[V1.0.0]

Application Form for Gavi NVS support

Submitted by

The Government of

Pakistan

Date of submission: **13 September 2017**

Deadline for submission:

i. 8 September 2017

Select Start and End Year of your Comprehensive Multi-Year Plan (cMYP)

Start Year	2014	End Year	2018

Form revised in 2016

(To be used with Guidelines of December 2016)

Note: Please ensure that the application has been received by Gavi on or before the day of the deadline.

Gavi

GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the 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 the Gavi. All funding decisions for the application are made at the discretion of the Gavi Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application.The Gavi will document any change approved by the Gavi, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the Gavi all funding amounts that are not 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 the Gavi, within sixty (60) days after the Country receives the Gavi's request for a reimbursement and be paid to the account or accounts as directed by the Gavi.

SUSPENSION/ TERMINATION

The 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 programmes described in the Country's application, or any Gavi-approved amendment to the application. The Gavi retains the right to terminate its support to the Country for the programmes described in its application if a misuse of Gavi funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the 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.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the Gavi, as requested. The 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 the Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the Gavi Transparency and Accountability Policy (TAP) and complies with the requirements therein.

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 the 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 the 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 the Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The 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.

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

1. Type of Support requested

Please specify for which type of Gavi support you would like to apply to.

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]
NVS follow-up campaign	Measles, 10 dose(s) per vial, LYOPHILISED	2018	2018	Not applicable

[1] Gavi may not be in a position to accommodate all countries first product preferences, and in such cases, Gavi will contact the country and partners to explore alternative options. A country will not be obliged to accept its second or third preference, however Gavi will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine.

If applying for any type of measles and/or MR support, summarise in the text box below the indicative major measles and rubella activities planned for the next 5 years (e.g. MCV2 introduction, measles or MR follow-up campaign, etc.).

Pakistan introduced MCV2 in 2009 in its routine immunization schedule for children. MCV1 is given at completion of 09 months and MCV2 at 15 months age. Both are given as monovalent measles vaccine procured by the Government of Pakistan from its own resource. However, routine coverage of both MCV 1 and MCV 2 doses remain stagnant since 2011 i.e. MCV1 – 61% and MCV2 – 53% according to WUENIC.

To supplement the population immunity due to low routine immunization coverage, country has implemented a number of SIAs in last 10 years. In 2007 – 08 a phased nationwide measles catch-up campaign was conducted. Later in 2010-12 a follow-up campaign was conducted in flood affected areas. In 2014 – 15 a nationwide campaign was conducted in phased manner. Except the 1st SIA (2007 – 08) most of these SIAs were conducted in response to outbreaks. Though administrative report always claimed very high vaccination coverage achieved through these SIAs but none could be verified through any independent post-SIA survey except 2014 SIA in Sindh province. On the other hand due to sub-optimalimprovement in routine immunization coverage the population immunity gained through these SIAs couldn't be sustained. Resultantly after every SIA, the reported number of measles cases went down but in couple of years it start raising again and eventually gives rise to outbreaks.

The number of measles cases reported in 2017 has increased in comparison to previous years. Total 19,148 suspected measles cases were reported in 2016 whereas in 2017 till September, 19,557 suspected measles cases reported. However, measles cases are likely to be underreported in Pakistan. The sensitivity of the surveillance system is 1.57 discarded measles cases per 100,000 population, below the target of a least 2.0 discarded cases per 100,000 population.

Since beginning of 2017, provinces are encountering increasing number of measles outbreaks. Maximum affected provinces are KP and Sindh in terms of case load. But other provinces and areas are also reporting outbreaks and sporadic cases. All the provinces conducted a measles risk analysis exercise for every districts using WHO tool which revealed over one-third districts across the provinces are either high risk or very high risk for measles.

In response to these outbreaks the provincial programs tried to limit the danger by conducting sporadic outbreak response immunization activities in different places over different time. But such small scale sporadic activities don't give very good result in improving population immunity in general. Considering the current situation and potential treat to an explosive outbreak in the next high season (Q1-Q2 2018), the technical experts of the partner organizations and NITAG recommended to conduct a nationwide high quality measles follow-up SIA as soon as possible.

To minimize morbidity and mortality and to avoid outbreaks the country desires to implement the SIA by March 2018 before the next high season. However, adequate preparation for a high quality campaign is of paramount importance and the program. The readiness of the districts and above level will be assessed repeatedly by the program at different stage of the preparation for proper understanding of the obstacles and taking appropriate intervention to overcome those.

The country is determined to conduct a good quality SIA achieving very high coverage (at least 95%) and sustain that achievement through improving routine immunization coverage in the following years. Several steps are taken and planned for a successful SIA e.g. strong SIA oversight body at national, provincial and district levels with highest level of administrative and political leadership, engagement of National and ProvincialEOC to benefit from their strength in coordination, monitoring and accountability, using other opportunities the Polio program may offer e.g. their data flow mechanism for speedy data transmission, analysis and monitoring of indicators, their direct disbursement mechanism, technical workforce at district and below level for supporting the district health management for microplanning, training, supervision and monitoring, using polio data for measles SIA microplanning, effective social mobilization by community based volunteers of Polio program and identifying missed children by them. A post – SIA independent survey is also planned and budgeted to validate reported coverage, to understand immunization barriers and most effective means of communication with the parents.

Besides ensuring a very good quality with high coverage in the next SIA, the country also took elaborate plan to improve routine immunization coverage. Equity analysis is ongoing in the districts to identify the most vulnerable population and bottlenecks to reach the unreached. Profiling of all urban slums is another important activity ongoing. Data from this exercise will help in understanding specific challenges in service delivery in these slums and in adopting appropriate strategies to mitigate those. Significant increase in resource allocation is made by the government by the program for the next five years to address the challenges identified through these interventions. Hundreds of new vaccinators and technical staff are hired for surveillance, data and other program areas at district, provincial and federal levels. Technology is being used by the program to address equity, better monitoring individual and collective performance and tracking defaulter children. Technology is also used to collect disaggregated data for immunization coverage, cold chain inventory and vaccine and logistics inventory. Incentive for performance also considered to be piloted in some areas both for service providers and recipients. All these interventions are aimed at improved routine immunization performance during next five year.

Country is also putting its effort in strengthening VPD surveillance including cases based measles surveillance. Since last year, weekly surveillance reporting timeliness and completeness has improved significantly. Online platform is developed and in use for surveillance reporting in two provinces and development in progress in other provinces. Regular monitoring of surveillance indicators through weekly surveillance bulletins and periodic review meeting helped in these improvements. Capacity building of the district surveillance coordinators is being developed using Gavi support. In an aim to introduce RCV by 2020, country is in process of establishing CRS surveillance. Four sentinel sites have been identified, SOPs/guidelines developed and training of concerned staff in the sites are completed. It's planned to improve routine MCV coverage to at least 80% by 2020 and conduct a nationwide MR campaign targeting wider age group children (15 yrs) in the same year followed by introduction of MR vaccine.

Measles SIA planned for 2018 will not only help in gaining population immunity against measles but also will support in strengthening routine immunization system. A detail description of how this objective could be achieved is described in the attached document titled Plan of Action.

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3. Executive Summary

Please provide a summary of your country's proposal, including the following the information:

- For each specific request, NVS routine support or NVS campaign :
  - The duration of support
  - The total amount of funds requested
  - Details of the vaccine(s), if applicable, including the reason for the choice of presentation
  - Projected month and year of introduction of the vaccine (including for campaigns and routine)

- Relevant baseline data, including:
  - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Target population from Risk Assessments from Yellow Fever and Meningitis A
  - Birth cohort, targets and immunisation coverage by vaccines

- Country preparedness
  - Summary of planned activities to prepare for vaccine launch, including EVM assessments, progress on EVM improvement plans, communication plans, etc.
  - Summary of EVM assessment and progress on EVM improvement plan

- The role of the Coordination Forum (ICC/HSCC or equivalent) and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal

- Follow up campaign

Globally, measles mortality has decreased remarkably, but efforts for measles and rubella control have also shown challenges. While the routine measles first dose (MCV1) coverage has increased globally from 73% in 2000 to 83% in 2009, this coverage has stalled and remained at 77-78% since 2010 in Gavi 73 countries. Other challenges include financial and programmatic sustainability for countries, determination of the target age group and ensuring high quality of campaigns. There are also concerns around campaigns being costly, detracting resources away from routine immunisation activities and possibly creating perverse monetary incentives. Measles activities are also being planned in isolation from other immunisation interventions with inadequate planning, budgeting and implementation processes.

