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ANNEX I

of the Commission Implementing Decision on the financing of the multiannual action plan in favour of the Asia region for 2021-2022

Action Document for Central Asia COVID-19 Crisis Response (CACCR) – Phase 2

ANNUAL PLAN

This document constitutes the annual work programme in the sense of Article 110(2) of the Financial Regulation, and action plans in the sense of Article 23(2) of NDICI-Global Europe Regulation.

1. SYNOPSIS

1.1 Action Summary Table

1. Title **CRIS/OPSYS business reference** **Basic Act**	Central Asia COVID-19 Crisis Response (CACCR) – Phase 2 CRIS number: 2021/043-342 Financed under the Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)
2. Team Europe Initiative	No
3. Zone benefiting from the action	The action shall be carried out in Central Asia Republics, namely Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.
4. Programming document	2021-2027 Asia-Pacific Regional MIP
5. Link with relevant MIP(s) objectives/expected results	Support for "resilience" and "prosperity" - Health is identified as a priority area in the Central Asia window of the 2021-2027 Asia-Pacific Regional MIP
PRIORITY AREAS AND SECTOR INFORMATION	
6. Priority Area(s), sectors	Building resilience and promoting prosperity
7. Sustainable Development Goals (SDGs)	**SDG 3** "Good Health and Well-being" Other significant SDGs (up to 9) and where appropriate, targets: **SDG 5** "Achieve gender equality and empower all women and girls" **SDG 8** "Decent work and economic growth" **SDG 10** "Reduced inequalities" **SDG 12** "Responsible consumption and production" **SDG 16** "Peace, Justice, and Strong Institutions" **SDG 17** "Partnerships for the Goals"
8 a) DAC code(s)	12220 - Basic health care (100%)
8 b) Main Delivery Channel	41000 - United Nations agency, fund or commission (UN) 41307 - WHO-Assessed - World Health Organisation - assessed contributions

9. Targets	□ Migration □ Climate **x** Social inclusion and Human Development **x** Gender □ Biodiversity □ Education[4] **X** Human Rights, Democracy and Governance[5]			
10. Markers (from DAC form)1	**General policy objective**	**Not targeted**	**Significant objective**	**Principal objective**
	Participation development/good governance	□	**X**	□
	Aid to environment	□	**X**	□
	Gender equality and women's and girl's empowerment	□	**X**	□
	Trade development	**X**	□	□
	Reproductive, maternal, new-born and child health	□	□	**X**
	Disaster Risk Reduction	□	**X**	□
	Inclusion of persons with Disabilities	□	**X**	□
	Nutrition	**X**	□	□
	RIO Convention markers	**Not targeted**	**Significant objective**	**Principal objective**
	Biological diversity	**X**	□	□
	Combat desertification	**X**	□	□
	Climate change mitigation	**X**	□	□
	Climate change adaptation	**X**	□	□
11. Internal markers and Tags:	**Policy objectives**	**Not targeted**	**Significant objective**	**Principal objective**
	Digitalisation	□	□	**X**
	Tags: digital connectivity		□	**X**
	digital governance		□	**X**
	digital entrepreneurship		□	□
	job creation		□	□

	digital skills/literacy digital services		**X** **X**	□ □
	Connectivity Tags: transport people2people Energy digital connectivity	□	**X** □ □ □ **X**	□ □ □ □ □
	Migration (methodology for tagging under development)	**X**	□	□
	Reduction of Inequalities (methodology for marker and tagging under development)	□	**X**	□
	COVID-19	□	□	**X**
BUDGET INFORMATION				
12 Amounts concerned	Budget line(s) (article, item): 14.020130 NDICI Middle East and Central Asia Total estimated cost: EUR 10,300,000.00 Total amount of EU budget contribution EUR 10,000,000.00 This action is co-financed in joint co-financing by the World Health Organisation for an amount of EUR 300,000.00.			
MANAGEMENT AND IMPLEMENTATION				
13. Type of financing	Project Modality Indirect management with an international organisation.			

1.2 Summary of the Action

The COVID-19 pandemic has severely affected people and economies worldwide, including in Central Asian Republics (CAR). Rapid COVID-19 vaccination in every country including in CAR is one of the key interventions to contain the pandemic and enable societies' and economies' recovery and their longer-term resilience.

The overall objective of this Action is to contribute to mitigating the impact and controlling the COVID-19 pandemic in CAR and reinforcing their longer-term health resilience. More specifically, the Action will provide assistance for: (i) a rapid and safe roll-out of vaccines, including setting up necessary legal and regulatory frameworks and information management systems, training medical staff involved in vaccination campaigns; (ii) building long-term resilience of routine immunisation systems to manage future vaccine-preventable disease outbreaks, including adequate monitoring and evaluation practices, development of immunisation plans and addressing vaccination inequity and (iii) building the capacity of CAR to achieve universal health coverage through the digitalisation of health systems and increased ability to collect and use quality health data.

The Action is based on the principle that "no one is safe until everyone is safe", as outlined in the Communication of 19 January 2021 on *a united front to beat COVID-19*[1]. This Action will support deployment of vaccines received by CAR through COVAX, the EU sharing mechanisms, and direct procurement from producers of COVID-19 vaccines.

The Action will be also embedded into the Team Europe approach focused on the achievement of Sustainable Goal 3 "Good Health and Well-being". The Action responds to one of the post-2020 priorities and targets of cooperation with CAR (health as part of the human development cluster) and the broader priorities of the EU cooperation with Asia and the Pacific (supporting resilience and prosperity). It will be fully aligned with the need to mainstream

[1] https://ec.europa.eu/info/sites/default/files/communication-united-front-beat-covid-19_en.pdf (europa.eu)

health, environment, and gender goals. An implementation mechanism and exchanging best practices, including country-as-the focus will be established.

2. RATIONALE

2.1 Context

The Action builds on and complements the ongoing Central Asia COVID-19 Crisis Response (CACCR) Programme Phase 1, implemented by the World Health Organisation (WHO) since July 2020 in Kazakhstan, Turkmenistan and Kyrgyzstan. The focus of the ongoing Action is to support national responses to the COVID-19 pandemic and strengthen national preparedness and response capacities, so that countries are better equipped to tackle future emergencies. The CACCR Phase 2 programme both complements and follows on naturally from it. Its main objective is to strengthen the resilience of immunisation systems of the five countries of CAR, facilitating a rapid exit from the COVID-19 pandemic and ensuring preparedness for future health crisis of this nature. It will serve to strengthen the general resilience of health systems in CAR. A key element will be the digitalisation of immunisation information systems.

The response to the COVID-19 pandemic is ongoing across the five CAR, with varying degrees of progress. Turkmenistan officially denies the existence of COVID-19 within its borders and has still not reported a single case. After reporting no cases since mid-Jan 2021, Tajikistan has in recent weeks started to report again which raises serious concerns about the reliability of the data reported by these two countries and their capacity to deal with public health crises. COVID-19 vaccine roll-out, largely relying on international solidarity (from COVAX and other sources, notably Russia and China), has been initiated in all 5 countries. The pace of the vaccination roll-out in the countries has been very slow, with only Kazakhstan reporting considerable progress with the roll-out, due to issues ranging from vaccine availability to low capacity and immunisation system inadequacies. Consequently, it will take much longer in these countries to reach the required level of population coverage. These challenges will be thoroughly addressed by the action proposed.

