Global Alliance for Vaccines and Immunisation (GAVI)

APPLICATION FORM FOR COUNTRY PROPOSALS

For Support to:

Immunisation Services, Injection Safety
and New and Under-Used Vaccines

Revised 15 January 2008

(To be used with Guidelines dated 15 July 2007)

Please return a signed copy of the document to:
GAVI Alliance Secretariat; c/o UNICEF, Palais des Nations, 1211 Geneva 10, Switzerland.

Enquiries to: Dr Ivone Rizzo, irizzo@gavialliance.org or representatives of a GAVI partner agency. All documents and attachments must be in English or French, preferably in electronic form.

CONTENTS

Executive Summary

One of the main priorities under the National Development Strategy is to reform the health system through reduction in infectious diseases and control of vaccine preventable diseases. The National Immunization Program (NIP) faced serious disruption of vaccination during the early 1990's. Shortage of vaccine and safe injection materials supply, cold chain equipment, lack of motivation of health staff, etc. resulted in decline of coverage rates and breakup of vaccine preventable diseases. Nevertheless, the Government with the support of different international agencies managed to revive the immunization service in the country. For the last five years Immunization coverage was officially reported at over 90 percent for all vaccines, but according to the decision of MoH to use State Statistical Agency demographic data to identify denominators for health services, **denominator has been significantly increased (from 158,000 to 186,126) and relatively coverage rates were decreased.**

Intensive collaboration with WHO, UNICEF, JICA, TICA and other international partners has brought a better performance in important aspects of immunization policies and practices, such as safer cold chain, adoption of injection safety principles and medical waste utilization after immunization activities, etc. Immunization services are free of charge. An adequate amount of AD syringes and safety boxes is supplied to the health facilities.

The National Immunization program in Tajikistan was financed mainly by donors. The main player in the NIP financing was GAVI (28%) and the rest came from UNICEF (21%), JICA(17%), WHO (9%), the national government (9%), sub-national government (9%), and Government of Turkey (7%). UNICEF supported procurement of traditional vaccines, social mobilization activities, short-term trainings, policy development, and technical and management aspects of immunization program. JICA supported procurement of traditional vaccines. The Government of Turkey procured a portion of measles vaccines. WHO supported diseases surveillance, program management, short-term trainings and policy development and provides technical assistance.

The GAVI offered financial assistance for procurement of Hep-B vaccine, injection supplies and strengthening of immunization system. With the GAVI ISS funds, all regional branches and 50% were provided with vehicles.

In September 2007, the Ministry of Health applied the NVS application to GAVI that was revised by IRC and approved in January by the GAVI board. Following the approval of NVS application, the Ministry of Health took the decision and apply for ISS support in February 2008.

The Government of Tajikistan has already proved its financial commitment by taking over 2.8% in 2008 of the vaccine costs starting from 2007. In 2008, the Government allocation for vaccine procurement reached 490,000 $USD. Given that the government funds will be used for vaccine procurement only, the National Immunization Program still needs external support to for operational component of National Immunization Program.

One of the key tasks defined under cMYP (2008-2010) is to increase immunization coverage level, which can be achieved through a number of activities priority areas such as supporting mobile immunization teams, enhancing monitoring and supportive supervision, improving registration and reporting system, capacity building of immunization services providers, improving infrastructure and cold chain equipment maintenance, social mobilization, etc.

All the above activities will allow the country to strengthen the system of immunization services in the priority districts.

2. Signatures of the Government and National Coordinating Bodies

Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of Tajikistan would like to expand the existing partnership with the GAVI Alliance for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests for GAVI support for Immunization Services Support.

The Government of Tajikistan commits itself to developing national immunisation services on a sustainable basis in accordance with the comprehensive Multi-Year Plan presented with this document. The Government requests that the GAVI Alliance and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Table N° 4.1 of page 13 of this application shows the amount of support in either supply or cash that is required from the GAVI Alliance. Table N° ……of page ……of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

"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 ……. The payment for the first year of co-financed support will be around …….. (specify month and year)."

Minister of Health:

Signature: ……

Name: Dr. Nusratullo Salimov

Date:

Minister of Finance:

Signature: ……

Name: Mr. Safarali Najmiddinov

Date:

National Coordinating Body - Inter-Agency Coordinating Committee for Immunisation:

We the members of the ICC/HSCC[1] met on the 06.02.08 (insert date) to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

- The endorsed minutes of this meeting are attached as DOCUMENT NUMBER:№3

Name/Title	Agency/Organisation	Signature
Dr Mirzoev A., Deputy Minister	**Ministry of Health**	
Dr. Nazarhudoeva., Epidemiologist	**Republican Centre of Immunoprophylaxis**	
Dr. Oktam Bobohodjaev, Head of Medical Services Department	**Ministry of Health**	
Dr. Kurbanov Sh., Head of MCH Department	**Ministry of Health**	
Dr. Azimov G., Head of	**Ministry of Health**	

[1] Inter-agency coordinating committee or Health sector coordinating committee, whichever is applicable.

