# APPLICATION FORM FOR GAVI NVS SUPPORT

Submitted by
**The Government of Tajikistan**
**for**
Pneumococcal routine

Gavi
The Vaccine Alliance

Reach Every Child
www.gavi.org

# 1 Gavi Grant terms and conditions

## 1.2 Gavi terms and conditions

### 1.2.1 Gavi terms and conditions

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

#### GAVI GRANT APPLICATION TERMS AND CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

**COMPLIANCE WITH GAVI POLICIES**
The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant

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

**USE OF COMMERCIAL BANK ACCOUNTS**

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

**ARBITRATION**

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

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

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

## 1.3 Gavi Guidelines and other helpful downloads

### Guidelines and documents for download

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

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

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

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

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

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

# 2 Review and update country information

## 2.1 Country profile

### 2.1.1 Country profile

**Eligibility for Gavi support**

Eligible

**Co-financing group**

Initial self-financing

**Date of Partnership Framework Agreement with Gavi**

7 November 2012

**Country tier in Gavi's Partnership Engagement Framework**

3

**Date of Programme Capacity Assessment**

March 2016

### 2.1.2 Country health and immunisation data

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

| | 2020 | 2021 |
|---|---|---|
| Total government expenditure | | |

| | |
|---|---|
| Total government health expenditure | |
| Immunisation budget | |

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

**The government planning cycle starts on the**

1 January

The current National Health Sector Plan (NHSP) is

| | |
|---|---|
| From | 2021 |
| To | 2026 |

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

2016-2020

**Is the cMYP we have in our record still current?**

| | |
|---|---|
| Yes☐ | No☒ |

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

*Note 1*

| | |
|---|---|
| From | 2021 |
| To | 2026 |

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

No Response

### 2.1.4 National customs regulations

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

Tajikistan purchases all vaccines through UNICEF procurement mechanism. The Republican Centre of Immunoprophylaxis (RCIP) is responsible for performing vaccine arrival and customs clearance procedures. When vaccines are ready for the shipment the supplier sends the package of documents to UNICEF Country Office at least two weeks before vaccines arrival: Invoices, Packing Lists, Certificate of Origin, Certificate of Conformity, Free Gift Certificate (by GAVI), transport document. The UNICEF Country Office and the Ministry of Health send letters and submit package of documents to the Ministry of Economic Development and Trade, which issues an Official Taxes Exemption Letter addressed to custom authorities. The RCIP submits the package of documents to the State Inspection Service of Phytosanitary and Plant Quarantine of the Ministry of Agriculture of Tajikistan for issuing an Act on absents of quarantine items.

Immediately after arrival in the country vaccines are temporarily stored in a cold room at the airport. The RCIP Logistician submits a Customs Declaration and package of documents and permit letters to the custom authorities. The Customs inspects documents and release vaccines to RCIP. The custom clearance documentation is prepared prior to the vaccine arrival and therefore, no major delays in custom clearance have occurred. The RCIP verifies that cold chain has been properly maintained throughout the period of transportation by checking the temperature-monitoring devices contained in the shipment. This check is recorded in standard UNICEF Vaccine Arrival Report. All vaccine shipments are transported from the airport to the National Vaccine Store in refrigerated vehicles and are accompanied by the RCIP Logistician.

### 2.1.5 National Regulatory Agency

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

The Government implements a centralized procurement of all vaccines through UNICEF procurement mechanism. All vaccines are quality-assured and pre-qualified by WHO. The State Service on Surveillance of Pharmaceutical Activities acts as the National Regulatory Authority (NRA), and is responsible for pharmaceuticals registration in Tajikistan. However, currently vaccines are not being registered in Tajikistan and the Ministry of Health issues a waiver for each vaccine shipment. The MoH plans to establish system for expedited registration of vaccines, prequalified by WHO and relevant activities will be included in the National Multi-Year Immunization Plan for 2021-2026.

The RCIP implements surveillance for adverse events following immunization. In 2020 the Ministry of Health issued an updated guidance on AEFI surveillance, which includes standard case definitions, provides instructions on AEFI management and defines reporting and investigation procedures. According to the Guidelines, all medical workers report AEFIs to RCIP through district level immunization centers, using standard case notification forms. The RCIP, in

collaboration with the National AEFI Expert Committee, the National Public Health Center, and NRA, performs investigation and causality assessment of serious AEFI cases. The RCIP implements national registry of AEFIs, conducts periodic analysis of AEFI surveillance data, and prepare reports to NRA, the National AEFI Experts Committee, and other stakeholders.

Dr Dr Saidzoda Faizali, the RCIP General Director is the national focal point for AEFI surveillance. His contact information is as following: Tel.: + 992372211073; e-mail: sfb-65@mail.ru.

## 2.2 National Immunisation Programmes

### 2.2.2 Financial Overview of Active Vaccine Programmes

IPV Routine

*Note 2*

| | 2020 | 2021 | 2022 |
|---|---|---|---|
| Country Co-financing (US$) | | | |
| Gavi support (US$) | 628,496 | 626,044 | 623,109 |

Pentavalent Routine

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Country Co-financing (US$) | 153,227 | | | | |
| Gavi support (US$) | 736,433 | | | | |

Rota Routine

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Country Co-financing (US$) | 172,831 | | | | |
| Gavi support (US$) | 1,015,921 | | | | |

**Summary of active Vaccine Programmes**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Total country co-financing (US$) | 326,058 | | | | |

| | | | |
|---|---|---|---|
| Total Gavi support (US$) | 2,380,850 | 626,044 | 623,109 |
| Total value (US$) (Gavi + Country co-financing) | 2,706,908 | 626,044 | 623,109 |

## 2.3 Coverage and Equity

### 2.3.1 Coverage and equity situation analysis

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

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

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

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

Describe lessons learned and best practices on the effectiveness of implemented activities to improve coverage and equity; recommendations on changes or new interventions that might be required to accelerate progress (include data to support any findings or recommendations).

Tajikistan has been consistently reporting high immunization coverage at national level. Administrative coverage rates with DTP1 and DTP3, reported through WHO/UNICED Joint Reporting Form on Immunization for 2013-2019, are shown in Figure 1.

Figure 1. DTP1 and DTP3 coverage (%), 2013-2019, Tajikistan

Source: WUENIC

The officially reported DTP1 and DTP3 coverage rates were above 95% for the last seven years. The DTP1-DTP3 drop-out rates ranged from 1% to 2 %. Similar high coverage rates were reported for the first dose of measles vaccine: in the last seven years MCV1 coverage ranged from 96% to 99%. MCV 2 coverage was lower in 2013-2015, ranging from 92% to 94%. However, from 2016-2019, MCV 2 coverage exceeded 95% (Figure 2).

Figure 2. Coverage with the first and second doses of measles vaccine, 2013-2019, Tajikistan.

Source: WUENIC

The analysis of immunization coverage at sub-national level demonstrates that in the last two years, the country does not face significant challenges in providing equal access to immunization in different geographic areas. In 2018-2019, >90% DTP3 coverage rates were reported by all regions (second administrative level territories). In 2018, Rasht region had lower (91%) DTP3 coverage however, in 2019, DTP3 coverage in Rasht region increased and reached 95%. In 2019, DTP3 coverage rates at regional level ranged from 95% in Rasht and Gornyi-Badakhshan regions to 97% in Dushanbe City and Khatlon and Soghd regions. (Figure 3).

Figure 3. DTP3 coverage rates by regions, 2018-2019, Tajikistan

Source: WHO/UNICEF JRF 2018, 2019

High immunization coverage rates were also observed at the third administrative level territories (districts). In 2018, only two out of 65 districts reported <90% DTP3 coverage. In 2019, all districts reached 90% DTP3 coverage and achieved the regional immunization goal.

High immunization coverage in Tajikistan was confirmed by the Demographic and Heath Survey, conducted in 2017. According to the survey results, 87% of children at the age of 24-35 months received three doses of DTP-containing vaccines, 87% were vaccinated with three doses of OPV, and 87% received the first dose of measles vaccine. Only 3% of children did not receive any vaccinations.

