PHC facilities are located in hard-to-reach / remote areas in the visited two districts	All renovated/ reconstructed facilities	Relevance: **Marginally relevant**	Less than 40% renovated facilities were found in remote / hard-to-reach areas in two assessed districts
36 PHC facilities renovated/reconstructed	Y1 – 0 Y2- 36 Y3 - 0	Implementation effectiveness: **Moderately effective**	Only 23 out planned 36 facilities (64%) have been renovated
Share of remote villages that received outreach / mobile serves at least twice per year	Y1 – 60 Y2 – 72 Y3 – 86	Implementation effectiveness: **Marginally effective**	Actual share of remote villages that receive outreach/mobile services at least twice a year cannot be established as data about the volume of outreach/mobile services is not being recorded in the system
Mobile teams provide integrated services (Imm, IMCI, Reproductive) by mobile visits in visited PHC facilities in 2013 and 2014	Mobile teams were expected to include different professionals	Efficiency: **Marginally efficient**	Mobile teams are only sometimes joined by family physician, IMCI manager and obstetrician

***** Original and revised targets are the same

3.4.3. Objective 3

Strengthen the capacity of PHC and Public Health staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc.



This objective intended to strengthen the capacity of PHC and public health staff through the provision of integrated training programs, which were to be delivered after a review of the existing programs for IMCI, reproductive health and immunization, as well as for VPD and AEFI surveillance after the development of integrated guidelines in close cooperation with WHO and UNICEF. Potential beneficiaries for these trainings were PHC staff, staff of Centers for Immunoprophylaxis and San-epid system and PHC managers. Trainings plans also envisioned specific modules on data use and data reporting for six pilot districts. However, the assessment revealed that the focus of this component was completely shifted onto immunization -related topics, and only immunization specific trainings were delivered, most likely due to the polio outbreak, which attracted significant attention from the government as well as partners. For more details about the delivered trainings see Table 5 below, which presents the list and topics covered during 2011-2013 and number of individuals trained.

Table 5. Trainings and number of trained people

Year	Topic	Trained personnel
2011	VPD Surveillance	33
2011	Immunization practice	212
2011	Joint surveillance	15
2011	Immunization data reporting	187
2013	VPD Surveillance	32
2013	Joint surveillance	17
2013	Immunization data reporting	174
2013	Community mobilization	84

The assessments also revealed that minor revisions were made to the existing Immunization guidelines, and that the trainings were not fully coordinated with the Alliance's partners. The assessment of the quality of the trainings was beyond the scope.

The assessment team was also informed that there is increased attention towards Acute Flaccid Paralysis (AFP) surveillance in Tajikistan, which most likely occurred after the polio outbreak.

With the exception of AFP, the national surveillance system does not routinely analyze the timely investigation of Vaccine Preventable Disease (VPD) cases, although case investigation cards collect relevant data. According to the national regulations VPD cases should be investigated within 48 hours after receipt of the notification. As a result of increased attention to polio surveillance all (100%) AFP cases are investigated timely in all districts countrywide. For more unbiased analysis the assessment team requested data on the timely investigation of Measles and Rubella cases since 2009 in all project districts. Data review showed that all notified cases were investigated on time.

Based on the indicators and measurement criteria selected by the assessment team for judging relevance and effectiveness of the Objective 3 following results were obtained:

Table 6 Objective 3 Assessment Rating

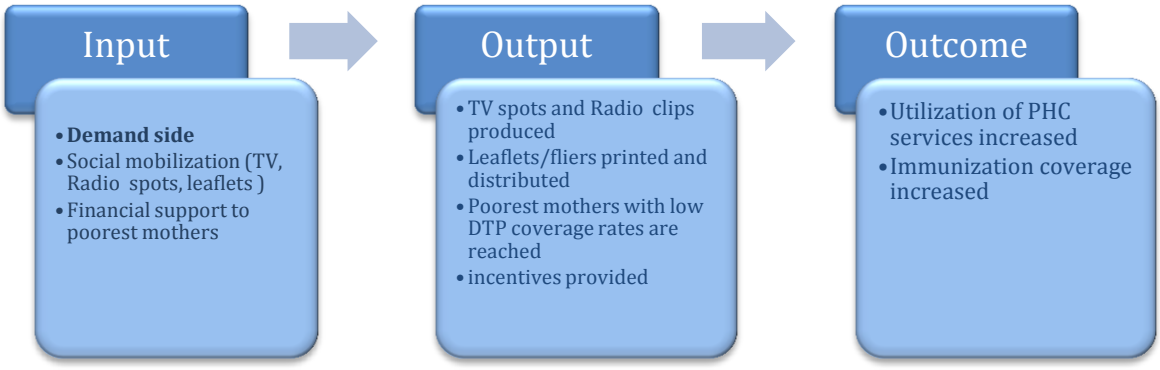
Description	Targets*	Results & Rating	Comments
Integrated Trainings: Medical staff (trainers, doctors, nurses) trained in integrated program (VPD, AEFI, IMCI, MCH) at PHC level	Y1 – 157 Y2 – 214 Y3 – 112	**Marginally Effective**	Nonintegrated trainings were provided, all trainings were immunization specific
Immunization Trainings: Medical staff trained on Immunization practice, VPD surveillance, immunization reporting.		Y1 – 157 Y2 – 214 Y3 – 112 **Fully Effective**	100% of targeted medical staff was trained
VPD surveillance: Reported Measles/Rubella that received timely investigation in 6 pilot district	Y2 – 90% Y3 – 100%	Y2 – 100% Y3 – 100% **Fully Effective**	All notified cases were investigated timely

* Original and revised targets are the same

3.4.4. Objective 4

Objective 4: Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers

The graph below presents the inputs, outputs and outcome of the objective based on the original proposal.



This objective was targeted at reducing demand -side barriers to care and at increasing the utilization of PHC and immunization services for children. Consequently the component aimed at raising public awareness of the importance of timely immunization and the steps to be followed in case of home deliveries, which for the time of proposal development in Tajikistan accounted to approximately 38%[49] of all deliveries,[50] and to reduce financial access barriers by delivering conditional cash transfers to the women most in need. To raise awareness, the program had to deliver social mobilization through different communication channels: TV, Radio, and the involvement of community based organizations in promoting certain behavior. To reduce financial access barriers, the program planned to develop and pilot a system of incentives such as Conditional Cash Transfer (CCT)[51] for the poorest mothers in only two districts out of six (Kumsangir and Farkhor). According to the proposal, the CCT had to be carefully monitored and evaluated with the help of operational research.

The Assessment revealed that the social mobilization produced: one video clip, 6 radio programs, two types of brochures (4,000 pcs. each) and 2 types of booklets (15,000 pcs. each) in 2011. During 2013, the materials included: One video clip, 3 TV programs, 6 radio programs, two types of brochures, and 2 types of booklets which were developed and distributed. Interviewed beneficiaries recalled TV spots about immunization. However, since other TV spots had been broadcast prior to the National Immunization Days, it was difficult for the population to distinguish, which one they saw. Leaflets were found in all visited facilities. The RCI director in Matcha reported that leaflets were also distributed at schools through a women's committee at Khukumat that had branches in Jamoats. In Kishlaka the midwife reported that illiterate women receive information at the health care facility and the midwife delivers these messages by reading informational material. In Farkhor kishlak a facility nurse uses school children to distribute leaflets among the

[49] Tajikistan Multiple Indicator Cluster Survey, 2005
[50] According to the latest study deliveries at home take place in 23% of cases (Demographic and Health Survey, 2012. USAID, Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health, UNFPA)
[51] Conditional cash transfer (CCT) aim to reduce poverty by making **welfare programs conditional upon the receivers' actions.** The government (or a charity) only transfers the money to persons who meet certain criteria. These criteria may include enrolling children into public schools, getting regular check-ups at the doctor's office, receiving vaccinations.

community members. In both districts, the RCI directors also prepare articles for monthly local newspapers.

District level stakeholders underline that the most effective way of delivering information to village women is face-to-face communication. Another way is through involvement of religious leaders, e.g. Oblast CI director in Sogd frequently uses this channel before national immunization days. Based on the DHS (2012)[52], 81.5% of rural women of reproductive age watch TV. Among the lowest wealth quintile, this rate is 75.6%.therefore along with direct communication, TV and video clips could be considered among appropriate informational channels for social mobilization.

Incentives: In the beginning of 2013 a working group was established to design CCT incentives model for mothers. The working group consisted of five people from the MoH, San-Epid department, and RCIP. Consultations were carried out with the MoH, the Sino Project funded by SDC and the Zdravplus Project, supported by USAID. This team did not consult with the WB and Ministry of Social Affairs, who have country-specific experience in the area of social support. To ensure equal treatment of the targeted districts, a decision was made to introduce incentives in all targeted districts rather than to pilot in two districts, as originally planned. For the selection of beneficiaries the program developed the following criteria: a mother had to have a child under 6 years old and should meet one of the following characteristics: a) single mothers; or b) mothers with more than 5 children; or c) mothers with a disabled child; or d) unemployed mothers. It was also decided not to provide cash as an incentive as it is difficult to monitor. Instead, a standard food package was developed consisting of: flour (10 kg), vegetable oil (3 liters), rice (3 kg), macaroni (3 kg), sugar (2kg) and soap (6 pieces)[53]. HSCC meeting minutes do not provide any evidence that these decisions were made through a consultative process with HSCC members. Furthermore, the majority of key informants learned about the details of the incentives model only after the model was implemented.

The RCIP conducted a competitive centralized procurement process for the incentive packages, and food packages were directly delivered to the pilot districts. Both visited districts informed the assessment team that they each received a quota of packages for 100 women from the center. Beneficiary selection criteria were communicated to the RCI directors through a phone call without written instructions, and RCI directors were asked to distribute the food parcels accordingly. The RCI heads involved local authorities in the beneficiary selection process, and participants from jamoats in consultation with district health administration and doctors developed the lists. These lists were discussed and

[52] Demographic and Health Survey, 2012; USAID, Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health, UNFPA

[53] While this package only included food and hygienic items, the UNICEF in 2009, while facilitating MCH working group for Health Sector Strategy development elaborated specific recommendation for a package composition, that were reflected in the special report prepared by UNICEF consultant Dr. Stephen J. Atwood, Albeit, this recommendations were not even considered when developing this package.

approved by Khukumats, and the packages were distributed during May 2013 in Matcha and in May 2014 in Farkhor. In the majority of cases, distribution took place at the health care facilities and district Center of Immunoprophyaxis office, while in some cases the director of the RCI himself distributed the support to the selected households. All beneficiaries signed the papers to prove receipt of the food support.

The inadequate rationale for the eligibility criteria, combined with poor documentation of the beneficiary selection policies and processes, meant that the assessment team was not able to evaluate appropriateness of the beneficiary selection for the incentive packages. Therefore, the final selection of beneficiaries raised concerns. For example, in Matcha 70 of the 100 women selected were village dwellers, but 30 were health personnel from the PHC facilities (cleaners and/or nurses included).

During the field visit in both districts, the beneficiaries were randomly selected and visited at home, or brought to the facility to verify receipt of the food support. All interviewed beneficiaries in both visited districts confirmed receipt of the packages, and said they were grateful to those who gave this support. However, they could not recall the purpose of this aid and/or why they benefitted from such assistance. In Matcha all women interviewed met the eligibility criteria described above, while in Farkhor one visited beneficiary could not be described as poor since the household had a vehicle. All interviewed mothers reported that they regularly vaccinated their children according to calendar, even before the food support had been delivered.

The Initial and revised program plan for the CCT included 3,400 beneficiaries. According to the APR for 2013 and the report prepared in Russian, a total of 1,034 beneficiaries received support in 2013-14. Overall, 38,738.37 USD was spent on this activity (i.e. 37.46 USD per beneficiary as opposed to 30.58 USD, as originally planned). As per the report prepared in Russian, 150 beneficiaries received social support in Matcha and 202 in Farkhor. However, according to the RCI data, 100 beneficiaries were targeted in each visited district, which indicates inconsistencies between the various reports and raises concerns.

The Majority of key informants considered the incentives model as currently designed to be inappropriate for Tajikistan. It has not triggered positive behavioral changes, and its high cost means that it is unsustainable. Indeed, far from triggering greater health utilization, it creates dependency amongst recipient families on food aid. Nor does the system is designed to minimize fraud. Furthermore, the global evidence is strong about positive impact of the CCT on facilitating service utilization and especially for poor. However, the study conducted in 2012 by the World Bank in Tajikistan[54] that looked at possible demand and supply-side incentives that could increase PHC utilization concluded that a voucher or CCT system is not appropriate in a given context due to the substantial risk of fraud and the possible creation

[54] Demand and Supply side incentives to increase utilization of primary health care services in Tajikistan. Part III: Synthesis report. The World Bank, Swiss TPH, Zerkalo. 27 November 2012

of administrative systems outside the health sector[55]. However, the program did not consider this evidence when the CCT component was being planned and designed.