A comprehensive approach is essential to bringing about lasting reductions in measles and rubella morbidity and mortality. Uniformly high and timely routine immunisation coverage in every country, every year is the cornerstone for achieving continuously high levels of population immunity. In this regard, Gavi's Board in December 2015 endorsed Gavi's new measles and rubella strategy, whose aim is to provide a single coherent approach to measles and rubella, primarily at increasing routine immunisation coverage, putting a strong focus on measles-rubella control. Routine immunisation will be complemented, as needed, by higher-quality, better-planned, more targeted and independently monitored campaigns.
The strategy supports a more comprehensive approach to measles and rubella, over a longer time period. Rather than offering support to campaigns and routine immunisation as separately planned, budgeted and implemented activities, Gavi is supporting countries to plan and deliver a coherent, integrated set of measles and rubella disease control activities. Countries will now be required to self-finance the first dose of measles vaccine in their national immunisation programme, and have a long term budgeted plan for measles and rubella activities, to ensure financial and programmatic sustainability.
Preventive vaccination campaigns and the introduction of new vaccines such as MR vaccine can be used as strategic opportunities to improve routine immunisation, for example by supporting microplanning to identify underserved populations. These opportunities need to be aligned with countries' expressed needs and priorities for routine immunisation to ensure that they address recognised gaps or problems. It is therefore recommended that as countries develop their

applications for measles and rubella support, they coordinate and align such requests with their applications for HSS support. Joint Appraisals and reviews of support should be used to ensure such linkages. This will help harmonise measles and rubella and HSS inputs, avoid possible redundancies and help maximise the effect of measles and rubella activities on strengthening the overall immunisation programme.
Gavi will support periodic measles follow-up campaigns at national or subnational levels, for Gavi-eligible countries which have not yet introduced MR, with a focus on children up to 5 years of age; noting that the timing, target age range, and geographical scope should be based on epidemiological data, and modelling wherever possible.
For Gavi-eligible countries which have introduced MR, support is available for periodic MR follow-up campaigns, again noting that the timing, target age range, and geographical scope should be based on epidemiological data, and modelling if available.

Improving measles vaccination coverage and reducing measles-related deaths is a global imperative. Measles remains one of the leading causes of death among young children globally, despite the availability of a safe and effective vaccine, an estimated 134,200 people globally, mostly under the age of five, died from measles in 2015 .This figure accounts for approximately about 367 deaths every day or 15 deaths every hour. (Measles Fact Sheet; WHO July 2017)

Pakistan, one of the developing countries, has seen a marked surge in death as well as number of measles cases in the recent years. (860 deaths were reported during 2011-2014 in Pakistan, and 110 deaths during 2015-2017). (EPI Routine Surveillance Data)

To supplement the immunity gap, a nationwide measles follow-up campaign was implemented in 2014-15 targeting children aged 09 – 119 months following a massive outbreak across the provinces in 2012-13. Though the coverage was not assessed through a post-SIA independent survey except in Sindh province which was found 84%, an immediate drop in the number of reported cases was observed from all provinces after the SIA. However, routine measles vaccination coverage didn't improve (MCV-1 61% and MCV-2 53%, WUENIC) enough to sustain the population immunity gained through the SIA.

Resultantly within 2 – 3 years number of susceptible children accumulated almost equal to annual birth cohort and increasing number of measles outbreaks and sporadic cases are being reported from different area of the country. A detail analysis of accumulation of susceptible children in different provinces is described in the Plan of Action attached with this application.

In 2016, total 19,148 suspected measles cases (Measles; fever with rash and cough or coryza or conjunctivitis) were reported from all over the country through national VPD surveillance system. In 2017 the situation got worse and (up to Week 40) a total of 19,557 suspected measles cases are reported. However, considering week sensitivity of the national surveillance system (annual case reporting rate 1.57 against optimum 2 per 100,000 population) these figures should be considered as underestimation of the actual scenario.

The highest number of suspected measles cases were recorded from KP (9,592) followed by Sindh (4,799). These two provinces conducted the follow-up SIA one year earlier (201$) than the rest of the country allowing ample time to accumulate the susceptible children equal to their annual birth cohort and thus lead to more outbreaks.

Table 1, Number of suspected and lab confirmed measles cases reported in 2016 and 2017 by province

Province	2016			2017		
	Suspected	Lab confirmed	Incidence/million	Suspected	Lab confirmed	Incidence/million
Punjab	2,414	287	2.91	2,692	861	8.57
Sindh	3,421	1,755	41.69	4,799	2,853	66.58
KP	12,014	544	18.82	9,592	1,642	55.29
Balochistan	276	34	3.82	1,228	175	19.31

GB	74	61	43.31	222	154	106.88
AJK	32	4	0.87	23	12	2.56
FATA	803	4	0.85	944	37	7.72
Islamabad	114	14	9.37	57	56	36.76
Total	**19,148**	**2,703**	**14.17**	**19,557**	**5,790**	**29.77**

Outbreaks in Khyber Pakhtunkhwa (KP) province are mostly reported from the central districts but individual cases are reported from all over the province. Sindh also shows a similar pattern reporting cases from all districts in the province. If no intervention is made immediately to fill the immunity gap, Punjab and Balochistan are expected to see increasing number of outbreaks in the next high season.

In response to the numerous outbreaks reported from different areas of the country, provinces have vaccinated about 4.8 million children below 5 years age during 2016 – 17 through many small scale outbreak response immunization activities. These activities were conducted in different small geographic area and over a long time span. Hence, though such interventions will protect these children and will prevent local outbreak in near future but overall impact on population immunity will be limited and thus will not help to develop herd immunity to break the chain of virus transmission.

Sindh province also conducted a limited measles mop-up SIA in Karachi city targeting 1.3 million children in August 2017 with support of local polio team. Independent assessment done by the partner staff of polio program indicates high coverage achieved (90%) but again this intervention was limited only in one city with high population movement. Impact of this mop-up campaign and other outbreak response immunization activities are discussed in the Plan of Action document.

Considering current epidemiological trend and other factors, to minimize further mortality and morbidity the NITAG recommended conducting a nationwide measles follow-up SIA targeting all children aged 09 – 59 months at the earliest. To avoid an explosive outbreak during early next year, the program planned to conduct the SIA by March-April 2018 subject to adequate preparation for operations and logistics in all districts.
Approximately 31 million children aged 09 – 59 months will be targeted in the 2018 SIA. All these children will be offered one dose of measles vaccine irrespective of their previous vaccination status and illness. The vaccination will be offered through all existing EPI fixed centers, newly established fixed centers, outreach vaccination sites and mobile vaccination teams in far flung areas. Special attention will be given to reach the nomadic population, communities live in remote and difficult areas e.g. desert, mountains, urban slums etc. to ensure nobody is left unreached. Experience of the polio SIAs and past measles SIAs will be used to adopt appropriate strategy to reach this marginalized population.

Based on lessons learned in the past SIAs especially in the recent mop-up SIA in Karachi, program has adopted many strategies to ensure a high quality SIA in 2018. Banking on polio data, knowledge, information and workforce for a good quality operational microplan, closely supervised training to ensure good quality, use of WHO SIA readiness assessment tool periodically and taking corrective actions accordingly, evidence based social awareness and communication strategy, phased implementation of the SIA in districts are few example of special consideration for conducting a high quality SIA. Most importantly very high level national, provincial and district oversight body will be established for the SIA to ensure close monitoring of the preparation and implementation and accountability at every step. Highest level of political/administrative leadership will be engaged in these oversight committees. District Polio Eradication Committee headed by the Deputy Commissioner will be leading the operation at the district level. Private sector especially Civil Society Organizations will be engaged in the SIA for social mobilization, service delivery and stronger monitoring. The coverage achieved through the SIA will be assessed by an independent post-SIA survey which will be done within one month after the SIA. Routine immunization will continue during the SIA without any disruption. Special attention will be given to ensure this during microplanning which is elaborated in the Plan of Action.

To sustain the population immunity gained through the SIA, the program also took elaborate plan to improve routine immunization coverage for measles and other antigens. The SIA itself will also help in many ways in improving the routine immunization beyond the campaign. The Plan of Action document

elaborates all these interventions.

Beside implementing the measles SIA for 09 – 59 months children in 2018, Pakistan also plans to conduct a MR campaign in 2020 targeting a wider range of children (up to 15 years) followed by introduction of MR vaccine in its routine immunization schedule. Extensive effort will be taken to improve routine immunization coverage during this period till MR introduction. Country has initiated launching CRS surveillance in four sentinel sites to understand the diseases burden of CRS. Data available through this surveillance system will help NITAG and policy maker to understand importance of the MR vaccine introduction at the earliest.