Sanitary and Epidemiological Department		
Mr. Naimi A, Deputy Head of Leading Department of State budget, Head of State and Investment Policy Department	**Ministry of Finance**	
Dr. Jabirov Sh., General Director	**Republican Center for Immunoprophylaxis**	
Dr. Turkov S., Deputy Direcor	**Republican Center for Immunoprophylaxis**	
Dr. Sabir Kurbanov, Health Program Officer	**UNICEF**	
Dr. Jaborov S, Programme Officer	**JICA**	
Dr. Nazira Artykova, Liaison Officer	**WHO**	
Mr. Kolchin V., HR Consultant	**World Bank**	
Dr. Rajabova L., Senior Specialist	**Asian Development Bank**	
Dr. Lailo Kurbonmamadova, Health Program Coordinator	**Aga Khan Foundation**	
Dr. Mehry Shoismatulloeva, EPI Officer	**WHO**	

In case the GAVI Secretariat has queries on this submission, please contact:

Name: Dr Shamsiddin Jabirov Title: General Director, RCIP

Tel No.:+992372 272694 Address: Chapaev Str. 8, Dushanbe, Tajikistan

Fax No.:+992372 211073 ……

Email: immune@rci.tajik.net ……

The GAVI Secretariat is unable to return documents and attachments to individual countries. Unless otherwise specified, documents may be shared with the GAVI partners and collaborators.

The Inter-Agency Coordinating Committee for Immunisation

Agencies and partners (including development partners and CSOs) supporting immunisation services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC/HSCC). The ICC/HSCC are responsible for coordinating and guiding the use of the GAVI ISS and NVS support. Please provide information about the ICC/HSCC in your country in the spaces below.

Profile of the ICC/HSCC

Name of the ICC: Inter Agency Coordination Committee

Date of constitution of the current ICC: June 2002

Organisational structure Stand alone structure

Frequency of meetings: 4 times a year

Composition:

Function	Title / Organization	Name
Chair	Deputy Minister of Health	Dr. Mirzoev S.
Secretary	Epidemiologist, Republican Center for Immunoprophylaxis	Dr. Nazarkhudoeva
Members	Deputy Ministry of Health	Dr. Mirzoev A.
	Epidemiologist of Republican Center of Imunoprophylaxis	Dr. Nazarhudoeva M.
	Head of the Health Care Services Department, Ministry of Health	Dr. Bobohodjaev O.
	Head of MCH Department	Dr. Kurbanov Sh.
	Head of Sanitary and Epidemiological Department, Ministry of HEalth	Dr. Azimov G.
	Deputy Head of Leading Department of State budget, Head of State and Investment Policy Department General Director, RCIP	Mr. Naimi A
	General Director, Republican Center of Immunoprophylaxis	Dr. Jabirov Sh
	Deputy Director, RCIP	Dr. Turkov S
	Health Program Officer	Dr. Sabir Kurbanov
	Programme Officer, JICA	Dr. Jaborov S
	Liaison Officer	Dr. Nazira Artykova
	Officer, World Bank	Mr. Kolchin V
	Senior Specialist	Dr. Radjabova L
	Health Program Coordinator	Dr. Lailo Kurbonmamadova
	National Professional Officer	Dr. Mehry Shoismatulloeva

Major functions and responsibilities of the ICC/HSCC:

The ICC of the MoH, chaired by the Minister of Health, has been established as a means for policy-level coordination of initiatives and projects related to immunization program. The ICC is not limited only to the coordination of GAVI support, but aims to enhance coordination and synergies

between different EPI interventions in the longer term. The ICC is a stand alone committee that will work to coordinate the EPI activities in the country. The Republican Center for Immunoprophylaxis is the leading department for coordination between MoH and other stakeholders, including all other EPI relate partners and the Ministry of Finance.

Overall role and function of ICC include coordination of all activities and projects and joint decision making processes. It is seen a body that will oversee al EPI related projects that will implemented in the country. Particularly the ICC will:

- Coordinate preparation, review, approve and submit proposals on GAVI applications
- Supervise the implementation and monitor the progress of GAVI funded activities being implemented
- Assess the impact of GAVI funded activities
- Ensure regular information sharing and communication between all partners involved

Three major strategies to enhance the ICC/HSCC's role and functions in the next 12 months:

1. Involve more partners and stakeholders into the ICC membership

2. Involve more decision makers into ICC in order to address and advocate EPI issues

3. Improve the quality of meetings through better information sharing and follow up after meetings

3. Immunisation Programme Data

Please complete the tables below, using data from available sources. Please identify the source of the data, and the date. Where possible use the most recent data, and attach the source document.

- Please refer to the Comprehensive Multi-Year Plan for Immunisation (or equivalent plan), and attach a complete copy (with an executive summary) as DOCUMENT NUMBER 2
- Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms on Vaccine Preventable Diseases and attach them as DOCUMENT NUMBERS 1
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.

Table 3.1: Basic facts for the year 2006 (the most recent; specify dates of data provided)

Please, note that the data under this section represent year 2006. Data for 2007 have been not analysed yet, therefore were not available.

