Classified as Internal

APPLICATION FORM FOR GAVI NVS SUPPORT

Submitted by

The Government of Pakistan

for

Measles-rubella 1st and 2nd dose routine, with catch-up campaign

Reach Every Child
www.gavi.org

1 Gavi Grant terms and conditions

1.2 Gavi terms and conditions

1.2.1 Gavi terms and conditions

The terms and conditions of the Partnership Framework Agreement (PFA) between Gavi and the Country, including those provisions regarding anti-corruption and anti-terrorism and money laundering, remain in full effect and shall apply to any and all Gavi support made pursuant to this application. The terms and conditions below do not create additional obligations or supersede those of the PFA. In the event the Country has not yet executed a PFA, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

GAVI GRANT APPLICATION TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES
The applicant country ("Country") confirms that all funding provided by Gavi will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by Gavi. All funding decisions for the application are made at the discretion of Gavi and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION
The Country will notify Gavi in its Joint Appraisal, or in any other agreed annual reporting mechanism, if it wishes to propose any change to the programme(s) description in its application. Gavi will document any change approved by Gavi according with its guidelines, and the Country's application will be amended.

RETURN OF FUNDS
The Country agrees to reimburse to Gavi all funding amounts that Gavi determines not to have been used for the programme(s) described in its application. The Country's reimbursement must be in US dollars and be provided, unless otherwise decided by Gavi, within sixty (60) days after the Country receives Gavi's request for a reimbursement and be paid to the account or accounts as directed by Gavi.

SUSPENSION/ TERMINATION
Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programme(s) described in the Country's application, or any Gavi-approved amendment to the application. Gavi retains the right to terminate its support to the Country for the programme(s) described in its application if a misuse of Gavi funds is confirmed.

NO LIABILITY
The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programme(s) in the Country; and (ii) the use or distribution of vaccines

and related supplies after title to such supplies has passed to the Country.
Neither party shall be responsible for any defect in vaccines and related supplies, which remain the responsibility of the relevant manufacturer. Gavi shall not be responsible for providing any additional funding to replace any vaccines and related supplies that are, or became, defective or disqualified for whatever reason.

INSURANCE

Unless otherwise agreed with Gavi, the Country shall maintain, where available at a reasonable cost, all risk property insurance on the Programme assets (including vaccines and vaccine related supplies) and comprehensive general liability insurance with financially sound and reputable insurance companies. The insurance coverage will be consistent with that held by similar entities engaged in comparable activities.

ANTI-CORRUPTION

The Country confirms that funds provided by Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

ANTI-TERRORISM AND MONEY LAUNDERING

The Country confirms that funds provided by Gavi shall not be used to support or promote violence, war or the suppression of the general populace of any country, aid terrorists or their activities, conduct money laundering or fund organisations or individuals associated with terrorism or that are involved in money-laundering activities; or to pay or import goods, if such payment or import, to the Country's knowledge or belief, is prohibited by the United Nations Security Council.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with Gavi, as requested. Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how Gavi funds are used.
The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, or any other agreed annual reporting mechanism, is accurate and correct and forms legally binding obligations on the Country, under the Country's law, to perform the programme(s) described in its application, as amended, if applicable.

COMPLIANCE WITH GAVI POLICIES

The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant

to the programme(s), including without limitation the Transparency and Accountability Policy (TAP) and complies with the requirements therein. All programme related policies, guidelines and processes are available on Gavi's official website and/or sent to the Country.

USE OF COMMERCIAL BANK ACCOUNTS
The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION
Any dispute between the Country and Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either Gavi or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: Gavi and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

Gavi will not be liable to the country for any claim or loss relating to the programme(s) described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. The Country is solely responsible for all aspects of managing and implementing the programme(s) described in its application.

1.3 Gavi Guidelines and other helpful downloads

Guidelines and documents for download

Please refer to the relevant guidelines concerning your request for support.

Please ensure to consult and download all documents. It is important to note that some documents must be completed offline, and will need to be uploaded in the final steps of your application.

This application form is designed to collect information needed by Gavi to process requests for support, plan procurement of vaccines, plan technical assistance, track data for future reporting, and more.

A key component of the application is a solid operational plan (New Vaccine Introduction Plan for routine support, or Plan of Action for campaign support), explaining how the country will

introduce the vaccine or conduct the envisaged campaign, with a corresponding budget. The New Vaccine Introduction Plan or Plan of Action must be submitted together with this application form and will be considered as the foundation of the support request.

For more information on the documents to submit with your application and what they should contain, please refer to the appropriate guidelines: http://www.gavi.org/support/process/apply/

2 Review and update country information

2.1 Country profile

2.1.1 Country profile

Eligibility for Gavi support

No Response

Co-financing group

Preparatory transition

Date of Partnership Framework Agreement with Gavi

19 May 2015

Country tier in Gavi's Partnership Engagement Framework

1

Date of Programme Capacity Assessment

No Response

2.1.2 Country health and immunisation data

Please ensure your Country health and immunisation data is up to date. If not, please go to the Overall expenditures and financing for immunisation section of the portal to submit this information.

	2019	2020
Total government expenditure	8,328.773	

Total government health expenditure	384.57
Immunisation budget	

2.1.3 National health planning and budgeting cycle, and national planning cycle for immunisation:

The government planning cycle starts on the

1 July

The current National Health Sector Plan (NHSP) is

From	2016
To	2025

Your current Comprehensive Multi-Year Plan (cMYP) period is

2019-2021

Is the cMYP we have in our record still current?

Yes☒ No☐

If you selected "No", please specify the new cMYP period, and upload the new cMYP in country documents section.

Note 1

From	
To	

If any of the above information is not correct, please provide additional/corrected information or other comments here:

2.1.4 National customs regulations

Please describe local customs regulations, requirements for pre-delivery inspection, and special documentation requirements that are instrumental for the delivery of the vaccine.

If the vaccine fulfils WHO pre-qualification and DRAP registration criteria the local custom clearances and pre-delivery inspection would be smoothly handled by Federal EPI as already being managed routinely.
Pakistan will proceed with procurement of its co-financing share of Measles-Rubella vaccine and devices for the routine immunization through UNICEF for which pre-advice, air-way bills, commercial invoices, packing lists, lot release certificate and certificate of analysis are required 2-3 weeks before the arrival of shipment at Islamabad International Airport.

2.1.5 National Regulatory Agency

Please provide information on the National Regulatory Agency in the country, including status (e.g. whether it is WHO-certified). Please mention a point of contact with phone number and e-mail address. UNICEF will support the process and may need to communicate licensing requirements to the vaccine manufacturers where relevant.

Drug Regulatory Authority of Pakistan (DRAP) is entitled to register any drug/ vaccine manufacturing company under Drug Act of Pakistan; 1976.
The DRAP is in a process of WHO-prequalification. The contact details of contact person is as below:
Mr. Asim Rauf
Chief Executive Officer, Drug Regulatory Authority of Pakistan
Telecom foundation (T-F) complex building, 7-Mauve Area,
G-9/4, Islamabad. 0092-51-9107316
contact@dra.gov.pk/ceo@dra.gov.pk

2.2 National Immunisation Programmes

2.2.2 Financial Overview of Active Vaccine Programmes

IPV Routine

Note 2

	2020	2021	2022
Country Co-financing (US$)			
Gavi support (US$)	6,611,938	6,599,153	6,582,869

PCV Routine

	2020	2021	2022	2023	2024

Country Co-financing (US$)	12,858,282	15,000,867	21,114,098	27,341,435	33,685,168
Gavi support (US$)	32,021,575	30,522,860	24,891,328	19,127,695	13,244,924

Pentavalent Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	4,652,027	5,428,115	7,639,207	9,893,132	12,188,212
Gavi support (US$)	12,887,185	12,362,724	10,339,882	8,267,174	6,152,240

Rota Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	16,690,226	19,281,956	25,527,872	14,524,563	17,888,333
Gavi support (US$)	34,703,657	32,392,215	26,327,633	10,285,235	7,159,313

TCV Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	2,614,876	4,240,511	5,965,278	7,724,117	9,517,536
Gavi support (US$)	6,754,492	8,969,212	7,376,542	5,751,121	4,092,455

Summary of active Vaccine Programmes

	2020	2021	2022	2023	2024
Total country co-financing (US$)	36,815,411	43,951,449	60,246,455	59,483,247	73,279,249

Total Gavi support (US$)	92,978,847	90,846,164	75,518,254	43,431,225	30,648,932
Total value (US$) (Gavi + Country co-financing)	129,794,258	134,797,613	135,764,709	102,914,472	103,928,181

2.3 Coverage and Equity

2.3.1 Coverage and equity situation analysis

Note: If a recent analysis of the coverage and equity analysis is already available, for example as part of a Joint Appraisal report, you may simply reference the report and section where this information can be found.

Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement. In particular, identify the areas and groups of low coverage or high inequity linked to geographic, socioeconomic, cultural or female literacy considerations, as well as systematically marginalized communities. Specify both the areas and/or populations with low coverage (%) and those with the largest absolute numbers of un-/under-vaccinated children. Among data sources, consider administrative data, coverage surveys, DHS/MCS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles.