This application is developed through an inclusive process involving all provinces, partners and key stakeholders including CSOs. A series of consultative meetings were held with Provinces. A technical committee was formed by the Federal EPI comprising of technical experts of EPI program, WHO and UNICEF. The draft application developed by the technical committee was shared with provinces, other partners and CSOs for their inputs and those were addressed accordingly. The application was initially submitted in May 2017 and again in September 2017 addressing recommendations of Gavi's Independent Review Committee (IRC). The National Interagency Coordination Committee (NICC) held on 10th August, 2017 endorsed the revised application for re-submission to Gavi.

A total budget of US$16,961,186 is submitted along with this application for operational support for the SIA. US$15,487,414 will be passed through WHO and the remaining US$1,473,772 will be passed through UNICEF. Vaccine and injection equipment will be procured through UNICEF supply division. According to Gavi policy Pakistan government will bear 5% co-financing share from its own resource.

Government of Pakistan like to express its sincere gratitude to Gavi for providing generous support to Pakistan for improving routine immunization, introducing new vaccines during the past decade and strengthening its overall health system in general. The EPI Pakistan request IRC and the Gavi to assist country's effort in saving millions of children from the menace of measles by implementing a very good quality SIA in 2018, improving routine immunization in the long run for sustaining the achievements and introducing MR vaccine in 2020. Government of Pakistan commits its sincere determination for conducting a very high quality SIA in 2018 with adequate preparation up to the satisfaction of all stakeholders and continuing its effort in improving routine immunization performance leading to achieve our goal for measles elimination.

4. Signatures

4.1. Signatures of the Government and National Coordinating Bodies

4.1.1. Government and the Inter-Agency Coordinating Committee for Immunisation

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

Measles, 10 dose(s) per vial, LYOPHILISED follow up campaign

The Government of Pakistan 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 and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Table(s) **8.2.2** in the NVS follow-up campaign of this application shows the amount of support in either supply or cash that is required from the Gavi.Table(s) **8.2.3** 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 **July**.

The payment for the first year of co-financed support will be around **September 2018** for Measles, 10 dose(s) per vial, LYOPHILISED.

Please note that this application will not be reviewed or recommended for approval by the Independent

Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NUMBER : 1 and 2 in Section 10. Attachments.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Mrs. Saira Afzal Tarar (Minister ofNHSRC)	**Name**	Dr. Nawaz Ahmed, Finance Adviser, Minister Finance
Date		**Date**	
Signature		**Signature**	

By signing this application form, we confirm 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).

This report has been compiled by (these persons may be contacted in case the Gavi Secretariat has queries on this document):

Full name	Position	Telephone	Email
Dr. Syed Saqlain Ahmad Gilani	National Programme Manager-EPI	0092-51-9255101	zain_asg2@hotmail.com

4.1.2. National Coordination Forum (Interagency Coordinating Committees (ICCs), Health Sector Coordinating Committees (HSCCs), and other equivalent bodies)

To be eligible for support, Gavi asks countries to ensure a *basic* functionality of their Coordination Forum (ICC/HSCC or equivalent body). Countries can demonstrate this by adhering to the requirements listed in section 5.2 of the General Guidelines. The information in this section and a set of documents submitted along with this application will help the Independent Review Committee (IRC) to assess adherence.

Profile of the Coordination Forum

Name of the Forum	National Inter-Agency Coordination Committee
Organisational structure (e.g., sub-committee, stand-alone)	Stand-alone, Headed by Minister of National Health Services, regulation & Coordination (NHSR|&C)

The Terms of Reference for the Coordination Forum is attached as DOCUMENT NUMBER : 4. The Terms of Reference should include all sections outlined in Section 5.2 of the General Guidelines..

Please describe the role of the Coordination Forum and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal:

- The application development has been a comprehensive and inclusive 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 in developing the application.
- A technical committee for 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. A country specific comprehensive consultative meeting was scheduled in Geneva from 22-24th March 2017 to discuss and focus on measles situation in Pakistan with representation from renowned experts from global institutions. Afterwards another consultative meeting with partners was held on 3rd April 2017 during which various aspects of Measles SIAs application were discussed and consensus achieved on proposed work-plan and timelines. This was followed by a Provincial Consultative Meeting to discuss further on the financial implications and seek government's commitment. The technical and development partner along with CSOs and EOC also participated in the provincial consultative meeting and provided their inputs.
- The application was modified based on input and comments received by IRC and shared with ICC members before its endorsement from the ICC.IRC recommended for its resubmission in September

2017.

The application got approved from Minister for State MoNHSR&C and Ministry of Finance.

4.1.3. Signature Table for the Coordination Forum (ICC/HSCC or equivalent body)

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **10/08/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 7 (please use the list for signatures in the section below).

Function	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Minister - National Health Services Regulation & Coordination Islamabad	Mrs Saira Afzal Tarar		
Secretary	National Programme Manager - EPI	Dr. Syed Saqlain Ahmed Gilani		
Members	World Health Organization (WHO) United Nations Children Fund (UNICEF) World Bank Government of Japan Rotary International United States Agency for International Development (USAID) Depar	Dr. Muhammad Assai Ardakani (List is Attached)		

By submitting the proposal we confirm that the quorum has been met. **Yes**

The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached are attached as DOCUMENT NUMBER : 6.

4.2. National Immunization Technical Advisory Group (NITAG)

Has a NITAG been established in the country ? **Yes**

We the members of the NITAG met on the **10/08/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation describing the decision-making process through which the recommendations were reached, attached as Document number 31.

4.2.1. The NITAG

Profile of the NITAG

Name of the NITAG	National Immunisation Technical Advisory Group2
Year of constitution of the current NITAG	2014
Organisational structure (e.g., sub-committee, stand-alone)	Stand-alone
Frequency of meetings	quarterly and as and when required

Function	Title / Organisation	Name
Chair	National Immunization Technical Advisory Group	DR. TARIQ BHUTTA
Secretary	National Programme Manager-EPI	Dr. Syed Saqlain Ahmad Gilani
Members	Planning Commission	Chief Health
	UNICEF	Chief Health and Nutrition

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

Major functions and responsibilities of the NITAG

The National Expanded Programme on Immunization Technical Advisory Group hold its meetings twice a year. The group provides 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 finalizes the decision based on the opinion of the members and keeping in view the relevant global guidelines. National Programme Manager EPI acts as the Secretary of the committee and is responsible for recording all such decisions in the minutes and circulating them to the members. The secretary of the committee forwards the approved minutes and recommendation of the meeting to the Ministry of NHSR and C. The Ministry then take measures as deemed appropriate. The secretary of the committee follows the implementation of the decision and keep the ministry informed.(Copy attached as document no.8)

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as **(Document Number: 8)**

5. Immunisation Programme Data

5.1 Background information

Please complete the table below, using the most recent data from available sources. Please identify the source of the data, and the date and attach the source document, where possible. The following documents should be referred to and/or attached:

- Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan). Please attach as DOCUMENT NUMBER 9.
- If applying for measles or measles rubella support, please check that the current cMYP includes all the information described in Annex 2 of the Measles and Rubella 2017 Application Guidelines. If this information is not included in the cMYP, please submit a cMYP addendum that covers the missing information and attach it as document number 40.
- New Vaccine Introduction Plan(s) / Plan of Action. Please attach as DOCUMENT NUMBER 12.
- New Vaccine Introduction Checklist, Activity List and Timeline. Please attach as DOCUMENT NUMBER 12.
- Effective Vaccine Management (EVM) assessment. Please attach as DOCUMENT NUMBER 20.
- Two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases.
- Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.
- In the case of Yellow Fever and Meningitis A mass preventive campaigns, the relevant risk assessments. Please attach as DOCUMENT NUMBER 24 and DOCUMENT NUMBER 25.

Please use the most recent data available and specify the source and date.

	Figure	Year	Source
Total population	214,528,850	2017	Preliminary Census Report
Birth cohort	7,508,510	2017	Preliminary Census Report
Infant mortality rate (per 1000)	68	2015	World Bank data
Surviving infants*[1]*	6,952,880	2017	Preliminary Census Report
GNI per capita (US$)	1,440	2015	Pakistan Economic Survey
Total Health Expenditure (THE) as a percentage of GDP	1	2015	World Bank data
General government expenditure on health (GGHE) as % of General government expenditure	37	2015	World Bank data

[1] Surviving infants = Infants surviving the first 12 months of life

5.1.1 Lessons learned

Follow up Support

If campaigns with Measles, MR vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. If this information is already included in Plan Of Action, please reference the document and in which section/page this information can be found.

Lessons Learned	Action Points
Please see section 'Lessons learned from past SIAs' in the Plan of Action document.	