	Figure	Date	Source
Total population	7,120,800	January 2007	State Statistical Agency, and Health care facilities
Infant mortality rate (per 1000)	65.0	January 2007	Official statistics of MoH, State Statistical Agency and Centre of Health Information System
Surviving Infants*	176, 706	January 2007	Statistical Agency and Centre of Health Information System
GNI per capita (US$)	390$USD	January 2007	Statistical Agency

Percentage of GDP allocated to Health	1.1%	January 2007	Statistical Agency
Percentage of Government expenditure on Health	25.0%	January 2007	Statistical Agency

* Surviving infants = Infants surviving the first 12 months of life

Please provide some additional information on the planning and budgeting context in your country:

Please indicate the name and date of the relevant planning document for health

The ***National Development Strategy of the Republic of Tajikistan for the Period to 2015***[2], ***The Strategy of the Republic of Tajikistan on the Health of the Population to 2010***[3], ***Poverty Reduction Strategy (PRS)*** and ***The Strategy of the Republic of Tajikistan on the Health of the Population to 2010*** identify the major priority directions for health system development in the country: **Conception of Health Care Reform of the Republic of Tajikistan** was developed and approved by the Government of Tajikistan in 2002. It provides a general framework for health reform directions and supports the strategies and interventions outlined in other strategy and policy documents. The main developmental strategies for the health care reform defined in this Conception.

The Ministry of Finance (MoF) is the main government body responsible for overall budgeting process and the health sector in Tajikistan is financed through the central and local taxation and donor support. The Ministry of Health (MoH) is in charge of the health sector planning, policy development and budgeting and is also responsible for management and financing of the Republican level health care facilities such as tertiary clinics, research institutes and vertically organized structures, among them Republican Center of Immunoprophylaxis. Primary and secondary level facilities are subordinated to the local administrations - “Hukumats” and their financing is performed through the local budget.

Is the cMYP (or updated Multi-Year Plan) aligned with this document (timing, content etc)

The Ministry of Health developed and approved Financial Sustainability Plan for National Immunization Program in 2002. Tajikistan was identified as the first country to start supporting the Comprehensive Multi-Year Planning (cMYP) process. WHO/EURO initiated the joint mission of WHO, UNICEF and World Bank to support the Ministry of Health to develop the cMYP. The cMYP missions considered being the best opportunity to address systematically the issue of sustainability of the National Immunization Program (NIP) including the vaccine sustainability planning. Developing a cMYP is also an opportunity to consolidate existing plans into a single document that addresses global, national and sub-national immunization objectives and strategies, and that also evaluates the costs and financing of that plan.

The Ministry of Health does not have the detailed implementation plan similar to cMYP, therefore the cMYP has been developed based on the existing **Conception of Health Care Reform of the Republic of Tajikistan as well ad Strategy of the Republic of Tajikistan on the Health of the Population to 2010.**

The cMYP has been revised in August-September 2007, and aligned with the health budget.

Please indicate the national planning budgeting cycle for health

[2] National Development Strategy of the Republic of Tajikistan till 2015. Section 7, pp 41-44

[3] The Strategy of the Republic of Tajikistan on the Health of the Population to 2010. This is the major planning document that cMYP is linked to.

The Ministry of Finance (MoF) is the main government body responsible for an overall budgeting process. The health sector in Tajikistan is financed through the central and local taxation and donor support. The MoH determines the structure and capacities of the Republican health entities (national tertiary-level facilities, research institutes, vertical structures e.g. Republican Immunization Center) that are financed from the central budget while district level facilities are subordinated to and financed by the local administration - "Hukumat". International financial institutions, (the World Bank and Asian Development Bank), UN agencies, bilateral donors and international NGOs are active in Tajikistan health sector mobilizing own resources and allocating through independent projects. The national planning budgeting cycle for health formed annually jointly by Ministry of Finance and Ministry of Health based on the planned activities of MoH and with consideration of limited resources of Government.

Please indicate the national planning cycle for immunisation

The Immunization Programme of the Republic of Tajikistan in 2003 – 2010. This document has been developed in close cooperation with all partners and members of the Interagency Coordination Committee (ICC). The programme has been framed within the policy framework for National Health Reform, in which decentralization and local development are fundamental policies to allow improved and enhanced access of the population to PHC services. The plan addresses improvement of immunization services management, capacity building, safety of injections, and ensuring of financial sustainability of immunizations services.

