UNITED NATIONS DEVELOPMENT PROGRAMME

PROJECT DOCUMENT

Republic of Tajikistan

Project Title: Health System Strengthening

Project Number: Award: 00104446; Output 00106006

Implementing Partner: UNDP Country office in Tajikistan

Start Date:

End Date:

PAC Meeting date:

Brief Description
Within this project UNDP in close cooperation with WHO and UNICEF will support the Ministry of Health and Social Protection of Population of the Republic of Tajikistan to strengthen the capacities of the national primary healthcare system to provide immunization basic services to population, living in remote areas, which include children and women of childbearing age, labor migrants and their families people consuming unsafe water and residing in areas of high risk for infectious diseases, adolescents, and prisoners and newly released inmates. There are approximately 2,500 fixed and mobile vaccination points in the country. However, the access of population living in mountainous and remote areas to quality immunization services is often limited due to absence of nearby PHC points and poor infrastructure. UNDP will assist with rehabilitation of the dilapidated PHC/immunization facilities and construction of the new health centers and PHC points in remote areas. UNDP support will contribute to the common actions of WHO, UNICF and the Ministry of Health and Social Protection to improve the quality of immunization and basic healthcare services to the population in catchment areas. The main objective of the project is to improve immunization service system through: *(i) Strengthening capacity of PHC with focus on immunization service quality and safety;* *(ii) Improving equity in vaccination by increasing immunization coverage in low performing and hard-to-reach areas;* *(iii) Improving implementation of the National Health Strategy "Population Health of Tajikistan 2010-2020" with focus on immunization; and* *(iv) Improving readiness of population to immunization and MCH services.*

Contributing Outcome (UNDAF/CPD, RPD or GPD):
UNDAF Outcome 3. People in Tajikistan benefit from quality, equitable and inclusive health, education and social protection systems

CPD Outcome 1. People in Tajikistan have their rights protected and benefit from improved access to justice and quality services delivered by accountable, transparent, and gender-responsive legislative, executive and judicial institutions at all levels.

Indicative Output(s):
CPD Output 1.1. The national and subnational governments have the capacity to strategically plan, budget, monitor and deliver basic services in an inclusive, transparent and participatory manner

Total resources required:		$3,608,166.0
Total resources allocated:		$3,608,166.0
	UNDP TRAC:	n/a
	Donor: GAVI	$3,608,166.0
	Government:	n/a
	In-Kind:	n/a
Unfunded:		n/a

Agreed by (signatures):

Government	UNDP
Print Name: **Mr. Nasim Olimzoda, Minister of Health and Social Protection of Population of the Republic of Tajikistan**	Print Name: **Mr. Jan Harfst, UNDP Country Director**
Date:	Date:

I. DEVELOPMENT CHALLENGE

Tajikistan achieved and sustained high immunization coverage for all antigens in past five years. Despite the success, the Ministry of Health and Social Protection of Population (MoHSPP) and development partners are concerned with:

- → Expected decrease in the immunization outcomes unless healthcare system bottlenecks are not addressed, particularly at the PHC level; and
- → Gender, geographic and socio-economic inequities in immunization outcomes.

There is a shortage of PHC facilities – 92 additional village health centers should be constructed and existing 725 facilities need major repair after infrastructure optimization in accordance with the National Strategy of restructuring health facilities[1]. Private sector is not well developed in healthcare service delivery and is mostly confined to pharmacies and dentists. Private health care providers do not participate in the implementation of the national immunization program.

Target population, comprising children and women of childbearing age, labor migrants and their families, people consuming unsafe water and residing in areas of high risk for infectious diseases, adolescents, and prisoners and newly released inmates in mountainous areas live far away from PHC facilities or cannot access them seasonally due to harsh climate and poor communication infrastructure. In remote and hard-to-reach locations, vaccination is carried out once a quarter of a year with the help of mobile teams, which have an impact on coverage, vaccine management, cold chain and maintenance. Approximately 85% of vaccination is carried out by fixed service delivery sites, 10-12% - during the campaign and 3-5% - by mobile teams. The number of vaccination sessions per month depends on the target population, e.g. maternity wards, town and district health centers have daily hours of immunization while rural health centers immunize 1-2 times a month.

Some of village health centers and health houses are dilapidated and not fully staffed, therefore cannot deliver the required volume and quality basic services to the population in catchment areas. Absence of appropriate working conditions (combined with relatively low remuneration of healthcare professionals) makes the attraction and/or retention of qualified human resources even more difficult.

Charging patients for vaccination in public settings, more frequently observed among households with "lower socio-economic status", which could impede the update of immunization services affecting primarily poor households.

Cultural factors that affect immunization of girls and contributes to the high rate of home deliveries in certain communities (mostly in rural areas across the country). There is no systematic research that explores underlying causes to inform medium and long-term policies (aiming at favorable changes in attitudes among target groups and/or advancing service delivery interfaces to meet the needs).

Relatively low readiness to immunization among mothers either living in urban areas or with high education, or in the wealthiest households that can be caused by the lack of knowledge or misconceptions (presumably caused by better accessed to misleading information on the benefits and safety of vaccination).

Access to essential PHC services, namely to MCH services, including immunization is affected by a set of health system weaknesses:

- o **Inadequate physical access to PHC preventive services** in remote/mountainous areas due to:
  - → absence of PHC facilities – 92 village health centers are missing according to the National Strategy of restructuring health facilities;
  - → difficult terrain and climate, requiring outreach services to provide services to hard to reach communities.
- o The **capacity of existing village health centers** to sustain the delivery of MCH services including immunization (in long run) deteriorates quickly that will decrease the coverage of population with the essential services even in relatively well performing areas. Most of village health center

[1] [1] Ministry of Health and Social Protection of Population of the Republic of Tajikistan

infrastructure is old and dilapidated, equipment is dysfunctional due to the insufficient investment and maintenance;

- In addition to the limited resource, **ineffective organization of the delivery of preventive services** (vaccination in particular), affects the immunization performance;
- **Incomplete birth registration** still remains an issue as noted in the previous HSS application, the birth registration was about 88% in 2000-2010 and remained at the same level (88.4%) according to the DHS 2012[2]. It can impede timely enrollment of newborns in the immunization and reporting;
- **Inadequate medical practices at the PHC level** – as noted in the NIP Program review; this was confirmed by the recent household study.

A comprehensive and systematic review of service delivery related bottlenecks is provided in the recent WHO analytical report – "WHO Health Service Delivery in Tajikistan - a synthesis of findings 2014" and the report on recent household survey on identifying the causes of missed immunized children under 5 conducted by HAPU/MoHSPP with technical WHO support (in June-September, 2014).

High share of home deliveries in some communities prevent newborns to be vaccinated timely by the first dose of OPV, HepB and BCG.

Low readiness to vaccination among certain population groups, including children and women of childbearing age, labour migrants and their families is alarming (urban, highly educated, relatively wealthy) as noted in DHS 2012. Furthermore, as revealed by the recent survey a) awareness of the population about the importance of vaccination is still weak; many people think that vaccination of children under 5 can cure diseases; and b) EIC materials and mass media activities (brochures, flyers, TV, etc.) used are rather weak; population mainly gets information from the medical personnel.

Difficulties in the retentions of qualified health professionals (due poor working conditions, insufficient financial incentives) in remote areas contributes to significant inequalities in the distribution of health workforce between urban and rural areas, or the capital city of Dushanbe and the periphery as highlighted in the Health System Review. Furthermore, the level of knowledge and skills of available health workers at all levels is low, as stated in JAR 2013.

The country implements a National Health Strategy 2010-2020 with support of the development partners to address the healthcare system weaknesses in areas of service delivery, health care financing, resource mobilization, information systems and governance. The MoHSPP together with the development partners identified the main bottlenecks of achieving immunization outcomes and proposed interventions to address them through the HSS project as follows:

1. Inadequate geographic access to essential MCH services at the PHC level, including immunization.
2. Obsolete and inadequate supply chain management system that result in stock-outs and contribute to missed opportunities.
3. Low demand for the timely immunization in communities with high rates of home deliveries.
4. Socio-economic inequity in immunization outcomes due to the relatively low demand for timely immunization among mothers living in urban areas, with high education and/or from the wealthiest families.
5. Gender inequity in the immunization outcomes due to the cultural factors.
6. Missed opportunities for vaccination due to the inadequate micro-planning and improper medical practices, home deliveries and associated inadequate perinatal care and birth registration problems.
7. Injection safety and waste management deficiencies at the PHC level.
8. Lack of reliability and quality of immunization, as well MCH service coverage data and integration of evidence into the PHC/MCH related decision making at different levels

[2] [2] Demographic Health Surveys, 2012

II. STRATEGY

The main objective of the joint program is to strengthen health system and **improve immunization service system among targeted population,** which contributes to the *UNDAF Outcome 3 – People in Tajikistan benefit from quality, equitable and inclusive health, education and social protection systems*.