The Assessment team is of the opinion that CCT component did not fulfill its initial goal for number of reasons. The original scheme design did not consider the available global evidence about the CCT design features[56]; therefore due to design weaknesses the purpose and aim of the CCT were completely undermined, and the scheme that was created looked more **like food aid for selected families without any conditions attached**. Furthermore, the beneficiary selection criteria included many factors that could determine vulnerability in Tajikistan, although they were not evidence-based and not supported by the national data. These criteria did not fully considered the social determinants that usually predict health utilization for mothers and children in Tajikistan.[57] Thereafter, instead of pilot testing in two districts with appropriate operational research and accumulating experience, the country embarked on implementation in all six districts, without appropriate evaluation. Despite this expansion, it failed to meet the beneficiary targets of 3,400 individuals. Finally, the cost per beneficiary of the package "piloted" seems excessive compared with the amounts reported in the literature from similar settings.[58,59,60] Therefore, the design of the model was not relevant to the desired output, which was increase of timely immunization coverage rates. During the beneficiary selection process, an individual approach was not considered (e.g. home deliveries, not immunized children, etc). In addition, recent evidence produced by the World Bank on inappropriateness of CCT or voucher system in Tajikistan[61] was not taken into consideration. All of the above might be caused by inadequate communication of the program plans and designed models among relevant stakeholders and consequently due to sub-optimal Technical Assistance (TA) provided to the government.

Below are the conclusions of the relevance and effectiveness of this objective, based on the assessment criteria developed by the assessment team:

[55] Ibid 54
[56] Lagarde M, Haines A, Palmer N. 2007. Conditional cash transfers for improving uptake of health services in low- and middle-income countries: a systematic review. Journal of the American Medical Association 298: 1900–10.
[57] Fan.l., Habibov N.N., 2009. Determinants of maternity healthcare utilization in Tajikistan: Learning from a national living standards survey. Health and Place.
[58] Gertler, Paul J. 2004. "Do Conditional Cash Transfers Improve Child Health? Evidence from PROGRESA's Control Randomized Experiment." American Economic Review 94 (2): 336–41.
[59] Maluccio, J Flores R. Impact evaluation of a conditional cash transfer program: the Nicaraguan red de protección social, Research Report No 141. Washington DC, USA: International Food Policy Research Institute (IFPRI), 2005.
[60] Glassman A, Gaarder M, Todd J. Demand-side incentives for better health for the poor: Conditional cash transfer programms in Latin America and the Caribbean. Economic and Sector Studies Series, Inter-American Development Bank, December 2006.
[61] Demand and Supply side incentives to increase utilization of primary health care services in Tajikistan. Part III: Synthesis report. The World Bank, Swiss TPH, Zerkalo. 27 November 2012

Table 7 Objective 4 Assessment Rating

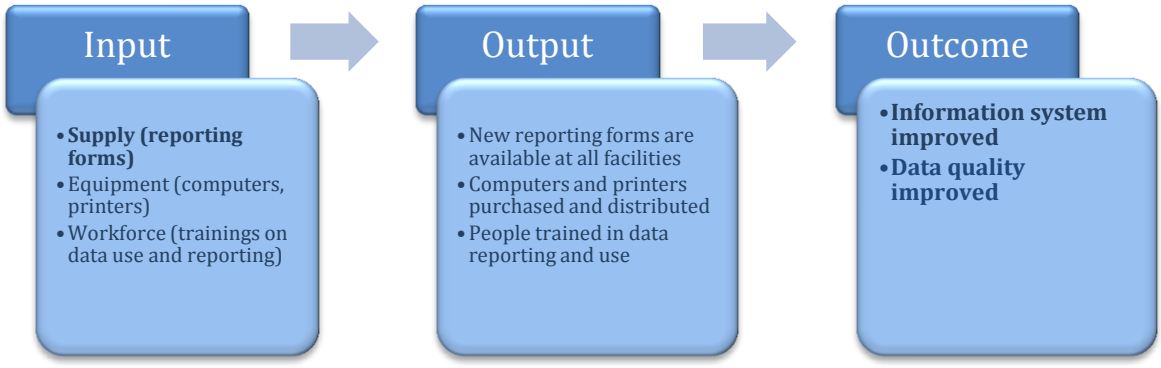
Description	Original Targets	Revised Targets	Results & Rating	Comments
Social mobilization: Well designed and relevant awareness campaign for target audience in a given socio-economic context			**Moderately effective**	Beneficiaries mention at least one sources of information and at least one message
Incentives: CCT model is appropriately designed to reach most in need and well implemented			**Marginally relevant**	Incentives did not seem to have targeted most in need and neither model design features seem appropriate
Incentives: Number of women benefiting from CCT	Y1 – 0 Y2 – 3400 Y3 – 3400	Y1 – 0 Y2 – 3400 Y3 – 0	Y1 – 0 Y2 – 1034 Y3 - 0 **Marginally effective**	30% of beneficiaries were reached

Finally, based on the findings mentioned above, combined with the findings of the World Bank study, the assessment team is of the opinion that the CCT component should not be considered in future HSS program of Tajikistan, unless contextual circumstances change radically.

3.4.5. Objective 5

Increase PHC capacity in data collection, reporting and analysis to facilitate evidence based decision -making and planning

The graph below presents the inputs, outputs and outcome of the objective based on the original proposal.



According to the original plans, the HSS program planned for PHC provider training in the revised PHC reporting forms that were to be supplied to all facilities along with 20 computer sets. Revised forms, trained staff and supplied equipment were expected to improve the timeliness and the quality of reporting. The outcome indicator proposed to measure achievements under this objective was: the number of PHC facilities timely submitting simplified reporting forms.

The assessment found that instead of revision and simplification of the PHC reporting forms, under this objective only forms/journals relevant to the immunization program were modified. This modification did not entail simplification, but instead added more fields. Consequently, all revised forms and journals were produced and distributed countrywide. The assessment team's visits to the facilities proved the availability the forms and journals on a PHC level.

While the focus of this objective was significantly adjusted during implementation, these adjustments were not discussed at the HSCC meetings or with key stakeholders involved in health Information work.

Instead of the 20 sets of computer equipment that were originally planned, 38 sets were purchased and distributed to the facilities on a central level and in the pilot districts. Trainings on the revised immunization information system were provided to all district centers of immunoprophylaxis and PHC mangers, and involved 62 individuals[62].

According to the NIP review in 2012, in general medical workers at sub-national and health facility levels performed their assigned tasks of recording and reporting immunization related information very well. However, the RCIP does not follow WHO's recommended method of determining the target population (denominator) for calculating coverage. Also, monitoring and analysis of the reported data is very weak, especially at the district and PHC levels. Routine reports are compiled and sent to the upper level, but without any analysis. While considerable information is recorded in health facility records, this information is not being used to detect problems or compare performance with previous years or with other health facilities. This inefficient use of data by those collecting it does not allow for improvements in the reliability of the overall RCIP reporting system[63].

Improving the reliability of immunization reporting and the effectiveness of monitoring in Tajikistan will require a long-term capacity building effort for medical workers at sub-national and health facility levels. It will also involve developing more effective monitoring tools, improving analytical skills, and taking local action to detect and correct problems. Training alone in its current content will not be sufficient to meet existing needs.

[62] Ibid 44
[63] Ibid11

In the proposal the following indicator was selected to measure the result of the objective: # of PHC facilities submitting simplified reporting forms on time. Due to the changed focus of the objective, the original indicator is no longer relevant. Therefore the assessment team chose the indicator that measures implementation effectiveness of activities undertaken: % of PHC facilities equipped with all registration/reporting books and forms for immunization.

Table 8 Objective 5 Assessment Rating

Description	Results & Rating	Comments
Visited facilities equipped with all registration/ reporting books forms for Immunization	**Fully effective**	100% of visited facilities equipped with immunization documentation

3.5 Analysis of Outcome Indicators

The Assessment Team selected two outcome indicators to measure HSS program results. As mentioned above other indicators (impact/outcome) provided in the proposal were not relevant to the activities actually implemented. These selected indicators are DTP-3 (Penta-3) and Hepatitis B-1 coverage rates, number of districts achieving ≥80% coverage rates for DTP-3 (Penta-3) and PHC utilization rate. For outcome measurement and in order to establish the possible contribution of the HSS program to these outcomes, the assessment team compared the data from pilot districts with the mean of the other districts in the same oblast. Also the data was collected for 2009-2013 to observe any changes in the trend that may have resulted because of the HSS program.

3.1.5. Immunization Coverage

Figure 5, Figure 6 and

Figure 7 present immunization coverage rates separately for the selected antigens and for different oblasts and/or zones. The data is presented for the period 2009-2013 and pilot districts are compared with of “non-pilots”. The Presented data reveals some differences in trends between the pilot and non-pilot districts. Namely:

- Immunization rates for both Penta 3 and Hepatitis improved in Gancha, while no major differences were noted in Matcha, which already had high immunization coverage rates in 2009;

In Khatlon oblast (see

- Figure 7) the differences were not that pronounced between pilot and non-pilot areas, although overall trend in Kumsangir revealed improvements after significant dip in 2010.

As for Khatlon oblast no differences were noted between pilot and non-pilot areas, although overall immunization coverage rates increased, especially for Penta-3 and reached levels above 80%. One of the explanations for this could be associated with the national level actions in the aftermath of polio outbreak in 2010. According to respondents, the GoT and partners organized impressive processes to control the polio outbreak in 2010-2011, and consequently several national immunization rounds were implemented[64], which may have led to improved immunization coverage against polio as well as with other vaccines.

Figure 5. Immunization Coverage in HSS pilot and non-pilot districts (mean) in Soghd Oblast

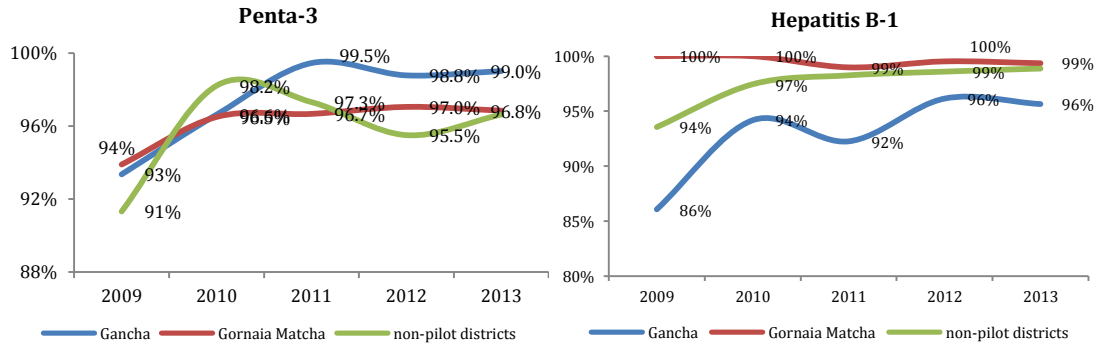
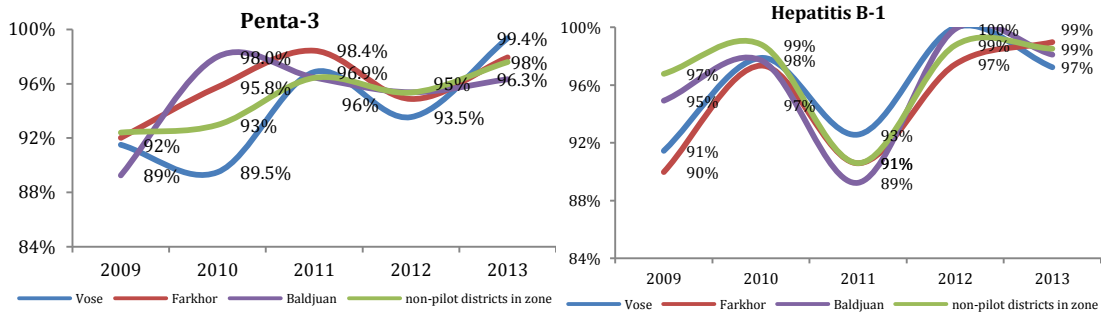
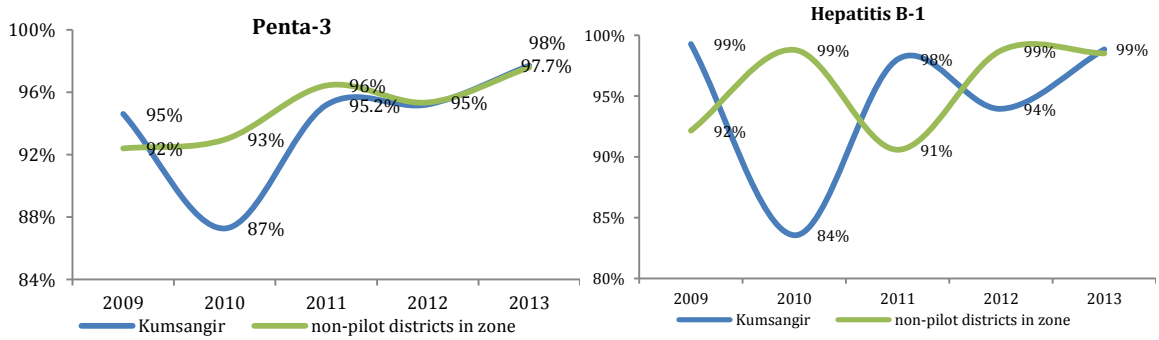


Figure 6. Immunization Coverage in HSS pilot and non-pilot districts (mean) in Kuliab Zone in Khatlon Oblast



[64] Ibid 11

Figure 7. Immunization Coverage in HSS pilot and non-pilot districts (mean) in Kurgan-Tube Zone in Khatlon Oblast



While interpreting immunization coverage results, a cautious approach is required as the data from different districts and oblast may hide quality differences in recording and reporting coverage rates. The Immunization Program Review [65] clearly identifies deficiencies in the Immunization information system, especially at district level (accuracy in registration /reporting, identification). The Lack of direct supervision from a higher level was named as one of the reasons for poor quality data. Under the HSS Program, frequent immunization monitoring visits were conducted from the RCIP to pilot districts and from district Immunization centers to facilities. This could have led to improved quality of registration/reporting and more accurate coverage rates for pilot districts compared to non-pilot ones. To assess the validity of administrative data, we looked at the Demographic Health Survey (2012), which provides oblast level coverage rates for different antigens. While for Pentavalent and Polio vaccines DHS data is not comparable with administrative data, because the age of surveyed children (18-29 months) differs from timely vaccination age (12 months), we still could use survey and administrative coverage rate (2012) for Hepatitis B at birth. In Sogd Oblast we noted almost no difference between administrative and survey data: 97.9% (DHS) vs. 98.2% (RCIP). As for Khatlon, the survey showed slightly lower rates: 94.6% (DHS) vs. 97.2 (RCIP), which either could fall within the error margin or could be due to over reporting in Khatlon. Consequently the assessment could not confirm or rule out that the HSS program may have contributed to increased immunization in GAVI HSS targeted districts.