Currently RCIP operates on the basis of the bylaw approved by the MoH and has a separate budget, which is formed from the central health budget. RCIP is responsible for planning, monitoring of EPI activities, provision of vaccines and supplies including reporting/registration documentation, data analysis, methodological guidance, and surveillance of vaccine preventable diseases. The National Immunization Program (NIP) in Tajikistan is financed from three sources: the central budget (National government), local budget (sub-national government) and international donors. Traditionally almost all direct costs of the NIP (vaccines, injection materials, program activities) have been covered by donors/EPI partners. Only recently the GoT committed to allocate approximately 2 million Somoni (521,512 USD) for the procurement of vaccines (for routine immunization) from 2008. For the overall strategic management the MoH approved the National Immunization Plan (2003) and later the Financial Sustainability Plan (2002-2007) developed by the RCIP with the support of development partners (WHO, UNICEF, WHO, etc.). Besides the strategic plan there are separate plans for certain program components, which are in line with WHO guidelines. Strategic planning function of the program is being strengthened with an Interagency Coordination Committee (ICC) in terms of coordination and partnership, but ICC potential as a coordination tool is not used in full capacity. The

Table 3.2: Current Vaccination Schedule: Traditional, New Vaccines and Vitamin A Supplement *(refer to cMYP pages)*

Vaccine *(do not use trade name)*	**Ages of administration** *(by routine immunisation services)*	**Indicate by an "x" if given in:**		**Comments**
		Entire country	**Only part of the country**	
OPV-0 + Hep 1	Within 24 hour after birth	X		
BCG	3-5 days after birth	X		
DTP-1 OPV-1 HepB-2	2 months	X		

DTP-2 OPV-2	3 months	X		
DTP-3 OPV-3 HepB-3	4 moths	X		
Measles-1 OPV-4	12 months	X		
DTP-4	16-23 months	X		
Measles-2 DT	6 years	X		
Vitamin A	6 months – 57 moths Postpartum women	X		Funded by UNICEF

The MoH plans to change calendar upon approval of current application through adding pentavalent vaccine (DTP+Hib+HepB) three times (2,3,4 moths). The new calendar will be followed as of June 2008 due to introduction of Hib combined vaccine

Revised Vaccination schedule

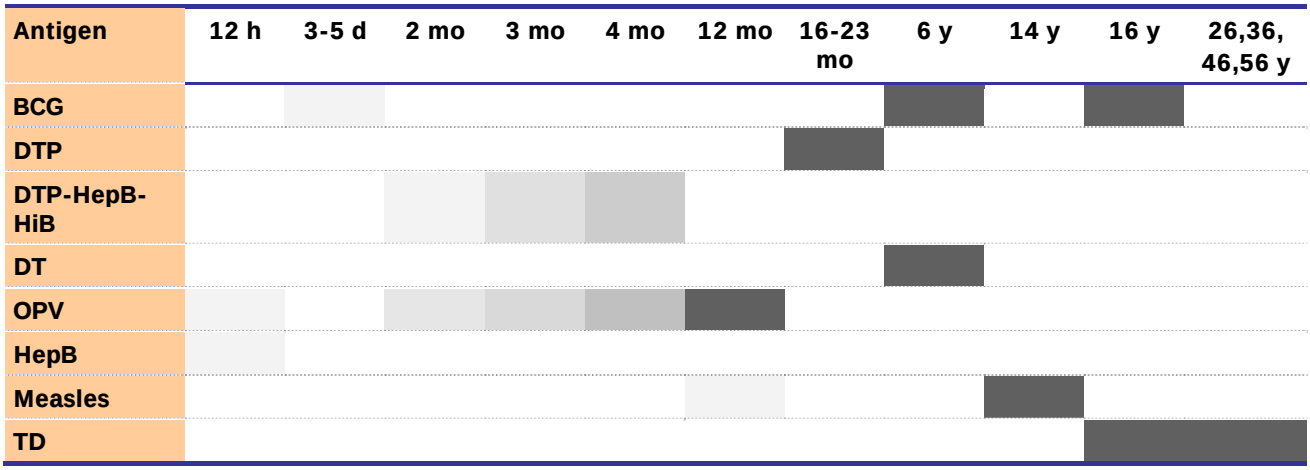

Table 3.3: Trends of immunisation coverage and disease burden
(as per last two annual WHO/UNICEF Joint Reporting Form on Vaccine Preventable Diseases)

Trends of immunisation coverage (in percentage)						Vaccine preventable disease burden		
Vaccine		Reported (cMYP, page 11, table 4)		Survey		Disease	Number of reported cases	
		2005	2006	2005	200…		2005	2006
BCG		79.3	80,5	95,1		Tuberculosis*	526	631
DTP	DTP1	82.0	82,5			Diphtheria	3	2
	DTP3	80,2	80,6	80,6		Pertussis	23	22
Polio 3		80,6	79,5	73,0		Polio	-	-
Measles (first dose)		81,0	80,6	85,6		Measles	-	3
TT2+ (Pregnant women)		-	-	-		NN Tetanus	-	-
Hib3		-	-	-		Hib **	-	-
Yellow Fever		-	-	-		Yellow fever	-	-

HepB3		78,6	78,7	68,5		hepB sero-prevalence*	-	-
Vit A supplement	Mothers (<6 weeks post-delivery)	79,0	82,0					
	Infants (>6 months)	80,0	81,3					

Comments: The national immunization coverage data worsened due to the changes of denominator (target group) in 2006.
* If available
** Note: JRF asks for Hib meningitis

If survey data is included in the table above, please indicate the years the surveys were conducted, the full title and if available, the age groups the data refers to:

MICS survey – conducted by UNICEF in 2005

Table 3.4: Baseline and annual targets *(refer to cMYP pages)*

Number	Baseline and targets					
	Base 2006	**Year 1 2008**	**Year 2 2009**	**Year 3 2010**	**Year 4 2011**	**Year 5 2012**
Births	188,991	194,853	201,495	206,029		
Infants' deaths	12,285	12,665	12,090	11,538		
Surviving infants	176,706	182,187	189,405	194,491		
Pregnant women	188,991	194,853	201,495	206,029		
Target population vaccinated with BCG	152,200	175,367	187,390	195,727		
BCG coverage*	80,5	90,0	93,0	95,0		
Target population vaccinated with OPV3	139,597	153,037	162,888	175,041		
OPV3 coverage**	79,0	82,0	84,0	86,0		
Target population vaccinated with DTP3***	142,425	149,393	159,100	167,267		
DTP3 coverage**	80,6	82,0	84,0	86,0		
Target population vaccinated with DTP1***	144,899	163,822	171,873	181,994		
Wastage[4] rate in base-year and planned thereafter	1,25	1,25	1,25	1,25		
Target population vaccinated with **3rd dose** of …HepB3……..	139,067	149,393	159,100	167,267		
……. Coverage**	78,7	82,0	84,0	86,0		
Target population vaccinated with **1st dose** of …HepB1……..	141,365	163,822	173,182	181,994		
Wastage[1] rate in base-year and planned thereafter	1,15	1,15	1,15	1,15		
Target population vaccinated with **1st dose** of Measles	141,365	149,393	159,100	167,267		
Target population vaccinated with **2nd dose** of Measles	139,598	158,237	168,054	176,340		

[4] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check **table α** after Table 7.1.

Measles coverage**		80,0	82,0	84,0	86,0		
Pregnant women vaccinated with TT+			-	-	-		
TT+ coverage****			-	-	-		
Vit A supplement	2006 6-59months		694,134	712,342	732,124		
	2006 Pas/women		135,350	156,672	160,876		
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100			2,2	2,2	2,1		
Annual Measles Drop out rate (for countries applying for YF)			-	-	-		

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants
*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women

Table 3.5: Summary of current and future immunisation budget *(or refer to cMYP pages)*

	Estimated costs per annum in US$ (,000)					
Cost category	**Base year**	**Year 1 2008…**	**Year 2 2009…**	**Year 3 2010…**	**Year 4 2011…**	**Year 5 2012…**
Routine Recurrent Cost						
Vaccines (routine vaccines only)						
Traditional vaccines	**524,210**	570,931	488,546	516,095		
New and underused vaccines	200,917	1,322,229	2,329,357	2,492,547		
Injection supplies	167,214	275,670	305,047	322,743		
Personnel						
Salaries of full-time NIP health workers (immunisation specific)	92,208	98,663	105,569	112,959		
Per-diems for outreach vaccinators / mobile teams	25,782	27,587	29,518	31,564		
Transportation	58,634	104,797	157,257	165,735		
Maintenance and overheads	169,062	173,488	181,187	188,213		
Training	52,000	353,780	275,860	78,740		
Social mobilisation and IEC	13,500	38,760	26,800	5,800		
Disease surveillance	52,878	79,900	77,900	15,600		
Program management	77,182	100,700	94,083	34,000		
Other		21,000	35,000	30,000		
Subtotal Recurrent Costs	**1,433,587**	**3,167,504**	**4,106,124**	**3,994,016**		
Routine Capital Costs						
Vehicles						
Cold chain equipment		103,786	53,219	36,050		
Other capital equipment		6,375	6,503	6,633		

Subtotal Capital Costs		**110,161**	**59,722**	**42,683**		
Campaigns						
Polio						
Measles						
Yellow Fever						
MNT campaigns						
Other campaigns						
Subtotal Campaign Costs						
GRAND TOTAL	2,022,095	3,907,369	4,839,628	4,757,646		

Please list in the tables below the funding sources for each type of cost category (if known). Please try and indicate which immunisation program costs are covered from the Government budget, and which costs are covered by development partners (or the GAVI Alliance), and name the partners.

Table 3.6: Summary of current and future financing and sources of funds *(or refer to cMYP)*

		Estimated financing per annum in US$ (,000)					
Cost category	**Funding source**	**2006**	**Year 1 2008**	**Year 2 2009**	**Year 3 2010**	**Year 4 20…**	**Year 5 20…**
Routine Recurrent Cost							
	1.Government	121,671	614,822	593,357	617,169		
	2. Sub-national	117,398	140,169	168,992	154,468		
	3.UNICEF	270,975	111,486	172,000			
	4.WHO	117,000	160,000				
	5.JICA	225,303	382,908				
	6.TICA	91,567					
	7.GAVI	368,131	1,654,048				
Routine Capital Costs		0					
	UNICEF		28,000	10,000			
	GAVI			15,400			
Other cost	1. Sub-national	588,508	629,704	673,783	720,948		
2.	2.						
3.	3.						
4.	4.						
5.	5.						
Campaigns		0	0	0	0		
1.	1.						