Describe the challenges underlying the performance of the immunisation system, such as:

- Health work force: availability and distribution;
- Supply chain readiness;
- Gender-related barriers: any specific issues related to access by women to the health system;
- Data quality and availability;
- Demand generation / demand for immunisation services, immunisation schedules, etc;
- Leadership, management and coordination: such as key bottlenecks associated with the management of the immunisation programme, the performance of the national/ regional EPI teams, management and supervision of immunisation services, or broader sectoral governance issues;
- Financing issues related to the immunisation programme that impact the ability to increase coverage, including bottlenecks related to planning, budgeting, disbursement and execution of resources;
- Other critical aspects: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports.

Describe lessons learned and best practices on the effectiveness of implemented activities to

improve coverage and equity; recommendations on changes or new interventions that might be required to accelerate progress (include data to support any findings or recommendations).

Worldwide there are significant inequalities in childhood vaccination based on various factors related to gender, area of residence, wealth and parental education. Immunization inequity has been a major problem for many countries. Urban rich infants are more likely to be immunized than rural or those living in urban slums. There is a clear correlation between household wealth and education of the women with immunization status of their children, where increasing wealth and education tends to associate with better immunization coverage.
In 2019, according to WUNIEC report, an estimated 123 million children globally received their recommended vaccines . Despite of this huge achievement, vaccination coverage has stagnated over the past few years and nearly 20 million children under 1 year of age did not receive the recommended three doses of diphtheria-tetanus-pertussis containing (DTP-3) vaccine during the same year. A quarter of these unimmunized children are in South Asia with almost 97 per cent residing in India, Pakistan and Afghanistan. Despite positive coverage trends over the past five years, Pakistan is still home to1.4 million missed children, 25% of Global unimmunized children. In addition, Pakistan is the last of three Polio endemic countries along with Afghanistan and Nigeria.
According to PDHS 2017-18, the national coverage for Penta 3 has improved from 54% (PDHS 2012-13) to 66% with huge disparities with respect to Fully Immunized Children (FIC) among provinces, ranging from as low as 29% in Balochistan to 80% in Punjab. The highest percentage of drop in coverage from Penta 1 to Penta 3 was observed in mothers with no education (14 %) and those belonging poor families (18%).
Only 49% of the children in the poorest wealth quintile received DTP-3 vaccine compared to 91 per cent in the richest wealth quintile. There is wide gap in the DTP-3 coverage in urban and rural areas across four provinces in Pakistan. In Sindh, DTP-3 coverage is 55 percent in urban compared to 46 percent in rural areas; 81 per cent in urban Khyber Pakhtunkhwa (KP) compared to 62 percent in rural KP and 57 percent in urban Balochistan compared to 26 percent in rural areas of the province. Huge inequities also exist between urban poor and urban rich population. A recently conducted profiling of urban slums and coverage assessment revealed that the coverage among urban poor is as low as 27% in Quetta, 53% Lahore, 54% Karachi and 76% in Multan. Same trends were observed in Measles 1 coverage, as shown in below table1&2 which demands urgent corrective actions.
The slums survey also revealed that highest number of zero dose children are also found among urban poor communities, ranging from 27% in Quetta to 5% in slums of Karachi as shown in below table. The most common reasons for zero dose children identified among slum communities are no permission from family, information regarding benefits of vaccines, fear of injection and vaccination preference.
Profound inequities exist in public health services due to demographic, geographic, economic, social, conflict and accessibility induced and gender related barriers. Evidence shows that unimmunized children are largely concentrated in the poorest wealth quintile despite increase in absolute income, hence there are calls for urgent need to reach out to these children.
Health Work Force: Availability and Distribution:
Pakistan is a huge country with almost 223 million population. There is an estimated annual birth cohort of 8 million live births in the country during 2020. A huge work force of skilled staff is required to vaccinate this large cohort. According to EPI Policy of Pakistan, there should be one vaccinator appointed for providing immunization services to 10,000 urban population and one vaccinator for 5,000 rural population. Currently, the number of vaccinators is 19,211 in total with

18,683 Males and 528 Female vaccinators. Out of the total 19,211, 6,464 are in Punjab, 5,667 in Sindh, 3,961 in KP, 1,777 in Balochistan, 283 in GB, 376 in AJK, 592 in Merged Districts and 90 in Islamabad. According to EPI policy for a total population of 229 Million (36.38% urban and 63.62% rural population) keeping in view the urban and rural divide, EPI requires a total number of 37,561 against the total of available 19,211 vaccinators. EPI programme at present is suffering a shortage of skilled staff. There are around 110,000 LHWs in the country 60,814 LHWs have received basic EPI training in RI. The table below summarizes all the health workforce in the country.

Province	Vaccinators	LHWs trained on RI	Other HR trained on RI*	Total HR Trained on RI
Punjab	6465	34710	12530	53,705
Sindh	5667	11177	4959	21,803
KP	3961	6551	3264	13,776
Merged Areas	592	279	2280	3,151
Balochistan	1777	1959	4572	8,308
Islamabad	90	306	781	1,177
GB	283	102	828	1,213
AJK	376	6036	1241	7,653
Pakistan	**19,211**	**61,120**	**30,455**	**110,786**

Cold Chain:
Provide data to verify sufficient capacity for campaign or provide a contingency plan to solve potential cold chain problems on lower distribution levels i.e. province/districts (by increasing frequency of distribution)
National and Provincial HQ level:
The current cold chain capacity (FR and CR) at federal and provincial level and requirement to accommodate MR vaccine for the campaign is as follows. There is shortage of 40m3 space at National Level which would be accommodated by making shipment plan for vaccine supplies with UNICEF.
Therefore available Cold chain space at Federal level will serve MR vaccine for the catch-up campaign.

Based on the analysis table EPI Pakistan has sufficient cold storage space to accommodate Measles Rubella SIA 2020 vaccine at Federal and Provincial Level. The Federal EPI with support of UNICEF has also installed 16 new Cold Rooms through Rota VIG which has further enhanced capacity to accommodate vaccines at Provincial levels.
District Level:
Punjab: At district level the Province Punjab has cold rooms of net capacity 3.3 m3 in each district and 10 m3 in each divisional headquarters which would be more than sufficient to accommodate MR campaign vaccine in addition to their routine immunization.
Sindh: Sindh province has cold rooms of 3.3 m3 net capacity in each district and cold rooms of

6.6 m3 net capacities at Hyderabad and Sukkur Division which is sufficient to accommodate MR SIA vaccine in addition to their RI immunization requirement.
Khyber Pakhtunkhwa: In KP cold rooms of net capacity 3.3 m3 are installed in 11 out of 25 districts which would be sufficient to accommodate MR vaccines for campaign 2021 at district level. Rest of districts are also equipped with ILRs through CCEOP which would be used to store the MR campaign vaccine.
Balochistan: In Balochistan Province the divisional headquarters like Makran, Zhob, Sibi, Nasirabad, Noshki zone and Musa Kehl are equipped with cold rooms of net capacity 3.3 m3 each, which would be sufficient to store the vaccine for the campaign. The vaccine would further be distributed to the districts which are equipped with ILRs. To further enhance the cold chain capacity at district level Balochistan is procuring 449 SDDs through UNICEF which would be in place before the MR campaign 2021.
Data Quality:
The administrative coverage data being reported by provinces and federating areas generally tend to over report. This is quite visible from BCG coverage which goes beyond 100% in many district s of Pakistan. There are negative dropout rates being reported. In order to identify the strengths and weaknesses of existing immunization reporting system, multiple rounds of Data Quality Assessments (DQA) have been conducted all over the country since 2015. In 2016, the Quality index (QI) of Sindh Immunization program was 47%, QI of Punjab was 82%, QI for KP was 60% and QI of Balochistan was 76%.in 2019, DQA was conducted for AJK and GB with an overall QI 86% and 59% respectively.
Latest DQA has been conducted for AJK and GB which showed significant improvements when compared with last rounds of DQA conducted in AJK and GB. Subsequently, Data Improvement Plans had been developed for all the provinces and federating areas. Extensive monitoring has been initiated on regular basis by provincial and district staff to improve data quality at all level with special focus on low performing areas.
Comprehensive EPI reviews have been conducted for Sindh, KP, Punjab, AJK and GB. There was over reporting trend observed for Penta-3 in Punjab province. Timeliness and completeness of the immunization data has improved over time but still needs more improvement for ensuring timely availability of data for analysis and decision making.
Improvement plans were developed based on the data quality assessments. The Improvement plans are being implemented in all provinces with close follow up by the health authorities at provincial and federal level. The improvement plan included mainly: quarterly review meeting at provincial level chaired by Secretary and or Health Minister, monthly review meeting at district level, integrated supervisor visits on regular basis in Punjab, enhanced monitoring and supervision at all levels that all districts and all health facilities visited at least one time in 2019. Digitalized tools like KOBO and other mobile applications are being used in Punjab and KP for supervision. Computerized management information system is used currently in all provinces for better data flow, verification and analysis for better decision making. The EPI program uses various software/applications (MIS, e-Vacc, ZM, VLMIS) for collecting and analysing data. There is no standardized nationwide software/application that is used by all vLMIS is available in all the districts of Pakistan but only used by Punjab and Sindh for transmitting coverage data. EPI MIS is also being used by KP, Balochistan, GB, AJK, and Islamabad.
According to the DQA reports, the immunization Coverage data and VPD surveillance data are not being analysed and used properly at district level and there is no system for provision of feedback to the UC level. Very high coverage or outliers and negative drop-outs, high drop-outs etc are not being properly analysed and mitigating actions are not being taken.
Digital Immunization child registry is developed and used in Sindh by Interactive Research and Development for child's registration which has registered around 2 million children since its inception in 2017 but still there are issues in complete utilization of the data, due to lack of timely transfer of capacities and tools to EPI program at provincial and district level, its

sustainability is still an issue.
Amid all these software, the burden of data entry has doubled as the data entry operators have to enter the data in multiple soft-wares. Based on the success of this experience, other provinces are planning to introduce digital child registries.
The compliance of merged areas reports on MIS is below 50% for the first quarter of 2019. Other than compliance issues there are basic data entry issues and hence the resulting percentages are also not correct. At this moment their reports cannot be used for analysis. In order to improve the coverage and data quality in the Merged Areas, extensive training for Mid-level Management and vaccinators have been conducted in 2019. There is also a MIS software training plan for the Merged Areas to enable them to use it easily.
The lack of one uniform reporting mechanism makes it difficult for managers to have a comprehensive overview of actual situation on ground making it difficult to use the data for decision making.