The communication "The EU and Central Asia - new opportunities for a stronger partnership" identifies support for "resilience" and "prosperity" as the principal areas of cooperation between the EU and Central Asia within the strategic framework of supporting greater collaboration and integration among the countries of Central Asia. These two pillars of the Strategy have been retained as the two priority areas of the Central Asia component of the Asia- Pacific Regional Indicative Programme for 2021-2027.

The COVID-19 pandemic has had a severe impact on the countries of the region, shutting down large sectors of their economies, including the generation of remittance from overseas work, principally in Russia. While there is a clear sense of urgency about the need to build back better on the basis of sustainable and inclusive economic development, it is also clear that this will only be possible once mass vaccination is successfully underway, which in turn requires a rapid and effective upgrading of immunisation systems across the region. The EU's own experience on this, as set out in the Communication on drawing the early lessons from the Coivd-19 pandemic (COM (2021) 380 final), is that working together at regional level has been the key to success, in view of the need for synergies, harmonisation and collaboration. At the same time, it will be essential to ensure the robustness of response systems to address future crises of this nature. The proposed CACCR Phase 2 programme is underpinned by the same approach.

2.2 Problem Analysis

COVID-19 vaccination:

It is planned to cover an estimated total of 22.6 million people in the initial phase of the COVID-19 vaccination campaign in CAR (based on national vaccine deployment plans). The populations planned for vaccination (based on the available information) currently range from 20% of the population in Kyrgyzstan (1.3 million), Tajikistan (6.7 million), Uzbekistan (6.7 million) and Kazakhstan (3.8 million) to 70% in Turkmenistan (4.2 million). Once the vaccine supply increases, it is anticipated that the total number of people who will be vaccinated in CAR will be much higher. COVID-19 vaccine deployment has started in CAR from February 2021. COVAX deliveries of AstraZeneca vaccines (AZ) and including donation of vaccines (US government supported Moderna) have taken place or expected in recent weeks in Kyrgyzstan, Tajikistan and Uzbekistan. CAR countries have also used other vaccines through bilateral deals for example Sinovac (Tajikistan, Kazakhstan), Sputnik-V (Turkmenistan, Uzbekistan, Kazakhstan), EpiVacCorona (Turkmenistan), Sinopharm (Turkmenistan, Kyrgyzstan), Sino-Uzbek in Uzbekistan including locally developed vaccines like Hayat-Vax and QazVac in Kazakhstan. Some of these vaccines have received the WHO EUL

and have been included in the COVAX portfolio in the meantime. The CAR have introduced the COVID-19 vaccination over a period of time: Kazakhstan on 1 February 2021, Kyrgyzstan on 29 March 2021, Tajikistan on 23 March 2021, Turkmenistan on 19 January 2021 and Uzbekistan on 1 April 2021. The following COVID-19 vaccination challenges faced by CAR have been identified by WHO/Europe based on a consultation with technical colleagues at regional level and in WHO country offices:

1. Increasing access to COVID-19 vaccines to ensure wider population coverage;
2. Monitoring safety of COVID-19 vaccines and vaccination;
3. Increasing demand and acceptance for COVID-19 vaccines and risk communication and community engagement;
4. Monitoring COVID-19 vaccine deployment and vaccination performance;
5. Strengthening vaccine and logistics management system to ensure continuous and timely supply of quality-assured vaccines.

The first challenge (1) will be dealt with through mechanisms like COVAX, bilateral agreements negotiated by governments and vaccine donations and sharing mechanisms from CAR partners. The last challenge (5) will be addressed through funding from similar mechanisms including developments Banks and Gavi (in three countries of the CAR, namely Kyrgyzstan, Tajikistan and Uzbekistan). While the guidance on the management system is provided by WHO, the vaccine logistics implementation is also supported by UNICEF in most of the CAR. The other three challenges (2,3 and 4) identified above are within the scope of WHO mandate, area of expertise and track-record and will be addressed as part of this action (under outcome 1).

Routine immunisation

Immunisation is one of the most cost-effective public health interventions for preventing, eliminating, and even eradicating life-threatening vaccine-preventable diseases, thereby minimizing child morbidity and mortality. Effective delivery of immunisation services encompasses vaccine and supply chain, trained staff, data monitoring, disease surveillance, community outreach and health records - all of which serve as the platform through which other basic primary health care services can be provided. Routine immunisation and primary health care contribute to health security by preventing diseases, supporting surveillance, and strengthening preparedness and response capacities for health emergencies. The reported routine immunisation coverage by the five CAR has been high , as illustrated in table 2.

Table 2: Immunisation coverage of diphtheria-tetanus-pertussis and measles containing vaccine

	National third-dose coverage of diphtheria- tetanus-pertussis containing vaccine - DTP3 coverage (2019)	National first-dose coverage of measles containing vaccine- MCV1 coverage (2019)
Kazakhstan	97%	99%
Kyrgyzstan	95%	96%
Tajikistan	97%	98%
Turkmenistan	99%	99%
Uzbekistan	96%	98%
Regional average	***95%***	***96%***

Despite the high reported national coverage, there are sub-optimal vaccination coverage levels in subnational areas leading to outbreaks of vaccine-preventable diseases affecting the pockets of vulnerable population.

The incidence of measles has increased in CAR in recent years, particularly in Kazakhstan, Kyrgyzstan and Uzbekistan (table 3). Measles cases in the CAR made up 64% of all reported measles cases in the WHO European region (53 Member States) for the time period December 2019 - November 2020. Repeated measles outbreaks point towards issues with (1) existing pockets of uncovered populations and (2) accuracy of vaccination coverage monitoring and reporting, especially at sub-national level.

Table 3. Reported measles cases in the 5 CAR and the WHO European Region from December 2018 - November 2019 and September 2019 - November 2020

	December 2018 - November 2019[2]	December 2019 - November 2020[3]

[2] https://www.euro.who.int/ data/assets/pdf file/0008/424952/2019-12-Epi Data EN December-2018-November-2019.pdf

[3] WHO/Europe | Vaccines and immunisation - EpiData 12/2020

	Measles cases	Measles incidence rate (per 1 million)	Measles cases	Measles incidence rate (per 1 million)
Kazakhstan	12,804	690	4,247	226
Kyrgyzstan	2,569	400	760	116
Tajikistan	7	0.8	168	17
Turkmenistan	0	0	0	0
Uzbekistan	1,974	60	4,208	125
Region	***115,594***	***124***	***14,149***	***15***

Immunisation challenges observed in CAR go beyond reported cases of measles and related potential monitoring and reporting issues. The population, which has never received vaccination against type 2 poliovirus in Tajikistan, remains vulnerable to circulating vaccine-derived poliovirus type 2 (cVDPV2) imported from Pakistan to Tajikistan, in November 2020 resulting in a massive outbreak of poliomyelitis (with 15 confirmed paralytic cases as of mid-July 2021). WHO has internally graded this situation in Tajikistan and neighboring countries as level 2 emergency.[4] The drivers of this large polio outbreak in Tajikistan are multiple. They range from global constraints with supply of inactivated polio vaccine (IPV) resulting in delays with the introduction of IPV, competing priorities of the national program due to simultaneous preparation and roll-out of COVID-19 vaccination, overstretched capacity of the national public health system and exhausted health budget. The outbreak in Tajikistan needs to be responded in a sub¬regional context involving Kyrgyzstan and Uzbekistan, which will have similar challenges with disease surveillance and preparedness for use of vaccines including campaigns as in Tajikistan. Detection of cVDPV2 in fully vaccinated children is another evidence of potential issues with immunisation data accuracy and reliability of reporting.