5.1.2 Health planning and budgeting

Please provide information on the planning and budgeting cycle in your country

Immunization operational plan is prepared following calendar year i.e. Jan – Dec

Budgeting cycle follows fiscal year i.e. Jul – Jun

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

Planning document for health (immunization) is PC-1 for EPI. The new EPI PC-1 is for the duration from 2015-16 fiscal year to 2019-20 fiscal year that has been approved from the required forum.

Current Comprehensive Multi-year Plan (cMYP) is for the duration of 2014-18. Programme is going to review and update it up to 2020 in this year (2017).

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

Pakistan is submitting a proposal for measles follow-up campaign in 2017 for its implementation in 2018. The current cMYP is aligned to cover the measles follow-up campaign in the year 2018. However, activities following the campaign that would lead the country towards achieving the global target of Measles/Rubella elimination by 2020 are not included in the current cMYP. A MR catch-up campaign followed by rubella containing vaccine introduction would be done in 2020.Activities for increasing population immunity through routine immunization and SIA, measles-rubella case based surveillance strengthening and other related activities will be addressed in the updated cMYP 2020. The updated/revised cMYP will be shared with Gavi as soon as it is approved by the competent authority.

Please indicate the national planning budgeting cycle for health

National planning cycle is Jan - Dec. Fiscal planning cycle is Jul – Jun

Please indicate the national planning cycle for immunization

National Immunization Planning cycle corresponds accordingly (Jan-Dec).

5.1.3 Coverage and equity

Please describe any health systems bottlenecks or barriers to access, utilisation and delivery of immunisation services at district level (or equivalent), for example geographic, socio-economic and/or gender-related barriers. Please indicated if there are specific populations of concern. If available, please provide subnational coverage and equity data highlighting geographic, socio-economic, gender-related, or other barriers and any other relevant categories of vulnerable or high-risk populations.

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 infants are more likely to be immunized than rural or those living in urban slums. There is the clear correlation between household wealth and education of the women, where increasing wealth and education tends to associate with better coverage. Wealth plays a vital role in accessing immunization services.

In Pakistan the analysis of the national surveys; Pakistan Demographic Health Survey (PDHS 2012-13) and Pakistan Social and Living standards Measurement survey (PSLM 2013-14) revealed no

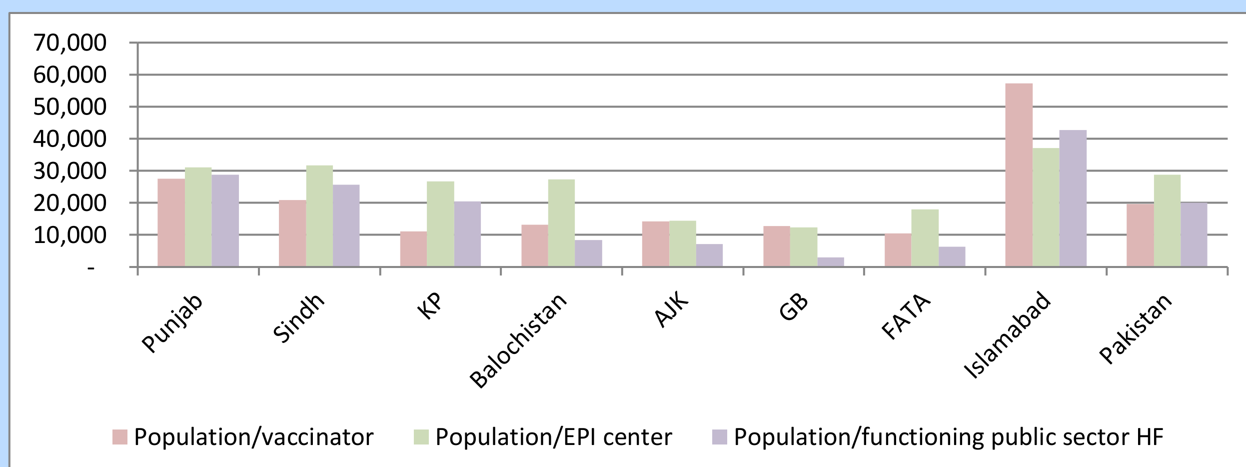
significant difference across gender. However, evidence shows consistent geographic and socioeconomic inequities which are in line with the findings of third party surveys. According to, PSLM 2013-14, 84% children aged 12-23 months are more likely to be fully immunized in urban areas compared to only 72% in the rural areas. Inequity also exists by wealth status of the households. Immunization coverage rates among children from households in the highest wealth quintile were found 53% compared to 27% in the lowest quantile. Children in the lowest wealth quintile are more likely to miss out vaccination compared to children in the highest wealth quintile in both urban as well as rural areas. It also shows that poverty is the main underlying factor. With children in the poorest household having immunization coverage rates that are one third of their counterparts in wealthier households but cultural and ethnic affiliation also influence child's access to immunization services. Children in these communities are at "high risk", because not only are vaccine preventable disease burden disproportionately concentrates, also levels of hygiene, access to medical care and education tends to be lower in these communities. Immunization coverage thus becomes a clear indicator highlighting existing inequities among children within the country, and can show the way to overcome these hurdles in order to address the inequities in immunization coverage. Furthermore, marked differences exist in the immunization coverage between children of women with no education (40 percent) and children of women at the middle, secondary, and higher educational levels (74 percent and above respectively) PDHS 2012-13.

In Pakistan significant disparities were observed in immunization coverage rates between the provinces and districts. While analyzing the district pattern of fully immunization rates based on record 12 out of total 36 districts are top ranked districts (>80% coverage) within Punjab. While 8 districts from Balochistan and Sindh province collectively are the bottom ranked districts (<10% coverage) . (PSLM 2014/15).

The 2016 administrative data indicates 96 districts achieving above 80% of Penta 3 coverage, 42 between 50-79% and 13 districts <50%. Around 79 districts are reporting dropout rate more than 10%. Similarly, the official 2016 measles coverage report (MCV1) shows 94 districts reporting above 80%, 42 between 50-79% and 15 districts < 50 %(JRF 2016)

Health infrastructure in Pakistan is not adequately providing services to population across, resulting in inaccessibility issues. Analysis of the data reveals that in Punjab, one EPI fixed center provides services to average 31,000 population as compare to 27,000 population in Balochistan. Similarly the population served by a vaccinator on average 27,500 in Punjab in comparison to 13,000 in Balochistan.

Figure 1, Health infrastructure capacity in provinces, Pakistan



Health seeking behavior of certain population groups also result in low utilization of health care services in remote and marginalized areas. Weak program management, limited social mobilization activities, lack of proper distribution of human resource and logistics are the major issues affecting the performance. Also, restricted mobility of the vaccinators, political influence regarding the appointment and posting of vaccinators, absenteeism, and dissatisfaction over the incentives, allowances, and overall service structures are the primary constraints leading to poor coverage in remote areas. Due to the presence of vulnerable migrant population, security issue, access to health services, highly populated urban slums and frequent natural disaster, boosting population's immunity against VPDs

especially against measles virus is crucial.

Detail strategies to reach the most vulnerable and marginalized communities are described in the following sections in the Plan of Action document,

1. Reaching high risk groups in urban slums, migrant and underserved
2. Reaching zero-dose children
3. Ensuring equity in coverage

Please explain how the proposed NVS support (activities and budget) will be used to improve coverage and equity of routine immunisation with reference to specifically identified health systems bottlenecks and/or specific populations of concern. For countries that will be receiving Gavi HSS and/or CCEOP funding concurrently with NVS funds, please also highlight how NVS funds will support/complement/leverage specific activities or investments included in those other grants.

The requested support to Gavi would enable Pakistan to reinforce its existing strategy to reach the underserved communities. Through this support monitoring and supervisory capacities of the programme will be enhanced at all levels which would later on strengthen the programme management. The training imparted to the health workers for the campaign will strengthen their capacity thus support in enhancing programme performance. Micro-plans developed during the preparation of the campaigns will identify deprived and marginalized populations that will be used by the EPI programme to reach these underserved communities in future planning. Similarly even distribution of team across the union councils would be bridging the gaps in service delivery by equally targeting the marginalized population. Through effectively planned ACSM activities, the campaign will be supporting RI in demand generation at grass root level. Involving local community influencers, religious leaders and school teachers will also enhance knowledge of the community regarding immunization. Dissemination of information on importance of vaccines will improve the trust of the community. Post campaign assessment survey planned at the end of the campaign would also highlight equity related barriers.