2.4 Country documents

Upload country documents

Please provide **country documents** that are relevant for the national immunisation programme and for multiple vaccines, to be taken into account in the review of your application. If you have already provided one or more of these country documents, you do not need to upload it/them again unless the document version changed. If documents cannot be provided, please use the comment functionality to explain why, or by when they will be available.

Note that only general country documents are uploaded here; at the end of section 3 (sub-section “Upload new application documents”) you will be required to provide those documents that are specific to the support requested (for example the new vaccine introduction plan and/or campaign plan of action, new budget, application endorsements etc.)

Country and planning documents

✓ **Country strategic multi-year plan** — PakNational cMYP201920_22-01-20_18.26.14.pdf

Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan

✓ **Country strategic multi-year plan / cMYP costing tool** — National cMYP 201920_22-01-20_18.27.34.xlsx

✓ Status of EVMA 2020_22-01-20_20.05.22.pdf

	Document	File
	Effective Vaccine Management (EVM) assessment	PakistanEVMreport30march21April2014Final12_22-01-20_19.48.07.pdf
✓	**Effective Vaccine Management (EVM): most recent improvement plan progress report**	National EVMIP_22-01-20_18.45.44.pdf
✓	**Data quality and survey documents: Final report from most recent survey containing immunisation coverage indicators**	DQA Report AJK 2018_22-01-20_20.08.12.pdf DQAGB 02092019_22-01-20_20.09.52.pdf
✓	**Data quality and survey documents: Immunisation data quality improvement plan**	KP Data Quality IP and Goals_23-05-20_00.26.23.xlsx
✓	**Data quality and survey documents: Report from most recent desk review of immunisation data quality**	IP Follow up GB_23-05-20_00.27.09.docx
✓	**Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation**	GB Data Quality IP and Goalsupdated_23-05-20_00.30.02.xlsx
✓	**Human Resources pay scale** If support to the payment of salaries, salary top ups, incentives and other allowances is requested	Pay_allow. for the year 201920 Dr. Sarbuland_23-05-20_00.49.19.xlsx

Coordination and advisory groups documents

National Coordination Forum Terms of Reference

ICC, HSCC or equivalent

NITAG TORs _22-01-20_19.51.56.pdf

National Coordination Forum meeting minutes of the past 12 months

Minutes of NICC Meeting JSAEM Mission_22-01-20_18.38.17.pdf

Minutes of NICC 3rd June 2019_22-01-20_18.36.49.pdf

Minutes of NICC 5th Aug 2019_22-01-20_18.37.40.pdf

Other documents

Other documents (optional)

Please also provide other country documents to support the review of the applications, for example Health Facility Assessment Reports, Knowledge-Attitude-Practice surveys or other demand-related surveys, if available.

Pakistan iSC Improvement RoadmapFinal draft_23-01-20_18.15.01.pdf

3 Measles-rubella 1st and 2nd dose routine, with catch-up campaign

3.1 Vaccine and programmatic data

Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.

Note 3

Measles-rubella 1st and 2nd dose routine

Preferred presentation	MR, 10 doses/vial, Lyophilised

Is the presentation licensed or registered?	Yes ☒ No ☐
2nd preferred presentation	MR, 5 doses/vial, Lyophilised
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	15 February 2021
Planned launch date	12 March 2021
Support requested until	2023

Measles-rubella catch-up campaign

Preferred presentation	MR, 10 doses/vial, Lyophilised
Is the presentation licensed or registered?	Yes ☒ No ☐
2nd preferred presentation	MR, 5 doses/vial, Lyophilised
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	15 February 2021
Planned launch date	12 March 2021
Support requested until	2023

3.1.2 Vaccine presentation registration or licensing

If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines,

and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.

Registered with DRAP

3.1.3 Vaccine procurement

Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund. Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?

Yes☐ No☒

If you have answered yes, please attach the following in the document upload section:* A description of the mechanism, and the vaccines or commodities to be procured by the country through this mechanism.* A confirmation that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. OR, for the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, a confirmation should be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

3.2 Target Information

3.2.1 Targets for routine vaccination

Please describe the target age cohort for the MR 1st dose routine immunisation:

Note 4

9 weeks ☐ months ☒ years ☐

Please describe the target age cohort for the MR 2nd dose routine immunisation:

15 weeks ☐ months ☒ years ☐

	2021
Population in the target age cohort (#)	7,609,408
Target population to be vaccinated (first dose) (#)	6,848,467

Population in the target age cohort for last dose(#)	7,609,408
Target population to be vaccinated for last dose (#)	6,848,467
Estimated wastage rates for preferred presentation (%)	20

3.2.2 Targets for campaign vaccination

Gavi will only provide support to countries for Rubella Containing Vaccine catch-up campaign by providing doses of MR vaccine for a target population of males and females aged 9 months to 14 years (the exact range in the scope of 9 months to 14 years old will depend on MR in the country).
Gavi will always provide 100% of the doses needed to vaccinate the population in the target age cohort.
Please describe the target age cohort for the measles-rubella catch-up campaign: (from 9m-14y).

From	9	weeks ☐	months ☒	years ☐
To	15	weeks ☐	months ☐	years ☒

	2021
Population in target age cohort (#)	96,367,824
Target population to be vaccinated (first dose) (#)	96,367,824
Estimated wastage rates for preferred presentation (%)	15

3.3 Co-financing information

3.3.1 Vaccine and commodities prices

Price per dose (US$) - Measles-rubella routine, 1st and 2nd dose

	2021
10 doses/vial,lyo	0.66

Commodities Price (US$) - Measles-rubella routine, 1st and 2nd dose (applies only to preferred presentation)

	2021
AD syringes	0.036
Reconstitution syringes	0.004
Safety boxes	0.005
Freight cost as a % of device value	3.2

Price per dose (US$) - Measles-rubella catch-up campaign

	2021
10 doses/vial,lyo	0.66

Commodities Price (US$) - Measles-rubella catch-up campaign (applies only to preferred presentation)

	2021
AD syringes	0.036
Reconstitution syringes	0.004
Safety boxes	0.005
Freight cost as a % of device value	3.2

3.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support.
Please note that the values represented in this table do not account for any switches in co-financing group. The calculations for the entire five year period are based on the countries co-financing group in the first year.

Note 5

	2021
Country co-financing share per dose (%)	
Minimum Country co-financing per dose (US$)	0.2
Country co-financing per dose	0.2

(enter an amount equal or above minimum)(US$)	

3.3.3 Estimated values to be financed by the country and Gavi for the procurement of supply

Measles-rubella routine, 1st and 2nd dose

	2021
Vaccine doses financed by Gavi (#)	15,365,600
Vaccine doses co-financed by Country (#)	6,035,900
AD syringes financed by Gavi (#)	14,197,900
AD syringes co-financed by Country (#)	5,577,100
Reconstitution syringes financed by Gavi (#)	
Reconstitution syringes co-financed by Country (#)	
Safety boxes financed by Gavi (#)	156,200
Safety boxes co-financed by Country (#)	61,350
Freight charges financed by Gavi ($)	232,288
Freight charges co-financed by Country ($)	91,246

2021

Total value to be co-financed (US$) Country	4,280,500
Total value to be financed (US$) Gavi	10,897,000
Total value to be financed (US$)	15,177,500

Measles-rubella catch-up campaign

	2021
Vaccine doses financed by Gavi (#)	113,714,100
AD syringes financed by Gavi (#)	106,004,700
Reconstitution syringes financed by Gavi (#)	
Safety boxes financed by Gavi (#)	1,166,075
Freight charges financed by Gavi ($)	1,722,898

	2021
Total value to be financed (US$) Gavi	80,682,500
Total value to be financed (US$)	80,682,500

3.3.4 Estimated projection of the required domestic financing for the measles monovalent component of MCV1

Countries are required to domestically finance the first dose in their measles containing vaccine routine (MCV1) in order to be able to receive Gavi support for any measles/ measles-rubella programmes. Below is the estimated projection of the required domestic financing for MCV1, based on the information provided in the previous sections.

Note 6

2021

Minimum number of doses financed from domestic resources	4,681,578
Country domestic funding (minimum)	3,071,115.17

3.3.5 Co-financing payment

Please indicate the process for ensuring that the co-financing payments are made in a timely manner.

