Application Form for Gavi NVS support

Submitted by

The Government of

Gambia

Date of submission: **12 September 2016**

Deadline for submission:

i. **9 September 2016**
ii. 1st May 2015
iii. 9 September 2015

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

Start Year	2017	End Year	2021

Form revised in 2016

(To be used with Guidelines of November 2015)

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

Gavi
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the Gavi, as requested. The Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

. The languages of the arbitration will be English or French.

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

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

1. Type of Support requested

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

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]
Routine New Vaccines Support	Meningococcal A, 10 dose(s) per vial, LYOPHILISED	2017	2021	
One-time mini catch-up campaign	Meningococcal A, 10 dose(s) per vial, LYOPHILISED	2017	2017	

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

2. Table of Contents

3. Executive Summary

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

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

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

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

- The nature of stakeholders' participation in developing this proposal
  - Inter-Agency Coordinating Committee
  - Partners, including CSO involvement

EXECUTIVE SUMMARY

Meningococcal Meningitis/cerebro-spinal meningitis is a contagious bacterial infection occurring sporadically throughout the world. Several different bacteria can cause the disease; Neisseria meningitidis is the one with potential to cause large epidemics. In 1996/97 epidemic seasons, The Gambia experienced the worst epidemics causing 1685 cases and 222 deaths with a Case Fatality Rate (CFR) of 13.1%. During these seasons, the Upper River Region (URR), one of the high risk regions recorded 1390 cases and 168 deaths with a CFR of 12%. Furthermore, from November 2000 to March 2001, 137 cases including 21 deaths were recorded.

Increased prevalence over the years, epidemiological shift, high susceptible populations coupled with globalization are major concerns. In addition, inadequate capacity of the health care system in relation to timely detection, diagnosis, management and treatment of cases as well as high poverty levels in The Gambia continue to hamper efforts in the control and prevention of Meningitis. In this regard, effective surveillance, mass vaccination campaigns and routine vaccine introduction remain to be the most cost effective strategies to eliminate Meningitis epidemic in The Gambia.

The objective of introducing the Meningococcal A conjugate is to reduce the occurrence of Meningitis epidemic that occasionally hits The Gambia with an aim of contributing to meningitis elimination in the African Region. The targeted age group for the vaccine will be children aged 18 months to administer at the same time with measles second dose. A total of 79514 (surviving infants) are expected to be vaccinated in 2017 when the vaccine is envisaged to be introduced.

A one-time mini catch-up campaign is also planned for July 2017 preceding the introduction to vaccinate the birth cohort (1-5yrs) that did not receive the first dose of MenA vaccine during and after the 2013 campaign in the country and will also not be part of the routine introduction (more than 18months old) in October 2017.

The 10-dose vial is the preferred choice of vaccine presentation. This decision was based on the fact that the country has had an experience with 10-dose formulations of MenAfriVac for the 2013 campaign and other routine vaccines such as measles. This choice will also maximize the use of cold chain space in anticipation

of concurrent or future vaccine introductions.

The country had attained 97% and 96%coverage rates for Penta 3 and MCV1 in 2015 respectively. Key among these achievements include the continuous availability of vaccines and other supplies at all levels, geographical access and committed health staff to deliver immunization services.

Compared to other countries within the sub region, The Gambia has a good track record of high immunization coverage due mainly to improved access with about 95% of the population living within the radius of 3-5kms of a health facility providing immunization services. Furthermore, the country has been at the forefront in the introduction of new and underused vaccines in the Sub Region; Hepatitis B (1990), Haemophilus influenza type b (1997), PCV-7 (2009), Measles Second Dose (2012), Rota Virus (2013) and IPV in 2015 to the traditional vaccines. It is therefore evident that introducing new vaccines is not a new concept in the country. The Post Introduction Evaluation conducted in 2015 showed that lessons and experiences exist in the country to serve as a guide in future introductions. Though experiences from the past exist, the country will prepare adequately in order to successfully introduce any new vaccine including the MenAfriVac.

The findings of the 2014 Effective Vaccine Management (EVM) assessment revealed that the only functional walk in cold room and walk-in freezer room with storage capacities of 4,180 litres and 3,320 litres is located at central level in Kotu. The storage capacity for the WICR is not adequate, with Rota supplies alone occupying about 60% of the storage space. Furthermore, as highlighted by the EVM assessment, there are two regions without vaccine stores and as such efforts should be made to build and equip these stores with cold chain equipment and also increasing the storage capacities of the five regions. Solar refrigerators, TCW 2000DC (SDD Battery less) would be the preferred choice for the cold chain system at regional level because of erratic electric supply. The country will take care of the problem by providing a walk –in-cold room and the provision of TCW2000 in the regions with inadequate cold chain capacity from the Gavi HSS grant expected to start in January, 2017

As part of the EVM recommendations, UNICEF provided funds for TOT and step down trainings on EVM. They also procure 200 fridge tags and 50 freeze tags to continuously monitor temperature at all levels in the country.

The VIG 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.

The campaign will target the age group 1-5 years. A total amount of US$303,281.40 will be required for the operational cost of the one time mini catch-up campaign. GAVI will provide 65.43% of the operational cost whilst the other part will be mobilized by government and other partners. The cost per person for the operation is US$0.99.

The process of the MenA proposal development in to the routine EPI started from discussions at the Inter-Agency Coordinating Committee (ICC) which is chaired by the Honourable Minister of Health and Social Welfare with representation from key government ministries, UN agencies (WHO and UNICEF), and bi-lateral agencies, NGOs, CSOs such as Rotary International, Child Fund, and Gambia Red Cross etc. The technical team also highlighted the need for a one-time mini catc-up campaign before the introduction so as t close the gap of susceptibles.

The ICC endorsed the MenA introduction application on September 6, 2016 for submission. The presentation made at the meeting highlighted the rationale for MenA Vaccine introduction, programmatic as well as budgetary considerations

This body is tasked with the responsibility of coordinating and monitoring activities that are implemented both for SIAs and routine immunization through quarterly meetings. It is therefore, believed that with the introduction of the vaccine in to the routine programme, the Gambia will be contributing to the meningitis elimination programme of the continent and also reduced the morbidity and mortality due to MenA in the country significantly

4. Signatures

4.1. Signatures of the Government and National Coordinating Bodies

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

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

Meningococcal A, 10 dose(s) per vial, LYOPHILISED routine introduction

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

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. Table(s) 6.2.3 of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of **June**.

The payment for the first year of co-financed support will be around **September 2017** for Meningococcal A, 10 dose(s) per vial, LYOPHILISED.

Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NUMBER : 2 and 1 in Section 10. Attachments.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Hon. Omar SEY	**Name**	Hon. Abdou KOLLEY
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
Baboucarr BOYE	Immunizatio Specialist - UNICEF	(+220)3360087	bboye@unicef.org
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Kebba M.S. GIBBA	EPI NPO - WHO	(+220)9943842	gibbak@who.int

4.1.2. National Coordinating Body - Inter-Agency Coordinating Committee for Immunisation

Agencies and partners (including development partners and NGOs) supporting immunisation services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC, Health Sector Coordinating Committee (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.

Profile of the ICC, HSCC, or equivalent committee

Name of the committee	ICC
Year of constitution of the current committee	1997
Organisational structure (e.g., sub-committee, stand-alone)	stand alone
Frequency of meetings	Quarterly

The Terms of Reference or Standard Operating Principles for the ICC, including details on the ICC membership, quorum, dispute resolution process and meeting schedules is attached as DOCUMENT NUMBER : 4.

Major functions and responsibilities of the ICC/HSCC:

1. Conduct quarterly and ad-hoc meetings to discuss issues relating to national immunization services

2. Review programme plans and progress made on immunization services including cold chain logistics, vaccines and EPI financing etc;

3. To approve all HSS/ISS activity work plans and budgets

4. Review all HSS/ISS technical and financial reports

5. Exist as coordination body for immunization services

6. Analyses the progress of immunization services

7. Provide suggestions to overcome constraints and challenges in immunization services

8. Endorse procedures for immunization service improvement

9. Support development of immunization long-term programs and secure their implementation

10 Support the coordination of immunization services at national and international level

11. Organize and coordinate advocacy for immunization service

12.Identify constraints/obstacles that may impede progress in the implementation of immunization services

13.To make recommendations as may be deemed necessary for programme improvement;

14.Co-ordination of donor support/funding with a view to avoid duplication and waste of efforts and/resources

15.Advocacy and resource mobilization for programme implementation

18.Provide support for special events such as NIDs and other supplementary immunization activities;

19.Advice on ways/approaches to enhance effective and efficient EPI service delivery;

Please describe how partners have provided support in preparation of the proposal:

Partners have provided the following support in preparation of this proposal.

1. Technical support in the preparation of this proposal

2. Financial support for the preparatory meetings

3 Review of proposal and supportive materials for comments

4.1.3. Signature Table for the Coordinating Committee for Immunisation

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **06/09/2016** 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 number 5. The

signatures endorsing the proposal are attached as Document number 6 (please use the list for signatures in the section below).

Please refer to Annex C of the 'Gavi HSS and NVS General Guidelines' for more information on ICCs.

Function	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Hon. Minister of Health	Omar SEY		
Secretary	EPI Deputy Manager- MOH&SW	Sidat FOFANA		
Members	WHO Country Representative, WHO	Dr.Charles SAGOE-MOSES		
	Country Director Action-Aid The Gambia	Mr. Omar BADGIE		
	Programme Officer, Child Fund The Gambia	Mr. Kebba CONTEH		
	Director Riders for Health	Mrs. Therese DRAMMEH		
	Directorate of Public Health Ministry of Health and Social Welfare	Mr.Saikou FATAJO		
	Directorate of Nursing Ministry of Health and Social Welfare	Ms. Margret GOMEZ		
	Directorate of Planning Ministry of Health and Social Welfare	Mr. Dawda CEESAY		
	Directorate of Human Resources Ministry of Health and Social Welfare	Mr. Omar Bun NJIE		
	Directorate of Health Promotion and Education Ministry of Health and Social Welfare	Mr. Modou NJAI		
	Head Reproductive and Child Health Ministry of Health and Social Welfare	Mr. Bafoday JAWARA		
	Director Health Promotion and Development Organization	Mr. Omar CEESAY		
	Director of National Pharmaceutical Services, Ministry of Health and Social Welfare	Mr. Babanding SABALLY		
	Regional Principal Public Health Officer,Western Region 2 ,Ministry of Health& Social Welfare	Mr.Mamo JATTA		
	Regional Director of Health Services,Western Region 1 ,Ministry of Health& Social Welfare	Mr. Alhagie SANKAREH		
	Epidemiology and Disease Control Programme	Mr Abdoulie CAMARA		

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

The minutes from the three most recent ICC meetings are attached as DOCUMENT NUMBER : 7.

4.2. National Immunization Technical Advisory Group (NITAG)

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

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

5. Immunisation Programme Data

5.1 Background information

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

- Please refer to the Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan) and attach a complete copy (with an Executive Summary) as DOCUMENT NUMBER 9. Please attach the cMYP costing tool as DOCUMENT NUMBER 10.
- Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NUMBER : 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.
- Please refer to the attached risk assessments in the case of yellow fever and meningitis A mass preventive campaigns.

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

	Figure	Year	Source
Total population	1,866,156	2016	GBoS 2003 Projected
Birth cohort	86,935	2016	cMYP 2017 - 2021
Infant mortality rate (per 1000)	34	2013	GBoS DHS
Surviving infants*[1]*	80,130	2016	cMYP 2017 - 2021
GNI per capita (US$)	740	2010	World Bank Report 2010
Total Health Expenditure (THE) as a percentage of GDP	5	2013	National Health Accounts 2013
General government expenditure on health (GGHE) as % of General government expenditure	50	2010	Extrapolated from 2005 NHA

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

5.1.1 Lessons learned

Routine New Vaccines Support

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. If they are included in the Introduction Plan, please cite the section only. If this information is already included in NVIP/POA, please reference the document and in which section/page this information can be found.

Lessons Learned	Action Points
1. COMMUNICATION Sufficient community awareness on the new vaccines introduced resulted to high acceptance and uptake eg Rota3 coverage for 2015 is at 97%	1. Community sensitisation activities planned and implemented prior to the introduction of the new vaccine
2. TRAINING Standardised training materials proved very helpful in the preparation of health workers for the introduction of the new vaccine	1. Training guidelines and materials prepared, printed and distributed before the new vaccine introduction 2. A two days training was organised for all staff on vaccine administration, injection safety, AEFI monitoring, data management and cold chain maintenance were conducted
3. WASTE MANAGEMENT Strengthened waste management system helped to improve	1. Incinerators were built and existing ones refurbished. 2. Incinerator attendants were identified and trained

the management of waste generated during the introduction and beyond	3. Waste disposal plan was developed and implemented in all the regions
4. COLD CHAIN Adequate cold chain capacity facilitated the smooth introduction of the new vaccine	1. Cold chain inventory and assessment conducted before the new vaccine introduction
5. POLITICAL SUPPORT Strong political will and commitment enhanced the successful introduction of the new vaccine	1 Government fulfilled its co-financing obligation 2. Active involvement of top government officials in National Launching and other media activities
6. SURVEILLANCE New vaccine introduction strengthened the existing surveillance system	1. Integration of the new vaccine surveillance into the IDSR 2. The laboratory capacity improved as a result of the new vaccine
7. MONITORING AND SUPERVISION Regular monitoring and supportive supervision enhanced the smooth introduction of the new vaccine	1. Monitoring and supervisory checklist were updated and implemented 2. monitoring and supervisory visits were conducted as planned
8. DATA QUALITY Updated dated collection tools proved useful in new vaccine introduction	1. Data collection tools were reviewed and finalised ahead of the new vaccine introduction
9. PARTNERSHIP Technical and financial support from relevant partners helped in the smooth introduction of the new vaccine	1. ICC meetings conducted for the planning and approval of the new vaccine introduction 2. Consultant hired to lead the proposal development

5.1.2 Health planning and budgeting

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

The planning cycle for the government is from January to December every year. Annual plans are sent to the Ministry of Finance for funding.