Pakistan has been the largest recipient of Gavi's support. The operationalization of Cold Chain Optimization Platform (CCE OP) shall support the country to address its most urgent cold chain needs. By addressing the cold chain requirements, the CCE OP will facilitate in strengthening routine EPI fixed centers and update out dated and non-functional cold chain equipment. Under the new Vaccine Introduction Grant (VIG) for Rota, Pakistan will be able to further enhance cold chain capacity, train immunization staff and workforce in vaccine administration, revise R& R tools along with utilizing funds for ACSM activities to deliver the messages for improving immunization coverage across the country.

The Vaccine Introduction Grant (VIG) for Rotavirus vaccine will also strengthen the Federal and Provincial EPI programs in terms of capacity development of workforce, enhancement of the cold chain, reinforcing recording and reporting mechanisms resultantly strengthening RI.

Gavi's reprogrammed funds available with WHO and UNICEF are being channelized to reach populations residing in hard to reach areas of Baluchistan and Federally Administrative Tribal Area (FATA) through technical assistance (HR and cold chain). While transferring these funds to the provinces, the provincial programs have been specifically emphasized to address the existing inequities within their districts.

The Multi-donor trust fund developed under the New National Immunization Support Project (NISP) with the support of World Bank, where Gavi is the main contributor, would enable Pakistan to enhance equitable coverage across the four provinces, by achieving disbursement linked indicators (DLIs). Huge support is expected upon achieving high performance in the agreed DLIs.

Please describe what national surveys take place routinely in country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers.

Pakistan Demographic Health Survey (PDHS) is a national survey conducted every 4-5 years.

Pakistan Social and Living standards Measurement survey (PSLM) is also a national survey conducted

every alternate year.

Multiple Indicator Cluster Survey (MICS) is done periodically at the provincial level.

KAP survey is also a periodic survey.

The country is in the process of conducting EPI coverage evaluation survey to assess the existing coverage of all routine EPI antigens for children. The objective of this survey is to provide reliable estimates of all routine EPI antigen coverage at district level with social- economic status, sex, maternal education and economic status of the family. Data on source of immunization and reasons for not receiving immunization will also be collected. The survey is expected to be completed by December 2017.

PDHS survey is also expected to be available by the end of 2017. These surveys will provide important information which would enable the programme in better planning in future.

This application also includes activities that will enable the programme in assessing gender and equity barriers. In lieu of the lesson learned from the past campaign more emphasis will be given to microplanning and post campaign assessment which will enable the programme in assessing the barriers.

For details please refer to the attached Plan of Action.

Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems.

The immunization recording and reporting tools were revised/ updated (2015) to allow collection of sex disaggregated data. However, compliance in reporting with the revised tools is not consistent in all the provinces. Program is making an effort to increase compliance and the use of such data at every level. The training planned for Rotavirus vaccine introduction have already included a session on Recording and Reporting tools with emphasis on gender disaggregated data. Training planned for Measles follow-up campaign will also emphasize on this important subject.

Currently EPI Programme is receiving sex disaggregated data through Vaccine Logistics Management Information System (vLMIS) which is fully implemented in Sindh Province (Districts and all towns of Karachi) whereas the new revised data collection tools reflects gender data and the staff in Sindh is being trained on the same. It is pertinent to mention here that the vLMIS is to be rolled-out throughout the country up to the district level by December 2017 ensuring availability of sex disaggregated data from across the country.

The EPI dashboard (In KP Province) provides district and province specific feedback on immunization data quality on a monthly basis by analyzing reported data. Immunization dashboards analyzes gender disaggregated data, timeliness of e-reporting patterns, immunization program performance regarding vaccination coverage, reporting patterns for vaccine-preventable diseases and highlights the status of the training of human resources working closely with the vaccination program. Dashboards also collect and analyses the concurrent monitoring data.

Federal EPI is also in process of development of a National EPI dashboard for programme indicators that would be capturing sex disaggregated provincial and Area-wise data by linking it with the Provincial MIS. The dashboard is expected to start functioning by end of 2017.

Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought or others)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities.

Pakistan is often struggling against the security threat and fighting against terrorism. The prevailing security situation, presence of refugees/IDPs, occasional natural disasters and political instability have further impacted health service delivery in all provinces. Children and their families continue to suffer from displacement due to security operations in the Federally Administered Tribal Areas (FATA). IDPs living off-camp are using existing available social services in KPK, which are already insufficient for the settled population and local communities, and to meet minimum humanitarian service delivery

standards. The displacement period actually offers an opportunity for government and humanitarian actors to reach previously unreached children with services.

Health camps focusing especially on multi-antigen vaccination services are being held to improve vaccination status among IDPs and migrant population (Refugee camps).

5.1.4 Data quality

To support country efforts to strengthen the availability, quality and use of vaccination coverage data for strengthened programme management, Gavi requires that countries applying for all types of Gavi support to undertake routine monitoring of vaccination coverage data through an annual desk review; conduct periodic (once every five years or more frequently where appropriate) in-depth assessments of routine administrative vaccination coverage data; conduct periodic (at least once every five years) nationally representative vaccination coverage surveys; and develop and monitor plans for improving vaccination coverage data quality as a part of their own core work plans.

5.2. Baseline and Annual Targets for Routine Vaccines

No NVS Routine Support is requested

5.3. Targets for Preventive Campaign(s)

No NVS Prevention Campaign Support this year

5.4. Targets for One time mini-catchup campaign(s)

No One time mini-catchup campaign this year

5.5 Targets for Follow up Campaign

Table 5.5 Target figures for measles / MR campaign (Please ensure targets are consistent with Section 7 and the Plan of Action in Section 9) COMPLETE SECOND AND THIRD COLUMNS ONLY FOR PHASED CAMPAIGNS.

	Target	**Target (if applicable, for phased* campaign)**	**Target (if applicable, for phased* campaign)**
Insert Year	2018		
Target age group	Start 9 months	Start 9 months	Start 9 months
	End 5 years	End 5 years	End 5 years
Total population in the target group (nationally)	30,838,522		
% of population targeted for the campaign	100.00		
Number to be vaccinated with measles / MR vaccine during the campaign	30,838,522.00		

*Phased: If a portion of the country is planned (eg. 1/3 of the country each year for 3 years)

Please download this worksheet to calculate the co-financing amounts for this campaign. This is a temporary tool to help while we wait for an online solution to be available. Short 8-step instructions are provided in the sheet.

6. New and Under-Used Vaccines (NVS Routine vaccines)

No NVS Routine Support is requested

7. NVS Preventive Campaigns

No NVS Prevention Campaign Support this year

8. NVS Follow-up Campaigns

8.1 Immunization coverage

Please provide in the table below the reported national annual coverage data for the first and second dose of measles-containing vaccine (MCV1 and MCV2) from the WHO/UNICEF Joint Reporting Form for the three most recent years.

Table 8.1: Reported MCV coverage

WHO/UNICEF Joint Reporting Form						
	Trends of reported national MCV1 coverage			**Trends of reported national MCV2 coverage (if applicable)**		
Year	2014	2015	2016	2014	2015	2016
Total population in the target age cohort	5965310	6043494	6161725	5965310	6043494	6161725
Number vaccinated	5368779	5192093	5516328	4330610	4193534	4684366
MCV Coverage (%)	90	86	90	73	69	76

Q8.1 If a survey assessing MCV1 coverage has been done during the last 3 years, please answer the following questions. If no survey has been done, please tick this box: ☐

Survey date: 2014-15

Methodology (DHS/MICS, EPI 30-cluster, LQAS, other): PSLM

Sample size: 81992

Number of clusters: 5428

Number of children:

Coverage: 83

Please provide in the table below reported national (or sub-national if applicable) coverage estimates for the three most recent measles or MR campaigns. Also provide post-campaign survey coverage estimates, if available.

Table 8.2: Measles / MR campaign coverage

	Reported		
Year	2007	2010	2014
Target age group	Start 9 months	Start 9 months	Start 6 months
	End 13 years	End 5 years	End 10 years
Total population in the target age group	66016215	20049432	59807209
Geographic extent (national, subnational)	National	National	National
Number vaccinated	66582317	21064628	61623769
Campaign Coverage (%)	101	105	103
Wastage rate (%) for measles / MR campaign	10	10	8

Q8.2 If a survey assessing coverage was done after each of the three last measles / MR campaigns, please answer the following questions (please repeat the following questions for each survey). If no survey has been done for the three previous campaigns, please tick this box: ☐

Survey date: 2015

Methodology (DHS/MICS, EPI 30-cluster, LQAS, other): WHO 30 Cluster Survey Methodology

Sample size: 52800

Number of clusters: 1320

Number of children: 51758

Coverage: 84

Survey date: not conducted

Methodology (DHS/MICS, EPI 30-cluster, LQAS, other):

Sample size:

Number of clusters:

Number of children:

Coverage:

Survey date: not conducted

Methodology (DHS/MICS, EPI 30-cluster, LQAS, other):

Sample size:

Number of clusters:

Number of children:

Coverage:

8.2 Financial support

8.2.1 Government financial support for past Measles / MR campaigns

Country should provide information on the total founding, and amount per targeted person, provided by the government for vaccines and for operational costs for at least the last measles / MR campaign. This should be the actual expenses but if not available, the final budget should be referred to. Please also provide information on funding provided by partners.