3.1.6. PHC Utilization rate

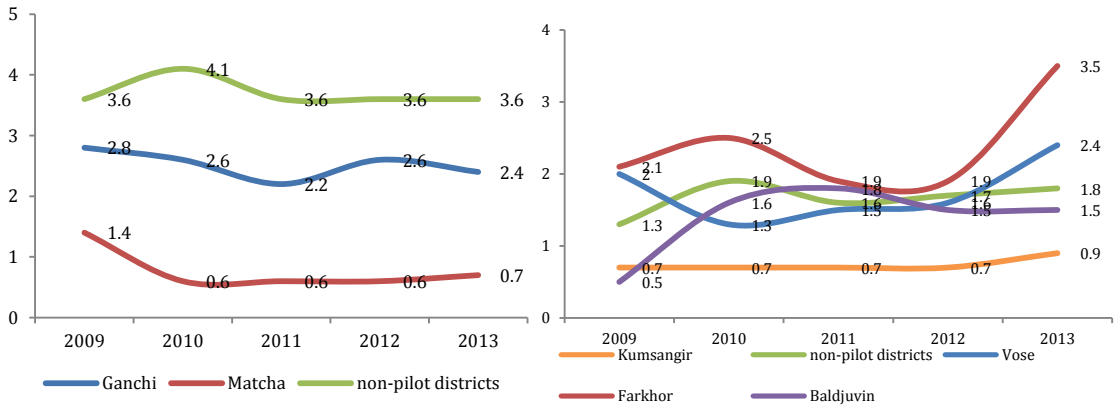
To evaluate HSS program outcomes we also looked at PHC utilization levels, which showed marked differences between Sogd and Khatlon oblasts. Especially in the former, PHC utilization was 2-3 times higher compared to Khatlon (see Figure 8). A Similar difference was also noted by the WB study (2012) and the observed difference could be explained by

[65] Ibid 11

specific MCH programs extensively implemented in Sogd oblast, which could have improved the population's awareness and consequently use of PHC services[66].

However, in Sogd Oblast during 2009-2013 no changes were observed in PHC utilization (see Figure 8 left chart). The differences between two pilot districts and non-pilot districts remained throughout the years and have not changed markedly. The Lowest utilization rates in Gornaia Matcha could be explained by geographic specificity (mountainous, many hard-to-reach villages). In 2009, seven new PHC facilities were constructed by ADB in Gornaia Matcha, which could have resulted in short-term increase of PHC utilization in that specific year. However, the subsequent drop is difficult to explain with available information. Based on this data, it could be concluded that the HSS program did not reveal any positive influence on PHC utilization in Sogd districts.

Figure 8. PHC utilization per capita in HSS pilot and non-pilot districts (mean) in Sogd and Khatlon Oblasts



Contrary to Sogd, in Khatlon oblast we have noted slight increase in PHC utilization in some pilot districts (Vose and Fakhor) when compared with non-pilots. Especially the trends of PHC utilization growth were obvious between 2012-2013. Pilot district Farkhor shows almost 2-fold increase during this period, possibly due to construction of two new PHC facilities, one of which and additional one were renovated with the funds provided by the HSS program. However it is difficult to establish causality between these investments and PHC utilization growth. Outreach/mobile clinics as well as population's awareness raising activities, supported by the HSS program, may have had positive influence on the utilization growth. Alternatively, aggressive polio campaigns may have resulted these changes. Nonetheless, lack of adequate data on these activities limits the assessment team's ability to associate HSS support with the improved PHC utilization.

[66] Ibid 54**Error! Bookmark not defined.**

4. Conclusions

In this section of the report we summarize the responses to the specific questions posed by GAVI for this assessment by addressing each question separately.

Q.1 - To what extent the activities set out in the HSS application were implemented as planned (quality, quantity, ways and means)?

As we have noted throughout the report, while overall design of the HSS program with its five key objectives was kept unchanged throughout implementation, specific activities planned/proposed in the HSS proposal underwent major revisions. Some of these changes were discussed and agreed within the HSCC meetings, while others were changed without thorough discussion and/or agreement with partners and/or GAVI. The country did not follow the rules governing such changes or the rules on their communication to the GAVI secretariat and HSCC with the help of APRs. The room for improvements and streamlining of communication between the country, partners and GAVI secretariat is significant and has to be exploited in future for going forward.

Overall, program implementation faced significant delays due to numerous objective and subjective reasons, which are discussed in detail earlier in the report. But the most important factors were probably: a) a lack of clear and streamlined communication between GAVI secretariat, the country and in-country partners due to individual or organizational reasons; b) inadequate risk and process management on the part of all involved, but especially by the GAVI secretariat and c) a lack of transparent and all-engaging collaboration at a country level.

Delayed implementation obviously called for adjustments in the activities and implementation schedule, originally designed in 2007 or almost four years prior to actual program start date. Therefore, some changes were introduced in the activities that were significant and had major consequences for the program outcomes. In particular, this relates to piloting the CCT. As we have already described, the concept of the CCT was completely changed during implementation. Instead of CCT, food parcels (food aid), which were not linked with improved health -seeking behavior of the clients, were implemented in all six districts and without adequate scale to achieve any tangible results and without proper operational research to allow for learning. Similarly, the scope of the PHC information system enhancement activities 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 quality of implemented activities also raises concerns. For example, PHC facility investments, which were originally destined for hard -to -reach areas with the objective of improving access to disadvantaged groups living in remote locations,

did not materialize fully, and only part of these investments benefitted remote communities. Similarly, the benefits delivered through food parcels are not clear because of the limited scale over a larger geographical area (only 100 women in each district benefited from this aid) and because of a wasted opportunity for learning by doing. It is assumed that the quality would have been better had the program ensured sufficient transparency and the adequate and timely engagement of expertise required for the design of such complex scheme, providing that such expertise was available within the country or from partners.

Finally, responsibility for program management was moved from a collection of diverse players over to the RCIP, which as an institution had limited capacity and expertise in health system related issues, including planning for PHC facility renovation and investments, and/or designing complex demand-side financing schemes such as CCT, etc. The situation was further aggravated when the critical MCH department of the MOH, and district health centers, were removed from HSS implementation. Both entities have an organizational mandate to ensure better integration of child health and immunization services and/or better planning for health provider network within the districts under their jurisdiction. On the other hand, program implementation by the RCIP ensured strong coordination between the HSS and National Immunization Programs. However, it is assumed that more inclusive engagement of various national players along with RCIP could have led to better results.

Q.2 - To what extent were activities, resources appropriately coordinated and assessed (given the pilot aspect of the program) and reported by the MOH to the GAVI Secretariat and Alliance partners?

Overall responsibility for coordination and oversight for the HSS program implementation was given to the HSCC, which was established by the government in 2007 to coordinate health sector reforms. While the HSCC had a broader mandate, in reality it only dealt with the GAVI HSS grant, as evidenced from the meeting minutes. Consequently this body had limited ability to coordinate the HSS program implementation with other health sector reform efforts that were taking place in the country. As a result, the appropriateness of the HSCC (with WHO, UNICEF and other partner presence) as a body to coordinate program implementation and provide oversight becomes questionable. Furthermore, based on the presented evidence the HSCC mostly failed in its coordination and oversight function over the HSS grant implementation, because the way meetings were planned and the way the meeting agenda evolved left key members of the HSCC with very limited information about the HSS program implementation, achievements and/or challenges. Finally, the role of 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.

All stakeholders agree that GAVI played an instrumental role in program implementation by triggering and facilitating the national processes, primarily through HSCC, but also using other means. However, this was not sufficient as GAVI does not have an adequate mechanism to closely oversee program implementation, for which it largely relies on in-country partners, who happened to be either supplied with limited information, inadequate for effective oversight, or who may not have played a more active role[67]. The assessment team thinks that more assertive and proactive management on the part of the GAVI secretariat could have been helpful in this context.

Moreover, the HSS program implementation was also hampered by other factors such as: *inadequate communication between GAVI and the Country, which* caused significant delays in information exchange from both ends; the *language barrier*, which delayed communication and information exchange between the country and GAVI and in some instances even led to miscommunication and poor understanding of the requirements set out in GAVI policies; *bureaucratic procedures* within the Government of Tajikistan as well as within WHO and GAVI, which caused numerous delays in funds transfer; and *institutional interests* of in-country partners struggling to emerge as GAVI HSS fund recipients, which also contributed to the delays in the program start.

Finally, the monitoring and evaluation framework, which was modified from what the GAVI IRC approved in 2008, seems to be one of the weakest aspect of HSS program execution. The Selection of inadequate (not sensitive) indicators and their use by the RCIP when communicating with HSCC and GAVI most likely limited the ability of all involved partners to detect implementation challenges in a timely manner, and to call for corrective measures. Most likely, the opportunities were also missed by not undertaking a joint annual HSS program review with in-country partner (UNICEF and WHO) participation, when most issues noted by the assessment team could have been captured. It is further concerning that such joint program reviews were requested by GAVI in its PFA, but were never implemented due to weaknesses of partnership arrangements, also found in other GAVI supported countries[68]. Consequently, the GAVI secretariat and/or in-country partners did not capture this inadequacy in the M&E framework, which raises concerns about effectiveness of the systems currently used by GAVI and its partners.

[67] Similar recommendations were generated by GAVI Health System Strengthening Support Evaluation 2009.

[68] HLSP 2009. GAVI Health System Strengthening Support Evaluation 2009. http://www.gavi.org/results/evaluations/hss-review/

Q.3 - To what extent were the funds used efficiently and as planned?

Based on the supplied financial information, which was only limited to the HSS annual program budgets and expenditure, and was not disaggregated by district, the funds were spent according to the approved budgets by the HSCC and within the agreed budgetary limits for the given objectives. The RCIP deserves credit for managing to stay within the budget envelopes while trying to address challenges emerging during implementation. Although, it has to be also mentioned that in many instances this occurred at the cost of reducing the program targets which obviously negatively affected overall program outcomes. The RCIP managed many outstanding issues quickly and effectively, including financial ones. However, it has to be noted that the weaknesses in financial systems mentioned above were mainly caused by institutional weaknesses of the RCIP, especially by the lack of experienced staff in the management of donor-funded programs, and by the lack of standard operational and financial management procedures that most likely led to deficiencies in financial record keeping. Consequently, the assessment team noted the limitations imposed by inadequate financial recording and reporting, which were especially observed on a local/district level, and program spend by objectives and/or respective activities.

Obviously these limitations constrained the assessment team's ability to evaluate financial efficiency. However some cases emerged which deserve to be noted. For example, the average cost of renovation per PHC facility increased by 83% compared to the original amounts budgeted in 2007, although inflation could partially explain such growth, but also weaknesses in financial/budget planning and management could as well be at fault. Increased costs were also spent on outreach and mobile teams, which seemed important inputs for increasing PHC utilization especially in the remote communities. However, the amounts spent on outreach and mobile teams cannot be verified on a rayon level, due to the lack of critical data related to the number of outreach and/or mobile visits conducted by teams in each district and due to missing financial records. Therefore the efficiency of this intervention could not be assessed. All this leads to the conclusion that due to inadequate financial management, the HSS program could be prone to inefficiencies, which the assessment team could neither confirm nor discount due to limitations in data available for this assessment.

Consequently, the overall financial management of the program deserves attention. These weaknesses were well documented early on in the process in the FMA commissioned by GAVI, and addressed during grant making, when fiduciary and procurement responsibilities were assigned to WHO CO. However, during implementation the fiduciary and procurement responsibilities given to WHO CO were not effectively exercised, which obviously increased financial risks for the HSS grant in a complex country environment such as Tajikistan. However, Tajikistan is

not the only exception, where WHO that maintains long-term relationship with the government and especially with the MoH, is hesitant to assume policing role of a fiduciary agent. Similar findings emerged from HSS evaluation conducted during 2009 in other GAVI supported countries[69]. Consequently it may be appropriate for GAVI to re-consider its current partnership model for financial risk management and seek for alternative solutions.