The following routine immunisation challenges common to the five CAR have been identified by WHO/Europe based on a consultation with technical colleagues at regional level and in WHO country offices:

1. Existence of pockets of un- and under-vaccinated susceptible population in subnational areas resulting in measles and polio outbreaks;
2. Inadequate capacity and skills of healthcare workers engaged in delivery of immunisation services and mid-level managers engaged in management of the immunisation programme at district and regional level;
3. Inadequate vigilance system to ensure monitoring safety of vaccines and vaccination;
4. Inadequate level of acceptance and demand for vaccines and vaccination and community engagement;
5. Inadequate monitoring and evaluation system and tools to monitor the immunisation programme performance, quality of immunisation data and inadequate use of local data for action.

All five challenges will be addressed as part of this action (under outcome 2). They all fall within the mandate, area of expertise and proven track-record of WHO/Europe.

Health information systems (HIS) and digitalisation of health systems

The COVID-19 pandemic has underscored the critical need in CAR to strengthen their health data and information systems, including surveillance and immunisation systems, and to ensure that the routes the data travel, from submission to use, are unobstructed. This applies widely to systems even beyond the health sector. In particular, the inability to effectively leverage the volume and different types of available data from routine health information systems has to date been a notable shortcoming of the pandemic response.

The Central Asian Republics Information Network (CARINFONET) is a collaborative network animated by WHO/Europe and bringing together the five countries as part of a platform for improving health information systems. It promotes collaboration within and between CAR to produce relevant, objective and accurate statistics. Thanks to this network, there is an overview of the current challenges of the CAR health information systems. These challenges have a clear and direct impact on the surveillance and immunisation systems. All these barriers have coexisted for decades, but only now have simultaneously impacted all countries in CAR and provoked an unprecedented crisis.

The following HIS challenges faced by CAR have been identified by WHO/Europe based on a consultation with technical colleagues at regional level and in WHO country offices as well as through the CARINFONET:

1. Lack of a national health data governance framework;
2. Difficulties to facilitate national and global data comparison and to facilitate the secondary use of data;

[4] https://www.who.int/emergencies/grading

3. Lack of health data standardization, such as the definitions, calculations, and formats of the data;
4. Lack of integration and interoperability between the different data and health information systems;
5. Lack of trained personnel to manage and use this data.

All five challenges will be addressed as part of this action (mainly under outcome 3). They all fall within the mandate, area of expertise and proven track-record of WHO/Europe.

The value of digital technologies in supporting national efforts to address different elements of ongoing COVID-19 pandemic response and recovery has been well recognised. Many of the technologies employed are not new, but their use in health systems has gained acceptance and further relevance in the context of responding to COVID-19 while maintaining the delivery of essential health services. Digitalisation has become an instrumental factor in modernizing health systems, creating new modes of health service delivery and unlocking the value of data that underpins their operation. Digital health is a key contributor in working towards universal health coverage by providing safe, timely and affordable access to health services for all and offers significant possibilities for improving the efficiency and reducing waste in the operation of health systems. Digital technologies can also facilitate training of the health workforce, improve surveillance and case management and can empower communities and individuals to improve their own health and well-being in innovative ways.

Despite the existence of state-level digitalisation initiatives aimed at strengthening national infrastructure and modernizing public services efforts, digitalisation of health systems in CAR countries has to date been largely piecemeal, being characterised by a lack of strategic investment and resources for digital health, an absence of governance and oversight, poor application of standards and limited training opportunities for healthcare professionals. COVID-19 has further exposed the chronic underinvestment in the digitalisation of primary health care and health information systems and highlighted an increased need for an integrated approach to the digitalisation of health systems. Digitalisation of immunisation information systems is an important tool to improve data for action and should be adopted as part of broader efforts for strengthening health information systems.

Kazakhstan has shown regional leadership among the CAR countries by investing in the design of a national digital health infrastructure and establishing the necessary legislative and regulatory foundations for developing a unified information space for the health care system and introducing national digital health services such as ePrescription and eReferral. Kyrgyzstan is rolling out the District Health Information System 2 (DHIS2) platform for epidemiological data management. However current infrastructures are limiting the roll-out to sub-national level. A full roll-out would require significant investment. DHIS2 is a platform that could sustain overall Health Information System (HIS) strengthening. Tajikistan is assessing the HIS to explore possibility to strengthen and expand DHIS2 implementation, including an EPI module & possibly COVID-19 vaccine module. Uzbekistan has implemented DHIS2-based TB electronic reporting system. There is interest to expand its use beyond the Tuberculosis programme, including the immunisation programme.

The following digital health systems challenges faced by CAR have been identified by WHO/Europe based on a consultation with technical colleagues at regional level and in WHO country offices:

1. Inadequate national digital health governance mechanisms;
2. Access of hard to reach populations and disadvantaged groups to digital technologies;
3. Inadequate health (including vaccination) information management systems and data accuracy;
4. Weak adoption of eHealth standards;
5. Poor health data governance;
6. Weak digital skills of healthcare professionals.

Health workers are at the forefront of the fight against COVID-19 in all countries, both as recipients and providers of the vaccine. This action will support and equip them with the right knowledge, tools and policies in addressing the COVID-19 pandemic. The aim is to ensure they are protected from the virus and constitute a high priority group for vaccination. National authorities, in particular Ministries of Health, the National Public Health Institutes and local health authorities, Ministries of Labour and Social Security, Ministries of Emergency Situations will directly benefit from the action and play a critical role. They will be implementing or co-implementing many of the policies, protocols and activities of this action. National regulatory authorities and import and customs officials will play a critical role in delivering market authorisations for vaccines and in ensuring smooth entry of procured or donated vaccines into the CAR countries.

Mobilising local civil society organisations (CSOs), especially those active in the health sector and in COVID-19 response, as well as other non-state actors to support the implementation and the achievement of the objectives of this action will be considered, particularly in activities related to responding to vaccine hesitancy and promoting demand and acceptance, such as public awareness raising, tackling disinformation and misinformation and providing fact- based information to local communities, however, the involvement of CSOs in the implementation of the objectives will be determined by the willingness of the respective Ministries of Health.