The activities of HSS project to be implemented by UNDP will directly contribute to achievement of the following immunization outcomes:

- *High immunization coverage sustained nationwide*
- *Geographic and socio-economic equity in immunization coverage improved*

UNDP support is based on the sound experience and comparative advantage in terms of established operational capacities for construction and rehabilitation of the rural social infrastructure addressing gender specific needs and sound experience in health items procurement. Through regular cooperation and coordination of project implementation with other implementing agencies: WHO, UNICEF and partners (MoHSPP) UNDP will ensure complementarities and synergy of the 'hard' and 'soft' components of HSS joint program.

The overall HSS programming framework is aligned with the National Health Strategy M&E system to ensure achievement of the HSS program expected outcome:

Output 1. Strengthen capacity of PHC with focus on immunization service quality and safety;
Output 2. Improve equity in vaccination by increasing immunization coverage in low performing and hard-to-reach areas;
Output 3. Improve implementation of the National Health Strategy "Population Health of Tajikistan 2010-2020" with focus on immunization; and
Output 4. Improve readiness of population to immunization and MCH services.

The HSS grant will be implemented by the three lead Implementers: the country offices of WHO, UNICEF and UNDP. MoHSSP will ensure overall coordination of the activities and will represent the Senior Beneficiary of the project. GAVI HSS funds will be directly channeled to the lead implementers in accordance with the budget and work plan and WHO CO Tajikistan will contribute to the activity plan by providing technical assistance within the framework of its expertise.

All three lead implementers will carry out procurement in accordance with the procurement plan and respective regulations of the agencies.

UNDP will be responsible for part of the activities implemented under the Output 1 and Output 2 including: a) procurement of vehicles and spare parts for PHC, b) rehabilitation of the existing PHC facilities and construction of the new PHC facilities, applying gender-responsive approach , c) procurement and installation of the necessary equipment and furniture, and d) optimization of transport use to benefit PHC and preventive services, as well as assessment of performance and quality of mobile team services.

WHO will be responsible for a) conducting operational research that is critical to inform certain HSS activities (e.g. selection of low performing districts/areas for PHC infrastructure investment, deployment of mobile team and advantaging home visiting services) and assess the HSS project implementation performance, and b) capacity building of PHC medical staff and management at the national and oblast levels.

UNICEF's areas of responsibilities include a) procurement and supply of cold chain equipment (including capacity strengthening for planning, installation and maintenance) and b) development of social mobilization and communication strategy and key information materials.

Lessons learned (relevant to UNDP part of HSS project)

Although the previous HSS, as well as other donor investments helped the country to upgrade immunization cold chain supply infrastructure, insufficient attention was paid to the maintenance and operation of cold chain equipment and transport. Based on the previous experience, the MoHSPP proposes to strengthen technical capacity in the country necessary for the maintenance of expensive equipment, to introduce innovative approach in terms of establishing a long term public-private partnership for the maintenance of equipment and uninterrupted operation of the immunization cold chain supply.

The support to mobile teams that was integrated into the National Health Strategy as a priority solution to increase coverage of hard-to-reach population will be continued and expanded to selected populations combined with home visiting services.

In addition, HSS grant will be used to accelerate expansion of mobile teams/outreach services in specific communities and generate sufficient evidence on its efficiency and effectiveness to secure public funds for sustaining its operation after the end of HSS grant. Therefore, the HSS grant is considered as a catalyst to implementing one of the priorities of the National Health Strategy.

General assumptions

The scale of support and investments is based on a profile of administrative units such as surviving infants/population per PHC facility, immunization coverage rates (administrative 2013) and home delivery rates. 28 districts performed the national average (96.1%) in 2013 when administrative DTP3 coverage figures are used for selection of priority districts. DTP3 coverage ranged from the lowest 90.4% to the highest 99.5%.

Considering administrative data accuracy concerns, the landscape of districts with low immunization performance might change dramatically. Therefore, it is expected that priority districts to be revised based on the findings of the immunization coverage evaluation survey (in 2015). Although the total number of PHC facilities to be constructed or refurbished will remain the same, quantities of PHC facilities (in districts with relatively higher immunization performance and in low performing districts/areas) might change.

III. RESULTS AND PARTNERSHIPS

Expected Results:

In line with the agreed distribution of responsibilities over implementation of the GAVI grant for Health System Strengthening, UNDP will be responsible for implementation of certain sets of activities planned under each two components/outputs of the grant approved by GAVI. In the framework of its Country Program Document for 2016-2020, UNDP will align the development support to be provided throughout this project with its strategic priority aimed at building capacities of the national and sub-national governments to deliver basic services in an inclusive, transparent, gender-responsive and efficient manner (ref. CPD Output 1.1).

UNDP will take responsibility for implementation of the following outputs and activities *(the activity numbering is retained from original HSS proposal for consistency)*:

Outcome: **Geographic and socio-economic equity in immunization coverage improved**

Output 1. Capacity strengthening of PHC with focus on immunization service quality and safety

1.C. Expand/upgrade transport for PHC including immunization *1.6. Procure necessary vehicles for PHC facilities and Centers of Immunoprophylaxis* *1.7. Optimize the use of transport to benefit PHC and preventive services*	This activity together with cold chain storage capacity strengthening and EVM improvement related activities increase performance of the supply chain for primary health care in general and contributes to the uninterrupted supply of vaccines to service delivery points particularly.
1.D. Improve MCH service delivery conditions (including immunization) in strategic districts (with high level of immunization coverage) *1.8. Capital repair of selected PHC facilities*	Immunization system performance is expected to suffer if PHC infrastructure is not optimized in areas with relatively high immunization coverage. Inadequate working conditions in dilapidated health facilities (village health centres) makes the

1.9. Construct new PHC facilities in selected areas *1.10. Purchase and install necessary medical equipment and furniture*	retention of PHC staff difficult. Furthermore, in some areas with high density of population the geographical access is below the national standards. These activities will contribute to the maintenance of satisfactory performance of immunization and will be implemented in accordance with the National PHC infrastructure Optimization Plan (that will be refined – see activity 2.6)

Output 2. Improve equity in vaccination by increasing immunization coverage in low performing and remote areas

2.A. Expansion of a network of mobile teams for reaching the population in hard-to-reach or low density areas *2.1. Assess the need for mobile services on an annual basis* *2.2. Establish and equip mobile teams* *2.3. Procure vehicles for mobile teams* *2.4. Support mobile team's operation* *2.5. Assess performance and quality of mobile team services*	This group of activities aim at reaching children in hard-to-reach areas and scarcely populated areas with poor access to fixed service delivery sites. The National PHC Infrastructure Optimization Plan does not envisage building Village Health Centres or Health Houses in some of such areas; therefore, mobile teams (composed of family doctors, vaccinators and midwives if needed) are proposed to cover this population with essential MCH services including immunization. The activities contribute directly to the reduction of geographical inequities in immunization coverage.
2.B. Improve geographical access to functional PHC facilities in hig *2.6. Refine PHC infrastructure optimization plan for selected districts* *2.7. Construct new facilities and provide capital repair of existing selected PHC facilities* *2.8. Select, recruit and train staff of selected medical facilities (and mobile teams) h-density population areas with low immunization coverage:*	These activities are expected to contribute to addressing geographical inequity in immunization coverage in areas with high density of population but with relatively low immunization coverage and poor PHC infrastructure in villages. As opposed to mobile teams, these activities provide more efficient and sustainable solution for reaching children with MCH and immunization services through fixed delivery sites.

Partnerships

A number of health financing and organization reforms piloted over the last decade in Tajikistan addressed most of health system bottlenecks in a limited number of administrative/geographic areas.

Introduction of new financing mechanisms including capitation at PHC level, case, scale up of BBP in 14 rayons have been supported by WHO, EU, Sino Project (SDC) and Quality health care project (QHCP) (USAID) in the last decade. Additionally, expansion to full per-capita financing for PHC services in Tajikistan is currently supported by the World Bank through an Institutional Development Fund (IDF) Grant. Furthermore, during 2014 WHO supported the development of Roadmap on implementation of comprehensive health financing reforms that should ultimately lead to introduction of MHI in 2017 to improve universal health coverage.

PHC infrastructure shortfalls are partially address by the WB supported Health Service Improvement Project (2013-2018). A set of healthcare financing related bottlenecks will be addressed in eight districts of Khatlon and Sughd regions through the introduction of Performance-Based Financing (PBF) of primary

healthcare (PHC) providers (village health centers and subordinated health houses). Finally, quality of care will be addressed through the training of PHC personnel on mother and child health (MCH) care using recently updated and MoHSPP approved training modules developed by the development partners, such as GiZ, UNICEF, UNFPA and WHO.

Furthermore, several development partners (such as WHO, EU, Sino Project (SDC), QHCP (USAID)), GIZ, etc.) support different activities to strengthen PHC, in particular family medicine practice. Accreditation of MCH health facilities allowing to improve quality of MCH service delivery has been supported by GIZ since 2013. Health management at PHC level including business planning at certain rayons are supported by Sino Project (SDC) and Aga-Khan. Restructuring of MCH in-patient facilities to provide efficient and quality MCH service in Khatlon region has been envisaged to be support by KFW in the upcoming year starting from 2014. Detailed analysis of waste management at PHC level is planned to be conducted by the MOH&SPP during 2014-2015 with the technical support of WHO.

