Global Alliance for Vaccines and Immunisation (GAVI)

APPLICATION FORM FOR COUNTRY PROPOSALS

For Support to: ***THE GAMBIA***

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

Revised 15 January 2008

(To be used with Guidelines dated 15 July 2007)

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

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

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Executive Summary

The Gambia is one of the smallest countries on the West Coast of Africa with a total land area of 11,000 square kilometres and an estimated total population of 1.5 million (projected from the 2003 Census). The infant and under-five mortality, though, still high at 75/1000 live births and 99/1000 live births respectively are on the decline. Common communicable diseases such as malaria, diarrhoea and respiratory infections including pneumonia are the major causes of morbidity and mortality among the under-fives.

In order to ensure an effective and efficient management of a functioning Public Health Sector, the Government has in 1993 further decentralized the management of the health system; thus dividing the country into six (6) Administrative Health Divisions. The Divisional Health Management Team (DHMT) is responsible for the planning and day to day administration together with the monitoring and supervision of health services including immunization services in the division.

The Gambia health care delivery system is based on the Primary Health Care (PHC) Strategy and was adopted since 1979. The health services are delivered through a net work of many primary health posts and health facilities (11 hospitals, 6 major health centres, 20 minor health centres, 39 dispensaries and 18 other special private health institutions). These are staffed by Medical Doctors, Nurses, Public Health Officers and Community Health Workers. They provide curative, preventive, promotive (community sensitization and rehabilitation health services) and child health services including immunization.

Compared to other countries within the sub-region, The Gambia has a good track record of high immunization coverage due mainly to increased access and service utilization. Furthermore, the Gambia added hepatitis B and *Haemophilus influenzae* type b (Hib) to the traditional vaccines in 1990 and 1997 respectively. It is envisaged that the pneumococcal conjugate would be introduced in the first quarter of 2009.

Globally, pneumonia and other respiratory infections are responsible for about 2 million deaths annually. In 2005, WHO estimated that 80% of these deaths can be directly linked to *Streptococcus pneumoniae*; the most important cause of severe pneumonia. About half of these deaths occur in children less than 5 years of age, mostly in developing countries.

Pneumococcal disease has been studied in The Gambia since 1982. The annual incidence of invasive pneumococcal disease (IPD) in the Upper River Region of The Gambia was shown to be 500 per 100,000 and 250 per 100,000 in children <1 year old and <5 years old respectively. In The Gambia and other African countries, invasive pneumococcal disease rates are up to 10 fold higher than in industrialised countries and the disease is a major cause of morbidity and mortality. Increasing resistance of the pneumococcal organism to commonly used antibiotics such as penicillin is being found worldwide, thereby increasing morbidity and mortality; hence the rationale for the introduction of a vaccine that could be effective against pneumococcal disease into The Gambian EPI system.

The high burden of pneumoccocal disease in The Gambia prompted studies to assess pneumoccocal conjugate vaccines. A large-scale pneumoccocal vaccine efficacy trial was conducted in the eastern part (CRR & URR) of the country in 2000-2005 using a 9-valent pneumococcal conjugate vaccine (PCV 9) and it was found to be very efficacious. Efficacy was 37% against radiological pneumonia, 77% against IPD caused by vaccine serotypes and 50% against the disease caused by all serotypes. The vaccine also reduced all cause hospital admissions by 15% and overall mortality by 16%. After this successful trial, it was deemed necessary to introduce a pneumococcal conjugate vaccine into the EPI Programme. The schedule will be in line with other EPI antigens (e.g. DPT/Hib) at 2, 3 and 4 months. However, the plan is to switch to Pentavalent in 2009 after the introduction of pneumococcal vaccine.

Currently, the only licensed and available pneumococcal conjugate vaccine contains seven serotypes (PCV 7), which has been shown to be safe and efficacious and is used routinely in several industrialised countries. PCV 7 has been used to vaccinate controls and other children of ages <4 years in CRR and URR after The Gambian trial without any reported safety issues. Additionally, over 7000 doses of PCV-7 have been administered to Gambians across all ages in a study aimed at determining the effects of vaccination on carriage of pneumococci at a village setting in Western region without any remarkable events. PCVs have been shown to be safe, immunogenic and induce immunological memory in Gambian infants. Considering the incidence of IPD, coverage and efficacy of PCV-7, about 160 cases per 100,000 children per year can be prevented annually through vaccination.
WHO considers that it should be a priority to include this vaccine in national immunization programmes, particularly in countries where mortality among children aged < 5 years old is >50/1000 live births or where > 50,000 children die annually.

However, due to the fact that the PCV-9 is not commercially available, the country will then use the PCV 7 vaccine in 2009. Furthermore, the Gambia will switch to new formulations and presentations as soon as they are available. There are indications that vaccines with 10 and 13 serotypes including serotypes 1 and 5, which are common causes of IPD in The Gambia, are being developed. A pneumococcal surveillance system is currently being implemented to monitor the effect of PCV 7 introduction in The Gambia.

The EPI Programme, since 1988, has been using solar refrigerators at health facility level for vaccine storage. The programme maintains a good cold chain network country wide. This consists of a cold room, electric refrigerators and freezers at central level, electric and solar powered freezers and refrigerators at regional and health facility levels. The national cold chain assessment in 2007 showed that there is enough space at central level to accommodate new vaccines. It also showed that four of the divisions have vaccine stores while two are without structures to house the cold chain equipment.

As part of the process in increasing the storage capacity at all levels, UNICEF in 2007, procured a regional cold room, 40 sets of solar refrigerators, 10 Freezers and 10 Ice liners in 2007. By the end of 2008, these equipments will be installed in various health facilities and all RHTs so as to accommodate the new vaccines. It is also planned that a regional cold room will be installed in CRR by the end 2008 to help accommodate vaccines for the two regions (CRR and URR) and the other regions will be supported with additional equipment (Freezers and Ice liners). The national level will be expanded with additional ice liners, and in future, depending on the availability of funds, it is envisaged that a cold room will be installed within the Western Health Region. All these plans, once implemented, will, more than adequately store vaccines during the planned period. There are also plans to build structures in two of the regions whose equipment are currently improperly housed. Funds will be made available from the recurrent budget for the construction of the structures in the two regions by the end of 2008. This introduction is incorporated into the cMYP 2007-2011.

The Gambia had benefited from GAVI ISS support for the past five years (2002-2006) which has gone a long way in strengthen the immunization programme. In order to maintain and consolidate the gains, the country is requesting for continued support during the next five years.

Currently, waste is being managed regionally; whereby filled safety boxes with sharps are periodically transported to the RHTs for incineration. The same system will continue to be utilized. However, in the very remote areas, it is planned that concreted pits will be constructed where not available, using GAVI funds for the burying of these wastes. Pre-implementation training will help to address this issue among others.

The Gambia will introduce pneumoccocal conjugate vaccine countrywide in the first quarter of 2009. Before the introduction the following pre-implementation activities will be carried out:

- Consensus building with key partners
- Review and update of data collection tools and training manual
- Community sensitization and development of IEC materials
- Training of health staff
- Cold chain expansion
- There are also plans to review and update the EPI Policy at a later day
-

There is already an existing mechanism for monitoring and reporting routine administrative data including feedback. This includes:

- Routine administrative data
- Bi-monthly meetings are conducted at central level where routine data is being reviewed and similar meetings are held at regional level monthly

- Monthly Supportive supervisory visits at all levels

- Bi-annual cluster surveys

The same mechanism will be used to monitor pneumococcal vaccine

Reporting will be done monthly, bi-monthly, annually and bi-annually.

2. Signatures of the Government and National Coordinating Bodies

Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of **The Gambia** would like to expand the existing partnership with the GAVI Alliance for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests for GAVI support for **the introduction of new vaccine**.....

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

Table N° **6.5** of page **27** of this application shows the amount of support in either supply or cash that is required from the GAVI Alliance. Table N° **6.4** of page **26** of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

"Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of **June**. The payment for the first year of co-financed support will be around **October 2008**."

Minister of Health:

Signature: .....

Name: DR. M.S. NJIE

Date: 24-04-'08

Minister of Finance:

Signature: .....

Name: MOD A. IC SECKA

Date: 25/04/08

DEPARTMENT OF STATE FOR FINANCE & ECONOMIC AFFAIRS * BANJUL *

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

We the members of the ICC met on the **16th April 2008** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

- The endorsed minutes of this meeting are attached as DOCUMENT NUMBER: 03

Name/Title	Agency/Organisation	Signature
WHO Representative	WHO Country Office	
Country Representative	UNICEF	
Country Director	Christian Children's Funds	
Country Director	Action Aid	
Executive Secretary	Red Cross Society	
Chair Person	Rotary International	
Country Director	Catholic Relief services	
Director	MRC, The Gambia	

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

Name: Mr. Kebba MS Gibba

Title: EPI Manager

Tel No.: (220) 4227390/9943842

Address: Medical & Health Dept.,

The Quadrangle, Banjul

Fax No.: 4227390

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Email:jippson@yahoo.co.uk

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

The Inter-Agency Coordinating Committee for Immunisation

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

Profile of the ICC/HSCC

Name of the ICC: Inter-agency Cordinating Committee

Date of constitution of the current ICC: 1995

Organisational structure: stand-alone

Frequency of meetings: Quarterly

Composition: Health & Finance Departments, WHO, UNICEF, Private Sector & Civil Society Organisations

Function	**Title / Organization**	**Name**
Chair	SOS for Health	Dr. Malick Njie
Secretary	EPI Manager	Mr. Kebba MS Gibb
Members	• WHO Country Representative • UNICEF Country Representative • Country Director Action Aid • Country Director,CCF • Executive Secretary, Red Cross Society • Unit Director, MRC • Chairperson, Rotary Int'l	• Dr. Nestor Shivute • Ms. Min-Whee Kang • Dr. K. Manneh • Mr. Eustace Cassell • Mr. William Jammeh • Dr. Tumani Kora • Ms. Oumou Tall

Major functions and responsibilities of the ICC/HSCC:
-Mobilise resources for EPI activities
-Advice the EPI programme on policy issue
- Review programme plans and progress made on EPI services
-Cordinate donor support

Three major strategies to enhance the ICC/HSCC's role and functions in the next 12 months:
1. Ensure quarterly meetings are held

2. Facilitate resource mobilization activities

3.Timely and regular feed back to ICC members

3. Immunisation Programme Data

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

- Please refer to the Comprehensive Multi-Year Plan for Immunisation (or equivalent plan), and attach a complete copy (with an executive summary) as DOCUMENT NUMBER: **01**
- Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms on Vaccine Preventable Diseases and attach them as DOCUMENT NUMBERS:**02**
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.

Table 3.1: Basic facts for the year 2007 (the most recent; specify dates of data provided)

	Figure	**Date**	**Source**
Total population	1.5 Million	2007	Projected from National Census 2003
Infant mortality rate (per 1000)	75/1000	2003	National Census 2003
Surviving Infants*	61,378	2007	HMIS/National Census 2003
GNI per capita (US$)	310	2006	World bank web site
Percentage of GDP allocated to Health	320 -340	2006	Department of State for Finance Economic Affairs
Percentage of Government expenditure on Health	13%	2006	Department of State for Finance and Economic Affairs

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

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

Please indicate the name and date of the relevant planning document for health Health Master Plan, 2007-2011

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

Please indicate the national planning budgeting cycle for health Annually (January – December)

Please indicate the national planning cycle for immunisation Annually (January – December)

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

Vaccine *(do not use trade name)*	**Ages of administration** *(by routine immunisation services)*	**Indicate by an "x" if given in:**		**Comments**
		Entire country	**Only part of the country**	
BCG	At birth	X		Majority of children are given at visits clinic after birth
Polio	At birth, 2nd m, 3rd month and 4th month and 9th months	X		5 doses with a Booster at the age of 18 months
DPT/HIb	2 month, 3 months and 4 months	X		3 doses and a booster is given 1 year after the 3rd dose
Hep. B.	At birth, 2 months and 4 months	X		
Measles	At 9 Months	X		No booster (Boosted by SIAs in 2003 and 2007 respectively. Given simultaneously with Yellow fever
Yellow Fever	At 9 Months	X		Given simultaneously with measles.
TT	First contact, 1 month later, 6 months, 1 year after 3rd dose, and 1 year after the 4th dose/subsequent pregnancy.	X		12 weeks of pregnancy or first clinic contact..
Vitamin A	6 – 11months (100,000 IU), 12 – 59 months (200,000 IU given at six months interval)	X		Also given to postpartum mothers up to 6 weeks after birth

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

Trends of immunisation coverage (in percentage)						**Vaccine preventable disease burden**		
Vaccine		**Reported**		**Survey**		**Disease**	**Number of reported cases**	
		2006	**2007**	**2004**	**2005**		**2006**	**2007**
BCG		90%	95%	92.2 %	98.3 %	Tuberculosis*	NA	NA
DTP	DTP1	95%	95%	98.4 %	98.5 %	Diphtheria,	0	0
	DTP3	93%	94%	92,2 %	95.1 %	Pertussis	0	0
Polio 3		90%	94%	91.6 %	93.6 %	Polio	0	0
Measles		89%	85%	89.3	91%	Measles	34	64
TT2+ (Pregnant women)		71%	74%	79.5 %	88%	NN Tetanus	0	2
Hib3		93%	94%	92.2 %	95.1 %	Hib **	3	0
Yellow Fever		87%	85%	88.%	90.7	Yellow fever	0	6
HepB3		88%	92.3 %	94.5 %	83.% %	hepB sero-prevalence*	2	0
Vit A supplement	Mothers (<6 weeks post-delivery)							
	Infants (>6 months)				85.5 %			

* If available
** Note: JRF asks for Hib meningitis

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

The survey data for 2003 was collected in 2004 and that of 2004 was in 2005. The title of the survey was Immunisation Coverage Survey. Age group was from 11 – 23 months. WHO Cluster Survey method was used.

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

Number		Baseline and targets					
		Base year 2005	**Year 1 2009**	**Year 2 2010**	**Year 3 2011**	**Year 4 20…**	**Year 5 20..**
Births		56,810	70813	72795	74834		
Infants' deaths			5948	6115	6286		
Surviving infants		60,201	64864	66680	68548		
Pregnant women		56,810	70813	72795	74834		
Target population vaccinated with BCG		56810	65148	69883	74085		
BCG coverage*		83.4%	92%	96%	99%		
Target population vaccinated with OPV3		57,638	70813	72795	74834		
OPV3 coverage**		91.4%	92%	96%	99%		
Target population vaccinated with DTP3***		56,402	0	0	0		
DTP3 coverage**		89.5%	0	0	0		
Target population vaccinated with DTP1***		60,201	64865	66,680	68548		
Wastage[1] rate in base-year and planned thereafter			5%	5%	4%		
Target population vaccinated with **3rd dose** of Penta velant ……..			60,972	63,346	65,120		
Penta Coverage (3rd Dose)			94%	95%	95%		
Target population vaccinated with **1st dose** of Pneumo ……..			64864	66680	68548		
Wastage[1] rate in base-year and planned thereafter			5%	5%	4%		
Target population vaccinated with Measles		51,357	57081	59346	61693		
Target population vaccinated with							
Measles coverage**		81.5%	88%	89%	90%		
Pregnant women vaccinated with TT2+		45,059	58774	64064	67350		
TT+ coverage****		66.1%	83%	88%	90%		
Vit A supplement	Mothers (<6 weeks from delivery)						
	Infants (>6 months)						
Annual DTP Drop out rate [(DTP1 - DTP3) / DTP1] x 100		4.1%	4%	4%	3%		

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

Annual Measles Drop out rate (for countries applying for YF)						

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

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

	Estimated costs per annum in US$ (,000)					
Cost category	**Base year 2005**	**Year 1 2009**	**Year 2 2010**	**Year 3 2011**	**Year 4 20…**	**Year 5 20…**
Routine Recurrent Cost						
Vaccines (routine vaccines only)						
Traditional vaccines	95,870	203,606	209,615	211,902		
New and underused vaccines	447,247	1,528,169	1,667,452	1,863,531		
Injection supplies	55,084	95,131	102,907	110,726		
Personnel						
Salaries of full-time NIP health workers (immunisation specific)	9348	9,920	10,119	10,321		
Per-diems for outreach vaccinators / mobile teams (For central and regional personnel)	76896	83,946	85,625	87,337		
Transportation	8036	67,621	41,6597	43,673		
Maintenance and overheads	114516	317,006	217,901	306,088		
Training	2390	106,121	54,122	60,724		
Social mobilisation and IEC	1000	15,478	19,576	16,103		
Disease surveillance	45000	109,082	88,835	113,488		
Program management	29856	48391	46,112	67,128		
Other (Salaries of	73016	104,041	115,064	127,454		

shared health workers)						
Subtotal Recurrent Costs	**958,259**	**2,688,512**	**3,033,925**	**3,018,665**		
Routine Capital Costs						
Vehicles	0	3714	0	0		
Cold chain equipment	31000	12,333	33,555	0		
**Other capital equipment	4800	121,965	124,404	126,892		
Subtotal Capital Costs	**35800**	**138,012**	**157,959**	**126,892**		
Campaigns						
Polio	0	0	0	0		
Measles	294038	0	614,223	0		
Yellow Fever	0	0	0	0		
MNT campaigns	0	0	0	0		
Other campaigns (Meningitis/0ther outbreaks)	588076	0	0	0		
Subtotal Campaign Costs	**882,114**	**0**	**614,223**	**0**		
GRAND TOTAL	**1,876,173**	**2,826,524**	**3,806,107**	**3,145,367**		

** This include building additional outreach stations, incinerators, protective gears and office equipment

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

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

		Estimated financing per annum in US$ (,000)				
Cost category	**Funding source**	**Base year 2005**	**Year 1 2009**	**Year 2 2010**	**Year 3 2011**	**Year 4**
Routine Recurrent Cost		543,117$	1,952,756	2,025,225	2,058,526	
1. Traditional Vaccines	1. Government	95870	190166	194786	187031	
2. New and under used vaccines	2. Government /GAVI	447247	1,454.038	1,581.116	1.761.871	
3.Injection supply	3. Government	55084	109729	117882	125792	
4. Personnel (salaries of full time NIP health	4.Government	9348		10119	10321	

workers (Immunisation specific).			9930			
5.Per diems (Central and regional)	5.Government , WHO, and UNICEF	76896	83946	85625	87337	
6. Transportation	Government, WHO and Unicef	8036	44365	36773	38545	
7.Maintenance and Over heads	7.Govermnent	114516	41861	34186	35895	
8. Training	8. Government ,WHO, Uniceg and GAVI	2390	106121	54122	60724	
9.Social Mob	9. Government and Unicef	1000	15478	19576	16103	
10.Disease surveillance	10. Government and WHO	45000	129699	109865	134939	
11.Programme management	11.Goverment, WHO and Unicef	29856	91960	90552	112457	
12.Others (salaries of shared health workers	12.Government	73016	103086	113928	126130	
13.	13.					
14.	14.					
Routine Capital Costs						
1. Vehicles	1. Government, WHO and Unicef		3714	0	0	
2.Cold chain equipment	2. Government and Unicef and GAVI	31000	12333	33555	0	
3.Otther capital equipment	3. Government , WHO and Unicef	4800	125148	127651	130204	
Campaigns						
1.Polio	1.	0	0	0	0	
2.Measles	2.	294038	233831	0	0	
3. Yellow fever	3.	0	0	0	0	
4.MNT	4.	0	0	0	0	
5.Others campaigns(Meningitis and other outbreaks)	5.	294076	0	0	0	
GRAND TOTAL		**2,323.420**	**2594537**	**2,929.757**	**2,938.814**	

**** Refer to cMYP (section 2.8- Sustainable EPI Financing)**

4. Immunisation Services Support (ISS)

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

Table 4.1: Estimate of fund expected from ISS

	Base Year (2006)	**Year 1 2007**	**Year 2 2008**	**Year 3 2009**	**Year 4 2010**	**Year 5 2011**
DTP3 Coverage rate	92.6%	90%	92%	94%	95%	95%
Number of infants reported / planned to be vaccinated with DTP3 (as in Table 3.4)	**61,455	55,241	58,050	60,972	63,346	65,120
Number of *additional* infants that annually are reported / planned to be vaccinated with DTP3		0	2808	2922	2374	1774
Funds expected ($20 per additional infant)		0	56,160	58,440	47,480	35,480

* 61,455 was calculated from the 1993 population census, whilst the data for 2007 to 2011 are calculated using the 2003 population census.
*Projected figures
** As per duration of the cMYP

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

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

Major Lessons Learned from Phase 1	**Implications for Phase 2**
Cold chain expansion and maintenance These funds were used for the purchase of solar refrigerators for both regional and the health facilities. It was also used for the maintenance of cold chain equipment e.g. national cold room Fuel support for the stand-by generators given to ensure functioning of the cold chain system	Such a system will continue to ensure continuous functioning of the cold chain system
2. ***Supportive supervision*** At national level, supervisory visits were conducted monthly to all regional health teams and health facilities with support from the fund. All RHTs were supported to carry out at least a visit to each health facility monthly	This practice will continue to improve and maintain quality service delivery

3. ***Capacity Building, including long term*** Health staffs at all levels were trained on EPI services using this fund. E.g. in-service trainings	This practice will continue to improve and maintain quality service delivery
4. **Outreach services supported** Fuel support were provided to the RHTs to minimize EPI/RCH outreach clinic cancellation	This practice will continue to improve and maintain high immunization coverage and to reduce trek cancellations
5. **Surveillance system strengthened** Motorcycles were procured for surveillance activities and as back-up for outreach services	This practice will continue to facilitate case detection and follow-up for vaccine preventable diseases
6. ***Flexibility in the use of funds*** Funds were utilized to address urgent EPI problems	The flexibility of use of funds to continue to ensure timely implementation of EPI activities
7. ***ICC participation*** Spending plans were reviewed and approved by ICC	This practice would continue to ensure timely implementation of activities

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

a) when you would like the support to begin:

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

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

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

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

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

5. Injection Safety Support (THIS SECTION IS NOT APPLICABLE)

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

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

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

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

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

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

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

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

[1] GAVI supports the procurement of AD syringes to deliver two doses of TT to pregnant women. If the immunisation policy of the country includes all Women in Child Bearing Age (WCBA), GAVI/The Vaccine Fund will contribute to a maximum of two doses for Pregnant Women (estimated as total births)

[2] To insert the number of infants that will complete vaccinations with all scheduled doses of a specific vaccine.

[3] Estimates of 100% of target number of children is adjusted if a phased-out of GAVI/VF support is intended.

[4] A standard wastage factor of 2.0 for BCG and of 1.6 for DTP, Measles, TT, and YF vaccines is used for calculation of INS support

[5] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero under other years. In case of a phased introduction with the buffer stock spread over several years, the formula should read: [F – number of doses (incl. wastage) received in previous year] * 0.25.

[6] It applies only for lyophilized vaccines; write zero for other vaccines.

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

6. New and Under-Used Vaccines (NVS)

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

Globally, pneumonia and other respiratory infections are responsible for about 2 million deaths annually. In 2005, WHO estimated that 80% of these deaths can be directly linked to *Streptococcus pneumoniae* (pneumococcus); the most important cause of severe pneumonia. About half of these deaths occur in children less than 5 years of age, mostly in developing countries

Increasing resistance of the pneumococcal organism to commonly used antibiotics such as penicillin is being found worldwide, thereby, increasing morbidity and mortality.

However, there is presently a pneumoccocal conjugate vaccine containing seven serotypes of pneumococcus (PCV-7) available, which is efficacious and safe. The vaccine is already licensed in more than 70 countries and is used in routine immunization in several industrialised countries with attendant impact on morbidity and mortality caused by pneumococcal disease.

Pneumococcal disease has been studied in The Gambia since 1982. The annual incidence of invasive pneumococcal disease (IPD) in the Upper River Region of The Gambia was shown to be 500 per 100,000 and 250 per 100,000 in children <1 year old and <5 years old respectively. In The Gambia and other African countries, invasive pneumococcal disease (IPD) rates are up to 10 fold higher than in industrialised countries and the disease is a major cause of morbidity and mortality.

The high burden of pneumoccocal disease in The Gambia prompted studies to assess pneumoccocal conjugate vaccines. A large-scale pneumoccocal vaccine efficacy trial was conducted in the eastern part (CRR & URR) of the country in 2000-2005 using a 9-valent pneumococcal conjugate vaccine (PCV 9) and it was found to be very efficacious. Thus efficacy was 37% against radiological pneumonia, 77% against IPD caused by vaccine serotypes and 50% against the disease caused by all serotypes. In addition the vaccine reduced all cause hospital admissions by 15% and overall mortality by 16%. After this successful trial, it was deemed necessary to introduce a pneumococcal conjugate vaccine into the EPI Programme. The schedule will be in line with other EPI antigens (e.g. DPT/Hib) at 2, 3 and 4mnths.

The currently licensed, PCV-7 is likely to provide protection against about 50% of cases of IPD in The Gambia. Unlike the PCV-9 (with about 80% protection in The Gambia) used for the Gambian efficacy trial, PCV-7 does not include serotypes 1 and 5, which constitute about one third of IPD seen in The Gambia. PCV-7 has been shown to be safe and efficacious and is used routinely in several industrialised countries. It has been used to vaccinate controls and other children in The Gambian trial regions without any reported safety issues.

PCVs are shown to be safe, immunogenic and induce immunological memory in Gambian infants. Considering the incidence of IPD, coverage and efficacy of PCV-7, about 160 cases per 100,000 children per year can be saved annually through vaccination.

WHO considers that it should be a priority to include this vaccine in national immunization programmes, particularly in countries where mortality among children aged < 5 years old is >50/1000 live births or where > 50,000 children die annually.

However, due to the fact that the PCV-9 is not commercially available, the country will use the PCV-7 in 2009 until it will be possible to deploy the 10- and 13-valent conjugate vaccines that are being developed.

Based on the increasing antimicrobial resistance and the availability of an effective vaccine against invasive pneumoccocal diseases, the ICC advised Government to introduce PCV-7 into the routine EPI programme in line with the cMYP (2007-2011).

The outcome and impact (programmatic and epidemiological) will be monitored using the routine monitoring and evaluation system. Additionally, a joint Gambia Government and the MRC (UK) Laboratories team is currently implementing pneumococcal surveillance system aimed at monitoring the impact of PCV-7 introduction in The Gambia.

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

The EPI Programme, since 1988, has been using solar refrigerators at health facility level for vaccine storage. The programme maintains a good cold chain network country wide. This consists of a cold room, electric refrigerators and freezers at central level, electric and solar powered freezers and refrigerators at regional and health facility levels. The national cold chain assessment in 2007 showed that there is enough space at central level to accommodate new vaccines. It also showed that four of the divisions have vaccine stores while two are without structures to house the cold chain equipment.

As part of the process in increasing the storage capacity at all levels, UNICEF in 2007, procured a regional cold room, 40 sets of solar refrigerators, 10 Freezers and 10 Ice liners. By the fourth quarter 2008, these equipment will be installed in various health facilities and all RHTs so as to accommodate new vaccines. This is being fully funded by Government and UNICEF. It is also planned that a regional cold room will be installed in CRR by the end 2008 to help accommodate vaccines for the two regions (CRR and URR) and the other regions will be supported with additional equipment (Freezers and Ice liners). The national level will be expanded with additional ice liners, and in future, depending on the availability of funds, it is envisaged that a cold room will be installed within the Western Health Region. All these plans, once implemented, will more than adequately accommodate the volume of vaccine needs. Government will also provide funds to build structures in two of the regions whose equipments are currently not properly housed.

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

		Formula	Year 1 2009	Year 2 2010	Year 3 2011	Year 4 20…	Year 5 20…
A	Annual ***positive*** volume requirement, including new vaccine (specify:_____) (litres or m3)[2]	*Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine*	17777 litres	19796 litres	22742 litres		
B	Annual ***positive*** capacity, including new vaccine (specify:_____) (litres or m3)	#	11528 litres	11528 litres	11528 litres		
C	Estimated minimum number of shipments per year required for the actual cold chain capacity	*A / B*	1.54	1.74	1.97		
D	Number of consignments / shipments per year	*Based on national vaccine shipment plan*	2	2	2		
E	Gap (if any)	*((A / D) - B)*	- 2640 litres	- 1630 litres	- 157 litres		
F	Estimated cost for expansion	*US $*					

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

The Government of The Gambia being conscious of the importance of immunization created a budget line item for Immunization and is highly committed to the procurement of routine and co-financing of the new vaccines. The Government has met its financial obligation to meet the Abuja target of 15% of its overall recurrent budget to the health sector. From January 2009, the Secretary of State for Health has given directive for the inclusion of co-financing amount to be incorporated into already existing budget line for immunization services. Through the ICC and NCG, regular briefings will be held with the Secretary of State for Health to ensure that immunization remains a principal focus for funding in order to reduce childhood morbidity and mortality.

In addition, Government has qualified for the Highly Indebted Poor Countries (HIPC) funds and it is envisaged that this will enable the Government to increase its budgetary allocation for immunization. A major strategy is to use data driven tools to advocate, through technical briefings, with the DoSFEA to ensure that a substantial part of this funds is allocated to the health sector.

In addition, the Government will also mobilise additional resources from GAVI HSS /Global Funds to support immunization services especially on cross-cutting issues e.g. capacity building and outreach services.

Partners and civil society organizations will all be involve in resource mobilization activities.

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

Both the health master plan and the EPI cMYP will be used for resource mobilization to support immunization services.

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

Disease	Title of the assessment	Date	Results
Invasive Pneumonia	Pneumococcal Vaccine Trial (PCV-9)	2000-2005	9-valent vaccine was used and was found to be 77% efficacious against disease of vaccine serotype and 37% efficacious against radiological pneumonia

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

Lessons Learned from the introduction of Hepatitis B (1990) and Hib (1997)	Solutions / Action Points
Vaccine Supply Issues ➢ Failure of the manufacturer to deliver the vaccine as agreed ➢ Inadequate storage capacity for the new vaccine	➢ Adequate and sustainable vaccine financing plan should be in place ➢ Government to commit manufacturers/researchers to provide vaccines for at least five years after trial ➢ To ensure that the terms and conditions of co-financing are well understood and committed to by relevant authorities, especially in the light of the need to co-finance the new vaccines ➢ To ensure that proper storage capacity is planned
Monitoring and supervision ➢ Surveillance was weak in relationship	➢ To enhance monitoring of AEFI

to AEFI monitoring ➢ Vaccine wastage and drop-out not monitored ➢ Supervision was weak at all levels	reporting ➢ To train health staff in surveillance of AEFI ➢ To review, update and print data collection tools including AEFI ➢ To enhance the monitoring of vaccine wastage and drop-out by training of health staff and strengthen supervision
Cold Chain ➢ Solarisation of all public health facilities thereby ensuring the functional cold chain system ➢ Additional cold chain equipment and spare parts procured and installed	➢ Functional cold chain system
Capacity Building Standardized trainings conducted successfully in all the regions ➢ Revision of data collection tools ➢ Training of staff in vaccine management, administration and disposal	
Political Support ➢ Evidence-based data facilitated the advocacy with Government and this led to political will and financial support for the introduction of new vaccines. -	➢ such evidence -based data will be used to show the impact of the vaccine on morbidity and mortality among the target group to ensure continuous political support .
Human resource management ➢ High staff commitment contributed to the successful introduction of new vaccines	➢ provide motivation scheme for the health staff such in-service training, housing, mobility
Community sensitization ➢ Sensitization of communities was good and communities were very receptive to new vaccines	➢ Ensure key messages for the new vaccine are clear and consistent ➢ Ensure that health workers are trained and have skills in Inter-personal communication

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

1) Pneumoccocal Conjugate Vaccine (PCV-7) in a liquid, single dose, pre-filled syringes as per GAVI.

2) Switching from tetra to pentavalent vaccine in a liquid single dose vial in 2009

First Preference Vaccine

As reported in the cMYP, the country plans to introduce PCV-7 vaccinations, using the liquid, pre-filled syringes vaccine, in single dose *liquid* form.

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

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

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

Table 6.3: Specifications of vaccinations with new vaccine

Vaccine: PCV-7	*Use data in:*		**Year 1 2009**	**Year 2 2010**	**Year 3 2011**	**Year 4 20…**	**Year 5 20…**
Number of children to be vaccinated with the third dose	*Table 3.4*	#	60,972	63,346	65,120		
Target immunisation coverage with the third dose	*Table 3.4*	#	94%	95%	95%		
Number of children to be vaccinated with the first dose	*Table 3.4*	#	64,864	66,680	68,548		
Estimated vaccine wastage factor	*Annex 2a or 2b* *Table E - tab 5*	#	1.05	1.05	1.05		
Country co-financing per dose *	*Annex 2a or 2b* *Table D - tab 4*	$	0.20	0.20	0.30		

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

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

Gambia Government		**Year 1 2009**	**Year 2 2010**	**Year 3 2011**	**Year 4 20…**	**Year 5 20…**
Number of vaccine doses	#	14,800	12,300	19,000		
Number of AD syringes	#	0	0	0		
Number of re-constitution syringes	#	0	0	0		
Number of safety boxes	#	175	150	225		
Total value to be co-financed by country	**$**	**51,500**	**42,500**	**65,500**		

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

		Year 1 2009	Year 2 2010	Year 3 2011	Year 4 20…	Year 5 20…
Number of vaccine doses	#	242,700	199,300	198,500		
Number of AD syringes	#	0	0	0		
Number of re-constitution syringes	#	0	0	0		
Number of safety boxes	#	2,675	2,225	2,225		
Total value to be co-financed by GAVI	**$**	1,612,500	1,335,500	1,348,000		

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

Second Preference Vaccine

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

Gambia is only interested in PFS as of now

- Please complete tables 6.3 – 6.4 for the new vaccine presentation
- Please complete the excel spreadsheets Annex 2a or Annex 2b for the new vaccine presentation and submit them alongside the application.

Procurement and Management of New and Under-Used Vaccines

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

Currently, vaccine supplies are procured through UNICEF and the same mechanism will continue and Government co-financing will also be channelled through UNICEF.

From the central level, vaccines will be distributed to the regions based on vaccine forecast. Shipment of vaccines will be done thrice in a year

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

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

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

The Gambia will introduce Pneumoccocal Conjugate Vaccine countrywide in 2009. Before the introduction of vaccine (2009-please refer to the introduction plan), the following pre-implementation activities will be carried out:

- Consensus building with key partners
- Review and update of data collection tools and training manual
- Community sensitization and development of IEC materials
- Training of health staff
- Cold chain expansion
- There are also plans to review and update the EPI Policy at a later day

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

Already there is an established GAVI account at the central bank of The Gambia managed by the Department of State for Health (EPI) and funds from GAVI should be channelled through this account.

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

Government co-financing payments will be disbursed by the Ministry of Finance and deposited at UNICEF Country Office. This mechanism has been successfully utilized over the years for the procurement of traditional vaccines

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

There is already an existing mechanism for monitoring and reporting routine administrative data including feedback. This includes:
Routine administrative data management
Bi-monthly meetings are conducted at central level where routine data is being reviewed and similar meetings are held at regional level monthly

Supportive supervisory visits at all levels

Bi-annual cluster surveys

The same mechanism will be used to monitor pneumococcal vaccine

Reporting will be done monthly, bi-monthly, annually and bi-annually.

New and Under-Used Vaccine Introduction Grant

Table 6.5: calculation of lump-sum

Year of New Vaccine introduction	N° of births (from table 3.4)	Share per birth in US$	Total in US$
2009	64,864		100,000

Please indicate in the tables below how the one-time Introduction Grant[4] will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP).

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

Cost Category	Full needs for new vaccine introduction	Funded with new vaccine introduction grant
	US$	**US$**
Training	**22,500**	**22,500**
Social Mobilization, IEC and Advocacy	**21,500**	**21,500**
Programme Management	**3,579**	**3,579**
Surveillance	**5,584**	**5,584**
Monitoring	**46,837**	**46,837**
Total IN USD	**100,000**	**100,000**

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

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

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

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

8. Documents required for each type of support

Type of Support	Document	DOCUMENT NUMBER	Duration *
ALL	WHO / UNICEF Joint Reporting Form (last two)	02	2006 & 2007
ALL	Comprehensive Multi-Year Plan (cMYP)	01	2007-2011
ALL	Endorsed minutes of the National Coordinating Body meeting where the GAVI proposal was endorsed	N/A	
ALL	Endorsed minutes of the ICC meeting where the GAVI proposal was discussed	03	2007
ALL	Minutes of the three most recent ICC meetings	As Above	
ALL	ICC workplan for the forthcoming 12 months	04	2008
Injection Safety	National Policy on Injection Safety including safe medical waste disposal (if separate from cMYP)	N/A	
Injection Safety	Action plans for improving injection safety and safe management of sharps waste (if separate from cMYP)	N/A	
Injection Safety	Evidence that alternative supplier complies with WHO requirements (if not procuring supplies from UNICEF)	N/A	
New and Under-used Vaccines	Plan for introduction of the new vaccine (if not already included in the cMYP)	See cMYP	2007-2011

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

ANNEX 1

Banking Form

SECTION 1 ***(To be completed by payee)***

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

Name of Institution: *(Account Holder)*		
Address:		
City – Country:		
Telephone No.:	**Fax No.:**	
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**
For credit to: ***Bank account's title***		
Bank account No.:		
At: ***Bank's name***		

Is the bank account exclusively to be used by this program? **YES ( ) NO ( )**

By whom is the account audited? .....

Signature of Government's authorizing official:
By signing below, the authorizing official confirms that the bank account mentioned above is known to the Ministry of Finance and is under the oversight of the Auditor General.

Name: ..... **Title:** ..... **Signature:** ..... **Date:** ..... **Address and Phone number**	**Seal:**
Fax number	
Email address:	

SECTION 2 ***(To be completed by the Bank)***

FINANCIAL INSTITUTION	**CORRESPONDENT BANK (*In the United States*)**
Bank Name:	
Branch Name:	
Address:	
City – Country:	
Swift code:	
Sort code:	
ABA No.:	
Telephone No.:	
Fax No.:	
Bank Contact Name and Phone Number:	

I certify that the account No. . . . . is held by *(Institution name)* . . . . . .at this banking institution.

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name:	**Signature:**
Title:	**Date:**
2 Name:	**Seal:**
Title:	
3 Name:	
Title:	
4 Name:	
Title:	

COVERING LETTER

(To be completed by UNICEF representative on letter-headed paper)

TO: GAVI Alliance – Secretariat
Att. Dr Julian Lob-Levyt
Executive Secretary
C/o UNICEF
Palais des Nations
CH 1211 Geneva 10
Switzerland

On the …… I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	.....	.....
Bank's authorizing official	.....	.....

Signature of UNICEF Representative:

Name .....

Signature .....

Date .....

COMMENTS ON THE APPLICATION

i) The DPT3 Coverage for 2007 is 94% as indicated in the JRF form submitted in April 2008. The initial 92% was extracted from the cMYP as a targeted coverage when it was being developed in 2006;

ii) When the cMYP was been developed in 2006, the DPT3 coverage was 89.2% for 2005 and the Programme targeted to improve coverage to 90% in 2007 nationally; but the actual coverage was more than the target (94%) as shown in the JRF submitted in April 2008;

iii) As shown in the cMYP costing tool, the targeted coverage for 2008 is 92%, but the actual coverage might be more than the targeted as the case for 2007;

iv) Tables 3.5 and 3.6 have been revised according to the cMYP costing tool. However, the previous figure were derived from the draft cMYP costing tool.

CLARIFICATIONS SUBMITTED AFTER THE REVIEW JULY 2008

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

Trends of immunisation coverage (in percentage)						**Vaccine preventable disease burden**		
Vaccine		**Reported**		**Survey**		**Disease**	**Number of reported cases**	
		2006	**2007**	**2004**	**2005**		**2006**	**2007**
BCG		90%	95%	92.2 %	98.3 %	Tuberculosis*	NA	NA
DTP	DTP1	95%	95%	98.4 %	98.5 %	Diphtheria,	0	0
	DTP3	93%	94%	92.2 %	95.1 %	Pertussis	0	0
Polio 3		90%	94%	91.6 %	93.6 %	Polio	0	0
Measles		89%	85%	89.3	91%	Measles	34	64
TT2+ (Pregnant women)		71%	74%	79.5 %	88%	NN Tetanus	0	2
Hib3		93%	94%	92.2 %	95.1 %	Hib **	3	0
Yellow Fever		87%	85%	88.%	90.7	Yellow fever	0	6
HepB3		88%	92.3 %	94.5 %	83.% %	hepB sero-prevalence*	2	0
Vit A supplement	Mothers (<6 weeks post-delivery)							

	Infants (>6 months)				85.5 %			

* If available
** Note: JRF asks for Hib meningitis

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

The survey data for 2003 was collected in 2004 and that of 2004 was in 2005. The title of the survey was Immunisation Coverage Survey. Age group was from 11 – 23 months. WHO Cluster Survey method was used.

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

Table 4.1: Estimate of fund expected from ISS

	Base Year (2006)	**Year 1 2007**	**Year 2 2008**	**Year 3 2009**	**Year 4 2010**	**Year 5 2011**
DTP3 Coverage rate	92.6%	94%	92%	94%	95%	95%
Number of infants reported / planned to be vaccinated with DTP3 (as in Table 3.4)	**61,455	65,810	58,050	60,972	63,346	65,120
Number of *additional* infants that annually are reported / planned to be vaccinated with DTP3		0	0	2922	2374	1774
Funds expected ($20 per additional infant)		0	0	58,440	47,480	35,480

* 61,455 was calculated from the 1993 population census, whilst the data for 2007 to 2011 are calculated using the 2003 population census.
*Projected figures
** As per duration of the cMYP

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

	Estimated costs per annum in US$ (,000)					
Cost category	**Base year 2005**	**Year 1 2009**	**Year 2 2010**	**Year 3 2011**	**Year 4 20…**	**Year 5 20…**
Routine Recurrent Cost						
Vaccines (routine vaccines only)						
Traditional vaccines	95,870	189,166	194,786	197,031		
New and underused vaccines	447,247	1,763,590	1,830,440	1,861,485		
Injection supplies	55,084	116,667	123,126	127,949		
Personnel						
Salaries of full-time NIP health workers (immunisation specific)	9,348	9,920	10,119	10,321		
Per-diems for outreach vaccinators / mobile teams (For central and regional personnel)	99,900	109,237	111,421	113,650		
Transportation	26,407	67,621	41,657	43,673		
Maintenance and overheads	114,217	317,006	271,902	306,088		
Training	2,390	106,121	54,122	60,724		
Social mobilisation and IEC	1,000	15,478	19,576	16,103		
Disease surveillance	45,000	109,082	88,835	113,488		
Program	29,856	48,391	46,112	67,128		

management						
Other (Salaries of shared health workers)	73,016	104,041	115,064	127,454		
Subtotal Recurrent Costs	**999,335**	**2,956,320**	**2,907,160**	**3,045,094**		
Routine Capital Costs						
Vehicles	0	0	0	0		
Cold chain equipment	31,000	12,333	33,555	0		
**Other capital equipment	3,600	121,965	124,404	126,892		
Subtotal Capital Costs	**34,600**	**134,298**	**157,959**	**126,892**		
Campaigns						
Polio	362,090	0	0	0		
Measles	294,038	0	614,223	0		
Yellow Fever	0	0	0	0		
MNT campaigns	0	0	0	0		
Other campaigns (Meningitis/0ther outbreaks)	588,076	0	967,696	0		
Subtotal Campaign Costs	**1,244,204**	**0**	**1,581,919**	**0**		
GRAND TOTAL	**2,278,139**	**3,090,618**	**4,647,038**	**3,171,986**		

** This include building additional outreach stations, incinerators, protective gears and office equipment

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

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

	Estimated financing per annum in US$ (,000)

Cost category	Funding source	Base year 2005	Year 1 2009	Year 2 2010	Year 3 2011	Year 4
Routine Recurrent Cost						
1. Traditional Vaccines	1. Government	95,870	189,166	194,786	197,031	
2. New and under used vaccines	2. Government /GAVI	447,247	1,763,590	1,830,440	1,861,485	
3.Injection supply	3. Government	55,084	116,667	123,126	127,949	
4. Personnel (salaries of full time NIP health workers (Immunisation specific).	4.Government	9,348	9,920	10119	10321	
5.Per diems (Central and regional)	5.Government , WHO, and UNICEF	99,900	109,237	111,421	113,650	
6. Transportation	Government, WHO and Unicef	26,407	67,621	41,657	43,673	
7.Maintenance and Over heads	7.Govermnent	114,217	317,006	271,902	306,088	
8. Training	8. Government ,WHO, Uniceg and GAVI	2,390	106,121	54,122	60,724	
9.Social Mob	9. Government and Unicef	1000	15,478	19,576	16,103	
10.Disease surveillance	10. Government and WHO	45,000	109,082	88,835	113,488	
11.Programme management	11.Goverment, WHO and Unicef	29,856	48,391	46,112	67,128	
12.Others (salaries of shared health workers	12.Government	73,016	104,041	115,064	127,454	
Routine Capital Costs						
1. Vehicles	1. Government, WHO and Unicef	0	0	0	0	
2.Cold chain equipment	2. Government and Unicef and GAVI	31000	12,333	33,555	0	
3.Otther capital equipment	3. Government , WHO and Unicef	3,600	121,965	124,404	126,892	
Campaigns						
1.Polio	1.	362,090	0	0	0	
2.Measles	2.	294,038	0	614,223	0	
3. Yellow fever	3.	0	0	0	0	
4.MNT	4.	0	0	0	0	

5.Others campaigns(Meningitis and other outbreaks)	5.	588,076	0	967,696	0	
GRAND TOTAL		**2,278,139**	**3,090,618**	**4,647,038**	**3,171,986**	

**** Refer to cMYP (section 2.8- Sustainable EPI Financing)**