3 DESCRIPTION OF THE ACTION

3.1 Objectives and Expected Outputs

The overall objective of this Action is to mitigate the health impacts of the COVID-19 pandemic in CAR and reinforce longer-term health systems resilience. This will contribute to accelerated progress towards universal health coverage and improved health and well-being of all people.

The Specific(s) Objective(s) (Outcomes) of this action are:

1. A rapid and safe deployment of COVID-19 vaccines in CAR is achieved;
2. Routine immunisation services in CAR are strengthened
3. Health information systems and the use of digital solutions in CAR countries digitalization are improved.

The Outputs to be delivered by this action contributing to the corresponding Specific Objectives (Outcomes) are:

Contributing to Outcome 1 (or Specific Objective 1):

1.1 Immunisation Health workforce is trained in deployment of COVID-19 vaccines and immunisation waste management.

1.x Vaccination sites are properly equipped and their distribution is optimised to ensure universal access to vaccinations

1.2 Vaccination coverage and vaccine safety events are monitored and analysed.

1.3 Evidence/insights to understand vaccine hesitancy/demand and acceptance as well as misinformation are collected and used to inform communication/information activities.

1.4 Digital vaccination registries are established to support the accuracy in monitoring of and effectiveness of COVID-19 vaccines and utilised as a part of routine vaccination programmes.

1.5 Policy dialogue and peer-to-peer learning on COVID-19 vaccination in CAR facilitated nationally and regionally.

Contributing to Outcome 2 (or Specific Objective 2):

2.1 Tailored immunisation implementation plans are developed and implemented to address the “barriers” identified by the formative research to address immunisation inequity.

2.2 Disease-specific surveillance platforms are reviewed and strengthened to detect any outbreak including capacity building to enable timely investigation and response.

2.3 Robust immunisation information systems for real-time monitoring of subnational vaccination coverage are strengthened/developed.

Contributing to Outcome 3 (or Specific Objective 3):

3.1 Health information systems are assessed and capacities to collect, analyze and use health information and data are strengthened.

3.2 National digital health capacities are assessed and strengthened.

3.3 Governance mechanisms of health information systems and digital health strengthened and peer-to-peer exchanges between countries facilitated

3.2 Indicative Activities

Activities related to Output 1.1:

- training modules on COVID-19 vaccination are developed;
- trainings to health care workers are provided.

Activities related to Output 1.2:

- staff training to manage vaccination data monitoring system;
- support the development of national and regional plans for monitoring vaccine coverage data and regular dissemination of the information;
- training of health workers on vaccine safety monitoring and reporting; ensure safety monitoring committees review COVID-19 vaccine safety data;
- support the development of surveillance plans for COVID-19 vaccine adverse events;
- support the development and management of a coordination mechanism between relevant stakeholders for exchange of vaccine safety information;
- support to define the standard data elements of Smart Vaccination Certificate (SVC) to improve recording and reporting of COVID-19 vaccination doses.

Activities related to Output 1.3:

- behavioural insights and formative research based on WHO tools to identify the public's risk perceptions, decision-making factors and barriers/drivers for accepting and utilizing COVID-19 vaccination to inform the intervention and communication plan for COVID-19 vaccine deployment;
- developing and implementing information and communication campaigns based on local research findings.

Activities related to Output 1.4:

- support the development of standardised national digital vaccination registries in each CAR country.

Activities related to Output 1.5:

- establish and effectively and transparently operate necessary governance structures (strategic and operational at national and/or subnational levels), ideally within the national COVID-19 emergency operational mechanism for pandemic response;
- organise bimonthly information exchange webinars on specific programmatic areas and facilitate quarterly information exchange webinars on best practices; establish regional platform to share experience between CAR on COVID-19 vaccination;
- conduct annual "Challenges and Innovation" webinars (or in-person consultation); ensure effective exchange of information and coordination with other programmes.

Activities related to Output 2.1:

- conduct rapid formative research in identified subnational areas of under-performance (based on monitoring of subnational vaccination coverage) to explore the reasons for low immunisation coverage;
- based on the evidence collected, support the development and implementation of subnational micro-plans and including necessary interventions for routine immunisation catch-ups.

Activities related to Output 2.2:

- review of the existing measles-rubella and poliomyelitis surveillance systems using WHO standard assessment including data collection and analysis processes;
- capacity building of the subnational vaccine-preventable disease surveillance and immunisation focal points on processes related to timely investigation and management of the cases respectively using WHO training modules

Activities related to Output 2.3:

- Assessment of immunisation information systems;
- identify the gaps and challenges in reporting and recording of vaccination coverage followed by development of appropriate tools to ensure timely subnational data analysis and use of data for action.

Activities related to Output 3.1:

- conduct an assessment of the national health information system to identify main strengths, weaknesses, opportunities, and threats in each of the main HIS domains (data collection; analysis; health reporting; knowledge translation; and governance & resources);

- integrate the vaccine-preventable disease surveillance and the immunisation information systems in the wider national health information system; support the design and adoption of improvement plans on data and health information systems for each country;
- provide capacity building (training) aimed at improving health information selection and use for

policymaking in CAR.

Activities related to Output 3.2:

- conduct a comprehensive national assessment of the status of digital health in each of the CAR countries to identify gaps and opportunities and help shape national action plans for digital health;
- establish a training and mentoring programme for senior health policy advisers with responsibility for digital health in CAR countries to increase knowledge on leadership in the management of national digital health programmes.

Activities related to Output 3.3:

- support the design and adoption of an updated work plan for CARINFONET and support the exchange of good practices and lessons learned from COVID-19 in the Forum; conduct study visits with special attention in areas where further improvement is needed;
- organise high-level meetings among CAR to facilitate direct knowledge exchange; assist health authorities to establish a digital health governance entity in each CAR country and enable development of an updated national digital health strategy;
- establish a CAR digital health network;
- convene quarterly meetings of the network and identify areas for mutual discussion and interregional collaboration.

3.3 Mainstreaming

The environmental and climate change risk screenings carried out in the design stage concluded that key environmental and climate-related aspects need be addressed during the implementation. The spreading of COVID-19 puts additional pressure on national systems of waste management, including of medical, household and other hazardous waste. A safe handling and disposal of generated waste (i.e. personal protection equipment, syringes, vials and other medical equipment) is a critical element in an effective emergency response. International good practice is available, for example, the UN Basel Convention's "Technical Guidelines on the Environmentally Sound Management of Biomedical and Healthcare Wastes". Given that medical and domestic waste can become mixed, the safe management of household waste is also likely to be important. Furthermore, access to water supply and sanitation is critical to addressing the spread of COVID-19, as basic hygienic measures constitute fundamental tools against the spread of the virus.

Gender Equality and empowerment of women and girls

As per OECD Gender DAC codes identified in section 1.1, this action is labelled as G1. This implies that the project implementers will consider gender issues. Project implementers will develop an agreed anti-discriminatory approach in particular in COVID-19 vaccination and routine immunisation activities both for aspects related to provision, delivery and acceptance of vaccine. They will also adequately educate women on the safety and efficacy of COVID-19 vaccine, who are overwhelmingly primary caretakers in their families and constitute a substantial majority of the health workforce. Moreover, they will put in place anti-discriminatory systems, which involve women health workers in the decision-making bodies that initiate emergency protocols. The action will be coherent with the EU Gender Equality Strategy. The evaluation and monitoring framework of the action will consider gender-disaggregated indicators.

Human Rights principles will be central in the implementation of the action. A particular attention will be paid to ensuring full respect for human rights and equal treatment of all. Persons with disabilities and pre-existing conditions (particularly girls, women and elderly) may be at greater risk due to inaccessible information about COVID-19 vaccination and may experience barriers to accessing health services including routine immunisation. All interventions and extra protection measures will be delivered to those who are at most risk of being disproportionately affected by the crisis. Containment measures, social distancing and self-isolation are also disproportionately affecting the *elderly* and those with pre-existing medical conditions. Project implementers will therefore pay particular attention to provide education and outreach to the elderly population and prioritise them for COVID-19 vaccination as they are in a highrisk group.

The pandemic has challenged not only health and economic systems, but also adversely impacted already fragile conditions for democracy in the region. Due to the emergency measures, the pandemic also took a heavy toll on electoral processes and freedom of assembly. The COVID-19 crisis opened the door to new risks of increased inequality and disinformation that undermines credibility of the EU and state authorities. This action will complement

the EU's efforts to strengthen democratic and civic resilience in Central Asia through supporting rapid and effective vaccination allowing a gradual return to normalcy for people. Digitalisation activities under outcome 3 will also contribute to democratization efforts in the region.

The cooperation with civil society organisations and other non-state actors, such as community-based organisations, will be considered in supporting the implementation and the achievement of the objectives of this action, notably in activities linked to addressing vaccine hesitancy, promoting vaccine acceptance and up-take, public awareness raising, especially among the rural communities as well as efforts related to tackling disinformation and misinformation and providing fact-based information to the population.

Countries and their civil protection systems, weakened by the heavy reorientation of all possible state resources to tackle the pandemic, are particularly vulnerable in the event of disasters. To ensure a proper level of *Disaster Risk Reduction*, the emergency response plans and recovery strategies need to be compatible with the country's efforts to fights the pandemic, due to an overlaying nature of risks that effect and threaten all sectors. The action will partly address this aspect through activities linked to assisting the Central Asia countries in implementing effective risk communication strategies and campaigns, underlying the importance of evidence-based risk communication to tackle misinformation.

3.4 Risks and Lessons Learnt

Category	Risks	Likelihood (H/M/L)	Impact (H/M/L)	Mitigating measures
Planning, processes and systems	Inadequate in-country governance and coordination of various government stakeholders and partners to manage the COVID-19 vaccine deployment	**H**	**H**	Ensuring the coordination of COVID-19 vaccination within the overall structure of national COVID-19 response going beyond the Ministry of Health and including other key stakeholders
Planning, processes and systems	Inadequate preparedness while the country decides to import/accept and deploy vaccine	**M**	**M**	Ensuring regular monitoring and evaluation of country-specific indicator-based preparedness level by in-country and regional coordination groups
Legality and regularity aspects	Delays in regulatory provisions to roll-out vaccine products and decision on liability and indemnification of the novel vaccines	**H**	**H**	Engagement of the national immunisation programme with the national regulatory authorities of drugs and vaccines including the coordination with the legal unit of the Ministry of Health on liability and indemnification agreement with COVAX and/or vaccine manufacturers
Legality and regularity aspects	Risks related to corruption	**M**	**H**	Ensure a high degree of transparency and accountability across the lifetime of the action
Communication and information	Poor acceptance of COVID-19 vaccine by the population groups and misinformation about the new vaccine	**M**	**M**	Context-specific communication campaigns by the immunisation programme, based on understanding of the causes through formative research, to communicate proactively on the safety, efficacy, quality and benefits of the vaccine

External environment	Inadequate supplies of COVID-19 vaccines	**M**	**M**	Explore options to access vaccine through COVAX or access to donated vaccines (outside the scope of the action).
External environment	Inadequate cold chain storage equipment	**M**	**M**	Scale-up efforts as part of the action to address cold chain issues. Strong coordination with other partners (including UN organisations) involved in cold chain related issues.
External environment	Political instability	**M**	**M**	Strong existing cooperation with existing administration (i.e. notably ministries of health) to ensure continuity despite political changes. Flexibility in implementation to account for change of priorities.
People and the organisation	Inadequate delivery of the available vaccine doses and delayed implementation of vaccine roll-out	**M**	**M**	Ensuring proper training of medical staff and cold chain management to store and distribute vaccine to the last delivery points including regular monitoring of the vaccine uptake
External systems and decision-making	Changing priorities of the Ministries of Health influencing decision-making on implementation of the activities	**M**	**M**	In-country multi-stakeholder consultative mechanism and periodic review of the planned activities. Flexibility in implementation to account for change of priorities.

Lessons Learned:

The Action will particularly seek synergies with existing EU COVID-19 response programmes in CAR, both at national and regional levels. The action will build on the existing EU regional COVID-19 response action in CAR, implemented by WHO/Europe, and national EU health actions (e.g. HDP in Tajikistan) as well as on the WHO-led and EU funded UHC-Partnership presently in three of the CAR. The current Central Asia COVID-19 response action implemented by WHO/Europe is targeting Kazakhstan, Turkmenistan and Kyrgyzstan. Its focus is on support COVID-19 national responses as well as supporting the strengthening of national preparedness and response capacities, so countries are better equipped to handle future emergencies. COVID-19 vaccination was not included in the scope of the action during its inception and the potential resources available to tackle COVID-19 vaccination related needs in the context of that action are therefore limited. The complementarity between this ongoing action and the one proposed here would be very high. As experience from countries with ongoing vaccination deployment shows, national COVID-19 containment measures remain essential in parallel to vaccination deployment. Also, some of the COVID-19 surveillance activities implemented as part of the ongoing action, even though limited and only targeting three of the CAR, will be complementing the more significant immunisation and broader health systems activities foreseen in the context of the proposed action. The Action builds upon the support provided by WHO/Europe to the CAR since mid-2020 to help them prepare for the deployment of COVID-19 vaccine and vaccination and the lessons learned from the initial 3-6 months of vaccination implementation in these countries. The experiences show that the efficient deployment of COVID-19 vaccines is not only depending on the availability of vaccine doses but also on systemic governance, service-delivery and vaccine demand issues described above. While the countries are keen to innovate and improvise to ensure effective deployment of the available vaccine doses to its population groups, building upon the existing routine immunisation service delivery and structure, there is a recognition of substantial need for technical assistance, capacity building of health workforce and support with procurement of necessary equipment to ensure delivery of potent vaccines. WHO/Europe will work closely with a range of partners on the different areas of intervention outlined here above. Collaboration with UNICEF will be particularly critical, especially in Gavi supported countries where the two organisations work closely and extensively together. Attention will be given to ensuring synergies with other actions implemented by international and bilateral partners in Central Asia including through the UN country teams, in which WHO is leading the COVID-19 vaccination deployment and delivery, but also more broadly through non-UN partners, notably through the pre-existing donor coordination mechanisms bringing together partners and national authorities. Implementation partners are currently mapping out their assistance plans to ensure maximum efficiency and complete coverage for all CAR in need of assistance. Technical assistance partners will include: WHO, UNICEF, ECDC, US CDC, Global Polio Eradication Initiative partners and funding partners will notably include: Gavi, the World Bank and the Asian Development Bank.

3.5 The Intervention Logic

The underlying intervention logic for this action is that rapid and safe deployment of COVID-19 vaccines is decisive to curb the number of COVID-19 cases and deaths. This Action assumes that existing Emergency Use Listing (WHO, EMA and other stringent regulatory authorities) vaccines remain effective against new variants. As evidence evolves on the need for any required booster doses and vaccination of wider-age groups, the need for an annual COVID-19 vaccination, similar to seasonal flu vaccination may happen. Building upon this, the Action besides having a COVID-specific component in the short-term, also plans to strengthen the overall routine vaccination system in the partner countries and related broader systemic issues related to health information systems and digitalisation of health systems.

The Action focusses on safe deployment of COVID-19 vaccine and assumes that the partner countries will gradually extend their vaccine access to wider population groups, as they become increasingly available, either through the COVAX Facility, bilateral agreements and/or EU vaccine sharing mechanisms. Availability of vaccines will be critical to ensure a high vaccination uptake amongst population groups. In addition, the Action is designed to strengthen countries' capacity across several critical programmatic areas of vaccine deployment. Institutional, technical assistance and capacity-building measures are foreseen to bolster the efforts of the five CAR. The effectiveness of the institutional strengthening measures will depend very much on the commitment of authorities at all levels, within the health sector and beyond, to take action, as well as their effective communication and cooperation with key stakeholders.

The implementation of activities across all outputs ofthe action requires technical expertise. The COVID-19 vaccination has started only a few months ago and initial lessons from this process were integrated into the design of the action. Based on this and past experience from routine immunisation, WHO Europe prepared and published in December 2020 and in January 2021 several guides related to COVID-19 vaccination implementation. These materials and upcoming ones will be actively used during implementation. Securing the availability of experts to advise the countries will also be important. The fact that the action is designed for a group of countries makes it possible to pool expertise. At the same time, country-specific work plans will be developed to account for potential different challenges and priorities. In order to exchange experience, policy dialogue will be facilitated at both national and regional level. Due attention to mainstreaming objectives will be paid as part of implementation.

3.6 Logical Framework Matrix

Results	Results chain: Main expected results (maximum 10)	Indicators: (at least one indicator per expected result)	Baselines (values and years)	Targets (values and years)	Sources of data	Assumptions
Impact	To contribute to mitigating the impact and controlling the COVID-19 pandemic in CAR and reinforcing their longer-term health resilience	1. # of COVID-19 related cases disaggregated by sex by week 2. # of COVID-19 related deaths disaggregated by sex by week	1 tbd 2 tbd	1 tbd 2 tbd	1. National COVID-19 surveillance report 2. National COVID-19 surveillance report	*Not applicable*
Outcome 1	A rapid and safe deployment of COVID-19 vaccines in CAR is achieved	1.1 % of health workers with complete dose series of COVID-19 vaccines 1.2 **%** population uptake with complete dose series of COVID-19 vaccines	1.1 22.8% (incomplete data - to be confirmed and updated) 1.2 4.3% (average of the coverage Week 28)	1.1 > 80% 1.2 > 80%	1.1. WHO online Vaccine programme monitor and national reports 1.2. WHO online Vaccine programme monitor and national reports	Access to safe vaccines of adequate volume Vaccines are effective against new variants Commitment by public authorities to take action Health workers willing to vaccinate and get vaccinated Vaccine-product specific hesitancy
Outcome 2	Routine immunisation services in CAR are strengthened	2.1 % districts with >95% DTP3 immunisation coverage 2.2 **%** suspected measles cases which have been investigated in a WHO accredited laboratory	2.1 73% 2.2 63% (one of the countries do not provide case-based line list)	2.1 > 80% 2.2 > 80%	2.1 WHO/UNICEF Annual Joint reporting Form 2.2 Monthly Measles and Rubella surveillance reports	Commitment by public authorities to take action Availability of resources to procure and deliver routine vaccines Access to routine vaccines
Outcome 3	The capacity of CAR countries to achieve universal health coverage through the digitalisation of health systems and increased ability to collect and use quality health data is improved	3.1 % of districts submitting timely, complete, accurate reports to national level 3.2 **%** of districts with digital solutions used for disease surveillance and case	3.1 tbd 3.2 tbd	3.1 tbd 3.2 tbd	3.1 Country health management information systems (HMIS) reports 3.2 WHO monitor and national reports	Commitment by public authorities to take action Availability of IT infrastructure

						Availability of technical expertise and data Availability of resources to collect and use data for decision making
Output linked to Outcome 1 **1.1**	Immunisation workforce working on deployment of COVID-19 vaccines is trained.	1.1.1 % health workers trained on COVID-19 vaccine deployment (disaggregated by sex at country level) 1.1.2 % change in	1.1.1 0 1.1.2 0	1.1.1 > 80% 1.1.2 > 50%	1.1.1 Project reports 1.1.2 Project reports	Availability of trainers Availability of time to attend training
Output linked to Outcome 1 **1.2**	Vaccination coverage and vaccine safety events are monitored and analysed.	1.2.1 % subnational immunisation units equipped with relevant IT equipment (disaggregated by country) 1.2.2 % countries with functional AEFI (adverse events following	1.2.1 To be confirmed 1.2.2 50% (to be confirmed)	1.2.1 > 80% 1.2.2 > 80%	1.1.1 Project reports 1.1.2 Project reports	Availability of technical expertise Interest of vaccination centres to be connected and report data
Output linked to Outcome 1 **1.3**	Evidence/insights to understand vaccine hesitancy/demand and acceptance as well as misinformation are collected and used to inform communication/information activities.	1.3.1 **%** countries conducting at least 2 rounds of formative research to identify the drivers and barriers to vaccination 1.3.2% countries with a communication and information plan to address vaccine hesitancy, demand and acceptance	1.3.1 0 1.3.2 0	1.3.1 100% 1.3.2 100%	1.3.1 Project reports 1.3.2 Project reports	Availability of technical expertise and feasibility to conduct field visits due to COVID-19 situation Agreement of Member States to conduct the review/activity
Output linked to Outcome 1 **1.4**	Digital vaccination registries are established to support the accuracy in monitoring of and effectiveness of COVID-19 vaccines and utilised as a part of routine vaccination programmes	1.4.1 % districts with digital vaccination registries implemented	1.4.1 To be confirmed	1.4.1 > 50%	1.4.1 Project	Availability of routine immunisation systems Availability of IT infrastructure