Expanded Programme on Immunization Pakistan has approved 5 year planning document named as PC-1 (2015-16 to 2019-20) in which funds for country's co-financing share for all GAVI vaccines are allocated. Every year the EPI submits new vaccine support renewal requests to GAVI (with approval of NICC) based on which, GAVI issues decision letter annually and country co-financing share is reflected accordingly for fiscal year and the EPI has been fulfilling all co-financing obligations in a timely manner since 2015-16.

If your country is in the accelerated transition phase for Gavi support, please answer the following question:

Please provide evidence that the co-financing obligations for the new introduction have been budgeted for, and elaborate on how the country plans to pay for the fully self-financing amounts. Please discuss the extent to which medium-term immunisation/health plans and medium-term expenditure frameworks incorporate the additional costs associated with this introduction. Discuss any co-financing defaults that may have happened in the last five years.

Currently, the GoP is financing Pentavalent, Rota and Pneumococcal vaccines under co-financing mechanism. The same mechanism will be applied for MR procurement. However, the EPI program in the country is shifting to recurrent budget from development budget. The country has not faced any default in last 5 years. The application has been approved by the ICC and which has been chaired by federal Health Minister and representatives of all provinces

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of:	June

The payment for the first year of co-financed support will be made in the month of:

Month	June
Year	2021

3.4 Financial support from Gavi

3.4.1 Routine Vaccine Introduction Grant(s)

Measles-rubella 1st and 2nd dose routine

Live births (year of introduction)

8,217,503

Gavi contribution per live birth (US$)

0.7

Total in (US$)

5,752,252

Funding needed in country by	15 September 2020

3.4.2 Campaign operational costs support grant(s)

Measles-rubella catch-up campaign

Population in the target age cohort (#)

Note 7

96,367,824

Gavi contribution per person in the target age cohort (US$)

0.55

Total in (US$)

53,002,302

Funding needed in country by	15 September 2020

3.4.3 Operational budget

Please complete the Gavi budgeting and planning template to document how the **Gavi Vaccine Introduction Grant** and the **Campaign Operational Costs support** grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the campaign and the introduction of the new vaccine. Please ensure to upload the completed budgeting and planning template as part of this application.

If Gavi's support is not enough to cover the full needs please indicate how much and who will be complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.

Budget for the vaccine introduction activities

Total amount - Gov. Funding / Country Co-financing (US$)

4280500

Total amount - Other donors (US$)

0

Total amount - Gavi support (US$)

10897000

Amount per target person - Gov. Funding / Country Co-financing (US$)

0.2

Amount per target person - Other donors (US$)

0

Amount per target person - Gavi support (US$)

.70

Budget for the campaign operational costs support

Total amount - Gov. Funding / Country Co-financing (US$)

8246942

Total amount - Other donors (US$)

0

Total amount - Gavi support (US$)

53002303

Amount per target person - Gov. Funding / Country Co-financing (US$)

0.086

Amount per target person - Other donors (US$)

0

Amount per target person - Gavi support (US$)

.55

3.4.4 Key Budget Activities

List the key budgeted activities to be undertaken in implementing the requested support. Please provide details on the key cost drivers, inputs and assumptions required for these activities.

• Microplanning for Campaign
• DSA for all supervisors, skilled staff, TAs social moilizers, TTSPs & education officers
• POL for DHMTs, 1st 2nd level supervisors
• Team transportation
• Transportation cost of vaccines and other supplies
• Printing of tools and form
• Procurement of AEFI Kits
• National & Provincial TOTs
• District Level Supervisor's (DHMT+2nd LEVEL+UCMOs) Training workshop
• Federal Monitoring

• Provincial Monitoring
• TA WHO
• DC/DHO Orientation Session
• Doctor's Orientation
• Provincial Level AEFI Training
• Cold Chain Maintenance
• Development & Printing of Banners
• Development of MIS application for M & E Strengthening
• Procurement of Mega Phone
• Waste Management
• Third Party Validation
• District Level Advocacy Seminar
• National Level Meetings
• Provincial Level Meetings
• Surveillance
• Micro-planning
• Data Entry Operators Training
• Procurement of Vaccine Carriers
• Procurement of Cold Boxes
• TA UNICEF
• Campaign Report & Dissemination
• Production of Audio/Video Documentary
• Development of Public Service Announcement
• Accelerated Mass Media Campaign. (Print, Electronic, Broadcast & Local Cable etc) for SIA
• SMS Campaign
• Mobile Miking
• Other ACSM Activities
• National Level Advocacy Seminar
• Provincial Level Advocacy Seminar
• School Sessions
• Demand Generation
Details are in the budget sheet.

3.4.5 Financial management procedures

Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.

The operational expenditure will be borne by GAVI for Routine introduction, operational and vaccine costs for campaign through WHO and UNICEF. The funds will be utilized mainly through the given procedures: WHO will use the DDM mechanism for transfer of bulk of funds upon completion of various activities like micro-planning and cascade training, monitoring, transportation and service delivery at provincial and district levels. At federal level the activities like procurement of coordination meetings, monitoring visits, and trainings will be funded through direct assistance.
UNICEF will conduct activities like new vaccine launch, advocacy seminars, ACSM activities, procurement of CCE and vaccines etc for provinces and areas directly in coordination with

provincial and federal EPI.
The cost of vaccines will be transferred from GAVI to UNICEF SD for vaccine procurement

3.4.6 Compliance with guidelines for use of Gavi financial support for human resources (HR) costs

Does the submitted application and budget comply with existing guidelines, criteria and requirements for use of Gavi financial support for human resources (HR) costs?

Yes☒ No☐

Please provide further information and justification concerning human resources costs, particularly when issues and challenges have been raised regarding the compliance with Gavi guidelines.

The application has been developed in compliance with GAVI HR guidelines

3.4.7 Fiduciary management

Please indicate whether funds for operational costs should be transferred to the government or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the government. Please note that UNICEF and WHO will require administrative fees as follows.

- **UNICEF Tripartite Agreement: 5%**
- **UNICEF Bilateral Agreement: 8%**
- **WHO Bilateral Agreement: 7%.**

The operational cost for the MR campaign will be received in the country through WHO and UNICEF based on the planned activities detailed in budget section attached. The funds for operational cost should be made available not later than September 2020 The funds for vaccines and logistics should be made available for the country with UNICEF SD by August 2020.

3.4.8 Use of financial support to fund additional Technical Assistance needs

Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the "One TA plan") with a view to assess that required support for the implementation of the new vaccine support is contained in the approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template. In addition, please indicate the programmatic areas for additional technical assistance

needs and the respective agencies providing the technical assistance (if already identified) below.

Note 9

All the staff recruited through the "One TA plan" will be much involved in the campaign related activities. However, since campaign is a huge operations and the coverage should be more than 95%, therefore, more technical assistance required at federal, provincial and district level. The proposed WHO TA in this application are meant to help in micro-planning development, review and validation, cascade training, ACSM activities, implement the readiness assessment on regular bases, and monitoring the implementation of the campaign. .

3.5 Strategic considerations

3.5.1 Rationale for this request

Describe the rationale for requesting these new programme(s), including the burden of disease. If already included in detail in the Vaccine Introduction Plan or Campaign Plan of Action, please cite the sections only.

The national administrative coverage for first dose of Measles during 2019 is 86% leaving behind missed children of 955,408. Measles -2 was introduced nationwide in RI schedule in 2009. Despite many efforts the coverage of the second dose of Measles was only 75% in 2019, as per the administrative reports. There is no vaccination against Rubella and hence a significant number of children in Pakistan are susceptible to Rubella infection.
According to PDHS 2017-18, the national coverage of MCV-1- was 73% only with wide inequities with respect to geography, socioeconomic status and maternal education. Highest coverage of Measles-1 was observed for Punjab followed by Islamabad capital territory and AJK with 82% coverage each. The lowest coverage of 33% was reported from Balochistan.
Pakistan has the highest number of unimmunized children in EMRO region. In 2019, a total of 9002 suspected cases of Measles were reported from all over the country with maximum cases i-e 50% under ten years of age. Punjab reported highest number of suspected Measles and Rubella cases followed by Sindh, KP and Balochistan. Rest of the federating areas did not report suspected Measles and Rubella cases mainly because of weak surveillance system.
According to International Disease Modelling, Pakistan is likely to experience more than 2 million cases of measles during 2020 if timely interventions are not done.(Please refer to Plan of Action)
Epidemiology and Transmission: Pakistan has reported 18% of suspected Measles cases among EMRO Region and 11% of the Lab confirmed Measles case burden of the region was shared by Pakistan by the end of week 48 during 2019. Measles incidence rate decreased from 154 in 2018 to 8.9 per million population in 2019 due to the implementation of successful National Measles campaign in October 2018. A total of 9031 suspected Measles cases were reported, out of which 8218(91%) specimen were sent for Lab confirmation of Measles and Rubella. The sample positivity rate for Measles decreased from 61% to 14% from 2018 to 2019.
In 2018, the incidence rate of Measles was 154 per million population with 608 recorded outbreaks all over the country. After the successful campaign in October 2018, the incidence rate fell to 8.9 per million population in 2019. However, the incidence rate of Rubella witnessed an increase to 5.84 per million in 2019 as compared to the incidence of 1 per million population in 2018.
Pakistan has got a robust case based surveillance system for Measles and Rubella. All health

facilities in the country are reporting on measles and rubella based on the case definition of Fever and rash only. Weekly bulletins on VPD including measles & rubella are issued every week at the national and provincial levels. The national reporting rate of Non-Measles and Non-Rubella increased from 1.2 in 2018 to 2.6 in 2019.
There is one National Measles/Rubella lab accredited by WHO and having proficiency test marks at 100% for the last five years. 91% of the collected samples were tested for Measles and Rubella. 100% of the samples were tested in the national lab and results reported back to EPI within 4 days
This highlights the improvement in surveillance system in the country.
International Disease Modelling (IDM): International disease modelling is used to describe the time course of Measles status and tracks disease severity over time. This model used on updated demographic, epidemiological, routine and campaign coverage data. The modelling gives different scenarios for the campaign for every province.
IDM modelling suggesting the best timing for campaign in April 2020 whereby more than 2 million cases and 40,000 deaths due to the Measles would have been averted. The 2nd option is to conduct the campaign in October 2020 and the third is to conduct in April 2021.