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

The relevant planning documents for the Ministry of Health are the Health Policy and the National Health Strategic Plan (NHSP - 2014 - 2020)

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

Yes. The updated cMYP (2017-2021) is about to be finalised

Please indicate the national planning budgeting cycle for health

The National health Strategic plan has a 7 year cycle. The current National Health Sector Strategic Plan covers 2014 to 2020.

Please indicate the national planning cycle for immunisation

The EPI has a 5 year cMYP developed to guide the immunisation programme. The current cMYP is ending in December and is being updated to cover 2017 to 2021. Annual plans are also developed for the upcoming year.

5.1.3 Gender and equity

Please describe any barriers to access, utilisation and delivery of immunisation services at district level (or equivalent) that are related to geographic, socio-economic and/or gender equity. Please describe actions taken to mitigate these barriers and highlight where these issues are addressed in the vaccine introduction plan(s).

Progress is being registered with immunization data collection tools revised to capture data by sex. However, cumulative immunization data at national level is not reported by gender. However gender does not seem to be a barrier in accessing immunisation services in the country.

Discuss how equity issues (geographic, socio-economic and/or gender) are being taken into account in the design of social mobilisation and other strategies to increase immunisation coverage. Highlight where these issues are addressed in the vaccine introduction plan(s).

Although no specific studies have been conducted, The DHS 2013 report did show variations in the immunization coverage even though the reasons for these variances in coverages between urban and rural areas were not elicited. The variations in the fully immunized coverage and drop-out rate between rural and

urban areas, demonstrate challenges that the immunization programme is faced with. During the social mobilisation activies of the new vaccine introduction, more focus will be place in urban areas in an attempt to bridge the equity gaps realised

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

No. However the routine immunisation data collection tools at facility level have been reviewed to capture sex dis-aggregated data.

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

No

If available, please provide additional information and documents on subnational coverage data, e.g. comparing urban/rural districts or districts with highest/lowest coverage, etc.

The DHS 2013 report did show variations in the immunization coverage even though the reasons for these variances in coverage between urban and rural areas were not elicited. The variations in the fully immunised coverage and drop-out rate between rural and urban areas, demonstrate challenges that the immunisation programme is faced with. The percentage of children who were fully immunised was higher in rural areas than in urban areas (84 percent compared with 67 percent). It was also higher among children whose mothers have no education (78.2%) or who only reached the primary level than among children whose mothers reached the secondary level or higher level (68.3%).

5.1.4 Data quality

Please attach a data quality assessment (DQA), report that has been completed within the previous 48 months with the most recently conducted national survey containing immunisation coverage indicators (DOCUMENT NUMBER: 27) and an immunisation data quality improvement plan (DOCUMENT NUMBER 28). If available, a progress report on the implementation of the improvement plan should also be submitted (DOCUMENT NUMBER: 11, DOCUMENT NUMBER: 28).

Please indicate what routine mechanisms to independently assess the quality of administrative data are in place, and if so what these mechanisms are and how they enable the country to track changes in data quality over time.

There has not been a DQA in the past 48 Months, however, data verification committees are formed at all levels to review and sign the data report before it is sent to the next level. The following will be instituted to improve on data qualty; 1. Train health workers and data entry clerks on data management 2. conduct bi-monthly meetings to review EPI data with feed back to all the levels 3. conduct monitoring and supportive supervision 5. participate in monthly in-service meetings at regional level and discuss immunization service issues. 5. The country plans to customize the E-Tracker of DHIS2 in 2017 to track immunization clients.

Please detail what household surveys have been conducted in recent years to independently assess immunisation coverage and equity, and describe any survey plans for the coming five year period.

A recent DHS was conducted in 2013 that higlights variations in immunization coverage between urban and rural araeas, the percentage of fully immunized were higher in rural areas than in urban areas (84% urban and 67% rural). it was also higher in children whose mothers have no education (78.2%) who only reach the primary level than among children whose mothers reach secondary level or higher level (68.3%).

5.1.6 Meningococcal A Immunisation coverage

Please provide information concerning immunisation coverage related to Meningococcal A vaccine (MenA)

Table 5.1.6: MenA Immunisation coverage

Coverage	2011		2012		2013	
	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*
Meningococcal A 1*st* dose (%)	0	0	0	0	0	0

Coverage	2014		2015	
	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*
Meningococcal A 1*st* dose (%)	0	0	0	0

Coverage	2011		2012		2013	
	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey
Supplementary Immunisation Activities (SIA) (%)	0	0	0	0	104	96.6

Coverage	2014		2015	
	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey
Supplementary Immunisation Activities (SIA) (%)	0	0	0	0

Note:

(1) National reported Administrative Coverage

(2) WHO/UNICEF estimates of national immunization coverage

Was the last Meningococcal A Supplementary Immunization Activities (SIA) administrative coverage or results of a survey of acceptable methodology **Results of a survey**

Please describe survey methodology:

The WHO post campaign evaluation was used with the help of an independent evaluator. The study was cross-sectional in approach and people aged 1-29 years as the primary study population. Caregivers of children were respondents. The WHO cluster sampling method was used to select the clusters and simple random sampling was used to selection of household . Data was collected through interviews using structured interviews using structured interview guide. vaccination cards were given during the campaign was used to determine the vaccination status of the study population. Quality assurance was ensured through: 1. Training of data collectors, monitors and supervisors 2. pre-testing of the data collection tools 3.field supervision of data collectors