Share of financing for last measles / MR campaign

Item	Category	Government Funding (US$)	Partner Support (US$)
Vaccines and injection supplies	Total amount	6248804.00	17903529.00
	Amount (US$) per target person	0.10	0.29
Operational costs	Total amount	10740707.00	10090075.00
	Amount (US$) per target person	0.17	0.16

Year of campaign: 2018

Estimated target population: **30,838,522**

The preliminary results of census were released by Pakistan Bureau of Statistics. These results have been reflected in the recent application of Gavi for vaccine dose calculation. Previous estimates were based on projected figures of the PC-I however since now the target population is available, it has been revised. Current population is shown as below:

	Total Population	**Target Population for Measles SIA 2018**
Punjab	110,012,442	15,814,289
Sindh	47,886,051	6,883,620
KP	30,523,371	4,387,735
Balochistan	12,344,408	1,774,509
FATA	5,001,676	718,991
CDA/ ICT	2,006,572	288,445
GB and AJK	6,754,330	970,935
G Total	**214,528,850**	**30,838,522**

Are the amounts provided based on final budget or actual expenses? Actual Expenses

8.2.2 Government financial support for past Measles / MR routine vaccines

To be eligible for measles and rubella vaccine support, countries must be fully financing with domestic resources the measles monovalent component of routine MCV1 that is already in their national immunisation schedule or have firm written commitments to do so from 2018 onwards. If your country is not currently fully financing with domestic resources the measles monovalent vaccine component of MCV1, please provide evidence that the country can meet this requirement from 2018 onwards through a decision recorded in the ICC minutes (or equivalent coordination forum) AND a signed letter from the Minister of Health and the Minister of Finance. Please attach these documents as Document Number 30 and 38 in Section 10 – Attachments.

Please provide information on the budget provided by the government for routine measles / MR vaccines and injection supplies for the past 3 years, in total amount and amount per child immunized. Please also provide information on funding provided by partners.

Share of financing for routine measles

Year	Category	Government Funding (US$)	Partner Support (US$)
2014	Total amount	3913142.00	
	Amount per child immunized		
2015	Total amount	1482020.00	
	Amount per child immunized		
2016	Total amount	6672539.00	
	Amount per child immunized		

8.2.3 Proposed support for upcoming Measles / MR

Country should provide information on the proposed total funding commitment, and amount per targeted person, that will be provided by the government for vaccines and supplies, and for operational costs, for the measles / MR campaign for which Gavi support is being requested. Gavi's support will not be enough to cover the full needs so please indicate in the table below how much and who will be complementing the government funds (refer to the Plan of Action and/or cMYP). Gavi will not replace government funding. Each country is required to contribute towards the costs of immunising its children against measles, using the past government contributions to measles / MR campaigns as the reference point.

Table 8.2.3a Proposed financing for the upcoming measles / MR follow up campaign for which Gavi support is requested

Item	Category	Country co-financing (US$)	Other donors' support (US$)	Gavi support requested (US$)
Vaccines and injection supplies	Total amount	666945.00		12671960.00
	Amount (US$) per target person	0.39		0.39

If you would like to co-finance a larger share than the minimum required, please provide information in Your co-financing row*.

Country group	Preparatory transition phase

	2018
minimum co-financing per dose	0.01
your co-financing per dose (please change if higher)	0.02

* In order to strengthen country ownership, a cost sharing requirement will be introduced for periodic measles and MR follow-up campaigns planned for implementation in 2018 onwards, per Gavi's updated Co-Financing Policy. This cost-sharing will not come into effect for follow-up campaigns planned for implementation in 2017. If the campaign is implemented in 2018 onwards, initial self-financing countries will be expected to co-finance 2%, and preparatory transition and accelerated transition countries will be expected to co-finance 5% of the costs of vaccines used in such campaigns.

Please download this worksheet to calculate the co-financing amounts for this campaign. This is a temporary tool to help while we wait for an online solution to be available. Short 8-step instructions are provided in the sheet.

Table 8.2.3b Calculation of grant to support the operational costs of the campaigns **

Year of Measles support	Total target population (from Table 5.5)	Gavi contribution per target person in US$	Total in US$
2018	30838522	0.55	16961187.10

Estimated target population: 30838522

** The grant is adjusted according to the transition stage of the country. Countries in preparatory transition phase will be provided up to $0.55 per targeted person, and countries which have entered accelerated transition phase up to $0.45 per targeted person. For initial self-financing countries, the amount will remain up to $0.65 per targeted person

Please describe how the grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population (refer to the cMYP and the Vaccine Introduction Plan).

Keeping in view lessons learned from the previous campaigns, Pakistan will ensure thorough preparations and prompt and swift transfer of funds to implement campaign related activities well in time.

Since adequate time is required for optimal preparation for the campaign for which it is requested that the funds are transferred by Gavi to the recepient partners atleast 6 months prior to the campaign. This timely transfer will minimize the risk of delayed preparation and thus compromising the quality of camapaign.

For details related to preparation of the campaign please refer to the attached Plan of Action.

Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs.

Budget is prepared based on the resources available and in line with the guidelines for the measles follow-up camapaign. The detailed budget is attached (Document no.22). Some of the operational expenses for the campaign wil be borne by the government e.g. consultative/ coordination meetings for proposal development and consensus, print and electronic media awareness campaigns, vaccine storage etc. reflected in the detailed budget. The country would also make an effort to mobilize resources from other sources as necessary.

Please complete also the ‘Detailed budget for VIG / Operational costs’ template provided by Gavi and attach as a mandatory document in the Attachment section.

Detailed budget attached as Document No. 22

8.3 Epidemiology and disease burden data

8.3.1 Epidemiological analysis

In order to plan and execute an effective follow-up campaign, to flexibly adjust key parameters and use tailored strategies to reach the unvaccinated, epidemiological data and modelling (if available) are essential. Please attach measles and rubella epidemiology and disease burden data relevant to the follow-up campaign application, providing a rationale for the timing, target age range, and geographical scope of the campaign should be based on epidemiological data, and modelling wherever possible as document number 39.

A detail epidemiological analysis is included in the Plan of Action, section Measles epidemiology in Pakistan.

9. Procurement and Management

9.1 Procurement and Management of New and Under-Used Vaccines Routine

No NVS Routine Support is requested

9.2 Procurement and Management for NVS Preventive Campaign(s)

No NVS Prevention Campaign Support this year

9.3 Product Licensure

For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines.

Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.

Measles vaccine is already in use in Pakistan's routine immunization schedule of childhood vaccination and the product has been registered with the Drug Regulatory Authority of Pakistan (DRAP); the mandatory registration forum for any drug/vaccine/medicine. For smooth operationalization of vaccine supply chain in the country, manufacturer should be registered with the DRAP.

Copy of licensure is attached as document no. 35

For each of the vaccine(s) requested, please provide the actual licensure status of the preferred presentation and of any alternative presentations, if required.

Copy of licensure is attached as document no. 35 (sub- attachment no.5)

Preferred presentation is measles vaccine (live attenuated) lyophilized 0.5ml with10 dose vial

Please describe local customs regulations, requirements for pre-delivery inspection, special documentation requirements that may potentially cause delays in receiving the vaccine. If such delays are anticipated, explain what steps are planned to handle these.

If the vaccine fullfills WHO prequalification and DRAP registration criteria then 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 vaccine and devices for the campaigh 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.

Please provide information on NRA in the country, including status (e.g. whether it is WHO-certified). Please include points of contact with phone numbers and e-mail addresses. UNICEF will support the process by communicating 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:

Dr. Muhammad Aslam

Chief Executive Officer, Drug Regulatory Authority of Pakistan

Telecom foundation (T-F) complex building,

7-Mauve Area,

G-9/4, Islamabad.

0092-51-9107308

contact@dra.gov.pk

draslamma@gmail.com

9.4 Waste management

Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), the safe handling, storage, transportation and disposal of immunisation waste, as part of a healthcare waste management strategy. Please describe the country's waste management plan for immunisation activities (including campaigns).