3.5.2 Alignment with country strategic multi-year plan / comprehensive multi-year plan (cMYP)

Please describe how the plans and key assumptions in this request align with the most recent country strategic multi-year plan (cMYP) and other national health and immunisation plans.

Measles elimination is set as one of the goals in cMYP and PC-1. Pakistan is aiming to control Rubella cases in the community and eliminate CRS by 2020 as Pakistan has committed to Global/ Regional Goals. The MR campaign will greatly enhance the immunization coverage of MR and thereby reducing the morbidity and mortality due to Measles and Rubella. Introducing Rubella in RI schedule will contribute to protect the new generation and will help in achieving Universal Immunization Coverage in the country. Federal Minister of Health, in close collaboration with provinces has developed immunization strategy till 2020-2023 in which the goal of more than 95% coverage of all antigens will be achieved. The MR campaign and introduction in RI will contribute greatly to the achieving the set goal.

3.5.3 Coordination Forum (ICC, HSCC or equivalent) and technical advisory committee (NITAG)

Provide a description of the roles of the national Coordination Forum (ICC, HSCC or equivalent body) and national immunization technical advisory group (NITAG) in developing this request.
If any of Gavi's requirements to ensure basic functionality of the relevant national Coordination Forum (ICC, HSCC or equivalent) were not met, please describe the reasons and the approach to address this. Requirements can be found in the general application guidelines.
In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG.

The Measles Rubella application development has been a comprehensive process involving participation of all the relevant stakeholders. Ministry of National Health Services, Regulations and Coordination (Mo NHSR&C) played a lead role in this regard, with Federal EPI being designated as the focal institution to collaborate and coordinate with the provincial/area counterparts and other stakeholders to develop the proposal. A technical committee for the development of the application was notified by the Federal EPI comprising of relevant technical officers in Fed EPI, WHO and UNICEF and a focal person was nominated to lead the process and meet the stringent timeline.

The efforts triggered after the NITAG meeting held on 17 November 2019, wherein it was recommended to submit MR application in January 2020 window. Application sections were discussed at length and consensus was attained on proposed timelines and work-plan. This was followed by a Provincial Consultative Meeting to discuss further on the strategy and timing of the campaign and its future implications as typhoid conjugate vaccine is also expected to be introduced during the same time period.

The technical and development partners along with CSOs also participated in the provincial consultative meeting and provided their inputs. The draft was shared with Gavi and alliance partners for peer review to incorporate their comments. The application was further modified based on input and comments received from the NICC members before its endorsement from the ICC.

The application got approved from Minister for State MoNHSR&C and Ministry of Finance before final submission to Gavi.

Profile of NITAG

Name of the NITAG National Immunization Technical Advisory Group
Year of constitution of the current NITAG 2014
Organisational structure (e.g., sub-committee, stand-alone) Stand-alone
Frequency of meetings Bi-annually and as and when required

Function Title / Organisation Name
Chair National Immunization Technical Advisory Group DR. TARIQ BHUTTA
Secretary National Programme Manager-EPI Dr. Rana Muhammad Saddar

Members Ex- Dean Children Hospital ,Lahore Prof. Tahir Masud
Public Health ,PIH Prof. Rukhsana Kasi
Pediatrician, Peshawar Prof. Gohar Rehman
Khyber Medical College, Peshawar Prof. Amin Jan
Lianas Medical University, Hyderabad, Sindh Prof. Salma Shaikh
Former Head of Department ,Mayo Hospital, Lahore Prof. Ashraf Sultan
Pediatrician Prof. D.S Akram
Department of Virology/ Microbiology, NIH Islamabad Office In-charge
Planning Commission Chief Health
WHO National Team Lead EPI
UNICEF Chief Health and Nutrition
Pakistan Pediatric Association (PPA) President
Pakistan Gyn/ Obs Society President

Major responsibilities of the NITAG

The National Expanded Programme on Immunization Technical Advisory Group shall hold its meetings twice a year. The group will provide the policy directions on the EPI related matters

like advocacy, immunization schedule, innovations in EPI, vaccine handling and storage and any other technical issues where National EPI Manager or ICC require policy direction. The NITAG may co-opt any other person to constitute a sub-committee for any specific task with the approval of the chairman. The NITAG will finalize the decision based on the opinion of the members and keeping in view the relevant global guidelines. National Programme Manager EPI will be the Secretary of the committee and will be responsible for recording all such decisions in the minutes and circulating them to the members.
The secretary of the committee shall forward the approved minutes and recommendation of the meeting to the Ministry of NHSR and C. The Ministry may then take measures as deemed appropriate. The secretary of the committee shall follow the implementation of the decision and keep the ministry informed.

3.5.4 Financial sustainability

Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?

Currently, the GoP is financing Pentavalent, Rota and Pneumococcal vaccines under co-financing mechanism. The same mechanism will be applied for MR procurement. However, the EPI program in the country is shifting to recurrent budget from development budget which will guarantee smooth financing for the procurement of all vaccines. The country has not faced any default in last 5 years. The application has been approved by the ICC and which has been chaired by federal Health Minister and representatives of all provinces who endorsed the application and committed to secure and fulfil their co-financing obligations.

The application has been duly signed by the federal minister of Health and representative of the finance ministry that chose the level of commitment on the part of the Government of Pakistan

3.5.5 Programmatic challenges

Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.

Governance, Accountability and Coordination:
Gaps in management capacity of the programme have negatively affected the vaccination coverage. Lack of accountability in EPI program in some provinces has led to poor EPI service delivery. This is reflected by the low attendance of vaccinators at their duty stations, poor IPC skills and non-responsive attitude of vaccinators. There are operational challenges like non-provision of POL for vaccinators to conduct regular outreach services and delayed disbursement of PC1 funds for implementation of program activities. Limited managerial

capacity has reflected through inequitable distribution of vaccinators, non-provision of services available for public & private health facilities, frequent transfer of managerial staff particularly the DHOs and non-productive district and provincial review meetings. Non-evidence-based decisions are having minimal impact in bringing about sustainable change and improvement in the performance at the lowest level. The lack of coordination between EPI program and other government sectors including PEI, MNCH, LHW programmes, Education and other line departments, CSOs, NGOs, Private sector, other development partners in the recent past has been deficient at all levels.

Service Delivery:

The provision of quality EPI services varied among provinces and districts, between rural vs. urban areas, within the communities in urban areas and among different wealth quintiles. Although the vaccination coverage was found to be higher in urban populations (93.9%) compared to (84.7%) rural populations (PDHS 2017-18),the coverage in urban poor, remote rural and security compromised areas remained quite low due to lack of access to and limited utilization of services by the marginalized population.

The BCG coverage in lowest wealth quintile (LWQ) is 70% as compared to 98% among highest wealth quintile (HWQ). The coverage of third dose of Pentavalent vaccine in LWQ is 49.1% compared to 91% in HWQ. The same trend was observed for other RI vaccines.

The educational level of the mothers has an effect on the immunization uptake and data suggests that the Penta-3 coverage was 60.6% in illiterate mothers as compared to 93.8% in mothers having secondary education.

Vaccination of children has also been impacted by mother’s empowerment in family decision making hierarchy, their level of health awareness, the physical distance they may need to travel to health facilities to get their children vaccinated and competing priorities for mothers at household level also contributed to low uptake of RI services (time barriers).

Lack of female vaccinators in service delivery has been a deterrent to vaccination in culturally sensitive communities e.g. Merged Areas, Balochistan, GB, South Punjab as all vaccinators are male as females are not permitted to work or are unavailable. This has made the mothers reluctant to access a health facility with male vaccinators. These gender-based barriers have impeded the progress of universal vaccination services.

Based on the intensive analysis done by all stakeholders and partners, the major bottlenecks for poor service delivery included poor planning and lack of accountability. Micro-plans were found to miss many remote rural areas, urban poor and security compromised communities. For example, in Balochistan and Sindh around 1700 and 950 areas respectively were missed from district / HF micro-plans in last measles SIA. The lack of use of technologies such as use of GIS for micro-planning and tracking the missed children and for identification of inaccessible areas has been a major limitation since the technology has been already made available but not being utilized.

In the whole of Pakistan, there are 1159/ 5603 UCs (21%) that do not have fixed EPI centers while the selected 46 Districts have 33 % UCs without fixed EPI sites.