Health information system and data management issues are addressed by EU supported initiatives; the present HSS project is expected to complement these activities focusing on the integration of immunization, as well as MCH services related to routine data flows into the health information mainstreams.

Stakeholder Engagement

The MoHSPP as the leading state authority on the development and implementation of the health and social protection policy is the main partner and beneficiary of the project. At the national level, the MoHSPP will assist in designing and monitoring of the necessary regulations, as well as provide support through its district and oblast level health and social protection departments. The MoHSPP will be a key member of the Steering Committee, will take part in regular monitoring of the project implementation and will provide its independed feedback on achievement of specified goals and objectives.

District and oblast level administrations of the selected areas will be directly involved in project implementation. The main role of the local administrations is to support the sustainable socio-economic status of the areas, improving welfare of people living in these areas, development of socio-economic infrastructure. UNDP has established a fruitful collaboration with the local authorities through building and strengthening their capacity in strategic planning and budgeting, management and leadership, resource mobilization, doing business, as well as improvement of the socio-economic infrastructure, which is expected to be used in project implementation.

CSOs are not involved (as lead implementers) in the HSS implementation. However, HSS project might entail the involvement of CSOs/NGOs: mini-grants might be awarded to CSOs/NGOs based on competitive selection process to support active engagement of communities and local governments in the organization and delivery of the MCH/immunization services in pilot districts. In addition, CSOs/NGOs could be involved in the implementation of social mobilization and communication strategy to target specific population groups.

The stakeholders also expected to be engaged in project implementation through the existing coordination mechanisms:

- → The Coordination Group (CG) was established in 2012 in order to design and implement the health sector reforms supported by the World Bank. The CG consists of 22 members who are technical experts and head of departments of the MoHSPP and is headed by the Minister of Health and Social Protection of the Population. The CG is not an independent legal entity and is an integrated part of the MoHSPP. The Deputy Minister will serve as the Coordinator responsible for a) daily coordination and oversight of the project activities and b) representing the MoHSPP on the HSS project activities that require communication with Government agencies and development partners. Relevant structural units under the responsibility of heads of department and specialists will implement most of activities the MoHSPP is directly in charge of;
- → The National Health Coordination Committee (NHCC) represents a sub-committee of the Donor Coordination Council (DCC) in charge of inter-sectoral coordination among the Government agencies and development partners at the national level. DCC is established within the framework of National Development Committee (INCC) under the President of the Republic of Tajikistan is in

place that deals with wider spectrum of issues. It deals with different sectors in Tajikistan. NHCC was established under the Government of the Republic of Tajikistan that deals with the wide health system issues focusing on the health priorities during each meeting;

→ The lead implementers, namely the Project Management Team on the Behalf of the MoHSPP, WHO, UNICEF and UNDP will report to the NHCC on an annual basis. The NHCC will compile and endorse the annual progress report on the HSS project implementation and the funding request to GAVI. The NHCC's primary function in the HSS project implementation governance is ensuring strategic oversight with active engagement of development partners.

South-South and Triangular Cooperation (SSC/TrC) and Knowledge

The HSS project envisages transfer of knowledge and skills to key personnel of the MoHSPP at the national and oblast level. Technical and advisory support from UNDP global Health and Development team will be sought as needed to ensure synergy with and to grasp potential benefit and knowledge from the other health-related activities implemented at UNDP corporate level. Best practices of other countries in supporting sustainable healthcare infrastructure and health system strengthening will be applied through learning and sharing the global knowledge with project partners and stakeholders. This approach ensures sustainable investment in human capital in areas of governance and management (unless offset by turnover of top level decision and technical opinion makers in the healthcare system)).

Sustainability and Scaling Up

Most of requested HSS funding constitutes investments in physical infrastructure (cold chain equipment, vehicles and buildings), as well as human resources (PHC managers and MCH/immunization medical personnel). Based on the experience of investments in the past, the country recognizes that additional efforts are needed to sustain investment related benefits:

→ The technical capacity of service providers and securing reliable quality cold chain maintenance services will be strengthened (by transferring knowledge and skills to technical professionals) to prolong the useful life of expensive equipment;

→ The Ministry of Health and Social Protection of Population will cover fully operational costs of newly constructed or refurbished and staffed village health centers ensuring uninterrupted delivery of essential MCH services during and after HSS project implementation;

→ The Ministry of Health and Social Protection of Population believes that extensive communication and social mobilization efforts will yield desired results and lower scale efforts would be sufficient to sustain the achievements (that will financed from the state budget);

→ Collection of evidence will be institutionalized and integrated immunization coverage evaluation and KAP surveys will be conducted regularly financed by the Ministry of Health and Social Protection of Population and development partners;

→ Training of PHC managers in priority areas is a short-term solution to cover urgent gaps; better integration of MLM modules in in-service training and introduction of the attestation of managers in immunization (and MCH services) is considered as a long-term solution for the capacity building and sustaining the required level of knowledge and skills.

Engagement of local communities and population including vulnerable and marginalized groups benefiting from project implementation in decision making and prioritization of activities will be insured through arrangement of community dialogues at the local level. The project will make sure that voices of different population groups are considered while planning and design of activities, including voices of local women, youth, children, people with disabilities and other vulnerable groups. Specific gender and social needs will be envisaged in the design of infrastructure projects, as well as environmental consideration will be taken into account to ensue resilience of rehabilitated/constructed health facilities.

PROJECT MANAGEMENT

Cost Efficiency and Effectiveness

The activities implemented by UNDP will make part of the portfolio of projects implemented by Communities program of UNDP. The portfolio approach allows saving on administrative and operational costs of the project, as well as benefit from the synergies with other infrastructure and social projects and activities implemented by the Communities program in rural areas. Monitoring of activities will be implemented by UNDP along with implementation of CO /CP monitoring plan. Area offices of Communities program will be engaged in direct management of activities at the local level.

Project implementation mechanism

The overall HSS grant will be implemented by the group of UN Agencies – WHO, UNICEF and UNDP. UNDP will be responsible for the part of activities of the grant. UNDP related activities will be implemented by Communities Programme (CP) utilizing the Direct Implementation Modality (DIM).

A joint Project Board will be established to provide strategic project management of the project, which will include representative of the donor (the GAVI Alliance), WHO, UNICEF, UNDP and the Government of Tajikistan (MoHSPP). The Project Board will review the progress of the project, including project reports and work plans. The Project Board will serve as a platform that key stakeholders will use it to discuss the overall direction of the project implementation, as well as to make strategic decisions to ensure the best use of resources to achieve goals and objectives.

The Project Board Meeting will be held regularly, at least once a year to discuss the work plan and project implementation.

International and local consultants will be involved on a need basis. UNDP will provide operational and management support in project implementation through its programme and operations units. For more effective communication of the project results, representatives of the donor and other key stakeholders will be invited to the Project Board meetings.

IV. RESULTS FRAMEWORK

Intended Outcomes as stated in the UNDAF:

Outcome 1. People in Tajikistan have their rights protected and benefit from improved access to justice and quality services delivered by accountable, transparent, and gender responsive legislative, executive and judicial institutions at all levels

Outcome 3. People in Tajikistan benefit from quality, equitable and inclusive health, education and social protection systems (

Outcome indicators as stated in the UNDP Country Programme Document, including baseline and targets:

CPD Outcome 1.

People in Tajikistan have their rights protected and benefit from improved access to justice and quality services delivered by accountable, transparent, and gender-responsive legislative, executive and judicial institutions at all levels.