Waste management is an important component of EPI activities. The programme will follow the ESMP guidelines to ensure that the waste produced through vaccination activities are properly disposed off ensuring safety of the service providers, recipients and community. Pakistan EPI program provides adequate Safety box for collection, transportation, storage and disposing of sharp wastes produced following vaccination activities to all EPI center and vaccination teams.

- Immunzation waste is segregated at source of generation.
- Syringes and its parts (e.g. cap) are disposed off in a safety box immediately after use without recapping.
- Other waste such as, empty vial/ampoule, vial cap, blister pack, blood stained cotton etc. are collected in a separate bag/container in the immunization sites.
- Safety boxes and other waste bags are returned to the health facility by the vaccinator for storage at a secured place for future re-use (if partially filled) or final disposal.

Final disposal of injection waste

- Auto combustion type of incinerators which achieve temperatures in excess of 800 oC are preferred to destroy all contaminated sharp wastes, including syringes and needles used for immunization. This equipment ensures the most complete destruction of sharp wastes and also reducing environmental pollution. However, in situations of limited resources and low level of immunization activities waste disposal may proceed as follows:

- The facilities that are remote and cannot undertake transport of immunization waste to a facility with incinerator in that case the immunization waste (filled safety boxes and other waste bags) shall be stored in a secured place in the health facility. All filled safety boxes and waste bags shall be burnt in a pit prepared for the purpose following standard measurement. The pit to be prepared in a secluded area which is out of reach of children and domestic animals within the premises of the health facility. After burning, the left over shall be covered with a thin layer of earth.
- The facilities without incinerators that are located close to a facility with incinerator, the waste should ideally be transported to the facility with incinerator for incineration.
- Incineration of the injection waste is recommended where standard incinerator is available.
- Pit burning or incineration whatever method is adopted, that always to be done under direct supervision of a responsible officer who would document the number of filled safety box and waste bags are disposed with date in a register.
- The EDO (H)/DHO shall be responsible for providing necessary guidance for disposal of injection waste according to local arrangements in accordance with the National Injection Safety Policy and monitoring its implementation.

9.5 Procurement and Management for Follow up Campaign(s)

9.5.1 Procurement for Measles, 10 dose(s) per vial, LYOPHILISED

Measles / MR vaccines and supplies supported by Gavi shall be procured through UNICEF unless requested otherwise by the country. Using the estimated total for the target population, please describe the estimated supplies needed for the measles / MR campaign in the table below. Please ensure estimates need to be consistent to Tables 5.5 and 8.2.3 a.

Table 9.5 Procurement information by funding source

		Proportion from goverment funds	Proportion from partner funds	Proportion from Gavi funds
Required date for vaccines and supplies to arrive	20/02/2018			
Estimated campaign date	19/03/2018			
Number of target population	30838533			
Wastage rate*	10			
Total number of vaccine doses	34230760	532288		10113478
Number of syringes	34230760	107827		2048711
Number of reconstitution syringes	3423076	9961		189262
Number of safety boxes	376538	16869		320509

9.5.2 Fiduciary Management Arrangement Data

Q8. Please indicate whether funds for operational costs in Section 8 should be transferred to the goverment 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 goverment. Please note that WHO and/or UNICEF may require administrative fees of approximately 7% wich would need to be covered by the operational funds.

The operational cost for the measles follow-up campaign to be received in the country through the development partners (WHO and UNICEF) based on the planned activities detailed in the budget section attached.

1. Name and contact information of the recipient organization(s)	1) Dr. Muhammad Assai Ardakani, WHO Representative Pakistan 2) Ms. Cristian Munduate (OIC Country Representative UNICEF, Pakistan)
2. Experiences of the recipient organization with Gavi, World Bank, WHO, UNICEF, the Global Fund or other donors-financed operations (e.g. receipt of previous grants)	**Yes or No?** **If YES**, please state the name of the grant, years and grant amount: and provide the following: **for completed Grants:** • What are the main conclusions with regard to use of funds? **for on-going Grants:** • Most recent financial management (FM) and procurement performance rating?

	• Financial management (FM) and procurement implementation issues? Yes.ISS, HSS, Vaccine Introduction Grant for Penta, PCV-10, IPV Vaccine and Measles SIA grant.Lengthy bureaucratic procedures within these organisations sometimes affect the overall outcome
3. Amount of the proposed grant (US Dollars)	USD 19.9 Million approximately
4. Information about financial management (FM) arrangements for Measles / MR campaign:	
Will the resources be managed through the government standard expenditure procedures channel?	No. Since the funds would be channelised through WHO and UNICEF therefore their policies would be applicable.
Does the recipient organization have an FM or Operating Manual that describes the internal control system and FM operational procedures?	Yes . WHO and UNICEF will follow their internal FM operational Procedures
What is the budgeting process?	The grant to be transferred by Gavi to the recipient organisations as described in the budget and the funds then will be distributed and budgeted to the respective organisations' country work plan
What accounting system is used or to be used, including whether it is a computerized accounting system or a manual accounting system?	WHO and UNICEF will use their own computerised accounting system
What is the staffing arrangement of the organization in accounting, auditing, and reporting?	Finance and administration unit f the respective partner agency will be responsible for accounting, auditing and reporting.
What is the bank arrangement? Provide details of the bank account opened at the Central Bank or in a commercial bank and the list of authorized signatories include titles	Not applicable as the grant will be transferred to WHO and UNICEF
What are the basic flows of funds arrangements in place or to be used to ensure timely disbursement of funds to Implementing Entities and to beneficiaries?	Funds will be used by the Partner agencies as per approved budget and work-plan through direct financial contribution (DFC) with implementing organs of the programme, direct implementation(DI) by the partner agencies, general external service(GES) with specific service providers and procurement service.
Does the implementing entity keep adequate records of financial transactions, including funds received and paid, and of the balances of funds held?	Yes
How often does the implementing entity produce interim financial reports?	Annually
Are the annual financial statements audited by an external audit firm or Government audit institution (e.g. Auditor General Department…)?	Audit procedure of the respective partner agencies are followed
5. Information about procurement management arrangements for vaccines and devices, other materials and services for the proposed measles / MR campaign:	

What procurement system(s) is used or will be used for the campaign?	to be done by UNICEF
Does the recipient organization have a procurement plan or a procurement plan will be prepared for the campaign?	Yes
Is there a functioning complaint mechanism?	Yes
What is the staffing arrangement of the organization in procurement? Does the implementing entity have an experienced procurement specialist on its staff?	Unicef Supply Division will support in procurement of vaccines and devices
Are there procedures to inspect for quality control of goods, works, or services delivered?	Yes
goods, works, or services delivered?	Yes

Please provide all of data in table below. It may be submitted as a separate file if preferred.

10. List of documents attached to this proposal

Table 1: Checklist of mandatory attachments

Document Number	Document	Section	File
42	Offline cofinancing calculator for this campaign	5.5, 8.2.3	Vaccine Requirement for Measles Campaign 8-9-2017.xlsx **File desc:** **Date/time :** 08/09/2017 11:18:01 **Size:** 18 KB
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	Endorsement_MoNHSRC.pdf **File desc:** **Date/time :** 04/09/2017 06:24:34 **Size:** 466 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	Endorsement_MoNHSRC.pdf **File desc:** **Date/time :** 04/09/2017 06:26:52 **Size:** 466 KB
4	Terms of Reference for the Coordination Forum (ICC/HSCC or equivalent) including all sections outlined in Section 5.2 of the General Application Guidelines (Note: countries applying before May 2017 can submit their existing Terms of Reference)	4.1.2	NICC TORs.docx **File desc:** **Date/time :** 04/09/2017 06:35:55 **Size:** 14 KB
5	Minutes of Coordination Forum meeting endorsing Proposal	4.1.3	Minuts of Meeting (NICC).pdf **File desc:** **Date/time :** 08/09/2017 12:58:02 **Size:** 1 MB
6	Signatures of Coordination Forum members in Proposal	4.1.3	Endorsement of NICC .pdf **File desc:** **Date/time :** 05/09/2017 05:47:26 **Size:** 527 KB
7	Minutes of the Coordination Forum meetings from the past 12 months before the proposal	4.1.3	ICC Minutes of Meeting.zip **File desc:** **Date/time :** 04/09/2017 06:38:17 **Size:** 98 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	NITAG- TORs .pdf **File desc:** **Date/time :** 04/09/2017 06:41:41 **Size:** 2 MB
30	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, ICC minutes committing to finance from 2018 onwards.		ICC minutes.docx **File desc:** **Date/time :** 04/09/2017 06:45:41 **Size:** 10 KB