2.	2.						
3.	3.						
4.	4.						
5.	5.						
GRAND TOTAL		1,900,553	2,995,394	3,631,789	3,818,368		

4. Immunisation Services Support (ISS)

Please indicate below the total amount of funds you expect to receive through ISS:

Table 4.1: Estimate of fund expected from ISS
Total requested amount is $**USD 496,740**

	Base Year2006	**Year 1 2008**	**Year 2 2009**	**Year 3 2010**	**Year 4 2011**	**Year 5 2012**
DTP3 Coverage rate	80.6	82	84	86		
Number of infants reported / planned to be vaccinated with DTP3 (as in Table 3.4)	142,425	149,393	159,100	167,262		
Number of *additional* infants that annually are reported / planned to be vaccinated with DTP3		6,968	9,707	8,162		
Funds expected ($20 per additional infant)		139,360	194,140	163,240		

* Projected figures
** As per duration of the cMYP

If you have received ISS support from GAVI in the past, please describe below any major lessons learned, and how these will affect the use of ISS funds in future.

Please state what the funds were used for, at what level, and if this was the best use of the flexible funds; mention the management and monitoring arrangements; who had responsibility for authorising payments and approving plans for expenditure; and if you will continue this in future.

Major Lessons Learned from Phase 1	**Implications for Phase 2**
1. The GAVI ISS support helped to improve considerably the DTP-3 coverage through conducting number of activities:	Variety of activities and flexibility of use of GAVI funds helped to address the priority issues of the National Immunization Program. While developing cMYP the main finding that came out

• Improved cold chain system through the provision of cold chain equipment into the regions as well provision of training on cold chain management for PHC staff • Communication between all Regional and some district Centres for Immunoprophylaxis has been improved through the provision of computer sand other supporting equipment. It helped to improve the reporting system in terms of completeness and timeliness • Improved monitoring and surveillance through the provision of reporting forms and registers as well as support of monitoring visits • Improved mobility of the immunization program through provision of vehicles and fuel to priority districts (hard to reach districts) • Improved awareness among community through printing and provision of IEC materials. The printing and provision of Immunization passports considerably improved the awareness of mothers about importance of timely vaccination, as well as track the immunization status during the home visits and monitoring • Improved disposal of the injection materials through construction of incinerators The above activities helped to achieve good results and positively contribute to improvement of Immunization Services in the country, which in turn increased the DTP-3 coverage. The applied mechanism worked well and the MoH would like to continue with the same mechanism during the phase 2. In addition, due to denominator increase **(from 158,000 to 186,126)** the **coverage rates were significantly decreased**.	was that secured funding will not cover resource requirements for the 2008-2020 years. Despite the considerable increase of the State budget into National Immunization Program, the available funding is not sufficient to cover major items under operation activities of NIP. Therefore, significant efforts needed to increase resources for immunization program. The ISS support will be an opportunity to keep the achieved results during Phase. Basically, the support will be used to cover unfunded components of the Immunization program as reflected in the cMYP, such as transportation, logistics, communication, monitoring and supportive supervision visits and other recurrent cost.

If you have not received ISS support before, please indicate:

a) when you would like the support to begin: As soon as the application is approved

b) when you would like the first DQA to occur:

In 2008

c) how you propose to channel the funds from GAVI into the country:

Through the existing bank account of Republic Centre of Immunoprophylaxis. This mechanism was used previously.

d) how you propose to manage the funds in-country:

The budget will be developed along with the plan of action. Both, plan of action and budget will be discussed and approved with ICC members. The expenditure of funds will be reported to the National ICC on the regular basis (every 6 onths)

e) who will be responsible for authorising and approving expenditures:

Dr Shamsidin Jabirov will be responsible for authorization and approval of expenditure

- Please complete the banking form (annex 1) if required

5. Injection Safety Support

- Please attach the National Policy on Injection Safety including safe medical waste disposal (or reference the appropriate section of the Comprehensive Multi-Year Plan for Immunisation), and confirm the status of the document: DOCUMENT NUMBER……

- Please attach a copy of any action plans for improving injection safety and safe management of sharps waste in the immunisation system (and reference the Comprehensive Multi-Year Plan for Immunisation). DOCUMENT NUMBER…….

Table 5.1: Current cost of injection safety supplies for routine immunisation

Please indicate the current cost of the injection safety supplies for routine immunisation.