CPD Output 1.1: The national and subnational governments have the capacity to strategically plan, budget, monitor and deliver basic services in an inclusive, transparent and participatory manner

Indicator 1.1.1: *Number of subnational governments/administrations which show improved capacities for planning, budgeting and monitoring, including on gender-responsive planning, budgeting and monitoring, basic service delivery*

Baseline: *2,* **Target (2020):** *4*

Applicable Output(s) from the UNDP Strategic Plan: Outcome 3: Countries have strengthened institutions to progressively deliver universal access to basic services

Project title and Atlas Project Number: Health System Strengthening, Award: 00104446; Output 00106006

EXPECTED OUTPUTS	OUTPUT INDICATORS	DATA SOURCE	BASELINE		TARGETS (by frequency of data collection)					DATA COLLECTION METHODS & RISKS
			Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5	
Output 1. Strengthen capacity of PHC with focus on immunization services quality and safety	*The number of necessary vehicles procured for PHC facilities and Centers of Immunoprophylaxis*	Reports of MoHSPP		2017	5	1	8	6		Project Reports
	The number of rehabilitated existing PHC facilities providing quality mother and child healthcare service	Reports of MoHSPP		2017				10	19	Project Reports
	The number of constructed new PHC facilities providing quality mother and child healthcare service	Reports of MoHSPP		2017				8	2	Project Reports
	The number of health facilities getting equipment and furniture	Reports of MoHSPP		2017				18		Project Reports

EXPECTED OUTPUTS	OUTPUT INDICATORS	DATA SOURCE	BASELINE		TARGETS (by frequency of data collection)					DATA COLLECTION METHODS & RISKS
			Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5	
<u>Output 2.</u> Improve equity in vaccination by increasing immunization coverage in low performing and remote areas	*The report on the annual needs in mobile services*	Reports of MoHSPP	0	2017	1					MoHSPP report
	The number of mobile team equipped	Reports of MoHSPP	5	2017	21					Project Reports
	The number of vehicles procured for mobile team	Reports of MoHSPP	5	2017	0	16	0	0	0	Project Reports
	The number of mobile team's operations supported	Reports of MoHSPP	5	2017	5	11	21	21	21	Project Reports, MoHSPP annual report
	Refined PHC infrastructure improvement plan	Reports of MoHSPP	0	2017	1					MoHSPP report
	The number of constructed new and rehabilitated PHC facilities in remote and hard-to-reach areas	Reports of MoHSPP	0	2017	0	9 constructed 27 rehabilitated 3 equipped	6 rehabilitated 39 equipped	24 rehabilitated 24 equipped	30 rehabilitated 30 equipped	Project Reports
	The number of training courses for mobile/new facilities	Reports of MoHSPP	0	2017			5			Project Reports

V. MONITORING AND EVALUATION

Monitoring Plan

Monitoring Activity	Purpose	Frequency	Expected Action	Partners (if joint)	Cost (if any)
Track results progress	Progress sex-disaggregated data against the results indicators in the RRF will be collected and analyzed to assess the progress of the project in achieving the agreed outputs	Annually	Slower than expected progress will be addressed by project management	MoHSPP, district and oblast level authorities	USD 50,000
Monitor and Manage Risk	Identify specific risks that may threaten achievement of intended results. Identify and monitor risk management actions using a risk log. This includes monitoring measures and plans that may have been required as per UNDP's Social and Environmental Standards. Audits will be conducted in accordance with UNDP's audit policy to manage financial risk	Annually	Risks are identified by project management and actions are taken to manage risk. The risk log is actively maintained to keep track of identified risks and actions taken	MoHSPP and project stakeholders	
Learn	Knowledge, good practices and lessons will be captured regularly, as well as actively sourced from other projects and partners and integrated back into the project	Annually	Relevant lessons are captured by the project team and used to inform management decisions.	MoHSPP and project stakeholders	
Annual Project Quality Assurance	The quality of the project will be assessed against UNDP's quality standards to identify project strengths and weaknesses and to inform management decision making to improve the project	Annually	Areas of strength and weakness will be reviewed by project management and used to inform decisions to improve project performance		
Review and Make Course Corrections	Internal review of data and evidence from all monitoring actions to inform decision making	Annually	Performance data, risks, lessons and quality will be discussed by the project board and used to make course corrections	MoHSPP and project stakeholders	
Project Report	A progress gender-positive report will be presented to the Project Board and key stakeholders, consisting of progress data showing the results achieved against pre-	Annually, and at the end of the project (final report)			

Monitoring Activity	Purpose	Frequency	Expected Action	Partners (if joint)	Cost (if any)
	defined annual targets at the output level, the annual project quality rating summary, an updated risk long with mitigation measures, and any evaluation or review reports prepared over the period				
Project Review (Project Board)	The project's governance mechanism (i.e., project board) will hold regular project reviews to assess the performance of the project and review the Multi-Year Work Plan to ensure realistic budgeting over the life of the project. In the project's final year, the Project Board shall hold an end-of project review to capture lessons learned and discuss opportunities for scaling up and to socialize project results and lessons learned with relevant audiences	Annually	Any quality concerns or slower than expected progress should be discussed by the Project Board and management actions agreed to address the issues identified		

Evaluation Plan

Evaluation Title	Partners (if joint)	Related Strategic Plan Output	UNDAF/CPD Outcome	Planned Completion Date	Key Evaluation Stakeholders	Cost and Source of Funding
Final project evaluation	WHO, UNICEF	The national and subnational governments have the capacity to strategically plan, budget, monitor and deliver basic services in an inclusive, transparent and participatory manner	People in Tajikistan benefit from quality, equitable and inclusive health, education and social protection systems	December 2021	MoHSPP, district and oblast level authorities	WHO budget, approx. $40,000

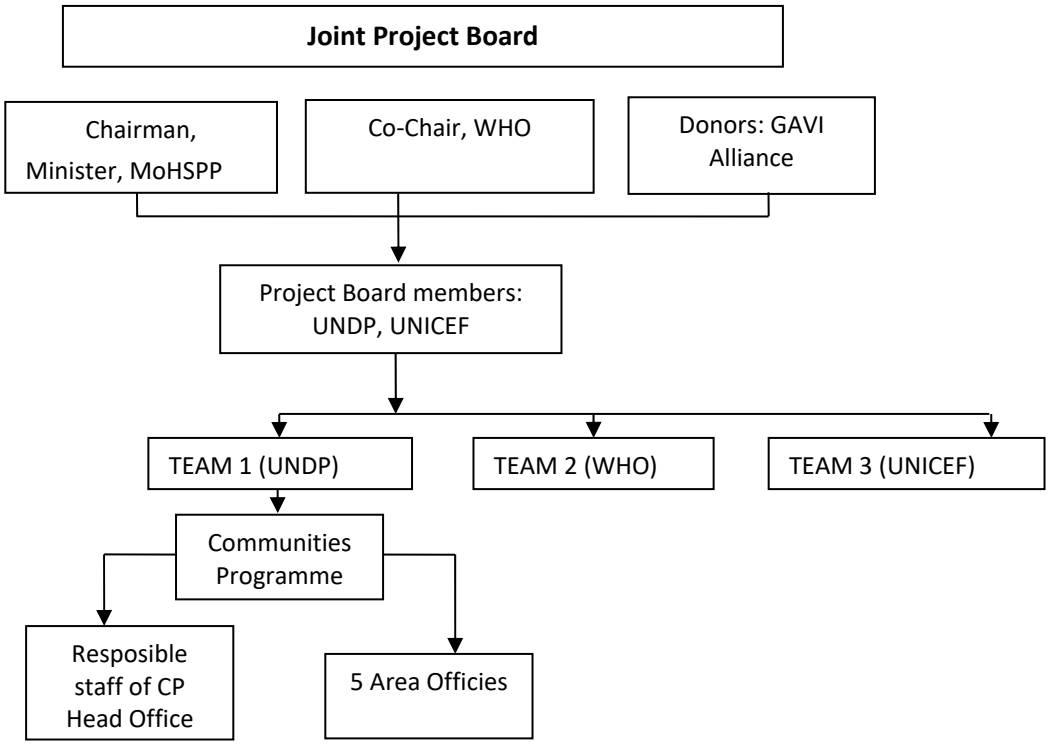
VI. MULTI-YEAR WORK PLAN

EXPECTED OUTPUTS	PLANNED ACTIVITIES	Planned Budget by Year					RESPONSIBLE PARTY	PLANNED BUDGET		
		Y1	Y2	Y3	Y4	Y5		Funding Source	Budget Description	Amount
Output 1. Strengthen capacity of PHC with focus on immunization services quality and safety *Gender marker: 1*	**1.C. Expand/upgrade transport for PHC including immunization**									
	1.6 Procurement of necessary vehicles and spare parts	$200,514	$15,042	$133,110	$102,028	$0	UNDP Tajikistan	GAVI		$450,694
	1.7 Optimization use of transport to benefit PHC and preventive services	$0	$0	$0	$0	$0	UNDP Tajikistan	GAVI		$0
	MONITORING	$9,000	$1,000	$3,000	$2,000	$0	UNDP Tajikistan	GAVI		$15,000
	Sub-Total for 1.C									**$465,694**
	1.D. Improve MCH service delivery conditions (including immunization) in strategic districts (with high level of immunization coverage)									
	1.8 Rehabilitation of the selected existing PHC facilities *ensuring gender-specific needs*	$0	$0	$0	$83,333	$156,334	UNDP Tajikistan	GAVI		$238,667
	1.9 Construction of new PHC facilities addressing both men and women needs	$0	$0	$0	$475,481	$119,370	UNDP Tajikistan	GAVI		$594,852
	1.10 Procurement and installation of necessary equipment and furniture	$0	$0	$0	$32,333	$0	UNDP Tajikistan	GAVI		$32,333
	MONITORING	$0	$0	$0	$8,000	$3,000	UNDP Tajikistan	GAVI		$11,000
	Sub-Total for 1.D									**$876,852**
Output 2. Improve equity in vaccination by increasing immunization coverage in low performing and remote areas *Gender marker: 1*	**2.A. Expansion of a network of mobile teams for reaching the population in hard-to-reach or low density areas**									
	2.1 – 2.2. Establishment and equipping the mobile team	$18,351	$0	$0	$0	$0	UNDP Tajikistan	GAVI		$18,351
	2.3 Procurement of vehicles for the mobile teams	$0	$220,556	$0	$0	$0	UNDP Tajikistan	GAVI		$220,556

