GAVI/13/174/sc/pe

The Secretary of State for Health
Department of State for Health and Social Welfare
The Quadrangle
Banjul
The Gambia

09 April 2013

Dear Minister,

Gambia's Proposal to the GAVI Alliance

I am writing in relation to the Gambia's proposal to the GAVI Alliance for New Vaccines Support for Rotavirus vaccines and Meningitis A Preventive Campaign**,** which was submitted to the GAVI Secretariat in August 2012.

Following a meeting of the GAVI Executive Committee (EC) on 15 February 2013 to consider the recommendations of the Independent Review Committee (IRC), I am pleased to inform you that Gambia has been approved with clarifications for Rotavirus vaccine and Meningitis A Preventive Campaign as specified in the Appendices of this letter. GAVI support also includes vaccine introduction grant and operational support which were approved by the DCEO on 27 March 2013.

In relation to your proposal for Rotavirus vaccines and a Meningitis A Preventive Campaign, Gambia has provided a satisfactory response to the clarifications that were required by the IRC.

The country will co-finance the procurement of Rotavirus vaccine in accordance with the GAVI co-financing policy, and the terms and conditions of this letter and its Appendices.

Meningitis A preventive campaigns are exempt from co-financing, however the country will cover the cost of the vaccines when the GAVI-supported campaign has reached its completion.

For your information, this document contains the following important attachments:
Appendix A: Description of approved GAVI support to Gambia
Appendix B: Financial and programmatic information for Rotavirus vaccine and Meningitis A
Appendix C: A summary of the IRC Report
Appendix D: The terms and conditions of GAVI Alliance support

The GAVI Alliance has recently sent a new Partnership Framework Agreement (PFA) designed to improve the ease and efficiency for countries to understand the GAVI requirements, all in one clear and standardised document. For ease of reference, the PFA will include Appendices in the same format as Appendix B.

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The following table summarises the outcome for each type of GAVI support applicable to Gambia:

New Vaccines Support *Type of vaccine*	**Approved for the first year**	**Approved for the second year**
Rotavirus	US$ 973,000	US$ 816,500
Rotavirus Vaccine Introduction Grant	US$ 100,000	-
Meningococcal A Preventive Campaign	US$ 792,500	-
Meningococcal A Operational support	US$727,500	-

Please do not hesitate to contact my colleague Par Eriksson - periksson@gavialliance.org if you have any questions or concerns.

Yours sincerely,

Hind Khatib-Othman
Managing Director, Country Programmes

cc: The Minister of Finance
The Director of Medical Services
Director Planning Unit, MoH
The EPI Manager
WHO Country Representative
UNICEF Country Representative
Regional Working Group
WHO HQ
UNICEF Programme Division
UNICEF Supply Division
The World Bank

Appendix A

Description of GAVI support to *Gambia* (the "Country")

New Vaccines Support (NVS)

The GAVI Alliance has approved the Country's request for supply of vaccine doses and related injection safety material which are estimated to be required for the 2013 and 2014 immunization programme as set out in Appendix B. Financing provided by GAVI for vaccines will be in accordance with:

- The GAVI Alliance Guidelines governing Gambia's proposal application; and
- The final proposal as approved by the IRC, including any subsequent clarifications.

The rotavirus vaccines provided will be used for routine immunisation of children under 12 months of age. The MenA vaccines provided are to be used for the MenA Preventive campaign to immunize the target population as indicated in the proposal The principles of the WHO-UNICEF-UNFPA joint statement on safety of injections (WHO/V&B/99.25) shall apply to all immunisation provided with these vaccines.

Item number 11 of Appendix B summarises the details of the approved GAVI support for vaccines in 2013 and 2014.

Any required taxes, customs, toll or other duties imposed on the importation of vaccines and related supplies cannot be paid for using GAVI funding.

GAVI is not responsible for any liability that may arise in connection with the distribution or use of vaccines and related supplies after title to such vaccines and related supplies has passed to the country, excluding liability for any defect in vaccines and related supplies, which remain the responsibility of the applicable manufacturer.

Country Co-financing

In accordance with the GAVI Co-financing Policy, the Country has agreed to make the required contribution to co-financing rotavirus vaccine doses in 2013. Item number 14 of Appendix B summarises the budget and the quantity of supply that will be procured with country's funds in 2013. The total co-financing amount indicates costs for the vaccines, related injection safety devices and freight.

Countries may select to co-finance through UNICEF Supply Division, PAHO's Revolving Fund, or self-procure their co-financing requirement following their own procedures, except for the Pneumococcal vaccine that needs to be procured through UNICEF.

If the purchase of the co-financed supply is carried out through UNICEF or PAHO, the payment is to be made to UNICEF or PAHO (whichever is applicable) as agreed in the Procurement Services Memorandum of Understanding between UNICEF or PAHO (whichever is applicable) and the country, and not to the GAVI Alliance. Please keep in contact with UNICEF or PAHO (whichever is applicable) to understand the availability of the relevant vaccine(s) and to prepare the schedule of deliveries.

The total co-financing amount expressed in item number 14 of Appendix B does not contain costs and fees of the relevant Procurement Agency, such as contingency buffer and handling fees.

Information on these extra costs and fees will be provided by the relevant Procurement Agency as part of the cost estimate to be requested by the country.
UNICEF/PAHO will share information with GAVI on the status of purchase of the co-financed supply. In accordance with the GAVI Co-financing Policy (http://www.gavialliance.org/about/governance/programme-policies/co-financing/), the co-financing contribution is payable annually to UNICEF/PAHO.

If the purchase of the co-financed supply is carried out by the Government, following its own procurement procedures and not procuring from UNICEF Supply Division or PAHO, the Government must submit to GAVI satisfactory evidence that it has purchased its co-financed portion of the vaccines and related supplies, including by submitting purchase orders, invoices, and receipts to GAVI. GAVI strongly encourages that countries self-procuring co-financed products (i.e.auto-disable syringes and syringe and needle disposal boxes) ensure that products appear on the applicable WHO list of pre-qualified products or, for syringe and needle disposal boxes, that they have obtained a certificate of quality issued by a relevant national authority.

GAVI support will only be provided if the Country complies with the following requirements:

Transparency and Accountability Policy(TAP): Compliance with any TAP requirements pursuant to the GAVI TAP Policy and the requirements under any Aide Memoire concluded between GAVI and the country.

Financial Statements & External Audits: Compliance with the then-current GAVI requirements relating to financial statements and external audits.

Grant Terms and Conditions: Compliance with GAVI's standard grant terms and conditions (attached in Appendix D).

Country Co-financing: GAVI must receive proof of country co-payment from the Country such as invoices or shipment receipts if neither UNICEF nor PAHO is the procurement agent for country co-financed vaccine for the prior calendar year.

Monitoring and Annual Progress Reports: Gambia's use of financial support for the introduction of new vaccinations with Rotavirus and Meningitis A vaccine(s) is subject to strict performance monitoring. The GAVI Alliance uses country systems for monitoring and auditing performance as well as other data sources including WHO/UNICEF immunization coverage estimates. As part of this process, National Authorities will be requested to monitor and report on the numbers of children immunised and the delivery of funds to co-finance the vaccine.

Gambia will report on the achievements and request support for the following year in the Annual Progress Report (APR). The APR must contain information on the number of children reported to have been vaccinated with DTP3 and 3 doses of pentavalent vaccine by age 12 months, based on district monthly reports reviewed by the ICC, and as reported to WHO and UNICEF in the annual Joint Reporting Form (JRF). The APRs will also contain information on country's compliance with the co-financing arrangements outlined in this letter. APRs endorsed by the ICC, should be sent to the GAVI Secretariat no later than 15 May every year. Continued funding beyond what is being approved in this letter is conditional upon receipt of satisfactory Annual Progress Reports and availability of funds.

Appendix B-1

ROTAVIRUS VACCINE SUPPORT

This Decision Letter sets out the Programme Terms

1. **Country:** Gambia
2. **Grant Number:** 1316-GMB-13a-X / 13-GMB-08b-Y
3. **Decision Letter no:** 1
4. **Date of the Partnership Framework Agreement:** N/A
5. **Programme Title:** New Vaccine Support
6. **Vaccine type:** Rotavirus
7. **Requested product presentation and formulation of vaccine:** Rotavirus 3 doses
8. **Programme Duration[1]:** 2013 - 2016
9. **Programme Budget (indicative): (subject to the terms of the Partnership Framework Agreement)**

	2013	2014	2015	2016	Total[2]
Programme Budget (US$)	US$973,000	US$816,500	US$847,000	US$890,000	US$3,526,500

10. **Vaccine Introduction Grant:** US$ 100,000 payable up to 6 months before the introduction
11. **Indicative Annual Amounts (subject to the terms of the Partnership Framework Agreement):[3]**

Type of supplies to be purchased with GAVI funds in each year	2013	2014
Number of Rotavirus vaccines doses	264,600	221,900
Annual Amounts (US$)	US$973,000	US$816,500

12. **Procurement agency:** UNICEF
    The Country shall release its Co-Financing Payments each year to UNICEF.
13. **Self-procurement:** N/A

[1] This is the entire duration of the programme.
[2] This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table.
[3] This is the amount that GAVI has approved.

14. Co-financing obligations: Reference code: 1316-GMB-13a-X-C
According to the Co-Financing Policy, the Country falls within the Low Income group. The following table summarises the Co-Financing Payment(s) and quantity of supply that will be procured with such funds in the relevant year.

Type of supplies to be purchased with Country funds in each year	**2013**	**2014**	**2015**	**2016**
Number of vaccines doses	9,900	8,600	9,000	9,500
Value of vaccine doses (US$)	US$34,509			
Total Co-Financing Payments (US$) (Including freight)	US$36,500	US$30,500	US$32,000	US$33,500

15. Operational support for campaigns: N/A

16. Additional documents to be delivered for future disbursements: The Country shall deliver the following documents by the specified due dates as part of the conditions to the approval and disbursements of the future Annual Amounts.

Reports, documents and other deliverables	Due dates

17. Clarifications: N/A

18. Other conditions: N/A

Signed by
On behalf of the GAVI Alliance

Hind Khatib-Othman
Managing Director, Country Programmes
02 April 2013

Appendix B-2

MENINGITIS A VACCINE SUPPORT

This Decision Letter sets out the Programme Terms

19. Country: Gambia

20. Grant Number: 13-GMB-16a-X / 13-GMB-17a-Y

21. Decision Letter no: 1

22. Date of the Partnership Framework Agreement: N/A

23. Programme Title: New Vaccine Support

24. Vaccine type: Meningitis A

25. Requested product presentation and formulation of vaccine: Meninigitis A, 10 dose(s) per vial, LYO

26. Programme Duration[4]: 2013

27. Programme Budget (indicative): (subject to the terms of the Partnership Framework Agreement)

	2013	2014	2015	2016	Total[5]
Programme Budget (US$)	US$792,500				US$792,500

28. Vaccine Introduction Grant: N/A

29. Indicative Annual Amounts (subject to the terms of the Partnership Framework Agreement):[6]

Type of supplies to be purchased with GAVI funds in each year	2013
Number of Meningitis A vaccines doses	1,242,500
Number of AD syringes	1,242,100
Number of re-constitution syringes	138,000
Number of safety boxes	15,325
Annual Amounts (US$)	US$792,500

30. Procurement agency: UNICEF

31. Self-procurement: N/A

[4] This is the entire duration of the programme.
[5] This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table.
[6] This is the amount that GAVI has approved.

32. Co-financing obligations: Reference code: N/A

According to the Co-Financing Policy, the Country falls within the Low Income group. The following table summarises the Co-Financing Payment(s) and quantity of supply that will be procured with such funds in the relevant year.

Type of supplies to be purchased with Country funds in each year	2013	2014	2015	2016
Number of vaccines doses				
Number of AD syringes				
Number of re-constitution syringes				
Number of safety boxes				
Value of vaccine doses (US$)				
Total Co-Financing Payments (US$) (Including freight)				

33. Operational support for campaigns: The support for operational costs for campaign will be disbursed in cash through UNICEF. The Country will need to contact the local UNICEF office to arrange the utilisation of GAVI funds to support the operational costs of the campaign.

	2013	2014
Grant amount (US$)	US$727,500	

34. Additional documents to be delivered for future disbursements: Not applicable

Reports, documents and other deliverables	Due dates

35. Clarifications: The Country shall provide the following clarifications prior to the disbursement of the Annual Amount in 2013: N/A

36. Other conditions: N/A

Signed by
On behalf of the GAVI Alliance

Hind Khatib-Othman
Managing Director, Country Programmes
02 April 2013

Appendix C

IRC NVS COUNTRY REPORT
Geneva, 8th – 19th October 2012

Type of support requested: **NVS**
Vaccines requested: **Rotavirus (3-dose schedule)**
Meningogoccal A Preventive Campaign

Country profile/Basic data (year)

Population [Est.]	1,734,278	Infant mortality rate (2003 Census)	75/1000
Birth cohort [JRF 2011]	77,584	Govt. Health expenditure	8%
Surviving infants [JRF 2012]	71,842	GNI/capita (year)	$740
DTP3 coverage (administrative)	96%	Co-financing country group*	Low income

*low income, intermediate or graduating

1. Type of support requested/Total funding/Implementation period

Vaccines and support requested:

1. Rotavirus vaccine in 1 dose vial, fully liquid, for 3 dose schedule.
   Amount requested: US$ 3,523,500 for vaccines and related supplies.
   Period: 2013-2016.
   New vaccine Introduction grant.
   Amount requested: US$ 100,000
2. Meningogoccal, 10 doses per vial, liquid.
   Amount requested; US$ 354,829.
   Period: 2013.

2. History of GAVI support

As may be seen in the tables below, there is a fairly long history of support by GAVI. The cMYP also shows that there has been GAVI support for almost every aspect of the country's immunisation programme.

Table 1. Vaccine support

NVS and INS support	Approval Period
Hep B	2002-2008
Hib mono	2002
DTP-Hib	2002-2008
DTP-HepB-Hib	2009-2015
Pneumococcal (PCV10)	2009-2011
Pneumococcal (PCV13)	2009-2015
Measles	2012-2016
INS	2002-2004

Table 2. Cash Support

Cash support	Approval Period
ISS 1	2002-2006
ISS 2	2007-2011
HSS	2010-2011

Total amount approved to date: US$18,736,875.

3. Composition & Functioning of the ICC

There is an ICC on which the relevant stakeholder and in-country partners are represented. Civil Society Organisations are represented; specifically, there are representatives of the Red Cross, Rotary, Action Aid and the Child Fund. The minutes report discussions of the need for the inclusion of the private sector. However, to date, there is no evidence that this has been done. The minutes [two for 2012] also show active discussions of the immunisation issues and needs, the plans for the introduction of the new vaccines, as well as those for the development of the proposals. As yet, there does not appear to be a NITAG.

4. Status of the National Immunisation Programme

The Gambia has been able to maintain high immunisation coverage levels – over 90% - since 2005. It has also successfully introduced new vaccines: HepB in 1990; *Haemophilus* type b in 1997; Pneumo in 2009; and Measles 2nd dose in 2012. The current proposals for the introduction of Rota into the routine immunisation system and the implementation of a prevention campaign for MenA are based on hospital admissions data, survey data and some surveillance data, all of which show the continuing seriousness of the disease burdens in these areas. The Gambia is in the Meningitis belt and there have been a number of outbreaks. It is hoped that this campaign targeted at persons aged 1-29 years old will build up the herd immunity so that this vaccine can then be incorporated into the routine immunisation programmes.

On the matter of gender, the country does not currently report on sex-disaggregated data, as the plans to record their data have only just been put in place. However, the proposal suggests that given the high immunisation coverage levels, there are unlikely to be any gender barriers in immunisation coverage. Laboratory surveillance in 2011 showed a total of 1,582 confirmed measles cases, of whom 8.5% were vaccinated, 74% were not vaccinated and 17.6% vaccination for whom vaccination status was unknown. It would have been useful to see a map of the distribution of the cases of measles by the 3 categories, vaccinated, not vaccinated and unknown. There is a passing reference to possible problems of coverage and access that may be related to poverty. However, this is not followed up anywhere, and the proposal states that given the topographical and demographic layout of the country, as well as high political will and commitment and good levels of community participation, there are no serious problems with equal access to the decentralised immunisation network. The proposal also notes that no surveys have found any problems in these areas.

A number of health system problems have been identified in the cMYP and in the reviews of past programmes. The principal weaknesses have been the availability of adequately and appropriately trained staff; the efficiency and effectiveness of the supervisory systems; the adequacy of the surveillance system; the insufficiency of the cold chain storage systems – especially at the sub-national levels; the need for an AEFI technical committee to ensure improved service delivery; the limited capacity to properly forecast vaccine needs and to calculate wastage and drop-out rates; and the difficulties in maintaining the levels of communication that can usefully support the immunisation network. There have been attempts to address these, and it is hoped that the funds now being requested will further help to tackle some of the weaknesses identified. In this proposal, there are further activities [namely, the purchase of freezers, vaccine carriers and small ice-packs] to expand

the cold chain capacity and particular emphasis is being placed on training, social mobilisation, monitoring and evaluation, communication and advocacy.

5. Comprehensive Multi Year Plan (cMYP) overview

The application and the period for implementation are in line with the cMYP for 2012-16. There is an adequate situational analysis of the status of the immunisation programmes in the country, and there are plans [with associated budgets] for the introduction of Rota and the preventive campaign for Meningitis. There is also a separate document on plans for the introduction of New Vaccines, which has been incorporated into the cMYP. The Plan also focuses a great deal of attention on the existing weaknesses in the immunisation system; it has described some of the corrective measures taken – especially in the areas of cold chain capacity extension, the provision of training on bundling principles, on monitoring of immunisation services [including AEFI], and on the monitoring of wastage and drop-out rates. Other activities to address identified problem areas were a review of the data collection tools and the implementation of staff motivation schemes. There are some remaining problems [and as stated in the proposal]: one is that "some of these incinerators are in a state of disrepair and would need to be rehabilitated before the introduction of the vaccine." There are also frequent references in the proposal and the cMYP to the factors that continue to hamper the surveillance, communication and supervision systems, the ability to monitor stocks, the preparation of operational plans and the high staff attrition (30-60%) levels.

There is no available National Plan; it is therefore not possible to determine whether or not the national objectives and planning strategies are appropriately defined and take into consideration the new introduction. Neither is it possible to identify any apparent or perceived linkages between cMYP and broader Health Sector planning.

EPI is well linked to other programmes e.g. Epidemiology and Disease Control, National Malaria Control, Leprosy/Tuberculosis Control, Integrated Management of Neonatal and Childhood Illnesses (IMNCI), National Aids Control Programme (NACP) and the Health Education Unit (HEU).

6. New vaccine introduction plan

The new vaccines being requested are appropriate in light of the disease burden reported for the country. However, it is difficult to properly assess the new vaccine introduction plan, as there is little specification of the actual preparatory and introduction grant activities that are to be conducted. Instead, only the broad activity categories have been used. A search for guidance from the Plan for NVS that has also been provided does not necessarily help, as although the same broad categories are utilized there is no specific description of what is to be done and - with the exception of the figure for Programme management - the budget allocations are different.

The activity areas described do indicate the intention to apply some of the lessons learned from previous efforts to introduce new vaccines. Thus, there will be a focus on sensitisation and training and on a review of the data monitoring tools so as to improve surveillance. However, very little is said about what, if anything, is to be done in the area of increasing staff motivation and commitment. The NVS plan states that there are plans to use funds provided by the GAVI and Global Fund HSS programmes. More clarity is required about what is to be done.

Examination of the cMYP does not provide more clarity, as the content of the broad categories is not always the same. Thus, for example, programme management in one case involves a range of supervisory activities, while in the cMYP it only refers to office facilities and supplies, the acquisition of IT equipment, and the conduct of operational research. As a result of this broad brush sweep and the difficulty in linking with the proposed activities in the cMYP, it is difficult to determine what exactly is to be done and the possible added value of the proposed activities. More important, however, is whether the proposed activities significantly address the significant problems that remain in the country. There is mention of plans to assist with micro-planning [an identified deficiency], but

it cannot be assumed that training trainers and the conduct of social mobilization activities will necessarily solve the problems of staff attrition and high movement levels or remove the current hindrances in the communication and supervisory systems, or solve the continuing difficulties with stock management, forecasting vaccine needs, and vaccine distribution, or address the limited capacity of staff at operational level to calculate wastage and drop-out rates. It would be useful to have some information on how the major problems of frequent staff movement and staff attrition or the removal of blockages to the conduct of good supervisory practices are to be handled [no doubt with the use of funding from other sources], and what – if any - might be the contribution of or linkages with the activities to be carried out under these grants.

The bases for the budgetary amounts requested are also not stated. In a bid to ensure quality mass vaccination campaign, additional freezers would be required at regional level for ice pack production. It is also stated that "part of the introduction grant would be used for the purchase of ten freezers to be distributed to the regions. In addition, 500 vaccine carriers and 1,000 small ice packs would be needed for the campaign." However, it is not clear how much of the budgetary allocation for cold chain equipment and maintenance in the budget is to pay for these acquisition costs. Also, there is a significant proportion allocated to human resources. It is necessary to see what this entails.

The mode of administration for rotavirus vaccine has been incorrectly stated in the Introduction Plan as intramuscular instead of oral, and the country has asked for LIQUID vaccine but the WHO pre-qualified vaccine is lyophilized. This needs to be adjusted. Procurement will be done by UNICEF.

Finally, there are some possible issues with the figures being used to calculate need and the requested budgets. There is an inconsistency in the population targets used: in the Costing tool (calculations G1171) campaign TP is 881,600 for 2014; GAVI proposal campaign target population for 2013 is 1,118,926. This proposal for the campaign also has the problem of an expectation of an anticipated buffer stock of 25% for the MenA campaign.

7. Improvement plan

The cMYP, as well as the proposal, has identified a number of strengths and weaknesses in the immunisation system. The EVM has also described some of these. There have been efforts to address these – especially in the areas of improving the cold chain capacity and the facilities for waste management, improving the data collection tools, the conduct of training to improve staff capacity levels, and the implementation of staff motivation schemes. The extent of the progress has not been identified but the country believes that they have been successful and previous experiences have provided important lessons for the current plans to introduce the new vaccines.

8. Cold chain capacity

An EVM was conducted in June 2011. The results of the assessment for the three levels of the cold chain system show that at the national level there were significant problems in the areas of vaccine distribution and management and the maintenance of the required storage temperatures. At the regional and health centre levels, there were problems in the areas of stock management, vaccine distribution and management, the information system, and the maintenance of the required storage temperature. Following the EVM assessment recommendations, an improvement plan was developed and implemented at the national, regional and health centre vaccine stores. Training needs of health staff, maintenance of cold chain equipment and supplies for procurement were also included in the recommendations. There is now adequate – and even excess – storage capacity. A separate estimation of the vaccine storage capacity was also done for the National level and the results support the country findings of sufficient vaccine storage capacity. The country has made great strides in improving the cold chain system. There are some areas that are still in progress. It is expected that all elements will be in place within the targeted time.

9. Financial Analysis

The country is proposing a one-time Men A campaign of 1-29 years of age in November 2013. The proposed budget appears to be less than US$ 0.65 per target population member maximum as per the GAVI campaign policy. GAVI campaign operational cost support of US$ 0.354 million has been estimated at the aggregate level using a target population estimate of 1,118,926. The total operational cost of the campaign is estimated to be US$ 0.674 million, so GAVI would be supporting 52% of total costs should the campaign go ahead. The total cost of US$ 0.674 is more than the operational costs for the campaign included in the cMYP of US$ 0.456 million. A Rotavirus 3 -dose schedule introduction is also proposed, which includes an introduction grant. The grant appears to be estimated correctly (ie. US$ 100,000 if <125,000 children).

More than 60% of the GAVI support for the Men campaign will be used for human resources. The next two most important categories are training and IEC. A balance of costs of this nature could be expected. Given the large size of the human resources component, some analysis of numbers of personnel receiving support and unit costs would be welcomed by the IRC. In general, figures – including lump sums - are provided and the bases of their calculation are unknown. Only limited monies are being used for cold chain. Some details, such as to how this envelope of funds will be used between per diems, supervision etc. would be useful.

Rotavirus and MenA campaign costs are included in the cMYP. The target population appears to have been included in 2014 (cell g1251), hence the funding gap for this year. Large cost differences between vaccine procurement costs for the Men campaign in the cMYP and in the GAVI proposal are evident. For example, US$ 0.881 million for vaccines supplies in Table Annex 3.1 D of the proposal and US$ 12 million in the cMYP. A spurious price seems to have been included in cell e144 of the calculations sheet. The funding gap is large (and overstated) given the prices and consequent total campaign costs. However, no specific measures to reduce the funding gap have been identified.

The introduction grant is relatively small, but some elements of campaign's operational support grants are substantial. The estimation of large cost components, such as human resource costs, would benefit from unit cost estimates as already stated.

According to the APR 2012, all traditional antigens are financed from government sources.

10. Co-financing arrangements

The co-financing arrangements appear to be satisfactory. Co-financing is paid by the government. In the past [2008] the country defaulted, but has met its obligations since that time.

11. Consistency across proposal documents

There is reasonably good consistency between the proposal, the cMYP, and the improvement plan in that the goals and objectives are similar. The existing monitoring and data reporting systems will be utilised, but will be modified so as to include information on Rota. There are a few minor inconsistencies: one is between vaccine coverage for rotavirus in 2016 between the proposal (94%) and the Improvement Plan (90%); another is between the date for rotavirus introduction in cMYP (8.0 – 2015) and the proposal (2013). For Meningococcus, there is an inconsistency between the target population numbers and year of campaign in the proposal (1,118,926 in 2013) and in the costing tool (cMYP) (928,000 for 2014).

Finally, it is also not easy to assess the actual and more immediate needs in some of the categories utilised [e.g. programme management, and Advocacy and Mobilisation] as they have somewhat different contents.

12. Overview of the proposal: Strengths & weaknesses

Strengths:
The goals and aims of the proposal are quite clearly laid out. There are also improvements that have been undertaken in response to the EVM report and which have significantly improved the cold chain network and systems. There is a good situational analysis and the problems that continue to plague the immunisation system have been clearly identified. Lessons learned from previous vaccination campaigns efforts to integrate new vaccines into the routine systems have been identified and the proposed efforts are expected to benefit from those experiences.

Weaknesses:
It is not clear what the specific activities planned under the various categories will be, and whether or not they will significantly address some of the more critical problems in the immunisation network and system – especially those having to do with vaccine management and distribution, cold chain maintenance and temperature control, adequate supervision and communication and staff movement and attrition. If not addressed, these can easily undermine the proper integration of the rota vaccine and the medium and longer term impacts of the MenA campaign. It may well be that the vaccines are successfully introduced, but the continuing problems within the immunisation system may come to hamper progress and accomplishments in the near and medium terms. This could be a missed opportunity to begin to zero in on the problem areas that have been identified.

The bases of the budgetary calculations have not been provided. The relationship with the budgetary needs and gaps as provided in the cMYP and the NVS plan is not clear. It is therefore difficult to properly understand the meaning of and justification for the budgetary allocations proposed.

50% of costs of the implementation of the meningococcal campaign rely on other sources of funding. These sources of funding are unclear.

There are some budgetary discrepancies that need to be resolved.

13. Recommendations

Vaccine: **Rotavirus (3 dose schedule)**
Recommendation: **Approval with clarifications**

Vaccine: **Meningococcal A Preventive Campaign**
Recommendation: **Approval with clarifications**

Clarifications for both vaccine requests:

1. Please provide a more specific and focused set of activities that are intended to be carried out under the broad categories identified in Tables 6.2.5 & 7.2.2. Greater specificity here should enable a better appreciation of the complementarily between the pre-introductory and actual operation and introduction activities.
2. Please provide clearer justification of the budgetary figures presented for both the operational costs for MenA campaign and the introductory grant for Rotavirus.
3. Please ensure that budgets in the cMYP and the NVS introduction plan are consistent.
4. Please address the inconsistencies noted in Sections 6, 9 & 11 above.

GAVI Alliance Terms and Conditions

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country:

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THIS PROPOSAL

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

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

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

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance 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 Alliance 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 Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY
The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

ARBITRATION
Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance 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 language of the arbitration will be English.

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

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

USE OF COMMERCIAL BANK ACCOUNTS
The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.