The vaccinators are concentrated mainly in central health facilities excluding large rural and remote areas. In addition to the deficiency of EPI sites, high percentage of the services are provided through outreach which are also not being conducted as planned due to lack of proper planning, non-payment of Petroleum, oil and lubricants (POL) cost, lack of supervision and accurate reporting.

Despite the presence of the widely spread private sector health care service providers, both formal and informal trusted by the communities, specifically in urban slums and remote rural areas, remains underutilized when the existing public health system fails to leveraging provision of EPI services.

Lack of integration of RI with other Primary health care (PHC) programs like MNCH, Nutrition

and National program for family planning, and with other government sectors like education, water and sanitation and stakeholders like district government in mega cities is a missed opportunity for improving the uptake of immunization services by marginalized communities and hence a challenge in reducing equity gaps.
Field monitoring observations have revealed non-compliance of vaccinators to SoPs (standard operating procedures) leading to AEFIs that cause vaccine hesitancy in the community negatively affecting vaccine coverage.
Low quality data and the culture of no data use for evidence-based decision making is hindering the provision of quality immunization services to the marginalized communities.
Monitoring, supportive supervision and surveillance:
Deficient supportive supervision due to high number of vacant sanctioned positions of supervisory cadre, lack of means of transportation, mobility for available staff are among the key bottlenecks.

Due to lack of uniform, standardized online/offline monitoring application all over the country, the findings of monitoring visits cannot be properly documented and analysed. The information generated from minimal monitoring and supervision activities is not being used for evidence-based planning and decision making which undermines the importance of improving and upgrading of monitoring and supervisory systems.
EVACC is another application used by EPI in Punjab, Balochistan and KP including Tribal Districts, primarily for monitoring vaccinator’s attendance in the field. However, it is not being used in Islamabad, AJK, GB and TDKP. EVACC is quite successful in ensuring vaccinator’s attendance and is successful in Punjab where the attendance rose from 60% to 90%.
VPD and AEFI surveillance reporting has improved in recent past however the surveillance systems are not well established to detect and report VPDs outbreaks to initiate a timely response. This is due to lack of adequate and competent human resource, lack of coordination among all actors (EPI/PEI) resulting into irregular sporadic reporting which cannot be triangulated with coverage data to understand the real bottlenecks for outbreaks in community. There is a need to standardize the reporting tools and unify the online reporting system. The capacity of staff related to surveillance needs further enhancement at all levels, to use this data to take timely action and future preventive measures. Moreover, the surveillance data is not triangulated with coverage data as evidence for decision making during the EPI reviews. At this point in time, the information sharing and communication gap needs to be bridged by utilizing new technologies.
Suspected Measles cases are only reported from Teaching hospitals, District headquarter hospitals and Tehsil Headquarter hospitals with very few cases being reported from primary health care facilities (Basic Health units, Rural Health centers, Civil dispensaries) and from the communities.
Community based surveillance is non-existent and VPD cases are hardly notified from hard-to-reach areas, areas where the population relies highly on traditional healers or alternative treatments. The CBVs and LHWs are underutilized to fill in this gap in the existing surveillance system and need to be utilized to help in reducing morbidity and mortality in the communities through early detection and early response.
In non-CBV/non-LHWs areas, community health workers/social mobilizers need to be engaged for establishing community-based surveillance.
Demand promotion:
The National Knowledge, Attitude, Practice and Behavior (KAPB) Survey from 2014 highlighted seven barriers in supply and demand to improve immunization coverage. 82% of community respondents report receiving their immunization information from the health service providers. There were gaps in LHW knowledge of vaccines (only 60% of LHWs interviewed were aware of the DPT vaccine).

At the time of KAPB Survey (2014), awareness on vaccine preventable diseases was low among caregivers and some healthcare providers. However, the results from the more recent Polio KAP Survey and Focus Group Discussions in 2017 and 2018 respectively and bottleneck analysis done by other development partners show that communities are aware of the benefits of immunization but are not accessing the services due to the poor interpersonal communication skills of vaccinators; lack of time and funds to travel long distances to vaccinate child; conflicting priorities; fatigue from constant Polio campaigns; low education level among female caregivers; security concerns in the area; and opposition from religious leaders and pediatricians about vaccine efficacy.

The consultations with the provinces/ areas identified three major bottlenecks in communication related to governance, service delivery and demand generation.

• There is inadequate engagement of local government around demand generation that leads to poor accountability and ownership in the process. Furthermore, there is weak coordination and engagement of government with community networks.

• The communities have lack of trust in quality of RI services offered by Public sector, resulting in low uptake of immunization services and high dropout rate. This is partly due to the limited capacity of front line workers in IPC skills and health education.

• In the absence of a proper health education system in the government, community awareness has not been prioritized in the RI programming which contributed to low awareness regarding importance of vaccination among marginalized communities. Until recently, media/social media has not been utilized effectively to counter myths and misconceptions among communities to address their fear leading to lower utilization of services. There is insufficient evidence to support planning of targeted interventions for Behavior Change Communication (BCC) in marginalized communities (urban poor, among different ethnic groups, remote rural, security compromised and etc) resulting in increased equity gaps. Lack of awareness on benefits of immunization in departments like education department, MNCH programme, Nutrition, Pediatric Association, District administration, local governments is an inhibiting factor in uptake of RI services by the community.

Mitigation measures for major challenges:

• Human resource: Human resource gap will be a challenge to overcome. However, the gap will be filled through mobilizing human resource from LHW program, nursing schools, paramedic staff and engaging private sector

• Routine Immunization will not be affected: Routine Immunization will be strengthened through engaging the social mobilizers of MR campaign for spreading the message of RI in the community. One social mobilizer will be provided at Fix center to mobilize all eligible children for routine immunization and for campaign especially in the CBV areas. All the antigens of RI will be delivered during the campaign days.

• Quality of campaign:

Following are the main components for achieving a high quality campaign:

o Governmental/Political Commitment: All levels of government and political leadership and parliamentarians will be engaged for the advocacy of the campaign. President, Prime Minister and his cabinet, Speaker of National and Provincial Assemblies will be approached for campaign ownership and provide support to the campaign at all levels of preparation and implementation.

o Quality Micro-planning: Quality Micro-planning is the key to a high quality campaign. New micro-plans will be developed based on latest targets, on census 2017-18 and the vast experience gained during Measles, TCV, Polio eradication and Outreach activities. The Micro-plans will be desk reviewed and field validated based on already developed tool. The development partner staff including Polio staff and consultants hired by WHO, UNICEF and BMGF at district and UC levels will be participating effectively in the development and validation of micro-plans.

o Engagement of Polio Program: The campaign will be conducted in full coordination with Polio program right from the beginning of the planning and preparation till the implementation of the campaign. National and Provincial EOCs are fully engaged in developing the MR Application. The Polio Program has committed to give enough space of time for the MR Campaign and all the staff at all levels to be involved in all the campaign activities, from preparation till implementation. Polio program will be engaged especially in micro-planning, desk review and field validation, TOT and cascade training, ACSM activities and monitoring of the campaign.
• Using Measles & TCV campaign Experience: All documented lessons learnt will be applied during this campaign:
o Prior consent of schools and parents based on standardized consent form developed by EPI and issued by education department
o Ensure that refusal schools will be identified during the preparatory phase of the campaign and Polio NIDs, will be addressed well before the campaign
o Vaccination teams will be provided with a jacket and cap for official and professional identity
o Crisis management plans will be developed in an extensive manner and staff will be trained and mock/simulation exercises will be carried out before the campaign at all levels
o School targets will be validated to get accurate targets to be used in the micro-planning process
o Quality training will be ensured at all levels, especially the social mobilizer training
o Engaging Education Department: Education department including public and private sector will be engaged from the planning phase of the campaign. Their staff will be involved in in all the preparatory meetings, including the micro-planning, trainings, etc. Teachers, headmasters and principals will be proactively engaged in community mobilization and act as an advocate for the campaign and to dispel the rumors or misgivings that may occur during the campaign in the community about vaccines in general and MR in specific. Parental consent will be obtained at least two weeks before the start of the campaign. Awareness sessions will be conducted in every school and madrassas (religious schools) before and during the campaign. Already developed SOPs during TCV campaign on organizing vaccination sessions in schools to alleviate the fear of injection (Anxiety-related AEFI) in the community will be adopted. Parent's teachers association will be involved right from the start of the campaign.
• Covering Out of School Children:
• Children out of schools like in factories, markets, workshops and street children, etc will be covered through mobile teams. The following measures will be taken to ensure the coverage of those children:
• Mapping of the out of school children will be carried out through involving NGOs, community leaders, UC health committees, UC chairperson and Trade Unions
• Rural Support Programs: The Rural Support Program (RSPs) has an extensive network across Pakistan which is recognized by the government at federal and provincial/area level. The RSPs will be engaged to mobilize out-of-school/street children's caregivers and employers to bring them in for vaccination.
• A special format for Inclusion of these out-of-school children will be part of the micro-plan
• Allocating special mobile teams for tracking and vaccinating the children in their respective places of work
• Extension of working hours to give ample chance for those children to be vaccinated after their working hours, wherever required
• These children will be given access to vaccination through private clinics in their areas or work places
• Special mobile teams with megaphones will be deployed to attract out-of-school-children for vaccination
• Extensive ACSM Plan: Following measures will be taken to create demand in the community for the uptake of vaccine:

• Crisis management plans will be developed in an extensive manner and staff will be trained and mock/simulation exercises will be carried out before the campaign at all levels
• Demand generation in the community will be carried out through extensive ACSM activities using electronic, print and social media with special emphasis on local cable TV
• IEC material will be developed and disseminated using NEOC/PEOC platforms like the Polio campaign, CSO network, PPA, schools and madrassas etc
• Advocacy sessions will be carried out with parliamentarians and local elected officials well before the start of the campaign
• Advocacy with religious support persons and community gatekeepers/ Influencers
• Involvement of private sector and professional organizations like Pakistan Pediatric Association, Pakistan Medical Association, Rotary, Trade Unions, Lions club for creating awareness in the community through workshops, official letters etc
• Line departments like Education Department, LHW Program, MNCH Program, Ministry of Human Rights, PPHI, Police department, Divisional and District Management etc will be mobilized through awareness and orientation sessions
• Specific awareness and orientation sessions will be arranged for media personnel to mobilize community and dispel the rumors and misconceptions
• Educational institutes in the country will be engaged through awareness seminars for spreading the message on benefits of immunization and importance of MR and other RI vaccines
• Drama theaters and float van will also be introduce to create the awareness among street children
• Extensive Mosque/Vehicle and Mega phone announcement will be carried out before and during the campaign especially in high risk areas
• Taking this campaign as an opportunity to increase the Routine Immunization,
• Routine immunization in the fixed site will continue throughout the campaign days
• Social mobilizers who are visiting house to house will refer the eligible children to the fixed centres for routine vaccination
• All children coming to fixed centres will be referred to the vaccination site through the social mobilizers deployed in the fixed centers
• Security issues will be mitigated by engaging EOC: There are no security compromised areas and that all the areas can be accessed by the vaccination teams. There are some areas in Karachi, Quetta block, KP and Merged Areas which needs some additional security measures. All the required security measures will be supported by NEOC/PEOC as per their standard procedures of Polio campaigns
• High risk population including the mobile population:
• Specific criterion will be developed to identify the high risk population using the previous experience of Measles, TCV and Polio Campaigns
• A customized social mobilization strategy will be adopted to capture these groups of children based on their unique characteristics
• In sparsely populated areas, far flung areas, Nomads, difficult terrain, children can be reached by mobile teams
• In urban slums or even in posh area with higher proportion of working parents, flexible
• timing for vaccination site to be followed
• Special vaccination team to be arranged to cover street children, field (during harvesting season), working children in bazaar/workshops, temporary settlers (e.g. nomads).
• Separate arrangements to put in place for children in hospitals, orphanages, prisons etc.

3.5.6 Improving coverage and equity of routine immunisation

Explain how the proposed NVS support will be used to improve the coverage and equity of routine immunisation, by detailing how the proposed activities and budget will contribute to overcoming key barriers.

New vaccine support (NVS) will be capitalized for switch from Measles to Measles-Rubella vaccine in Pakistan.
This will also provide an opportunity to strengthen routine immunization coverage, reduce equity gaps and to achieve universal immunization coverage among target population.
Equity focused planning and micro-planning will be the key to achieve high coverage during campaigns as witnessed in previous national Measles SIA in 2018 and provincial TCV campaign in 2019. NVS support will provide time and resources through proposed activities for refining micro-plans and for making them equity focused. Equity gaps in provision of routine immunization services to marginalized populations through identification of persistently missed or refusal children particularly in urban and peri-urban slums will be addressed. It will facilitate rationalized distribution of field staff for optimal coverage of uncovered or partially covered areas. Through effective utilization of EPI/PEI synergy, a systematic tracking of zero dose, defaulter and refusal children will be done. All the refusal schools (refusal for Polio SIAs, Measles and TCV campaign) will be enlisted and targeted during pre-campaign period to vaccinate the target population in these schools. District and provincial management will be sensitized to lead these initiatives with active involvement of Education department and private schools organizations in their respective provinces and districts.
In addition to that, new outreach points/sites will be identified during micro-planning for Polio - SIA which can later be continued as effective service delivery sites for essential Immunization service delivery through outreach activities.
Private sector will be trained and involved during the campaign and their support will be sought for providing equitable RI services in areas where functional EPI centers are absent.
Conduction of quality trainings prior to MR campaign and switch in routine immunization will refresh knowledge and improve skills of staff at all levels. Since it will encompass all aspects of immunization in routine including reporting and monitoring, data will consequently improve in quality.
Optimization of cold chain for absorption of additional vaccine load will be done on priority in hard to reach, difficult to access, urban slums and in private sector etc.
Robust and inclusive communication plan including crises communication will be developed that will explore possibilities of establishment of community platforms for engaging with local government bodies, leaders and influencers to mobilize hesitant and resistant communities. A structured community-centric approach will lead to the conversion of refusals and in building community trust on vaccine and immunization services. This will also help to establish social accountability at all levels.
Vigorous monitoring and supportive supervision trainings during campaign will also develop the capacity of supervisors at all levels to produce quality data and its use for evidence-based planning and decision making for essential immunization after switching to MR.
Currently, Congenital Rubella Syndrome surveillance is being conducted through four sentinel sites out of which two are in Punjab and two are in Sindh. There is a plan of to expand the sentinel sites in remaining two provinces and Islamabad. These measures will strengthen the VPD surveillance system in the country. For details please refer to Plan of Action

3.5.7 Synergies

Describe potential synergies across planned and existing Gavi support, including planned introductions, campaigns and HSS support. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions. Furthermore, how is the requested support complementary and creating synergies with the support of other Global Health Initiatives, such as the Global Fund and GFF?

Note 10

Cognizant of the wide age range of the target population, effective preparation and community awareness remains instrumental for the success of a vaccination campaign and new vaccine introduction. Mass level campaigns cannot be conducted without collaboration of all relevant stake holder and field workforce.

Working closely with the Pakistan Polio Eradication Initiative, EPI had successfully conducted a nationwide measles Supplementary Immunization Activity achieving around 93% coverage evaluated by third party. The Catch-up campaign of Typhoid Conjugate Vaccine in Sindh, is another example of close collaboration with PEI and education department.

The engagement of Pakistan Pediatric Association in TCV campaign has been exemplary and renowned Pediatricians were working hand in hand with the EPI programme to making the campaign a success.

Learning lesson from the past and considering the scope of the task, EPI intends to replicate the same level of coordination and cooperation with the line departments, ministries, PEI programme, Pediatric association, private sector including CSOs as witnessed in the past. Building on further, the engagement of community influencers, coalitions, key local / religious leaders and caregivers would further be enhanced to achieve the goal synergies through PEI, PPA and CSOs involvement.

Under the vision of the Ministry, NHSR&C, integrated services delivery package is being introduced in a phased manner and staring from super high risk union councils of the country, aiming to deliver essential health package to the vulnerable populations. The initiative is undertaking laborious planning work, jointly with EPI and PEI and the provincial governments to generate adequate resources following health system strengthening approach. These efforts are further improving synergies and ties at the lowest level of service delivery.

Under the Gavi's health system grant (HSS-additional funding) high risk districts have been prioritized to support polio eradication initiative by bridging the immunity gap in the vulnerable communities. The grant aims to strengthen surveillance activities in the districts besides investing in improving service delivery at the health facility, outreach services and innovations in mobile approach to reach hard to reach population e.g. those in urban slums. Recent increasing trends of community resistance witnessed during past polio campaigns is posing threat to routine immunization too. In such a challenging environment where traditional methods of reaching the un-reached are becoming more and more complex and out-dated, there is need of the hour to tackle the issue in a more collaborative and innovative way to not only expand the service delivery of vaccines to those who are in dire need but it also mandates engagement of the programmes through a novel approach. Training of PEI staff on RI would further potentiate the capacity of the front-line works to address the community's concerns. The awareness raising envisioned in HSS grant and during MR-campaign and routine introduction of new vaccine would be complementing each other.

Furthermore, EPI-Pakistan has introduced IPV, Rota and TCV in the recent past and gained sufficient capacity around new vaccine introduction. Similarly, recent measles campaigns (in 2018) and TCV campaign (in 2019 in Sindh) has not only enhanced the programmes' capacity

but also generated debate to consider future financial implications around such introductions. Having an LMIC status, the country is heading towards accelerated transition phase and there remains a financial risk with every new vaccine that is introduced in the programme. Alongside, Measles still remains a major public health threat and challenge, while incremental increase in rubella case has further made the introduction of MR essential. Thus the Federal and Provincial Government have started working on shifting the vaccines cost from development to recurrent side of the budget.

3.5.8 Indicative major measles and rubella activities planned for the next 5 years

Summarise in one paragraph the indicative major measles and rubella activities planned for the next five years that are reflected in the annual EPI plan (e.g. measles second dose introduction, measles or measles-rubella follow up campaign, etc.).

Pakistan has planned to conduct MR campaign in 2021 through which about 96.3 million children from 9 months to 15 years would be targeted in all provinces and areas. The programme has set 95% coverage target for the campaign. Following this campaign, EPI would switch both doses of Measles Vaccine with Measles-Rubella Vaccine in routine immunization at the age of 9 months and 15 months respectively. Subsequently, the country would follow Measles and Rubella Elimination Plan for the next 5 years as per attached document.

3.6 Report on Grant Performance Framework

Grant Performance Framework – Application Instructions

The Grant Performance Framework (GPF) contains all indicators that will be used to monitor programmatic performance for your requested type of support. Targets that were entered for number to be vaccinated in section 3 on the Target Information tab, have been carried over into their respective indicators in the GPF. Based on these numbers, coverage and dropout rate targets were calculated (where applicable). These appear as “calculated targets”. If you wish to revise these target values, please revise in the application form – they are not editable in the performance framework. In addition, as a part of your application, there are several items to be filled directly into the GPF. These are broken into required and optional items, below:

Required

1. In addition to the calculated targets, country targets are required to be submitted for outcome indicators. These targets should align to those in your cMYP or NHSP. If these targets are not in your cMYP or NHSP, or are the same as the calculated targets, please enter “NA” for each target value.
2. Additional indicators that appear in the Performance Framework that are not included in the application form. Please enter targets for these indicators.
3. For many indicators, reporting dates have been pre-populated. For those that have not yet been pre-populated, please add reporting dates.

Optional

1. Adding data sources to existing indicators: If there are data sources for indicators that you would like to include, you may add an additional source by clicking on the pencil icon next to the indicator name.
2. Adding new indicators: Gavi requires all countries to report on core indicators, which are already included in the GPF. If you wish to add supplemental indicators to monitor performance, you may do so by clicking the “Add indicator” button at the respective performance level (Outcome, Intermediate Result, or Process).

Please note that the GPF is filtered by default to only show indicators that are relevant to the specific types of support contained in the application. You may view the entire GPF by using the “Grant Status” filter. Please ensure your pop-up blocker is disabled when launching the GPF.

If you have any questions, please send an email to countryportal@gavi.org.

3.7 Upload new application documents

3.7.1 Upload new application documents

Below is the list of **application specific documents** that must be provided with your application.

In the case a document cannot be provided, please use the comment box to explain why, or by when it will be available.

Application documents

New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline

If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication.

PoA MR campaignRI22nd May _2020_26-05-20_14.25.25.xlsx

PoA MR catchup campaign and introduction22nd May 2020 _final_26-05-20_14.23.27.pdf

Gavi budgeting and planning template

Revised MR Campaign Budget of Pakistan 23May2020_25-05-20_00.40.48.xlsm

Revised NVS Support for MR_Introduction in Pakistan Budget_23May2020_25-05-20_00.40.09.xlsm

Most recent assessment of burden of relevant disease

If not already included in detail in the Introduction Plan or Plan of Action.

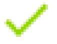
01FELTP Pakistan Weekly Epidemiological Report Dec 30 Jan 05 2019_22-01-20_15.42.37.pdf

PakistanMRScenarioComparisonAugust2019_22-01-20_15.41.49.pdf

Sources and justification of campaign target population estimates (if applicable)

No file uploaded

Endorsement by coordination and advisory groups



National coordination forum meeting minutes, with endorsement of application, and including signatures

The minutes of the national coordination forum meeting should mention the domestic funding of MCV1

Minutes of Meeting NICC 15th Jan 2020_23-01-20_20.08.25.pdf

Attendence NICC_23-01-20_19.43.43.pdf

Endorsement MR Members Signature_23-01-20_19.43.06.pdf

NITAG meeting minutes

with specific recommendations on the NVS introduction or campaign

Approved Minutes of Meeting NITAG 17th Dec 2019_22-01-20_15.31.45.pdf

Vaccine specific

cMYP addendum

PakNational cMYP201920_22-01-20_16.00.42.pdf

	Situation analysis and 5 year plan captured in the cMYP or as an addendum to the cMYP	
✓	**Annual EPI plan** Annual EPI plan detailing planning of all measles and rubella-related activities for the current year, including realistic timelines, designated responsible individual(s) and a budget	Annual PlanEPI_23-01-20_18.21.23.xlsx
✓	**Other documents (optional)**	Pakistan iSC Improvement RoadmapFinal draft_23-01-20_17.56.18.pdf
✓	**MCV1 self-financing commitment letter** If the country is not yet financing the measles monovalent component of MCV1, a letter signed by the Minister of Health and Minister of Finance committing for the country to self-finance MCV1 from 2018 onwards.	MCV1 selffinancing commitment letter Justification_23-01-20_18.08.25.pdf
✓	**Measles (and rubella) strategic plan for elimination**	Measles rubella elimination plan 20202024_23-01-20_20.09.08.pdf

4 Review and submit application

4.1 Submission Details

Country vaccine funding summary

Please review the estimated projections for new vaccine programmes included in this application.

Active Vaccine Programmes

Note 11

IPV Routine

	2020	2021	2022
Country Co-financing (US$)			
Gavi support (US$)	6,611,938	6,599,153	6,582,869

PCV Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	12,858,282	15,000,867	21,114,098	27,341,435	33,685,168
Gavi support (US$)	32,021,575	30,522,860	24,891,328	19,127,695	13,244,924

Pentavalent Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	4,652,027	5,428,115	7,639,207	9,893,132	12,188,212
Gavi support (US$)	12,887,185	12,362,724	10,339,882	8,267,174	6,152,240

Rota Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	16,690,226	19,281,956	25,527,872	14,524,563	17,888,333
Gavi support (US$)	34,703,657	32,392,215	26,327,633	10,285,235	7,159,313

TCV Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	2,614,876	4,240,511	5,965,278	7,724,117	9,517,536
Gavi support (US$)	6,754,492	8,969,212	7,376,542	5,751,121	4,092,455

Total Active Vaccine Programmes

	2020	2021	2022	2023	2024
Total country co-financing (US$)	36,815,411	43,951,449	60,246,455	59,483,247	73,279,249
Total Gavi support (US$)	92,978,847	90,846,164	75,518,254	43,431,225	30,648,932
Total value (US$) (Gavi + Country co-financing)	129,794,258	134,797,613	135,764,709	102,914,472	103,928,181

New Vaccine Programme Support Requested

Measles-rubella 1st and 2nd dose routine, with catch-up campaign

	2021
Country Co-financing (US$)	4,280,500
Gavi support (US$)	87,078,000

Total country co-financing (US$)	
Total Gavi support (US$)	
Total value (US$) (Gavi + Country co-financing)	

Total Portfolio Overview – Existing Programs + New Vaccine Support Requested (US$)

	2020	2021	2022	2023	2024
Total country co-financing (US$)	36,815,411	48,231,949	60,246,455	59,483,247	73,279,249

Total Gavi support (US$)	92,978,847	177,924,164	75,518,254	43,431,225	30,648,932
Total value (US$) (Gavi + Country co-financing)	129,794,258	226,156,113	135,764,709	102,914,472	103,928,181

Contacts

Person(s) who should be contacted in case Gavi needs to ask for more information in regard to the application.

Name	Position	Phone Number	Email	Organisation
Dr. Rana Muuhammad Safdar	National Program Manager EPI	0092519255101	drsafdar64@yahoo.com	MoNHSR&C, Federal EPI

Comments

Please let us know if you have any comments about this application

We faced problem while saving the document

Government signature form

The Government of Pakistan would like to expand the existing partnership with Gavi for the improvement of the immunisation programme of the country, and specifically hereby requests Gavi support for:

Measles-rubella 1st and 2nd dose routine, with catch-up campaign

The Government of Pakistan commits itself to developing national immunisation services on a sustainable basis in accordance with the national health and immunisation strategic plans. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

The co-financing commitments in this application include the amount of support in either supplies or cash that is requested from Gavi, and the financial commitment of the Government for the procurement of this new vaccine.

Please note that Gavi will not review this application without the signatures of both the Minister of Health and Minister of Finance (and Minister of Education, if applicable) or their delegated authority.

We, the undersigned, affirm that the objectives and activities in this request are fully aligned with the national health and immunisation strategic plans (or equivalent), and that funds for implementing all activities, including domestic funds and any needed vaccine co-financing will be included in the annual budget of the Ministry of Health.

We, the undersigned, further affirm that the requested funding for salaries, salary top-ups/allowances, per diems and incentives does not duplicate funding from other sources (e.g. from other donors).

We, the undersigned, further affirm that the terms and conditions of the Partnership Framework Agreement between Gavi and the Country remain in full effect and shall apply to any and all Gavi support made pursuant to this application.[1]

Minister of Health (or delegated authority)

Name

Date

Signature

Minister of Finance (or delegated authority)

Name

Date

Signature

For countries requesting HPV support, with a school linked strategy, the signature of the Minister of Education (or delegated authority) is also required.

Minister of Education (or delegated authority)

Name

Date

Signature

[1] In the event the Country has not yet executed a Partnership Framework Agreement, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

Appendix

NOTE 1
The new cMYP must be uploaded in the country document section.

NOTE 2
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.

NOTE 3
* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* Due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the "support requested until" field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

NOTE 4
* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* The wastage rate applies to first and last dose.

NOTE 5
Co-financing requirements are specified in the guidelines.

NOTE 6
*The price used to calculate costs is based on UNICEF-single dose per vaccine procurement cost for measles monovalent vaccine.** This value will differ from the total cost if the vaccine selection is MR, as a country is only required to finance the cost of the measles monovalent vaccine.

NOTE 7
Note: The population in the target age cohort used here is the number you entered for year one in the target information section.

NOTE 8
https://www.gavi.org/support/process/apply/additional-guidance/#leadership

NOTE 9
A list of potential technical assistance activities in each programmatic area is available here: http://www.gavi.org/support/pef/targeted-country-assistance/

NOTE 10
E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.

NOTE 11
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.