Q.4 - To what extent did the HSS program contribute to observed trends in the following indicators: a) Increasing basic vaccination (DPT-3, Hep B1) and what was the GAVI HSS program contribution? b) Increasing PHC utilization and what was the GAVI HSS program contribution?

Although we noted increasing immunization coverage rates and also increasing PHC utilization rates in Khatlon oblast, the assessment team could not establish plausible links between the HSS program and the observed changes. Several factors had a critical influence on this. First of all, data limitations due to the weaknesses noted in the M&E framework imposed significant constraint on the assessment team's ability to obtain more granular data about the program outcomes and compare it with the results achieved in other non-pilot districts. Secondly, the districts targeted by this program also received the assistance provided by ADB and other donors. Consequently, changes observed in the data trends for immunization coverage and for PHC utilization may have been affected by other programs/projects as well or by active polio campaigns in the aftermath of polio outbreak.

Q.5 - To what extend has the MOH learnt from the pilot activities in the HSS program?

The list of documents supplied to the assessment team as well as information provided by the stakeholders revealed that limited documentation and learning occurred during the HSS implementation. Namely, the global as well as local evidence accumulated about the CCT seems to have been completely ignored by the implementers and the opportunities to adequately design the intervention have been missed.

Furthermore, the HSS program planned for operational research for the CCT component. However, weaknesses in the design and implementation of the CCT, which have been noted in this report, indicate that such operational research would have had limited value if implemented, because of the failure to pilot CCT in targeted districts.

Recently RCIP commissioned household survey to PAU aiming at evaluation of barriers to immunization services on a household level. While this is a welcome

[69] HLSP 2009. GAVI Health System Strengthening Support Evaluation 2009. http://www.gavi.org/results/evaluations/hss-review/

development, the research has not been completed yet and the results are expected to emerge over the coming weeks.

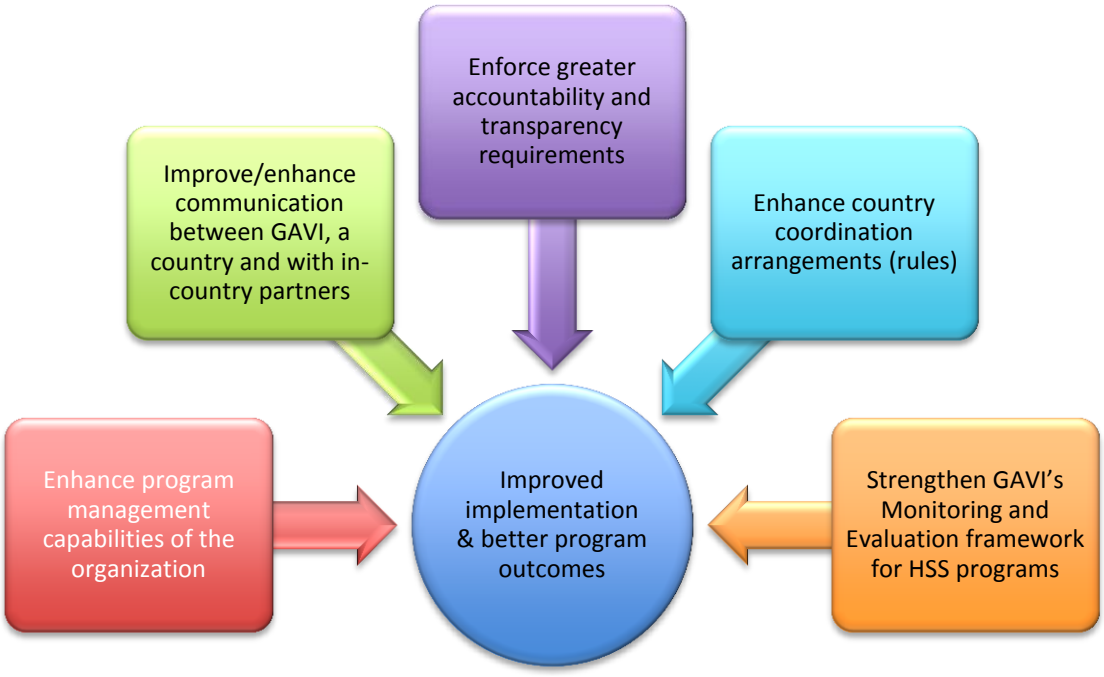
Finally, it is expected that this assessment may also provide some lessons to the MoH, which if considered could help with future program design as well as with implementation.

5. Recommendations

Based on the findings of this assessment we have formulated recommendations, which may help GAVI improve/enhance its systems in a way that ensures improved implementation and better program outcomes. We have also elaborated a set of country-specific comments to help the authorities in Tajikistan improve program design and implementation management. Therefore, in the following section we will describe four emerging recommendations for GAVI's consideration and in the section thereafter we provide set of recommendations aimed at the country government.

5.1 Recommendations to GAVI

The figure below depicts those five key areas around which we have formulated our recommendations. It is envisioned that addressing these five key issues will be instrumental in improved program implementation with better outcomes.



Recommendation 1: Enhance program management capabilities of the organization

- Either exploit full potential of the Alliance's current partnership model, where possible, or develop alternative mechanisms necessary to more proactively support country program implementation.
- In high-risk countries, such as Tajikistan, hands off management model, currently at work within the GAVI secretariat, may increase risk-exposure to programmatic and financial risks and may not provide adequate levers for risk management/mitigation.

Recommendation 2: Improve/enhance communication between GAVI, the country and with in-country partners. These improvements could entail:

- Formalizing communication timelines between GAVI and the country with the objective of shortening and clearly defining response timelines/deadlines for both parties;
- Improving the secretariat's communication (maybe even formalizing in the operational policies) with the country and involved partners in order to maintain frequent, transparent and all-inclusive communication with HSCC members and to ensure that they are fully up-to-date and engage in a timely manner when necessary;
- IRC reports should include detailed comments on the progress and identify deviations from original plans, indicators and targets. However, remote review of documents, which may not hold quality and adequate information for the HSS program monitoring is expected to impose limitations, unless the format and content of APRs are more adjusted to HSS needs;
- Developing adequate in-country support with the help of partners to reduce language related barriers and accelerate information exchange between the secretariat and the country.

Recommendation 3: Enforce greater accountability and transparency requirements

- Ensure that GAVI operational policies clearly define accountability responsibilities for the secretariat as well as for the partner country and set clear rules based on principles of mutual accountability. Though current TAP includes such provisions, albeit they operate on much higher level and do not provide clear guidance on how to operationalize the policy elements in any given country.
- In the current system it is not clear how IRC approved programmatic targets can be enforced and/or how the country could be held accountable for achieving the objectives stated in the original proposal. Consequently, developing institutional assurance mechanisms/systems seems necessary if country accountability has to be enforced and program results achieved. However, this cannot be done without countries being able to revise the

original targets in light of changes in the country context. Therefore, clearly defining and communicating the processes through which countries will be allowed to revise their original program targets seems to be necessary;

- As a signatory to the IHP+ initiative, GAVI should enforce and proactively facilitate joint annual program reviews with the active involvement of in-country partners. While such provisions were incorporated in the MOU, in the case of Tajikistan such reviews were never produced, and consequently the enforceability mechanism seems to have failed.

Recommendation 4: Enhance country coordination arrangements (rules) by:

- Considering imposing a mandate for semi-annual (or annual) review of program progress against set targets, timelines and budgets;
- Considering tightening transparency requirements on HSCC meeting notes to be shared with all involved and, if possible, published on the internet;
- Considering tightening transparency requirement on GAVI -supported programs by imposing mandates for: a) placing GAVI -funded program description in a local language on governmental websites; b) translating and placing annual budgets and annual expenditure reports on publicly accessible internet sites; c) ensuring that program targets and monitoring and evaluation results are also publicly accessible.

Recommendation 5: Strengthen GAVI's Monitoring and Evaluation framework for HSS programs

Current M&E guidance for GAVI HSS grants includes set of indicators (e.g. National level DPT3 coverage; number/share of districts achieving ≥ 80% DPT3 coverage; under five mortality rate) that are not relevant for monitoring HSS grants. The external HSS evaluation team arrived at similar conclusions in 2009[70]. Consequently we repeat their suggestion and recommend GAVI to revise HSS M&E guidance and include appropriate set of indicators, which allow adequate measurement of outcomes resulting from HSS investments.

5.2 Recommendations to the country

Recommendation 1: Improve HSCC functionality

a. Ensure that HSCC implements its coordination and oversight role effectively, through following up on program progress routinely, identifying shortfalls and deviations from the original plans and taking corrective measures;

[70] HLSP 2009. GAVI Health System Strengthening Support Evaluation 2009. http://www.gavi.org/results/evaluations/hss-review/

b. Ensure annual joint review of the program with the active engagement and participation of partners;

Recommendation 2: Ensure engagement of adequate/experienced stakeholders and in-country partners

a. Encourage active involvement of the partners and other stakeholders in program planning, monitoring and annual and mid-term evaluation;
b. Ensure that HSS program activities have an integrated approach and different players of the health system are involved.
c. Solicit technical assistance as needed from experienced consultants;

Recommendation 3: Improve management arrangements and enhance financial management systems

a. Staff program implementation unit with adequate, experienced and qualified human resources in program management, M&E and financial management;
b. Develop standard operating procedures for program management and necessary M&E tools;
c. Ensure a qualified external audit on an annual basis and compliance with the financial management requirements of GAVI.

Recommendation 4: Increase transparency of program implementation

a. HSCC and program implementers have to ensure the transparency of programmatic and financial data.
b. Ensure the transparency of the processes and accountability for program results.

Recommendation 5: The HSS Program-specific recommendations

The assessment team was also asked to provide specific recommendations for the development of a new HSS program. the assessment team is of the opinion that all the objectives of the former HSS program are important and relevant for strengthening health system capacity and to improve immunization coverage and facilitate PHC utilization, with the exception of the CCT. While the value of CCT is well documented in other country settings and in the global literature, the assessment team thinks that in a given country context in Tajikistan the CCT component is note relevant, unless country conditions change significantly. Therefore, the assessment team recommends that all program objectives be continued, but with improved management (including financial management), enhanced governance and coordination arrangements, adequate monitoring and evaluation and adequate and routine reporting on the progress achieved. The only intervention that is not recommended for implementation is demand -side incentives for mothers. Based on

country-specific evidence[71], the CCT or voucher system for mothers in Tajikistan could not be recommended at this stage due to the large administrative costs and risk of fraud.

Furthermore, the following should also be considered for the new HSS program country:

a. Consider community needs and a PHC infrastructure optimization plan during facility selection for renovation/reconstruction;
b. Undertake close supervision of construction work, and maintain accurate records on investment costs to be able to assess efficiency of this intervention;
c. Develop annual plans for outreach and mobile visits and develop and implement an adequate monitoring system to capture necessary programmatic data;
d. Enhance services integration by joining different health personnel for outreach /mobile visits;
e. Use partners' technical capacity to deliver quality trainings, assess the effectiveness of those trainings and implement refresher-courses and on-the-job trainings when required;
f. With the help of adequate technical assistance and in close coordination with the partners involved in the HMIS development, design and implement adequate interventions to improve the quality of the health and immunization information system and ensure that adequate local capacity is developed to use data for planning and decision-making;
g. In terms of Social mobilization activities, more emphasis should be placed on face-to-face communication as one of the most effective methods to reach the rural population, especially less educated people;
h. Use a district -specific approach for planning and implementing interventions

The Assessment team believes that lessons learned as a result of this work will help the country stakeholders, partners and GAVI Alliance to jointly make positive changes towards accelerating and sustaining high immunization coverage in Tajikistan.