Output 1.5 linked to Outcome 1	Policy dialogue and peer-to-peer learning on COVID-19 vaccination in CAR facilitated nationally and regionally.	1.5.1 National operational governance structure for COVID-19 vaccine deployment in place (yes/no) 1.5.2 # information exchange webinars/consultations conducted with project support	1.5.1 Varies by country 1.5.2 5	1.5.1 Yes 1.5.2 20	1.5.1 Progress report 1.5.2 Progress report	Countries accept to exchange of experience
Output 2.1 linked to Outcome 2	Tailored immunisation implementation plans are developed and implemented to address the "barriers" identified by the formative research to address immunisation	2.1.1 **%** of subnational tailored vaccine service delivery micro-plans developed with project support 2.1.2% of subnational action plans implemented with project support	2.1.10 2.1.20	2.1.1 > 80% 2.1.2 > 80%	2.1.1 Progress report 2.1.2 Progress report	Availability of technical expertise and data
Output 2.2 linked to Outcome 2	Disease-specific surveillance platforms are reviewed and strengthened to detect any outbreak including capacity building to enable timely investigation and management.	2.2.1 % countries conducting review of measles-rubella and poliomyelitis surveillance systems 2.2.2% national and subnational surveillance managers trained on "WHO vaccine-preventable disease surveillance standards	2.2.10 2.2.20	2.2.1 100% 2.2.2 100%	2.2.1 Progress report 2.2.2 Progress report	Availability of technical expertise and data
Output 2.3 linked to Outcome 2	Robust immunisation information systems for real-time monitoring of subnational vaccination coverage are strengthened/developed.	2.3.1 % countries conducting review of routine immunisation data management system 2.3.2% countries with data management system to monitor subnational vaccination coverage	2.3.1 0 2.3.2 0	2.3.1 100% 2.3.2 100%	2.3.1 Progress report 2.3.2 Progress report	Availability of technical expertise and data, feasibility to conduct field visits linked to COVID-19 situation and agreement of Member States to conduct the review
Output 3.1 linked to Outcome 3	Health information systems are assessed and capacities to collect, analyze and use health information and data are strengthened.	3.1.1 **%** countries conducting assessment of health information systems 3.1.2 % countries with a health information strategy	3.1.1 tbd 3.1.2 tbd	3.1.1 tbd 3.1.2 tbd	3.1.1 Progress report 3.1.2 Progress report	Availability of technical expertise and feasibility to conduct field visits linked to HIS assessments and agreement of Member States to conduct the assessment

Output 3.2 linked to Outcome 3	National digital health capacities are assessed and strengthened.	3.2.1 % countries conducting assessment of digital health capacities 3.2.2 % countries with a digital health strategy	3.2.1 tbd 3.2.2 tbd	3.2.1 tbd 3.2.2 tbd	3.2.1 Progress report 3.2.2 Progress report	Availability of technical expertise and feasibility to conduct field visits linked to digital health assessments and agreement of Member States to conduct the assessment
Output 3.3 linked to Outcome 3	Governance mechanisms of health information systems and digital health strengthened and peer-to-peer exchanges between countries facilitated	3.3.1 Sub-regional operational governance structure for health information systems and digital health (yes/no) 3.3.2 # information exchange webinars/consultations conducted with project support	3.3.1 tbd 3.3.2 tbd	3.3.1 Yes 3.3.2 tbd	3.3.1 Progress report 3.3.2 Progress report	Countries accept to exchange of experience

4 IMPLEMENTATION ARRANGEMENTS

4.1 Financing Agreement

In order to implement this action, it is not envisaged to conclude a financing agreement with the partner countries.

4.2 Indicative Implementation Period

The indicative operational implementation period of this action, during which the activities described in section 3 will be carried out and the corresponding contracts and agreements implemented, is 60 months from the date of adoption by the Commission of this Financing Decision. Extensions of the implementation period may be agreed by the Commission's responsible authorising officer by amending this Financing Decision and the relevant contracts and agreements.

4.3 Implementation Modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures[5].

4.3.1 Indirect Management with an international organisation

This Action may be implemented in indirect management with the World Health Organisation. The implementation by this entity entails carrying out activities identified in Section 3. The envisaged entity has been selected by the Commission's services on the basis of the highly specific and technical characteristics of the activities, which require the technical competence and high degree of specialisation of the WHO. The leading global role of the WHO in the area of health system strengthening as well as its strong presence in Central Asia give the institution a primary role in ensuring complementarity between this action and other strategies and actions at international, regional and national levels.
The WHO has also been selected because of its so far timely and effective implementation of the first phase of the Central Asia COVID-19 Crisis Response (CACCR 1), that started in July 2020.

Health security is a key element of WHO responsibility at the global and regional levels, particularly relevant to controlling and support to the Member States on international spread of communicable diseases. The International Health Regulations, administered by WHO, provide the legal instrument for doing so. In its capacity as UN agency responsible for coordinating international health efforts, WHO is the best placed body to implement such an action, in cooperation with the partner countries and other key stakeholders. WHO has the necessary technical expertise, is able to mobilise required specific expert support, and maintains productive relations with both national authorities and EU Delegations. The WHO will ensure due accounting and reporting for this new regional action in a dedicated way and distinct from the ongoing CACCR programme (phase 1).

If negotiations with the above-mentioned entity fail, that part of this action may be implemented in indirect management with another international organisation. The implementation by this alternative entity would be justified because of the following criteria: technical expertise and capacity to ensure buy-in from partner countries in Central Asia.

4.3.2 Changes from indirect to direct management mode (and vice versa) due to exceptional circumstances

If negotiations fail both with the WHO and with the other IO to be selected with the criteria mentioned in the last sub-paragraph of the above section (4.3.1.), that part of this action may be implemented in direct management.

[5] www.sanctionsmap.eu Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.

4.4 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply.

The Commission's authorising officer responsible may extend the geographical eligibility on the basis of urgency or the unavailability of services in the markets of the countries or territories concerned, or in other duly substantiated cases where application of the eligibility rules would make the realisation of this action impossible or exceedingly difficult (Article 28(10) NDICI-Global Europe Regulation).

4.5 Indicative Budget

Indicative Budget components	**EU contribution (amount in EUR)**	**Indicative third-party contribution, in currency identified**
Indirect management with the World Health Organisation - cf. section 4.3.1	**10,000,000**	300,000
Evaluation - cf. section 5.2 **Audit** - cf. section 5.3	N.A. (will be covered by another Decision)	N.A.
Total	**10,000,000**	300,000

4.6 Organisational Set-up and Responsibilities

A regional Project Steering Committee (PSC) will be set up to ensure coordination and complementarity of the different project activities in each country. It will comprise representatives of the European Commission, the European External Action Service, the EU Delegations, implementing partners and other stakeholders as appropriate.

In addition, in each CAR, the implementing partner will ensure that regular exchanges and consultation take place with both national authorities and EUDs through a national steering mechanism. The latter will ensure that the implementation of the project is fully aligned with the national response to the COVID-19 outbreak and national COVID-19 vaccination efforts. It will also ensure close coordination with the relevant national authorities, the EU delegation, the UN organisations under the Resident Coordinator system and other stakeholders as appropriate while facilitating interaction with relevant initiatives.

