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| **Application Form for Country Proposals** |

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| *New Routine Vaccines Support* |
| *Preventive Campaign Support* |

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| Date of submission: **13 September 2013** |

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| **Deadline for submission: 15 September 2013** |

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

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| **Form revised in 2013** |

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| **(To be used with the June 2013 Guidelines)** |

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| **Please submit the Proposal using the online platform** |
| [https://AppsPortal.gavialliance.org/PDExtranet](https://appsportal.gavialliance.org/PDExtranet) |

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| Enquiries to: proposals@gavialliance.org or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and the general public. The Proposal and attachments must be submitted in English, French, Spanish, or Russian. |
| Note: Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline. |
|  The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.  |

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| **GAVI ALLIANCE****GRANT TERMS AND CONDITIONS** |
| **FUNDING USED SOLELY FOR APPROVED PROGRAMMES** |
| The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of fulfilling the program(s) described in the Country's application. Any significant change from the approved program(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.  |
| **AMENDMENT TO THE APPLICATION** |
| The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the program(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's 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 its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by GAVI Alliance, within sixty (60) days after the Country receives the request from GAVI Alliance's for a reimbursement and must be paid to the account or accounts as directed by 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 programs described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programs described in its 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 its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice. |
| **AUDITS AND RECORDS** |
| The Country will conduct annual financial audits, and share these with the GAVI 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 Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations for the Country, under the Country's law, to perform the programs described in its application, as amended, if applicable, in the APR. |
| **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 complies with the requirements therein. |
| **USE OF COMMERCIAL BANK ACCOUNTS** |
| The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event. |
| **ARBITRATION** |
| Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time will be submitted to arbitration at the request of either the GAVI 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 languages of the arbitration will be English or French. |
| For any dispute for which the amount at issue is USD 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 programs described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. The Country is solely responsible for all aspects of managing and implementing the programs described in its application. |

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| **1. Application Specification** |
| Please specify which type of GAVI support you would like to apply for. |

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| **Type of Support** | **Vaccine** | **Start Year** | **End Year** | **Preferred second presentation[1]** |
| New Routine Vaccines Support | Rotavirus, 2 -dose schedule | 2014 | 2015 | Rotavirus, 3 -dose schedule |
| Preventive Campaign Support | Meningococcal type A, 10 dose(s) per vial, LYOPHILISED | 2014 | 2014 |  |

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| **[1]** GAVI may not be in a position to accommodate every country's first product preferences, and in such cases, GAVI will contact the country and the partners to explore alternative options. A country will not be obliged to accept its second or third preference, however GAVI will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine. If a country does not indicate a second or third preference, it will be assumed that the country prefers to postpone introduction until the first preference is available. It should be noted that this may delay the introduction in the country. |

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|  |  |  | [*6.2.1 Co-financing information*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSRoutine611) |
|  |  |  | [*6.2.2 Specifications of vaccinations with new vaccine*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSRoutine612) |
|  |  |  | [*6.2.3 Portion of supply to be procured by the country (and cost estimate, USD)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSRoutine613) |
|  |  |  | [*6.2.4 Portion of supply to be procured by the GAVI Alliance (and cost estimate, USD)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSRoutine614) |
|  |  |  | [*6.2.5 New and Under-Used Vaccine Introduction Grant*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSRoutine615) |
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|  | [*7. NVS Preventive Campaigns*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSPreventiveCampain) |
|  |  | [*7.1. Assessment of burden of relevant diseases related to campaigns (if available)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSPreventiveCampain1) |
|  |  | [*7.2 Request for Meningococcal type A, 10 dose(s) per vial, LYOPHILISED campaign support*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSPreventiveCampain71) |
|  |  |  | [*7.2.1 Summary for Meningococcal type A campaign support*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSPreventiveCampain711) |
|  |  |  | [*7.2.2 Grant Support for Operational Costs of the Meningococcal type A Campaign*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CNVSPreventiveCampain712) |
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|  | [*8. Procurement and Management*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CProcurementandManagement) |
|  |  | [*8.1 Procurement and Management of New and Under-Used Vaccines Routine*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CProcurementandManagement1) |
|  |  | [*8.2 Procurement and Management for NVS Preventive Campaign(s)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CProcurementandManagement2) |
|  |  |  | [*8.2.1 Procurement and Management for Meningococcal type A, 10 dose(s) per vial, LYOPHILISED campaign*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CProcurementandManagement821) |
|  |  | [*8.3 Vaccine Management (EVSM/ EVM/ VMA)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CProcurementandManagement3) |
|  |  | [*8.4 Waste management*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CProcurementandManagement4) |
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|  | [*9. Additional Comments and Recommendations from the National Coordinating Body (ICC/HSCC)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAdditionalCommentsandRecommendations) |
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|  | [*10. List of documents attached to this proposal*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CListofdocumentsattached) |
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|  | [*11. Annexes*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnexes) |
|  |  | [*Annex 1 - NVS Routine Support*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex1) |
|  |  |  | [*Annex 1.1 Rotavirus, 2 -dose schedule*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex11) |
|  |  |  | [*Table Annex 1.1 A Rounded up portion of supply that is procured by the country and estimate of relative costs in the USD*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex11A) |
|  |  |  | [*Table Annex 1.1 B Rounded up portion of supply that is procured by GAVI and estimate of relative costs in USD*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex11B) |
|  |  |  | [*Table Annex 1.1 C Summary table for Rotavirus vaccine, 2 dose schedule*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex11C) |
|  |  |  | [*Table Annex 1.1 D Estimated numbers for Rotavirus, 2 dose schedule, associated injection safety material and related co-financing budget (page 1)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex11D) |
|  |  | [*Annex 2 - NVS Routine – Preferred Second Presentation*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex2) |
|  |  |  | [*Annex 2.1 Rotavirus, 3 -dose schedule*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex21) |
|  |  |  | [*Table Annex 2.1 A Rounded up portion of supply that is procured by the country and estimate of relative costs in the USD*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex21A) |
|  |  |  | [*Table Annex 2.1 B Rounded up portion of supply that is procured by GAVI and estimate of relative costs in USD*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex21B) |
|  |  |  | [*Table Annex 2.1 C Summary table for Rotavirus vaccine, 3 dose schedule*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex21C) |
|  |  |  | [*Table Annex 2.1 D Estimated numbers for Rotavirus, 3 dose schedule, associated injection safety material and related co-financing budget (page 1)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex21D) |
|  |  | [*Annex 3 - NVS Preventive campaign(s)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex3) |
|  |  |  | [*Table Annex 3.1 C Summary table for vaccine Meningococcal type A, 10 dose(s) per vial, LYOPHILISED*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex31A) |
|  |  |  | [*Table Annex 3.1 D Estimated numbers for Meningococcal type A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 1)*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex31B) |
|  |  | [*Annex 4*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex4) |
|  |  |  | [*Table Annex 4A: Cost of Commodities*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex4A) |
|  |  |  | [*Table Annex 4B: Freight cost as percentage of value*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex4B) |
|  |  |  | [*Table Annex 4C: Low - Minimum country's co-payment per dose of co-financed vaccine.*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex4C) |
|  |  |  | [*Table Annex 4D: Wastage rates and factors*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex4D) |
|  |  |  | [*Table Annex 4E: Vaccine maximum packed volumes*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CAnnex4E) |
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|  | [*12. Banking Form*](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CBankingForm) |

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| **3. Executive Summary** |

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| [Please provide a summary of your country's proposal, including the following the information:](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CApplicationSpecification) |
|  |  |  |  |
|  | [For each specific request, NVS routine support or NVS campaign:](file:///%5C%5Czeus%5Cxtrf%5C2013%5CGAVI_Alliance%5COCT692_2013%5COCT692_2013_1_FR_EN%5CFrom_Proofreading%5CApplicationSpecification)  |
|  |  | The duration of support |
|  |  | The total amount of funds |
|  |  | Details of the vaccine(s), if applicable, including the reason for the choice of presentation |
|  |  | Projected month and year of introduction of the vaccine |
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|  | Relevant baseline data, including: |
|  |  | DTP3 and Measles data coverage (as reported on the WHO/UNICEF Joint Reporting Form) |
|  |  | Birth cohort, targets and immunization coverage by vaccines |
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|  | Country preparation level |
|  |  | Summary of EVM assessment and progress on EVM improvement plan |
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|  | The nature of the stakeholders' participation in developing this proposal |
|  |  | Inter-Agency Coordinating Committee |
|  |  | Partners |
|  |
| The Islamic Republic of Mauritania lies between latitudes 15° and 27°N and has a surface area of 1,030,700 km². It is bordered by Morocco and Algeria in the North, Mali in the East and North-East, Senegal in the South and the Atlantic Ocean in the West.For the year 2013, the Mauritanian population is estimated at 3,413,929 inhabitants, with an average density of around 3.2 inhabitants/km² and regional disparities. The population is predominantly young. The crude birth-rate is 40 per 1000 while life expectancy at birth is 51 years. The annual population growth rate is 2.4% (2000). More than 61% of this population is under 25 years of age and the mother-child group makes up 66% of the populace. This situation exerts enormous pressure on the social services in general, and on the healthcare system in particular, while also highlighting the importance accorded to problems specific to these groups.In 2009, the life expectancy at birth was 57 years (55 years for men and 60 years for women), while, as per the MICS report, on the national level, the child-juvenile and infant mortality rates per thousand were 118 and 75 respectively in 2011. Furthermore, the total fertility rate (4.6% in 2007 compared to 4.7% in 2000) and the contraceptive prevalence rate (9.3% in 2007 compared to 5.1% in 2000) have remained quite stable or have shown marginal improvement in the past decade.The under-15 (years) group represents 42% of the total population, whereas children under-five and under-one account for 18.5% and 4.19% respectively.The Poverty Reduction Strategy Paper (PRSP II) shows that between 2006 and 2010, the average economic growth rate is 3.7% excluding the oil sector, and 4% including it. This was much lesser than half of the estimated figure projecting a growth of 9.4% for the period 2006-2010. The main reasons accounting for this situation are: (i) poor results in the oil industry, (ii) international food, energy and financial crisis, and (iii) the different institutional changes in the country during this period. However, it is worth noting that significant achievements, financed by the Government’s own resources, have been witnessed recently in the infrastructure and basic services sector benefiting the most deprived section of the population.From an administrative perspective, the country is divided into 13 Wilayas (regions), 54 Moughataas (districts) and 216 Municipalities, managed respectively by Walis (Governors), Hakems (Prefects) and Mayors.According to the EPCV 2008 (Continuous Survey on Households' Living Conditions), the poverty rate in the country is 42%. This rate, though less than the 2004 result (46.7 %), is way higher than the desired target (25%) set for 2015. Poverty continues to mainly be a rural phenomenon; in 2008, the rural sector represented more than 77.7% (or 2.9 additional points when compared to 2004) of the national poverty and nearly 60% of the rural population lived below the poverty line, compared to 20.8% for urban areas. Furthermore, independent farmers remaining among the socio-economic groups considered the most poverty-stricken with an affliction rate of almost 70%. In close conjunction with poverty, and again based on the EPCV 2008 data, the unemployment rate was at 31.2% in 2008.As far as the financial resources are concerned, a budgetary framework for 2012-2020 was developed, considering the additional needs for upgrading to high-impact assistance schemes for MDGs and other priority conditions; it enabled to compute the requirement of the sector in terms of Public Health Budget (internal and external funding) totaling 110 billion Ouguiyas for NHDP1 (2012-2015) and 206 billion Ouguiyas for NHDP (2016-2020). (1USD=300 Ouguiyas, MRO)According to the public health expenditure review (RDPS) 2005-2010, “the per-capita public health expenditure at constant MRO prices has shown significant positive movement between 2005 and 2010, increasing from 3709 to 6171, or an average annual variation of 10.7%. This demonstrates the substantial increase in resources that benefit from the health sector in Mauritania, compared to the other sectors of economic activity”. National Health Development Plan (2012-2020) 2011, Page 42The efforts undertaken for implementing the Strategic Plan for the Development of Human Resources (PSDRH) drafted in 2006 – enabled to develop staffing standards for the first levels of the pyramid (except the service sector) and to adopt a special status for personnel covering the major categories.However, the staffing standards developed were not really consensual and did not cover all types of structures. These are not regularly updated and lack realism partly due to absence of a basic assessment model and inadequate involvement of all the participants; besides, these tools (standards, statutes …) are not shared by the local managers, and are thus ineffectively applied on the field.The vaccination coverage rates of routine EPI antigens gradually increased till 2010. Initially, the coverage levels were not really encouraging until 2010, however, the revival of immunization activities in 2010 enabled to obtain extremely satisfactory results, spiraling up from 64% of DTP3 vaccination coverage rate in 2009 and 2010 to 75% in 2011, and then 78.4% in 2012.According to the latest national survey on vaccination coverage (2004), the main reasons for non-vaccination revolve around the following issues:* Lack of information (41%)
* Absence of the vaccinator and/or unavailability of the vaccine (14.6%)
* Distant immunization centers (14.2%) and ignorance of the importance of returning the child for immunization (8.2%).

The reasons related to immunization services (no vaccinator, unavailability of vaccines, lack of inter-personnel communication, etc.) are the most relevant.The EPI Comprehensive Multi-Year Plan (cMYP), covering the period 2012-15, is based on the National Health Development Plan (NHDP) and provides for the introduction of new vaccines and implementation of steps to control and reduce vaccine wastage and improve the vaccination coverage. The national planning cycle for health provides for a 3-year frequency (three-year rolling plan). The NHDP is rooted in the Governmental framework for the fight against poverty (PRSP) and covers the period 2012-2020.**1.** **Nature of the proposal.**Through this proposal, the Government of Mauritania is seeking the GAVI Alliance’s support for the introduction of vaccines against Rotavirus infections in the routine EPI in 2014 and for an immunization campaign against Meningococcal A Meningitis, (one round) targeting a population of 1,546,236 inhabitants in the 1- 29 years age-group, equivalent to 70% of the total population of the country (31 Districts out of the country’s total of 54).**2.** **Explanation of proposal for vaccine against Rotavirus infections**The introduction of DTP-HepB-Hib in 2009 with a coverage rate of 78.4% for 2012 had a beneficial effect on the health of Mauritanian children. Based on these results and to enhance the protection spectrum of Mauritanian children against vaccine-preventable diseases, the Ministry of Health is seeking the support of GAVI Funds to include a new vaccine against Rotavirus in the routine immunization program.The single-dose oral vaccine in liquid form, administered orally in two doses at an interval of 4 weeks, is specifically adapted to Mauritania’s needs. It is easy to use and store and quickly achieves a high coverage.**3.** **Explanation of the proposal for the conjugated vaccine against meningitis A (MenAfriVac)**For the introduction of the conjugated vaccine against Men A in Mauritania, a meningitis evaluation was conducted by the WHO using the district prioritization tool (DPT). This decision support tool relies on mixed, quantitative and qualitative methods. It uses monitoring data and integrates local meningitis specifications and risk factors, opinion of local experts, institutional memory and the opportunity to expand the immunity coverage for Nm A at the regional level. These factors were considered while framing the following strategy:1. Introduction of the vaccine in 2014 in the form of mass vertical campaigns immunizing those in the age-group of 1-29 years, i.e.; nearly 70% of the total population;
2. Immunization of 31 Moughataas (districts) (Barkéol, Guérrou, Kankossa, Kiffa, M'Bagne, Kaédi, Maghama, Monguel, OuldYengé, Sélibaby, Amourj, Bassikounou, Djigueni, Néma, Oualata, Timbedra, Aioun, Kobeni, Tamchekett, Tintane, Boumdeid, Aleg, Bababé, Boghé, MaghtaaLahjar, Moudjéria, Tichitt, Tidjikja, Boutilimit, R'Kiz, Rosso), spread over 8 regions-wilayas (Assaba, Brakna, Gorgol, Guidimagha, HodhCharghi, Hodh Gharbi, Tagant and Trarza), or a target population of 1,546,236 persons, corresponding to 1,716,822 doses.

**4.** **Cold Chain**The last Effective Vaccine Management assessment (EVM) was carried out in November 2010, just before the introduction of the pneumococcal vaccine in the country. This EVM helped identify gaps at every level. An improvement plan was implemented 2 years ago and continues to date with two high capacity cold rooms being installed at the central level (30 m3 and 10 m3). The ordering of a large batch of cold chain equipment (200) would considerably enhance the storage capacity and the cold chain logistics. Note that the plan provides for electric-to-solar transition. Based on a pre-determined logistics plan, the vaccines once received at the central level will be transported to regions and districts in isotherm coolers/boxes with batteries. During immunization sessions, the vaccines will be stored and kept safe in vaccine carriers provided with cushion pads and frozen batteries for the safety of vaccines. **6.** **Introduction plan for new vaccines**Based on its extensive experience in organizing mass immunization campaigns (polio and measles integrated with deworming and vitamin A supplementation) and introduction of new vaccines (Hepatitis B, 2005, Pentavalent 2009 and Pneumococcus planned for November 2013), Mauritania intends to introduce the vaccine against Rotavirus in the routine EPI and organize a mass campaign targeting the population in the 1-29 age group, in compliance with the introduction plans.The following measures will be taken:* Advocacy for high-level political commitment
* Micro-planning in districts by involving administrative authorities and community leaders
* Training of all the agents involved in routine immunization for Rotavirus and campaign for MenAfriVac (central and regional supervisors, immunization officers…)
* Strengthening of the cold chain fleet and waste management
* Strengthening of the target disease surveillance and control over Adverse Events Following Immunization (AEFI)
* Introduction of case-wise monitoring
* Introduction of monitoring rotavirus infections through creation of sentinel site.
* Social mobilization and communication at all levels with emphasis on crisis communication.

**7.** **Expected Results*** For Rotavirus, the aim is to have 14% coverage in the first year and gradually attain 89% protection cover in 2015.
* For MenAfriVac, Mauritania intends to immunize at least 95% of the target population of 1,546,236 inhabitants by establishing strong social mobilization.

**8.** **Partners**The usual operational partners of the Ministry of Health in the EPI initiative, some of whom are also involved in the preparation of this proposal, are WHO, UNICEF, World Bank, Rotary International, GAVI, Counterpart as well as two civil society networks, notably VACNET and REJAV.**9.** **Funding**The Rotavirus vaccine will be introduced in the third quarter of 2014 and the costs will be borne by GAVI, with the Government contributing 0.20 USD per dose, or (156,297) for 2014 and (937,536) for 2015. For the campaign against MenAfriVac, operational costs in the amount of USD 0.65 per immunized person, which is equivalent to nearly **USD 1,005,000**, will be funded by GAVI. This funding will enable to cover the main aspects of the campaign, from planning and implementation to evaluation.The Government has committed to mobilize resources necessary to meet the shortfalls in campaign funding and the potential additional costs. |

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| **4. Signatures** |

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| **4.1. Signatures of the Government and National Coordinating Bodies** |

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| **4.1.1. Government and the Inter-Agency Coordinating Committee for Immunization** |

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| The Government of Mauritania would like to expand the existing partnership with the GAVI Alliance for the improvement of the country's routine infant immunization program and specifically requests GAVI support for: |

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| Rotavirus, 1 dose(s) per vial, ORAL routine introduction |
| Meningococcal type A, 10 dose(s) per vial, LYOPHILISED preventive campaigns |

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| The Government of Mauritania commits itself to developing national immunization 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 immunization of children as outlined in this application. |

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| Table(s) 6.2.4 in the NVS Routine section of this application shows the amount of support in either supply or cash that is required from the GAVI Alliance. Table(s) 6.2.3 of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).  |

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| 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 **March**. |

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| The payment for the first year of co-financed support will be around **March** **2014** for Rotavirus, 2-dose schedule. |

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| Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NO.: 1 and 2 in Section 10. Attachments. |

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| **Minister of Health (or delegated authority)** | **Minister of Finance (or delegated authority)** |
| **Name** | AHMEDOU OULD HADEMINE OULD JELVOUNE (Minister) | **Name** | THIAM DIOMBAR (Minister) |
| **Date** |  | **Date** |  |
| **Signature** |  | **Signature** |  |

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

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| **Full name** | **Position** | **Telephone** | **Email** |
| Dr André Yameogo | UNICEF Maternal and child health specialist  | 22 33 05 74/ 45 29 98 21 | ayameogo@unicel.org |
| Dr Ishagh El Khalef | EPI/NUT WHO | 22 30 59 48 | khalefi@mr.afro.who.int |
| Dr M'Barek Ould Houmeid | National EPI Coordinator | 22 24 37 95/46 45 97 87 | mbarekohoumeid@yahoo.fr |

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| **4.1.2. National Coordinating Body - Inter-Agency Coordinating Committee for Immunization** |

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| Agencies and partners (including development partners and NGOs) supporting immunization services are coordinated and organized through an inter-agency coordinating mechanism (ICC, HSCC, or equivalent committee). The ICC, HSCC, or equivalent committee is responsible for coordinating and guiding the use of the GAVI NVS routine support and/or campaign support. Please provide information about the ICC, HSCC, or equivalent committee in your country in the table below. |

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| **Profile of the ICC, HSCC, or equivalent committee** |

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| **Name of the committee** | Inter-agency Coordination Committee (ICC) |
| **Year of constitution of the current committee** | 2002 |
| **Organizational structure (e.g., sub-committee, stand-alone)** | Committee created by order of the Health Minister |
| **Frequency of meetings** |  1 meeting per quarter/4 meetings per year |

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| The Terms of Reference or Standard Operating Principles for the ICC, including details on ICC membership, quorum, dispute resolution process and meeting schedules is attached as DOCUMENT NO.: 4. |

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| Major functions and responsibilities of the ICC/HSCC: |

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| The main functions of ICC<?xml:namespace prefix = o />* Validation and monitoring the progress of the program action plans
* Educate the national and international partners who can provide their support to the program
* Coordinate the activities and commitments of the partners
* Fix the strategic guidelines of the program
* Discuss and resolve the problems in the program
* Monitor the preparation of basic program documents (JRF, APR, Submissions...)
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| Please describe how partners have provided support in preparation of the proposal: |

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| Technical and Financial support: The partners are members of the technical committee responsible for the preparation of strategic and operational documents of the program including proposals and submissions to GAVI. They also participate financially in the management of people, resources of the ministry of health as in the peer review workshops.  |

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| **4.1.3. Signature Table for the Coordinating Committee for Immunization** |

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| We the members of the ICC, HSCC, or equivalent committee [1] met on the **09/09/2013** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached as Document no. 5. The signatures endorsing the proposal are attached as Document no. 6 (please use the list for signatures in the section below). |

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| Please refer to Annex D of the Guidelines for more information on ICCs. |

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| **Function** | **Title / Organization** | **Name** | **Please sign below to indicate the attendance at the meeting where the proposal was endorsed** | **Please sign below to indicate the endorsement of the minutes where the proposal was discussed** |
| **Chair** | Secretary General of the Ministry of Health | Dr. El Moctar HENDE |  |  |
| **Secretary** | National Co-coordinator of EPI | Dr. M'BAREK OULD HOUMEID |  |  |
| **Members** | Representative from Rotary International | See scanned page in the attachment |  |  |
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| By submitting the proposal we confirm that the quorum has been met. **Yes** |

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| The minutes from the three most recent ICC meetings are attached as DOCUMENT no.: 7. |

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| **4.2. National Immunization Technical Advisory Group** |

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| Has a NITAG been established in the country? **No** |

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| **5. Immunization Program Data** |

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| **5.1 Background information** |

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| Please complete the table 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. |

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| ▪  | Please refer to the Comprehensive Multi-Year Plan for Immunization (cMYP) (or equivalent plan) and attach a complete copy (with an Executive Summary) as DOCUMENT NO. 10. Please attach the cMYP costing tool as DOCUMENT NO. 11. |
| ▪  | Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NO.: 12 |
| ▪  | Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases |
| ▪  | Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc., as appropriate. |

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

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|  | **Figure** | **Year** | **Source** |
| Total population | 3,333,915 |  | 2012 | NSO (Obtained from the projection of general population census data 2002) |
| Infant mortality rate (per 1000) | 75 |  | 2011 | MICS Survey 2011 |
| Surviving infants[1] | 135,397 |  | 2012 | NSO (National Statistics Office) |
| GNI per capita (USD) | 1,200 |  | 2012 | WB |
| Total Health Expenditure (THE) as a percentage of GDP | 5 | % | 2011 | WB 2011 |
| General government expenditure on health (GGHE) as % of General government expenditure | 8 | % | 2012 | Health account (DPAHI) |

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

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| **5.1.1 Lessons learned** |

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| **New Routine Vaccines Support** |

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| If new or under-used vaccines have already been introduced in your country, please give details of the lessons learned from previous introduction(s) specifically for: storage capacity, protection from accidental freezing, staff training, cold chain, logistics, coverage and drop-out rates, wastage rate, etc., and suggest action points or actions taken to address them. Please refer to previous Post Introduction Evaluations (PIE), if applicable. |

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| **Lessons Learned** | **Action Points** |
| 1. Inadequate Storage capacity  | A vaccine management assessment was conducted in November 2010 and enabled identifying the GAP to be bridged to have a sufficient storage capacity for the introduction of new vaccines such as the vaccine against Pneumococcus and Rotavirus.To overcome this inadequacy, the action plan planned for 2011: strengthening the storage capacity at the national level by ordering a cold room; already ordered on funding from UNICEF. Acquisition of new equipment based on this assessment should enable bridging the storage gap for the introduction of a new vaccine mainly the one against Rotavirus.In 2012, efforts were made to improve the storage capacity by distributing 16 Cold rooms in the regions housing the Malian refugees to strengthen immunization in border areas and refugee camps. Two cold rooms, one with 30m3 for the central level and the other with 10m3 for the medical delegation of Nouakchott were purchased by the Ministry of Health which are already operational.In 2013, 200 cold rooms were ordered, to bridge the gap at regional level and prepare the introduction of Rotavirus and MenAfriVac.RCW50s are being replaced by solar cold chains.  |
| 2. Insufficient staff training | In 2011, training for immunization staff was conducted in stages beginning with the central team, who in-turn will form a pool of trainers who are responsible for training the other intermediate and peripheral levels in stages. In 2012, a total of 432 head nurses were trained on EPI management in addition to the two groups of regional and district focal points (one group per quarter). These meetings enabled the central level to exchange views with the regional level and update their knowledge on FRDJ TAG and the Vaccination coverage monitoring diagram.Supportive supervision was conducted twice a year on the field, with a specific emphasis on data management. |
| 3. Inadequate maintenance of the cold chain: | The first measure taken was an exhaustive inventory of the entire cold chain fleet with all technical specifications of devices followed by a renewal of cold chain devices in certain areas. In 4 of the 13 regions, we signed a contract with experienced cold chain technicians for the maintenance of the cold chain and training local health staff on repairing small breakdowns. In the other regions, maintenance tasks were carried out.In 2013, a national contract for cold chain maintenance is being finalized with a public corporation specialized in this field. Also, the State is in the process of transitioning to solar devices and 100 refrigerators are already ordered for the 2013 fiscal year. |
| 4. Insufficient rolling stock: | Apart from the cold chain, the rolling stock causes problems mainly in terms of transporting inputs from the capital to the most remote regions and to the most peripheral regions. This recurrent problem is due to a significant lack of rolling stock; EPI does not have their own vehicles, should grab other opportunities to transport vaccines and materials in the regions; this also generates shortages due to dispatch delays. One of the strategic axes of the EPI action plan, strengthening logistics (rolling stock) mainly by providing an automotive fleet for all regions of the country and the central level as well as the purchase of a Pick-up vehicle and a truck for transporting vaccines and inputs are ordered. Currently, the central EPI unit has a Pick-up vehicle which was funded by UNICEF in 2011.  |
| 5. Increased drop-out rate of 17% in 2012: | Provision of immunization services was problematic due to increased drop-out rates. This is partly related to the lack of staff training and insufficient logistics / cold chain.As mentioned above, an improvement in the provision of services resulting in regular immunization activity, well-trained staff and efficient logistics will contribute in reducing the drop-out rates.On this aspect, well-received staff training, with proper communication of the message for adherence to the EPI schedule and advantages related to immunization will improve this inadequacy. The routine EPI communication plan which is being prepared and with many private radio stations and local news television channels, will influence the population.The drop-out rate decreased between 2011 and 2012 from 21% to 17% due to several activities carried out under the EPI relaunch mainly mobile advanced activities in difficult to access areas, commemoration of the African Immunization Week and also the integration of routine immunization with campaigns, etc.   |
| 6. Increased vaccine wastage rates: | Approximate and incomplete filling of program management tools does not enable a proper evaluation of wastage rates and currently data available is unreliable. The only factual data on which we can rely are those from the studies conducted in 1999 and funded by ARIVA, the results of which are as follows:BCG: 40.78%DTP: 28.23%OPV: 17.18%MV: 39.71%TT: 47.38%Efforts were made to improve the management of antigens. Training was organized at the health worker location, supports with an emphasis on wastage rates were prepared, standardized and provided to all immunization facilities. This training, including the most recent one, was conducted in the beginning of July 2013. This will still be strengthened and supportive supervision will be more regular. According to the administrative data, the wastage rate in 2010 was 15% for DTP hep B Hib vaccine. (Habib to be reviewed) the national objectives were to reduce the wastage rates to 5% for the coming years. Based on the limited data available, this rate is at 5%. |
| 1. Absence of accidental freezing2. Growth in human resources provided to the program | During and after the introduction of the Pentavalent vaccine, throughout the country, no accidental freezing was reported.For a successful introduction of the new vaccine (penta) the government allocated qualified health personnel in the program to bridge the gaps. |

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| **Preventive campaign support** |

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| If campaigns with Meningococcal type A vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. |

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| **Lessons Learned** | **Action Points** |
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| **5.1.2 Health planning and budgeting** |

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| Please provide information on the planning and budgeting cycle in your country |
| The national planning cycle is derived from the Strategic Framework to Fight Poverty 2011-2015  |
| Please indicate the name and date of the relevant health planning document |
| A National Plan of Medical Development 2012-2020, based on the National Health Policy 2006-2015 and the National strategic framework to fight poverty 2011-2015 |
| Is the cMYP (or updated Multi-Year Plan) aligned with the proposal document (timing, content, etc.?) |
| The cMYP is aligned with the national planning and health sector documents. The new cMYP covers the period 2012-2015 and includes the major axes of NHDP 2012-2020 for immunization |
| Please indicate the national planning budgeting cycle for health |
| The health sector budget is prepared through a participatory process from the district level up to the directorates and programs of the Ministry of Health on the basis of the Medium Term Expenditure Framework MTEF (2012-2015) which is aligned to NHDP. This health expense framework is found in the triennial medium term expenditure document from the Ministry of Finance, prepared in 2013 and covers the period (2013-2015).   |
| Please indicate the national planning cycle for immunization |
| The EPI multi-year plan (cMYP) covers the period 2012-2015. It is in line with the national health policy 2006-2015 and national health development plan 2012-2020. |

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| **5.1.3 Preparatory activities** |

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| Please provide an outline of all **preparatory** activities for vaccine introduction |
| The ICC meeting is to establish the three preparatory committees (Technical, Logistics and communication)For this purpose, preparatory activities related to this introduction are planned for. They are: 1. Provide high-level advocacy in the country (Circulars sent to administrative and health authorities)
2. Strengthen the cold chain capacity at various levels

a)       Installation of two cold rooms for EPI and health delegation of Nouakchottb)       Upgrade the old cold roomsc)       Revise the storage capacity at central and regional level (a physical inventory of the cold chain was taken in March 2013)1. Revise program management tools to include the new vaccines
2. Strengthen staff capabilities (a technical program guide was prepared including new vaccines on which the staff were trained), the District and regional focal points are grouped regularly.
3. Educate the health staff, clinicians and community (Routine EPI communication plan being prepared with a component for introducing New vaccines)
4. Set-up a sentinel site for monitoring Rotavirus diarrhea cases in referral hospitals (Pediatric service)
5. Strengthen the case-wise monitoring, by considering experiences from Measles, yellow fever and polio and learning lessons from first countries that have introduced MenAfriVac. For this purpose, guides and case-wise monitoring tools will be revised. A cascade training of health and laboratory workers will be conducted. Purchase of reagents and laboratory equipment and a system for transporting samples from health centers to referral laboratories will be established.

Ensure monitoring and evaluation of the introduction process. |

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| **5.1.4 Gender and equity** |

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| Please describe any barriers in access to immunization services that are related to geographic, socio-economic and/or gender equity and actions taken to mitigate these barriers. Highlight where these issues are addressed in the vaccine introduction plan(s). |
| Mauritania is a vast country of 1,086,000 km2 with a density of not more than 3 persons/km2. 2/3 of the population resides in the southern part of the country. There is a wide dispersion of households, especially in the Northern regions which is very extensive and sparsely populated. According to the MICS 2011 survey, there is no gender-discrimination in the immunization services offered to Mauritanian populations. In certain southern parts of the country, the access to health services is not always easy in the rainy season. Aware of this fact, the Government has established an ambitious plan of urbanizing and regrouping populations as well as building an extensive road network linking most of the major cities of the country with an emphasis on the poverty triangle located in the central part of the country. This plan is based on the Strategic Framework to Fight Poverty (2011-2015).While awaiting the complete implementation of the plan, the integrated advanced and mobile activities organized by the districts, enables providing immunization and administration of other high-impact interventions to children living in difficult to access areas. These mobile/advanced outputs also:Cover the marginalized communities without health facilities and help resolve problems of geographical and socio-economic barriers thereby reducing the equity issues. |
| Discuss how equity issues (geographic, socio-economic and/or gender) are being taken into account in the design of social mobilization and other strategies to increase immunization coverage. Highlight where these issues are addressed in the vaccine introduction plan(s). |
| The country considers all specifications and all equality issues in the process of developing social mobilization and immunization strategy.All the citizens from 0 to 11 months, for Rotavirus, and from 1 to 29 years, for Meningitis, across the country, will benefit from immunization without any gender discrimination.While awaiting the improvement in health coverage, the mobile/advanced strategies will be continued or strengthened both in routine and mass campaigns. This will ensure the coverage of all children living in the difficult to reach areas or who are deprived of any nearby health facilities.  |
| Please indicate if sex disaggregated data is collected and used in immunization routine reporting systems. |
| The notification system for routine immunization does not separately consider the data by gender. |
| Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought)? If Yes, please describe how these issues may impact your immunization program, planning for introduction of routine vaccines or campaigns and financing of these activities. |
| Since January 2012, Mauritania welcomed nearly 80,000 refugees on its Malian border. Immunization is provided continuously through fixed and mobile sites within the Mberra refugee camp. The health facilities of the refugee camp and those of the host community have benefited from Cold chain equipment (CC). In 2013, the population also benefited from immunization campaigns against measles and polio and 03 rounds of the mother/child week with immunization as an entry point.No case of polio or measles was reported in the camp since the beginning of the inflow to date.EPI conducts a monitoring and supervision activity every month and a staff member is always there on site along with the staff from the government health center. Some partners conduct sustained activities on site; they are Doctors without borders (MSF-Belgium), Agencies of the UN system and a national NGO which, in partnership with UNICEF, supports the government health center in immunization both within the camp and the host population. |

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| **5.1.5 Data quality** |

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| Please attach a data quality assessment report, if one has been completed within the past 36 months (DOCUMENT NO.: 13). If available, an improvement plan and progress report on the implementation of the improvement plan should also be submitted (DOCUMENT NO.: 14, DOCUMENT NO.: 15). |

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| **5.2. Baseline and Annual Targets (NVS Routine Support)** |

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| Please refer to cMYP pages to assist in filling-in this section. |

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|  | **Number** | **Base Year** | **Baseline and Targets** | **Baseline and Targets** |
|  |  | **2012** | **2014** | **2015** |
| **Total births** | 146,692 | 153,818 | 157,510 |
| **Total infants’ deaths** | 11,295 | 11,844 | 12,128 |
| **Total surviving infants** | 135,397 | 141,974 | 145,382 |
| **Total pregnant women** | 146,692 | 153,818 | 157,510 |
|  |  |  |  |
| **Target population vaccinated with BCG** | 126,970 | 150,742 | 155,935 |
| **BCG coverage** | 87 % | 98 % | 99 % |
|  |  |  |  |
| **Target population vaccinated with OPV3** |  |  |  |
| **OPV3 coverage** | 78 % | 84 % | 89 % |
|  |  |  |  |
| **Number of infants vaccinated (to be vaccinated) with DTP1** | 127,636 | 129,991 | 137,153 |
| **Number of infants vaccinated (to be vaccinated) with DTP3** | 106,193 | 119,258 | 129,389 |
| **DTP3 coverage** | 78 % | 84 % | 89 % |
| **Wastage[1] rate in base-year and planned thereafter (%) for DTP** | 4 | 5 | 5 |
| **Wastage[1] factor in base-year and planned thereafter for DTP** | 1.04 | 1.05 | 1.05 |
|  |  |  |  |
| **Target population vaccinated with 1st dose of Rotavirus** | 0 | 21,666 | 137,153 |
| **Target population vaccinated with 2nd dose of Rotavirus** | 0 | 19,876 | 129,389 |
| **Target population vaccinated with 1st dose of Rotavirus** | 0 | 21,666 | 137,153 |
| **Target population vaccinated with 3rd dose of Rotavirus** | 0 | 19,876 | 129,389 |
| **Rotavirus coverage** | 0 % | 14 % | 89 % |
| **First Presentation: Rotavirus, 2 dose schedule** |  |  |  |
|  | **Wastage [1] rate in base-year and planned thereafter (%) {0}** | 0 | 5 | 5 |
|  | **Wastage [1] factor in base-year and planned thereafter (%)** | 1.00 | 1.05 | 1.05 |
|  | **Maximum wastage rate value for Rotavirus, 2 dose schedule** | 5 % | 5 % | 5 % |
| **Second Presentation: Rotavirus, 3 dose schedule** |  |  |  |
|  | **Wastage [1] rate in base-year and planned thereafter (%) {0}** | 0 | 5 | 5 |
|  | **Wastage [1] factor in base-year and planned thereafter (%)** | 1.00 | 1.05 | 1.05 |
|  | **Maximum wastage rate value for Rotavirus, 3 dose schedule** | 5 % | 5 % | 5 % |
|  |  |  |  |
| **Number of infants vaccinated (to be vaccinated) with 1st dose of TT+** | 52,249 | 64,604 | 70,879 |
| **TT+ coverage** | 36 % | 42 % | 45 % |
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| **Annual DTP Dropout rate [(DTP1 – DTP3)/ DTP1 ] x 100** | 17 % | 8 % | 6 % |

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| **[1]** Number of infants vaccinated out of total births |
| **[2]** Number of infants vaccinated out of total surviving infants |
| **[3]** Indicate total number of children vaccinated with either DTP alone or combined |
| **[4]** Number of pregnant women vaccinated with TT+ out of total pregnant women |
| **[5]** 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. |

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| **5.3. Baseline and Annual Targets for Preventive Campaign(s)** |

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| **5.3.1 Baseline and annual targets (Meningococcal type A campaign)** |

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| Cohort for Meningococcal type A is population 1-29 years old |

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| **Table 5.3.1 Baseline NVS preventive campaign figures for Meningococcal type A** |

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|  | **Base Year** | **Baseline and Targets** |
|  | **2012** | **2014** |
| **Total births** | 92,689 | 87,192 |
| **Total population 1-29 years old** | 1,474,605 | 1,546,236 |
| **Target population to be vaccinated with Meningococcal type A** | 0 | 1,546,236 |
| **Meningococcal type A (campaign) coverage (%) [1]** | 0 % | 100 % |
| **Wastage rate (%) for Meningococcal type A (campaign)** | 0 | 10 |
| **Wastage factor for Meningococcal type A** | 1 | 1.11 |

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| **[1]** Number of persons vaccinated out of total target population |

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

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| **6.1. Assessment of burden of relevant diseases (if available)** |

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| **Disease** | **Title of the assessment** | **Date** | **Results** |
| rotavirus | WHO | 2012 | Rotavirus, first cause of global viral gastro-enteritis and will be responsible for 30%-40% of hospitalization. First cause of dehydrating diarrhea, 600,000-800,000 cases of child deaths in Africa. Three quarters of children in developing countries have an episode of Rotavirus before the age of 12 months. peak frequency = 4-24 months |
| data on diarrheas  | NHIS Mauritania |  | According to a recent study, diarrheas represent 14.2% of the reasons for infant and child consultation at Nouakchott, capital of Mauritania. This percentage increased to 24% for children aged less than 5 years, thus showing similarities between Mauritania and other countries regarding the prevalence of childhood diarrheas and related rotavirus etiologies. |

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| **6.2. Requested vaccine (Rotavirus, 2 dose schedule)** |
| As reported in the cMYP, the country plans to introduce Rotavirus, using, 2 dose Rotavirus schedule. |
| When is the country planning to conduct this vaccine? **November 2014** |
| Please note that, due to a variety of factors, the launch date may vary compared to the date stipulated in the application. GAVI will work closely with countries and their partners to address these issues. |

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| **6.2.1. Co-financing information** |
| If you would like to co-finance an amount higher than the minimum, please provide information in your co-financing row. |

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| **Country group** | Low |

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|  | **Year 1** | **Year 2** |
|  | **2014** | **2015** |
| **Minimum co-financing** | 0.20 | 0.20 |
| **Your co-financing (please change if higher)** | 0.20 | 0.20 |

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| **6.2.2. Specifications of vaccinations with new vaccine** |

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|  | **Data from** |  | **Year 1** | **Year 2** |
|  |  | **2014** | **2015** |
| **Number of children to be vaccinated with the first dose** | Table 5.2 | # | 21,666 | 137,153 |
| **Number of children to be vaccinated with the second dose** | Table 5.2 | # | 19,876 | 129,389 |
| **Immunization coverage with the second dose** | Table 5.2 | # | 14.00 % | 89.00 % |
| **Country co-financing per dose** | Table 6.2.1 | $ | 0.2 | 0.2 |

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| **6.2.3. Portion of supply to be procured by the country (and cost estimate, USD)** |
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|  |  | **2014** | **2015** |
| **Number of vaccine doses** | **#** | 4,400 | 26,200 |
| **Number of AD syringes** | **#** | 0 | 0 |
| **Number of re-constitution syringes** | **#** | 0 | 0 |
| **Total value to be co-financed by the Country [1]** | **$** | 12,000 | 70,500 |

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| [1] The co-financing amount for low-income countries indicates the cost of the vaccines and any freight charges. The total co-financing amount does not contain the 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. |

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| **6.2.4. Portion of supply to be procured by GAVI Alliance (and cost estimate, USD)** |
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|  |  | **2014** | **2015** |
| **Number of vaccine doses** | **#** | 54,100 | 324,000 |
| **Number of AD syringes** | **#** | 0 | 0 |
| **Number of re-constitution syringes** | **#** | 0 | 0 |
| **Total value to be co-financed by GAVI** | **$** | 145,000 | 868,000 |

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| **6.2.5. New and Under-Used Vaccine Introduction Grant** |

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| **Calculation of Vaccine Introduction Grant for the Rotavirus, 2 dose schedule** |

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| **Year of New Vaccine Introduction**  | **Births (from Table 5.2)** | **Share per Birth in USD** | **Total in USD** |
| 2014 | 153.818 | 0.80 | 123.054 |

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| The Grant will be based on a maximum award of $0.80 per infant in the birth cohort with a minimum starting grant award of $100,000 |

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| Please describe how the GAVI Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan). |

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| As in previous introductions, a detailed utilization plan will be prepared in close collaboration with the technical team and validated by the ICC which includes the following activities:1.   Social mobilization and Spot radio and television communication, SMS, flyers, banners, use of volunteers for educating households, involvement of civil society.2.   Logistics: preparation and production of management tools, maintenance of cold chain equipment3.   Strengthening the capacity of the immunization personnel: train all the vaccinators4.   Waste management5.   Monitoring and evaluation: post-introduction evaluations will be conducted throughout the country |

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| Please summarize in the table below the full costs of preparing for and introducing the vaccine, and specify which items are expected to be covered with the one-time GAVI grant. Please note that the country will be required to submit a detailed budget for the Vaccine Introduction Grant prior to release of funds. |

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| **Cost (and finance) to introduce the Rotavirus, 2 dose schedule USD** |

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| **Cost Category** | **Total cost for preparation of and delivery of campaign in USD** | **Funded with GAVI introduction grant in USD** |
| **Training** | 17,242 | 17,242 |
| **Social Mobilization, IEC and advocacy** | 39,370 | 13,937 |
| **Cold Chain Equipment & Maintenance** | 3,937 | 13,937 |
| **Vehicles and Transportation** | 4,390 | 10,453 |
| **Program Management** | 3,484 | 13,937 |
| **Surveillance and Monitoring** | 13,937 | 8,711 |
| **Human Resources** | 3,000 | 3,000 |
| **Waste Management** | 1,742 | 1,045 |
| **Technical Assistance** | 0 | 0 |
| **Other (please specify)** |  |  |
|  | 17,422 | 17,522 |
| **Total** | **104,524** | **99,784** |

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

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| Co-financing is provided completely by the State and no gap is possible.  |

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| **7. NVS Preventive Campaigns** |

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| **7.1. Assessment of burden of relevant diseases related to campaigns (if available)** |

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| **Disease** | **Title of the assessment** | **Date** | **Results** |
| Meningitis  | Epidemiological data from WHO | 2012 | Meningitis is responsible for approximately 170,000 cases of deaths every year. Approximately 10% to 20% of patients develop a disability. This situation leads to a heavy socio-economic burden for the families. The fatality rates for this disease are often very high reaching at 50%, if care is not provided. Despite measures taken by the health facilities to ensure a good reduction, the fatality rate exceeds 10%. |
| Meningitis | Epidemiological data from WHO | 2012 | 40 cases were notified in the three regions (Assaba, Hodh Gharbi and Hodh Gharbi) |
| Meningitis | Epidemiological data from WHO | 2009 | Meningococcal meningitis is responsible for approximately 80 to 85% of cases in the meningitis belt, where epidemics occur every 7 to 14 years.During the epidemic season of 2009, 14 African countries that implemented strengthened monitoring has recorded a total of 88,199 suspected cases, including 5,352 deaths, the highest number since 1996 epidemics. |
| Meningitis |  National monitoring system | 2002 | 66 cases of meningitis including 5 deaths |

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| **7.2. Request for Meningococcal type A, 10 dose(s) per vial, LYOPHILISED campaign support** |
| **7.2.1. Summary for Meningococcal type A campaign support** |
| When is the country planning to conduct this vaccine? **October 2014** |
| Please give a summary of the cMYP and/or the Meningococcal type A, 10 dose(s) per vial, LYOPHILISED introduction plan sections that refer to the introduction of Meningococcal type A, 10 dose(s) per vial, LYOPHILISED. Outline the key points that informed the decision-making process (data considered etc.) and describe the plans for social mobilization and micro planning, including strategies for insecure or hard-to-reach areas. |
| For the introduction of the conjugated vaccine against Men A in Mauritania, a meningitis evaluation was conducted by the WHO using the district prioritization tool (DPT). As a result of this analysis, the government decided to begin the process of preparing its submission to GAVI which includes the following steps:1. Introduction of the vaccine in 2014 in the form of vertical mass campaigns protecting the population of the 1-29 year age-group, or approximately 70% of the total population.
2. Immunization of 31 Districts (Barkéol, Guérrou, Kankossa, Kiffa, M'Bagne, Kaédi, Maghama, Monguel, Ould Yengé, Sélibaby, Amourj, Bassikounou, Djigueni, Néma, Oualata, Timbedra, Aioun, Kobeni, Tamchekett, Tintane, Boumdeid, Aleg, Bababé, Boghé, Maghtaa Lahjar, Moudjéria, Tichitt, Tidjikja, Boutilimit, R'Kiz, Rosso), spread over 8 regions (Assaba, Brakna, Gorgol, Guidimagha, Hodh Charghi, Hodh Gharbi, Tagant and Trarza),or a target population of **1,546,236** persons, corresponding to approximately **1,716,822** doses.
3. Various steps leading to the implementation of campaigns were discussed. They include, but are not limited to, the application to GAVI to be submitted in September 2013, recording the vaccine, regional micro-planning workshops and the monitoring and evaluation of these campaigns. A local committee for organizing campaigns including the WHO and UNICEF will be responsible for managing the entire process.
4. A communication plan is being prepared including both the routine EPI components and the introduction of new vaccines. This plan also considers the communication in the crisis period and plans actions to be carried out before, during and after the official launch. The plan will address the specific context of Mauritania, objectives to be achieved, strategies and main activities, including the evaluation, and a few critical steps for implementation, as well as required budget.
5. The opportunities to strengthen the monitoring of meningitis in the introduction of the conjugate vaccine against NmA were planned for.
6. The monitoring, detection and attentive response to epidemics, and case management were considered.

Based on experiences from previous campaigns conducted in Mauritania and lessons learned on the introduction of new vaccines, the main strategies for implementation recommended for the success of this inaugural campaign for introducing the conjugate vaccine against Meningitis A will be:1. Strengthening coordination at all levels (National, regional and local);
2. Strengthening the micro-planning process at the peripheral level for a better definition of roles and responsibilities, a better estimation of resources.
3. Strengthening communication/social mobilization especially in its local communication part with the involvement of local leaders;
4. Strengthening of personnel capabilities at all levels by training on various components of immunization campaigns;
5. Revision and multiplication of data management tools
6. Efficient supply of vaccines and inputs throughout the campaign;
7. Poor vaccine stock management and monitoring their use;
8. Strict implementation of injection safety and waste management;
9. Strengthening the pharmacovigilance, especially strengthening the AEFI monitoring and their proper management.
10. Strengthening supervision, monitoring and evaluation

This campaign requires a significant participation from international participants working in Mauritania (WHO, UNICEF, European Union, USAID, Rotary, Red Cross etc.) and economic operators (mobile phone), Para public and private companies.In order to measure the impact of this campaign, a case-wise monitoring system will be established.  Such as the first countries who have already introduced MenAfriVac, guides and case-wise monitoring tools will be revised. Cascade training for health and laboratory workers, purchase and equipment of the laboratory with reagents and equipment, and strengthening the mechanism for transporting the samples to referral laboratories will be carried out. Information technology (internet and SMS), will be used for data transmission.Clinical studies for MenAfriVac are being conducted and an indication for use in children aged less than 1 year is expected in January 2014. The country plans to introduce the vaccine when it is available in routine EPI based on the same co-financing principles for other new vaccines (pneumococcal in 2012 and Rotavirus in 2013). |
| Please summarize the cold chain capacity and readiness to accommodate new vaccines, taking into consideration training, cold chain and other logistic requirements. If cold chain expansion is required state how it will be financed, and when it will be in place. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled. |
| The cold chain is an essential component of the immunization program.Based on the data from the vaccine management assessment conducted in November 2010, the cold chain fleet was significantly strengthened to increase the storage capacities of antigens at all levels of the health pyramid before the introduction of the pneumococcal vaccine (2013), rotavirus vaccine and then for the preventive campaign against Meningitis (2014).The orders already placed by UNICEF and the Government helped strengthen the capabilities of all regions, sufficiently, during 2012-2013.An inventory of cold chain equipment was conducted in March 2013. The information collected was processed and analyzed using the CC equipment inventory tool adopted by the WHO.In all, 538 cold chain devices were surveyed in all health facilities in the country. The central level has 2 Cold rooms of which one is a negative room with a gross capacity of 10,000 liters and the other positive room has a gross capacity of 20,000 liters, 1 MK304 refrigerator with a net capacity of 108 liters, 4 TFW800 freezers with a net capacity of 145 liters each and 2 HBD-286 freezers with a capacity of 224 liters used for freezing batteries and a 75 KVA generator ensures relay in case of a power failure.Note that Mauritania has ordered 2 cold rooms, one of 30m3 being installed at central EPI and the other of 10m3 at the Regional Health Directorate of Nouakchott.The positive storage capacities currently available at the central level with the installation of the new cold room of 30m3, mentioned above, not only helps in storing all quantities required for the routine program but also in the introduction of PCV-13 vaccines (against pneumococcal), Rotarix vaccine (against Rotavirus) and MenAfriVac vaccine (against Meningitis).The situational analysis shows that for regional health directorates who have had operational devices during the evaluation, negative storage capacity can accommodate negative storage. The situation until 2015 does not show any significant additional requirement. The equipment planned in 2011 and during acquisition is able to bridge all the gaps. Maintenance of business equipment after this evaluation contributed to resolving the problem.For the campaign, the vaccine will be distributed in various regions and isotherm boxes will be used to transport the vaccine from regional level to districts. The districts will use these boxes and ice-boxes available at their level to transport the vaccines to health centers.  Based on the availability on the field, all teams will each have a vaccine carrier for implementing the campaign. However, the mobile teams will need an ice-box and an additional vaccine carrier to store vaccines and batteries. |
| Please describe how the campaign activities will contribute to strengthening routine immunization services. Please refer to specific activities to be undertaken during planning and implementation, to evaluate the implementation of the routine strengthening activities completed during the campaign, and to assess, via an independent survey, the quality and coverage achieved through the campaign. |
| Activities of the campaign will contribute in strengthening the routine through:        The results of micro-planning workshops and the budgeting of activities for the introduction will be used for planning the routine;        Advocacy and awareness at the authorities’ location will be utilized for immunization in general,    Strengthening cold chain logistics: cold rooms, refrigerators, freezers, vaccine carriers and ice-boxes will be used after the campaign to improve the storage capacity.        The communication plan prepared by considering the component of introducing new vaccines and routine EPI.     Plan for procurement of inputs to health facilities will also be used for routine EPI; vaccines and consumables can be transported to the areas, especially less accessible during the campaign;Monitoring, follow-up, supervision: The campaign supervisors benefit from their movement in regions/districts to supervise the routine, discuss with local officers and update expected reports. |
| Please submit relevant documentation to support the estimates of the size of the campaign target population (as DOCUMENT NO.: 18). |

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| **7.2.2. Grant Support for Operational Costs of the Meningococcal type A Campaign** |

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| **Table 7.2.2:** Calculation of grant to support the operational costs of the campaigns |

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| **Year of Meningococcal type A support** | **Target population vaccinated (from Table 5.3)**  | **GAVI contribution per target person in USD** | **Total in USD** |
| 2014 | 1,546,236 | 0.65 | 1,005,053 |

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| [1] The Grant will be based on a maximum award of $0.65$ per target person |

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| Please describe how the grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population (refer to the cMYP and the Vaccine Introduction Plan). |
| The introduction grant will be used for the acquisition of inputs, strengthening the capabilities of participants and system and increased use of immunization.  The vaccines and injection material will be procured through UNICEF-Mauritania  Strengthening the cold chain at operational level by establishing the maintenance contract  Training and retraining the regional, EPI district managers and vaccinators        Printing and distribution of adapted supervision tools        Conduct supportive supervision         Reproduction of revised reporting tools        Set-up reporting tools in regional and district head-quarters  Social mobilization Communication        Organization of the inaugural ceremony         Conference-discussions at the central level        Communication activities in regional and district head-quarters        Communication activities in the USPs        Reproduction of revised social mobilization materials        Set-up revised social mobilization materials in regional headquarters  Conduct an evaluation after introductionPreparation and distribution of a technical document on the introduction of various vaccines from routine EPI to DRAS |

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| **Cost (and finance) of the Meningococcal type A, 10 dose(s) per vial, LYOPHILISED campaign USD** |

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| **Cost Category** | **Total cost for preparation of and delivery of campaign in USD** | **Funded with GAVI introduction grant in USD** |
|  | **2014** | **2014** |
| **Training** | 30,000 | 30,000 |
| **Social Mobilization, IEC and advocacy** | 100,000 | 80,000 |
| **Cold Chain Equipment & Maintenance** | 350,000 | 300,000 |
| **Vehicles and Transportation** | 100,000 | 80,000 |
| **Program Management** | 10,000 | 10,000 |
| **Surveillance and Monitoring** | 50,000 | 50,000 |
| **Human Resources** | 200,000 | 200,000 |
| **Waste Management** | 25,000 | 25,000 |
| **Technical Assistance** | 50,000 | 50,000 |
| **Planning** | 35,000 | 35,000 |
| **Volunteer incentives** | 0 | 0 |
| **Other (please specify)** |  |  |
| **Assessment** | 25,000 | 25,000 |
| **Preparation and duplication of tools** | 25,000 | 25,000 |
| **Monitoring** | 20,000 | 20,000 |
|  | 75,000 | 75,000 |
| **Total** | **1,095,000** | **1,005,000** |

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

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| The campaign budgeting gives a total cost of USD 1,095,000 of which USD 1,005,000 will be provided by GAVI.  Mobilization will be made by the State and its local partners such as the World Bank to fill the GAP of approximately USD 90,000. |

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| **8. Procurement and Management** |

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| **8.1 Procurement and Management of New and Under-Used Vaccines Routine** |

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| **Note:** The PCV vaccine must be procured through UNICEF to be able to access the price awarded by the Advance Market Commitment (AMC). |

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| 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): |
| In 1996, Mauritania initiated the vaccine independence, and since then a budget line is provided every year for the procurement of vaccines and consumables. The vaccines are received and stored at central level cold chains which in turn distribute them.The country decided that its vaccines will be procured through UNICEF in compliance with an MOU with UNICEF for refundable purchases. The funds will be regularly disbursed by the Government to the GAVI UNICEF bank account for traditional vaccines as part of the Vaccine Independence Initiative (VII). |
| b) If an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or the GAVI Alliance) is requested, please document |
|  |  | Other vaccines or immunization commodities procured by the country and descriptions of the mechanism used. |
|  |  | The functions of the National Regulatory Authority (as evaluated by WHO) to show they comply with WHO requirements for the procurement of vaccines and assured quality. |
| Not Applicable (N/A) |
| c) Please indicate how funds should be transferred by the GAVI Alliance (if applicable) |
| GAVI funds will be transferred to the bank account of the Ministry of Health, the details of which are provided in the appendix |
| d) Please indicate how the co-financing amounts will be paid (and who is responsible for this) |
| A budget line is given in the financial law for the procurement of traditional vaccines and the proportionate share of the State in the purchase of new vaccines. These funds are completely transferred to the country’s account opened at UNICEF as part of the vaccine independence initiative. The EPI coordinator estimates the vaccine requirements, Secretary general validates and sends them, to the DAF of the Ministry of Health who deals with the transfer from the public treasury to UNICEF, for execution  |
| e) Please describe the financial management procedures that will be applied for the management of the NVS cash support, including procurement. |
| With regards to Rotavirus, a fixed contribution of approximately USD 100,000, for the preparation of the introduction itself, is generally allocated. These funds will be used as follows;Firstly a utilization plan is prepared by the EPI coordinator and presented for amendment after validation by the ICC. Once the plan is validated, it is sent to GAVI for disbursement to the account of the Ministry of Health; These funds are disbursed on the basis of a check co-signed by the National EPI coordinator and the EPI financial and administrative head on filing the request justifying the activity. The EPI coordinator, also the ICC secretary, provides management and justification of expenses. |
| f) Please outline how coverage of the new vaccine will be monitored and reported (refer to cMYP) |
| The immunization data for vaccine against Rotavirus will be collected in the health units and health centers on the same standard tools provided by EPI which are already being used for other vaccines. These tools will initially be revised to integrate the aspects related to the Rotavirus vaccine. This data will be validated by the local health managers before sending them to the higher level as is normally the case. At the district level the monitoring will be on a monthly basis and reviews will be organized quarterly at regional and central level to measure the progress made and identify the bottle-necks. At the national level, the immunization data will be periodically validated by the ICC before sharing them at the international level.The DQS will be one of the pillars which the data quality monitoring will rely on.Auto-evaluation of data quality will also be strengthened at decentralized level.The international level will be notified by:* GAVI annual progress report;
* WHO/UNICEF Joint Reporting Form
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| g) If applying for second dose measles, does the country wish to have the support in cash or in-kind? **N/A** |

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| **8.2 Procurement and Management for NVS Preventive Campaign(s)** |

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| **8.2.1 Procurement and Management for Meningococcal type A, 10 dose(s) per vial, LYOPHILISED campaign** |
|  a) Please show how the support will operate and be managed including procurement of vaccines (GAVI expects that countries will procure vaccine and injection supplies through UNICEF):  |
| There is a provision under the current mechanism for the purchase of traditional vaccines and consumables through UNICEF, under the terms of the memorandum of agreement for the provision of procurement services between UNICEF and the Ministry of Health in Mauritania.  |
| b) Please describe the financial management procedures that will be applied for the management of the preventive campaign cash support, including any procurement to be incurred. |
| Under the preventive meningococcal campaign, funds of approximately USD 1,005,000 will be managed as follows: Once the proposal is approved, a utilization plan will be prepared and presented to the ICC for validation and sent to GAVI. The amounts for operational costs will go through the WHO and deposited in the accounts of the Ministry of Health upon submission of a request duly signed by the Secretary General. The Director of Financial Affairs of the Ministry of Health will manage and transfer at various cost center levels.   At the end of the campaign, a technical report and a financial statement will be prepared, presented to ICC and sent to the partners.With respect to external purchases, especially vaccines, consumables and cold chain equipment, we suggest that their allocation should be deducted from the campaign budget and transferred directly by GAVI to UNICEF who will ensure the procurement and transport as per its own procedures and in compliance with the MOU signed between this institution and Mauritanian government.  Finally, the social mobilization funds will go through UNICEF and transferred as per the same procedure described above (for WHO) in the accounts of the Ministry of Health. |
| c) Please indicate if the campaign is going to be phased, and if so, how this will be done. |
| The vaccine will be introduced in the fourth quarter of 2014 in 31 Districts (Barkéol, Guérrou, Kankossa, Kiffa, M'Bagne, Kaédi, Maghama, Monguel, Ould Yengé, Sélibaby, Amourj, Bassikounou, Djigueni, Néma, Oualata, Timbedra, Aioun, Kobeni, Tamchekett, Tintane, Boumdeid, Aleg, Bababé, Boghé, Maghtaa Lahjar, Moudjéria, Tichitt, Tidjikja, Boutilimit, R'Kiz, Rosso), spread over 8 regions (Assaba, Brakna, Gorgol, Guidimagha, Hodh Charghi, Hodh Gharbi, Tagant and Trarza). Introduction of the vaccine in 2014 in the form of vertical mass campaigns protecting the 1-29 year population age-group, or approximately 70% of the total population, or 1,546,236 people. This vaccine is introduced in the country through a vast immunization campaign. Under this submission, an initial campaign plan with MenAfriVac was prepared. The plan will address the specific context of Mauritania, objectives to be achieved, strategies and main activities, including the evaluation, and a few critical steps for implementation, as well as required budget, according to the regular strategies described in the cMYP. |
| d) Please outline how coverage of the new vaccine will be monitored and reported (refer to the cMYP and/or the Meningococcal type A, 10 dose(s) per vial, LYOPHILISED campaign introduction plan) |
| The coverage will be monitored by the intermediary of immunization activity reports and through the vaccination coverage survey at the end of the campaign.- Administrative monitoring (daily coverage estimates)-  Daily monitoring (during the campaign) by supervisors in the advanced and mobile strategic areas.- An evaluation of the campaign including vaccination coverage according to the WHO methodology will be conducted at the 31 districts concerned. |

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| **8.3 Vaccine Management (EVSM/ EVM/ VMA)** |

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| Under the new guidelines, it is mandatory for countries to conduct an Effective Vaccine Management (EVM) assessment prior to an application for introduction of a new vaccine. This EVM should have been conducted within the preceding 36 months. |
| Did the country have Effective Vaccine Management (EVM) in the past? **Yes** |
| When was the EVM conducted? **December 2010** |
| Please attach the most recent EVM report (DOCUMENT NO.: 20, 21, 22), the corresponding EVM improvement plan (DOCUMENT NO.: 21) and progress on the EVM improvement plan (DOCUMENT NO.: 22). The improvement plan should include a timeline, budget of committed resources for these activities and funding gaps, if any, as well as M&E indicators to monitor implementation progress. |
| Does the country plan to conduct an Effective Vaccine Management (EVM) Assessment in the future? **Yes** |
| When is the next Effective Vaccine Management (EVM) Assessment planned? **November 2013** |

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| **8.4 Waste management** |

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| Please describe the country’s waste management plan for immunization activities (including campaigns). Include details on the safe handling, storage, transportation and disposal of immunization waste. |
| It is accepted that waste management constitutes a major concern for all immunization programs.  This concern is strengthened since Mauritania adopted the widespread use of Auto-disable syringes (AD syringes) while ensuring sterility of injection material used for each dose have increased the amount of needle waste to be managed.  All injections are administered using Auto-disable syringes (AD syringes). The technical sheets on injection safety will be provided to all service delivery points. The usage precautions will be adhered to (one AD syringe per person, a dilution syringe per vial of antigen, no pre-filling or recapping of syringes...)All used needles will be collected immediately in safety boxes (SB). The guidelines for collecting (3/4) and securing (closed, taped, identified, stored in a secure location...) SB will be carefully monitored. During the mass campaigns, the following are the waste management strategies:* Firstly, pre-collect safety boxes from immunization points to district headquarters by the supervisors
* Collection from headquarters to areas identified for incinerating these boxes
* Incinerate boxes in incinerators

All 54 districts of the country need to have an incinerator. In the 31 districts concerned by the campaign, incinerators should be built to avoid transporting waste (safety boxes) to another incineration location (plant, hospitals, neighboring districts...)  |

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| **9. Additional Comments and Recommendations from the National Coordinating Body (ICC/HSCC)** |

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| Comments and Recommendations from the National Coordinating Body (ICC/HSCC) |

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| We would like to remind that the versions of the proposal downloaded in MS Word pose difficulties such as executive summary does not appear, but also other paragraphs that can be mixed. We observed that for question no. 8 (purchase and management) and other questions. Most of the comments received from colleagues are already entered on the portal while they are completely mixed on WORD. These difficulties are encountered this year, for the first time, when downloading in MS WORD. In this respect, we urge GAVI to consider the fact that the MS WORD version does not completely reflect that which is written on the online portal.<?xml:namespace prefix = u5 />  |

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| **10. List of documents attached to this proposal** |

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| **Document Number** | **Document** | **Section** | **Mandatory**  | **File** |
|  |  |  |  | Signatures MS\_MF.pdf |
| 1 | MoH Signature (or delegated authority) of Proposal |  | bl | File desc: PDF file, signatures of the ministries of health and finance. |
|  |  |  |  | Date/time: 9/12/2013 11:48:59 AM |
|  |  |  |  | Size: 719370 |
|  |  |  |  | Signatures MS\_MF.pdf |
| 2 | MoF Signature (or delegated authority) of Proposal |  | bl | File desc: PDF file, signatures of the ministries of health and finance. |
|  |  |  |  | Date/time: 9/12/2013 11:50:35 AM |
|  |  |  |  | Size: 719370 |
|  |  |  |  | Signatures CCIA.pdf |
| 3 | Signatures of ICC or HSCC or equivalent in Proposal |  | bl | File desc: PDF file, signatures of the members of ICC. |
|  |  |  |  | Date/time: 9/12/2013 11:52:48 AM |
|  |  |  |  | Size: 1372766 |
|  |  |  |  | ARRETE CCIA PEV.pdf |
| 4 | Terms of Reference for the ICC | 4.1.2 | bl | File desc: PDF File, decree regarding creation of the ICC with TOR. |
|  |  |  |  | Date/time: 9/11/2013 1:21:36 PM |
|  |  |  |  | Size: 83849 |
|  |  |  |  | PV CCIA 9 sept 2013.pdf |
| 4 | Minutes of ICC/HSCC meeting endorsing Proposal |  | bl | File desc: PDF File, Minutes of the ICC meeting endorsing the proposal. |
|  |  |  |  | Date/time: 9/11/2013 1:24:46 PM |
|  |  |  |  | Size: 3098853 |
|  |  |  |  | PPaC\_Mauritanie\_15112011.doc |
| 5 | comprehensive Multi Year Plan - cMYP |  | bl | File desc: Word File on cMYP 2012-2015 |
|  |  |  |  | Date/time: 9/11/2013 1:33:02 PM |
|  |  |  |  | Size: 1832448 |
|  |  |  |  | Costing tool Mauritanie15112011.xls |
| 6 | cMYP Costing tool for financial analysis |  | bl | File desc: Excel file on cMYP budget |
|  |  |  |  | Date/time: 9/11/2013 1:35:22 PM |
|  |  |  |  | Size: 3484672 |
|  |  |  |  | Plan\_Introduction\_Rota\_Mau\_20130913.doc |
| 7 | Plan for NVS introduction (if not part of cMYP) | 5.1 | bl | File desc: Word file, Introduction Plan for Rotavirus |
|  |  |  |  | Date/time: 9/13/2013 1:22:29 PM |
|  |  |  |  | Size: 1137664 |
|  |  |  |  | PV réunions CCIA.rar |
| 7 | Minutes of last three ICC/HSCC meetings |  | bl | File desc: Zip file with four minutes of meetings held in 2013 with the endorsement of the proposal. |
|  |  |  |  | Date/time: 9/11/2013 1:30:22 PM |
|  |  |  |  | Size: 9787131 |
|  |  |  |  | Suivi du plan d'amélioration de la GEV 2012-2013.pdf |
| 8 | Improvement plan based on EVM |  | bl | File desc: PDF File, monitoring the recommendations of the improvement plan in EVM |
|  |  |  |  | Date/time: 9/12/2013 12:38:35 PM |
|  |  |  |  | Size: 487075 |
|  |  |  |  | Plan\_Introduction\_Men\_ Mau 20130910.doc |
| 18 | Campaign target population documentation | 7.x.1 | bl | File desc: WORD file, Plan for the campaign against meningitis (Men Afrivac) |
|  |  |  |  | Date/time: 9/11/2013 1:53:53 PM |
|  |  |  |  | Size: 2145792 |
|  |  |  |  | EVM report Mauritanie\_110.rar |
| 20 | EVM report | 8.3 | bl | File desc: FPDF file, EVM report conducted end of 2010. |
|  |  |  |  | Date/time: 9/11/2013 1:44:44 PM |
|  |  |  |  | Size: 10188318 |
|  |  |  |  | Suivi du plan d'amélioration de la GEV 2012-2013.pdf |
| 22 | EVM improvement plan progress report | 8.3 | bl | File desc: PDF File, monitoring the recommendations of the improvement plan in EVM |
|  |  |  |  | Date/time: 9/12/2013 12:39:40 PM |
|  |  |  |  | Size: 487075 |

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| **11. Annexes** |

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| **Annex 1 - NVS Routine Support** |

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| **Annex 1.1 - NVS Routine Support (Rotavirus, 2 dose schedule)** |
| **Table Annex 1.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in USD** |

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|  |  | **2014** | **2015** |
| **Number of vaccine doses** | **#** | 4,400 | 26,200 |
| **Number of AD syringes** | **#** | 0 | 0 |
| **Number of re-constitution syringes** | **#** | 0 | 0 |
| **Total value to be co-financed by the Country [1]** | **$** | 12,000 | 70,500 |

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| **Table Annex 1.1 B: Rounded up portion of supply that is procured by GAVI and estimate of relative costs in USD** |

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|  |  | **2014** | **2015** |
| **Number of vaccine doses** | **#** | 54,100 | 324,000 |
| **Number of AD syringes** | **#** | 0 | 0 |
| **Number of re-constitution syringes** | **#** | 0 | 0 |
| **Total value to be co-financed by GAVI** | **$** | 145,000 | 868,000 |

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| **Table Annex 1.1 C: Summary table for vaccine Rotavirus, 2 -dose schedule** |

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| **ID** |  | **Data from** |  | **2014** | **2015** |
|  | **Number of surviving infants** | Table 5.2 | # | 141,974 | 145,382 |
|  | **Number of children to be vaccinated with the first dose** | Table 5.2 | # | 21,666 | 137,153 |
|  | **Number of children to be vaccinated with the second dose** | Table 5.2 | # | 19,876 | 129,389 |
|  | **Number of children to be vaccinated with the third dose** | Table 5.2 | # | 119,258 | 129,389 |
|  | **Immunization coverage with the second dose** | Table 5.2 | % | 14.00 % | 89.00 % |
|  | **Immunization coverage with the third dose** | Table 5.2 | % | 84.00 % | 89.00 % |
|  | **Number of doses per child** | Parameter | # | 2 | 2 |
|  | **Estimated vaccine wastage factor** | Table 5.2 | # | 1.05 | 1.05 |
|  | **Number of doses per vial** | Parameter | # | 1 | 1 |
|  | **AD syringes required** | Parameter | # | No | No |
|  | **Reconstitution syringes required** | Parameter | # | No | No |
|  | **Safety boxes required** | Parameter | # | No | No |
| **g** | **Vaccine price per dose** | Table Annexes 4A | $ | 2.55 | 2.55 |
| **cc** | **Country co-financing per dose** | Table 6.4.1 | $ | 0.2 | 0.2 |
| **ca** | **AD syringe price per unit** | Table Annexes 4A | $ | 0.0465 | 0.0465 |
| **cr** | **Reconstitution syringe price per unit** | Table Annexes 4A | $ | 0 | 0 |
| **cs** | **Safety box price per unit** | Table Annexes 4A | $ | 0.58 | 0.58 |
| **fv** | **Freight cost as % of vaccines value** | Table Annexes 4B | % | 5.00 % | 5.00 % |
| **fd** | **Freight cost as % of devices value** | Parameter | % | 0 | 0 |

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**Table Annex 1.1 D: Estimated numbers for Rotavirus, 2 dose schedule, associated injection safety material and related co-financing budget (page 1)**

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|  |  | **Formula** | **2014** |
|  |  |  | **Total** | **Government** | **GAVI** |
| **A** | **Country co-finance** |  | 7.47 % |  |  |
| **B** | **Number of children to be vaccinated with the first dose** | Table 1 | 21,666 | 1,619 | 20,047 |
| **C** | **Number of doses per child** | Vaccine parameter (schedule) | 2 |  |  |
| **D** | **Number of doses needed** | B x C | 43,332 | 3,237 | 40,095 |
| **E** | **Estimated vaccine wastage factor** | Wastage factor table | 1.05 |  |  |
| **F** | **Number of doses needed including wastage** | D x E | 45,499 | 3,399 | 42,100 |
| **G** | **Vaccines buffer stock** | (F – F of previous year) \* 0.25 | 11,375 | 850 | 10,525 |
| **I** | **Total vaccine doses needed** | (((F + G) / Vaccine package size) + 1) \* Vaccine package size | 58,374 | 4,361 | 54,013 |
| **J** | **Number of doses per vial** | Vaccine parameter | 1 |  |  |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | (D + G) x 1.11 | 0 | 0 | 0 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | I / J \* 1.11 | 0 | 0 | 0 |
| **N** | **Cost of vaccines needed** | I x g | 148,854 | 11,120 | 137,734 |
| **O** | **Cost of AD syringes needed** | K x ca | 0 | 0 | 0 |
| **P** | **Cost of reconstitution syringes needed** | L x cr | 0 | 0 | 0 |
| **Q** | **Cost of safety boxes needed** | M x cs | 0 | 0 | 0 |
| **R** | **Freight cost for vaccines needed** | N x fv | 7,443 | 556 | 6,887 |
| **S** | **Freight cost for devices needed** | (O+P+Q) x fd | 0 | 0 | 0 |
| **T** | **Total fund needed** | (N+O+P+Q+R+S) | 156,297 | 11,675 | 144,622 |
| **U** | **Total country co-financing** | I 3 cc | 11,675 |  |  |
| **V** | **Country co-financing % of GAVI supported proportion** | U / T | 7.47 % |  |  |

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| **Table Annex 1.1 D: Estimated numbers for Rotavirus, 2 dose schedule, associated injection safety material and related co-financing budget (page 2)** |

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|  |  | **Formula** | **2015** |
|  |  |  | **Total** | **Government** | **GAVI** |
| **A** | **Country co-finance** |  | 7.47 % |  |  |
| **B** | **Number of children to be vaccinated with the first dose** | Table 1 | 137,153 | 10,245 | 126,908 |
| **C** | **Number of doses per child** | Vaccine parameter (schedule) | 2 |  |  |
| **D** | **Number of doses needed** | B x C | 274,306 | 20,490 | 253,816 |
| **E** | **Estimated vaccine wastage factor** | Wastage factor table | 1.05 |  |  |
| **F** | **Number of doses needed including wastage** | D x E | 288,022 | 21,515 | 266,507 |
| **G** | **Vaccines buffer stock** | (F – F of previous year) \* 0.25 | 60,631 | 4,529 | 56,102 |
| **I** | **Total vaccine doses needed** | (((F + G) / Vaccine package size) + 1) \* Vaccine package size | 350,153 | 26,156 | 323,997 |
| **J** | **Number of doses per vial** | Vaccine parameter | 1 |  |  |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | (D + G) x 1.11 | 0 | 0 | 0 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | I / J \* 1.11 | 0 | 0 | 0 |
| **N** | **Cost of vaccines needed** | I x g | 892,891 | 66,697 | 826,194 |
| **O** | **Cost of AD syringes needed** | K x ca | 0 | 0 | 0 |
| **P** | **Cost of reconstitution syringes needed** | L x cr | 0 | 0 | 0 |
| **Q** | **Cost of safety boxes needed** | M x cs | 0 | 0 | 0 |
| **R** | **Freight cost for vaccines needed** | N x fv | 44,645 | 3,335 | 41,310 |
| **S** | **Freight cost for devices needed** | (O+P+Q) x fd | 0 | 0 | 0 |
| **T** | **Total fund needed** | (N+O+P+Q+R+S) | 937,536 | 70,031 | 867,505 |
| **U** | **Total country co-financing** | I 3 cc | 70,031 |  |  |
| **V** | **Country co-financing % of GAVI supported proportion** | U / T | 7.47 % |  |  |

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| **Annex 2 - NVS Routine – Preferred Second Presentation** |

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| **Annex 2.1 - NVS Routine Support (Rotavirus, 3 dose schedule)** |
| **Table Annex 2.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in USD** |

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|  |  | **2014** | **2015** |
| **Number of vaccine doses** | **#** | 4,400 | 26,200 |
| **Number of AD syringes** | **#** | 0 | 0 |
| **Number of re-constitution syringes** | **#** | 0 | 0 |
| **Total value to be co-financed by the Country [1]** | **$** | 12,000 | 70,500 |

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| **Table Annex 2.1 B: Rounded up portion of supply that is procured by GAVI and estimate of relative costs in USD** |

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|  |  | **2014** | **2015** |
| **Number of vaccine doses** | **#** | 54,100 | 324,000 |
| **Number of AD syringes** | **#** | 0 | 0 |
| **Number of re-constitution syringes** | **#** | 0 | 0 |
| **Total value to be co-financed by GAVI** | **$** | 145,000 | 868,000 |

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| **Table Annex 2.1 C: Summary table for vaccine Rotavirus, 3 -dose schedule** |

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| **ID** |  | **Data from** |  | **2014** | **2015** |
|  | **Number of surviving infants** | Table 5.2 | # | 141,974 | 145,382 |
|  | **Number of children to be vaccinated with the first dose** | Table 5.2 | # | 21,666 | 137,153 |
|  | **Number of children to be vaccinated with the third dose** | Table 5.2 | # | 19,876 | 129,389 |
|  | **Immunization coverage with the third dose** | Table 5.2 | % | 14.00 % | 89.00 % |
|  | **Number of doses per child** | Parameter | # | 3 | 3 |
|  | **Estimated vaccine wastage factor** | Table 5.2 | # | 1.05 | 1.05 |
|  | **Number of doses per vial** | Parameter | # | 1 | 1 |
|  | **AD syringes required** | Parameter | # | No | No |
|  | **Reconstitution syringes required** | Parameter | # | No | No |
|  | **Safety boxes required** | Parameter | # | No | No |
| **g** | **Vaccine price per dose** | Table Annexes 4A | $ | 3.5 | 3.5 |
| **cc** | **Country co-financing per dose** | Table 6.4.1 | $ | 0.2 | 0.2 |
| **ca** | **AD syringe price per unit** | Table Annexes 4A | $ | 0.0465 | 0.0465 |
| **cr** | **Reconstitution syringe price per unit** | Table Annexes 4A | $ | 0 | 0 |
| **cs** | **Safety box price per unit** | Table Annexes 4A | $ | 0.58 | 0.58 |
| **fv** | **Freight cost as % of vaccines value** | Table Annexes 4B | % | 5.00 % | 5.00 % |
| **fd** | **Freight cost as % of devices value** | Parameter | % | 0 | 0 |

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| **Table Annex 2.1 D: Estimated numbers for Rotavirus, 3 dose schedule, associated injection safety material and related co-financing budget (page 1)** |

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|  |  | **Formula** | **2014** |
|  |  |  | **Total** | **Government** | **GAVI** |
| **A** | **Country co-finance** |  | 7.47 % |  |  |
| **B** | **Number of children to be vaccinated with the first dose** | Table 1 | 21,666 | 1,619 | 20,047 |
| **C** | **Number of doses per child** | Vaccine parameter (schedule) | 2 |  |  |
| **D** | **Number of doses needed** | B x C | 43,332 | 3,237 | 40,095 |
| **E** | **Estimated vaccine wastage factor** | Wastage factor table | 1.05 |  |  |
| **F** | **Number of doses needed including wastage** | D x E | 45,499 | 3,399 | 42,100 |
| **G** | **Vaccines buffer stock** | (F – F of previous year) \* 0.25 | 11,375 | 850 | 10,525 |
| **I** | **Total vaccine doses needed** | (((F + G) / Vaccine package size) + 1) \* Vaccine package size | 58,374 | 4,361 | 54,013 |
| **J** | **Number of doses per vial** | Vaccine parameter | 1 |  |  |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | (D + G) x 1.11 | 0 | 0 | 0 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | I / J \* 1.11 | 0 | 0 | 0 |
| **N** | **Cost of vaccines needed** | I x g | 148,854 | 11,120 | 137,734 |
| **O** | **Cost of AD syringes needed** | K x ca | 0 | 0 | 0 |
| **P** | **Cost of reconstitution syringes needed** | L x cr | 0 | 0 | 0 |
| **Q** | **Cost of safety boxes needed** | M x cs | 0 | 0 | 0 |
| **R** | **Freight cost for vaccines needed** | N x fv | 7,443 | 556 | 6,887 |
| **S** | **Freight cost for devices needed** | (O+P+Q) x fd | 0 | 0 | 0 |
| **T** | **Total fund needed** | (N+O+P+Q+R+S) | 156,297 | 11,675 | 144,622 |
| **U** | **Total country co-financing** | I 3 cc | 11,675 |  |  |
| **V** | **Country co-financing % of GAVI supported proportion** | U / T | 7.47 % |  |  |

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| **Table Annex 2.1 D: Estimated numbers for Rotavirus, 3 dose schedule, associated injection safety material and related co-financing budget (page 2)** |

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|  |  | **Formula** | **2015** |
|  |  |  | **Total** | **Government** | **GAVI** |
| **A** | **Country co-finance** |  | 7.47 % |  |  |
| **B** | **Number of children to be vaccinated with the first dose** | Table 1 | 137,153 | 10,245 | 126,908 |
| **C** | **Number of doses per child** | Vaccine parameter (schedule) | 2 |  |  |
| **D** | **Number of doses needed** | B x C | 274,306 | 20,490 | 253,816 |
| **E** | **Estimated vaccine wastage factor** | Wastage factor table | 1.05 |  |  |
| **F** | **Number of doses needed including wastage** | D x E | 288,022 | 21,515 | 266,507 |
| **G** | **Vaccines buffer stock** | (F – F of previous year) \* 0.25 | 60,631 | 4,529 | 56,102 |
| **I** | **Total vaccine doses needed** | (((F + G) / Vaccine package size) + 1) \* Vaccine package size | 350,153 | 26,156 | 323,997 |
| **J** | **Number of doses per vial** | Vaccine parameter | 1 |  |  |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | (D + G) x 1.11 | 0 | 0 | 0 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | I / J \* 1.11 | 0 | 0 | 0 |
| **N** | **Cost of vaccines needed** | I x g | 892,891 | 66,697 | 826,194 |
| **O** | **Cost of AD syringes needed** | K x ca | 0 | 0 | 0 |
| **P** | **Cost of reconstitution syringes needed** | L x cr | 0 | 0 | 0 |
| **Q** | **Cost of safety boxes needed** | M x cs | 0 | 0 | 0 |
| **R** | **Freight cost for vaccines needed** | N x fv | 44,645 | 3,335 | 41,310 |
| **S** | **Freight cost for devices needed** | (O+P+Q) x fd | 0 | 0 | 0 |
| **T** | **Total fund needed** | (N+O+P+Q+R+S) | 937,536 | 70,031 | 867,505 |
| **U** | **Total country co-financing** | I 3 cc | 70,031 |  |  |
| **V** | **Country co-financing % of GAVI supported proportion** | U / T | 7.47 % |  |  |

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| **Annex 3 - NVS Preventive campaign(s)** |

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| **Annex 3.1 - NVS Preventive campaign(s) (Meningococcal type A, 10 dose(s) per vial, LYOPHILISED)** |
| **Table Annex 3.1 C: Summary table for CAMPAIGN Meningococcal type A, 10 dose(s) per vial, LYOPHILISED** |

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|  | **Data from** |  | **2014** |
| **Total campaign population** | Table 5.3.1 | # | 1,546,236 |
| **Immunization coverage** | Table 5.3.1 | % | 100.00 % |
| **Number of persons to be vaccinated** | Table 5.3.1 | # | 1,546,236 |
| **Number of doses per persons** | Parameter | # | 1 |
| **Estimated vaccine wastage factor** | Table 5.3.1 | # | 1.11 |
| **Vaccine stock on 31st December <span style="background-color:#D9D9D9">{0}</span> \* (see explanation footnote)** | Table 5.3.1 | # | 0 |
| **Number of doses per vial** | Parameter | # | 10 |
| **AD syringes required** | Parameter | # | Yes |
| **Reconstitution syringes required** | Parameter | # | Yes |
| **Safety boxes required** | Parameter | # | No |
| **Vaccine price per dose** | Table Annexes 4A | $ | 0.5544 |
| **AD syringe price per unit** | Table Annexes 4A | $ | 0.0465 |
| **Reconstitution syringe price per unit** | Table Annexes 4A | $ | 0.037 |
| **Safety box price per unit** | Table Annexes 4A | $ | 0.58 |
| **Freight cost as % of vaccines value** | Table Annexes 4B | % | 10.00 % |
| **Freight cost as % of devices value** | Parameter | % | 10.00 % |

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| **Table Annex 3.1 D: Estimated number of Meningococcal type A, 10 dose(s) per vial, LYOPHILISED associated injection safety material and related co-financing budget (page 1)** |

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|  |  | **Formula** | **GAVI** |
|  |  |  | **2014** |
| **B** | **Number of persons to be vaccinated with the first dose** |  | 1,546,236 |
| **C** | **Number of doses per persons** |  | 1 |
| **D** | **Number of doses needed** | B x C | 1,546,236 |
| **E** | **Estimated vaccine wastage factor** | Wastage factor table | 1.11 |
| **F** | **Number of doses needed including wastage** | D x E | 1,716,322 |
| **G** | **Vaccines buffer stock** | 0 | 0 |
| **I** | **Total vaccine doses needed** | (((F + G) / Vaccine package size) + 1) \* Vaccine package size | 1,716,822 |
| **J** | **Number of doses per vial** | Vaccine parameter | 10 |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | (D + G) x 1.11 | 1,716,322 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | I / J \* 1.11 | 190,568 |
| **N** | **Cost of vaccines needed** | I x g | 0.55 |
| **O** | **Cost of AD syringes needed** | K x ca | 79,808.97 |
| **P** | **Cost of reconstitution syringes needed** | L x cr | 7,052 |
| **Q** | **Cost of safety boxes needed** | M x cs | 0 |
| **R** | **Freight cost for vaccines needed** | N x fv | 0 |
| **S** | **Freight cost for devices needed** | (O+P+Q) x fd | 8,687 |
| **T** | **Total fund needed** | (N+O+P+Q+R+S) | 1,047,354.97 |

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| **Note: There is no co-financing for NVS preventive campaigns** |

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| **Annex 4** |

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| **Table Annex 4A: Cost of Commodities** |

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| **Vaccine** | **Presentation** | **2014** | **2015** | **2016** |
| **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID** | 1 | 2.036 | 1.986 | 1.927 |
| **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID** | 10 | 2.036 | 1.986 | 1.927 |
| **DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED** | 2 | 2.036 | 1.986 | 1.927 |
| **HPV bivalent, 2 dose(s) per vial, LIQUID** | 2 | 4.600 | 4.600 | 4.600 |
| **HPV quadrivalent, 1 dose(s) per vial, LIQUID** | 1 | 4.500 | 4.500 | 4.500 |
| **Measles second dose, 10 dose(s) per vial, LYOPHILISED** | 10 | 0.286 | 0.296 | 0.322 |
| **Meningococcal type A, 10 dose(s) per vial, LYOPHILISED** | 10 | 0.554 | 0.582 | 0.611 |
| **MR, 10 dose(s) per vial, LYOPHILISED** | 10 | 0.532 | 0.565 | 0.591 |
| **Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID** | 2 | 3.500 | 3.500 | 3.500 |
| **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID** | 1 | 3.500 | 3.500 | 3.500 |
| **Rotavirus, 2 dose schedule** | 1 | 2.550 | 2.550 | 2.550 |
| **Rotavirus, 3 dose schedule** | 1 | 3.500 | 3.500 | 3.500 |
| **Yellow Fever, 10 dose(s) per vial, LYOPHILISED** | 10 | 0.907 | 0.923 | 0.923 |
| **Yellow Fever, 5 dose(s) per vial, LYOPHILISED** | 5 | 0.907 | 0.923 | 0.923 |

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| **Supply** | **Form** | **2014** | **2015** | **2016** |
| **AD-SYRINGE** | SYRINGE | 0.047 | 0.047 | 0.047 |
| **RECONSTIT-SYRINGE-PENTAVAL** | SYRINGE | 0.037 | 0.037 | 0.037 |
| **RECONSTIT-SYRINGE-YF** | SYRINGE | 0.037 | 0.037 | 0.037 |
| **SAFETYBOX** | SAFETYBOX | 0.580 | 0.580 | 0.580 |

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| **Note:** WAP - weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 liquid doses, 2 lyophilized doses and 10 liquid doses. For Yellow Fever, it applies to 5 dose lyophilized and 10 dose lyophilized) |

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| **Table Annex 4B: Freight cost as percentage of value** |

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| **Vaccine Antigen** | **Vaccine Type** | **No Threshold** | **500,000$** |
| **<=** | **>** |
| DTP-HepB-Hib | HEPBHIB |  | 25.50 % | 6.40 % |
| HPV bivalent | HPV | 3.50 % |  |  |
| HPV quadrivalent | HPV | 3.50 % |  |  |
| Measles second dose | MEASLES | 14.00 % |  |  |
| Meningococcal type A | MENINACONJUGATE | 10.20 % |  |  |
| MR | MR | 13.20 % |  |  |
| Pneumococcal (PCV10) | PNEUMO | 3.00 % |  |  |
| Pneumococcal (PCV13) | PNEUMO | 6.00 % |  |  |
| Rotavirus | ROTA | 5.00 % |  |  |
| Yellow fever | YF | 7.80 % |  |  |

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| **Table Annex 4C: Low - Minimum country's co-payment per dose of co-financed vaccine.** |

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| **Vaccine** | **2014** | **2015** |
| **Rotavirus, 1 dose per vial, ORAL** | 0.2 | 0.2 |

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| **Table Annex 4D: Wastage rates and factors** |

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| The following table shows the wastage rates for routine and campaign vaccines, set for 2014. |

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| **Vaccine** | **dose(s) per vial** | **Maximum Vaccine wastage rate\*** | **Benchmark Wastage Rate\*\*** |
| DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | 1 | 5 % |  |
| DTP-HepB-Hib, 10 dose(s) per vial, LIQUID | 10 | 25 % | 15 % |
| DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED | 2 | 10 % |  |
| HPV bivalent, 2 dose(s) per vial, LIQUID | 2 | 10 % |  |
| HPV quadrivalent, 1 dose(s) per vial, LIQUID | 1 | 5 % |  |
| Measles second dose, 10 dose(s) per vial, LYOPHILISED | 10 | 40 % |  |
| Meningococcal type A, 10 dose(s) per vial, LYOPHILISED | 10 | 10 % |  |
| MR, 10 dose(s) per vial, LYOPHILISED | 10 | 25 % |  |
| Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID | 2 | 10 % |  |
| Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | 1 | 5 % |  |
| Rotavirus, 2 dose schedule | 1 | 5 % |  |
| Rotavirus, 3 dose schedule | 1 | 5 % |  |
| Yellow Fever, 10 dose(s) per vial, LYOPHILISED | 10 | 40 % |  |
| Yellow Fever, 5 dose(s) per vial, LYOPHILISED | 5 | 10 % |  |

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| Comments: |

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| \* Source - WHO indicative wastage rates |

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| \*\* Source - Country APRs and studies, approved by WHO, UNICEF, and the GAVI Secretariat |

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| Note: HPV demonstration projected wastage rates are the same as the vaccine |

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| **Table Annex 4E: Vaccine maximum packed volumes** |

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| **Kindly note that this table is for reference purposes only and includes GAVI- and non GAVI supported vaccines.** |

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| **Vaccine product** | **Designation** | **Vaccine formulation** | **Admin route** | **No. of doses in the schedule** | **Presentation (doses/vial, prefilled)** | **Packed volume vaccine (cm3/dose)** | **Packed volume diluents (cm3/dose)** |
| BCG | BCG | lyophilized | ID | 1 | 20 | 1.2 | 0.7 |
| Diphtheria-Tetanus-Pertussis | DTP | liquid | IM | 3 | 20 | 2.5 |  |
| Diphtheria-Tetanus-Pertussis | DTP | liquid | IM | 3 | 10 | 3 |  |
| Diphtheria-Tetanus | DT | liquid | IM | 3 | 10 | 3 |  |
| Tetanus-Diphtheria | Td | liquid | IM | 2 | 10 | 3 |  |
| Tetanus Toxoid | TT | liquid | IM | 2 | 10 | 3 |  |
| Tetanus Toxoid | TT | liquid | IM | 2 | 20 | 2.5 |  |
| Tetanus Toxoid UniJect | TT | liquid | IM | 2 | Uniject | 12 |  |
| Measles | Measles | lyophilized | SC | 1 | 1 | 26.1 | 20 |
| Measles | Measles | lyophilized | SC | 1 | 2 | 13.1 | 13.1 |
| Measles | Measles | lyophilized | SC | 1 | 5 | 5.2 | 7 |
| Measles | Measles | lyophilized | SC | 1 | 10 | 3.5 | 4 |
| Measles-Rubella freeze dried | MR | lyophilized | SC | 1 | 1 | 26.1 | 26.1 |
| Measles-Rubella freeze dried | MR | lyophilized | SC | 1 | 2 | 13.1 | 13.1 |
| Measles-Rubella freeze dried | MR | lyophilized | SC | 1 | 5 | 5.2 | 7 |
| Measles-Rubella freeze dried | MR | lyophilized | SC | 1 | 10 | 2.5 | 4 |
| Measles-Mumps-Rubella freeze dried | MMR | lyophilized | SC | 1 | 1 | 26.1 | 26.1 |
| Measles-Mumps-Rubella freeze dried | MMR | lyophilized | SC | 1 | 2 | 13.1 | 13.1 |
| Measles-Mumps-Rubella freeze dried | MMR | lyophilized | SC | 1 | 5 | 5.2 | 7 |
| Measles-Mumps-Rubella freeze dried | MMR | lyophilized | SC | 1 | 10 | 3 | 4 |
| Polio | OPV | liquid | Oral | 4 | 10 | 2 |  |
| Polio | OPV | liquid | Oral | 4 | 20 | 1 |  |
| Yellow fever | YF | lyophilized | SC | 1 | 5 | 6.5 | 7 |
| Yellow fever | YF | lyophilized | SC | 1 | 10 | 2.5 | 3 |
| Yellow fever | YF | lyophilized | SC | 1 | 20 | 1.5 | 2 |
| Yellow fever | YF | lyophilized | SC | 1 | 50 | 0.7 | 1 |
| DTP-HepB combined | DTP-HepB | liquid | IM | 3 | 1 | 9.7 |  |
| DTP-HepB combined | DTP-HepB | liquid | IM | 3 | 2 | 6 |  |
| DTP-HepB combined | DTP-HepB | liquid | IM | 3 | 10 | 3 |  |
| Hepatitis B | HepB | liquid | IM | 3 | 1 | 18 |  |
| Hepatitis B | HepB | liquid | IM | 3 | 2 | 13 |  |
| Hepatitis B | HepB | liquid | IM | 3 | 6 | 4.5 |  |
| Hepatitis B | HepB | liquid | IM | 3 | 10 | 4 |  |
| Hepatitis B UniJect | HepB | liquid | IM | 3 | Uniject | 12 |  |
| Hib liquid | Hib\_liq | liquid | IM | 3 | 1 | 15 |  |
| Hib liquid | Hib\_liq | liquid | IM | 3 | 10 | 2.5 |  |
| Hib freeze-dried | Hib\_lyo | lyophilized | IM | 3 | 1 | 13 | 35 |
| Hib freeze-dried | Hib\_lyo | lyophilized | IM | 3 | 2 | 6 |  |
| Hib freeze-dried | Hib\_lyo | lyophilized | IM | 3 | 10 | 2.5 | 3 |
| DTP liquid + Hib freeze-dried | DTP+Hib | liquid+lyop. | IM | 3 | 1 | 45 |  |
| DTP-Hib combined liquid | DTP+Hib | liquid+lyop. | IM | 3 | 10 | 12 |  |
| DTP-Hib combined liquid | DTP-Hib | liquid | IM | 3 | 1 | 32.3 |  |
| DTP-HepB liquid + Hib freeze-dried | DTP-Hib | liquid | IM | 3 | 10 | 2.5 |  |
| DTP-HepB liquid + Hib freeze-dried | DTP-HepB+Hib | liquid+lyop. | IM | 3 | 1 | 22 |  |
| DTP-HepB-Hib liquid | DTP-HepB+Hib | liquid+lyop. | IM | 3 | 2 | 11 |  |
| DTP-HepB-Hib liquid | DTP-HepB-Hib | liquid | IM | 3 | 10 | 4.4 |  |
| DTP-HepB-Hib liquid | DTP-HepB-Hib | liquid | IM | 3 | 2 | 13.1 |  |
| DTP-HepB-Hib liquid | DTP-HepB-Hib | liquid | IM | 3 | 1 | 19.2 |  |
| Meningitis A/C | MV\_A/C | lyophilized | SC | 1 | 10 | 2.5 | 4 |
| Meningitis A/C | MV\_A/C | lyophilized | SC | 1 | 50 | 1.5 | 3 |
| Meningococcal A/C/W/ | MV\_A/C/W | lyophilized | SC | 1 | 50 | 1.5 | 3 |
| Meningococcal A/C/W/Y | MV\_A/C/W/Y | lyophilized | SC | 1 | 10 | 2.5 | 4 |
| Meningitis W135 | MV\_W135 | lyophilized | SC | 1 | 10 | 2.5 | 4 |
| Meningitis A conjugate | Men\_A | lyophilized | SC | 2 | 10 | 2.6 | 4 |
| Japanese Encephalitis | JE\_lyo | lyophilized | SC | 3 | 10 | 15 |  |
| Japanese Encephalitis | JE\_lyo | lyophilized | SC | 3 | 10 | 8.1 | 8.1 |
| Japanese Encephalitis | JE\_lyo | lyophilized | SC | 3 | 5 | 2.5 | 2.9 |
| Japanese Encephalitis | JE\_lyo | lyophilized | SC | 3 | 1 | 12.6 | 11.5 |
| Japanese Encephalitis | JE\_liq | liquid | SC | 3 | 10 | 3.4 |  |
| Rota vaccine | Rota\_lyo | lyophilized | Oral | 2 | 1 | 156 |  |
| Rota vaccine | Rota\_liq | liquid | Oral | 2 | 1 | 17.1 |  |
| Rota vaccine | Rota\_liq | liquid | Oral | 3 | 1 | 45.9 |  |
| Pneumo. conjugate vaccine 7-valent | PCV7 | liquid | IM | 3 | PFS | 55.9 |  |
| Pneumo. conjugate vaccine 7-valent | PCV7 | liquid | IM | 3 | 1 | 21 |  |
| Pneumo. conjugate vaccine 10-valent | PCV-10 | liquid | IM | 3 | 1 | 11.5 |  |
| Pneumo. conjugate vaccine 10-valent | PCV-10 | liquid | IM | 3 | 2 | 4.8 |  |
| Pneumo. conjugate vaccine 13-valent | PCV-13 | liquid | IM | 3 | 1 | 12 |  |
| Polio inactivated | IPV | liquid | IM | 3 | PFS | 107.4 |  |
| Polio inactivated | IPV | liquid | IM | 3 | 10 | 2.5 |  |
| Polio inactivated | IPV | liquid | IM | 3 | 1 | 15.7 |  |
| Human Papilomavirus vaccine | HPV | liquid | IM | 3 | 1 | 15 |  |
| Human Papilomavirus vaccine | HPV | liquid | IM | 3 | 2 | 5.7 |  |
| Monovalent OPV-1 | mOPV1 | liquid | Oral |  | 20 | 1.5 |  |
| Monovalent OPV-3 | mOPV3 | liquid | Oral |  | 20 | 1.5 |  |

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| **12. Banking Form** |

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| In accordance with the decision on financial support made by the GAVI Alliance, the Government of Mauritania hereby requests that a payment be made via electronic bank transfer as detailed below: |  |
|  |  |  |  |  |
| **Name of Institution (Account Holder):** |  |  |
|  |  |  |
|  |  |  |  |  |
| **Address:** |  |  |
| **City Country:** |  |  |
| **Telephone no.:** |  | **Fax no.:** |  |  |
|  | **Currency of the bank account:** |  |  |
| **For credit to:** |  |  |  |  |
| **Bank account's title:** |  |  |
| **Bank account no.:** |  |  |
| **Bank's name:** |  |  |
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| --- |
| Is the bank account to be used by this program exclusively?  |

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| --- |
| By who is the account audited?  |

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| --- |
| Signature of Government's authorizing official |

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| --- | --- | --- |
|  |  | **Seal** |
| **Name:** |  |  |
|  |  |  |
| **Title:** |  |  |
|  |  |  |
| **Signature:** |  |  |
|  |  |  |
| **Date:** |  |  |

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| --- |
| **FINANCIAL INSTITUTION** |
|  |
| **Bank Name:** |  |
| **Branch Name:** |  |
| **Address:** |  |
| **City Country:** |  |
| **Swift Code:** |  |
| **Sort Code:** |  |
| **ABA No.:** |  |
| **Telephone No.:** |  |
| **FAX No.:** |  |

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| --- |
| **CORRESPONDENT BANK** |
| **(In the United States)** |
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| --- |
| I certify that the account no. is held by at this banking institution |
| The account is to be signed jointly by at least (number of signatories) from the following authorized signatories: |
|  |  |
| **1** | **Name:** |  |
|  | **Title:** |  |
|  |  |
| **2** | **Name:** |  |
|  | **Title:** |  |
|  |  |
| **3** | **Name:** |  |
|  | **Title:** |  |

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|  |  |
|

|  |
| --- |
| **Name of bank's authorizing official** |
|  |
| **Signature:** |
|  |
|  |
| **Date:** |  |
| **Seal:** |
|  |
|  |
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