5.2. Baseline and Annual Targets (NVS Routine Support)

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

Number	Base Year	Baseline and Targets			
	2016	2017	2018	2019	2020
Total births	86,990	88,991	91,038	93,131	95,273
Total infants' deaths	6,860	7,018	7,179	7,344	7,513
Total surviving infants	80,130	81,973	83,859	85,787	87,760
Total pregnant women	86,990	88,991	91,038	93,131	95,273
Target population vaccinated with OPV3*[1]*	77,726	79,514	81,343	84,071	86,005
OPV3 coverage*[2]*	97 %	97 %	97 %	98 %	98 %
Target population vaccinated with DTP1*[1]*	79,329	81,153	83,020	84,929	86,882
Target population vaccinated with DTP3*[1]*	77,726	79,514	81,343	84,071	86,005
DTP3 coverage*[2]*	97 %	97 %	97 %	98 %	98 %
Wastage*[3]* rate in base-year and planned thereafter (%) for DTP	15	15	15	15	15
Wastage*[3]* factor in base-year and planned thereafter for DTP	1.18	1.18	1.18	1.18	1.18
Target population vaccinated with Meningococcal*[1]*	77726.0	79514.0	81343.0	84071.0	86005.0
Meningococcal A coverage*[2]*	97 %	97 %	97 %	98 %	98 %
First Presentation: Meningococcal A, 10 dose(s) per vial, LYOPHILISED					
Wastage*[3]* rate in base-year and planned thereafter (%)	15	15	15	15	15
Wastage*[3]* factor in base-year and planned thereafter (%)	1.18	1.18	1.18	1.18	1.18
Maximum wastage rate value for Meningococcal A, 10 dose(s) per vial, LYOPHILISED	50 %	50 %	50 %	50 %	50 %
Target population vaccinated with 1st dose of MCV	77,726	79,514	81,343	84,071	86,005
MCV coverage*[2]*	97 %	97 %	97 %	98 %	98 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	2 %	2 %	2 %	1 %	1 %

[1] Indicate total number of children vaccinated with either DTP alone or combined

[2] Number of infants vaccinated out of total surviving infants

[3] 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.

Number	Baseline and Targets
	2021
Total births	97,465
Total infants' deaths	7,686
Total surviving infants	89,779
Total pregnant women	97,465
Target population vaccinated with OPV3*[1]*	87,983
OPV3 coverage*[2]*	98 %
Target population vaccinated with DTP1*[1]*	88,881
Target population vaccinated with DTP3*[1]*	87,983
DTP3 coverage*[2]*	98 %
Wastage*[3]* rate in base-year and planned thereafter (%) for DTP	15
Wastage*[3]* factor in base-year and planned thereafter for DTP	1.18
Target population vaccinated with Meningococcal*[1]*	87983.0
Meningococcal A coverage*[2]*	98 %
First Presentation: Meningococcal A, 10 dose(s) per vial, LYOPHILISED	
Wastage*[3]* rate in base-year and planned thereafter (%)	15
Wastage*[3]* factor in base-year and planned thereafter (%)	1.18
Maximum wastage rate value for Meningococcal A, 10 dose(s) per vial, LYOPHILISED	50 %
Target population vaccinated with 1st dose of MCV	87,983
MCV coverage*[2]*	98 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	1 %

[1] Indicate total number of children vaccinated with either DTP alone or combined

[2] Number of infants vaccinated out of total surviving infants

[3] 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.

5.3. Targets for Preventive Campaign(s)

No NVS Prevention Campaign Support this year

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

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

Number	Base Year	Baseline and Targets
	2016	2017
Target population vaccinated with Meningococcal*[1]*	0	305,269
Wastage*[3]* rate in base-year and planned thereafter (%)	0	10
Wastage*[3]* factor in base-year and planned thereafter (%)	1.00	1.11
Maximum wastage rate value for Meningococcal A, 10 dose(s) per vial, LYOPHILISED	10 %	10 %

[1] Indicate total number of children vaccinated with either DTP alone or combined

[2] Number of infants vaccinated out of total surviving infants

[3] 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.

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

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

If already included in detail in the Introduction Plan or Plan of Action, please cite the section only.

Disease	Title of the assessment	Date	Results
Meningitis	Pediatric Bacterial Meningitis	January to December, 2015	CFS Culture Results HIb-1 case, negative-4 Strepto Pneumo-1 case, negative-7 Nissieria Meningitidis-1 case, negative-1
Meningitis	Pediatric Bacterial Meningitis	January to December, 2015	PBM LATEX Agglutination HIb-1 case , negative-4 Strepto Pneumo-1 case, negative-7 Nissieria Meningitidis-1 case, negative-1
Diarreheoa	Rota sentinel Surveillance	January to December, 2015	79 cases

6.2. Requested vaccine (Meningococcal A, 10 dose(s) per vial, LYOPHILISED)

As reported in the cMYP, the country plans to introduce Meningococcal A, using Meningococcal A, 10 dose(s) per vial, LYOPHILISED.

When is the country planning to introduce this vaccine? **October 2017**

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.

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain equipment and other logistical requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. The Independent Review Committee requires assurance that the cold chain is ready or will be ready for the routine introduction of the new vaccine, and evidence/plans need to be provided. All proposals that include Gavi- financing for cold chain equipment intended for vaccine storage shall need to procure equipment pre-qualified by WHO under their Performance Quality and Safety (PQS) program. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi.

The supply chain consists of a National Vaccine Store (40m3 WICR) which is based in Kotu at Central Medical Stores complex and is about 30 kilometres from the airport. The national vaccine store distributes vaccines and injection supplies to the five regions quarterly and to health facilities in the two regions that do not have vaccine stores. The health facilities collect vaccines and injection supplies from the regional vaccine stores monthly. The Gambia EPI started using solarized cold chain equipment in 1986. Presently, four regions (LRR, NBWR, NBER and URR) are using TCW2000 solar refrigerators. Of recent, a support from Unicef provided a 15m3 solarised cold in CRR. Two regions (WHR1 and WHR 2) have no regional cold storage facilities and supplies are distributed directly from the national cold store. All the public health facilities providing immunisation services use either RCW50DC or TCW2000 solar fridges.

A 30m3 cold room is required at central level as show in the cold chain analysis in the introduction plan. The Gambia started to use solarized cold chain equipment in public health facilities since 1986, to address the high running cost of maintaining electrical refrigerators.Twelve (12) solar refrigerators were procured for two regions in 2004, thirty-Four (34) and three (3) refrigerators in 2009 and 2014 respectively for four other regions. WR1 needs 8 TCW2000, WR2 needs 6, URR 2 in 2017. The replacement plan of the the existing refrigerators and gaps in the cold chain system have been factored in the Gavi HSS and it is anticipated to start in January 2017.Finalized forecast plans for vaccines, cold chain equipment and other EPI related items are submitted to UNICEF for processing.

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.

Country group	Initial self-financing phase

	2017	**2018**	**2019**
Minimum co-financing	0.20	0.20	0.20
Your co-financing (please change if higher)	0.20	0.20	0.20

	2020	**2021**
Minimum co-financing	0.20	0.20
Your co-financing (please change if higher)	0.20	0.20

6.2.2. Specifications of vaccinations with new vaccine

	Data from		**2017**	**2018**	**2019**	**2020**
Immunization coverage	Table 5.2	%	97%	97%	98%	98%
Number of children to be vaccinated with the first dose	Table 5.2	#	79,514	81,343	84,071	86,005

Country co-financing per dose	Table 6.4.1	$	0.2	0.2	0.2	0.2

	Data from		2021
Immunization coverage	Table 5.2	%	98%
Number of children to be vaccinated with the first dose	Table 5.2	#	87,983
Country co-financing per dose	Table 6.4.1	$	0.2

6.2.3. Portion of supply to be procured by the country (and cost estimate, US$)

		2017	2018	2019
Number of vaccine doses	#	40,240	33,219	34,418
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country *[1]*	$	23,501	19,401	20,101

[1] The co-financing amount for initial self-financing countries indicates costs for 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.

		2020	2021
Number of vaccine doses	#	35,103	35,788
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by the Country *[1]*	$	20,501	20,901

[1] The co-financing amount for initial self-financing countries indicates costs for 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.

6.2.4. Portion of supply to be procured by Gavi (and cost estimate, US$)

		2017	2018	2019
Number of vaccine doses	#	77,260	63,781	66,082
Number of AD syringes	#	114,298	90,891	94,213
Number of re-constitution syringes	#	13,043	10,768	11,156
Number of safety boxes	#	0	0	0
Total value to be co-financed by Gavi	$	49,833	40,997	42,479

		2020	2021
Number of vaccine doses	#	67,397	68,712
Number of AD syringes	#	96,100	98,310
Number of re-constitution syringes	#	11,378	11,600
Number of safety boxes	#	0	0
Total value to be co-financed by Gavi	$	43,325	44,184

6.2.5. New and Under-Used Vaccine Introduction Grant

Calculation of Vaccine Introduction Grant for the Meningococcal A, 10 dose(s) per vial, LYOPHILISED

Year of New Vaccine Introduction	Births (from Table 5.2)	Share per Birth in US$	Total in US$
2017	88,991	0.80	100,000

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

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).

The VIG will be used to prepare the ground for the new vaccine introduction. The following key activities will be carried out for smooth introduction.

i) Advocacy & Communication: Advocacy and communication play a key role in involving and sensitizing the Gambian Population particularly decision/policy makers and women in the delivery and utilization of immunization services. In this regard, the social mobilization activities will begin with the sensitization of regional and district authorities as well as Technical Advisory Committees (TACs) members, who will in turn sensitize their respective communities. During these regional meetings, the critical role for community sensitization will be emphasized.Radio and television programmes will also be organized in different radio stations in different languages across the country. Communication support materials will be produced and distributed to the communities.

ii) Data Management: The data collection tools such as tally books, registers, clinic cards and monthly returns would be reviewed and finalized to include the Rota vaccine in consultation with stakeholders at regional and health facility levels. The existing routine data collection and reporting system will be used. In addition, the Comprehensive Multi year Plan is reviewed to include MenA vaccine into the routine services.

iii) Cold Chain & Logistics: The EPI Programme has a good network of the cold chain system. The cold chain technicians will carry out preventive maintenance of the cold chain equipment country wide before the introduction of the MenA vaccine.

iv) Waste Management: There are incinerators built in 2010 (one in each region) for the management of immunization wastes. These incinerators will be fully utilized during the introduction of the vaccine. However, some of these incinerators are in a state of disrepair and would be rehabilitated before the introduction of the vaccine.

v) Central Level Monitoring: The central EPI team will conduct a country wide supervisory visit to assess the state of preparedness at regional and health facility levels for the introduction of the new vaccine.

vi) Regional Level Monitoring: Each region will carry out regular supervisory visits to the health facilities to assess the state of preparedness in relation to the new vaccine introduction.

vii) Training: Training of trainers will be conducted at central level including regional supervisors followed by cascade trainings at service delivery level. The training will focus on vaccine administration, vaccine storage, safe injection practices, AEFI monitoring and surveillance etc etc

viii) Launching: There would be launching ceremony at central level. These would be graced by authorities at national and regional levels.

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

Detailed budget attached as Document No. 22.

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.

The Total cost for the introduction is US$151,474.78. Gavi will provide USD999998.98 (66.02%).The government with partners like UNICEF, WHO, The Gambia Red Cross, Child Fund would compliment the effort of Gavi for the MenA vaccine introduction. The government will fund part of the preparatory technical, advocacy meetings and transportation of vaccines and other supplies to the regions. this estimated at US$4595.87 (3.03%). Other Partners like WHO and UNICEF are expected in the areas of waste management, surveillance, TA needs at a tune of **US$46879.93 (30.95%)**.

6.2.6.Technical assistance

Please describe any particular area(s) the Ministry would require technical assistance to support the introduction of Meningococcal A.

The country may need TA in the following areas:

1. AEFI monitoring

2. Post introduction evaluation

6.3 Request for MenA one-time mini catch-up campaign, Meningococcal A, 10 dose(s) per vial, LYOPHILISED campaign support

6.3.1 Summary for MenA one-time mini catch up campaign support

When is the country planning to conduct this campaign? **August 7**

Describe the target population and geographical coverage for the Gavi supported MenA one-time mini catch-up campaign. Please provide a rationale for expanding one time mini-catch up campaigns to areas not covered by the preventive mass vaccination campaign. If available please submit relevant documentation to support the estimates of the size of the mini-catch up campaign target population (as DOCUMENT NUMBER : Where Gavi support is not sufficient for the campaign, The Government will mobilize additional resources locally from the health budget and partners like WHO, UNICEF, Child Fund etc to supplement the amount provided by Gavi.The Government of The Gambia will contribute US$72,192.19 towards the operational cost, while partners like WHO and UNICEF will be contributing US$32664.70 towards the total cost of the campaign.

Both the current health master plan (2007-2020) and the EPI cMYP(2017-2021) will be used for resource mobilization to support immunization services. During the development process of the cMYP, firm financial commitment was given by WHO, and UNICEF to support immunization services in the country.
).

2017

Please give a summary of the cMYP and/or the [MenA vaccine] introduction plan sections that refer to the introduction of Meningococcal A, 10 dose(s) per vial, LYOPHILISED.

Meningococcal Meningitis/cerebro-spinal meningitis is a contagious bacterial infection occurring sporadically throughout the world. Several different bacteria can cause the disease; Neisseria meningitis is the one with potential to cause large epidemics. Twelve serotypes have been identified, six of which (A.B, C, W135, X and Y) cause major epidemics in the Meningitis belt. In The Gambia, epidemics records have shown serotype A as the predominant type responsible for epidemics. However, in August 2012, an epidemic of W135 was experienced in the Gambia with 175 cases and 9 deaths recorded. As a result of the above, The Gambia successfully implemented a campaign in November 2013 targeting 1-29 years old population

In 1996/7 epidemic seasons, The Gambia experienced the worst epidemics causing 1685 cases and 222 deaths with a case fatality rate (CFR) of 13.1%. During this season, the Upper River Region; one of the high risk regions recorded 1390 cases and 168 deaths with a case fatality rate of 12%. Furthermore, from

November 2000 to March 2001, 137 cases including 21 deaths were recorded.

Increased prevalence over the years, epidemiological shift, high susceptible populations coupled with globalization is major concerns for meningitis control. In addition, inadequate capacity of the health care system in relation to timely detection, diagnosis, management and treatment of cases as well as high poverty levels in The Gambia continue to hamper efforts in the control and prevention of Meningitis. In this regard, effective surveillance strong routine immunization services and mass vaccination campaigns remain to be the most effective strategies to eliminate meningitis epidemics in The Gambia.

The mass vaccination campaign conducted in the country in November 2013 targeted persons aged 1-29 years totalling to 1177922. There was an administrative coverage of 104% and the post campaign evaluation revealed coverage of 96.6%. Since the campaign, cases have tremendously reduced. However, there is a need to conduct a one-time mini Catch-up campaign for the birth cohort (which will not be part of the routine introduction: >18 months old) in order to sustain the gains made with regards to reducing the cases of Meningitis Type A. The Government of the Gambia through the Inter-Agency Coordinating Committee (ICC) plans to conduct this campaign in July 2017 to pave the way for the routine introduction in October 2017. The campaign will target all children in the country aged 1-5 years old using a 10 dose LYOPHILISED MenA vaccine (MenAfriVac) as the preferred choice of vaccine presentation. A total of 305,269 children are targeted for a 7 days campaign.

6.2.2 Grant Support for Operational Costs of the MenA one-time mini catch-up campaigns

Table 6.2.2: calculation of grant to support the operational costs of the campaigns

Year of Men A one time mini catch-up campaigns	Total target population	Gavi contribution per target person in US$	Total in US$
22	2,017	305,269.00	1

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

Please describe how the grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population (refer to the cMYP which should include one-time mini catch up campaign and the Vaccine Introduction Plan)

The Gambia lies in the meningitis belt across the African Continent with seasonal meningitis out breaks. In 2013, the Gambia conducted a MenA catchup vaccination campaign using the MenAfriVac and since then, the incidence of MenA has reduced significantly. It is worth noting that a large volume of vaccine was left after the campaign and were later supplied to the health facilities to immunize all children attaining one year of age. Consequently, transmission of meningitis was interrupted for several years.

It is therefore, believed that with the introduction of the vaccine in to the routine programme, the Gambia will be contributing to the meningitis elimination programme of the continent and also reduced the morbidity and mortality due to MenA in the country significantly.

The objective of introducing the Meningococcal A conjugate is to reduce the occurrence of Meningitis epidemic that occasionally hits The Gambia. The 10-dose vial is preferred. This decision was based on the fact that the country has had an experience with 10-dose formulations of MenAfriVac for the 2013 campaign and other routine vaccines such as measles. This choice will also maximize the use of cold chain space in anticipation of concurrent or future vaccine introductions.

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.

The main objective of the proposed Catch-up MenA preventive campaign is to vaccinate the new birth cohort (1-5yrs) that did not receive the first dose of MenA vaccine after the 2013 campaign in the country.

The campaign will target the age group 1-5 years. A total of 305,269 (16%) people out of a total population of 1.8 million (2013 census) country wide have been targeted for the campaign. The campaign is scheduled to take place in July 2017.

The activities to be implemented for the campaign will include micro planning and training at all levels, advocacy and social mobilization, data collection tools, training manual, logistics distribution, and payment of personell conducting/supervising vaccination at mobile and fixed posts like schools, markets in all communities as well as waste management. The post campaign evaluation will be conducted to validate the campaign results and highlight constraints, challenges, best practices and recommendations for future campaigns.

Please complete also the 'Detailed budget for VIG / Operational costs specifically for one time mini catch-up campaigns' template provided by Gavi and attach as a mandatory document in the Attachment section. Detailed budget attached as Document No. 18. (Countries are encouraged to identify synergies across the vaccine introduction grant (VIG) for routine immunizations and operational costs for mini catch-up campaigns).

7. NVS Preventive Campaigns

No NVS Prevention Campaign Support this year

7.1.1 Epidemiology and disease burden for Meningococcal A

Please select at least one of the following information sources to justify Meningococcal A disease burden results:

Epidemiological information on burden of disease:

☐ 1 - Risk assessments

☐ 2 - Other

8. Procurement and Management

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

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

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 or PAHO's Revolving Fund):

Currently, vaccines and other EPI supplies are procured through UNICEF and the same mechanism will continue to be utilized for the introduction of the MenA

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

- A description of the mechanism and the vaccines or commodities to be procured by the country
- Assurance that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. For the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, assurance should also be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

There is no alternative mechanism, all procurements are done through UNICEF

c) If receiving direct financial support from Gavi (such as operational support for campaigns or VIG activities), please indicate how the funds should be transferred by Gavi.

Based on the current challenges in implementing the FMA recommendations, the country is suggesting the VIG to be channelled through UNICEF. However,if the FMA recommendations are resolved before the VIG disbursment, then the country would prefer the funds to be sent through the government financial system.

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

The government co-financing payments as required for other vaccines has been disbursed by the Ministry of Finance and deposited into the EPI account managed by UNICEF Supply Division in Copenhagen. This mechanism has been successfully utilized over the years for the procurement and co-financing of traditional and new vaccines respectively. The same mechanism will be used for the payment of co-financing of the MenA vaccine

e) Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including procurement.

The EPI manger initiates the request for funds through the Permannent Secretary for the Ministry of Health for approval. The approved memo is processed by the accounts Unit of the MOH through the National Treasury before funds are received at the Central Bank of The Gambia.

f) Please outline how coverage of the introduced vaccine will be monitored, reported and evaluated (refer to cMYP and Introduction Plan)

There is an already existing mechanism for monitoring and reporting of routine administrative data. The same system would be used for the MenA coverage after updating the data collection tools. the following systems are also in place:
- monitoring the coverage using the monthly reports and monitoring charts at service delivery level.
-Bi monthly meetings will be conducted at central level where routine data (feedback) is being reviewed and similar meetings are held at regional level monthly.
-Supportive supervisory visits will be conducted by the central level to all the regions and health facilities.

whilst regional health teams visit each health facility monthly.
- Biennial cluster survey will be conducted using standard WHO EPI survey tools to validate the routine administrative data.
-Annual GAVI Progress Reports and joint reporting form will be submitted
The current system of monthly, bi monthly, quarterly, annual reporting and feedback will continue at all levels

g) If applying for measles second dose, does the country wish to have the support in cash or in-kind? **N/A**

8.2 Procurement and Management for NVS Preventive Campaign(s)

No NVS Prevention Campaign Support this year

8.3 Product Licensure

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

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

The Gambia has established a National Regulatory Authority (NRA) mandated to certify and license vaccines and pharmaceuticals. The NRA would require documentation from the manufacturers before any new vaccine is shipped into the country. To ensure quality and standard, Procurement of vaccines and supplies will be done through UNICEF. The process of licensure will include a dossier from the manufacturer to the WHO country office. This will then be sent to the national regulatory authority for review and verification for the final licensing. Fast track method is sometimes used, which is based on WHO prequalification. However, the MenAfriVac has been licensed and approved for usage since 2013 campaign

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

The MenA campaign was conducted in 2013 and the vaccine had already been registered.

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

In the Gambia Unicef sends in the pre-shipping documents of all stocks expected in the country to the EPI and the clearing officer of MOH. The clearing officer for the Ministry of Health clears all vaccines, drugs and injection supplies on behalf of the Ministry. He liases with the customs department and follow all local custom regulations. He is notified prior to the arrival of the goods to enhance all the neccessary paper transactions. There are no special documentation protocols that can cause delay for vaccine handling. Pre-delivery is not required,since the vaccine are comming through Unicef.

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

The the national Medicine Control Agency mandated by an act to certify vaccines and licienned vaccines and pharmaceuticals. To ensure quality and standard, Procurement of vaccines and supplies will be done through UNICEF. The process of licensure will include a dossier from the manufacturer to the WHO country office. This will then be sent to the national regulatory authority for review and verification for the final licensing**.** Fast track method is sometimes used, which is based on WHO prequalification.

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8.4 Vaccine Management (EVSM/EVM/VMA)

It is mandatory for countries to conduct an Effective Vaccine Management (EVM) assessment prior to an application for the introduction of a new vaccine. This EVM should have been conducted within the preceding **5 years**.

When was the EVM conducted? **November 2014**

Please attach the EVM improvement plan progress report (DOCUMENT NUMBER:21); and if not previously provided, please attach the most recent EVM assessment report (DOCUMENT NUMBER : 20,19,21) and the corresponding EVM improvement plan (DOCUMENT NUMBER : 19). 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 progress of implementation.

When is the next Effective Vaccine Management (EVM) Assessment planned? **November 2017**

8.5 Waste management

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

The Gambia was supported during the introduction of PCV-7 to revamp the waste management system with the installation of six waste disposal units. ADB project and WHO have provided some incinerators to strengthen the waste management system.

Injection Safety is assured by the use of AD Syringes. Bundling will continue to be implemented at all levels. The quality of vaccines to be used will continue to be a key priority and as such UNICEF procurement system would be used

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

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

We members of the ICC, at meeting held on the 6th September 2017, having been presented with MenA application documents, and being satisfied with the content, do hereby endorse the application for submission to Gavi for support to introduce the MenA vaccine into the routine immunisation in The Gambia.

10. List of documents attached to this proposal

10.1. List of documents attached to this proposal

Table 1: Checklist of mandatory attachments

Document Number	Document	Section	File
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	Signature of Hon. Minister of Health.pdf **File desc:** **Date/time :** 06/09/2016 09:41:26 **Size:** 252 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	Signature of Hon. Minister of Finance.pdf **File desc:** **Date/time :** 06/09/2016 09:46:36 **Size:** 252 KB
4	Terms of Reference for the ICC	4.1.2	ToR - ICC.doc **File desc:** **Date/time :** 05/09/2016 09:28:38 **Size:** 34 KB
5	Minutes of ICC/HSCC meeting endorsing Proposal	4.1.3	MINUTES OF THE INTER AGENCY COORDINATING COMMITTEE MEETING ENDORSING THE APPLICATION.pdf **File desc:** **Date/time :** 06/09/2016 01:50:45 **Size:** 246 KB
6	Signatures of ICC or HSCC or equivalent in Proposal	4.1.3	Signatures of ICC on the Endorsement of the Proposal.pdf **File desc:** **Date/time :** 07/09/2016 08:41:47 **Size:** 688 KB
7	Minutes of last three ICC/HSCC meetings	4.1.3	MINUTES OF THE LAST THREE MEETINGS OF THE ICC.pdf **File desc:** **Date/time :** 06/09/2016 01:55:26 **Size:** 316 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	NITAG DOCUMENT.doc **File desc:** **Date/time :** 05/09/2016 09:41:20 **Size:** 22 KB
Planning, financing and vaccine management			
9	comprehensive Multi Year Plan - cMYP	5.1	The Gambia cMYP_2017-2021_Draft.docx **File desc:** **Date/time :** 05/09/2016 01:05:05 **Size:** 733 KB
10	cMYP Costing tool for financial analysis	5.1	The Gambia_cMYP_Costing_Tool_Draft_2017-2021.xlsx **File desc:** **Date/time :** 05/09/2016 12:30:30 **Size:** 3 MB

11	M&E and surveillance plan within the country's existing monitoring plan	5.1.4	Finalised copy of validated M&E 11-08-2015.pdf **File desc:** **Date/time :** 05/09/2016 12:22:07 **Size:** 1 MB
12	Vaccine introduction plan	5.1	FINAL_MENA INTRODUCTION PLAN.doc **File desc:** **Date/time :** 06/09/2016 12:32:09 **Size:** 1 MB
13	Introduction Plan for the introduction of RCV / JE / Men A / YF into the national programme	7.x.4	FINAL_MENA INTRODUCTION PLAN.doc **File desc:** **Date/time :** 06/09/2016 12:33:01 **Size:** 1 MB
19	EVM report	8.3	6. The Gambia EVM Assessment.doc **File desc:** **Date/time :** 30/08/2016 08:56:09 **Size:** 3 MB
20	Improvement plan based on EVM	8.3	7. Gambia EVM Improvement Plan_2014.xlsx **File desc:** **Date/time :** 30/08/2016 08:57:03 **Size:** 98 KB
21	EVM improvement plan progress report	8.3	8. GAM EVM IMPROVEMENT PLAN 2014_STATUS OF IMPLEMENTATION.xls **File desc:** **Date/time :** 30/08/2016 08:57:28 **Size:** 218 KB
22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2, 6.x.2	MenA VIG and Mini Catachup Campaign Budget.xls **File desc:** **Date/time :** 05/09/2016 10:23:50 **Size:** 114 KB
27	Data quality assessment (DQA) report	5.1.4	DQA REPORT.doc **File desc:** **Date/time :** 05/09/2016 09:43:36 **Size:** 22 KB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	No file loaded
14	Annual EPI Plan with 4 year forward view for measles and rubella		No file loaded