EXPECTED OUTPUTS	PLANNED ACTIVITIES	Planned Budget by Year					RESPONSIBLE PARTY	PLANNED BUDGET		
		Y1	Y2	Y3	Y4	Y5		Funding Source	Budget Description	Amount
	2.4 – 2.5 Supporting mobile team's operation	$18,000	$41,800	$76,800	$76,800	$76,800	UNDP Tajikistan	GAVI		$290,200
	MONITORING	$2,000	$5,000	$3,000	$3,000	3,000	UNDP Tajikistan	GAVI		$16,000
	Sub-Total for 2.A									**$545,107**
	2.B. Improve geographical access to functional PHC facilities in high-density population areas with low immunization coverage:									
	2.6 Refining PHC infrastructure improvement plan for selected districts	$0	$0	$0	$0	$0	UNDP Tajikistan	GAVI		$0
	2.7 Construction of new and rehabilitation of existing PHC facilities in selected areas	$0	$756,222	$119,222	$239,444	$302,556	UNDP Tajikistan	GAVI		$1,417,444
	2.8 Selection, recruitment and training staff (mobile/new facilities) for selected medical facilities	$0	$8,796	$0	$0	$0	UNDP Tajikistan	GAVI		$8,796
	MONITORING	$0	$16,000	$3,000	$5,000	$3,000	UNDP Tajikistan	GAVI		$27,000
										$1,453,241
Evaluation *(as relevant)*	EVALUATION									
General Management Support		$19,829	$85,153	$27,051	$82,114	$53,125				**$267,272**
TOTAL										**$3,608,166**

VII. GOVERNANCE AND MANAGEMENT ARRANGEMENTS

The joint Project Board will act as the coordination mechanism for the joint project. The Project Board will be co-chaired by the Minister of Health and Social Protection of Population and the WHO. Senior management of UNDP, WHO and UNICEF will be members of the Project Board. It will also representative of the donor organization – GAVI Alliance.



Programme Manager (CPM), CP Dushanbe staff members and UNDP/CP Area Offices will provide programmatic and operational support to the target districts. They also will be involved for the implementation of daily management and complementary functions. UNDP Programme Analyst will provide strategic oversight of the project implementation and project quality assurance at the level of the Country office.

The main project management functions are:

- UNDP Programme Analyst (sustainable and equitable economic development portfolio, 5% engagement) will provide strategic oversight, advisory management support, general project implementation quality assurance, as well as other programmatic support;
- Communities Programme Manager (25%) will ensure overall management of project implementation and activities. He/she will coordinate the project activities with relevant state bodies and other stakeholders at the national level. CP Manager will be acting under the direct supervision of UNDP Senior Management and will deliver the main executing project decisions to Project Board;
- CP Dushanbe staff will support PM in programme/operations activities and daily coordination of practical implementation of all activities and reporting;

- CP Area Offices will be implementing project activities at the local level. Following staff of the Area Office will be accommodated for the project implementation, depending on the annual scope and location of activities:
    - Area Office Managers to oversee the project implementation, quality control, setting up the M&E framework in collaboration with CP Monitoring and Evaluation Specialist, ensuring timely delivery of reports, administrative support;
    - Local Development Specialist responsible for all project activities and products, preparation of TORs, formulation of strategies and provision of policy advice;
    - Area Officies Civil Engineers (50%) – responsible for overall activities related to implementation of infrastructure projects, sub projects design, preparation of BoQ, quality control, monitoring and evaluation of sub-projects;
- International/local consultants will be engaged based on the need to provide technical expertise required for the project.

VIII. LEGAL CONTEXT

This Project Document together with the United Nations Development Assistance Framework (UNDAF) for Tajikistan (2016-2020) and the UNDP Country Programme Action Plan (CPAP, 2016-2020) will be the instrument referred to as such in Article I of the Standard Basic Assistance Agreement between the Government of Tajikistan and the United Nations Development Program (signed by the parties on 1 October 1993).

Consistent with the Article III of the Standard Basic Assistance Agreement (SBAA), the responsibility for the safety and security of the Implementing Partner and its personnel and property, and of UNDP's property in the Implementing Partner's custody, rests with the Implementing Partner. To this end, the Implementing Partner shall:

a) put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried;

b) assume all risks and liabilities related to the implementing partner's security, and the full implementation of the security plan.

UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of the Implementing Partner's obligations under this Project Document.

The Implementing Partner agrees to undertake all reasonable efforts to ensure that none of the UNDP funds received pursuant to the Project Document are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by UNDP hereunder do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be accessed via http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml. This provision must be included in all sub-contracts or sub-agreements entered into under/further to this Project Document".

IX. RISK MANAGEMENT

Option b. UNDP (DIM)

1. UNDP as the Implementing Partner will comply with the policies, procedures and practices of the United Nations Security Management System (UNSMS.)
2. UNDP as the Implementing Partner will undertake all reasonable efforts to ensure that none of the project funds are used to provide support to individuals or entities associated with terrorism and that the recipients of any amounts provided by UNDP hereunder do not appear on the list maintained by the Security Council Committee established pursuant to resolution 1267 (1999). The list can be accessed via http://www.un.org/sc/committees/1267/aq_sanctions_list.shtml. This provision must be included in all sub-contracts or sub-agreements entered into under this Project Document.
3. Social and environmental sustainability will be enhanced through application of the UNDP Social and Environmental Standards (http://www.undp.org/ses) and related Accountability Mechanism (http://www.undp.org/secu-srm).
4. UNDP as the Implementing Partner will: (a) conduct project and programme-related activities in a manner consistent with the UNDP Social and Environmental Standards, (b) implement any management or mitigation plan prepared for the project or programme to comply with such standards, and (c) engage in a constructive and timely manner to address any concerns and complaints raised through the Accountability Mechanism. UNDP will seek to ensure that communities and other project stakeholders are informed of and have access to the Accountability Mechanism.
5. All signatories to the Project Document shall cooperate in good faith with any exercise to evaluate any programme or project-related commitments or compliance with the UNDP Social and Environmental Standards. This includes providing access to project sites, relevant personnel, information, and documentation.
6. UNDP as the Implementing Partner will ensure that the following obligations are binding on each responsible party, subcontractor and sub-recipient:
    a. Consistent with the Article III of the SBAA *[or the Supplemental Provisions to the Project Document]*, the responsibility for the safety and security of each responsible party, subcontractor and sub-recipient and its personnel and property, and of UNDP's property in such responsible party's, subcontractor's and sub-recipient's custody, rests with such responsible party, subcontractor and sub-recipient. To this end, each responsible party, subcontractor and sub-recipient shall:
        i. put in place an appropriate security plan and maintain the security plan, taking into account the security situation in the country where the project is being carried;
        ii. assume all risks and liabilities related to such responsible party's, subcontractor's and sub-recipient's security, and the full implementation of the security plan.
    b. UNDP reserves the right to verify whether such a plan is in place, and to suggest modifications to the plan when necessary. Failure to maintain and implement an appropriate security plan as required hereunder shall be deemed a breach of the responsible party's, subcontractor's and sub-recipient's obligations under this Project Document.

c. Each responsible party, subcontractor and sub-recipient will take appropriate steps to prevent misuse of funds, fraud or corruption, by its officials, consultants, subcontractors and sub-recipients in implementing the project or programme or using the UNDP funds. It will ensure that its financial management, anti-corruption and anti-fraud policies are in place and enforced for all funding received from or through UNDP.

d. The requirements of the following documents, then in force at the time of signature of the Project Document, apply to each responsible party, subcontractor and sub-recipient: (a) UNDP Policy on Fraud and other Corrupt Practices and (b) UNDP Office of Audit and Investigations Investigation Guidelines. Each responsible party, subcontractor and sub-recipient agrees to the requirements of the above documents, which are an integral part of this Project Document and are available online at www.undp.org.

e. In the event that an investigation is required, UNDP will conduct investigations relating to any aspect of UNDP programmes and projects. Each responsible party, subcontractor and sub-recipient will provide its full cooperation, including making available personnel, relevant documentation, and granting access to its (and its consultants', subcontractors' and sub-recipients') premises, for such purposes at reasonable times and on reasonable conditions as may be required for the purpose of an investigation. Should there be a limitation in meeting this obligation, UNDP shall consult with it to find a solution.

f. Each responsible party, subcontractor and sub-recipient will promptly inform UNDP as the Implementing Partner in case of any incidence of inappropriate use of funds, or credible allegation of fraud or corruption with due confidentiality.

   Where it becomes aware that a UNDP project or activity, in whole or in part, is the focus of investigation for alleged fraud/corruption, each responsible party, subcontractor and sub-recipient will inform the UNDP Resident Representative/Head of Office, who will promptly inform UNDP's Office of Audit and Investigations (OAI). It will provide regular updates to the head of UNDP in the country and OAI of the status of, and actions relating to, such investigation.

g. *Choose one of the three following options:*
   Option 3: UNDP will be entitled to a refund from the responsible party, subcontractor or sub-recipient of any funds provided that have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document. Such amount may be deducted by UNDP from any payment due to the responsible party, subcontractor or sub-recipient under this or any other agreement.