	Annual requirements		***Cost per item (US$)***		***Total Cost (US$)***
Year	***Syringes***	***Safety Boxes***	***Syringes***	***Safety Boxes***	
20…					

Table 5.2: Estimated supply for safety of vaccination with …….. vaccine

(Please use one table for each vaccine BCG(1 dose), DTP(3 doses), TT(2 doses) [1], Measles(1 dose) and Yellow Fever(1 dose), and number them from 5.1 to 5.5)

		Formula	**Year 1 20…**	**Year 2 20…**	**Year 3 20…**	**Year 4 20…**	**Year 5 20…**
A	Number of children to be vaccinated [2]	*#*					
B	Percentage of vaccines requested from GAVI [3]	*%*					
C	Number of doses per child	*#*					
D	Number of doses	*A x B/100 x C*					
E	Standard vaccine wastage factor [4]	*Either 2.0 or 1.6*					
F	Number of doses (including wastage)	*A x B/100 x C x E*					
G	Vaccines buffer stock [5]	*F x 0.25*					
H	Number of doses per vial	*#*					
I	Total vaccine doses	*F + G*					
J	Number of AD syringes (+ 10% wastage) requested	*(D + G) x 1.11*					
K	Reconstitution syringes (+ 10% wastage) requested [6]	*I / H x 1.11*					
L	Total of safety boxes (+ 10% of extra need) requested	*(J + K) / 100 x 1.11*					

[1] GAVI supports the procurement of AD syringes to deliver two doses of TT to pregnant women. If the immunisation policy of the country includes all Women in Child Bearing Age (WCBA), GAVI/The Vaccine Fund will contribute to a maximum of two doses for Pregnant Women (estimated as total births)
[2] To insert the number of infants that will complete vaccinations with all scheduled doses of a specific vaccine.
[3] Estimates of 100% of target number of children is adjusted if a phased-out of GAVI/VF support is intended.
[4] A standard wastage factor of 2.0 for BCG and of 1.6 for DTP, Measles, TT, and YF vaccines is used for calculation of INS support
[5] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero under other years. In case of a phased introduction with the buffer stock spread over several years, the formula should read: [F – number of doses (incl. wastage) received in previous year] * 0.25.
[6] It applies only for lyophilized vaccines; write zero for other vaccines.

- If you do not intend to procure your supplies through UNICEF, please provide evidence that the alternative supplier complies with WHO requirements by attaching supporting documents as available.

6. New and Under-Used Vaccines (NVS)

Please give a summary of the cMYP sections that refer to the introduction of new and under-used vaccines. Outline the key points that informed the decision-making process (data considered etc):

Please summarise the cold chain capacity and readiness to accommodate new vaccines, stating how the cold chain expansion (if required) will be financed, and when it will be in place. Please use attached excel annex 2a (Tab 6) on the Cold Chain. Please indicate the additional cost, if capacity is not available and the source of funding to close the gap

Table 6.1: Capacity and cost (for positive storage) (*Refer to Tab 6 of Annex 2a or Annex 2b)*

		Formula	Year 1 20…	Year 2 20…	Year 3 20…	Year 4 20…	Year 5 20…
A	Annual ***positive*** volume requirement, including new vaccine (specify:_____) (litres or m3)[5]	*Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine*					
B	Annual ***positive*** capacity, including new vaccine (specify:_____) (litres or m3)	#					
C	Estimated minimum number of shipments per year required for the actual cold chain capacity	*A / B*					
D	Number of consignments / shipments per year	*Based on national vaccine shipment plan*					
E	Gap (if any)	*((A / D) - B)*					
F	Estimated cost for expansion	*US $*					

Please briefly describe how your country plans to move towards attaining financial sustainability for the new vaccines you intend to introduce, how the country will meet the co-financing payments, and any other issues regarding financial sustainability you have considered (refer to the cMYP):

[5] Use results from table 5.2. Make the sum-product of the total vaccine doses row (I) by the unit packed volume for each vaccine in the national immunisation schedule. All vaccines are stored at positive temperatures (+5°C) except OPV which is stored at negative temperatures (-20°C).

Table 6.2: Assessment of burden of relevant diseases *(if available)*:

Disease	Title of the assessment	Date	Results

If new or under-used vaccines have already been introduced in your country, please give details of the lessons learnt from storage capacity, protection from accidental freezing, staff training, cold chain, logistics, drop out rate, wastage rate etc., and suggest solutions to address them:

Lessons Learned	Solutions / Action Points

Please list the vaccines to be introduced with support from the GAVI Alliance (and presentation):

First Preference Vaccine

As reported in the cMYP, the country plans to introduce*……. (antigen)* vaccinations, using …… vaccine, in *……(n° of doses per vial) ……. (lyophilized or liquid)* form.

Please refer to the excel spreadsheet Annex 2a or Annex 2b (for Rotavirus and Pneumo vaccines) and proceed as follows:

- Please complete the "Country Specifications" Table in Tab 1 of Annex 2a or Annex 2b, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose[6].
- Please summarise the list of specifications of the vaccines and the related vaccination programme in Table 6.3 below, using the population data (from Table 3.4 of this application) and the price list and co-financing levels (in Tables B, C, and D of Annex 2a or Annex 2b).
- Then please copy the data from Annex 2a or 2b (Tab "Support Requested") into Tables 6.4 and 6.5 (below) to summarize the support requested, and co-financed by GAVI and by the country.
- Please submit the electronic version of the excel spreadsheets Annex 2a or 2b together with the application