As part of its prerogative of budget implementation and to safeguard the financial interests of the Union, the Commission may participate in the above governance structures set up for governing the implementation of the action.

5 PERFORMANCE MEASUREMENT

5.1 Monitoring and Reporting

The day-to-day technical and financial monitoring of the implementation of this Action will be a continuous process during the implementation period of the Action, and part of the implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (Outputs and direct Outcomes) as measured by corresponding indicators, using as reference the logframe matrix (for project modality) and the partner's strategy, policy or reform action plan list (for budget support).

Performance and monitoring of the Action will be undertaken in accordance with Article 10 of the General Conditions for Contribution Agreements. Performance measurement will be based on the intervention logic and the log frame

matrix, including its indicators.

- Performance measurement will aim at informing the list of indicators that are part of the log frame matrix.
- In certain cases, mainly depending on when the monitoring exercise is launched, contribution to the specific objectives/outcomes will also be part of monitoring and for this to happen indicators defined during planning/programming at the outcome level will be the ones for which a value of measurement will need to be provided.
- In evaluation, the intervention logic will be the basis for the definition of the evaluation questions. Evaluations do mainly focus on the spheres of direct (outcomes) and indirect (impacts) influence. As such, indicators defined for these levels of the intervention logic will be used in evaluation.

National reporting mechanisms and statistics, specific project reports, as well as project implementing partners, will be a regular source of data, and monitoring and reporting will be handled by the project staffs. Given the structure of the project and the focus on immediate needs, an information note including initial results and key monitoring and evaluation elements gathered in the initial phase of the project (7-8 months) will be presented to the programme's Steering Committee (PSC) and subsequently shared with Commission services. The PSC will also review and validate the country plans developed for each phase of the project.

Each of the project activity is related to specific outcomes/outputs and equipped with quantified indicators and deliverables. Throughout the implementation, the achieved results will be checked against original activity plans and project deliverables set as milestones. Indicator-based reporting will be performed based on the Logframe. Relevant indicators will have to be disaggregated by country, geographic unit, age group, and gender. Where feasible, data specific for most vulnerable groups should be included. In case of discrepancies, the project team will propose and introduce corrective measures. The normal procedure for eliminating discrepancies will be (a) recognition of discrepancy, (b) estimation of the level of discrepancy and potential impact (time, quantity and quality wise), (c) definition of reasons (internal and external), (d) preparation of a contingency plan (responsibilities, activities), (e) implementation of a contingency plan and (f) review.

Regular internal reporting will be established at the onset of the project with all project stakeholders and will contribute to the overall project evaluation reporting. While the monitoring will be a constant process, at the key milestones of the project, internal evaluation will be implemented. Following this, evaluation reports will be prepared annually, including a final report. These reports will be submitted every year to the PSC for review before formal submission to Commission services.

5.2 Evaluation

A final evaluation will be carried out for this Action or its components via independent consultants. It will be carried out for accountability and document the learning at various levels (including for policy revision), taking into account in particular the fact that the action has an important procurement element. The Commission shall inform the implementing partner at least 3 months in advance of the dates envisaged for the evaluation missions. The implementing partners shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports shall be shared with the partner country and other key stakeholders following the best practice of evaluation dissemination. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner countries, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project. The financing of the evaluation shall be covered by another measure constituting a Financing Decision.

Keeping in mind the commitment of both parties to the effective and efficient operation of the Agreement, any interim or final evaluation of the project shall either be jointly conducted by the parties or, if not possible due to duly justified reasons, WHO shall invite representatives of the Commission to participate in any *ad hoc* Evaluation Management Group formed for the purpose of any evaluation exercises at the Commission's own expense. In the latter case, the evaluation shall be carried out in accordance with the provisions of the WHO Evaluation Policy and WHO shall request and consider comments from the Commission on the terms of reference before the evaluation exercise takes place. Furthermore, the Commission's comments shall also be requested on the different deliverables prior to final approval (as a minimum, on the draft evaluation report). As with other evaluations undertaken in WHO, once completed it will be published on the webpage of the Evaluation Office and a summary will be included in the annual evaluation report to WHO's Executive Board.

5.3 Audit and Verifications

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audit or verification assignments for one or several contracts or agreements. Any verification by the European Commission of the action will be performed in accordance with the verification clauses agreed between the implementing partner and the European Commission, in the Financial and Administrative Framework Agreement. The financing of the verification shall be covered by another measure constituting a financing decision.

6 STRATEGIC COMMUNICATION AND PUBLIC DIPLOMACY

The 2021-2027 programming cycle will adopt a new approach to pooling, programming and deploying strategic communication and public diplomacy resources.

It will remain a contractual obligation for all entities implementing EU-funded external actions to inform the relevant audiences of the Union's support for their work by displaying the EU emblem and a short funding statement as appropriate on all communication materials related to the actions concerned. This obligation will continue to apply equally, regardless of whether the actions concerned are implemented by the Commission, partner countries, service providers, grant beneficiaries or entrusted or delegated entities such as UN agencies, international financial institutions and agencies of EU member states.

However, action documents for specific sector programmes are no longer required to include a provision for communication and visibility actions promoting the programmes concerned. These resources will instead be consolidated in Cooperation Facilities established by support measure action documents, allowing Delegations to plan and execute multiannual strategic communication and public diplomacy actions with sufficient critical mass to be effective on a national scale.

APPENDIX 1 REPORTING IN OPSYS

An Intervention (also generally called project/programme) is the operational entity associated to a coherent set of activities and results structured in a logical framework aiming at delivering development change or progress. Interventions are the most effective (hence optimal) entities for the operational follow-up by the Commission of its external development operations. As such, Interventions constitute the base unit for managing operational implementations, assessing performance, monitoring, evaluation, internal and external communication, reporting and aggregation.
Primary Interventions are those contracts or groups of contracts bearing reportable results and respecting the following business rule: 'a given contract can only contribute to one primary intervention and not more than one'. An individual contract that does not produce direct reportable results and cannot be logically grouped with other result reportable contracts is considered a 'support entities'. The addition of all primary interventions and support entities is equivalent to the full development portfolio of the Institution.

Primary Interventions are identified during the design of each action by the responsible service (Delegation or Headquarters operational Unit).
The level of the Primary Intervention is defined in the related Action Document and it is revisable; it can be a(n) (group of) action(s) or a (group of) contract(s).

Tick in the left side column one of the three possible options for the level of definition of the Primary Intervention(s) identified in this action.
In the case of 'Group of actions' level, add references to the present action and other action concerning the same Primary Intervention.
In the case of 'Contract level', add the reference to the corresponding budgetary items in point 4.5, Indicative Budget.

Option 1: Action level		
□	Single action	Present action: all contracts in the present action
Option 2: Group of actions level		
□	Group of actions	Actions reference (CRIS# 043-342)
Option 3: Contract level		
X	Single Contract 1	Contribution Agreement
□	Single Contract 2	
□	Single Contract 3	
	(...)	
□	Group of contracts 1	