[71] Ibid 54

Annex 1 HSS Assessment Matrix

Input	Output /Outcome Targets	Indicator	Assessment Methodology/Criteria	Sources
Objective # 1. Strengthen evidence-informed decision making at central and local government levels in order to build financial commitment for PHC services, focusing on immunization				
-	- Number of policy briefs developed and presented - Y1 – 3 - Y2 – 3 - Y3 – 3 Also we will consider evaluating the information use that originates from M&E system for evidence-based decision making	- Number of annual policy briefs prepared and presented to the central and local gov. level based on the content	- < 40% - marginally effective - 40-80% - moderately effective - 80-100% - fully effective	- Policy Briefs - In-depth Interviews
Objective # 2. Increase access to PHC services in remote and hard-to-reach areas				
2011: - Six two-day workshops in 6 pilot districts for 48 heads of health facilities and 24 Jamoat heads - Training of 54 HC workers and 12 IPC and PHC heads (at two-day workshop) - Purchase of 6 vehicles for all mobile teams, as well as basic small medical equipment and cold chain equipment. - Financial support for mobile	- Facilities renovated/ reconstructed: Y1 – 0 Y2 – 36 Y3 – 0 - Remote villages in pilot districts that receive outreach services at least twice	**Relevance:** - Renovated/reconstructed PHC facilities are located in hard-to-reach / remote areas based on two districts **Implementation effectiveness:**	**Relevance:** - < 40% - marginally relevant - 40-80% - moderately relevant - 80-100% - fully relevant **Implementation effectiveness:** (separately for Infrastructure and	- MOH order - Project Reports - In-depth Interviews - Facility Observation - Provider FGD - Beneficiaries FGD - Facility records

Input	Output /Outcome Targets	Indicator	Assessment Methodology/Criteria	Sources
teams (transportation, per-diem) from August **2013:** - 23 facilities renovated - Purchase of 100 refrigerators - Financial support for PHC doctors for outreach (transportation, per-diem) - Financial support for mobile teams (transportation, per-diem)	a year: Y1 – 60 Y2 – 72 Y3 – 86	- Infrastructure: Number of PHC facilities renovated/reconstructed - Outreach: Remote villages that received outreach / mobile serves twice per year **Efficiency:** Provision of integrated services (Imm, IMCI, Reproductive) by mobile visits in visited PHC facilities in 2013 and 2014	Outreach) - < 40% - marginally effective - 40-80% - moderately effective - 80-100% - fully effective **Efficiency:** - < 40% - marginally efficient - 40-80% - moderately efficient - 80-100% - fully efficient	
Objective # 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc				
2011: - Five guidelines on PHC topics developed and submitted to MoH for approval - 100 PHC staff trained on Immunization and other PHC topics **2013:** - 26 PHC staff trained on VPD surveillance - 15 RCIP and SES staff trained on VPD joint surveillance - 168 mangers of PHC facilities	Number of medical staff (trainers, doctors, nurses) trained in integrated program (VPD, AEFI, IMCI, MCH) at PHC level: Y1 – 157 Y2 – 214 Y3 – 112 % Of reported VPD that received timely	**Training:** Number of medical staff (trainers, doctors, nurses) trained in integrated program (VPD, AEFI, IMCI, MCH) at PHC level **VPD surveillance**: % of reported Measles/Rubella that received timely investigation in 6 pilot districts	**Training:** - < 40% - marginally effective - 40-80% - moderately effective - 80-100% - fully effective **VPD Surveillance:** - < 40% of Y2 target - marginally effective - 40-80% of Y2 target - moderately effective - 80 - 100% of Y2 target - fully	- Project Reports - Statistical forms from Central Statistics and RCIP: ○ Annual Reports on VPDs by districts in Khatlon and Sogd for 2009-2013 ○ Number of VPD cases investigated timely by districts in Khatlon and Sogd for 2009-2013

Input	Output /Outcome Targets	Indicator	Assessment Methodology/Criteria	Sources
trained planning, M&E, use of data	investigation in 6 pilot districts Y1 – 80% Y2 – 90% Y3 – 100%		effective	
Objective # 4. Increase public awareness of immunization and develop a system of incentives for mothers				
Supply: **2011:** - Two types of brochures (4,000 pcs. each) and 2 types of booklets (15,000 pcs. each) developed and distributed mainly in hard-to-reach and remote settlements. - One video clip - 6 radio programs **2013:** - Two types of brochures, 2 types of booklets developed and distributed - One video clip - 6 radio programs - 3 TV programs	**Social mobilization:** Well designed and relevant awareness campaign for target audience in a given socio-economic context -	**Social mobilization:** Appropriate communication channels used for awareness rising	**Social mobilization:** - Beneficiaries mention at least one source information and could not mention message - marginally effective - Beneficiaries mention at least one sources information and at least one message - moderately effective - Beneficiaries mention at least one sources information and two or more messages - fully effective	- Project Reports - In-depth Interviews - Providers FGD - Beneficiaries FGD
Demand - 1034 women provided CCT	**Incentives**: - Number of women benefiting from CCT	**Incentives**: - CCT model is appropriately designed to reach most in need	**Incentives:** - CCT model design does not target most in need, or model design appropriately targets	- Qualitative data

Input	Output /Outcome Targets	Indicator	Assessment Methodology/Criteria	Sources
	Y1 – 0 Y2 – 3400 Y3 – 3400	and well implemented - Number of women benefiting from CCT	most in need but implementation has significant deviations from the model - marginally effective - CCT model design appropriately targets most in need but implementation has slight deviations from the model - moderately effective - CCT model design appropriately targets most in need and implementation follows the model - fully effective Number of beneficiary women from CCT - < 40% - marginally effective - 40-80% - moderately effective - 80-100% - fully effective	
Objective # 5. Increase capacity of PHC facilities in the collection and reporting of evidence-based data in a timely manner				
2011 - Office equipment (computers, modems and printers) for the electronic collection, processing and presentation of reporting data purchased and distributed to 18 facilities - Revised approved and published accounting and reporting forms. - Three three-day training courses	Facilities supplied with Immunization documentation	% of visited facilities equipped with all registration/reporting books forms for Immunization	**Effectiveness** - < 40% - marginally effective - 40-80% - moderately effective - 80-100% - fully effective	- Facility observation

Input	Output /Outcome Targets	Indicator	Assessment Methodology/Criteria	Sources
for 75 executives in data sources, collection, analysis and reporting.				
Utilization of Program budget				
		Volume and timeliness of expenditures by year	Annual expenditures by objective compared to the plan	Program an financial reports

Outcome indicators

Indicator / Targets	Description	Assessment Methodology	Data Sources
DTP coverage (district level)	DTP-3 coverage under 1 in all districts of Khatlon and Sogd oblasts since 2009	Trend analysis with comparison with other districts of the same oblast	RCIP data
Number of districts achieving Y3 >=80% DTP-3 coverage	Number of districts achieving >=80% DTP-3 coverage Y3	Trend analysis	RCIP data
Hepatitis B1 coverage Y3 - 90%	Hep 1 coverage in all districts of Khatlon and Sogd oblasts since 2009	Trend analysis with comparison with other districts of the same oblast	RCIP data
Annual PHC Utilization Rate increased	Annual PHC Utilization Rate in pilot districts since 2011	- No increased trend of annual PHC Utilization Rate in two pilot districts since 2011- not effective - Increased trend of annual PHC Utilization Rate in two pilot districts since 2011and 2013 rate is higher compared to other districts of the same Oblast – effective	Central Medical Statistics Data: ○ Annual PHC utilization rate per districts in Khatlon and Sogd Regions since 2009

Annex 2 List of reviewed documents

N	Document	Language
1	GAVI_HSS Guidelines March 2007	Eng
2	GAVI HSS Detailed information	Eng
3	TJK GAVI HSS Adjusted Application, Final, March 7, 2008	Eng
4	TJK GAVI HSS Adjusted Application Final, Annex A, Output Indicators	Eng
5	TJK GAVI HSS Adjusted Application Final, Annex B, Budget breakdown by quarters	Eng
6	TJK GAVI HSS Adjusted Application Final, Annex C, Adjusted Plan of Activities, February, 2008	Eng
7	TJK GAVI HSS Adjusted Application Final, Annex D, Budget Detailed	Eng
8	TJK GAVI HSS Proposal Review , IRC comments, November 2007	Eng
9	Annual Progress Report (APR) for2008	Eng
10	Annual Progress Report (APR) for2009	Eng
11	Annual Progress Report (APR) for2010	Eng
12	Annual Progress Report (APR) for2011	Eng
13	Annual Progress Report (APR) for2011-HSS section	Eng
14	Annual Progress Report (APR) for2012	Eng
15	Annual Progress Report (APR) for2013	Ru
16	APR_GAVI Decision Letter_8 Sept 2008 (on 2007)	Eng
17	APR_GAVI Decision Letter_14 Aug 2008	Eng
18	APR_GAVI Decision Letter_14 Jan 2010 (on 2009)	Eng
19	APR_GAVI Decision Letter_25 Aug 2010 (on 2009)	Eng
20	APR_GAVI Decision Letter_22 Nov 2010 (on 2009)	Eng
21	APR_GAVI Decision Letter_10 June 2011 (on 2010)	Eng
22	APR_GAVI Decision Letter_27 Sept 2011 (on 2010)	Eng
23	APR_GAVI Decision Letter_16 Feb 2011 (on 2010)	Eng
24	APR_GAVI Decision Letter_2013 (on 2012)	Eng
25	IRC report 2006 on APR 2005	Eng
26	IRC report 2007 on APR 2006	Eng
27	IRC report 2009 on APR 2008	Eng
28	IRC report 2011 on APR 2010	Eng
29	IRC report 2013 on APR 2012	Eng
30	HSCC Meeting Minutes, March 4, 2008	Eng
31	HSCC meeting Minutes, December 10 2010	RU

32	HSCC Meeting Minutes, December 10, 2010	Eng
33	HSCC Meeting Minutes, April 5, October 5 2011	Eng
34	HSCC Meeting Minutes, January 27, April 12 2012	Eng
35	HSCC Meeting Minutes, April 19, 2013	Ru
36	HSCC Meeting Minutes, April 13, 2014	Ru
37	ICC Meeting minutes 2010	Eng
38	ICC Meeting minutes 2010	Ru
39	Working Group (WG) Minutes_21.02.08	Eng
40	Working Group (WG) Minutes_25.02.08	Eng
41	Aide Memorie, 29 Nov 2011	Eng
42	GAVI GoT Partnership Agreement, 2012	Eng
43	Tajikistan Financial Statement for ISS grant, 2010	RU
44	Tajikistan GAVI HSS Audit Report for 2011	Ru
45	Tajikistan GAVI HSS Audit Report for 2013	Ru
46	Financial Management Assessment Report , August 15-17, 2010	Eng
47	GAVI HSS quarterly Report (April-June), 2011	Ru
48	GAVI HSS Annual report for 2013	Ru
49	Tajikistan GAVI HSS detailed action plan 2011	Ru
50	Tajikistan GAVI HSS detailed action plan 2013	Ru
51	Tajikistan GAVI HSS detailed action plan 2014	Ru
52	Tajikistan GAVI HSS M&E Indicators performance, 2011	Ru
53	Tajikistan GAVI HSS M&E Indicators performance, 2013	Ru
54	Tajikistan GAVI HSS Mobile team guideline	Ru
55	Tajikistan GAVI HSS Mothers incentive system scenarios	Ru
56	Tajikistan GAVI HSS Financial report for 2011	Ru
57	Tajikistan GAVI HSS Financial report for 2013	Ru
58	Tajikistan GAVI HSS Financial report for 2014 (January-April)	Ru
59	Government of Tajikistan cMYP, 2007 for the period 2008-2010	Eng
60	Government of Tajikistan cMYP, 2010 for the period 2011-2015	Eng
61	Tajikistan Community and basic health project, WB, final report, December, 2010	Eng
62	Tajikistan National Health Strategy for the period 2010-2020	Eng
63	Tajikistan Health Sector Analysis, EU, May 2013	Eng
64	National Immunization Program Review, Tajikistan, 2012	Eng
65	Tajikistan, Health Services Improvement Project, WB, 2013	Eng

66	WHO EURO, Tajikistan, EVSM Report, November 19-24,2007	Eng
67	WHO EURO, Tajikistan EVSM-VMA-EVM Report, April 5-10, 2010	Eng
68	WHO EURO, Tajikistan, EVM Report, 2012	Eng
69	Tajikistan MICS3, 2005	Eng
70	Tajikistan LSMS Full Report, 2007	Eng
71	Tajikistan Demographic and Health Survey Report, 2012	Eng
72	Millennium Development Goals, Tajikistan Progress Report, 2010	Eng
73	Tajikistan Joint Annual Review, 2013	Eng
74	Demand and supply-side incentives to increase utilization of primary health care services in Tajikistan, Quantitative research report, WB, Swiss TPH, Zerkalo, November 2012	Eng
75	Demand and supply-side incentives to increase utilization of primary health care services in Tajikistan, Qualitative research report, WB, Swiss TPH, Zerkalo, November 2012	Eng
76	Tajikistan Policy Briefs, 2013	Eng

Annex 3 List of organizations representatives of which were interviewed

Organization	Number of key Informants
The GAVI Alliance	2
Ministry of Health (current and former)	6
Social Agency	1
Ministry of Finance	1
Center for Medical Statistics	2
Health Policy Unit	1
PIC Under MoH	4
RCIP	3
SES	1
UNICEF (current and former)	3
WHO (current former)	3
ADB	1
WB	1
USAID/Zdrav plus	1
District level	8
Total Number of Key informant Interviews	**38**

Annex 4 In-depth interview and Small Group Discussion guides

In-depth Interview Guides

ASESSMENT QUESTIONS	SUB QUESTIONS	HSCC	HRIRD / HPAU	MCH	RCIP / Program Iml Unit	WHO / UNICEF	Other donors	Rayon health Departm.	Rayon Immu Center / rayon IMCI center	Jamoat	Facility managers	Document review / Quantitative data source
Implementation Effectiveness:												
To what extent were the activities set out in the HSS application implemented as planned (quality, quantity, ways and means)?												
To what extent were the role of GAVI secretariat, national agencies and partners at country level effective in the implementation and monitoring process?	When was HSCC developed? Was it created solely for GAVI HSS grant?	+	+	+		+						
	How would you describe the roles of agencies involved in coordination, program management, implementation and M&E of the HSS grant: (probe for HSCC, HIRID, HPAU, MCH department, RCIP, WHO CO. Was this process regulated by any decree?	+	+	+	+	+	+					MoH order / MOU
	Based on your experience what were strengths and weaknesses of the coordination and management of the HSS program	+	+	+	+	+	+	+	+		+	
	How helpful are HSCC decisions / recommendations in management of GAVI HSS program? Could you recall specific examples?		+	+	+	+	+					Meeting minutes 2013