Table 6.3: Specifications of vaccinations with new vaccine

Vaccine:……	*Use data in:*		**Year 1 20…**	**Year 2 20…**	**Year 3 20…**	**Year 4 20…**	**Year 5 20…**
Number of children to be vaccinated with the third dose	*Table 3.4*	#					
Target immunisation coverage with the third dose	*Table 3.4*	#					
Number of children to be vaccinated with the first dose	*Table 3.4*	#					
Estimated vaccine wastage factor	*Annex 2a or 2b Table E - tab 5*	#					
Country co-financing per dose *	*Annex 2a or 2b Table D - tab 4*	$					

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 6.4: Portion of supply to be co-financed by the country (and cost estimate, US$)

		Year 1 20…	**Year 2 20…**	**Year 3 20…**	**Year 4 20…**	**Year 5 20…**
Number of vaccine doses	#					
Number of AD syringes	#					
Number of re-constitution syringes	#					
Number of safety boxes	#					
Total value to be co-financed by country	**$**					

[6] *Table D1 should be used for the first vaccine, with tables D2 and D3 for the second and third vaccine co-financed by the country*

Table 6.5: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		Year 1 20…	Year 2 20…	Year 3 20…	Year 4 20…	Year 5 20…
Number of vaccine doses	#					
Number of AD syringes	#					
Number of re-constitution syringes	#					
Number of safety boxes	#					
Total value to be co-financed by GAVI	**$**					

- Please refer to http://www.unicef.org/supply/index_gavi.html for the most recent GAVI Alliance Vaccine Product Selection Menu, and review the GAVI Alliance NVS Support Country Guidelines to identify the appropriate country category, and the minimum country co-financing level for each category.

Second Preference Vaccine

If the first preference of vaccine is in limited supply or currently not available, please indicate below the alternative vaccine presentation

- Please complete tables 6.3 – 6.4 for the new vaccine presentation

- Please complete the excel spreadsheets Annex 2a or Annex 2b for the new vaccine presentation and submit them alongside the application.

Procurement and Management of New and Under-Used Vaccines

a) Please show how the support will operate and be managed including procurement of vaccines (GAVI expects that most countries will procure vaccine and injection supplies through UNICEF):

b) If an alternative mechanism for procurement and delivery of supply (financed by the country or the GAVI Alliance) is requested, please document:

- *Other vaccines or immunisation commodities procured by the country and description of the mechanisms used.*
- *The functions of the National Regulatory Authority (as evaluated by WHO) to show they comply with WHO requirements for procurement of vaccines and supply of assured quality.*

c) Please describe the introduction of the vaccines (refer to cMYP)

d) Please indicate how *funds* should be transferred by the GAVI Alliance (if applicable)

e) Please indicate how the co-financing amounts will be paid (and who is responsible for this)

f) Please outline how coverage of the new vaccine will be monitored and reported (refer to cMYP)

New and Under-Used Vaccine Introduction Grant

Table 6.5: calculation of lump-sum

Year of New Vaccine introduction	N° of births (from table 3.4)	Share per birth in US$	Total in US$
		$ 0.30	

Please indicate in the tables below how the one-time Introduction Grant[7] will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP).

Table 6.6: Cost (and finance) to introduce the first preference vaccine (US$)

Cost Category	Full needs for new vaccine introduction	Funded with new vaccine introduction grant
	US$	**US$**
Training		
Social Mobilization, IEC and Advocacy		
Cold Chain Equipment & Maintenance		
Vehicles and Transportation		
Programme Management		
Surveillance and Monitoring		
Human Resources		
Waste Management		
Technical assistance		
Other (please specify)		
Other (please specify)		
Other (please specify)		
Other (please specify)		
Total		

- Please complete the banking form (annex 1) if required

Please complete a table similar to the one above for the second choice vaccine (if relevant) and title it **Table 6.7: Cost (and finance) to introduce the second preference vaccine (US$)**

[7] The Grant will be based on a maximum award of $0.30 per infant in the birth cohort with a minimum starting grant award of $100,000

7. Additional comments and recommendations from the National Coordinating Body (ICC/HSCC)

8. Documents required for each type of support

Type of Support	Document	DOCUMENT NUMBER	Duration *
ALL	WHO / UNICEF Joint Reporting Form (last two)		
ALL	Comprehensive Multi-Year Plan (cMYP)		
ALL	Endorsed minutes of the National Coordinating Body meeting where the GAVI proposal was endorsed		
ALL	Endorsed minutes of the ICC/HSCC meeting where the GAVI proposal was discussed		
ALL	Minutes of the three most recent ICC/HSCC meetings		
ALL	ICC/HSCC workplan for the forthcoming 12 months		
Injection Safety	National Policy on Injection Safety including safe medical waste disposal (if separate from cMYP)		
Injection Safety	Action plans for improving injection safety and safe management of sharps waste (if separate from cMYP)		
Injection Safety	Evidence that alternative supplier complies with WHO requirements (if not procuring supplies from UNICEF)		
New and Under-used Vaccines	Plan for introduction of the new vaccine (if not already included in the cMYP)		

** Please indicate the duration of the plan / assessment / document where appropriate*