   Where such funds have not been refunded to UNDP, the responsible party, subcontractor or sub-recipient agrees that donors to UNDP (including the Government) whose funding is the source, in whole or in part, of the funds for the activities under this Project Document, may seek recourse to such responsible party, subcontractor or sub-recipient for the recovery of any funds determined by UNDP to have been used inappropriately, including through fraud or corruption, or otherwise paid other than in accordance with the terms and conditions of the Project Document.

   Note: The term "Project Document" as used in this clause shall be deemed to include any relevant subsidiary agreement further to the Project Document, including those with responsible parties, subcontractors and sub-recipients.

h. Each contract issued by the responsible party, subcontractor or sub-recipient in connection with this Project Document shall include a provision representing that no fees, gratuities, rebates, gifts, commissions or other payments, other than those shown in the proposal, have been given, received, or promised in connection with the selection process or in contract execution, and that the recipient of funds from it shall cooperate with any and all investigations and post-payment audits.

i. Should UNDP refer to the relevant national authorities for appropriate legal action any alleged wrongdoing relating to the project or programme, the Government will ensure that the relevant national authorities shall actively investigate the same and take appropriate legal action against all individuals found to have participated in the wrongdoing, recover and return any recovered funds to UNDP.

j. Each responsible party, subcontractor and sub-recipient shall ensure that all of its obligations set forth under this section entitled "Risk Management" are passed on to its subcontractors and sub-recipients and that all the clauses under this section entitled "Risk Management Standard Clauses" are adequately reflected, *mutatis mutandis*, in all its sub-contracts or sub-agreements entered into further to this Project Document.

X. ANNEXES

1. Social and Environmental Screening Template

Project Information

Project Information	
1. Project Title	Health System Strengthening
2. Project Number	Award: 00104446; Output 00106006
3. Location (Global/Region/Country)	Tajikistan, countrywide

Part A. Integrating Overarching Principles to Strengthen Social and Environmental Sustainability

QUESTION 1: How Does the Project Integrate the Overarching Principles in order to Strengthen Social and Environmental Sustainability?
Briefly describe in the space below how the Project mainstreams the human-rights based approach
The project envisages strengthening health system to address health issues of the most vulnerable population. The proposed interventions aimed at improvement of immunization service system to ensure equity in vaccination by increasing immunization coverage in low performing and hard-to-reach areas; and readiness of population to immunization and MCH services.
Briefly describe in the space below how the Project is likely to improve gender equality and women's empowerment
Although there is no gender related inequity in immunization coverage, hence no interventions were proposed to tackle gender related inequities, the proposed M&E approach remains sensitive to early detection of signals of possible gender inequality (in PHC service coverage and utilization) through the following mechanisms: → All operational research, immunization coverage evaluation surveys and KAP surveys specifically, will collect sex-disaggregated data and analyze it from a gender perspective; → Recording and reporting of sex-disaggregated data through routine medical statistics will be ensured, particularly while assessing the feasibility of integration of immunization related data flow into national HMIS. The project also will address such a bottlenecks as *gender inequity in the immunization outcomes due to the cultural factors*, in order to ensure achieving and sustaining immunization outcomes.
Briefly describe in the space below how the Project mainstreams environmental sustainability
The project does not directly contribute to environmental sustainability. It will cover environmental sustainability in the framework of building health system infrastructure.

Part B. Identifying and Managing Social and Environmental Risks

QUESTION 2: What are the Potential Social and Environmental Risks? *Note: Describe briefly potential social and environmental risks identified in Attachment 1 – Risk Screening Checklist (based on any "Yes" responses). If no risks have been identified in Attachment 1 then note "No Risks Identified" and skip to Question 4 and Select "Low Risk". Questions 5 and 6 not required for Low Risk Projects.*	**QUESTION 3: What is the level of significance of the potential social and environmental risks?** *Note: Respond to Questions 4 and 5 below before proceeding to Question 6*			**QUESTION 6: What social and environmental assessment and management measures have been conducted and/or are required to address potential risks (for Risks with Moderate and High Significance)?**
Risk Description	***Impact and Probability (1-5)***	***Significance (Low, Moderate, High)***	***Comments***	***Description of assessment and management measures as reflected in the Project design. If ESIA or SESA is required note that the assessment should consider all potential impacts and risks.***
Risk 1: Human rights: Capacity of local authorities and duty-bearers might be limited to support and enable results expected within the Project, due to lack of knowledge and skills and their engagement with other priorities at the district level	I – 3 P- 2	**Moderate**		Close cooperation will be maintained with local authorities; capacity building activities are envisaged to increase adherence and accountability to project results; the schedule of activities is adjusted to ensure the effective and timely implementation of project activities in the project target areas
Risk 2: Community Health, Safety and Working Conditions Potential that construction and renovation works pose the safety risk to local communities, including children (due to possibility of structural collapse, and physical hazard to health and safety of people during operations)	I – 2 P - 1	**Low**		Applicable policies, laws and regulations related to potential community, health and safety risks will be properly reviewed and taken into account in design and implementation of all structural and renovation works. When needed, gap-filling measures will be undertaken.
	QUESTION 4: What is the overall Project risk categorization?			
	Select one (see SESP for guidance)			**Comments**
	Low Risk	☐		
	Moderate Risk	☑		**Capacities of the national and sub-national government institutions and duty-bearers might be limited to ensure**

			appropriate function and prioritization of the HSS and immunization activities, thus affecting the quality of service provided
	High Risk	☐	
	QUESTION 5: Based on the identified risks and risk categorization, what requirements of the SES are relevant?		
	Check all that apply		**Comments**
	Principle 1: Human Rights	☑	Capacities of the national and sub-national government institutions and duty-bearers might be limited to ensure project results (require regular monitoring and timely mitigation measures)
	Principle 2: Gender Equality and Women's Empowerment	☐	
	1. Biodiversity Conservation and Natural Resource Management	☐	
	2. Climate Change Mitigation and Adaptation	☐	
	3. Community Health, Safety and Working Conditions	☑	Risks associated with construction and rehabilitation infrastructure (easy to manage and mitigate)
	4. Cultural Heritage	☐	
	5. Displacement and Resettlement	☐	
	6. Indigenous Peoples	☐	
	7. Pollution Prevention and Resource Efficiency	☐	

Final Sign Off

Signature	*Date*	*Description*
QA Assessor		UNDP staff member responsible for the Project, typically a UNDP Programme Officer. Final signature confirms they have "checked" to ensure that the SESP is adequately conducted.
QA Approver		UNDP senior manager, typically the UNDP Deputy Country Director (DCD), Country Director (CD), Deputy Resident Representative (DRR), or Resident Representative (RR). The QA Approver cannot also be the QA Assessor. Final signature confirms they have "cleared" the SESP prior to submittal to the PAC.
PAC Chair		UNDP chair of the PAC. In some cases PAC Chair may also be the QA Approver. Final signature confirms that the SESP was considered as part of the project appraisal and considered in recommendations of the PAC.

SESP Attachment 1. Social and Environmental Risk Screening Checklist

Checklist Potential Social and Environmental Risks		
Principles 1: Human Rights		**Answer (Yes/No)**
1.	Could the Project lead to adverse impacts on enjoyment of the human rights (civil, political, economic, social or cultural) of the affected population and particularly of marginalized groups?	No
2.	Is there a likelihood that the Project would have inequitable or discriminatory adverse impacts on affected populations, particularly people living in poverty or marginalized or excluded individuals or groups? [3]	No
3.	Could the Project potentially restrict availability, quality of and access to resources or basic services, in particular to marginalized individuals or groups?	No
4.	Is there a likelihood that the Project would exclude any potentially affected stakeholders, marginalized groups, from fully participating in decisions that may affect them?	No
5.	Is there a risk that duty-bearers do not have the capacity to meet their obligations in the Project?	Yes
6.	Is there a risk that rights-holders do not have the capacity to claim their rights?	No
7.	Have local communities or individuals, given the opportunity, raised human rights concerns regarding the Project during the stakeholder engagement process?	No
8.	Is there a risk that the Project would exacerbate conflicts among and/or the risk of violence to project-affected communities and individuals?	No
Principle 2: Gender Equality and Women's Empowerment		
1.	Is there a likelihood that the proposed Project would have adverse impacts on gender equality and/or the situation of women and girls?	No
2.	Would the Project potentially reproduce discriminations against women based on gender, especially regarding participation in design and implementation or access to opportunities and benefits?	No
3.	Have women's groups/leaders raised gender equality concerns regarding the Project during the stakeholder engagement process and has this been included in the overall Project proposal and in the risk assessment?	No
4.	Would the Project potentially limit women's ability to use, develop and protect natural resources, taking into account different roles and positions of women and men in accessing environmental goods and services?	No
Principle 3: Environmental Sustainability: Screening questions regarding environmental risks are encompassed by the specific Standard-related questions below		
Standard 1: Biodiversity Conservation and Sustainable Natural Resource Management		
1.1	Would the Project potentially cause adverse impacts to habitats (e.g. modified, natural, and critical habitats) and/or ecosystems and ecosystem services?	No
1.2	Are any Project activities proposed within or adjacent to critical habitats and/or environmentally sensitive areas, including legally protected areas (e.g. nature reserve, national park), areas proposed for protection, or recognized as such by authoritative sources and/or indigenous peoples or local communities?	No
1.3	Does the Project involve changes to the use of lands and resources that may have adverse impacts on habitats, ecosystems, and/or livelihoods? (Note: if restrictions and/or limitations of access to lands would apply, refer to Standard 5)	No
1.4	Would Project activities pose risks to endangered species?	No
1.5	Would the Project pose a risk of introducing invasive alien species?	No
1.6	Does the Project involve harvesting of natural forests, plantation development, or reforestation?	No
1.7	Does the Project involve the production and/or harvesting of fish populations or other aquatic species?	No