	How helpful was the GAVI secretariat in the process of the program implementation?	+	+	+	+	+	+					
To what extent were the management of HSS and EPI well-coordinated?	Can you describe how the coordination between HSS program and EPI was achieved? E.g. were EPI needs considered when planning for the HSS Can you recall specific examples of good or weak coordination between EPI and HSS by providing specific example?	+	+	+	+	+	+		+			
What existing mechanisms and procedures were applied for the program implementation	The HSS funds were channeled through WHO country office, why such mechanism was proposed? Now looking backwards do you think this was effective mechanism and why you think so?	+	+	+	+	+	+					
	Can you describe how HSS funds were channeled from RCIP to lower level? And did funds reached them timely?			+	+	+		+		+		
	When procurement was required what procurement mechanism was used? National regulations, WHO regulations (as per proposal)?			+	+	+						
	Are you part of the tenders committee, have you reviewed all procurements, do you have objections to tender process of the GAVI HSS program					+						
	How FMA was conducted (frequency, tender procedures)		+	+	+	+						FMA Reports
What contextual factors could explain the actual implementation rate?	GAVI approved HSS grant in 2008, however first tranche was made in April 2011 due to delayed signature of MOU between GAVI and MOH, what was the reason of this delay?	+	+	+	+	+	+					

	What was the reason of delayed transfer of funds from the WHO CO to the special bank account of RCIP in 2011? How this was explained and who provided this reasoning?	+	+	+	+	+	+					
	What was the reason of delayed transfer of second tranche in 2012? How this was explained and who provided this reasoning?	+	+	+	+	+	+					
	Have you received the third tranche timely? If not what was the reason?	+	+	+	+	+						
To what extent did program management appropriately adapt to challenges, changes in context and long delays observed spending funds? Were the responses adequately addressing the issues?	Which agency was responsible to solve the problem? What actions were taken to respond to delays in transfers? In your opinion were the response/managerial actions adequate, what else could have been done?	+	+	+	+	+	+					
	What other factors contributed to program implementation delay? Did polio outbreak affect program implementation?	+	+	+	+	+	+					
	The program activities were not changed since 2008 proposal; in your opinion did it require any reprograming to respond to changes? (e.g. polio outbreak, change of DTP-3 coverage, IMR as a criteria to district selection)?	+	+	+	+	+	+					
To what extent was the M&E component well designed and implemented?	In your opinion are the targets for all indicators well defined? If not please explain why?	+	+	+	+	+	+					

	Are there any challenges in collecting information for indicators? Does it require any additional effort? Can you tell us how much additional effort it demands?		+	+	+	+		+				
	Please describe role of the M&E groups established in all 6 districts, could you share guidelines and specific questionnaires developed for monitoring purposes, do they produce reports? How these monitoring groups are supervised?		+	+	+	+		+			+	M&E guidelines / questionnaires; reports
	How monitoring data were/are used for planning and/or decision making, please give example?	+	+	+	+	+		+				
	Has GAVI HSS M&E framework been integrated into national M&E system? Can you show/tell example why you think so?	+	+	+	+	+						
To what extent were activities, resources appropriately coordinated, and assessed (given the pilot aspect of the programme) and reported by the MOH to the GAVI Secretariat and Alliance partners?												
	How the reporting process to GAVI was coordinated by HRIRD? Was the information timely submitted by implementing agencies?	+	+	+	+	+	+					
Implementation of program activities												
Objective #1. Strengthen evidence-informed decision making at central and local government levels in order to build financial commitment for PHC services, focusing on immunization	How many policy briefs were developed under the GAVI HSS Program in 2011 and 2013-2014?		+									Policy briefs
	How these policy briefs were disseminated among the key stakeholders and local level? Please describe the usual practice.		+	+	+	+	+	+				

	Please describe dissemination process for each policy brief?		+									
	Have you received the policy briefs developed by the MoH during the last three years? What was the topic about, Which were most interesting you? How the briefs were communicated to you? Please describe give examples how the process worked							+	+	+	+	Policy briefs
	Did you use the information/data presented in the policy briefs? Please give examples (e.g. contribution from local government to PHC and public health services)	+	+	+	+	+	+	+	+	+	+	
Objective # 2. Increase access to PHC services in remote and hard-to-reach areas	Who was responsible for implementation of this objective at the national and district level?		+	+	+			+				
	How the 35 rural health facilities (health houses) were selected for renovation in 2013? In the proposal 36 facilities have to be renovated, what is the status of the last 36th facility?			+								MOH Order
	Are all selected facilities located in hard-to-reach areas? If not why did you select such facilities?			+	+	+						reports
	In 2013 23 out of selected 35 were renovated, were any renovations done in 2014?			+								reports
	What activities were carried out to obtain in-kind contribution from the local governments? Who was responsible for this and how this was achieved?			+				+		+	+	

	What contribution was made by the local governments? Did local communities contributed for all 23 facilities renovation in 2013? What was contribution in monetary terms? Was it 30% of total cost?			+				+		+	+	reports
	What were major challenges during facility selection / renovation?			+				+		+	+	
	In 2013 100 refrigerators were procured and distributed? Why 100 were purchased if in total 35 facilities were/will be renovated? How the facilities were selected? Where any challenges with the procurement?			+	+		+		+		+	+
	Was any other equipment purchased for the facilities? Are there plans for other equipment?			+	+		+		+			
	How the financial support (operational expenses) was provided to the doctors for outreach activities in 2011 and 2013-14? Please describe the procedures (how money is transferred, how financial reporting is done)?			+	+			+	+		+	Financial reports
	How many outreach activities per village were accomplished since 2011?. How many visits were planned per year? What where the challenges?			+	+			+	+		+	
	number of outreach activities by villages by year											plans, reports
	How many mobile team visits were planned per year? What where the challenges?			+	+			+	+		+	
	Number of mobile team visits per village per year			+	+			+	+			plans, reports
	What is the mobile team composition? Can you list what services are provided during one mobile visit?			+	+			+	+		+	

	Does outreach indicator in the proposal include both (mobile team and doctor visits)			+	+							
	How implementation of all activities under this objective was monitored? Challenges, use of M&E data, how feedback was provided to lower level?			+	+			+	+		+	monitoring reports
Objective # 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc	Which guidelines were used for PHC training under the HSS program? When these guidelines were developed? Which modules are included in the training curricula?			+	+		+	+	+			guidelines training curricula
	Immunization Program review of 2012 underlines lack of accents on injection safety in the Immunization guidelines. Do current immunization guidelines (changes after 2012) include emphasis on avoidance of recapping?				+			+				
	Are these guidelines included into the basic training program for PHC staff?		+	+	+							
	How many PHC staff was trained in 2013 and 2014, did integrated trainings were provided or separated trainings were held		+	+	+			+	+		+	
	Number of PHC staff trained by year by topic		+	+	+			+	+			reports
	Was ToT on VPD and AEFI conducted (as planned) and how many trainers were trained?			+	+			+	+		+	Number of trainers;

	Was training of district public heath staff provided, were all districts covered?			+	+			+	+		+	Number of trained staff training curricula;
	What main challenges are currently in immunization practice, waste management, cold chain, injection safety, etc.			+	+		+		+		+	
	Were on-the-job trainings on immunization practice carried out in the PHC facilities? were all districts covered?				+			+	+		+	No of on-the-job trainings
	Was operational support provided to public health staff to conduct case investigation? What were challenges has timeliness of the investigation improved?				+			+	+		+	
	Number of VPD cases reported in all disticts in Khatlon and Sogd 2009 - 2014 *Number of VPD cases timely investigated in all districts in Khatlon and Sogd* 2009 - 2014											Central Stat Dep Reports; RCIP reports
	Were integrated guidelines for supportive supervision developed? Were the mechanisms for joint supportive supervision developed? Were trainings provided? Are supportive supervisions conducted? (composition of team, plans, reports)			+	+	+		+	+		+	Guideline; Plans, reports
	Initial plan included training of pilot district PHC management staff, how many districts were covered by trainings in 2013-14? Why the initial plan was adjusted?											Number of trainings, no of participants
	Does PHC management use acquired knowledge in practice, e.g. have micro planning improved since trainings, are there any examples?		+	+	+	+	+	+	+		+	

	Where trainings, acquired knowledge evaluated? Challenges, use of evaluation results?			+	+	+		+	+		+	Evaluation reports
Objective # 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	One video clip and 6 radio programs were developed in 2011, how long they were broadcasted? Are new TV/radio materials developed since then?		+	+	+	+		+	+	+	+	
	In your opinion how effective was each of these channels to reach hard-to-reach population, are there any evidences that show what proportion of this population was reached?		+	+	+	+		+	+	+	+	
	Have village health committees been established? What is role, composition, are they functional? What kind of activities they did?			+	+			+		+	+	report
	How the model of conditional cash transfers (CCT) was developed? Who was involved in the design? What are procedures for selection, What is amount of cash transfer?		+	+	+			+		+	+	Model
	Was baseline study conducted before model implementation?		+	+								Baseline report
	How model implementation took place, how beneficiary women were selected? were there any challenges, were there cases of not following selection criteria?		+	+	+	+	+	+	+	+	+	
	Do newborns benefited from free civil registration under CCT model?		+	+	+			+	+	+	+	

	○ *Number of newborns since 2009 in Khatlon and Sogd districts* ○ *Number of registered newborns since 2009 in Khatlon and Sogd districts*											*Civil registration office (Khukumat); Regional Heath department reports*
	Has initial target of 3,400 women remain the same, what is the plan to cover all of them? If not what are the factors impeding reaching planned number of beneficiaries		+	+	+							
	How CCT distribution is monitored and evaluated? When Operational research will be conducted to evaluate CCT?		+	+	+			+	+	+	+	monitoring reports; operational research report
	How this objective contributed to increased PHC utilization?		+	+	+	+	+	+			+	
	Annual PHC utilization rate per districts in Khatlon and Sogd Oblast since 2009, 2014 6 m											Statistical reports from CMSI
Objective # 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning	Which statistical forms were revised? Are the revised forms available to all PHC facilities		+	+	+			+	+		+	Revised Statistical forms

	How many Computer equipment packages were distributed in 2011 and 2013? Are the computers used? what are challenges (e.g. computer knowledge) and how they are addressed?		+	+	+			+	+		+	No of computer packages
	Where ToT provided? Where PHC staff trained on revised forms in all districts?		+	+	+			+	+		+	No of trainers; No of trained PHC staff
	How PHC facilities are performing on maintenance of new forms (timelines, completeness , accuracy), what are challenges and how they are addressed?		+	+	+	+		+	+		+	
	No of PHC facilities submitting revised forms timely since 2011											CMSI data
	Did these forms help to save time on data collection and reporting, e.g. how much time was spent per month before simplification and now?			+	+			+	+		+	
Efficiency:												
To what extent were the funds used efficiently and as planned?												
Where the funds by activities used as planned. If not what was the reason?	*Volume and timeliness of expenditures*											Financial reports
Results:												
To what extent did the HSS programme contribute to observed trends in the following indicators:												
DTP3 and overage? (in supported districts)	What was the GAVI HSS program contribution in increasing basic vaccination (DPT-3), Hep B1	+	+	+	+	+	+					

	DPT-3 coverage by districts in Khatlon and Sogd oblasts since 2009 *HepB1 coverage by districts in Khatlon and Sogd oblasts since 2009*											RCIP reports
Other indicators selected by the country as part of its HSS grant?	Please provide any examples of success of GAVI HSS program which we have not covered yet. What were the key factors that contributed to this success?	+	+	+	+	+	+	+	+			
	Please provide any examples of failure of GAVI HSS program which we have not covered yet. What were the key factors that caused the failure?	+	+	+	+	+	+	+	+			
To what extend has the MOH learnt from the pilot activities in the HSS programme?												
What were lessons learned	What are the lessons learnt during the implementation process? What worked well and why? What did not work well and why?	+	+	+	+	+	+	+	+			
	What were the positive and negative unintended consequences of the HSS program?	+	+	+	+	+	+	+	+			

Small Group Discussion guides / In-depth Interviews with PHC Personnel

Outreach activities:

- How long has it been since you implement outreach activities?
- How many people go out together for outreach activities? Which personnel?
- What types of services do you offer within outreach activities?
- Approximately how many outreach activities were accomplished this year within the region? Which villages (kishlaks) were covered? (data on outreach activities in Y2011 and YY2013-2014)
- How many visits were planned per year? (show a plan)
- Did you receive any financial support (operational expenses for travel, accommodation) for outreach activities in Y2011 and YY2013-14? Please describe the procedures such as how did you receive money? how and to whom did you report on outreach?
- What where the challenges? (probe: money not received timely, insufficient amount of money, climate problems, accommodation problems)

Mobile Team visits:

- How long has it been since Mobile Team visits are implemented
- What is the usual composition mobile team?
- Approximately how many mobile team visits were accomplished this year within the district? Which villages (kishlaks) were covered? (data on outreach activities in Y2011 and YY2013-2014)
- How many visits were planned per year?(show a plan)
- What kind of services do you provide during mobile team visits? (number of children and adults served)
- What where the challenges? (e.g. per-diem not received timely, fuel not available, broken car, climate problems)
- How you were/are supervised? Did you have any interaction with your supervisor? If yes, in what way?

Trainings:

- Have you received any trainings since Y2011? What was the topic(s), (e.g. for VPD surveillance in Y2013)
- What was the duration of trainings, who provided the trainings?
- Have you received training materials (ask to show if available)

VPD surveillance

- In your opinion are there any changes with regard to VPD detection, notification, investigation? What are challenges with notification?

Supervision

- Were on-the-job trainings on immunization practice carried out in you facilities? If yes who provided, how often, hoe useful werethey?
- Can you recall if joint supervision was provided from district level, what was composition of the supervisory team, was it helpful?

Awareness / CCT

- Can you recall a video clip, radio programs on immunization topic? When it was last broadcasted?
- Do you know about financial incentives to mothers to motivate them to bring child to the facility?
- What's your opinion about this model? How were mothers selected?
- Did you notice any increase in PHC service utilization rates for children since Y2013?

Information System

- Have you revised reporting forms? Have they become less?

Small group discussion guide for beneficiaries

Selection criteria: mothers of infants under 2 years of age

- Single mothers
- Mothers with dependable children
- Mothers of disabled children
- Unemployed parents

Accesses to services

- Do you bring your child to check up / immunization to the facility? If not what is the reason (e.g.: distance, money for transportation / visits, low trust, fear of immunization, influence from family members)
- Have you paid for such visits? If yes how much

Awareness

- Can you recall a video clip, radio programs on immunization topic? When it was last broadcasted? What do you remember from that clip/program? What it was about?
- Did you receive booklet / brochure at the facility? What it was about?

Incentives

- When did you receive incentive, from whom, what was the volume, who was handing over it to you? What were you told when you were given the incentive?
- What was amount? Who gave you this money? When did you receive it (before or after the visit)?
- Have your children been vaccinated before receipt of the incentive? If no, then why?
- Did you receive free birth certificate from Jamoat?
- If you had not received this amount would you have brought your child to the facility?
- If you do not receive an incentive for the next child, will you bring him to facility?

Annex 5 List of collected quantitative information and data sources

N	Quantitative Data	Data Sources
1	DTP 3 coverage by districts	RCIP
2	Hep B1 coverage by districts	RCIP
3	# of MR cases per Soghd and Khatlon Oblasts	RCIP
4	# of Measles and Rubella cases timely investigated in Soghd and Khatlon Oblasts	RCIP
5	PHC utilization rate per 10,000	National Center for Medical Statistics
6	# of Health Facilities renovated	APR, Annual Report in Russian
7	# of women received social package	APR, Annual Report in Russian
8	Revised budget for 2011, 2013, 2014	Program Implementation Center/Financial Manager
9	Expenditure for 2011, 2013, 2014	Program Implementation Center/Financial Manager
10	# of Cold Chain Equipment procured	APR, Annual Report in Russian
11	# of office equipment procured	APR, Annual Report in Russian
12	#of people trained	Program Implementation Center
13	# of Health facilities renovated in Farkhor	RCI, Director
14	# of Health facilities renovated in Matcha	RCI, Director
15	# of Women receiving social package in Farkhor	RCI, Director
16	# of Women receiving social package in Matcha	RCI, Director

Annex 6 Main steps of GAVI HSS program development during 2007-2014

Year	KEY POINTS
2007	• GAVI HSS proposal was submitted to the GAVI Alliance on 5th October • HSS Proposal was approved on December 10, with following conditions: a. Revision of the proposed activities and the budgetary allocations based on the 2006 World Bank GNI per capita figure of US$390. b. Better elaboration of the Indicators and inclusion of indicators and measures that will allow the monitoring of the proposed program of work. c. A more detailed breakdown (and on a quarterly basis) of the budgetary allocations ***GAVI Alliance decision letter #GAVI/07/431/cb/at, 2007***
2008	• HSS application was revised according to the IRC comments • On March 3 HSCC endorsed the revised HSS application • Revised HSS proposal was resubmitted to the GAVI Alliance • GAVI HSS proposal for an amount of $1,314,500 for the period 2008 to 2010 was approved by the IRC • GAVI requested from the GoT correct fund arrangements, bank details, SWIFT code and any corresponding US bank details to make first disbursement and ensure speedy smooth fund flow ***GAVI Alliance decision letter #GAVI/08/221/CB/ba, sent to the GoT on 14 August, 2008***
2009	• The disbursement of the first tranche was pending signature of an MOU with GAVI Alliance. It was over 12 months since the decision letter was sent to the MoH in Tajikistan (August 14, 2008) • The IRC requested that the GoT complete the process of signing of the MOU with GAVI. • The GAVI secretariat should follow up with WHO as a matter of priority the status of the MOU. ***GAVI IRC Report on APR 2008 sent to the GoT in September, 2009***
2010	• The first disbursement of HSS funding was pending signature of the MoU and submission of the outstanding ISS audit report (due end of September 2009) requested by the GAVI Alliance; ***GAVI Alliance decision letter, GAVI/09/305/ir, 14, January, 2010*** • Financial Management Assessment was conducted in August 2010. ***FMA report August 15-27, 2010*** • The approved amount of HSS was US$ 1,314,500 with US$ 282,000 disbursed in August 2010 ***FMA report, August 14-15, 2010*** • ISS audit reports were submitted to GAVI Alliance and reviewed and cleared by GAVI Secretariat TAP team. ***GAVI Alliance decision letter, GAVI/10/195/at/na/jy 2 August, 2010*** • HSCC meeting held on December 10. Draft budget for the GAVI HSS Project for 2011-2013 and a draft realization plan for the GVAI HSS project for 2011-2013 was approved; ***HSCC Meeting Minutes N1, December 10, 2010*** • WHO CO Tajikistan requested extension of period covered under the GAVI HSS Grant due to the the delays experienced in HSS fund transfer***; WHO CO Tajikistan Letter to the GAVI Alliance N 1-6/283-303, 27 December, 2010***

2011	• GAVI extended the project time frame to the period 2011-2013 due to the delays experienced in HSS fund transfer. GAVI understands and agrees that current HSS fund transfer arrangements through WHO to Tajikistan will remain same and Tajikistan will comply with recommendations and terms as laid out in recent financial management assessment (FMA) report. ***GAVI Alliance decision Letter, GAVI/11/048/na/dl, 16 February 2011*** • GAVI requested that in case of major changes or deviations from original proposal, HSS implementation should be reprogrammed, such reprogramming should be reviewed and approved by HSCC and the reprogramming should be submitted with the APR to be reviewed by IRC. ***GAVI Alliance decision Letter, GAVI/11/048/na/dl, 16 February 2011*** • In April GAVI HSS funds were transferred to the RCPI bank account through the WHO CO bank account • HSCC meeting of April 5 approved changes in the GAVI HSS action plan and budget for 2011. ***HSCC meeting minutes N1, April 5, 2011*** • In May the MoH sent a letter to the GAVI requesting a change on the fund channeling mechanism for HSS support and to transfer funds directly to the RCPI special bank account. ***MoH Letter to the GAVI (ref 116,2011), 6 May, 2011*** • GAVI responded to the MoH letter on June10th and informed that as per GAVI TAP policy: a. Tajikistan's request has implications on programmatic as well as in financial management aspects. b. Such request should be discussed at the HSCC and should be endorsed by all the HSCC members. If the HSCC endorses departure from the WHO mechanism, Tajikistan needs to submit a reprogrammed plan for HSS in the next APR to clarify the role of WHO as a technical assistance and financial management party. c. In the reprogramming Tajikistan also needs to clarify how other relevant stakeholders and other MoH departments such as maternal and child health will be implementing their HSS activities if funds are going to the RCIP account. d. With changes requested Tajikistan needs to clarify the role of the Health Reform and International Relations department, as in the original proposal it was indicated that the management unit for GAVI HSS will be established under this unit. e. In light of TAP GAVI will revise the draft Aide Memoire to indicate that two separate accounts (one for ISS and one for HSS) will be established by Tajikistan, RCIP with a co-signature of WHO authorities for both accounts. f. WHO financial approval and recording systems should be followed for all disbursements g. Both ISS and HSS funds should be reflected in the national budget. h. Any change of an approved funding mechanism has to be revisited to ensure that it addresses all areas of potential fiduciary risks. i. Changes may further delay the disbursement of HSS funds to Tajikistan. ***GAVI Alliance decision letter, GAVI/11/174/NA, 10 June, 2011*** • IRC Report on APR 2010, sent in July stated that no HSS activities occurred in 2010 because of delays in funds reaching Tajikistan. Activities are scheduled to start in May 2011. No new funding is requested. However, the country is

	requesting a change in the timeframe of HSS implementation to 2011-2012. An FMA was conducted in August 2010 and a change in the funding mechanism is yet to be agreed. No funds can be transferred to Tajikistan until the FMA and Aide Memoir is finalized. The country is requested to complete the FMA and Aide Memoire process; this is a pre-requisite for the disbursement of funds. ***IRC Report on APR for 2010, July 2011*** • In September GAVI Alliance requested GoT to complete the FMA and sign Aide Memoire. This is pre-requisite for the disbursement of funds. **GAVI Alliance decision letter, GAVI/11/23/sc, 27 September, 2011** • GAVI representative (who participated at the HSCC meeting) clarified that the program was designed two years ago, therefore the MoH should revise some of the activities. Proposal on changing of HSS funding flow will strengthen the local capacity, however this does not free the WHO CO from financial monitoring responsibility, other organization members of the HSCC should be involved in this process. • The HSCC approved that GAVI HSS funds should be directly transferred to the RCIP bank account. ***HSCC meeting minutes N2, October 5, 2011*** • In December Aide Memoire between the GAVI Alliance and GoT was signed. ***Aide Memoire, 29 November, 2011***
2012	• HCSS fund disbursement is pending on APR 2011, due May 15th 2012. ***HSCC Meeting Minutes N1, January 27, 2012*** • External audit for 2011 was conducted in April. ***External HSS audit report April, 2012*** • APR for 2011 and Audit report for 2011 were endorsed**.** ***HSCC Meeting Minutes N2, April 25, 2012*** • In November Partnership Framework agreement between the GAVI Alliance and GoT was signed. ***Agreement ref N TJK-01***
2013	• In April HSCC meeting was held and discussed APR for 2012. ***HSCC Meeting Minutes N2 April 19, 2013*** • GAVI IRC report on APR for 2012 was sent in July. IRC endorsed a no cost extension for HSS implementation timeframe to 2012. IRC report mentions that as per APR Tajikistan was to receive the second tranche for the HSS in 2012, however these funds were transferred to the special account for HSS on Jan. 10, 2013. In this regard, all the HSS activities planned for 2012 were adjourned to 2013. Therefore, the country requests an extension to the year 2014 and requests final tranche. ***IRC Report on APR for 2012*** • GAVI Alliance requested MoH to submit following documents by the specified due dates as part of the conditions for approval and disbursements of the future Annual Amount a. APR by May 15 or as negotiated with Secretariat. APR should provide detail on the progress against milestones and targets against baseline data for indicators identified in the proposal. The APRs should also include a financial report on the use of GAVI support for HSS b. Interim unaudited financial reports. Unless stated otherwise in the existing Aide Memoire between GAVI and the Country, the Country shall deliver interim unaudited financial reports on the HSS cash support no later than 45 days after the end of each 6-month reporting period (15 February for the period covering 1 July - 31 December and 15 August for the period covering 1 January - 30 June). Failure to submit timely reports

	may affect future funding. c. In order to receive a disbursement for the second approved year of the HSS grant (2014), Country shall provide GAVI with a request for disbursement, which shall include the most recent interim unaudited financial report. d. Cash disbursed under HSS support may not be used to meet GAVI's requirements to co-finance vaccine purchases. e. In case the Country wishes to alter the disbursement schedule over the course of the HSS program, this must be highlighted and justified in the APR and will be subject to GAVI approval. It is essential that HSCC be involved with this process both in its technical process function and its support during implementation and monitoring of the HSS program proposal. Utilization of GAVI support stated in this letter will be subject to performance monitoring. ***GAVI Alliance decision letter***
2014	• Independent audit for 2013 was conducted. **Audit report, February 2014** • HSCC meeting was held on April 13, HSCC endorsed APR for 2013 **HSCC Meeting Minutes #2, April 13, 2014**

Annex 7 HSS Program budget (initial and Revised)

Program Objectives	Initial Budget				Revised budget				Variance
	2011	2013	2014	Total	2011	2013	2014	Total	
Objective #1. Strengthen evidence-informed decision making at central and local government levels in order to build financial commitment for PHC services, focusing on immunization		**5,350**	**5,350**	**10,700**	-	**5,350**	**5,130**	**10,480**	**-2%**
1.1. Develop, publish and distribute policy briefs on impact of government policies and PHC reforms on MDGs #4 and #5 using the key monitoring indicators and results of different surveys		2,250	2,250	4,500		2,250	2,030	4,280	-5%
1.2. Review issues on immunization coverage and PHC services in general at inter-sectoral government meetings, HSCC and Ministerial meetings during the budget formulation process to lobby for appropriate financing		2,800	2,800	5,600		2,800	2,800	5,600	0%
1.3. Review issues on immunization coverage and PHC services in general at regional, district and jamoat government meetings to lobby for appropriate financing based on evidence		300	300	600		300	300	600	0%
Objective # 2. Increase access to PHC services in remote and hard-to-reach areas	**136,846**	**466,040**	**131,040**	**733,926**	**147,468**	**504,300**	**83,840**	**735,608**	**0%**
2.1.Renovate rural health facilities (Health Houses) in remote villages with counterpart participation of the local governments and local communities on the basis of their applications to the MOH (according to PHC rationalization plan)	25,746	191,000		216,746	25,702	280,300		306,002	41%
2.2.Provide basic equipment, including cold bags, medical supplies and small parts to PHC facilities in selected districts	500	144,000		144,500	465	144,000		144,465	0%
2.3. Provide operational support to PHC staff for conducting outreach activities through covering their transportation expenditures and per diems	18,000	72,000	72,000	162,000	8,927	48,000	42,000	98,927	-39%
2.4.Establish mobile teams on the basis of the needs assessment for poor hard-to-reach areas that do not have medical staff or where there is only one medical worker if she is away on a training course	92,600	59,040	59,040	210,680	112,374	32,000	41,840	186,214	-12%
Objective # 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc	**47,691**	**116,119**	**86,744**	**250,554**	**95,195**	**62,810**	**105,178**	**263,183**	**5%**
3.1. Review existing training programs on IMCI, reproductive health, immunization conducted by different agencies and develop unified guidelines for PHC	3,800			3,800	59,813			59,813	1474%
3.2. Training on VPD and AEFI, IMCI, MCH for medical staff in PHC facilities in selected districts (not covered by current programs)	19,500	82,860	63,360	165,720	31,429	44,200	105,178	180,807	9%
3.3. Conduct training for staff of public health services on VPD, AEFI surveillance	7,875	7,875		15,750	3,953	6,400		10,353	-34%
3.4. Conduct timely investigation and undertake preventive measures to halt the spread of VPDs	4,250	17,000	17,000	38,250					-100%
3.5. Develop mechanisms and procedures for joint supervision (district health centers, district reproductive health centers, district centers for IMCI, centers for immunprofylaxis etc.)	5,916	6,384	6,384	18,684		10,210		10,210	-45%
3.6. Conduct training of PHC management on data use, monitoring and planning to improve effectiveness of PHC services building on the training program developed under the WB/SIDA financed	6,350	2,000		8,350		2,000		2,000	-76%

Program Objectives	Initial Budget				Revised budget				Variance
	2011	2013	2014	Total	2011	2013	2014	Total	
CBHP									
Objective # 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	**15,500**	**69,175**	**68,820**	**153,495**	**3,099**	**78,658**	**88,020**	**169,777**	**11%**
4.1. Increase public awareness on importance of timely immunization and steps to be followed in case of home deliveries	3,300	800	800	4,900	3,099	24,000	20,000	47,099	861%
4.2. Broaden the existing mobilization programs on the basis of an integrated approach and scale up to the selected districts		13,350		13,350		13,350	2,720	16,070	20%
4.3. Harmonize activities of existing community health committees and NGOs working in the area of MCH, conduct short TOT workshops, and provide necessary methodological guidelines		2,720	2,720	5,440		2,720		2,720	-50%
4.4. Develop and pilot a system of incentives for poorest mothers in hard-to-reach areas with high share of home deliveries based on international experience on conditional cash transfers	700	52,305	51,000	104,005		38,588	51,000	89,588	-14%
4.5. Operational research on effectiveness and financial sustainability of the pilot (4.4) to evaluate the possibility for the scale up	11,500		14,300	25,800			14,300	14,300	-45%
Objective # 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning	**66,400**	**24,000**	**24,000**	**114,400**	**-**	**24,000**	**24,185**	**48,185**	**-58%**
5.1. Improve the Health information System in Health Data Collection at primary level for further automatisation	38,400	24,000	24,000	86,400		24,000	24,185	48,185	-44%
5.2. Build capacity for timely processing and exchange of data at district level	28,000			28,000					-100%
Sub-total	**266,437**	**680,684**	**315,954**	**1,263,075**	**245,762**	675,118	306,353	1,227,233	-3%
Management and administration	15,798	17,846	17,846	51,490	17,789	23,412	27,447	68,648	33%
TOTAL	**282,235**	**698,530**	**333,800**	**1,314,565**	263,551	**698,530**	**333,800**	1,295,881	-1%
WHO commission%					18,684			18,684	
					282,235			1,314,565	

Annex 8 HSS program expenditures

Revised Budget and Expenditures by program objectives by years

Program Objectives	Revised Budget				Expenditure				%	
	2011	2013	2014	Total	2011	2013	2014 (Jan-Apr)	Total	2011	2013
Objective #1. Strengthen evidence-informed decision making at central and local government levels in order to build financial commitment for PHC services, focusing on immunization	-	**5,350**	**5,130**	**10,480**	-	**6,067**	**1,433**	**7,500**		**113 %**
1.1. Develop, publish and distribute policy briefs on impact of government policies and PHC reforms on MDGs #4 and #5 using the key monitoring indicators and results of different surveys		2,250	2,030			2,587	540	**3,127**		115 %
1.2. Review issues on immunization coverage and PHC services in general at inter-sectoral government meetings, HSCC and Ministerial meetings during the budget formulation process to lobby for appropriate financing		2,800	2,800			3,143	736	**3,880**		112 %
1.3. Review issues on immunization coverage and PHC services in general at regional, district and jamoat government meetings to lobby for appropriate financing based on evidence		300	300			336	157	**493**		112 %
Objective # 2. Increase access to PHC services in remote and hard-to-reach areas	**147,468**	**504,300**	**83,840**	**735,608**	**151,724**	**473,951**		**625,676**	**103%**	**94%**
2.1.Renovate rural health facilities (Health Houses) in remote villages with counterpart participation of the local governments and local communities on the basis of their applications to the MOH (according to PHC rationalization plan)	25,702	280,300			21,491	223,121		**244,612**	84%	80%
2.2.Provide basic equipment, including cold bags, medical supplies and small parts to PHC facilities in selected districts	465	144,000			470	152,650		**153,121**	101%	106 %
2.3. Provide operational support to PHC staff for conducting outreach activities through covering their transportation expenditures and per diems	8,927	48,000	42,000	98,927	5,454	58,283	9,736	**73,474**	61%	121 %
2.4.Establish mobile teams on the basis of the needs assessment for poor hard-to-reach areas that do not have medical staff or where there is only one medical worker if she is away on a training course	112,374	32,000	41,840	186,214	124,309	39,897	7,302	**171,507**	111%	125 %
Objective # 3. Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc	**95,195**	**62,810**	**105,178**	**263,183**	**89,025**	**63,094**	**69,505**	**221,624**	**94%**	**100 %**
3.1. Review existing training programs on IMCI, reproductive health, immunization conducted by different agencies and develop unified guidelines for PHC	59,813				59,640			**59,640**	100%	
3.2. Training on VPD and AEFI, IMCI, MCH for medical staff in PHC facilities in selected districts (not covered by current programs)	31,429	44,200	105,178		27,285	43,433	69,505	**140,224**	87%	98%
3.3. Conduct training for staff of public health services on VPD, AEFI surveillance	3,953	6,400			2,100	6,552		**8,652**	53%	102 %
3.4. Conduct timely investigation and undertake preventive measures to halt the spread								-		

Program Objectives	Revised Budget				Expenditure				%	
	2011	2013	2014	Total	2011	2013	2014 (Jan-Apr)	Total	2011	2013
of VPDs										
3.5. Develop mechanisms and procedures for joint supervision (district health centers, district reproductive health centers, district centers for IMCI, centers for immunprofylaxis etc.)		10,210				10,672		**10,672**		105 %
3.6. Conduct training of PHC management on data use, monitoring and planning to improve effectiveness of PHC services building on the training program developed under the WB/SIDA financed CBHP		2,000				2,436		**2,436**		122 %
Objective # 4. Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	**3,099**	**78,658**	**88,020**	**169,777**	**2,340**	**85,798**	**62,566**	**150,705**	**76%**	**109 %**
4.1. Increase public awareness on importance of timely immunization and steps to be followed in case of home deliveries	3,099	24,000	20,000		2,340	32,096	10,345	**44,781**	76%	134 %
4.2. Broaden the existing mobilization programs on the basis of an integrated approach and scale up to the selected districts		13,350	2,720			11,839		**11,839**		89%
4.3. Harmonize activities of existing community health committees and NGOs working in the area of MCH, conduct short TOT workshops, and provide necessary methodological guidelines		2,720				3,125	52,221	**55,346**		115 %
4.4. Develop and pilot a system of incentives for poorest mothers in hard-to-reach areas with high share of home deliveries based on international experience on conditional cash transfers		38,588	51,000			38,738		**38,738**		100 %
4.5. Operational research on effectiveness and financial sustainability of the pilot (4.4) to evaluate the possibility for the scale up			14,300					-		
Objective # 5. Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning	**-**	**24,000**	**24,185**	**48,185**	**-**	23,738	25,400	**49,138**		**99%**
5.1. Improve the Health information System in Health Data Collection at primary level for further automatisation		24,000	24,185			23,738	25,400	**49,138**		99%
5.2. Build capacity for timely processing and exchange of data at district level										
Sub-total	**245,762**	675,118	306,353	1,227,233	243,090	652,648	158,904	1,054,641	**99%**	**97%**
Management and administration	17,789	23,412	27,447	68,648	20,461	45,882	5,872	72,215	115%	196 %
TOTAL	263,551	**698,530**	**333,800**	1,295,881	263,551	698,530	164,776	1,126,857	**100%**	**100 %**
WHO commission%	18,684			18,684	18,684					
	282,235			1,314,565	282,235					

Annex 9 Comparison of Original and New output indicators by objectives

Objective	Indicators from the Proposal	New Indicator	Comment
Objective 1: Strengthen evidence-informed decision making at central and local government levels in order to build financial commitment for PHC services, focusing on immunization	1.1 Annual policy briefs developed based on impact analysis with focus on progress towards achieving MDGs #4 and #5	Annual policy briefs developed based on impact analysis with focus on progress towards achieving MDGs #4 and #5	Similar
		# of ICC and HSCC meetings where immunization related issues are discussed	
		# of meetings at the national, oblasts and district level where immunization related issues are discussed	
Objective 2: Increase access to PHC services in remote and hard-to-reach areas	2.1 # of RHFs in GAVI pilot districts that improved their physical infrastructure (renovated and equipped) under GAVI HSS	# of RHFs in GAVI pilot districts that improved their physical infrastructure (renovated and equipped) under GAVI HSS	Similar
	2.2. # of remote villages in pilot districts that received outreach services at least 2 times per year	#of trainings provided for the health facility managers and local authorities on the proposal writing on facility reconstruction	The new indicators do not provide information for measuring indicator 2.2
		# health managers trained on proposal writings	
		# Jamoat heads trained on proposal writings	
		# of developed and submitted proposals on the renovation of health facilities	
		# of mobile teams established	
		# of trained mobile team members	
		# of mobiles and outreach health workers received refresh trainings	
		# of small equipment procured and distributed	
		# of refrigerators procured	
		# of cold bags procured	
		# of thermometers procured	
		# of generators procured	
		# of Ice packs	
		# of vehicles procured	
		% of financing out of total funds for patronage services	
		% of financing out of total funds for mobile teams	
Objective 3:	3.1 # of medical staff trained in	# of WG established	Due to change of focus of the

Objective	Indicators from the Proposal	New Indicator	Comment
Strengthen the capacity of PHC and PH staff based on the updated and harmonized guidelines that integrate IMCI, VPD and AEFI surveillance etc	integrated and standardized programs related to VPD, AEFI, IMCI, MCH at the PHC level (Including trainers, doctors, nurses) 3.2. % of reported VPD that received timely investigation	# of guidelines developed # of round tables conducted to discuss issues related to the PHSC quality # of ToT on EPI # of workshop for the relevant specialists to organization of the active surveillance and AEFI # of trainings on the issues of the active surveillance and AEFI # of trainings of vaccinators on safe immunization practices # of trainings on "Immunization in practice" # of ToT on joint supportive monitoring # of trainings on data collection and use planning and monitoring.	program (immunization focus only) no integrated trainings were provided. New indicators provide information separately on # trainings on VPD, AEFI. New indicators do not provide information on indicators 3.2.
Objective 4: Increase demand for timely immunization through increased awareness and development of a system of incentives for mothers	4.1 # of women benefiting from the conditional cash transfer program	# of mothers motivated from program # of developed and printed materials # of developed TV spots # of trainings on social-mobilization	Although the formulation is different the new indicators count number of benefiting mothers as per design of the incentives model
Objective 5: Increase capacity of PHC facilities in collection and reporting of data in a timely manner to base decisions on them and to use them for planning	5.1 # of PHC facilities submitting simplified reporting forms on time specified by the MOH HRIR Department	# of office equipment procured and distributed # of trainings conducted on data recording and reporting # of printed forms # of refresher courses for on immunization recording and reporting conducted	Due to change of focus of the objective (only immunization information system focus), the old indicator was not included in the framework The new indicators do not measure objective results (e.g. quality of reported data)