The DHS show ed that there were no differences in vaccination coverage between males and females. There was also no correlation between coverage rates and the level of mother's education. However, DHS revealed differences in vaccination coverage between children living in urban and rural areas: only 76% of children at the age of 24-35 months residing in urban areas received all basic vaccinations, as compared with 84% of children in rural areas. There was also difference in immunization coverage between children from families with different income levels: children from wealthier families has lower coverage rates than children form families with lower income levels. For example, DTP3 coverage in children 24-25 months of age

from the highest wealth quintile families was 77%, whereas DTP3 coverage in children form the lowest, second, and middle quintiles families was 89-90%.
The lower coverage rates among urban and wealthier families demonstrated by 2017 DHS, can be partly explained by higher rates of missed opportunities to vaccinate children due to not justified contraindications in these populations. The most recent evaluation of immunization coverage in Tajikistan, which was conducted in June 2020 with WHO support, showed that the vaccine providers delayed or denied primary series of vaccination to infants due to unjustified contraindications. These contraindications were issued mostly by medical specialists (neurologists, pediatricians, and others). The high rates of missed opportunities due to not justified contraindications were also identified as an important reason for low coverage by 2014 survey Identification of Barriers to Vaccination of Children under 5 (WHO/EU/MoH, 2014). The survey demonstrated that 38% of the respondents (parents) indicated medical contraindications as the reason for not vaccinating their children and 27% of respondents told that they did not vaccinate children due to fear of post immunization complications. The wealthier families and those residing in big cities, have better access to specialized medical care and therefore, their children receive contraindications more often than children from poorer families or families from rural settings.

Following WHO recommendations, in 2021, the MoH plans to revise the National Guidelines on Medical Contraindications against Immunization and to conduct comprehensive trainings for health care professionals, including medical specialists on vaccines safety and contraindications against vaccination. These trainings will help to improvise medical workers' confidence in vaccines and will contribute to reducing missed opportunities to vaccinate children due to not justified contraindications. WHO will provide technical support to the MoH in conducting these trainings in 2021 using TCA funds.

Another reason of lower immunization coverage rates among urban children and children from wealthier families is a higher proportion of vaccine hesitant parents in these populations. The 2019 EPI Review found that large cities have higher rates of parental refusals from vaccination. The anti-vaccine publications are broadly disseminated in the Internet and social media, and urban and wealthier families have better access to and more often use of these resources.

In 2019, the MoH implemented a Knowledge, Attitude, Practice and Behavior survey to better understand parents' attitude towards immunization and identify key audiences and messages to address vaccine hesitancy. The survey revealed that many parents consider vaccination to be not safe for their children, especially for those who have chronic diseases or health conditions. Based on the study findings, the MoH developed and has been implementing Immunization Communication and Social Mobilization Strategy. Tajikistan also developed an excellent experience in raising awareness of the importance and safety of immunization and increase immunization coverage through participation in annual European Immunization Week. The MoH will continue implementing Immunization Communication and Social Mobilization Strategy and European Immunization Week to further address vaccine hesitancy, improve vaccine acceptance and create demand for vaccination, including in urban and wealthier families.

The 2020 evaluation of immunization coverage revealed that in some districts, medical workers faced challenges in vaccinating children from Roma communities. Parents from these communities often do not register their children in health care facilities or if registered, do not bring them for vaccination.

Some health facilities managed to reach high immunization coverage among children from Roma populations by establishing effective collaboration with their leaders and advocating for

the support to vaccination. The National Immunization Programme plans to share these best practices with primary health care facilities immunization staff form other districts and regions and facilitate their implementation on entire territory of the country.

Following the WHO Regional Office for Europe recommendations, the Ministry of Health did not interrput immunization services during COVID-19 pandemic. However, the MoH officials and medical workers reported a decline in routine vaccines uptake in April and May 2020 because many parents, especially in cities, did not bring their children for vaccination due to fear of SARS-CoV-2 infection. In addition, some health care facilities cancelled vaccination sessions because they could not provide separate entrances for sick and healthy children. The increased workload of vaccine providers related to COVID-19 response activities also contributed to decreasing immunization coverage. In order to address this challenge, in Q2-3 2020, the NIP implemented a campaign to provide catch-up immunization to children who missed vaccinations due to COVID pandemic. The RCIP and regional and district immunization staff enhanced supportive supervision of health facilities to ensure timely and complete catch-up vaccination. According to monthly reports, the catch-up campaign was implemented successfully, and the NIP expects reaching >95% DTP3 coverage in 2020. This experience will be used by NIP to maintain high immunization coverage rates if COVID-19 diseases incidence will increase again.

## 2.4 Country documents

### Upload country documents

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

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

### Country and planning documents

✓ **Country strategic multi-year plan**

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

TJK cMYP 20162020 Costing and Financing Section_19-01-21_15.46.58.docx

TJK cMYP 20162020FinalEURO with costfin_23-05-19_09.55.29.docx

| | | |
|---|---|---|
| ✓ | **Country strategic multi-year plan / cMYP costing tool** | TJKcMYP 20162020 Scenario A HPV_19-01-21_15.46.21.xlsx |
| ✓ | **Effective Vaccine Management (EVM) assessment** | EVM report ENG16091619.53.26_23-05-19_09.56.28.doc |
| ✓ | **Effective Vaccine Management (EVM): most recent improvement plan progress report** | EVMprogressreport20051717.04.45_23-05-19_10.01.46.PDF |
| ✓ | **Data quality and survey documents: Final report from most recent survey containing immunisation coverage indicators** | TJKDQA Report. 16.01.2018RUSFinal 1_19-01-21_15.53.08.docx |
| ✓ | **Data quality and survey documents: Immunisation data quality improvement plan** | DQAOperational Action PlanTJKMarch 2017FINAL01061811.11.36_23-05-19_10.05.18.docx |
| ✓ | **Data quality and survey documents: Report from most recent desk review of immunisation data quality** | отчет_по улуч. качест. данных 20182020_19-01-21_16.00.59.pdf |
| ✓ | **Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation** | DQA reportTJKMarch 201725111822.04.24_23-05-19_10.06.10.docx |

**Human Resources pay scale** — No file uploaded

If support to the payment of salaries, salary top ups, incentives and other allowances is requested

### Coordination and advisory groups documents

✓ **National Coordination Forum Terms of Reference** — Приказ МКК от 4 апреля 2018г №316_19-01-21_16.01.38.pdf

ICC, HSCC or equivalent

✓ **National Coordination Forum meeting minutes of the past 12 months** — МКК заседание №2_19-01-21_16.02.44.pdf; МКК заседание №1_19-01-21_16.02.26.pdf

### Other documents

**Other documents (optional)** — No file uploaded

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

# 3 Pneumococcal routine

## 3.1 Vaccine and programmatic data

### Choice of presentation and dates

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

*Note 3*

Pneumococcal routine

| | |
|---|---|
| Preferred presentation | PCV10, 4 doses/vial, Liquid |
| Is the presentation licensed or registered? | Yes ☐ No ☒ |
| 2nd preferred presentation | PCV13, 1 dose/vial, Liquid |
| Is the presentation licensed or registered? | Yes ☐ No ☒ |
| Required date for vaccine and supplies to arrive | 2 May 2022 |
| Planned launch date | 1 September 2022 |
| Support requested until | 2025 |

### 3.1.2 Vaccine presentation registration or licensing

**If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines, and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.**

According to the local regulations on the marketing authorization of medicines and supplies there are two legal procedures for registration of vaccines in the country. One is a standard procedure which may take from 2 to 6 months, and the second is an accelerated procedure which may be obtained within 1 month. Also, the local regulations envisage entry of unregistered vaccines and supplies using the one-time permission procedure, which is currently used for routine vaccines shipments. The MoH plans to establish a system for expedited registration of vaccines prequalified by WHO, and relevant activities will be included in the National Multi-Year Immunization Plan for 2021-2026.

### 3.1.3 Vaccine procurement

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

| | |
|---|---|
| Yes☐ | No☒ |

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

## 3.2 Target Information

### 3.2.1 Targets for routine vaccination

**Please describe the target age cohort for the Pneumococcal routine immunisation:**

*Note 4*

The target group for vaccination are children under 1 year of age. The country decided not to implement catch-up vaccination in the year of the introduction due to competing public health priorities. In 2021- Q1-2 2022, Tajikistan is going to conduct IPV/OPV catch-up camping and implement COVID-19 vaccination.

The preferable scheme for immunization of children is the 2p+1 schedule as with this scheme high level antigens are produced during the second year of life of a child, which is ideal for formation of herd immunity. The first and second dose of PCV vaccine will be give together with the first and third doses of Penta vaccine. In order to reduce multiple injections during a single visit of a child, IPV vaccine will be moved to from 4 months to 3 months together with the second dose of Penta vaccine. The third dose of PCV will be given at the age of 12 months with OPV4 and MR1 vaccines.

The following scheme will be used:

1. 2 months: OPV1 + Penta1 + Rota1 + PCV1;
2. 3 months: OPV2 + Penta2 + Rota2 +IPV;
3. 4 months: OPV3 + Penta3 + PCV2;
4. 12 months: OPV4 + MR1 + PCV3.

| | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|
| Population in the target age cohort (#) | 256,698 | 261,832 | 267,069 | 266,560 |
| Target population to be vaccinated (first dose) (#) | 69,308 | 222,557 | 240,362 | 253,232 |

| | | | | |
|---|---|---|---|---|
| Target population to be vaccinated (last dose) (#) | | 183,282 | 227,009 | 239,904 |
| Estimated wastage rates for preferred presentation (%) | 15 | 15 | 15 | 15 |

## 3.3 Co-financing information

### 3.3.1 Vaccine and commodities prices

Price per dose (US$) - Pneumococcal routine

*Note 5*

| | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|
| 4 doses/vial,liq | 3.05 | 3.05 | 3.05 | 3.05 |

Commodities Price (US$) - Pneumococcal routine (applies only to preferred presentation)

*Note 6*

| | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|
| AD syringes | 0.036 | 0.036 | 0.036 | 0.036 |
| Reconstitution syringes | | | | |
| Safety boxes | 0.005 | 0.005 | 0.005 | 0.005 |
| Freight cost as a % of device value | 0.68 | 0.68 | 0.68 | 0.68 |

### 3.3.2 Country choice of co-financing amount per vaccine dose

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

*Note 7*

| | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|
| Country co-financing share per dose (%) | 6.56 | 6.56 | 6.56 | 6.56 |
| Minimum Country co-financing per dose (US$) | 0.2 | 0.2 | 0.2 | 0.2 |
| Country co-financing per dose (enter an amount | 0.2 | 0.2 | 0.2 | 0.2 |

| | |
|---|---|
| equal or above minimum)(US$) | |

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

Pneumococcal routine

| | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|
| Vaccine doses financed by Gavi (#) | 151,900 | 813,600 | 799,200 | 827,600 |
| Vaccine doses co-financed by Country (#) | 10,700 | 57,100 | 56,100 | 58,100 |
| AD syringes financed by Gavi (#) | 157,000 | 836,500 | 801,700 | 827,600 |
| AD syringes co-financed by Country (#) | | | | |
| Reconstitution syringes financed by Gavi (#) | | | | |
| Reconstitution syringes co-financed by Country (#) | | | | |
| Safety boxes financed by Gavi (#) | 1,750 | 9,225 | 8,825 | 9,125 |
| Safety boxes co-financed by Country (#) | | | | |
| Freight charges financed by Gavi ($) | 605 | 3,218 | 3,083 | 3,184 |
| Freight charges co-financed by Country ($) | 43 | 226 | 217 | 224 |

| | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|
| Total value to be co-financed (US$) Country | 33,000 | 174,500 | 171,500 | 177,500 |

| | | | | |
|---|---|---|---|---|
| Total value to be financed (US$) Gavi | 471,000 | 2,519,500 | 2,474,000 | 2,562,000 |
| Total value to be financed (US$) | 504,000 | 2,694,000 | 2,645,500 | 2,739,500 |

### 3.3.4 Co-financing payment

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

The funds for co-financing will be transferred directly to the UNICEF Regional Procurement Department by the Ministry of Finance upon the request of the Ministry of Health and Social Protection of Population in coordination with UNICEF Country Office at the appropriate date. The RCIP will be responsible for all operations related to the funds transfer. This process allowed Tajikistan to provide co-financing payments to Gavi in time for the last five years.

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

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

n/a

| | |
|---|---|
| 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: | September |

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

| | |
|---|---|
| Month | December |
| Year | 2022 |

## 3.4 Financial support from Gavi

### 3.4.1 Routine Vaccine Introduction Grant(s)

Pneumococcal routine

**Live births (year of introduction)**

263,281

**Gavi contribution per live birth (US$)**

0.8

**Total in (US$)**

210,624.8

| | |
|---|---|
| Funding needed in country by | 30 November 2022 |

### 3.4.2 Operational budget

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

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

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

9700

**Total amount - Other donors (US$)**

0

**Total amount - Gavi support (US$)**

210624

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

0.04

**Amount per target person - Other donors (US$)**

0

**Amount per target person - Gavi support (US$)**

0.8

### 3.4.3 Key Budget Activities

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

Coordinating and monitoring preparation and implementation

• Establish a working group to coordinate and monitor implementation of preparatory activities prior to PCV introduction and coordinate evaluation after the introduction
• Revise regulatory and normative documents
• Revise immunization guidelines and/or development of PCV specific annexures to the existing documents:
o Immunization schedule
o Immunization services and practices
o Vaccine management
• Print and disseminate updated regulatory documents and immunization guidelines to all oblast and rayon SES, and to all health centres

Planning for procurement and distribution of PCV
• Update MOH-UNICEF 5-year forecasting tool with PCV requirements
• Distribute vaccine to regional and district vaccine stores and health facilities according to existing procedures

Expanding and upgrading cold chain, logistics and improving vaccine management
• Monitor the supply and installation of cold chain equipment provided by HSS Gavi grant and CCEOP
• implement the vaccine management training planned under the HSS Gavi grant and CCEOP
• Revise and update vaccine management tools to include PCV

Revising health and immunization management information/data system
• Revise immunization recording and reporting forms, including immunization cards, immunization certificate, monthly and annual reporting forms;
• Print and disseminate updated immunization recording and reporting forms to all health care facilities and public health centres
• Revise AEFI surveillance guidelines and AEFI reporting forms
• Print and disseminate AEFI surveillance guidelines and AEFI reporting forms

Monitoring and evaluation of PCV introduction
• Conduct supervision visits from national level to oblast/rayon/municipality level and from rayon/municipality level to health facility level shortly after the introduction
• Conduct post-introduction evaluation using standardized WHO PIE Tool

Training of health workers involved in vaccination

• Develop a training plan with strategy, number and type of healthcare workers to be trained, duration and content of training, materials to be developed, monitoring and evaluation
• Develop training and educational materials on pneumococcal vaccine and other interventions to prevent and control pneumonias
• Implement cascade training, from national level to oblast/rayon/municipality level and from rayon/municipality level to health facility level, with an initial training of trainers for national and regional level immunization staff and paediatricians
• Conduct National Conference on pneumococcal diseases and vaccines for health care professionals and medical academia to ensure their support to PCV introduction.

### 3.4.4 Financial management procedures

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

The Republic of Tajikistan procures all routine vaccines exclusively through the UNICEF Supply Division. The Memorandum of Understanding between the MOH and UNICEF on procurement of vaccines was signed on 30 March 2004 and is valid to present. The support for introduction of pneumococcal vaccine will operate through the usual GAVI-UNICEF collaboration mechanisms and financial management procedures. The RCIP will be responsible for all financial management of the co-financing payments.

As per current FMA between Gavi and Tajikistan, the NVS direct financial support (VIG) will be managed by the Alliance Partners. The partners' committal documents will be raised for all relevant contracts, including procurement in accordance to partners' rules and regulations.

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

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

Yes☒ No☐

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

The Republic of Tajikistan complies with all guidelines and requirements for the use of Gavi financial support for human resources (HR) costs.

### 3.4.6 Fiduciary management

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

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

Funds should be transferred to WHO and UNICEF. The funds are expected to be in the country in September 2021.

### 3.4.7 Use of financial support to fund additional Technical Assistance needs

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

*Note 9*

Partners will support conducting a National Conference on pneumococcal diseases and vaccines for health care professionals and medical academia to ensure their support to PCV introduction; conducting a formative research and developing communication strategy for PCV introduction tailored to targeted audience and Implement advocacy, communication and social mobilization activities according to communication plan. Corresponding activities will be included in 2021 and 2022 TCA.

## 3.5 Strategic considerations

### 3.5.1 Rationale for this request

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

(Translation below)

Заболеваемость пневмониями, менингитом и сепсисом является серьезной проблемой общественного здравоохранения Таджикистана. Согласно данным Государственного учреждения «Республиканский центр медицинской статистики и информации» Министерства здравоохранения и социальной защиты населения Республики Таджикистан, за последние пять лет в республике ежегодно регистрируются более 25000 случаев пневмонии, 38500 случав сепсиса и 2300 случаев менингита у детей в возрасте до 5 лет. Согласно расчетным данным Всемирной организации здравоохранения 5655 случаев этих заболеваний и 2348 случаев смерти от них обусловлено пневмококковой инфекцией.

Заболеваемость пневмониями, менингитами и сепсисом характеризуется высокой частотой обращения за медицинской помощью и госпитализации, необходимостью проведения продолжительного и интенсивного лечения, а также высоким риском развития долгосрочных последствий и инвалидности. Поэтому пневмококковые заболевания оказывают значительную нагрузку на систему здравоохранения и наносят серьезный экономический ущерб государству.

В настоящее время существует возможность предотвратить заболеваемость и смертность от пневмококковой инфекции с помощью вакцинации. Всемирная организация здравоохранения рекомендует внедрение пневмококковых вакцин в календари плановой вакцинации во всех странах. К 2020 году 148 стран в мире проводят плановую вакцинацию детей против пневмококковой инфекции, в том числе соседние с Таджикистаном страны Центрально-Азиатского региона: Казахстан, Кыргызстан, Узбекистан, и Туркменистан. Многие страны продемонстрировали, что внедрение пневмококковых вакцин привело к снижению заболеваемости и смертности от пневмококковых инфекций на 90-100% среди детей, а также среди более старших возрастных групп, не привитых против пневмококковой инфекции, за счет эффекта коллективного иммунитета. Так, в Канаде, Нидерландах, Великобритании и США вакцинация детей привела к практической элиминации пневмококковой инфекции, обусловленной серотипами, включенными в состав вакцин, среди всего населения, включая лиц пожилого возраста.

Таджикистан имеет возможность получить поддержку ГАВИ во внедрении пневмококковой вакцины, которая включает в себя предоставление вакцины по цене 0,2 доллара США за дозу. Стоимость вакцины и инъекционных материалов для вакцинации детей в возрасте до 1 года в Таджикистане составит 150000 долларов США в год. Для сравнения, стоимость пневмококковой вакцины на рынке европейских стран варьирует от 20 до 60 долларов США за дозу. Гави также предоставит финансовую поддержку для проведения подготовительных мероприятий в размере 196800 долларов США.

Исследования продемонстрировали, что внедрение пневмококковой вакцины в календарь плановой иммунизации детей в странах, которые получают поддержку ГАВИ, является высоко экономически эффективным, поскольку при низкой стоимости вакцины, позволяет предотвратить тяжелые формы пневмоний, менингитов и сепсисов и, связанные с ними, расходы на оказание медицинской помощи, а также предотвратить смертность

обусловленную этими заболеваниями, среди детей (за счет прямой защиты) и пожилых людей (за счет непрямой защиты).
Принимая во внимание следующие факторы:
• Высокую заболеваемость и смертность от пневмококковых заболеваний среди детей раннего возраста в Таджикистане;
• Высокую нагрузку на систему здравоохранения в силу тяжести заболеваний, обусловленных пневмококком, требующих оказания стационарной медицинской помощи, включая интенсивную терапию;
• Тяжелое финансовое бремя на систему здравоохранения ввиду длительного периода госпитализации, дорогостоящего лечения, а также тяжелых осложнений, которые могут привести к инвалидности;
• Наличие эффективных и безопасных вакцин, которые получили пре-квалификацию ВОЗ и привели к практической элиминации пневмококковых заболеваний, обусловленными серотипами, включенными в состав вакцин, в странах, которые внедрили пневмококковые вакцины в календарь иммунизации;
• Рекомендации ВОЗ для всех стран о необходимости внедрения пневмококковой вакцины в календари плановой вакцинации детей:
• Возможность получения поддержки Гави во внедрении пневмококковой вакцины и ее высокую экономическую эффективность:
Национальная техническая группа экспертов по иммунизации рекомендовала Министерству здравоохранения внедрить пневмококковую вакцину в календарь иммунизацииТаджикистана в 2022 году.

(Translation here)

Morbidity from pneumonia, meningitis and sepsis constitutes a serious problem for the Public Health System of Tajikistan. Data provided by the State Republican Centre for Medical Statistics and Information under the Republic of Tajikistan Ministry of Health and Social Protection of the Population shows that over the last five years 25,000 cases of pneumonia, 38,500 cases of sepsis, and 2,300 cases of meningitis have been registered annually in children under 5. According to the World Health Organisation estimate, 5,655 cases of the above diseases and 2,348 related deaths were caused by pneumococcal infection.
Morbidity linked to pneumonia, meningitis, and sepsis is characterized by a high rate of medical encounters and hospitalisations, a need for extended intensive treatment, and a high risk of developing long-term complications and disabilities. This is why pneumococcal diseases exert a significant burden on the national health system and do serious harm to the country's economy.
Currently, morbidity and mortality from pneumococcal infection can be prevented by means of vaccination. The World Health Organisation recommends all countries to introduce the pneumococcal vaccine into their routine immunisation schedules. As of 2020, routine immunisation of children against pneumococcal infection was carried out in 148 countries, including those neighbouring Tajikistan in the Central-Asian Region — Kazakhstan, Kyrgyzstan, Uzbekistan, and Turkmenistan. Many countries have already demonstrated that implementation of pneumococcal vaccines contributes to the reduction of mortality from pneumococcal infections by 90-100% not only among vaccinated children, but also among unvaccinated older age groups due to herd immunity effect. Thus, in Canada, the Netherlands, the UK, and the USA vaccination of children has led to practical eradication of the pneumococcal infection, caused by the viral serotypes contained in the vaccine formulations, among the whole population, including the elderly.
Tajikistan is eligible to Gavi's support for pneumococcal vaccine introduction, including the provision of the vaccine at the price of $US 0.2 per dose. The annual cost of vaccine and injection consumables for the vaccination of infants under 1 year old in Tajikistan will amount to $US 150,000. By comparison, the cost of pneumococcal vaccines in European markets varies from $US 20 to $US 60 per dose. Gavi will also provide Tajikistan with financial support for the vaccine introduction preparatory activities to the amount of $US 196,800.
Research shows that the introduction of the pneumococcal vaccine into schedules of routine childhood immunisation in Gavi supported countries is highly cost effective, because, due to low vaccine cost, it

allows to prevent severe forms of pneumonia, meningitis, and sepsis as well as related medical treatment expenses and mortality among children (through direct protection) and the elderly (through indirect protection).
Taking into consideration the following factors:
• high morbidity and mortality rates among young children in Tajikistan;
• high burden for the health system due to the severity of pneumococcal diseases, which require hospital treatment, including intensive therapy;
• high financial burden for the health system due to long-term hospital care, high-cost treatment and severe complications, which may result in disability;
• availability of effective and safe vaccines, which have been pre-qualified by WHO and lead to practical eradication of the pneumococcal diseases caused by the viral serotypes contained in the vaccine formulations in the countries where pneumococcal vaccines were introduced into routine immunisation schedules;
• WHO recommendations to all countries on the introduction of the pneumococcal vaccine into their routine childhood immunisation schedules; and
• availability of Gavi's support for the pneumococcal vaccine introduction and the latter's high cost efficiency
the National Immunisation Technical Advisory Group recommended the Republic of Tajikistan Ministry of Health to introduce the pneumococcal vaccine into the National Immunisation Scheme in 2022.

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

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

A new National Health Strategy for 2021-2030 is in the final stages of the development and will be submitted for the Republic of Tajikistan Government approval soon. The Strategy defines the Government's vision and strategic directions in implementing reforms in health care and social protection system, establishes the framework for action, and identifies the ways forward. One of the major strategic directions is to provide accessible and quality-assured healthcare and social protection services to the population. The Government considers immunization against vaccine-preventable diseases as one of the priority areas of the healthcare sector. The Strategy defines the sustainable implementation of the National Immunization Programme as the major goal to implement this strategic direction and to reach expected outcome of reducing child morbidity and mortality. The introduction of pneumococcal vaccine along with implementation of other interventions to prevent and treat pneumonias will help to avert more than 2,000 deaths attributable to pneumococcal diseases in young children and therefore, is fully aligned with the strategic objectives of the National Healthcare Strategy for 2021-2030.

The current cMYP 2016-2020 included introduction of pneumococcal vaccine however, the introduction was postponed due to limited financial resources and competing public health priorities (introduction of one dose IPV and MMR). The new cMYP 2021-2026 is in the process of development and will be finalized in mid-2021. The development of the new cMYP was delayed because the immunization programme staff and MoH officials were busy with implementation of COVID-19 response activities. The introduction of pneumococcal vaccine will be one of the strategic priorities of the new cMYP and the relevant costs will be included in its budget. The Pneumococcal Vaccine Introduction Plan will be included in the cMYP as an attachment.

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

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

The PCV Vaccine application development has been a comprehensive and inclusive process involving participation of all the relevant stakeholders. MoH and RCIP played a leading role with the support and close collaboration with WHO, UNICEF, NITAG and ICC.

The NITAG was established in Tajikistan in 2016 by the Ministry of Health order to provide evidence-base recommendations to the MoH on immunization policy and practice and to enable the Ministry of Health to make informed decisions. The major functions and responsibilities of the NITAG include:
- Policy analysis and strategy formulation for the eradication/elimination and control of vaccine-preventable diseases;
- Assessment of the NIP's performance;
- Collection and identification of important data for policy decision-making;
- Provision of recommendations for the use and introduction of new and under-used vaccines based on the particular circumstances of the country.

Tajikistan NITAG meets all six criteria that WHO uses to assess the functionality of advisory bodies, including the provision of a legislative basis for the NITAG, the availability of written terms of reference, representation of at least five disciplines within NITAG members, conducting annual NITAG meetings, advance sharing of the meeting agenda and documents, and declarations of interest by NITAG members.

To develop recommendations on pneumococcal vaccine, NITAG established a Working Group, which included experts with the necessary expertise and representatives of all national stakeholders. The Working Group used a systematic approach to collect, evaluate, and synthesize evidence according to defined criteria (disease burden, vaccine characteristics, cost-effectiveness considerations, programmatic feasibility, and acceptance of vaccine by public and medical workers) and prepared background document and draft recommendations for NITAG deliberations. NITAG discussed the background document and Working Group's conclusions at its meeting and recommended the MoH to introduce pneumococcal vaccine into routine immunization programme with GAVI support in 2022.

The ICC was established by the MoH order in 2001 and is a stand-alone committee that meets on a quarterly basis. Its major functions and responsibilities include:

- Provide technical and financial support in the implementation of the NIP's priorities;
- Review EPI policy and strategies and propose changes and amendments to the NIP;
- Provide support on evaluation and planning of long-term and short-term and activities;
- Foster partnership in immunization field and mobilization of resources;
- Establish good partnerships to coordinate effective and rational use of local and external resources;
- Share information among national and external partners and relevant organizations and donors;
- Assist in social mobilization efforts and creation of public opinion on importance of immunization.

At its meeting in August 2019, the ICC discussed and supported NITAG recommendations on introduction of pneumococcal vaccine into routine immunization programme.

### 3.5.4 Financial sustainability

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

The detailed information on resource requirements for procurement of vaccines and injection supplies as well as projected Government and donors allocations are presented in Figure 1.

Общая стоимость вакцин и материалов Гави Другие доноры Вакцины, закупаемые правительством Со-финансирование Стоимость без софинансирования Выделение ресурсов правительством (в Таджикских сомони с учетом прогнозируемой инфляции) Баланс

| RU | Years | | | | |
|---|---|---|---|---|---|
| | 2021 | 2022 | 2023 | 2024 | 2025 |
| Общая стоимость вакцин и материалов Overall cost of vaccines and materials | 6,148,560 | 7,102,950 | 7,890,564 | 7,949,870 | 8,117,056 |
| Gavi Гави | 3,537,473 | 4,408,643 | 4,941,531 | 4,913,777 | 4,998,743 |
| Другие доноры - Other donors | 859,175 | - | - | - | - |
| Вакцины, закупаемые правительством Government-procured vaccines | 1,751,912 | 2,694,308 | 2,949,033 | 3,036,093 | 3,118,313 |
| Со-финансирование Co-financing | 417,469 | 439,194 | 555,056 | 573,678 | 583,495 |
| Стоимость без софинансирования | 1,334,443 | 2,255,114 | 2,393,977 | 2,462,415 | 2,534,818 |

| | | | | | |
|---|---|---|---|---|---|
| Cost without co-financing | | | | | |
| Выделение ресурсов правительством (в Таджикских сомони с учетом прогнозируемой инфляции) Government-allocated funds (in Tajik adjustment for anticipated inflation) | 1,950,000 | 1,950,000 | 1,950,000 | 1,950,000 | 1,950,000 |
| Баланс Balance | 615,557 | -305,114 | -443,977 | -512,415 | -584,818 |

2021 2022 $ 7,102,950 $ 4,408,643 $ - $ 2,694,308 $ 439,194 $ 2,255,114 $ 1,950,000 $ -305,114
2023 $ 7,890,564 $ 4,941,531 $ - $ 2,949,033 $ 555,056 $ 2,393,977 $ 1,950,000 $ -443,977
2024 $ 7,949,870 $ 4,913,777 $ - $ 3,036,093 $ 573,678 $ 2,462,415 $ 1,950,000 $ -512,415
2025 $ 8,117,056 $ 4,998,743 $ - $ 3,118,313 $ 583,495 $ 2,534,818 $ 1,950,000 $ -584,818

The total financing of procurement of routine and new vaccines, including PCV, and injection during the period 2021-2025 was estimated at 37.2 million US$. The projections are based on vaccine price estimates provided by the UNICEF Supply Division and includes UNICEF handling fee and fee for freight, insurance and inspection as well as costs to the Government with custom clearance and other expenses such as bank and administrative fees. The projections use current vaccine prices based on currently utilized product choices by the NIP. The incremental (vaccine) cost of PCV introduction is calculated at the amount of US$8,080,500. The projected GAVI and Government expenditures for procurement of vaccines and supplies for the period 2021-2025 are provided in the Table below:

Government (US$) Gavi (US$) Total (US$)
2022 31,000 443,500 474,500
2023 164,000 2,372,000 2,536,000
2024 161,000 2,329,500 2,490,500
2025 167,000 2,412,500 2,579,500

HPV introduction brings in approximately 4.5% increase to annual vaccine costs (in addition to the incremental Gavi co-financing increases).

Gavi is the major source of financing of Tajikistan National Immunization Program. Total contribution of Gavi in the procurement of vaccines and injection supplies will amount to 22.8 million US$ which will constitute 61% of all required funding.
Government is the second major source of National Immunization Program funding, contributing 9,8 million US$ accounting for 26.2% of all required funding.

In 2021, the procurement of MMR vaccine will be supported by World Bank in the amount of 859,173 US$ which will constitute 14.0% of required funding for that year. The Government is currently conduct negotiations with JIKA for continuation of the financial support beyond 2021.

The Government of the Republic of Tajikistan is steadily increasing the budget (in local currency) for procurement of vaccines, and allocates sufficient funds to provide co-financing payments to GAVI. For the last three years, immunization programme financing increased from 7.8% to 8.3% of the total MoH budget. The MoH defined immunization as a priority in 2021-2023 budget. Government has been fully implementing its co-financing commitments to Gavi and has been proving timely payments annually. However, due to expected devaluation of local currency, the amount of predicted Governments contribution in US$ remains the same in 2021-onwards.

Even with the increased Government funding (in local currency), the increasing funding gap is expected in 2022-onwards. The funding gap increases from 305,114 US$ in 2022 (4% of total annual budget) to 584,818 (7% of total annual budget) in 2025.
The main strategies to ensure sustainable financing of procurement of vaccines and injection safety supplies as well as financial sustainability of National Immunization Programme in general will be defined by the new cMYP for 2021-2026, which will include following strategic directions:
• Increasing state funding for national immunization program for meeting Gavi co-financing requirements for introduction of PCV during the cMYP 2021-2026 period;
• Increasing reliability of financing from the domestic sources;
• Conducting fundraising and advocating activities to secure additional financial support for procurement of vacceins and injection safety supplies;
This could include the following:
- Continue advocating for prioritization of immunization in the Government agenda
- Advocate for increase of budget allocations and timely release of funds budget allocations for introduction of PCVs;
- For raising additional funds, accelerate communication and collaboration with international development partners to provide evidence-based information and strong justification of the need in introduction of PCV.
- Conducting fundraising activities and work with donor community to secure additional funding for filling program funding gaps;
- Provide national level decision makers with evidence-based information on the essential need in introduction of PCV in 2022 for meeting Sustainable Development Goals

### 3.5.5 Programmatic challenges

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

The National Immunization Programme Review was conducted in Tajikistan in 2019 with WHO and UNICEF support. The review acknowledged the NIP achievements, such as high immunization coverage and progressively reaching national, regional and global immunization

goals; increasing Government's expenditures on immunization; well-structured and organized immunization system at all administrative levels; dedicated medical workers and immunization staff; and well-functioning immunization information system.

The EPI review identified the following programmatic challenges that need to be addressed to successfully introduce PCV:

• High turnover of medical staff in primary health care facilities due to low salaries of health care workers.

The MoH successfully implemented a performance-based financing pilot project supported by World Bank, which helped to increase the salary and motivate the current workforce. In 2021, the MoH plans to expand this project to Khatlon, Sughd and DRS, and prepare grounds for its expansion to GBAO oblast with the support of HSS funds.

• EPI review revealed that some medical workers had poor understanding of how to estimate coverage rates and limited use of coverage data for evaluating immunization programme performance in their catchment areas:
The NIP developed an excellent experience in conducting trainings for medical workers on Immunization in Practice, which helped to improve medical workers' knowledge and skills in immunization, including coverage estimates in past. The refresher IP trainings for front line medical workers will be conducted in 2021, prior to PCV introduction, in order to increase quality of immunization data and their use for improvement of immunization programme performance. These trainings will be financed by HSS funds and the corresponding activities are included in the HSS workplan.

• The EPI review noted a low sensitivity of AEFI surveillance system as there were very few AEFI cases reported in the reviewed period.
In order to address this challenge, the NIP has developed a new National AEFI Guidelines and conducted trainings for trainers on AEFI reporting, management, and investigation. In 2021, further trainings for front line medical workers will be conducted. The refresher trainings on AEFI and VPD surveillance will be included into programme of trainings for medical workers on PCV introduction.

• The NIP has limited managerial and coordination capacity, in terms of staff quantity, capacity and modern managerial skills.

The previous RCIP experience demonstrated that regular trainings for middle-level immunization managers helped to enhance and optimize their immunization-related work. In 2021, the NIP plans to conduct MLM trainings for more than 500 key immunization staff and for district level health authorities. In addition, the NIP plans to evaluate the effectiveness of the provided training courses and their impact on the quality of immunization services, including services for populations living in hard-to-reach and remote regions. The corresponding activities and financial resources will be included in the cMYP for 2021-2026, which is currently being developed and will be finalized in 2021.

The RCIP consider supportive supervisions as one of the major tools to improve the capacity of immunization staff in regional and district immunization centers. The RCIP plans to conduct supervisory visits within the first month after PCV introduction to identify possible errors and undertake timely corrective measures, as well as on-the-job trainings for immunization staff.

The NIP plans to carry out regular teleconferences with regional and district level immunization centers and to conduct Middle-Level-Managers trainings for key health staff to enhance and optimize their immunization-related work.

Cold chain

The NIP with the support of international partners, conducted three assessments of the vaccine and cold chain management process: 2015 Effective Vaccine Management (EVM) Assessment, 2018 Cold Chain Inventory, Needs Assessment and Rehabilitation Plan, and 2018 Immunization Coverage and Equity Improvement Plan for CCEOP. The major challenges in vaccine management and cold chain identified by these assessments, are listed below:

• The existing volumes of cold storage and transport of the national, subnational and district warehouses were not sufficient to provide a future need for vaccine storage volumes. Lack of storage capacity prevented the country from implementing an appropriate system for the distribution and management of vaccine stocks, including vaccine stockpile and materials;
• The existing vaccine distribution system exposed vaccines to uncontrolled risks: unreliable and inadequate transport for the delivery of vaccines to district warehouses and lack of facility transport of vaccines for district warehouses and facilities providing immunization services:
• Absence and/or unreliable active cold chain equipment: 28% (840) of facilities did not have active cold chain equipment; domestic refrigerators accounted for 72% of the equipment used; the service life of 68% of PQS vaccine freezers and 46% of ILR was over 10 years or unknown;
• Significant limitations in temperature monitoring: lack of any temperature monitoring device is found at 3.3% of vaccine refrigerators, and lack of continuous temperature monitoring - at almost all facilities; no monitoring of exposure to freezing during transportation of vaccines.

The Vaccine cold chain inventory and needs assessment conducted in Tajikistan in 2017, shoud that the required storage volume per Fully Immunized Child (FIC) for vaccines requiring storage at +2 +8 Cº will increase by about 44 percent with the introduction of new vaccines in potentially single-dose vials (PCV, HPV vaccine), reaching 400.5 $cm^3$ at central, 405.3 $cm^3$ at district levels and 418.8 $cm^3$ at immunization service delivery level. The NIP developed a Cold Chain Rehabilitation & Maintenance Plan to establish adequate vaccine storage capacity to address future programme needs at the national vaccine store, sub-national and district level stores. The plan included a detailed list of equipment to be procured for each vaccine store. From 2018- 2020, the plan of procurement was fully implemented with the support of GAVI HSS and CCEOP grants. The RCIP procured 7 cold rooms, 883 refrigerators bundled with voltage regulators to replace old and domestic refrigerators in health care facilities, 66 freezers, 1040 cold boxes and 1170 vaccine carriers and 40,963 icepacks to transport vaccines from regional level to immunization sites. In addition, 5 generators and 2 voltage stabilizers were procured and delivered to Immunoprophylactic centers in Bokhtar, Rasht, Rudaki and Dushanbe. 8 refrigerated vehicles were procured to transport vaccines from regional vaccines stores to district level. The RCIP procured and distributed to regional and district level vaccine stores 3,000 electronic freeze indicators, 8 central temperature monitoring systems and 435 30-day temperature recorders. With this upgrade the volume of cold chain has reached required 400.5 $cm^3$ per fully vaccinated child at central and 405.3 $cm^3$ per fully vaccinated child at district vaccine stores and is sufficient to accommodate pneumococcal vaccine and HPV vaccine, which are planned to be introduced in in future.

To facilitate the distribution, installation, development of a repair/maintenance plan and capacity building for repairs and maintenance of the procured cold chain equipment, UNICEF contracted a local company to closely work with MOHSP and WHO experts to develop a cold chain operational deployment plan for national, regional and levels. 49 health managers at the national level, 74 in Sogd oblast, 70 in Bokhtar, 29 in Kulob, 40 in GBAO and 48 in RRS were trained by the contractor on the use of the equipment. In addition, the company identified potential technicians and refrigerators repair technicians across the country and trained 42 technicians on repair and maintenance of the cold chain equipment. The trained technicians would provide equipment repair services to the health centers in case of need for a repair of cold chain equipment. SOP on use and maintenance/repair of the equipment at national and subnational level has been developed.
In 2020-2021, the NIP plans to conduct training for regional level vaccine stores staff on vaccine management, including usage of central temperature monitoring systems and wastage rates estimates. The trainings on vaccine storage and transportation will be conducted for the staff of the Custom Office of the International Airport. The NIP will continue conducting temperature mapping at national regional and district level vaccine stores.
The new EVM assessment, which was planned in Q1 2020 was postponed due to COVID-19 pandemic and will be conducted as soon as travel restrictions are removed.

Data quality:

The Data quality assessment (DQA) for immunization was carried out in Tajikistan in March of 2017. The result of the assessment revealed the following gaps regarding data quality in the immunization service:
• Immunization recording and reporting is entirely paper-based and resource and time consuming
• Discrepancies in target population estimates between the RCIP reports and official national statistics, which may negatively influence the accuracy of immunization coverage.
• Some vaccine providers experience difficulties in estimating immunization coverage at health facility level and do not effectively use immunization data for action.
Based on the assessment finding and recommendations, the plan of action to improve immunization data quality in Tajikistan was developed. The plan includes the key activities necessary to generate data collection and provide an accurate assessment of vaccine coverage comparable at the national level:
• Improving the quality, accuracy and effectiveness of data recording and reporting.
• Improving the practice of analyzing immunization data and its use at all administrative levels.
• Standardizing the use of electronic databases on immunization data management, analysis and reporting at all administrative levels
• Standardizing and/or improving the census process by households and defining the target group.
• Improving worker’s knowledge and skills in managing immunization data, analyzing and using its results
In 2018, the NIP with UNICEF support developed an electronic system to monitor vaccine coverage and vaccines stocks at national, regional, and district levels. In 2018-2020, the series of trainings on improvement of immunization data quality and use of the new electronic system for immunization reporting was conducted for regional and district level immunization staff as well as for medical workers from primary health care facilities throughout the country. In 2019, the NIP with WHO support revised monthly and annual immunization reporting forms in order to simplify and standardize the reporting and developed completion instructions. The

corresponding amendments were made in the national Middle-Level Managers and Immunization on Practice training modules. These activities were funded and implemented with support of HSS funds. In 2020-2021, the NIP plans to continue implementing the Data Quality Improvement Plan, including conducting evaluation to identify and characterize the target population, analyzing national migration patterns to better understand seasonality of patient movement, assessing the existing capacity (IT, HR) for electronic data management, establishing a work group to provide ongoing external review and guidance on data quality, management and use. The corresponding activities are included in the HSS Action Plan and will be financed by GAVI HSS grant.

AEFI surveillance

Low sensitivity of AEFI monitoring system identified by 2019 EPI Review, may negatively influence capacity of immunization programme to timely detect and investigate cases of adverse events following immunization with pneumococcal vaccine and communicate the finding to the public and medical workers to prevent rumors and negative publicity.
In order to address this challenge, the NIP developed a new National AEFI Guidelines and conducted trainings for trainers on AEFI reporting, management, and investigation. The trainings for front line medical workers on a new AEFI Surveillance Guidelines will be continued in 2021 to cover all districts of the country. The refresher trainings on AEFI and VPD surveillance will be included into the programme of trainings for medical workers on PCV introduction.

### 3.5.6 Improving coverage and equity of routine immunisation

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

Demand Generation and Vaccine Hesitancy

There is a risk that the introduction of pneumococcal vaccine may be negatively affected by public concerns about vaccines safety revealed by the Knowledge, Attitude, Practice and Behavior Survey conducted in Tajikistan in 2019. In order to address vaccine hesitancy, the MoH developed and has been implementing Immunization Communication and Social Mobilization Strategy. The NIP adapted John Hopkins University Guidelines on Interpersonal Communication in Immunization, and in 2020, RCIP jointly with ehe National Center for Clinical Education and the National Center for Promotion of Healthy Life Style conducted trainings for medical workers to improve their capacity in interpersonal communication with vaccine hesitant parents. The implementation of the Communication Strategy will be continued in the period before the introduction of pneumococcal vaccine to address challenges with parental and medical workers vaccine safety concerns. The findings and recommendations of KAPB survey will be used to develop and implement a Social mobilization and communication plan for PCV Introduction.

The Plan for PCV Introduction will include communication and social mobilization activities tailored to main target audiences: parents, health professionals, and journalists. The NIP will review, update and develop appropriate education and information materials for medical professionals, vaccination staff, media and population on benefits of pneumococcal vaccination and safety of the new vaccine. The NIP plans to use 2022 European Immunization Week to broadly disseminate information about introduction of PCV vaccine and provide accurate, objective, up-to-date evidence on PCV vaccines to medical workers and population

In order to improve access to hard-to-reach populations, the NIP will continue sharing and facilitating implementation of best practices in reaching children from Roma communities by establishing effective collaboration with the community leaders.The GAVI vaccine introduction grant would represent an important contribution to implementation of the planned communication and advocacy activities.

In 2021, prior to PCV introduction, the NIP is going to revise the National Guidelines on Contraindications in order to align it with WHO recommendations, and to conduct trainings for medical workers to increase their confidence in vaccines, including PCV and to reduce missed opportunities to vaccinate children due to not justified contraindications. WHO will provide technical and financial support in conducting these trainings as a part of Targeted Country Assistance. To ensure that medical workers will not use false contraindications against PCV, the information about PCV vaccine safety, contraindications, and safety of multiple injections will be included in the programme of trainings for medical workers on PCV introduction.

The trainings for medical workers on Pneumococcal vaccine introduction will include complement of interpersonal communication to improve their capacity to discuss vaccines values and benefits with vaccine hesitant parents. The trainings programme will also include refresher training on microplanning and estimating vaccine coverage to timely identify under-vaccinated populations and undertake efforts to improve their vaccine uptake.

Education and information materials (banners, leaflets, brochures etc.) for parents on the introduction of pneumococcal vaccine will contain information about benefits and safety of pneumococcal vaccines and immunization in general and will provide parents with references to trusted sources of information, including Ministry of Health, NIP, and WHO websites. The education and information materials will be disseminated through health facilities throughout the country being equally accessible to the parents of children of both genders and from all socio-economic population groups.

Information on the new vaccine introduction will also be spread through the mass media. The parents in remote settlements without access to mass media or the internet will be informed about the new vaccine by the health personnel while staying in maternity hospitals, during neonatal home and health center visits. In rural areas, the health workers will involve community leaders and local administrators for the purpose of disseminating information, relying on community support of the new vaccine introduction and generating positive attitudes toward vaccinations in general. The Immunization Programme staff and health workers will organize meetings with religious leaders at the national and regional levels to obtain their support for the Immunization Programme and new vaccine introduction.

Post introduction evaluation (PIE) planned 6 months after the introduction, will provide an opportunity to evaluate the effectiveness of PCV introduction communication strategy and to

revise it according to the evaluation finding if necessary.

Tajikistan introduced three new vaccines in the last five years: rotavirus vaccine (2015), IPV (2018), and MMR (2019). All introductions were successful: vaccines were well accepted by medical workers and parents and high coverage rates were achieved shortly after the introductions. According to WHO/UNICEF coverage estimates in 2019 Tajikistan reached 97% coverage with two doses of rotavirus vaccine, 96% coverage with one dose of IPV, and 96-97% coverage with the first and the second doses of MMR correspondingly. The country implements sentinel surveillance for diarrheal diseases in young children to monitor impact of rotavirus vaccines. The Joint Appraise Review in 2019 noted that the surveillance demonstrated dramatic decrease in frequency of hospitalizations due to diarrheas after the introduction of rotavirus vaccine.

### 3.5.7 Synergies

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

*Note 10*

Tajikistan was awarded the GAVI Health System Strengthening (HSS) grant in 2017 of a total amount of US$ 9.660.000 to be implemented over a period of five years. This financial support is currently channeled through WHO, UNICEF and UNDP while the country is strengthening its financial and programme management systems. The grant objectives are to strengthen primary health care capacity, with focus on the quality and safety of immunization services; improve equity in vaccination by increasing immunization coverage in low performing and hard-to-reach areas; improve the implementation of the National Health Strategy "Population Health of Tajikistan 2010-2020", with focus on immunization; improve the population's commitment to immunization and other MCH services.

In 2019, the country was awarded with CCEOP in the amount of (amount?) and HSS Additional Funds (US$ 4,5 million)  to further contribute to HSS objectives.

According to the Partnership Framework Agreement, the first level of coordination mechanism - the Technical Working Group (TWG) has been established and regular meeting conducting with the purpose of coordination of the day to day management of HSS Programme.  The TWG consists of technical and programmatic staff of the implementing partners – MoHSPP, RCIP, UNICEF, WHO, UNDP, and works in close collaboration with the Gavi Secretariat. The TWG is chaired by the Deputy Minister of Health and Social Protection of Population and secretariat is coordinated by the WHO Country Office. The TWG carries out periodic review and progress assessment of the Project activity and contributes to establishing mechanisms for the project sustainability in Tajikistan.

The Technical Working Group will work together with the Interagency Coordination Committee will to ensure coordination, synergies and complementarities in implementing HSS and CCEOP grants and introducing pneumococcal vaccine.

HSS, HSS Additional Funds, CCEOP and TCA support have been used to address immunization programmatic challenges, that may negatively affect introduction of pneumococcal vaccine. In particular, HSS funds will be used to extend a performance-based financing pilot project to Khatlon, Sughd, DRS, and GBAO oblasts to increase the salary and motivate the health care workers and reduce turnover of medical staff in primary health care facilities and improve quality of primary health care. In addition, HSS and TCA funds will be used to conduct IP and MLM trainings for front line medical workers and immunization staff. These trainings will help to increase quality of immunization data and their use by health care workers for improvement of immunization programme performance. They will also improve managerial capacity of immunization staff and will contribute to enhancing and optimizing their immunization-related work.

The MoH utilized the HSS and CCEOP grants to establish adequate vaccine storage capacity to address future programme needs at the national vaccine store, sub-national and district level stores. The MoH developed and implemented Cold Chain Rehabilitation & Maintenance Plan, which included procurement and instalment of additional cod chain equipment. With this upgrade the volume of cold chain has reached required 400.5 $cm^3$ per fully vaccinated child at central and 405.3 $cm^3$ per fully vaccinated child at district vaccine stores and is sufficient to accommodate pneumococcal vaccine and HPV vaccine, which are planned to be introduced in future. In 20201, the HSS finds will be used to conduct trainings for vaccine stores staff to improve management of all vaccines, including the new pneumococcal vaccine.
HSS funds has been used to implement the Data Quality Improvement Plan, including simplification and standardization of immunization reporting system and trainings of medical workers on new reporting mechanisms. In 2020-2021, the NIP will continue the Plan implementation to improve the accuracy of coverage estimates, including PCV coverage and the use of immunization data to improve immunization programme performance.

The HSS funds has been utilized to overcoming key barriers for reaching high coverage and equity of routine immunization, which will contribute to generating demand and providing equal access to pneumococcal vaccine. The NIP conducted the Knowledge, Attitude, Practice and Behavior Survey and developed and has been implementing Immunization Communication and Social Mobilization Strategy to address challenges with parental and medical workers vaccine safety concerns. The implemented activities, including building capacity of medical workers in interpersonal communication, will contribute to better acceptance of pneumococcal vaccine. The findings and recommendations of KAPB survey will be used to develop and implement a Social mobilization and communication plan for PCV Introduction.

The PCV introduction will also contribute towards reaching the goals and objectives of HSS and CCEOP support. The trainings for medical workers on PCV introduction will contain refresher trainings on microplanning, immunization information, vaccine management, AEFIs, and interpersonal communication. These trainings will help to improve medical workers capacity to accurately record and report immunizations, estimate coverage and use immunization data to improve immunization progamme performance. The medical workers will improve their skills in detecting and reporting AEFIs and ensuring proper vaccine storage and adequate injection safety practices. The trainings conducted prior to the introduction of PCV will contribute to increasing medical workers' confidence in all vaccines and improve their capacity to effectively communicate with vaccine hesitant parents. The education materials developed for PCV introduction will include information about benefits and safety of immunization in general and will provide parents with references to trusted sources of information.

### 3.5.8 Integrated disease control, existing interventions

**Please describe any existing interventions for the prevention and treatment of pneumonia and diarrhoea and the status of implementation.**

Tajikistan has been implementing Integrated Management of Childhood Illness (IMCI) since 1998. The implementation of IMCI improved management of childhood illness and the quality of advice for care, assisted in the conduct of preventive interventions and fostered the timely referral of seriously ill children to hospital. The IMCI also helped to optimize the quality of care delivered by primary health care outpatient facilities. IMCI facilitated establishment of regular behavioral patterns for parents, improved nutrition and disease prevention and appropriate management of the treatment prescribed.

The IMCI contributed to the reinforcement and scaling-up intervention to prevent and control of pneumonia and diarrheas and to the improvement of quality of care. According to 2017 DHS, 70% of infants receive predominantly breastfeeding until the age of 6 months and 72% of children are continuingly breastfed until the age of 12-15 months. Parents of 69% of children with acute respiratory infection syndrome under age of 5 sought for medical advice or treatment form health care provide and health care facility.

Tajikistan has successfully introduced Hib-containing pentavalent vaccine and has been reporting high coverage (above 95%) since the introduction. The country traditionally reports high coverage (above 95%) with the first and the second doses of measles vaccine.

As the result of implemented activities, the under 5 mortality in Tajikistan reduced from 83 death per 1000 live births in 1998 to 340 deaths per 1000 live births in 2019. According to the Global Health Observatory, the mortality of children under 5 years of age due to acute lower respiratory infections reduced from 20 deaths per 1,000 live births in 2000 to 6 deaths per 1000 live births in 2017. The introduction of PCV will contribute to further reduction of morbidity and mortality due to pneumonia and other pneumococcal diseases in young children.

### 3.5.9 Integrated disease control, barriers

**Please provide any considerations for how vaccination could strengthen delivery and communication of additional health interventions. Please highlight any barriers that you may foresee with integrating vaccination with other health interventions.**

Suboptimal level of infant breastfeeding remains an area for improvement in Tajikistan, causing preventable deaths and delaying children's physical and cognitive development. According to the Demographic Health Survey 2017, only 36% of infants receive exclusive breastfeeding at the age from 0 - 5 months. The medical care seeking behavior of parents also needs the improvement. Parents of 30% of children under 5 years of age with symptoms of acute respiratory syndrome do not seek for medical workers advice.

The MoH plans to provide integrated delivery and communication of health interventions aiming to reduce child morbidity and mortality due to pneumonias through creating synergies between IMCI interventions and PCV introduction activities. The communication and social mobilization activities implemented prior to PCV introduction, including information materials for parents will

contain messages to improve community knowledge and promote healthy child feeding practices, including breastfeeding and improve parental health care seeking behavior.

The training for frontline healthcare workers on PCV introduction will be used as an opportunity to improve medical workers knowledge and skills in promoting appropriate child nutrition as well as providing effective treatment of pneumonias.

The MoH does not foresee significant barriers with integrating vaccination with other health interventions because immunization is integrated in the primary health care in Tajikistan. The immunization service is provided to all population free of charge by primary health care facilities. The general practitioners and community nurses deliver vaccinations and implement IMCI, including promotion of health nutrition and health care seeking behavior among parents, as well as treatment of childhood diseases and referral for hospital care.

## 3.6 Report on Grant Performance Framework

### Grant Performance Framework – Application Instructions

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

**Required**

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

**Optional**

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

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

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

## 3.7 Upload new application documents

### 3.7.1 Upload new application documents

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

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

**Application documents**

| | | |
|---|---|---|
| ✓ | **New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline**<br>If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication. | PCV Plan TJK RUS final_19-01-21_16.07.31.docx |
| ✓ | **Gavi budgeting and planning template** | Budgeting and Planning Template TJK Final_19-01-21_16.07.52.xlsm |
| ✓ | **Most recent assessment of burden of relevant disease**<br>If not already included in detail in the Introduction Plan or Plan of Action. | TajikistanHibSpnDiseaseBurden27Jul09_19-01-21_16.08.28.pdf |

**Endorsement by coordination and advisory groups**

✓ **National coordination forum meeting minutes, with endorsement of application, and including signatures** — Протокол МКК №1_19-01-21_16.15.52.pdf

✓ **NITAG meeting minutes**

with specific recommendations on the NVS introduction or campaign — Мактуби НТКПИ_19-01-21_16.09.20.docx

### Vaccine specific

**Other documents (optional)** — **No file uploaded**

# 4 Review and submit application

## 4.1 Submission Details

### Country vaccine funding summary

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

**Active Vaccine Programmes**

*Note 11*

IPV Routine

| | 2020 | 2021 | 2022 |
|---|---|---|---|
| Country Co-financing (US$) | | | |
| Gavi support (US$) | 628,496 | 626,044 | 623,109 |

Pentavalent Routine

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Country Co-financing (US$) | 153,227 | | | | |
| Gavi support (US$) | 736,433 | | | | |

Rota Routine

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Country Co-financing (US$) | 172,831 | | | | |
| Gavi support (US$) | 1,015,921 | | | | |

**Total Active Vaccine Programmes**

| | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| Total country co-financing (US$) | 326,058 | | | | |
| Total Gavi support (US$) | 2,380,850 | 626,044 | 623,109 | | |
| Total value (US$) (Gavi + Country co-financing) | 2,706,908 | 626,044 | 623,109 | | |

**New Vaccine Programme Support Requested**

Pneumococcal routine

| | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|
| Country Co-financing (US$) | 33,000 | 174,500 | 171,500 | 177,500 |
| Gavi support (US$) | 471,000 | 2,519,500 | 2,474,000 | 2,562,000 |

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

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

| 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Total country co-financing (US$) | 326,058 | | 33,000 | 174,500 | 171,500 |
| Total Gavi support (US$) | 2,380,850 | 626,044 | 1,094,109 | 2,519,500 | 2,474,000 |
| Total value (US$) (Gavi + Country co-financing) | 2,706,908 | 626,044 | 1,127,109 | 2,694,000 | 2,645,500 |

## Contacts

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

| Name | Position | Phone Number | Email | Organisation |
|---|---|---|---|---|
| Fayzoli Saidzoda | General Director Republican Center for Immunization | +992 37272694 | sfb-65@mail.ru | Republican Center for Immunization |

## Comments

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

No Response

## Government signature form

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

Pneumococcal routine

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

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

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

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

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

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

| **Minister of Health (or delegated authority)** | **Minister of Finance (or delegated authority)** |
|---|---|
| Name | Name |
| Date | Date |
| Signature | Signature |

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

**Minister of Education (or delegated authority)**

Name

Date

Signature

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

# Appendix

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

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

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

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

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

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

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

### NOTE 4
* For PCV administration to infants, WHO recommends: 3 primary doses (the 3p+0 schedule); or 2 primary doses plus a booster (the 2p+1 schedule). If the 3p+0 schedule is used, vaccination can be initiated as early as 6 weeks of age with an interval between doses of 4-8 weeks, with doses given at 6, 10, and 14 weeks or at 2, 4, and 6 months, depending on programmatic convenience. If the 2p+1 schedule is selected, the 2 primary doses should be given during infancy as early as 6 weeks of age at an interval preferably of 8 weeks or more for the youngest infants and 4-8 weeks or more between primary doses for infants aged 7 months. One booster dose should be given between 9-15 months of age. In 2015, the Strategic Advisory Group of Experts on Immunization (SAGE) reviewed the evidence on the administration of multiple injectable vaccines during the same visit and found that evidence supports co-administration. Therefore, countries should not make modifications to recommended

immunisation schedules with the aim of preventing multiple injections during the same visit when such modifications are not evidence-based.

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

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

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

* The wastage rate applies to first and last dose.

### NOTE 5
For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

### NOTE 6
Note: the basis for the calculation of the VIG or Ops amount will be 100% of the population in the target age cohort.

### NOTE 7
Co-financing requirements are specified in the guidelines.

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

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

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

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