[3] Prohibited grounds of discrimination include race, ethnicity, gender, age, language, disability, sexual orientation, religion, political or other opinion, national or social or geographical origin, property, birth or other status including as an indigenous person or as a member of a minority. References to "women and men" or similar is understood to include women and men, boys and girls, and other groups discriminated against based on their gender identities, such as transgender people and transsexuals.

1.8	Does the Project involve significant extraction, diversion or containment of surface or ground water?	No
1.9	Does the Project involve utilization of genetic resources? (e.g. collection and/or harvesting, commercial development)	No
1.10	Would the Project generate potential adverse transboundary or global environmental concerns?	No
1.11	Would the Project result in secondary or consequential development activities which could lead to adverse social and environmental effects, or would it generate cumulative impacts with other known existing or planned activities in the area?	No
Standard 2: Climate Change Mitigation and Adaptation		
2.1	Will the proposed Project result in significant[4] greenhouse gas emissions or may exacerbate climate change?	No
2.2	Would the potential outcomes of the Project be sensitive or vulnerable to potential impacts of climate change?	No
2.3	Is the proposed Project likely to directly or indirectly increase social and environmental vulnerability to climate change now or in the future (also known as maladaptive practices)?	No
Standard 3: Community Health, Safety and Working Conditions		
3.1	Would elements of Project construction, operation, or decommissioning pose potential safety risks to local communities?	Yes
3.2	Would the Project pose potential risks to community health and safety due to the transport, storage, and use and/or disposal of hazardous or dangerous materials (e.g. explosives, fuel and other chemicals during construction and operation)?	No
3.3	Does the Project involve large-scale infrastructure development (e.g. dams, roads, buildings)?	No
3.4	Would failure of structural elements of the Project pose risks to communities? (e.g. collapse of buildings or infrastructure)	Yes
3.5	Would the proposed Project be susceptible to or lead to increased vulnerability to earthquakes, subsidence, landslides, erosion, flooding or extreme climatic conditions?	No
3.6	Would the Project result in potential increased health risks (e.g. from water-borne or other vector-borne diseases or communicable infections such as HIV/AIDS)?	No
3.7	Does the Project pose potential risks and vulnerabilities related to occupational health and safety due to physical, chemical, biological, and radiological hazards during Project construction, operation, or decommissioning?	No
3.8	Does the Project involve support for employment or livelihoods that may fail to comply with national and international labor standards (i.e. principles and standards of ILO fundamental conventions)?	No
3.9	Does the Project engage security personnel that may pose a potential risk to health and safety of communities and/or individuals (e.g. due to a lack of adequate training or accountability)?	No
Standard 4: Cultural Heritage		
4.1	Will the proposed Project result in interventions that would potentially adversely impact sites, structures, or objects with historical, cultural, artistic, traditional or religious values or intangible forms of culture (e.g. knowledge, innovations, practices)? (Note: Projects intended to protect and conserve Cultural Heritage may also have inadvertent adverse impacts)	No
4.2	Does the Project propose utilizing tangible and/or intangible forms of cultural heritage for commercial or other purposes?	No
Standard 5: Displacement and Resettlement		
5.1	Would the Project potentially involve temporary or permanent and full or partial physical displacement?	No
5.2	Would the Project possibly result in economic displacement (e.g. loss of assets or access to resources due to land acquisition or access restrictions – even in the absence of physical relocation)?	No
5.3	Is there a risk that the Project would lead to forced evictions?[5]	No
5.4	Would the proposed Project possibly affect land tenure arrangements and/or community based property	No

[4] In regards to CO_2, 'significant emissions' corresponds generally to more than 25,000 tons per year (from both direct and indirect sources). [The Guidance Note on Climate Change Mitigation and Adaptation provides additional information on GHG emissions.]

[5] Forced evictions include acts and/or omissions involving the coerced or involuntary displacement of individuals, groups, or communities from homes and/or lands and common property resources that were occupied or depended upon, thus eliminating the ability of an individual, group, or community to reside or work in a particular dwelling, residence, or location without the provision of, and access to, appropriate forms of legal or other protections.

	rights/customary rights to land, territories and/or resources?	
Standard 6: Indigenous Peoples		
6.1	Are indigenous peoples present in the Project area (including Project area of influence)?	No
6.2	Is it likely that the Project or portions of the Project will be located on lands and territories claimed by indigenous peoples?	No
6.3	Would the proposed Project potentially affect the human rights, lands, natural resources, territories, and traditional livelihoods of indigenous peoples (regardless of whether indigenous peoples possess the legal titles to such areas, whether the Project is located within or outside of the lands and territories inhabited by the affected peoples, or whether the indigenous peoples are recognized as indigenous peoples by the country in question)?	No
6.4	Has there been an absence of culturally appropriate consultations carried out with the objective of achieving FPIC on matters that may affect the rights and interests, lands, resources, territories and traditional livelihoods of the indigenous peoples concerned?	No
6.5	Does the proposed Project involve the utilization and/or commercial development of natural resources on lands and territories claimed by indigenous peoples?	No
6.6	Is there a potential for forced eviction or the whole or partial physical or economic displacement of indigenous peoples, including through access restrictions to lands, territories, and resources?	No
6.7	Would the Project adversely affect the development priorities of indigenous peoples as defined by them?	No
6.8	Would the Project potentially affect the physical and cultural survival of indigenous peoples?	No
6.9	Would the Project potentially affect the Cultural Heritage of indigenous peoples, including through the commercialization or use of their traditional knowledge and practices?	No
Standard 7: Pollution Prevention and Resource Efficiency		
7.1	Would the Project potentially result in the release of pollutants to the environment due to routine or non-routine circumstances with the potential for adverse local, regional, and/or transboundary impacts?	No
7.2	Would the proposed Project potentially result in the generation of waste (both hazardous and non-hazardous)?	No
7.3	Will the proposed Project potentially involve the manufacture, trade, release, and/or use of hazardous chemicals and/or materials? Does the Project propose use of chemicals or materials subject to international bans or phase-outs?	No
7.4	Will the proposed Project involve the application of pesticides that may have a negative effect on the environment or human health?	No
7.5	Does the Project include activities that require significant consumption of raw materials, energy, and/or water?	No

2. Risk Analysis.

Project Title: Health System Strengthening	**Award ID:** 104446	**Date:** ???

Description of risk	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	Mitigation Measures
Activity 1B:			
Institutional Risks: Internal – Governments internal review and approval procedures (related to public expenditure management and procurement) could cause delay in the procurement of goods and services and thus, in project implementation	**Medium**	**Medium**	The procurement of a large portion of commodities (cold chain equipment) was transferred to UNICEF, mitigating the risks associated with public procurement practices. The MoHSPP will communicate the HSS project procurement plan for 5 years (see Attachment #7) to the Government to secure support from relevant line ministries and set clear time line.
Fiduciary Risks: Sub-contractors selected through public procurement mechanism to construct new and rehabilitate existing PHC facilities fail to achieve the value-for-money objective or do not use some portion of funds for intended purpose	**Medium**	**Low**	The MoHSSP will apply two risk mitigation measures: • Risk-spreading: several qualified vendors will be selected with smaller face value of contracts (versus bulk procurement of civil works) to decrease the fiscal space for fiduciary risks • Fiduciary risk assessment of potential vendors will be conducted prior to contracting and strict mechanisms of financial accountability and operational monitoring and evaluation will be incorporated in the service contracts to minimize misappropriation of funds
Operational Risks: External - Fiscal space shrinks limiting the state's ability to take over fully operational costs and sustain critical MCH services including immunization	**Low**	**Medium**	The MoHSPP in consultations with the development partners will re-prioritize interventions under these objective to match resource requirements for the operation with available internal and external funding resources
Programmatic and Performance Risks: External- Epidemiological situation deteriorates (out-breaks of polio or other VPD) due to the threats (for	**Low**	**Medium**	The MoHSPP will apply to in-country and international donors to provide emergency support for the management of outbreak(s).