31	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	Minutes of Meeting NITAG.docx **File desc:** **Date/time :** 04/09/2017 06:41:41 **Size:** 26 KB
38	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, a signed letter from the Minister of Health and the Minister of Finance committing to finance from 2018 onwards.		Not applicable.docx **File desc:** **Date/time :** 05/09/2017 06:05:05 **Size:** 10 KB
Planning, financing and vaccine management			
9	Comprehensive Multi Year Plan - cMYP	5.1	cMYP Word Files.zip **File desc:** **Date/time :** 04/09/2017 06:54:39 **Size:** 45 MB
10	cMYP Costing tool for financial analysis	5.1	cYMP Excel Files.zip **File desc:** **Date/time :** 04/09/2017 06:59:28 **Size:** 17 MB
11	M&E and surveillance plan within the country’s existing monitoring plan	5.1.4	M&E.zip **File desc:** **Date/time :** 08/09/2017 12:16:34 **Size:** 484 KB
12	New vaccine introduction plan (NVIP), New Vaccine Introduction Checklist and Activity List & Timeline for routine vaccines or Plan of Action (PoA) for campaign vaccines	5.1,7.2.3	Final POA.docx **File desc:** **Date/time :** 08/09/2017 12:28:29 **Size:** 733 KB
14	Annual EPI Plan with 4 year forward view for measles and rubella		Measles rubella elimination plan-.docx **File desc:** **Date/time :** 08/09/2017 12:31:04 **Size:** 1 MB
20	Improvement plan based on EVM	9.3	National EVMIP_2015.pdf **File desc:** **Date/time :** 04/09/2017 07:07:30 **Size:** 985 KB
21	EVM improvement plan progress report	9.3	EVMIP Report.docx **File desc:** **Date/time :** 08/09/2017 12:34:55 **Size:** 206 KB
22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2,6.x.2,8.2.3	Budgeting and Planning Template 191216 - Final (5-9-2017).xlsx **File desc:** **Date/time :** 08/09/2017 05:19:30 **Size:** 2 MB
32	Data quality assessment (DQA) report	5.1.4	DQA Pakistan Report v.040716.pdf **File desc:** **Date/time :** 05/09/2017 06:15:25 **Size:** 6 MB

37	Evidence of self-financing MCV1	5.1.5	CHEQUES ISSUED TO UNICEF.zip **File desc:** **Date/time :** 05/09/2017 06:16:10 **Size:** 1 MB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	Not applicable.docx **File desc:** **Date/time :** 05/09/2017 06:18:25 **Size:** 10 KB
15	HPV Region/ Province profile	6.1.1	Not applicable.docx **File desc:** **Date/time :** 05/09/2017 06:18:49 **Size:** 10 KB
16	HPV Key Stakeholder Roles and Responsibilities	6.1.1,6.1.2	Not applicable.docx **File desc:** **Date/time :** 05/09/2017 06:19:34 **Size:** 10 KB
17	Evidence of commitment to fund purchase of RCV (in place of the first dose of MCV) / for use in the routine system	5.1.6, 6.1.7	Not applicable.docx **File desc:** **Date/time :** 05/09/2017 06:19:34 **Size:** 10 KB
18	Campaign target population documentation	8.x.1, 6.x.1	Press Release 25-08-2018.pdf **File desc:** Preliminary Census Results **Date/time :** 08/09/2017 12:40:08 **Size:** 103 KB
19	EVM report	9.3	Pakistan_EVM_report_30_march-21_April__2014_Final1 (2).pdf **File desc:** **Date/time :** 04/09/2017 07:12:20 **Size:** 1 MB
24	Risk assessment and consensus meeting report for Yellow Fever, including information required Section 5.3.2 in the General Guidelines on YF Risk Assessment process	5.1	Not applicable.docx **File desc:** **Date/time :** 05/09/2017 06:20:08 **Size:** 10 KB
25	Post Introduction Evaluation report from any recent NVS introduction	5.1	PAK__PIE_PCV10__March 2015_Report_(draft 11 May 2015) (1).docx **File desc:** **Date/time :** 04/09/2017 07:12:20 **Size:** 109 KB
26	List of areas/districts/regions and targets to be supported for meningitis A mini catch up campaigns		Not applicable.docx **File desc:** **Date/time :** 05/09/2017 06:22:01 **Size:** 10 KB
27	National Measles (& Rubella) elimination plan if available		Measles rubella elimination plan-.docx **File desc:** **Date/time :** 05/09/2017 07:54:15 **Size:** 1 MB

28	A description of partner participation in preparing the application	4.1.3	Development partners description.docx **File desc:** **Date/time :** 05/09/2017 06:22:02 **Size:** 14 KB
33	DQA improvement plan	5.1.4	DQ IP.zip **File desc:** **Date/time :** 04/09/2017 07:15:12 **Size:** 340 KB
34	Plan of Action for campaigns	8.1, 8.x.4	Final POA.docx **File desc:** **Date/time :** 08/09/2017 12:36:47 **Size:** 733 KB
35	Other		FINAL EPI Policy_17 Nov '14.pdf **File desc:** **Date/time :** 04/09/2017 07:16:03 **Size:** 1 MB
			Final Communication Strategy.pdf **File desc:** **Date/time :** 04/09/2017 07:19:40 **Size:** 22 MB
			KAPB 2014 NATL final text 15 12 14 (1).pdf **File desc:** **Date/time :** 04/09/2017 07:21:34 **Size:** 10 MB
			Health Sector Plan.pdf **File desc:** **Date/time :** 04/09/2017 07:23:12 **Size:** 490 KB
			ESMP.pdf **File desc:** **Date/time :** 04/09/2017 07:24:38 **Size:** 536 KB
			Disposal of Waste.docx **File desc:** **Date/time :** 05/09/2017 04:57:13 **Size:** 111 KB
			Progress Update DQA Pakistan.docx **File desc:** **Date/time :** 05/09/2017 04:58:03 **Size:** 26 KB
			Registration Certificate.pdf **File desc:** **Date/time :** 05/09/2017 05:00:07 **Size:** 120 KB

			PDHS Final Report as of Jan 22-2014.pdf **File desc:** **Date/time :** 05/09/2017 05:38:28 **Size:** 2 MB
			PSLM_2014-15_National-Provincial-District_report.pdf **File desc:** **Date/time :** 05/09/2017 05:39:37 **Size:** 10 MB
			IRC.zip **File desc:** **Date/time :** 08/09/2017 12:50:58 **Size:** 5 MB
36	Strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control		Not applicable.docx **File desc:** Not applicable **Date/time :** 05/09/2017 05:36:25 **Size:** 10 KB
39	Epidemiological analysis/evidence	8.3.1	Epidemiological_Analysis_7 Sep_'17.docx **File desc:** **Date/time :** 08/09/2017 12:35:38 **Size:** 2 MB
40	Post Campaign Coverage Survey report for MR catch-up applications	5.1.x	Not applicable.docx **File desc:** Not applicable **Date/time :** 05/09/2017 05:34:47 **Size:** 10 KB
41	cMYP addendum on measles and rubella		cMYP Addendum.docx **File desc:** **Date/time :** 05/09/2017 05:32:00 **Size:** 1 MB

11. Annexes

Annex 1 - NVS Routine Support

No NVS Routine Support is requested

Annex 2 - NVS Routine – Preferred Second Presentation

No NVS Routine – Preferred Second Presentation requested this year

Annex 3 - NVS Preventive campaign(s)

No NVS Prevention Campaign Support this year

Annex 4

No NVS Routine Support is requested

No NVS Prevention Campaign Support this year

12. Banking Form

In accordance with the decision on financial support made by the Gavi, the Government of Pakistan hereby requests that a payment be made via electronic bank transfer as detailed below:

Name of Institution (Account Holder):			
Address:			
City Country:			
Telephone no.:		**Fax no.:**	
		Currency of the bank account:	
For credit to:			
Bank account's title:			
Bank account no.:			
Bank's name:			

Is the bank account exclusively to be used by this program?

By who is the account audited?

Signature of Government's authorizing official

		Seal
Name:		
Title:		
Signature:		
Date:		

FINANCIAL INSTITUTION		**CORRESPONDENT BANK (In the United States)**	
Bank Name:			
Branch Name:			
Address:			
City Country:			
Swift Code:			
Sort Code:			
ABA No.:			
Telephone No.:			
FAX No.:			

I certify that the account No is held by at this banking institution

The account is to be signed jointly by at least (number of signatories) of the following authorized signatories:

1		
	Name:	
	Title:	
2		
	Name:	
	Title:	
3		
	Name:	
	Title:	

Name of bank's authorizing official
Signature:
Date:
Seal: