



Health System Strengthening (HSS) Cash Support

Application Package –ProposalForm

This proposal form is for use by applicants seeking to request Health Systems Strengthening (HSS) cash support from the GAVI Alliance. Countries are encouraged to participate in an iterative process with GAVI Alliance partners, including civil society organisations, in the development of HSS proposals prior to submission of this application for funding.

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A completed application comprises the following documents. Countries may wish to attach additional national documents as necessary (see list at the end of this form).

HSS Proposal Forms and Mandatory GAVI attachments → Please place an 'X' in the box when the attachment is included		
No.	Attachment	X
1.	HSS Proposal Form	X
2.	Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members	X
3.	HSS Monitoring & Evaluation Framework	X
4.	Detailed work plan and detailed budget	X

Existing National Documents - Mandatory Attachments Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents. → Please place an 'X' in the box when the attachment is included		
No.	Attachment	X
5.	National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions	X
6.	National M&E Plan (for the health sector/strategy)	X
7.	National Immunisation Plan	X
8.	Country cMYP	X
9.	Vaccine assessments (EVM, PIE, EPI reviews), if available	X
10.	Terms of Reference of Health Sector Coordinating Committee (HSCC)	X

All applicants are encouraged to read and follow the accompanying guidelines in order to correctly fill out this form. Each corresponding section within the Guidelines provides more detailed instructions and illustrative instructions on how to fill out the proposal form.

GAVI's Approach to Health System Strengthening

The following bullets outline GAVI's approach to health system strengthening and should be reflected in an HSS grant:

- One of GAVI's strategic goals is to *"contribute to strengthening the capacity of integrated health systems to deliver immunisation"*. The objective of GAVI HSS support is to address system bottlenecks to achieve better immunisation outcomes, including coverage and equity. As such, it is necessary for the application to be based on a strong bottleneck and gap analysis, and present a clear results chain demonstrating the link between proposed activities and improved immunisation outcomes.
- GAVI's approach intends to deliver and document results. The performance of the HSS grant will be measured through intermediate results as well as immunisation outcomes such as diphtheria-tetanus-pertussis (DTP3) coverage, measles coverage, and percent of districts reporting at least 80% coverage. Therefore the application must include a strong Monitoring & Evaluation (M&E) framework aligned with the national M&E plan or national M&E processes.
- Performance based funding is a core approach of GAVI HSS support. All applications must align with the new GAVI performance based funding (PBF) approach introduced in 2012. Countries' performance will be measured based on a predefined set of PBF indicators against which additional payments will be made to reward good performance in improving immunisation outcomes.
- GAVI supports the principles of alignment and harmonization (in keeping with Paris, Accra and Busan declarations and the International Health Partnership, IHP+). The application must demonstrate how GAVI support is aligned with country health plans and processes,

complementary to other donor funding, and uses existing country systems, such as for financial management and M&E. The IHP+ Common Monitoring and Evaluation Framework is used as a reference framework in these guidelines.

- GAVI supports the use of Joint Assessment of National Strategies (JANS). A JANS assessment is not a requirement for a GAVI HSS application. If a country has conducted a JANS assessment the findings can be included in the HSS application. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.
- GAVI encourages a consultative and participatory approach for developing this HSS proposal, particularly across relevant departments in the Ministry of Health (including Planning, EPI, HMIS, M&E), across development partners, and civil society. While the HSCC (or equivalent) is required to sign off on this application, the ICC (or equivalent) also needs to be consulted and involved in the proposal development process.
- GAVI encourages countries to request funding for technical support in their HSS application for grant implementation, monitoring and capacity building.
- GAVI encourages countries to identify and build linkages between HSS support and new vaccine introduction support (as GAVI New Vaccines Support). These linkages must be demonstrated in the application. Countries will need to demonstrate systems readiness¹ for new vaccine introductions in the context of routine immunisation services. GAVI HSS support will be for strengthening these routine immunisation services.
- GAVI's approach to HSS includes support for strengthening information systems and improving data quality. Strong information systems are of fundamental importance both to countries and to GAVI. Countries are strongly encouraged to include in their proposals actions to strengthen data systems, including surveys and the institutionalization of routine mechanisms to track data quality improvements over time.
- GAVI supports innovation. Countries are encouraged to be innovative in their identification of activities which will have a catalytic effect on addressing HSS bottlenecks to improving immunisation outcomes.
- GAVI encourages applicants to include funding for Civil Society Organisations (CSOs) in implementation of HSS support to improve immunisation outcomes. CSOs can receive GAVI funding through two channels: (i) funding from GAVI to MOH and then transferred to CSO, or (ii) direct from GAVI to CSO. Please refer to Annex 4 of the guidelines for further details.
- Applications must include details on lessons learned from previous HSS grants from GAVI or support from other sources.
- Applications must include information on how sustainability and equity (including geographic, socio-economic, and gender equity) will be addressed.
- Applications will need to show the additionality of GAVI support to reducing bottlenecks and strengthening the health system, relative to support from other partners and funding sources.
- Cash disbursed for HSS support must be used solely to fund HSS activities. These funds may not be used to purchase vaccines or meet GAVI's requirements to co-finance vaccine purchases, and shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies.

¹ For a definition of 'systems readiness' see: http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/

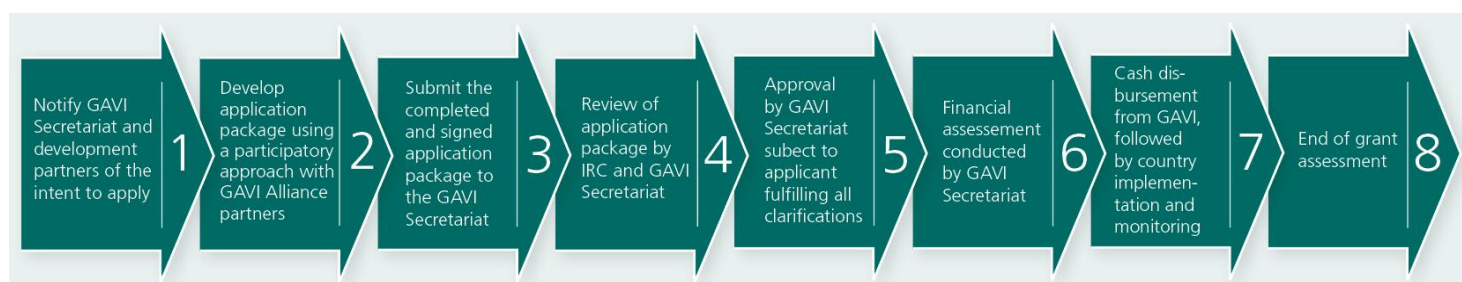
Application and Implementation Process

This application form has key instructions, but for more detailed information please see the attached guidelines for completing a GAVI HSS proposal. The application process for GAVI HSS proposals is similar to the process of applying for new and underused vaccines. The process of taking a decision to apply for GAVI funding and work with GAVI Alliance partners to develop a proposal (Steps 1 and 2 in Figure 1 below) will require adequate time; as much as possible, it should be planned to link with existing country planning processes.

Countries are encouraged to participate in an iterative process with GAVI Alliance partners, CSOs and development partners in the development of HSS proposals prior to submission of this application for funding. Steps 1-7 indicate the standard steps for GAVI HSS application process. Countries should allow 9-12 months for these steps. Steps 1-3 are expected to take 3-4 months, while steps 4-7 typically take 6-9 months.

Please note that if approved your application for HSS support will be made available on the GAVI website and may be shared at workshops and training sessions. Applications may also be shared with GAVI Alliance partners and GAVI's civil society constituency for post-submission assessment, review and evaluation.

Figure 1: Application and Implementation Process



PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION	
For further instructions, please refer to the Guidelines for Completing the HSS Application	
Applicant:	Ministry of Health
Country:	KYRGYZ REPUBLIC
Proposal title:	GAVI Health Systems Strengthening (HSS) cash support
Proposed start date:	01/2014
Duration of support requested:	5 years
Total funding requested from GAVI:	4,596,656 USD
Contact Details	
Name	Ms. Saginbaeva D.Z.
Organisation and title	Ministry of Health, Minister
Mailing address	148, Moskovskaya str., Bishkek, 720040
Telephone	996 312 62 18 65
Fax	996 312 66 07 17
E-mail addresses	mz@med.ks

Signatures: Government endorsement	
Please note that this application will not be reviewed or approved by GAVI without the signatures of both the Ministers of Health & Finance and their delegated authority.	
ALL SIGNATURES ATTACHED IN ANNEX	
Minister of Health	Minister of Finance
Name: Ms. Saginhaeva D.Z.	Name: Ms. Lavrova O.V.
Signature:	Signature:
Date: 23.09.2013	Date: 1.10.2013

HSCC SIGNATURE PAGE
For submission with GAVI HSS application

ALL SIGNATURES ATTACHED IN ANNEX

Health Sector Coordination Committee

Country **Kyrgyz Republic** Date of HSS application **16.09.2013**

We the members of the HSCC, or equivalent committee [1] met on 16.09.2013 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

[1] Health Sector Coordination Committee or equivalent committee which has the authority to endorse this application in the country in question.

Name of the HSCC in country **Health Policy Council**

Health Sector Coordination Committee			
Name/Title	Agency/Organisation	Signature	Date
Ms. Suyumbaeva P. U. – State Secretary	Ministry of Health		
Mr. Kaliev M.T. – Deputy Minister	Ministry of Health		
Mr. Choibekov K.N. – Deputy Minister	Ministry of Health		
Ms. Abdrahmanova C.A. – Head of Department of Coordination and Reform Implementation	Ministry of Health		
Ms. Eshhodjaeva A.S. – Head of Department of Medical Care and Medicinal Policy	Ministry of Health		
Ms. Nazarova Z.D. – Head of Financial Policy Department	Ministry of Health		
Mr. Ismailov M.A. – Head of Department Personal Work and Medical Education	Ministry of Health		
Mr. Sydykanov A.S. – Chief of Public Health Unit	Ministry of Health		
Mr. Djemuratov K.A. – Chairman	Hospital Association		
Ms. Mukeyeva S.T. – Director	FGP Association		

Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes No X

Individual members of the HSCC may wish to send informal comments to: gavihss@gavialliance.org
All comments will be treated confidentially.

PART B – EXECUTIVE SUMMARY

For further instructions, please refer to the Guidelines for Completing the HSS Application

→ Please provide an executive summary of the proposal, of no more than 2 pages, with reference to the items listed below:

1. *The main bottlenecks for achieving immunisation outcomes addressed within this proposal and how proposed objectives in this application will address these bottlenecks and improve immunisation outcomes.*
2. *Objectives and the related budget for each objective.*
3. *The proposed implementation arrangements including the role of government departments and civil society organisations. Please include a summary of financial management, procurement and M&E arrangements.*

TWO PAGES MAXIMUM

The overall goal of the current Proposal is to reduce child mortality. The specific objective is to ensure that not less than 95% of children under 2 years of age receive vaccinations that are part of the country's national routine immunization schedule.

Several bottlenecks were identified that impede the achievement of the above objective:

- Bottleneck 1: Low awareness, beliefs and attitudes among the population
- Bottleneck 2: Lack of communication skills and practice among health workers
- Bottleneck 3: Geographical access to MCH services in remote mountainous areas
- Bottleneck 4: Low availability of health services in urban migrant settlements
- Bottleneck 5: Out-of-date knowledge, skills and practices among health workers
- Bottleneck 6: Deficiencies in cold chain infrastructure
- Bottleneck 7: Manual data collection

Based on the analysis of these bottlenecks, the following objectives have been identified:

- Objective 1 (1,012,928 USD): Increase knowledge, trust and demand for MCH services among the population. This objective will tackle the problem with increasing refusals to vaccinations due to lack of knowledge, misconceptions and anti-vaccination propaganda (Bottlenecks 1 & 2).
- Objective 2 (406,125USD): Strengthen primary health care facilities to increase access to basic MCH services and immunization for urban migrants and hard-to-reach rural areas. This objective will tackle the problem with pockets in the country with lower access to PHC and immunization services (Bottlenecks 3 & 4).
- Objective 3 (674,361 USD): Increase capacity of PHC workers to provide quality child immunization services. This objective aims to improve the quality of immunization services through updated guidelines and training (Bottleneck 5). It will emphasize detection, diagnosis and treatment of adverse effects following immunization (AEFI).
- Objective 4(1,806,022 USD): Strengthen physical capacity of cold chain. This objective tackles deficiencies in the cold chain as described in Section 5 (Bottleneck 6).
- Objective 5 (587,106 USD): Strengthen the data collection system to ensure timeliness and accuracy of information on immunization services. Existing paper-based system contributes to low quality of immunization services as described in Section 5 (Bottleneck 7).

The total budget of the Proposal is 4,596,655 USD, of which 110,113 USD are allocated for administration of the Grant.

The above five objectives will strengthen the overall health system in Kyrgyzstan by strengthening primary health care facilities, increasing skills and capacity of PHC workers, and improving the data collection system.

GAVI HSS activities will be implemented by the existing governmental structures in the MOH, MHIF, SSEDPD (State Sanitary Epidemiological Diseases Prevention Department), and RCI (Republican Centre for Immunoprophylaxis), as indicated in the Plan of Work, to ensure full harmonization with implementation arrangements of National Health Reform Program (Den Sooluk). It is proposed to maintain the post of Technical Coordinator from the previous HSS support, who will work closely with all structures implementing the activities of the GAVI HSS Program. Civil society organizations, like district health committees and village health committees, will take part to the field implementation of the HSS activities.

GAVI HSS funds will be accumulated in a special account of the Ministry of Health, which is open at the Office of the Treasury. The Ministry of Health, in accordance with the action plan will be holding HSS funding. Funds will be managed according to standard budgetary procedures of the country. In line with forming and approving annual plans and budgets for Den Sooluk, the GAVI HSS Working Group will make a draft annual plan of work and budget (workplan and budget attached to the application).

Procurements under the current Proposal will be included into the Annual Procurement Plan of the Den Sooluk Health Reform Program. The Plan is prepared by the MOH and reviewed by all participating donors, including GAVI in the future, during the Fall Health Summit (September). The Procurement Unit of the MOH will be responsible for all of the procurement-related activities.

Monitoring and evaluation of the grant will be carried out by existing governmental structures in the MOH, MHIF, SSEDPD, and RCI, in accordance with the M&E Framework attached to the application. The M&E procedures will be in line with the ones used for Den Sooluk.

PART C– SITUATION ANALYSIS

For further instructions, please refer to the Guidelines for Completing the HSS Application

1. Key relevant health and health system statistics

→ Please complete the table below providing the most recent statistics for the key health, immunisation, and health system indicators listed.

→ Where possible, data on the key statistics should be presented showing wealth quintile differences, and disaggregated by sex.

→ If available disaggregated data for the key statistics indicators showing differences by geographic location (region / province) and urban / rural should be included in the space provided after the table.

*Where possible, GAVI asks for both country administrative data as well as from 'other' data sources. Please state the source of 'other' data in brackets after entering the value. 'Other' recommended data sources are DHS/MICS or recent coverage estimates from WHO/UNICEF. If the difference between these reported data are more than 5% points, the country should include an explanation as to how they plan to strengthen data quality as part of the HSS grant.

Key Statistics							
Indicator	Source	National Average	Percentage difference between highest & lowest quintiles	Sex (Please provide disaggregated data where available)			Year
				M	F	Total	
DTP3 coverage	Administrative Data	96.1					2012
	Other* (DHS 2012)	80.6					2012
Measles 1 st dose coverage	Administrative Data	98					2012
	Other* (DHS 2012)	96.5					2012
Drop-out rate between DTP1 & DTP3	Administrative Data	4.6					2012
	Other* (DHS 2012)	16.7					2012
Percent of districts with DTP3 coverage ≥80%	Administrative Data	100					2012
	Other* (state source)	n/a					
DTP3 coverage in the lowest wealth quintile is +/- X% points of the coverage in the highest wealth quintile	Administrative Data	n/a					
	Other* (state source)	n/a					
Fully immunised child coverage (%)	Administrative Data	n/a					2012
	Other* (DHS 2012)	69.6					2012

Additional Health System Statistics			
Indicator	Source	Value	Year
Under Five Mortality	Administrative Data	23.2	2012
	Other* (DHS 2012)	31	2012
Total Expenditure on Health (THE) as percentage of GDP	Administrative Data	n/a	
	Other* (WDI)	6.5	2011
Per capita expenditure on health (current US\$)	Administrative Data	n/a	
	Other* (WDI)	71.3	2011
Total health sector budget for the year of application (US\$)	Administrative Data	225,076,043	2013
	Other* (state source)	n/a	
Percent of the health sector budget funded by the government from domestic sources	Administrative Data	91.9	2012
	Other* (state source)	n/a	
Budget of EPI programme for the year of application (US\$)	Administrative Data	823 514	2013
	Other* (state source)	n/a	
Percent of subnational level facilities with cold chain capacities fit for purpose (based on WHO definition "fit for purpose")	Administrative Data	80	2012
	Other* (state source)	n/a	
Timeliness and completeness of facility and district (or equivalent) reporting	Administrative Data	87.5 (timeliness 75%, completeness 100%)	2012
	Other* (state source)	n/a	

Please use the space below to provide:

- **Explanation of any disparities between administrative statistics and 'other' statistics and details of any plans to improve data quality to address these disparities.**
- **Further disaggregation of the Key Statistics Indicators (if available). This data will be used to illustrate equity differences by geographic location and urban/rural.**

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Disparities between administrative and other data

There is no real explanation given to the disparities between Administrative and DHS 2012 data, except the fact that it is recognized that the collection of data on immunization is suffering in its quality due to several issues (manual collection, central level with access only to oblast level, children's immunization cards often lost, etc). The bottleneck 7 and the objective 5 of this application will address this issue, with plans to improve data monitoring quality.

Up to now, in order to optimize the collection and recording of data on immunization, analysis and transmission to the next level, with financial support from GAVI, the project " Strengthening health systems" in 2010 developed a computerized information system for immunization. The system provided a personalized account of vaccinated population, the creation of a common database of vaccination, automated process planning and immunization reporting. In addition, a computerized information system for immunization can keep a record of the use of vaccines and create a

database of cold chain equipment.

Currently, this information system is being tested and improvements at the regional and central levels of immunization services.

The objective 5 of this application will continue to address this issue by scaling up the software developed under GAVI HSS I and link the immunization data to the New-born Registry.

Disaggregated data

Official statistics, broken down by geographical area and urban / rural areas, as well as data by urban migrants do not currently exist in Kyrgyzstan.

However, although there are no disaggregated data, there are national strategies who exist, on how to tackle equity differences by geographic location and urban/rural, as per below:

- One of the strategic goals is the definition of the population living in remote areas, groups of "risk" and identifying the reasons for their non-vaccination. To do this, set up on the basis of the regional centres of family medicine, mobile vaccination teams are reaching people in remote regions of the country and attempts to ensure their orderly vaccination.
- Also applicable, experience of "visiting" vaccination teams to immunize school children and the public "groups" of risk (migrants, people of faith, etc.).
- Then within the framework of WHO's strategy to "cover every area", with the financial support of the GAVI HSS 1, were organized mobile teams in 20 of the most remote areas, which allowed for immunization services and other types of medical care to access more than 200 villages located in remote mountainous areas. As a result, coverage with all kinds of vaccines at the national level has increased by 2.2-2.4 %.
- Finally European Immunization Week (EIW) on a yearly basis made possible to improve vaccination coverage among internal migrants living in the new buildings, located around Bishkek and other major cities of the country, people who are not registered in medical institutions. It eventually reached 17,553 people, including children under the age of 14 (8528 people), basically 48.5 % of the subject contingent and 9025 people who live without and registration. Outbound and mobile teams of health workers were covering 625 settlements.

2. Description of the National Health Sector

This section will provide GAVI with the country context which will serve as background information during the review of the HSS proposal.

→ *Please provide a concise overview of the national health sector, covering both the public and private sectors, including CSOs, at national, sub-national and community levels, with reference to NHP or other key documents.*

→ *Please include a copy of the National Health Strategy/Plan as Attachment 5. If the NHP is in draft format please provide details of the process and timeline for finalising it. If there is not an NHP, or if other documents are referenced in this section, please provide these other key relevant documents.*

It is recommended that applicants refer to GAVI's health system strengthening grant categories detailed in the Application Guidelines (Table 1, Under 'Key Terms'). For each of the categories listed in the Guidelines (2.1-2.7) please provide a short commentary. In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, and provide reference to the relevant section in the National Health Plan for further detail.

TWO PAGES MAXIMUM

The National Health Reform Program (NHP) called Den Sooluk (attached), covering the 2012-2016 period, is the 3rd sector strategy supporting a continuous track of reform. Based on the burden of disease, four priority health improvement areas have been selected: (i) Cardio-vascular diseases (CVDs), (ii) Mother and child health (MCH), Tuberculosis (TB), and HIV infection (HIV).

Health care system strengthening dimension of the NHP focuses on the removal of those health system barriers that have undermined the delivery of core services needed to achieve health gains. Health system barriers have been identified for each of the four priority health improvement areas grouped around the main functions of health systems: (i) public health, (ii) individual health services, (iii) financing, (iv) resource generation (human resources, drugs & medical supplies, information systems) and (v) governance.

Service delivery

The health services delivery system consists of three levels of care facilities. Primary health care (PHC) facilities comprise Feldsher-Obstetrical Ambulatory Points (FAPs), family group practices (FGPs), and family medicine centres (FMCs). FAPs provide PHC services in remote rural areas. They are usually staffed by at least one paramedic health worker, called feldsher, but in larger villages, FAPs employ also a midwife and a nurse. FAPs offer the most basic services such as antenatal and postnatal care, immunizations, and health education. FGPs are the main providers of PHC services and usually consist of three to five doctors. FMCs are the largest outpatient health facilities in the country. They employ between 10 and 20 doctors providing primary and specialized outpatient services, as well as diagnostics and minor surgeries. Typically, there is one FMC per rayon (district) that is responsible for all FGPs and FAPs located in their respective catchment area.

In addition, there are 27 General Practice Centres (GPC) that provide both primary and secondary care. GPCs were formed in 2006 by merging territorial hospitals and PHC facilities in remote areas with population less than 25,000 people.

There is no data on exact proportion of services delivered by private implementers. The role of non-governmental organisations (NGO) and faith-based implementers is also very limited.

Mechanisms are in place for ensuring quality of service delivery as planned in NHP, Den Sooluk.

Health System in Transition (HiT) 2011 review (attached) may provide more data on service delivery.

Workforce and Human Resources

There are three levels of health workers: (i) physicians, (ii) midlevel health workers, including nurses, midwives, and feldshers, and (iii) lower level health workers. In addition, there are non-medically trained community health workers organized in Village Health Committees.

Lack of health care human resources in rural and remote areas of the Kyrgyz Republic continues to deteriorate. The problem is not in the absolute number of trained personnel, but in the number of professionals needed for rural areas (e.g. doctors in family medicine), lack of social and economic

conditions to attract young professionals, poor involvement of representatives of LSGs and LSAs to address staffing issues in the field. To date, two main conditions determine the selection of workplace by professionals – these are the availability of housing (social benefits, the degree of development of social infrastructure) and the wage.

Therefore, the actions of the Ministry of Health for human resources policy should be aimed at addressing the following barriers: irrational distribution of medical staff resulting in a critical situation with medical specialists in the country, especially in remote and inaccessible areas; there is incompliance of the system for professional training with the needs of practical health care and modern international standards.

Procurement and Supply Chain Management System

Limitations in storage and distribution facilities, particularly for vaccine products, are not described in the NHP. Information provided here in the HSS application are described in the EVM assessment 2011, and in the cMYP 2012-2016.

The overall level of compliance with the cold storage and transport capacity is low at oblasts and health facilities, and very low at central store. Vaccine refrigeration and dry storage capacities were insufficient with current immunization calendar at three oblasts and 10/16 health facilities assessed. Several of surveyed health facilities were equipped with domestic refrigerators. Although they are cheap and relatively well serviced, their weak insulations and uneven inner temperature distributions may put vaccines in risk. Weaknesses in the distribution system include incorrect transportation from oblasts to rayons and health facilities. They pick up their monthly supplies from oblast stores using locally arranged vehicles.

There is no computerized stock management system. All vaccine arrivals and vaccine dispatches are recorded manually to a stock book. A sample of these stock records at central level shows that stock balances are not kept up-to-date.

Kyrgyzstan seems to have both push system at higher levels and pull systems at lower levels of the supply chain. Vaccines are supplied to the national program twice a year through UNICEF Procurement Services. Domestic vaccine supply chain has four levels. National store distributes vaccine and immunization supplies four times a year to all oblasts and cities (push system). Once every month, rayon stores using their own vehicles travel to oblast stores to pick up needs (pull system most probably). Health centres, using the same requisition system, collect vaccines from the rayon cold stores (pull system) using public transportation.

Health Information Systems

Overall measures to improve HMIS are provided in the NHP, but not at a high level of details.

Health facilities submit data on a monthly basis to district SES, who aggregate these and submit to regional (oblast) SES. Oblast SESs are responsible for aggregating and checking the data submitted by districts and sending their reports to the RCI. At health facility and district SES level, the data system is entirely paper-based, with the exception of a few districts that have computers. These districts may use computers but there is no specific software, so they submit their data in World or Excel tables. At the oblast level, data are entered in computers using Excel and in some cases Word. Oblast SES submits their reports on paper to RCI with the exception of a few oblasts that use internet to send their reports. Thus, the system is not computerized and there is no single software that allows for data recording, collection and sharing.

Special software for the immunization status registry and vaccine supplies management was developed under GAVI HSS I and was piloted in selected facilities with support of USAID/Maternal and Child Health Integrated Program. Based on the results of the pilot and the review of the Technical Working Group, improvements are being introduced into the software. A larger pilot encompassing entire Chui oblast is planned for 2014, following which scale-up to the entire country is planned.

The main data quality mechanism at health facility level is annual checks conducted by district SES during their supervisory visits. They check Forms N°5 and N°6, Journal of Monthly Planning, Journal of Vaccine Supplies etc. Data quality checks must be conducted at least once a year, but where financing allows it, they take place more often. Data quality checks at district level are done by oblast SES, while RCI is responsible for conducting annual checks of data provided by oblast SES.

A MICS or DHS survey, including vaccination coverage module is conducted every 5 years. The most recent DHS survey has been conducted in 2012. A preliminary draft report provides vaccination coverage

estimates (available on <http://www.measuredhs.com/pubs/pdf/PR27/PR27.pdf>).

Community and Other Local Actors

Village Health Committees (VHCs) serve as the basis for the Community Action for Health (CAH) model. VHCs are independent community-based organizations whose members work as volunteers. Their members are trained by primary care staff to implement health related activities, prioritized by their communities. With support of health promotion units they implement different health strategies collectively called "Health Actions". These health actions are implemented with support from various international partners or local governments in coordination with FGPs/FAPs. As the name implies, VHCs are limited to rural areas.

The National health reform program includes development and implementation of a mechanism to involve the urban population in the programs of health promotion and disease prevention (program "Healthy Cities", etc.).

Legal, Policy and Regulatory Environments

Stakeholder engagement for planning, budgeting and implementation of activities for HSS and immunization service delivery is to be outlined. It is mainly represented through a) the Council on Health Policy (CHP), through b) the Partnership between the Kyrgyz Government and Development Partners for the National Program on Health Care Reform 2012-2016, c) the Interagency Coordinating Committee on Immunization (ICC). Resolutions and terms of reference of those three bodies are attached.

Key laws or policies that guarantee rights to healthcare and immunization are the following: Law "On Health Protection of the Citizens of the Kyrgyz Republic", 1992 with following amendments; Law "On Health Insurance of Citizens of the Kyrgyz Republic", 1999 with following amendments; Law "On Immunoprophylaxis of Infectious Diseases", 2001 with following amendments; and the annual laws on the State Guaranteed Benefits Package.

The key mechanism to encourage voice and participation of the community in planning and monitoring of services is provided through CAH as described in previous section.

Health and Community Systems Financing

Health system of the Kyrgyz Republic has three main sources of financing: (i) public, (ii) private and (iii) external financing. Public financing includes both republican and local budgets and payroll contribution to the MHIF. Private funds include household out-of-pocket payments directly at the facility. External financing represents funds provided by international donors through parallel financing or budget support.

From the republican budget, funds flow to the Ministry of Health, the MHIF and other ministries and agencies. The Ministry of Health finances tertiary care facilities and the SSES services and institutions.

The MHIF accumulates funds at the republican level, including revenues from the mandatory health insurance system and the Social Fund, and distributes them to the regions to finance provision of the SGBP in health facilities at the primary and secondary level.

The other ministries and agencies finance health facilities of their respective parallel health system, such as the military hospital of the Ministry of Defence.

The major performance based programme that provides incentives to health care providers to deliver primary healthcare services, including immunization, is the Results-Based Financing Project currently under the first pilot stage that includes only hospitals.

3. National Health Strategy and Joint Assessment of National Health Strategy (JANS)

This section will be used to determine how immunisation is addressed in the national health plan, and what the key findings of an independent JANS assessment of the strategy were. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.

→ *Please provide a reference to the relevant sections and pages in the NHP which outline immunisation policies, objectives, and activities.*

→ *If a Joint Assessment of the National Health Strategy (JANS) has been conducted, please provide the JANS report as an attachment.*

→ *Please provide a summary of how the government and partners have addressed the weaknesses and recommendations identified in the JANS or attach the country's response.*

ONE PAGE MAXIMUM

The current National Program "Immunoprophylaxis" for 2013- 2017 was approved by the Resolution of the KR Government and is synchronized with the National Health Care Reform Program of the Kyrgyz Republic "Den Sooluk" for 2012-2016. Immunization issues are reflected in two components of the program "Mother and Child Health Protection" (MCH) and "Public Health".

NHP refers to immunization coverage as one of the key objectives for child health sub-program, under MCH program (table 5 pg.23 of the NHP). The specific objective is to ensure that 95% of children under 2 years of age receive vaccinations that are part of a country's national routine immunization schedule.

Under the "Core population services" (pg.23), it includes community-based activities and social mobilization to improve public awareness and support for immunization. NGOs and Village Health Committees are to play a key role. Social mobilization activities constitute the majority of MCH component related to immunization, but due to the budget deficit, the source of funding for these activities has not been identified yet.

Under the "Core individual services" (pg.23-24), among the measures listed to improve the quality of services in health care organizations is delivery of a standard package of recommended preventive services to all children. This includes timely vaccination according to the National immunization calendar. The majority of measures aimed at improving public access to immunization services are envisaged in the Plan of implementation of the cMYP, as one of the strategic areas of "Immunoprophylaxis" Program is "To improve access to immunization services for the population and maintaining high level of immunization coverage". But the deficit in cMYP budget makes full implementation of these activities impossible.

Barriers listed in table 6 (pg.24-25) include barriers to immunization, such as low awareness and responsibility of population regarding maternal and child health and imbalance of specialists in the regions and cities.

Section on Overcoming systemic barriers, specifically on health promotion services (pg.35), includes activities that aim at improving child health, including immunization. Section on Strengthening the management system and improving the quality of medical services (pg.39-40) includes activities such as (i) introduction of incentive mechanisms for stimulation of motivation of health care organizations and health professionals to provide quality services; and (ii) introduction of the system for continuous quality improvement, specifically introduction of clinical protocols and guidelines based on evidence-based medicine. These are activities will also improve quality of immunization services. Activities aimed at reducing shortage of rural health workers and improving pre- and in-service education as described in the section on human resources (pg.45-46) will also contribute to immunization services.

A detailed table of how the government and partners have addressed the weaknesses and recommendations identified in the JANS are provided in annex 1 pg.48-62 of the JANS (attached).

4. Monitoring and Evaluation Plan for the National Health Plan

This section will provide background information on how the country organises M&E arrangements and whether this proposal is aligned and complementary to national M&E plans.

→ *Please attach a copy of the M&E Plan for the national health plan.*

→ *Please provide a summary of how the National M&E Plan is implemented in practice. In your answer refer to relevant sections of the M&E Plan in the national health plan for further details.*

→ *Please provide a description of how development partners are involved in the M&E of the national health plan implementation and financing. Is there a Joint Annual Health Sector Review (JAR) and if so how and when are they are conducted? Please outline the extent of GAVI involvement in the JAR process.*

→ *Is the immunisation programme review linked to the Joint Annual Review (JAR)? Please state Yes/No.*

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As part of the SWAp, great efforts have been made to reduce the number of overlapping monitoring mechanisms. As a result, a Package of indicators for monitoring of the Den Sooluk NHP was developed and approved by the MOH and development partners (attached).

The M&E strategy is based on four pillars which jointly will provide a full picture of implementation progress in Den Sooluk: (i) an M&E indicator package based on routine and annually monitored data collected mainly through existing HMIS; (ii) regular coverage studies assessing progress with expanding core services; (iii) health system studies ordered by the MOH/MHIF/SES looking into progress and obstacles in removing key health system barriers; and (iv) large scale household and patient surveys. The indicator package will include oblast level indicators.

Ministry of Health Department of Health Reform Coordination and Implementation prepares and presents M&E indicator Package to discuss outcomes and develop recommendations during Annual Joint Reviews (JARs) and Health Summits biannually and at meetings of the Public Steering Committee. In addition, it makes a health policy research plan based on requests from Departments of the MoH and MHIF with further approval by the Health Policy Council of the MoH. At the oblast level, responsibility lays with the Coordination committees on health system management that include Deputy Governor on social affairs, oblast coordinator and heads of oblast health organizations. Discussion of results and development of recommendations will also involve providers at both oblast and rayon levels.

M&E strategy envisions close cooperation between Kyrgyz Government and development partners (WHO, DfID, UNICEF, KFW, USUD, WB, etc.). JARs and Health Summits provide the main mechanisms for their contribution. Also, development partners provide financing and technical assistance for key studies under pillars ii-iv described above. GAVI has been involved in JAR on two occasions in the past, one of which was during JANS.

The immunization programme review is linked to the JAR as part of the review of public health services and MCH.

5. Health System Bottlenecks to Achieving Immunisation Outcomes

This section will be used to understand the main bottlenecks affecting the health system performance. The analysis here underpins the application, ensuring the proposed activities are designed to address the bottlenecks.

→ *Please describe key health and immunisation system bottlenecks at national, sub-national and community levels preventing your country from improving immunisation outcomes. Consider bottlenecks to providing services to specific population groups, such as the under reached, marginalized or otherwise disadvantaged populations. The country is also asked to consider gender related barriers to accessing quality services.*

In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, providing a reference to the relevant section in the National Health Plan for further detail.

→ *Please refer to bottlenecks which impact on gender and equity-related access to immunisation.*

→ *Please reference the analytical work that led to identification of the bottlenecks.*

→ *Describe the bottlenecks identified in any new vaccine proposals submitted to GAVI, the National Health Plan, and any recent health sector assessments such as the Effective Vaccine Management (EVM) assessment or Post Introduction Evaluation (PIE).*

→ *Which of the above specified bottlenecks will be addressed by the current proposal? Which bottlenecks are addressed by other national or externally supported programmes?*

In order to keep this section concise, please summarise the key bottlenecks and provide references to the relevant sections in existing bottleneck analyses. Please ensure the referenced analyses are provided as attachments.

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Bottleneck 1: Low awareness, beliefs and attitudes among the population

This is one of the key barriers to improved MCH that is identified in the NHP (pg.25). It is also supported by existing MOH data and analytical work. According to a study on social and medical reasons for mortality among children less than 2 years of age by Ibraimov et al (2009), delayed care seeking was one of the key reasons for complications and deaths. Often caretakers fail to recognize danger signs and seek care before a child is in a critical condition. Also, according to Ibraimov et al (2009), 11.5% of caretakers in the study initially sought care from mullahs and traditional healers.

According to MOH department on MCH services, in 2012, 12.3% of women who died during delivery did not receive any ANC services. Given ANC services are widely available and are exempt from co-payments, it appears that lack of awareness of importance of ANC services was at least one of the reasons for women not registering and receiving ANC. Moreover, pregnant women also often fail to recognize danger signs in pregnancy and delay seeking care leading to negative outcomes.

A recent UNICEF supported study (M-Vector, 2013, pg.2-11), also shows that religious beliefs about harmfulness of immunization may influence caretakers' decisions not to immunize their children.

Bottleneck 2: Lack of communication skills and practice among health workers

According to a recent household survey (N=6,766 children under 5 years of age) on vaccination coverage supported by WHO (M-Vector, 2010), health workers are still the main source of information on vaccination. Moreover, according to a recent WHO review of side effects following the introduction of PENTA (Benes & Miheeva, June 2012, pg.13), increased refusals and negative attitudes towards vaccines was due partly to the fact that health workers did not effectively communicate with parents failing to provide them with sufficient information about benefits of PENTA vaccine, expected or normal reaction to it among certain children, and procedures to follow if there are any side effects. Health workers were also not fully prepared to communicate with religious leaders about importance of maternal and child health services, including immunization.

Bottleneck 3: Geographical access to MCH services in remote mountainous areas

According to facility data, although the average figures for the country and the oblast show a very high coverage around 95%, with very little variation, there are some districts with coverage well

below the national average. Thus, according to Republican Centre for Immunization (RCI) 2011 data, Sokuluk district in Chui oblast has only 77.5% coverage with mumps vaccine. In Uzgen district of Osh oblast coverage against measles and rubella is 86.3% and with mumps 70.5%. In Kizil-Kiya the Penta vaccine coverage is 92%, in Leilek district of Batken Penta vaccine coverage is 89.9% and against measles and rubella 84.6%. BCG vaccination coverage in Kara-Bura district of Talass oblast is 84.5%. Polio vaccine coverage in Manass district of Talass oblast is only 86% and in Karasui district of Osh oblast only 76.3%, considering that in 2011 there was a national campaign for polio immunization. However, facility-based data has its well-known weaknesses, particularly in Kyrgyzstan and thus, there are likely to be more areas with lower coverage.

Geographic access due to terrain and seasonal factors was also identified as one of the barriers in the previous GAVI HSS application submitted by Kyrgyzstan. The challenge of delivering services to hard-to-reach areas is noted in cMYP 2012-2016 that suggests the use of mobile teams (pg.9).

Bottleneck 4: Low availability of health services in urban migrant settlements

Apart from hard-to-reach areas, urban migrant population has been identified as a vulnerable group with expected lower than average vaccination coverage as a result of low access to basic health services (Akunov et al.). Large-scale migration in Kyrgyzstan began in the 1990s and was, first of all, a response to social insecurity, unemployment and high poverty rates in rural areas. Data from National Statistics Committee shows that in 2001 there were 1.1 million internal migrants that had moved from rural areas to the cities (Akunov et al). Bishkek attracts the biggest number of internal migrants. The number of internal migrants currently living in Bishkek is not known, but given the 2010 violent conflict in the South causing hundreds of families to leave the area and continued economic decline in rural areas, it is expected that there has been an increase in the number of migrants in Bishkek since 2001.

The study by Akunov et al. is the only study so far that has been conducted on the health status of urban migrants. According to it, there is a complex array of reasons, including poor infrastructure, poverty, lack of appropriate personal documents, and unawareness of their basic rights to health care.

Under the existing legislation, enrolment of the population to FGP is free but patients must have local residence registration ("propiska"). Under the State Guaranteed Benefits Package (SGBP), FGP provides basic health services irrespective of their local residence registration. Thus, FGP serving a suburban settlement has to serve internal migrants (including pregnant women and children) who are not enrolled on the basis of residence certificates issued by local neighbourhood officers ("kvartalnie"). This category of population is registered in a separate book and is not entered into the enrolment database. At the same time, financing of FGP is provided only for the enrolled population. It means that FGP doctors render services to un-enrolled migrants at the expense of the enrolled urban population (consultations, tests, drugs), and receive no remuneration for extra workload.

Continued decrease in the share of consultations delivered at patient's home and substantial decrease in the share of visits to FGP in the period of 2006 – 2009 may suggest on-going crisis related to human resources and limited PHC resources which make home visits not possible. This is especially problematic for health care facilities located in catchment areas populated with internal migrants where workload per doctor is extremely high and newly arrived migrants do not know where to seek care, as well as for facilities that serve remote villages.

The Government with support of Soros Foundation is intensifying its efforts in implementing electronic database of enrolment which should partly address the issue of access for internal migrants by eliminating the need for "propiska" or "spravka" from "kvartalnie" in order to enrol. Once facilities can enrol internal migrants without these documents easier, they can get per capita financing for them and will have an incentive to treat them. However, these measures require substantial time to be implemented.

Bottleneck 5: Out-of-date knowledge, skills and practices among health workers

According to a recent WHO review of side effects following the introduction of Penta (Benes & Miheeva, June 2012), health workers providing vaccination did not follow the basic rules that would

ensure safety of vaccines and minimize adverse effects following immunization. The report notes cases where health workers advised caretakers of children with AEFIs to follow wrong treatment that goes against current international practices and recommendations (Benes & Miheeva, June 2012, pg.13). "Incompetence of health workers" was listed as one of the reasons for refusals in a recent UNICEF supported study on attitudes towards immunization of children among parents (M-Vector, 2013, pg.2).

The existing system of surveillance, diagnosis and treatment of adverse events following immunization does not correspond to WHO recommendations on minimizing AEFIs, the use of opened multi-dose vials, classification of different types of cases, and investigation procedures (Benes & Miheeva, June 2012).

During the previous GAVI HSS, 410 immunologists, feldshers and nurses were trained in "Immunization in practice", but even the 65% coverage of staff of all vaccination points requires the training of additional 840 health workers.

Checklists for supervisory visits and training of supervisors were conducted as part of GAVI HSS I but there is a need for support of operational costs. Currently, they are not conducted with adequate frequency, often meeting a bare minimum requirement, which is once a year.

Bottleneck 6: Deficiencies in cold chain infrastructure

As it is described in detail in Kyrgyzstan EVM assessment (October 2011) there are important deficiencies in cold chain infrastructure that weaken quality of immunization services and at times lead to avoidable post-vaccine side effects.

During the previous HSS project, the cold chain was strengthened with additional refrigerators, refrigerator trucks and construction/repair of cold store rooms. With additional support of JICA, the strengthening of the cold chain in the Southern part of Kyrgyzstan is now being completed.

The cMYP 2012-2016 refers to the increase of storage when introducing new vaccines, a threefold increase when new vaccines – rotaviral, pneumococcal and pentavalent – are included in the inoculations calendar. Accordingly, the capacity of the refrigerating equipment should be increased as well. It is also necessary to use specialized motor transport available in district/urban public healthcare organizations for vaccine transportation more rationally as well as acquire additional off-the-road vehicles for transporting vaccines to remote mountainous areas of the country.

In 2012, the National immunization program conducted inventory of cold chain equipment at the level of the National vaccine warehouse, in the Oblast/regional vaccine warehouses, as well as health care facilities, giving vaccinations. The Inventory has provided data on the number and capacity of refrigeration equipment by each facility, including the information on duration of its lifetime. Based on the inventory data, the KR Ministry of Health has developed Plan of Procurements of additional refrigeration equipment for vaccine storage. Additional equipment should enable the country to provide proper storage conditions for the vaccines, currently used in immunization program, to introduce pneumococcal and rotavirus vaccines in 2015-2016, as well as to replace equipment that has been in operation for a long period of time. Given introduction of 2 new vaccines, the useful capacity of vaccines storage will increase from 111.8 cm³ to up to 213.4 cm³ (1.9 times) per fully immunized child (FIC).

In this connection the KR Ministry of Health plans to finance procurements partially against the MOH budget (replacement of outdated refrigeration equipment) under the MCH and Public Health Components, and partially against the GAVI grant on PCV introduction, as well as GAVI support in strengthening health care systems (HSS -2). It will result in allocation of the largest portion of the GAVI HSS -2 budget (40%) for strengthening of cold chain capacity of the country.

Bottleneck 7: Manual data collection

Currently, the data on immunization, including vaccine supplies, is collected manually and the system is almost entirely paper-based (see Section 2, subsection on HIS, of the Proposal). It takes two to three weeks from the day facilities collect and send their data to district level to the day the central level receives and compiles it. At the central level there is a direct access only to the oblast

level data. This impacts the quality of data received at the central level and decisions that are based on such data. Moreover, it limits the RCI's capacity to make timely informed decisions. In addition, under the current system children's immunization cards are often lost (especially with high rate of internal migration), making it difficult to ascertain child's immunization status.

Under the previous GAVI HSS, software for the immunization status registry and vaccine supplies management was developed and piloted with additional support of USAID. However, several issues were discovered during the pilot and further improvements of the software are being made. However, there is no funding for the planned scale-up, specifically the purchase of computers and training.

6. Lessons Learned and Past Experience

This description will highlight to GAVI how lesson-learning has been incorporated into the design of the activities. It will provide the evidence base that demonstrates that the proposed activities will be effective, and that implementing them will achieve the desired intermediate results and immunisation outcomes.

→ Please use the table in the proposal form to summarise the evidence base and/or lessons learned related to each of the objectives in the proposal. Applicants are asked to provide examples specific to their country of relevant interventions that were successful.

→ In addition please provide examples illustrating the challenges to successful implementation. If no evidence base exists within the country of question, please note 'not applicable'.

**Where possible, please provide evidence of this learning by providing a reference or a web-link to a published document related to each example.*

TWO PAGES MAXIMUM

Experience of GAVI HSS -1 implementation indicates the need to improve efficiency of HSS activities and strengthen inter-sectoral cooperation in close alignment (coordination) with the National health care reforms program "Den Sooluk".

Objective	Example(s) of lessons learned, highlighting both successes and challenges
Objective 1: Increase knowledge, trust and demand for MCH services among the population	Health workers are the main source of information to the population concerning vaccination. Increased refusals and negative attitudes towards vaccines are due partly to the fact that health workers do not effectively communicate with parents, failing to provide them with sufficient information about benefits of vaccines. Health workers are also not fully prepared to communicate with religious leaders about importance of maternal and child health services, including immunization. A lesson learnt from the previous National Health Strategy is the need to change population attitudes and practices to health and health services in order to improve the efficiency of key health interventions.
Objective 2: Strengthen primary health care facilities to increase access to basic MCH services and immunization for urban migrants and hard-to-reach rural areas	Despite the fact that the overall immunization coverage is high, there are some groups where coverage is not sufficient. This applies especially to repeated vaccination, like DTP3, for children in rural areas and from poor families, and among migrant workers in cities. Low level of awareness of the population (vulnerable groups, domestic workers, etc.) about their rights under the "State guarantee program to ensure the citizens of the Kyrgyz Republic of health care in primary care", including immunization, limits their ability to receive services in an appropriate way. All this can have a negative impact on immunization coverage. Research is needed among urban workers, to better understand the reasons for the lack of coverage and lack of use of health services. The study should be based on the existing qualitative study with the assessment of the public perception of the problems of health and access to services- This study will be complemented by quantitative estimates of the use of services and immunization.
Objective 3: Increase capacity of PHC workers to provide quality	Developed within the "Strengthening health systems", economic incentives have been designed to increase the coverage and quality of health services at the primary care level by enhancing the motivation of health personnel. The basic principle of this mechanism is to accrue material incentives, the

child immunization services	size of which depends on the achievement of health personnel performance on key indicators. Economic incentives have been implemented for all providers of primary level in areas of the country. However, the estimated results and impact achieved are not fully satisfactory. As a tool of motivation for health personnel, this mechanism is not effective enough: no real impact on job satisfaction of health personnel, size of bonuses recognized inconsequential, marked delay in the payment of bonuses. Some of the problems are associated with the lack of effective mechanisms due to low internal management. Improving the quality of services should be attributed to the whole complex of measures implemented in the health sector. However, to achieve the targets of the health of the population, it is necessary to introduce economic incentives, and other measures aimed at improving the quality of services. In conclusion, Kyrgyzstan already has experience with pay-for-performance in primary health care and lessons learnt from its evaluation can and should be used as helpful guidance for the design of the future program (available on http://hpac.kg/images/pdf/prp69.r.pdf) Quality and safety of immunization, including AEFI surveillance, is a globally subject always more important in regards of management of possible adverse events. The experiences showed, if not properly detected, reported, investigated, managed and communicated, that AEFI could really damage a national programme of immunization and the trust among the population. Other lessons learnt in the recent years showed that strengthening and widening the knowledge of quality and safety of immunization, including AEFI surveillance, to key health professionals, remain a fundamental component of an immunization programme.
Objective 4: Strengthen physical capacity of cold chain	During the previous HSS project, the cold chain was strengthened with additional refrigerators, vehicles for vaccines transportation and repair of cold store rooms. With additional support of JICA, the strengthening of the cold chain in the Southern part of Kyrgyzstan is now being completed. The cMYP refers to the increase of storage (a threefold increase) when new vaccines – rotaviral, pneumococcal and pentavalent – will be included in the vaccination calendar. Accordingly the capacity of the refrigerating equipment should be increased as well. It is also necessary to make available specialized refrigerated vehicles in district/urban areas for a more rational transportation of vaccines, as well as acquiring additional 4-wheel drive vehicles for remote mountainous areas of the republic. It will also be necessary to continue the support equipment in order to complete the cold chain in the northern part of the country. This part is characterized by mountain areas, including many areas that are hard to reach, particularly during wintertime, resulting in vaccinations being less timely.
Objective 5: Strengthen the data collection system to ensure timeliness and accuracy of information on immunization services	Currently, the data on immunization, including vaccine supplies, is collected manually and the system is paper-based. It is also a time consuming system until the data is compiled at central level. This impacts the quality of data received at the central level and decisions that are based on the use of such data. District level facilities do not have internet, so the data still cannot be sent up directly; only at oblast level they send data to the central level using internet. Thus at the central level they have direct access only to the oblast level data. Quality control of the accuracy and on-time data is therefore difficult with such a system.

PART D - PROPOSAL DETAILS

For further instructions, please refer to the Guidelines for Completing the HSS Application

7. Objectives of the Proposal

This section will be used to assess whether the proposed objectives are relevant, appropriate and aligned with the National Health Plan and cMYP, and contribute to improving immunisation outcomes. It will also ensure alignment with the bottleneck analysis above.

→ Please succinctly describe the immunisation and HSS objectives to be addressed in this proposal and explain how they relate to, and contribute to, reducing HSS and immunisation bottlenecks (identified in section C.5 above) and strengthening of the health system. Please describe how these objectives are aligned with those in the national health plan and cMYP.

The objectives need to be aligned to and numbered in the same way in the HSS M&E Framework (Attachment 3) and also in the detailed Budget, Gap Analysis and Workplan Template (Attachment 4).

For each objective, please describe:

- a) Which immunisation outcomes will be improved by implementing the activities, and how will the activities contribute to their improvement? Please focus on the key activities related to each objective rather than every single activity. Please demonstrate this link in the next section on the results chain.*
- b) Whether and how the proposed objectives relate to the equity and gender related barriers to access as identified in the bottleneck analysis, and how the objectives will result in narrowing the equity gap in immunisation coverage and contribute to reaching the under reached, underserved and marginalised populations. Countries are requested to consider gender related and geographic barriers to access of immunisation and other health services.*

→ Please list and describe all of the proposed activities in the Budget, Gap Analysis and Workplan Template. If GAVI funding is requested to go into pooled funds, please attach the Annual Work Plan and Budget for the pooled fund and related TORs.

This description will be used to assess if the proposed key activities will be sufficient to achieve the identified immunisation outcomes.

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The overall objective of the GAVI HSS application is to maintain the vaccination coverage of at least 95%, corresponding to the expected program result regarding immunization coverage stated in the NHP (pg.23).

The GAVI HSS proposal is closely linked to the cMYP 2012-2016 and is needed for the implementation of the health systems related key strategic areas of the Plan (pg.5-6). Specifically:

- Improving the infrastructure
- Increasing access to immunization
- Ensuring quality and safety of immunization services
- Increased efficiency of monitoring and management of data
- Increase knowledge and active involvement of the population in immunization process

The GAVI HSS proposal will contribute to the target of immunization outcome by securing a high acceptance for immunizations among the population in general as well as targeting underserved population groups with out-reach activities. Improved quality, proper identification and treatment of adverse reactions are expected to contribute to the confidence for immunizations. Strengthening of the cold chain and the data collection, reporting and analysis will contribute to providing the necessary logistics and data for decision making.

Objective 1: Increase knowledge, trust and demand for MCH services among the population

This objective will tackle the problem with increasing refusals to vaccinations due to lack of knowledge, misconceptions and anti-vaccination propaganda (Bottlenecks 1 & 2).

This component will be implemented in close cooperation with UNICEF that has experience, materials and guidelines on work with religious leaders on a number of health issues, including immunization. With support

from UNICEF, in July 2013 MOH has adopted Strategy and accompanying plan of work on increasing the trust of the population for immunization program for 2013. The existing funding is for 2013 only. GAVI HSS proposal will build on this Strategy.

Activities on social mobilization are identified in cMYP 2012-2016 (pg.45).

Key activities include:

1. Training of PHC workers and immunization program staff in communication skills on immunization issues based on adaptation of existing training modules such as "Communication for Immunization Programmes" (WHO/ EPI, 2004) and UNICEF guidelines and materials developed as part of their "Gulazyk" program in Kyrgyzstan;
2. Awareness raising campaigns during National Immunization Days using TV and radio programs with participation of popular Kyrgyz artists and public figures and by distributing CDs and leaflets in schools and from door-to-door to households;
3. Organization of quarterly meetings between local religious leaders, VHCs and health workers that give an opportunity for health workers to answer questions that community and religious leaders may have about safety of certain interventions, their benefits, and cultural as well as religious taboos related to them, targeting Southern regions.

Objective 2: Strengthen primary health care facilities to increase access to basic MCH services and immunization for urban migrants and hard-to-reach rural areas

This objective will tackle the problem with pockets in the country with lower access to PHC and immunization services (Bottlenecks 3 & 4). Two population groups have been identified, people living in hard-to-reach areas and internal migrants living in Bishkek and Osh.

One of the main approaches to reach the pockets of under-coverage is use of mobile teams. Under the GAVI HSS I forty districts received vehicles for mobile teams and support for their operational costs. No focused efforts have been made to improve access to PHC for the urban migrants.

Key activities include:

1. Development of performance-based system providing incentives for health workers to achieve increased coverage of among the groups living in hard-to-reach areas and urban migrant settlements;
2. Support with operating costs of mobile teams for outreach activities in urban settlements and hard-to-reach areas;
3. Financial incentives to neighbourhood committees ("kvartalnie") to provide legal counselling and other assistance to internal migrants in order to enrol them with PHC providers in their current settlement.

Indicators, mechanisms for monitoring and verification, payment procedures will be developed as part of the current Proposal and will be based on the experience of GAVI HSS I as described in midterm evaluation by Abdaimova et al (2010). Specifically, the incentive amount was too small to make a significant difference in the behaviour of health care personnel. In addition, the complicated formula used for calculation of the bonus payment mechanism exacerbated the transparency issues related to formulation of payments. Moreover, the development of the new PB system will take place in close consultations with the World Bank that is in the process of developing a larger PBF program focusing on secondary care level.

Neighbourhood committees are most familiar with those living in their areas and are responsible for providing certificates of temporary residence and other documents related to housing and residence. Under this Proposal, they would receive a small amount for each member of their community who gets enrolled with local FGP.

Objective 3: Increase capacity of PHC workers to provide quality child immunization services

This objective aims to improve the quality of immunization services through updated guidelines and training (Bottleneck 5). It will emphasize detection, diagnosis and treatment of adverse effects following Immunization (AEFI). Key activities include:

1. Revision of standard case definitions, reporting protocols, and guidelines for diagnosis and treatment of AEFIs;
2. Separate oblast level training of 840 physicians, nurses and feldshers (1 from each FGP and 2 from each territorial and oblast level hospitals) on Immunization in Practice, focusing on new vaccines and AEFIs;
3. Establishment and training of an expert review committee at national level for case detection, case reporting and case investigation/review;
4. Support of operational costs for conducting integrated supervisory visits for basic MCH services including

vaccine-preventable diseases and IMCI in accordance with existing guidelines for supportive supervision.

Objective 4: Strengthen physical capacity of cold chain

This objective tackles deficiencies in the cold chain as described in Section 5 (Bottleneck 6). It includes the procurement of refrigerators and cold store rooms as well as support to maintenance of cold chain equipment. A summary of the infrastructure investment activities by different levels of the vaccine supply chain is as below:

	National	Oblast	Rayon	Health facility	Total
Refrigerated truck, 30m3	1	1			2
Pickup vehicle (for vaccine cold boxes)		2			2
Cold Rooms 10m3		2	4		6
Refrigerator MK404, 135L.			70		70
Refrigerator MK204, 75L.				105	105
Refrigerator MK144, 48 L.				360	360
Voltage regulator			70	465	535
Long range cold boxes (20-25 L.)		50	250	30	330
Short range Cold boxes (5-7L.)			200	500	700
Long range vaccine carriers (2-4.4 L.)				1600	1600
Short range vaccine carriers (1.6-1.9 L.)				1000	1000
Electronic irreversible freeze indicator			500		500
30-day electronic refrigerator logger, PC			500	500	1000
30-day temperaturelogger docking station			50		50
Thermometers		100	500	2000	2600

Objective 5: Strengthen the data collection system to ensure timeliness and accuracy of information on immunization services

Existing paper-based system contributes to low quality of immunization services as described in Section 5 (Bottleneck 7).

This grant will support the scale up of the software developed under GAVI HSS I (Section 5) and will link the immunization data to the New-born Registry. The software will allow to computerize a number of important activities, including:

1. Monitoring of immunization coverage, by age and sex, at the level of facility, district, oblast and country;
2. Monitoring of timeliness of immunization;
3. Monitoring of long-term medical counter indications for vaccination & AEFIs;
4. Monitoring of vaccines and other supplies (syringes, etc.);
5. Monitoring of vaccine usage rate.

Improved coverage will be achieved through the links of the Immunization Registry (part of the software that contains information on immunization status of each registered child) with the New-born Registry. The link to the New-born Registry – that is in operation at maternity wards across the country and contains the information on all the facility-based births, including the initial set of vaccines provided – will allow better monitoring of coverage by immunization services.

Key activities include:

1. Purchase of computers to be used for the new software to be placed with vaccination nurse/immunologist in FMCs and independent FGPs, oblast and central level RMIC, district SES and RCI;
2. Training of 280 health workers (1 vaccination nurse/immunologist and a back-up from each FMC and independent FGP, plus 1 staff of the district SES);
3. Providing resources for one consultant stationed at the RCI to support the implementation of the software, manual development, on the job training and IT support during 18 months of the scale-up.

This will be a logical step given the support in previous GAVI HSS.

8. Results Chain

This description will detail to GAVI how the proposed activities will result in improved immunisation outcomes.

→ *Please present a Results Chain using the template provided in the application form for each objective. This diagram should demonstrate how activities contribute to achieving outputs / intermediate results and how outputs/intermediate results contribute to achieving immunisation outcomes. The outputs / intermediate results should link directly to the HSS bottlenecks identified in Section 5 and should address or contribute to addressing the selected bottlenecks for the GAVI HSS proposal.*

(Please only include the key 4-5 activities for each objective that are central to delivery of intermediate results and immunisation outcomes. It is not necessary to list all activities for each objective. The full list of activities should be completed in the workplan and budget (see Section 10)).

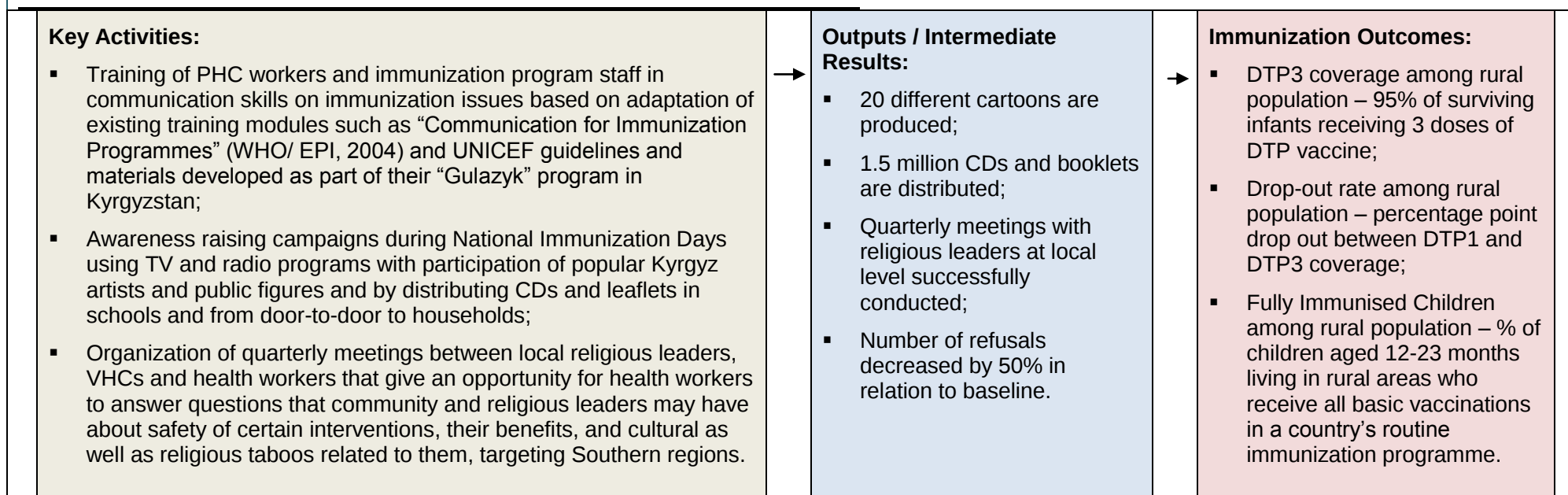
→ *The Results Chain should be consistent with the HSS M&E Framework. For every output / intermediate result and immunisation outcome listed in the Results Chain there should be corresponding indicator(s) in the HSS M&E Framework to measure achievement.*

→ *Please note that a GAVI HSS proposal must include the six immunisation outcome indicators listed in the Guidelines Key Terms Section. Applicants are encouraged to include other immunisation outcome indicators as well which relate specifically to the part of the health system where funds will be used.*

→ *Each result and outcome listed in the results chain should have a corresponding indicator in the Monitoring and Evaluation Framework.*

THREE PAGES MAXIMUM

Objective 1: Increase knowledge, trust and demand for MCH services among the population



Objective 2: Strengthen primary health care facilities to increase access to basic MCH services and immunization for urban migrants and hard-to-reach rural areas

Key Activities: ▪ Development of performance-based system providing incentives for health workers to achieve increased coverage of among the groups living in hard-to-reach areas and urban migrant settlements; ▪ Support with operating costs of mobile teams for outreach activities in urban settlements and hard-to-reach areas; ▪ Financial incentives to neighbourhood committees ("kvartalnie") to provide legal counselling and other assistance to internal migrants in order to enrol them with PHC providers in their current settlement.	→	Outputs / Intermediate Results: ▪ A service model developed and in operation through in-service, outreach service and/or mobile teams; ▪ % of facilities offering routine child immunization services (including outreach) is increased by 20% in relation to the baseline; ▪ % of population living in urban migrant settlements around Bishkek and Osh enrolled with local PHC facility is increased by 50% in relation to the baseline.	→	Immunization Outcomes: ▪ DTP3 coverage in hard-to-reach districts and urban settlements – 95% of surviving infants receiving 3 doses of DTP vaccine; <u>OR</u> ▪ % of districts with DPT3 coverage <80%; ▪ Equity in immunization coverage – DTP3 coverage in the lowest wealth quintile is +/- 10% points of the coverage in the highest one.
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Objective 3: Increase capacity of PHC workers to provide quality child immunization services

Key Activities: ▪ Revision of standard case definitions, reporting protocols, and guidelines for diagnosis and treatment of AEFIs; ▪ Separate oblast level training of 840 physicians, nurses and feldshers on Immunization in Practice, focusing on new vaccines and AEFIs; ▪ Establishment and training of an expert review committee at national level for case detection, case reporting and case investigation/review; ▪ Support of operational costs for conducting integrated supervisory visits for basic MCH services including vaccine-preventable diseases and IMCI in accordance with existing guidelines for supportive supervision.	→	Outputs / Intermediate Results: ▪ New Guidelines developed, printed, distributed and in use in all health facilities; ▪ 840 physicians, nurses and feldshers are trained on Immunization in Practice; ▪ Number of AEFIs is reduced by 50% in relation to base line; ▪ % of health workers passing health worker knowledge surveys is increased by 10% each year.	→	Immunization Outcomes: ▪ Drop-out rate (national) – percentage point drop out between DTP1 and DTP3 coverage; ▪ Fully Immunised Child (national) – % of children aged 12-23 months who receive all basic vaccinations in a country's routine immunization programme.
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Objective 4: Strengthen physical capacity of cold chain

Key Activities:

- Procurement of new specialized refrigerators, voltage stabilizers, short/long range cold boxes/vaccine carriers, and temperature monitoring equipment;
- Purchase of 6 additional cold rooms (10 m3) for district and oblast level to ensure correct temperatures and storage conditions for vaccines
- Purchase of 2 refrigerated vehicles (30 m3) for national and oblast level to establish adequate capacity for vaccine distribution and supply;
- Purchase of 2 pickup vehicles to establish adequate capacity for vaccine distribution and supply from oblast to district level in Northern oblasts;
- Support for repairing/refurbishment and maintenance of oblast/district level vaccine stores, i.e. to ensure protection from freezing temperatures in winter time;
- Support of maintenance & repairing costs of cold rooms and refrigerators for vaccines at oblast/district/service provision level with gradual phase-out and take-over by the state budget.

Outputs / Intermediate Results:

- % of vaccination points that have the required cold chain equipment increased from 72.7% to 100%;
- % of vaccination points where temperatures are monitored with electronic freeze indicators increased from 30% to 100%;
- % of sub-national level facilities with cold chain capacities fit for purpose (based on WHO definition "fit for purpose") from 80% to 100%;
- Vaccine wastage rate for BCG is not increasing from current wastage;
- Vaccine wastage rate for DTP is not increasing from current wastage;
- % of facilities offering immunization services that have tracer items for delivery of immunization including:
 - At least one staff trained in EPI in last 2 years;
 - Cold box/vaccine carrier with ice packs;
 - Functioning refrigerator and thermometer;
 - Sharps container.

Immunisation Outcomes:

- Drop-out rate (national) – percentage point drop out between DTP1 and DTP3 coverage;
- DTP3 coverage (national) – 95% of surviving infants receiving 3 doses of DTP vaccine;
- Measles coverage (national) – % of surviving infants receiving first dose of measles vaccine.

Objective 5: Strengthen the data collection system to ensure timeliness and accuracy of information on immunization services

Key Activities: ▪ Purchase of computers to be used for the new software to be placed with vaccination nurse/immunologist in FMCs and independent FGPs, oblast and central level RMIC, district SES and RCI; ▪ Training of 280 health workers (1 vaccination nurse/immunologist and a back-up from each FMC and independent FGP, plus 1 staff of the district SES); ▪ Providing resources for one consultant stationed at the RCI to support the implementation of the software, manual development, on the job training and IT support during 18 months of the scale-up.	Outputs / Intermediate Results: ▪ 170 Computers are purchased and distributed to PHC facilities, district SES, RCI, oblast and central level RMIC; ▪ 280 health workers are trained in new software; ▪ Timeliness and completeness of facility reporting; ▪ Timeliness and completeness of district reporting; ▪ % of new-borns registered in the Immunization Registry is increased from 0 to 90%; ▪ % of facilities that do not have full immunization history available for all children under five years of age enrolled in their facility is reduced in relation to baseline.	Immunization Outcomes: ▪ Increase in scores in data quality report card; ▪ Drop-out rate – percentage point drop out between DTP1 and DTP3 coverage.
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IMPACT: Please provide an impact statement and indicator(s)

- Under five mortality rate is reduced from 31 (baseline DHS 2012) to 28 (projection 2018 in the M&E framework).
- % of deaths among children under five years of age due to infectious disease is reduced from 5.5% (baseline MoH) to 2.5% (projection 2018 in the M&E framework).
- Reduced incidence of vaccine-preventable diseases among children under 5 years of age.

ASSUMPTIONS:

- Proposed activities will be implemented as planned;
- Immunization outcome indicators will be achieved as the result of implementation of proposed activities;
- VPDs are an important direct and indirect contributor to child morbidity and mortality in Kyrgyzstan;
- Increased coverage by EPI vaccines will lead to reduction in infectious diseases among children under 5 years of age;
- The gains in health achieved through increased immunization coverage and decrease in VPDs will not be offset by new diseases among children under 5 years of age, resulting in absence of change or even increase in child morbidity and mortality.

9. Monitoring & Evaluation Framework

This description will enable GAVI to assess how programme performance will be monitored and to ensure alignment with National M&E arrangements. The proposed M&E framework for the HSS grant should link to the proposed results chain. While the Results Chain provides the rationale for how the proposed activities will result in improved immunisation outcomes, this section provides details of how the monitoring and evaluation will be undertaken.

→ *Please provide an HSS grant Monitoring & Evaluation Framework as Attachment 3 (please complete the GAVI template).*

→ *Please provide a description of how the monitoring and evaluation will be carried out for the grant, indicating how M&E is aligned with the national health plan results framework.*

→ *Which sources of data will be used?*

→ *How much budget will be allocated to M&E of this grant?*

→ *Please describe the M&E system strengthening activities to be funded through this proposal.*

→ *Please identify one or more immunisation outcomes for each objective. These will be used for PBF's performance payment (see Figure 1 on page 7 of the Guidelines)*

→ *Please identify a number of intermediate results indicators related to each objective of the grant that shall be used for tracking the overall progress of the grant implementation (these will be used for PBF's programmable section (see Figure 1 on page 7). These are the same intermediate results indicators that are included in the Monitoring & Evaluation Framework, and will be used to measure the outputs/intermediate results that are included in the results chain in Section D.8.*

Please note that GAVI strongly recommends that each proposal includes an end of grant assessment in their M&E Framework.

TWO PAGES MAXIMUM

Monitoring the GAVI HSS program will be integrated into the National Monitoring & Evaluation Strategy Framework (attached). The impact of the GAVI HSS program will be measured by the national DTP coverage, for which the goal is to maintain at least 95% coverage. This impact indicator is part of the indicators for monitoring the National Reform Program "Den Sooluk" (Package of indicators attached). This indicator will also be monitored specifically for the target groups, urban migrants and population of hard-to-reach areas. A baseline of the DTP coverage for the target groups will be established.

For each of the five objectives, outcome indicators have been identified (GAVI HSS M&E framework attached). The outcome indicators are part of and will be monitored through the regular immunization program information system.

The output indicators, identified for each service delivery area, like the number of people trained, the number of refrigerators purchased etc., will be measured by the program.

These indicators will be complemented by a number of in-depth evaluation studies to understand causal factors behind trends in indicators, and to assess the effectiveness of program implementation.

1. Survey on immunization coverage rate among internal migrants living in Bishkek and Osh
2. Brief study on the current capitation payments to PHC facilities serving areas with concentration of internal migrants around Bishkek and Osh as compared to the real number of served population, legal and other perceived barriers to access to PHC services by these groups

Indicator(s)	Source
Immunisation Outcome Indicator (Mandatory)	
DTP3 coverage - % of surviving infants receiving three doses of the diphtheria-tetanus-pertussis vaccine (DTP3)	RCI
DTP3 coverage numerator (number of doses administered through routine services)	RCI, RMIC
DTP3 coverage denominator (number in target group)	RCI, RMIC
MCV1 coverage - % of surviving infants receiving first dose of measles containing vaccine	RCI
MCV1 coverage denominator (number in target group)	RCI, RMIC
Geographic equity of DTP 3 coverage - % of districts that have at or above 80% DTP3 coverage	RCI, RMIC
Socio-economic equity in immunisation coverage - DTP3 coverage in the lowest wealth quintile is +/- X % points of the coverage in the highest wealth quintile	MoH
Drop out rate - percentage point difference between DTP1 and DTP3 coverage	RCI
Proportion of children fully immunised - % of children aged 12-23 months who receive all basic vaccinations in a country's routine immunisation program	RCI
DTP3 coverage (rural)- % of surviving infants receiving three doses of the diphtheria-tetanus-pertussis vaccine (DTP3)	RCI, RMIC
DTP3 coverage (Bishkek)- % of surviving infants receiving three doses of the diphtheria-tetanus-pertussis vaccine (DTP3)	RCI, RMIC
Drop-out rate (rural) – percentage point drop out between DTP1 and DTP3 coverage	RCI
Fully Immunised Children (rural) – % of children aged 12-23 months living in rural areas who receive all basic vaccinations in a country's routine immunisation programme	RCI, RMIC
Increase in scores in data quality report card	RCI
Output / Intermediate results indicator	
Cartoons are produced	MoH
CDs and booklets are distributed	MoH
Number of refusals	RCI
New Guidelines developed, printed, distributed and in use in all health facilities	MoH
Physicians, nurses and feldshers are trained on Immunization in Practice	MoH
Number of AEFIs	RCI, DDPME
% of health workers passing health worker knowledge surveys is increased by 10% each year	MoH
% of vaccination points where temperatures are monitored with electronic freeze indicators	RCI
% of sub-national level facilities with cold chain capacities fit for purpose (based on WHO definition "fit for purpose")	RCI
Vaccine wastage rate for BCG	RCI
Vaccine wastage rate for DTP	RCI
% of facilities offering immunisation services that have tracer items for delivery of immunisation	RCI
Computers are purchased and distributed to PHC facilities, district SES, RCI, oblast and central level RMIC	MoH
Health workers are trained in new software	MoH
Timeliness and completeness of facility reporting	RCI

Timeliness and completeness of district reporting	RCI
% of newborns registered in the Immunization Registry	RMIC
% of facilities that do not have full immunization history available for all children under five years of age enrolled in their facility	RMIC

Monitoring of activities will be conducted against the funds, allocated for Program management, as well as against the funds, allocated for supervision visits.

10. The Proposal Development Process

This section will give an overview of the process of proposal development, outlining contributions from key stakeholders.

→ Address all the items listed below. Indicate if any of these are not applicable and explain why:

- a. The main entity which led the proposal development and coordination of inputs. It is possible to have multiple lead implementers, however the country must decide which department will lead the proposal development process.*
- b. The roles of HSCC and ICC.*
- c. Cooperation between EPI programme and the other departments of MOH involved in the proposal development.*
- d. Involvement of subnational level (provincial, district, etc.) entities.*
- e. The role of CSOs in the proposal development. Applicants must describe whether the HSCC/ICC worked with any CSO platforms/coalitions, or just with individual organisations. Please provide the names of the specific CSOs or of the CSO platforms involved.*
- f. The names and roles of other specific development partners/donors.*
- g. The role of the private sector, if applicable.*
- h. Description of technical assistance received during the proposal development. Include the source of technical assistance and a comment on the quality and usefulness of that technical assistance.*
- i. Description of the overall process of proposal development: duration, main steps of the proposal development, analytical work involved in the proposal development, links between the proposal development and national health sector planning/budgeting, links between the proposal development and JANS (if applicable).*
- j. Description of the most challenging elements during the proposal development and how they were resolved.*

TWO PAGES MAXIMUM

The GAVI HSS proposal (application) was prepared by a technical working group (TWG), established on the 3rd September 2012. The TWG was made up of many stakeholders from the Ministry of Health, the Health Insurance Fund, the State Sanitary Epidemiological Diseases Prevention Department (SSEDPD), The Republican Centre for Immunization, and the Centre for Health Policy Analysis.

The application process was lead by the Deputy Minister. The National Immunization Program took an active part in the development of the application. They were involved in formulating components, objectives and activities, and in defining financial requirements and monitoring and evaluation indicators.

Technical and advisory assistance were provided by WHO, UNICEF, and the Kyrgyz-Swiss-Swedish Health Project.

The application was discussed at the Interagency Coordinating Committee on Immunization and was approved by the Health Policy Department of the Ministry of Health.

The GAVI HSS application was also discussed in March 2013, when a expanded mission of GAVI, WHO, UNICEF worked in Kyrgyzstan. Objectives and activities were discussed at that time.

Finally a GAVI Financial Management Assessment (FMA) mission took place in March 2013, and a report was issued in September 2013 (attached).

Interagency Coordination Committee on Immunization (ICC) & Health Policy Council (HPC)

In Kyrgyzstan there are two bodies that execute the coordination functions within the health sector regarding immunization: (i) the Interagency Coordination Committee on Immunization (ICC) and (ii) the Health Policy Council (HPC).

The ICC is a national technical coordination committee for immunization issues that was constituted in December 2000. The ICC is currently chaired by the Deputy Minister. The committee also consists of representatives from the SSEDPD, other department and centre within the MoH and representatives from International Organisations and Civil Society Organisations: USAID, WHO, UNICEF, World Bank, Soros Foundation, Association for Health Promotion, Kyrgyz-Swiss-Swedish Project. The committee meets quarterly or when necessary.

Major functions and responsibilities of the ICC are provided by a Government Resolution(attached).

The Health Policy Council (HPC) is the highest organ of policy approval and consists of different Representatives and Heads of Departments within the MoH, and under the MoH organs. The Minister of Health is the chairman. The HPC is coordinated by the Department of Coordination and Reform Implementation.

Major functions and responsibilities of the HPC are provided by a Decree of MoH (attached).

11. Detailed Budget and Workplan Narrative

This description will be used to assess if the proposed budget shows sufficient justification for the proposed activities and activity costs within the HSS grant.

→ Please provide a detailed budget and workplan as Attachment 4 to this proposal. Please refer to the Guidelines for the list of items required from the budget and workplan. It is highly recommended that applicants use the GAVI HSS Budget, Gap Analysis and Workplan template as Attachment 4. However, countries can also provide this information in the format of an existing national Annual Operational Plan or equivalent document.

→ Please include additional information on the assumptions within the budget and justification of unit costs to demonstrate that they are reasonable and supported by in-country planning. These assumptions and unit cost justifications may be inserted here or attached as separate documentation.

TWO PAGES MAXIMUM

Budgeting the NHP

The costs for the current health sector services are estimated to USD 1 billion for the period 2013-2017. The additional costs for implementing the reforms of the Den Sooluk have been calculated by the Den Sooluk working group, using a micro-costing technique. The costing includes only the activities that are additional to the costs for the current health sector and have been estimated to USD 33.5 – 34 million for the five-year period. The first costing exercise arrived at USD 59 million. Since then there has been a process to adapt the implementation of Den Sooluk to expected available funding.

Budgeting the National Immunization Programme - cMYP

The cMYP for 2012-2016 with its Costing & Financing Tool (both attached) provide the budget of the National Immunization Program for a 5-year period. The total cost of the plan is USD 39.5 million, including shared health system costs (salaries, etc.) for USD 14.3 million. Part of the cost is vaccines for USD 13.5 million, and another part is service delivery for USD 8.4 million. General expenses will be financed by the Government, vaccine costs are expected to be shared between the Government with contributions from GAVI as well as the HSS costs. The GAVI HSS proposal is derived from the cMYP, and further elaborated with the 5 objectives) and budgeted in details.

Another costing document, parallel to cMYP, is the National Immunization Program 2013-2017, called "Immunoprophylaxis Program", with its budgeting included (attached). It provides an update on the above different costs.

GAVI HSS budget

Now for the GAVI HSS proposal, a detailed budget has been established (attached), listing all activities under the 5 objectives, allocating them unit costs, amounts of work for each activity, and estimating the overall costs of all these detailed activities. All explanations are inserted in the Excel spreadsheets.

GAVI HSS workplan

A detailed workplan has been elaborated (attached), listing all activities of the 5 objectives, putting them in a 5-year timeframe (2014-2018). A monthly workplan has also been elaborated for the year 2014.

12. Gap Analysis & Complementarity

This description will ensure GAVI is aware of support provided by other donors, thereby avoiding overlap or duplication, and highlighting the value-added of the requested GAVI support.

→ Please complete a gap analysis that is related to each of the GAVI HSS proposal objectives. The gap analysis should use information as available in National Health Sector Strategy/Plan, cMYP, or other gap analysis conducted, to show the total resource requirements for health systems strengthening related to each of the proposal objectives. Applicants are encouraged to use the GAVI HSS Budget, Gap Analysis and Workplan Template but can choose an existing country template.

→ For each of the objectives, applicants should list different resources for HSS financing already in place that contribute to the proposal objective, including government and external donor contributions, the project name if applicable (or indicate budget support), duration of support, funding amount provided (in US\$), and geographic location covered by the support. The guidelines provide more detail on the key required elements of the gap analysis.

→ In the box below, please provide a narrative description of other efforts by the Government or development partners that focus on the bottlenecks that are addressed by the proposal objectives, including the timeframe and the geographic location of this support, thereby highlighting the value-added of GAVI support and how the current proposal complements those efforts.

GAVI encourages the use of data from existing gap analyses, rather than undertaking a new gap analysis.

TWO PAGES MAXIMUM

Financing of the NHP

The financing of the health sector from the government is estimated to USD 200 million per year and a total of USD 1 billion for 2013-2017. The health sector receives 13% of the total government budget. In addition, the donors are expected to contribute with USD 60 million for the same period. About 50% of the donor funds are channelled through the SWAP mechanism and the other 50% is expected to reduce the gap in financing the SGBP. Also an additional financing with no cost estimates are the donor-funded programs outside the SWAP mechanism.

Financing of the National Immunization Program

Currently the National Immunization Program is mainly funded by the Government (2/3) and by GAVI (1/3). No other sources of funding are anymore available, WHO and UNICEF participating mainly with technical assistance.

Gap analysis

Since there has been a process to adapt the implementation costs for the Den Sooluk to the estimated available financing there is no financial gap, at least not in theory. In practice, as observed by the JANS, there is a funding gap for the SGBP, which is part of the USD 1 billion provided by the government, since the health sector will not likely receive all of the USD 1 billion.

As shown in the NHP financial gap analysis, there are considerable gaps in the financing of the Den Sooluk. The GAVI HSS financing is therefore needed for the implementation of the health systems parts of the cMYP and GAVI has been identified as the source of financing in the Den Sooluk costing for these activities. No financing for this will likely be available through the SWAP mechanism, considering other financial gaps. The support from GAVI will be truly additional to the Government.

For the specific gap analysis (attached) in the GAVI HSS proposal, considering only the 5 objectives listed into the proposal, and according to the National Immunization Plan budget 2013-2017, assumption were made that the Government could fund what they were budgeting in their own program. The rest, the proposal 5 objectives activities, is left with the potential GAVI HSS funding.

13. Sustainability

This description will enable GAVI to assess whether issues of sustainability have been adequately addressed.

→ *Please describe how the government is going to ensure sustainability of the results achieved by the GAVI grant after its completion. This should encompass sustainability of financing for immunisation services and health system strengthening, as well as programmatic sustainability of results.*

→ *If there are other recurrent costs included in this proposal please describe how the country will cover these costs after the funding finishes.*

TWO PAGES MAXIMUM

A factor that contributes to financial sustainability is the fact that the GAVI funding is part of a package of HSS support within the SWAP and the package is also supported by the Government and other donors. The GAVI HSS support and available support from other sources are taken into account and included in the annual workplans and budgets. When support from GAVI will end, the funding will be substituted by funding from the Government and potentially other sources or the budget will be reduced, due to activities which will end (capital investment). The government has expressed its ambition to continue to support the immunization incentives, initiated by the GAVI HSS funds, which will also contribute to sustainability.

More specifically:

Objective 1 “Increase knowledge, trust and demand for MCH services among the population”: These activities should be highly sustainable, as promoting popular participation and civil society engagement will create a driving force for sustainability.

Objective 2 “Strengthen primary health care facilities to increase access to basic MCH services and immunization for urban migrants and hard-to-reach rural areas”: As mentioned above the Government committed to continue the pay-for-performance incentives.

Objective 3 “Increase capacity of PHC workers to provide quality child immunization services”: The investment in workers skills on AEFI could be considered sustainable, as it may avoid the Government to be embarked in costly reaction of wrongly managed adverse events.

Objective 4 “Strengthen physical capacity of cold chain”: Equipment like cold chain equipment has a good lifespan, providing enough time to envisage their future replacement, and the required financial mechanism for it.

Objective 5 “Strengthen the data collection system to ensure timeliness and accuracy of information on immunization services”: Investing in new technology and data management will allow to spare costs in processing data. The financial sustainability of such a program is obvious as electronic costs are lower than mailing and phone costs, not to say the reduction in time spent by the immunization workers.

PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

For further instructions, please refer to the Guidelines for Completing the HSS Application

14. Implementation Arrangements

This section will be used to determine if the necessary arrangements and responsibilities for management, coordination, and technical assistance inputs of the implementing parties have been put in place to ensure that programme activities will be implemented.

Please describe:

→ *How the grant implementation will be managed. Identify key implementing entities and their responsibilities with regard to specific grant activities.*

→ *Mechanisms which will ensure coordination among the implementing entities.*

→ *Financial resources from the grant proceeds that will be allocated to grant management and implementation.*

→ *The role of development partners in supporting the country in grant implementation.*

TWO PAGES MAXIMUM

GAVI HSS activities will be implemented by existing governmental structures in the MOH, MHIF, SSEDPD and RCI, as indicated in the Plan to ensure full harmonization with implementation arrangements of Den Sooluk. It is proposed not to establish a separate project management unit but rather to maintain the post of Technical Coordinator from the previous HSS support. The GAVI HSS Technical Coordinator will work closely with all structures implementing the activities of the GAVI HSS Program, take part in committee meetings, provide information about progress of implementing activities, seek the support of committees where needed, and ensure appropriate information flows within the country as well as between the country and the GAVI Secretariat.

In general, the MOH Department of Health Policy Analysis is responsible for coordinating all health system strengthening activities under Den Sooluk including coordinating and facilitating planning, implementation and reporting processes. Maternal and Child Health is a priority program in Den Sooluk and direct implementation responsibility is assigned to the MOH Department of Prevention and Curative Services. This assignment of implementation responsibilities ensures maximum integration of maternal and child health activities in the health system at all levels. In addition, other departments and agencies are also involved in activities relevant for immunization such as the Public Health Department, State Sanitary Epidemiological Disease Prevention Department, Centre for Immunoprophylaxis, etc. The Technical Coordinator for the GAVI HSS support will work closely with these two departments and others on a regular basis and will provide a link for the GAVI secretariat in between the summits as required.

In line with forming and approving annual plans and budgets for Den Sooluk, the GAVI HSS Working Group will make a draft annual plan of work and budget. The Working Group will be coordinated by a Technical Program Coordinator who will be the primary point person for all activities included in the HSS program proposal and the contact person for communication with the GAVI Secretariat. For the annual workplan and costing, review and recommendations will be sought from the ICC. The draft workplan and budget will be submitted to the MOH Department of Strategic Planning and Reform Implementation in charge of compiling the overall annual workplan and budget for Manas Taalimi, this on time for the September SWAp joint review. Approval will be provided by the MOH Health Policy Council, the highest organ of policy approval.

Agreement with the development partners will be sought at the September Health Summits whose purpose is to approve program activities and corresponding funding for the following year. GAVI representatives will be invited to take part in the annual health summits and approve annual workplan and budget in the context of the overall Den Sooluk workplan. The agreed annual workplan for GAVI HSS will be approved by an order of the MOH.

Annual activity reports will be prepared by the MOH with the support of the Technical Coordinator and will be provided to GAVI 60 days after the end of the calendar year. The progress report will then be presented as part of the progress report of Den Sooluk at the spring health summit.

In the context of the SWAp, all procurement is conducted corresponding to the Kyrgyz public procurement law which corresponds to international requirements and best practices. All international competitive bidding and involvement of Technical Assistance require approval from joint financiers.

Procurements under the current proposal will be included into the Annual Procurement Plan of the Den Sooluk Health Reform Program. The Plan is prepared by the MOH and reviewed by all participating donors, including GAVI in the future, during the fall Health Summit (September). The Procurement Unit of the MOH will be responsible for all of the procurement-related activities. The procurement procedures have been agreed with the participating donors and are described in detail in the Procurement Manual and the Development Grant Agreement concluded between the Government of the Kyrgyz Republic and the International Development Association in 2006.

The implementation experience of GAVI HSS I points to the need of improving the effectiveness of the HSS activities and coordination with other health sector activities. This will be done through bi-monthly meetings with the TWG, improving the links between the GAVI HSS and the implementation of the Den Sooluk.

To integrate the activities of governmental and international organizations and to strengthen partnerships through coordination of resources, as well as monitoring of transparency of financial reporting on GAVI funds, the Interagency Coordinating Committee on Immunization (ICC) has been operational in the country on a permanent basis since 2001.

The main functions and responsibilities of the ICC:

1. Assistance in development and approval of the national immunization policy, multi-year plans on immunization in the context of health care system reforms.
2. Coordination of technical and financial support of immunization program by partners, development of the key principles of cooperation among international organizations to ensure the most efficient use of resources, as well as to attract new resources to support and develop immunization programs.
3. Monitoring and evaluation of cost-effectiveness and rationale of measures, aimed at immunization program objectives and goals implementation.
4. Discussion of the issues related to immunization program and development of recommendations for its improvement.

Main functions and responsibilities of the Scientific and Technical Group of Experts on Immunization (NITAG).

1. Advisory support on the issues of development of optimal national policies and strategies in the field of immunization.
2. Advisory support on the issues of monitoring of immunization programs impact.
3. Advisory support in collecting important data and information.
4. Determining the needs of additional data or research needs for development of immunization policy.

15. Involvement of CSOs

This description will be used to assess the involvement of CSOs in implementation of the proposed activities. CSOs can receive GAVI funding through GAVI HSS grants going to the MoH and then transferred to the CSO².

→ Please describe how CSOs will be involved in the implementation of the grant activities, indicating the approximate budget allocated to CSOs.

→ Please ensure that any CSO implementation details are reflected within the detailed budget and workplan.

TWO PAGES MAXIMUM

Civil society organizations, like village health committees and district health committees were supporting during the first GAVI HSS program the components of social mobilization and active involvement of the population in the issues of health promotion and preventive measures.

Village Health Committees (VHC) have played an important role in raising awareness and implementing a healthy lifestyle among the rural population. They have successfully expanded their activities in all fields and work in the most remote areas on a number of issues related to MCH.

Village Health Committees are the core of the Community Action for Health (CAH) program. They are supported by Government agencies such as the Office of Health Promotion, and by the staff of the primary health care group of family physicians and medical stations. VHC is an organization established at the community level with volunteers, aimed at improving health to people in their villages. They are not part of the public health system, but cooperate with it as independent civil society organizations.

VHCs form associations at the district level (district health committees), which are registered as legal entities in the form of non-governmental organizations (NGOs). These neighbourhood health committees, in turn, are combined into a national federation of VHC. The CAH in Kyrgyzstan aims to promote and enhance cooperation between rural communities represented by the volunteers of village health committees, and the public health system. CAH program is implemented at the national level, and is part of the national health care reform program.

At this point, in Kyrgyzstan are organized 1400 VHC, which cover 80 percent of the villages of the republic.

With such a network of CSOs, it is obvious that the new GAVI HSS proposal will much benefit in collaborating with them once again.

² In special circumstances grant funds can go directly from GAVI to a CSO, please refer to the Application Guidelines for further information.

16. Technical Assistance

This description will outline to GAVI how technical assistance will support implementation of the proposed activities.

→ Please describe technical assistance (consultancy services) included in the grant activities. Please describe how this technical assistance will improve the way health systems and immunisation programme function.

→ Please outline how technical assistance will improve institutional capacities of government agencies and CSOs and contribute to sustainability.

ONE PAGE MAXIMUM

Objective 1: Increase knowledge, trust and demand for MCH services among the population

For the development of information and educational materials, based on available information (WHO module to raise community support for immunization), and based on the experience of other Muslim countries with successful interaction between health workers and religious leaders regarding communication, technical assistance was included into the GAVI HSS proposal. Another necessary provision for technical cooperation is with UNICEF in relation to their existing experience and materials on the basic principles of working with community and religious leaders. These technical assistances will allow raising the level of communication expertise within the country and its institutions.

Objective 2: Strengthen primary health care facilities to increase access to basic MCH services and immunization for urban migrants and hard-to-reach rural areas

In this area, there will be a continuity to get the support from a Health System specialist for designing the financial mechanism to achieve and sustain this objective (e.g. WB project specialist). It is in line with what was started during the GAVI HSS I.

Objective 3: Increase capacity of PHC workers to provide quality child immunization services

One of the key barriers identified in maintaining the trust of the population to health services, particularly immunization program, is the out-dated clinical protocols and standards on adverse events following immunization (AEFI), which should be in accordance with WHO global recommendations. The Kyrgyz existing system of surveillance, diagnosis, investigation and treatment of AEFI does not correspond to those recommendations. In this area the embedded international technical assistance within the GAVI HSS proposal was necessary, and will also allow to strengthen the skills within the government agencies.

Objective 4: Strengthen physical capacity of cold chain

The technical assistance in this area will mainly be for the procurement. As cold chain equipment will be procured using UNICEF procurement system, the UNICEF Supply Division will bring here its technical experience in supporting the acquisition and delivery of adequate cold chain equipment.

Objective 5: Strengthen the data collection system to ensure timeliness and accuracy of information on immunization services

Under the previous GAVI HSS, the software for the immunization data management was developed and piloted. Now for the full introduction of the software, technical assistance with one consultant during 18 months was budgeted. Her/his presence and the impact of her/his work will allow the immunization staff to take over on this important matter.

17. Risks and Mitigation Measures

This information reflects the risk of a country not being able to implement the proposed activities within this grant proposal and/or spend the funds as approved by GAVI. It is expected that the Lead Implementer will be responsible for assessing and ensuring that risk mitigation measures are actually implemented.

→ If the country has existing health sector risk analysis please attach these assessments and provide here a brief reference to the relevant sections.

→ If the country does not have existing health sector risk analysis, please complete the table below for each of the proposed objectives. Please refer to the Guidelines for Completing the HSS Application for a description of the various types of risk. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.

Description of risk	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	Mitigation Measures
Objective 1: Increase knowledge, trust and demand for MCH services among the population			
<i>Fiduciary Risks:</i>	Low	Low	
<i>Institutional Risks: Lack of human resources within the MoH to manage the activities</i>	Medium	Medium	Reinforced use of technical assistance to support the management of activities whenever required
<i>Operational Risks: Lack of human resources within the MoH to implement the activities</i>	Medium	Medium	Reinforced use of technical assistance to support the implementation of activities whenever required
Overall Risk Rating for Objective 1	Low to medium	Low to medium	
Objective 2: Strengthen primary health care facilities to increase access to basic MCH services and immunization for urban migrants and hard-to-reach rural areas			
<i>Fiduciary Risks:</i>	Low	Low	
<i>Institutional Risks: Lack of human resources within the MoH to manage the activities</i>	Medium	Medium	Reinforced use of technical assistance to support the management of activities whenever required
<i>Operational Risks: Lack of human resources within the MoH to implement the activities</i>	Medium	Medium	Reinforced use of technical assistance to support the implementation of activities whenever required
Overall Risk Rating for Objective 2			

Objective 3: Increase capacity of PHC workers to provide quality child immunization services			
<i>Fiduciary Risks:</i>	<i>Low</i>	<i>Low</i>	
<i>Institutional Risks: Lack of human resources within the MoH to manage the activities</i>	<i>Medium</i>	<i>Medium</i>	<i>Reinforced use of technical assistance to support the management of activities whenever required</i>
<i>Operational Risks: Lack of human resources within the MoH to implement the activities</i>	<i>Medium</i>	<i>Medium</i>	<i>Reinforced use of technical assistance to support the implementation of activities whenever required</i>
Overall Risk Rating for Objective 3			
Objective 4: Strengthen physical capacity of cold chain			
<i>Fiduciary Risks:</i>	<i>Low</i>	<i>Low</i>	
<i>Institutional Risks:</i>	<i>Low</i>	<i>Low</i>	
<i>Operational Risks:</i>	<i>Low</i>	<i>Low</i>	
Overall Risk Rating for Objective 4	Low	Low	
Objective 5: Strengthen the data collection system to ensure timeliness and accuracy of information on immunization services			
<i>Fiduciary Risks:</i>	<i>Low</i>	<i>Low</i>	
<i>Institutional Risks:</i>	<i>Low</i>	<i>Low</i>	
<i>Operational Risks:</i>	<i>Low</i>	<i>Low</i>	
Overall Risk Rating for Objective 5	Low	Low	
TWO PAGES MAXIMUM The Financial Management Assessment Report (2013) concluded: The financial management arrangements in the Health sector, including budgeting, accounting, internal controls, reporting and staffing have been rated moderately satisfactory by the recent assessment of the World Bank. The FMA GAVI HSS concluded on the risk-rating Moderate for GAVI programme. The rating is based on the recent improvements in the health sector's PFM as a result of the implementation of SWAP led requirements for financial management, and existing controls over funds management under current system of GAVI funds flow.			

18. Financial Management and Procurement Arrangements

In this section applicants are requested to describe:

→ a) *The proposed financial management mechanism for this proposal*

→ b) *Financial Management Arrangements Data Sheet: The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for oversight, planning and budgeting, budget execution (incl. treasury management and funds flow), procurement, accounting and financial reporting (incl. fixed asset management), internal control and internal audit, and external audit. CSOs can receive GAVI funding through two channels: (i) funding from GAVI to MOH and then transferred to CSO, or (ii) direct from GAVI to CSO. Please refer to Annex 4 of the Guidelines for further details*

→ c) *The main constraints in the (health sector's) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfil the above functions.*

4 pages (more pages necessary if more than one lead implementer)

Question (a): applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one. A rationale for this choice should be provided.

In order to ensure consistent implementation of the program proposed financing mechanisms for the GAVI HSS program:

GAVI HSS funds will be directed to a specific foreign currency account and then the money will be converted into Kyrgyz soms in accordance with the exchange rate National Bank. GAVI HSS funds will be accumulated in a special account of the Ministry of Health, which is open at the Office of the Treasury.

The Ministry of Health, in accordance with the action plan will be holding HSS funding responsible for the implementation of activities in accordance with the workplan.

Funds as soon as they will enter the system of the Treasury will be managed according to standard budgetary procedures of the country.

While GAVI funds will be included in a combined total budget, the Ministry of Health and the Ministry of Finance will ensure that GAVI funds will be used to carry out the planned activities proposed in this application.

Question (b): Financial Management Arrangements Data Sheet

Any recipient organization/country proposed to receive direct funding from GAVI must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).

1. Name and contact information of Focal Point at the Finance Department of the recipient organization	Nazarova Z. D. Finance Department Ministry of Health Tel: +996 312 66 26 Email: z_nazarova@mz.med.kg
2. Does the recipient organization have experience with GAVI, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES

3. If YES • Please state the name of the grant, years and grant amount. • For completed or closed Grants of GAVI and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • For on-going Grants of GAVI and other Development Partners: Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	Name: Strengthening Health Systems 2007-2012 Total bid amount was 1,155 million U.S. dollars The current funding mechanism for programs is organized by the IFP and the HSS through the Central Treasury and has a stand open to the GAVI account "special fund" for the Ministry of Health. It does not mix with any other donor funds. This mechanism provides an efficient allocation of funds as they are received from GAVI. Date and time of cash flows are unpredictable and therefore are not reflected in the planning stage of the budget preparation. These funds are included in the budget after the receipt of funds.
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	GAVI HSS activities will be implemented and oversight by existing governmental structures in the MOH, MHIF, SSEDPD, and RCI as indicated in the workplan to ensure full harmonization with implementation arrangements of Den Sooluk. It is proposed not to establish a separate project management unit but rather to maintain the post of Technical Coordinator from the previous HSS support. The GAVI HSS Technical Coordinator will work closely with all structures implementing the activities of the GAVI HSS Program, take part in committee meetings, provide information about progress of implementing activities, seek the support of committees where needed, and ensure appropriate information flows within the country as well as between the country and GAVI Secretariat. In general, the MOH Department of Health Policy Analysis is responsible for coordinating all health system strengthening activities under Den Sooluk including coordinating and facilitating planning, implementation and reporting processes. Maternal and child health is a priority program in Den Sooluk and direct implementation responsibility is assigned to the MOH Department of Prevention and Curative Services. This assignment of implementation responsibilities ensures maximum integration of maternal and child health activities in the health system at all levels. In addition, other departments and agencies are also involved in activities relevant for immunization such as the Public Health Department, State Sanitary Epidemiological Disease Prevention Department, Centre for Immunoprophylaxis, etc. The Technical Coordinator for the GAVI HSS support will work closely with these two departments and others on a regular basis and will provide a link for the GAVI secretariat in between the summits as required. The implementation experience of GAVI HSS I points to the need of improving the effectiveness of the HSS activities and coordination with other health sector activities. This will be done through bi-monthly meetings with the TWG, improving the links between the GAVI HSS and the implementation of the Den

	Sooluk.
5. Who will be responsible for the annual planning and budgeting in relation to GAVI HSS?	In line with forming and approving annual plans and budgets for Den Sooluk, the GAVI HSS Working Group will make a draft annual workplan and budget. The Working Group will be coordinated by a Technical Program Coordinator who will be the primary point person for all activities included in the HSS program proposal and the contact person for communication with the GAVI Secretariat. For the annual workplan and costing, review and recommendations of the ICC will be sought. The draft workplan and budget will be submitted to the MOH Department of Strategic Planning and Reform Implementation in charge of compiling an overall annual workplan and budget for NHP on time for the September SWAp joint review. Approval will be provided by the MOH Health Policy Council, the highest organ of policy approval. Agreement with the development partners will be sought at the September Health Summits whose purpose is to approve program activities and corresponding funding for the following year. GAVI representatives will be invited to take part in the annual health summits and approve annual plans of work and budget in the context of the overall Den Sooluk plan of work. The agreed annual workplan for GAVI HSS will be approved by an order of the MOH. Annual activity reports will be prepared by the MOH with the support of the Technical Coordinator and will be furnished to GAVI 60 days after the end of the calendar year. The progress report will then be presented as part of the progress report of Den Sooluk at the spring health summit.
6. What is the planning & budgeting process and who has the responsibility to approve GAVI HSS annual work plan and budget?	The final approval will be through the Ministry of Health decree after the process described above has been completed.
7. Will the GAVI HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	GAVI HSS funds will be directed to a specific foreign currency account and then the funds will be converted into Kyrgyz soms in accordance with the exchange rate National Bank. Banking form will be signed by the Minister of Health and the head of the regional branch of the Treasury, and will be certified by the Head of Country Office UNICEF.
9. Will GAVI HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	GAVI HSS funds will be accumulated in a special account of the Ministry of Health, which is open at the regional office of the Treasury.
10. Would this bank account hold only GAVI funds or also funds from other sources (government and/or donors- "pooled account")?	Only GAVI funds.

11. Within the HSS programme, are funds planned to be transferred from central to decentralized levels (provinces, districts etc.)? If YES , please describe how fund transfers will be executed and controlled.	YES The Ministry of Health, in accordance with the HSS action plan, holds funds. Funding can be done in two ways (a) the funds are primarily allocated to the organization responsible for the implementation of activities under the approved action plan, or (b) the funds are sent directly for implementing measures.
Procurement	
12. What procurement system will be used for the GAVI HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	Development Partners' procurement procedures are used as part of the fiduciary risks mitigation measures under the SWAp. Same system will be used for GAVI HSS Programme.
13. Are all or certain items planned to be procured through the systems of GAVI's in-country partners (UNICEF, WHO)?	Cold chain equipment will be procured using UNICEF system.
14. What is the staffing arrangement of the organization in procurement?	Purchases will be included in the annual procurement plan for health care reform program "Den Sooluk." The Procurement Division of the Ministry of Health will be responsible for activities related to procurement. Procurement procedures have been agreed to by all participating donors, and are described in detail in the Procurement and grant agreement for the development, between the Government of the Kyrgyz Republic and the International Development Association on 10 March 2006.
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES All procurement procedures, including complaint mechanisms, are described in detail in Procurement Manual, developed under the Grant Agreement between the Government of the Kyrgyz Republic and IDA from 10 March 2006.
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES Dispute resolution procedures are described in detail in Procurement Manual, developed under the Grant Agreement between the Government of the Kyrgyz Republic and IDA from 10 March 2006.
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organization in accounting, and reporting?	FM specialist will be hired for GAVI HSS – same as GAVI HSS I
19. What accounting system is used or will be used for the GAVI HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?)	1-C

20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Financial reporting on the implementation of the Grant HSS in the program format will be prepared by an expert on financial management. The financial statements will be prepared on a monthly basis. Reports on financial monitoring of the GAVI HSS funds will be channelled to the GAVI Secretariat within 60 days of the end of each quarter.
Internal control and internal audit	
21. Does the recipient organization have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES
22. Does an internal audit department exist within recipient organization? If yes, please describe how the internal audit will be involved in relation to GAVI HSS.	YES The Ministry of Health has set up an internal audit department. As part of SWAp, detailed arrangements for audit have already been developed. According to these measures, the Internal Audit Sector at the Ministry of Health is responsible to conduct an internal audit of health facilities and other institutions which are under the Ministry of Health, at least once a year. The department activity is conducted in accordance with state regulations. This is all described in detail in the Operational Guidelines for Financial Management.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)? ³	YES In accordance with the Law of the Kyrgyz Republic, all public funds are verified by the Chamber of Accounts. The Chamber conducts performance audits to assess the effectiveness of the use of funds under the various programs. The annual external audit of GAVI HSS funds will be done the Chamber of Accounts.
25. Who is responsible for the implementation of audit recommendations?	Finance Department of the Ministry of Health.

³ If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.

THREE PAGES MAXIMUM

Question (c): Please indicate the main constraints in the (health sector's) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfil the above functions

HALF PAGE MAXIMUM

Without a well-functioning system of financing, the health sector cannot achieved universal coverage for health services, and preserve and strengthen health achievements of previous reforms. It is extremely important to focus efforts on improving the capacity of financial sector managers and workers, creating conditions and incentives for health care providers to increase knowledge on financial management, and internal control and management accounting. Fiduciary aspects, as reflected in the implementation of the Program "Manas taalimi" have continued in the program "Den Sooluk". We need now to continue to develop activities to improve the capacity and efficiency of the financial management sector, as well as to reduce the fiduciary risks impeding the successful execution of the goals and objectives of the Den Sooluk and the GAVI HSS proposal.

Fiduciary aspects to enhance the management of health resources include:

- a) Increasing the capacity of the Ministry of Health Professionals, HIF, executives and financial officers, with training on financial management in health care;
- b) Continuation and completion processes for automated accounting and reporting;
- c) Integration of information systems from HIF and the Ministry of Health, and creation of a single medical and financial information resource;
- d) Improvement and institutionalization of the process of data collection and compilation of national health accounts;
- e) Improving procurement mechanisms, capacity building of professionals in the development and evaluation of technical specifications at the level of the Ministry of Health and health organizations;
- f) Strengthening internal audit and internal control, development of regulations to establish a system of internal control for health organizations, and strengthening financial management within health care organizations;
- g) Financial and operational audit according to international standards on an annual basis.

HSS Proposal Forms and Mandatory GAVI attachments

→ Please place an 'X' in the box when the attachment is included

No.	Attachment	X
1.	D1. HSS Application (final version)	X
2.	D2a. Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector D2b. Signature Sheet for Coordinating Committee (HSCC-HPC) members D2c. Signature Sheet for Interagency Coordination Committee (ICC) members(2pg)	X X X
3.	D3. HSS Monitoring & Evaluation Framework (final version)	X
4.	D4. HSS Detailed Workplan & Budget (final version)	X

Existing National Documents - Mandatory Attachments

Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.

→ Please place an 'X' in the box when the attachment is included

No.	Attachment	X
5.	D5a. National Health Reform Program Den Sooluk 2012-2016 D5b. Costing Den Sooluk 2013	X X
6.	D6a. M&E Strategy Den Sooluk 2012-2016 D6b. Package of Indicators Den Sooluk 2012-2016	X X
7.	D7. National Immunization Program 2013-2017	X
8.	D8a. cMYP Immunization 2012-2016 D8b. cMYP Immunization Costing & Financing 2012-2016	X X
9.	D9a. EVM Assessment 2011 D9b. EVM Improvement Plan 2013	X X
10.	D10a. HSCC-HPC Terms of Reference D10b. ICC Terms of Reference D10c. Joint Statement GoK Partners	X X X

Existing National Documents - Additional Attachments

Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.

→ Please place an 'X' in the box when the attachment is included

No.	Attachment	X
11.	D11. Joint Assessment Den Sooluk 2011	X
12.	D12. FMA Report 2013	X
13.	D13. HiT Kyrgyzstan 2011	X
14.	D14. Minutes of HPC, ICC	X

Applicants are strongly encouraged to carefully read the instructions provided within the relevant sections of the guidelines before completing the application form.