Description of risk	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	Mitigation Measures
instance, due to cross-border migration with Afghanistan) and a need arises to reallocate scarce resources urgently			
Other Risks:			
Overall Risk Rating for Activity 1.B	**Medium**		
Activity1.C:			
Institutional Risks: No objective specific risk			
Fiduciary Risks: Sub-contractors selected through public procurement mechanism to construct new and rehabilitate existing PHC facilities fail to achieve the value-for-money objective or do not use some portion of funds for intended purpose	**Medium**	**Low**	The MoHSSP will apply two risk mitigation measures: • Risk-spreading: several qualified vendors will be selected with smaller face value of contracts (versus bulk procurement of civil works) to decrease the fiscal space for fiduciary risks • Fiduciary risk assessment of potential vendors will be conducted prior to contracting and strict mechanisms of financial accountability and operational monitoring and evaluation will be incorporated in the service
Fiduciary Risk: support to mobile teams and home visiting (covering per diems and travel related expenditures)	**Low**	**Low**	The MoHSSP will channel the funds to selected PHC facilities as part of state healthcare budget subject to public financial management procedures and rules. The personnel of mobile teams and home visiting service will be reimbursed by designated healthcare facilities in accordance with the national accounting rules. The M&E officer of the HSS project will check regularly whether financial reports (and primary documents proving transfer of funds to staff members) correspond to the workload and actual performance.
Operational Risks: no objective specific risk			
Programmatic and Performance Risks: Coverage of hard-to-reach population by mobile	**Low**	**Low**	The MoHSSP may consider temporary reallocation of these services to other geographical areas (less affected by the

Description of risk	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	Mitigation Measures
teams (and home visiting services to a certain extent) can be impeded due to unusually harsh climatic conditions or natural disasters			climate) or compensation of missed opportunities through accelerated delivery of services whenever appropriate
Other Risks:			
Overall Risk Rating for Activity 1.C	**Low**	**Low**	
Activity 2.A			
Institutional Risks: no objective specific risk			
Fiduciary Risks:			
Operational Risks:			
Programmatic and Performance Risks: External - Political situation deteriorates and the government is not able to adhere to the implementation of long-term health strategies due to turnover of key decision makers and changes in priorities	**Low**	**Low**	The MoHSSP will adjust the implementation plan of the long-term health strategies (at targets if necessary) to compensate unexpected delays and move toward attainment of development goals. The MoHSSP in collaboration with partners will increase the visibility of public health strategies (including immunization) securing understanding and support from legislative and other branches of executive government to minimize a possible negative impact of turnover of key decision makers and associated revision of health sector priorities
Other Risks:			
Overall Risk Rating for Activity 2.A	**Low**	**Low**	
Activity 2.B			
Institutional Risks: no objective specific risk			
Fiduciary Risks: no objective specific risk			
Operational Risks: no objective specific risk			
Programmatic and Performance Risks: External - Socio-economic situation deteriorates and	**Low**	**Medium**	The MoHSSP together with development partners will introduce alternative financing mechanisms and will

Description of risk	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	Mitigation Measures
financial barriers impede access to and utilization of PHC services (including immunization)			reallocate available funding to high priority public interventions such as immunization as well as other preventive MCH service to mitigate this risk
Other Risks:			
Overall Risk Rating for Activity 2.B	**Low**	**Medium**	

3. Project Board Terms of Reference and TORs of key management positions

1. General information about the Project

Immunization is one of the basic services of primary health care (PHC). There are approximately 2,500 fixed and mobile vaccination points in the country. However there is still a shortage of PHC facilities. Private sector is not well developed in healthcare service delivery and is mostly confined to pharmacies and dentists, therefore it doesn't participate in the implementation of the national immunization program.

Moreover, some populations in mountainous areas live far away from PHC facilities or cannot access them seasonally due to harsh climate and poor communication infrastructure. Also some of village health centers and health houses are dilapidated and not fully staffed, therefore cannot deliver the required volume and quality basic services to the population in catchment areas. Absence of appropriate working conditions (combined with relatively low remuneration of healthcare professionals) makes the attraction and/or retention of qualified human resources even more difficult.

The main objective of the project "Health System Strengthening" is ***improvement of immunization of service system***, which is expected to be achieved through the following Outputs:

- Output 1: Strengthening capacity of PHC with focus on immunization service quality and safety;
- Output 2: Improving equity in vaccination by increasing immunization coverage in low performing and hard-to-reach areas;
- Output 3: Improving implementation of the National Health Strategy "Population Health of Tajikistan 2010-2020" with focus on immunization; and
- Output 4: Improving readiness of population to immunization and MCH services.

2. Project Board/Steering Committee: structure and membership

The Project Board (PB) makes a central element of the Health System Strengthening Project and is aimed to provide overall guidance and strategic direction to the project, including development, periodic revision, and implementation of the project strategy, and adaptation of global policies and best practices to country circumstances. The PB carries out monitoring and progress assessment of the Project activity and contributes to establishing mechanisms for the Project sustainability in Tajikistan. The PB is responsible for ensuring and monitoring of project technical and substantive quality.

The PB will serve as a platform for the major stakeholders of the project to discuss the overall progress of the project, and make strategic decisions and recommendations to be implemented by the project team.

The PB will consist of senior staff of the participating UN agencies, representatives of relevant government agencies representing interests of beneficiaries, and donor organizations. The PB meetings are co-chaired by the WHO Representative in Tajikistan and a high level representative of the Ministry of Health and Social Protection of Population of Tajikistan.

The responsibilities of Co-Chairs include:

- → Organization of the Project Board's meetings and invitation of participants.
- → Conducting meetings and encouraging all members for equal participation in discussions and evaluation of project;
- → Maintaining the meeting procedures as per principles of transparency and efficiency;
- → Approving of the Project Board's resolutions and sign Committee minutes.

Regular members of Project Board include representatives/senior staff of the following entities:

1. UN agencies (WHO, UNDP, UNICEF)
2. Ministry of Health and Social Protection of Population of Tajikistan.
3. GAVI Alliance.

Due to the complexity and inclusiveness of the Project activities, the PB may also invite to the meetings independent representatives and technical experts from other governmental organization, UN agencies,

local civil society organizations and international partner organizations, depending on the specific objectives and topic discussed at the specific PB's meeting.

3. Role and main functions of the Project Board

The PB will act as the coordination and management mechanism for the project. Its major role is to provide strategic oversight and direction of the programme, in order to ensure that it retains strategic focus, and delivers the agreed benefits. *It will:*

- → Make strategic decisions and provide guidance to senior management of implementing agencies;
- → Review and approve a consolidated summary annual work plan prepared by the project implementing agencies, ensuring that it is focused and consistent with deliverables set out in the Project Document;
- → Receive and if necessary approve progress reports against the work plans and take strategic decisions on how to address any major challenges brought to the PB's attention;
- → Monitor progress and impact of any wider issues - e.g. sector reform and other legislative changes, financial situation, programmes by other partners - that might impact upon the project and ensure that these are reflected as necessary within the project.
- → Consider and approve any substantive changes in the action plan or budget of the project upon submission of a solid justification by implementing agencies, should this be necessary;
- → Represent, as necessary, the interests of the project in high level government and development partners' discussions.

4. Responsibilities of the PB members

Each member of the PB should have a possibility to carry out the following functions:

- → Get acquainted with the concepts of the project, progress reports and annual work plans in advance, before the PB's meeting is held;
- → Consider the progress of the project against the targets set in the project logframe, provide remarks and comments as to reports and work plans;
- → Participate in monitoring of the execution of the Project in the field;
- → Participate in monitoring and evaluation of the activities implemented by UN agencies and the entire programme as a whole;
- → Participate in fact-finding visits to potential beneficiaries;
- → If necessary, participate in training and capacity building exercises that the project holds for potential beneficiaries.

5. Requirements to the work and representatives to the PB

- → The members of the PB should take all required measures to ensure full objectivity of the PB decision, both actual and formal (visible), and should avoid conflicts of interest or excessive influence. The representatives to the PB are obliged to ensure objectivity in the decision-making process using a principle of consensus, to exclude questions of personal character and conflict of interests as well as possible external influences.
- → In a case where a representative to the PB has any financial interest in the project or a conflict of interests with the project's vendors and contractors, s/he is obliged to inform the members of the PB well in advance and abstain from participation in the discussion even if s/he is not an executor under the project.

6. Financing

- → Members of the PB will fulfil the duties on a voluntary no-pay basis, without a financial compensation.
- → A compensation of expenses related to projects monitoring and evaluation and other Project related activities can be carried out upon submission of all confirming documents, according to the UN procedures and standards, and should be approved prior to expenses are made.

7. Steering Committee's meetings

The PB will meet at annually to ensure coherence, review progress, adjust programming and endorse joint annual work plans.

The minutes of the PB will be taken by the assigned Project responsible staff. UNDP office in Tajikistan will ensure that discussions and decisions taken at the PB are complementary and well communicated to all stakeholders and partners.