15	HPV roadmap or strategy	6.1.1	No file loaded
16	HPV summary of the evaluation methodology	5.1.6	No file loaded
17	Evidence of commitment to fund purchase of RCV for use in the routine system in place of the first dose of MCV	7.x.3	No file loaded
18	Campaign target population documentation	7.x.1, 6.x.1	No file loaded
23	Risk assessment and consensus meeting report for MenA. If the DPT was used instead, please include this.	7.1	No file loaded
24	National Measles (& Rubella) elimination plan if available		No file loaded
25	A description of partner participation in preparing the application	4.1.3	No file loaded
26	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	No file loaded
28	DQA improvement plan	5.1.4	No file loaded
29	Plan of Action for campaigns	7.1, 7.x.4	MenA Catch-up Campaign Implementation Plan.doc **File desc:** **Date/time :** 05/09/2016 12:38:49 **Size:** 678 KB
30	Other		No file loaded

31	Evidence of self-financing MCV1	5.1.5	No file loaded

11. Annexes

Annex 1 - NVS Routine Support

Annex 1.1 - NVS Routine Support (Meningococcal A, 10 dose(s) per vial, LYOPHILISED)

Table Annex 1.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in US$

		2017	2018	2019	2020
Number of vaccine doses	#	40,300	33,300	34,500	35,200
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country ***[1]***	**$**	24,000	19,500	20,500	21,000

		2021
Number of vaccine doses	#	35,800
Number of AD syringes	#	0
Number of re-constitution syringes	#	0
Number of safety boxes	#	0
Total value to be co-financed by the Country ***[1]***	**$**	21,000

Table Annex 1.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$

		2017	2018	2019	2020
Number of vaccine doses	#	77,300	63,800	66,100	67,400
Number of AD syringes	#	114,300	90,900	94,300	96,100
Number of re-constitution syringes	#	13,100	10,800	11,200	11,400
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by Gavi	**$**	50,000	41,000	42,500	43,500

		2021
Number of vaccine doses	#	68,800
Number of AD syringes	#	98,400
Number of re-constitution syringes	#	11,600
Number of safety boxes	#	0
Total value to be co-financed by Gavi	**$**	44,500

Table Annex 1.1 C: Summary table for vaccine Meningococcal A, 10 dose(s) per vial, LYOPHILISED

ID		Data from		2017	2018	2019	2020
	Number of surviving infants	Table 5.2	#	81,973	83,859	85,787	87,760
	Immunization coverage	Table 5.2	%	97%	97%	98%	98%
	Number of children to be vaccinated with the first dose	Table 5.2	#	79,514	81,343	84,071	86,005
	Number of doses per child	Parameter	#	1	1	1	1
	Estimated vaccine wastage factor	Table 5.2	#	1.18	1.18	1.18	1.18
	Number of doses per vial	Parameter	#	10	10	10	10
	AD syringes required	Parameter	#	Yes	Yes	Yes	Yes
	Reconstitution syringes required	Parameter	#	Yes	Yes	Yes	Yes
	Safety boxes required	Parameter	#	No	No	No	No
cc	**Country co-financing per dose**	Table 6.4.1	$	0.2	0.2	0.2	0.2
ca	**AD syringe price per unit**	Table Annexes 4A	$	0.041	0.041	0.041	0.041
cr	**Reconstitution syringe price per unit**	Table Annexes 4A	$	0.004	0.004	0.004	0.004
cs	**Safety box price per unit**	Table Annexes 4A	$	0.005	0.005	0.005	0.005
fv	**Freight cost as % of vaccines value**	Table Annexes 4B	%	3.36%	3.36%	3.36%	3.36%
fd	**Freight cost as % of devices value**	Parameter	%	0	0	0	0

ID		Data from		2021
	Number of surviving infants	Table 5.2	#	89,779
	Immunization coverage	Table 5.2	%	98%
	Number of children to be vaccinated with the first dose	Table 5.2	#	87,983
	Number of doses per child	Parameter	#	1
	Estimated vaccine wastage factor	Table 5.2	#	1.18
	Number of doses per vial	Parameter	#	10
	AD syringes required	Parameter	#	Yes
	Reconstitution syringes required	Parameter	#	Yes
	Safety boxes required	Parameter	#	No
cc	**Country co-financing per dose**	Table 6.4.1	$	0.2
ca	**AD syringe price per unit**	Table Annexes 4A	$	0.041
cr	**Reconstitution syringe price per unit**	Table Annexes 4A	$	0.004
cs	**Safety box price per unit**	Table Annexes 4A	$	0.005
fv	**Freight cost as % of vaccines value**	Table Annexes 4B	%	3.00%
fd	**Freight cost as % of devices value**	Parameter	%	0

Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 1)

		Formula	2017		
			Total	Government	Gavi
A	Country co-finance	*V*	34.25 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	79,514	27,231	52,283
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	79,514	27,231	52,283
E	Estimated vaccine wastage factor	*Table 5.2*	1.18		
F	Number of doses needed including wastage	*D x E*	93,827	32,133	61,694
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	23,457	8,034	15,423
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	117,500	40,240	77,260
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	114,298	0	114,298
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	13,043	0	13,043
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.11*	0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	66,388	22,736	43,652
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	4,658	0	4,658
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	55	0	55
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	2,233	765	1,468
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	73,334	23,501	49,833
U	Total country co-financing	*I x country co-financing per dose (cc)*	23,500		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	34.25 %		

Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 2)

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	*V*	34.25 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	81,343	27,857	53,486
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	81,343	27,857	53,486
E	Estimated vaccine wastage factor	*Table 5.2*	1.18		
F	Number of doses needed including wastage	*D x E*	95,985	32,871	63,114
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	540	185	355
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	97,000	33,219	63,781
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	90,891	0	90,891
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	10,768	0	10,768
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.11*	0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	54,805	18,769	36,036
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	3,704	0	3,704
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	45	0	45
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	1,844	632	1,212
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	60,398	19,401	40,997
U	Total country co-financing	*I x country co-financing per dose (cc)*	19,400		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	34.25 %		

Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 3)

		Formula	2019		
			Total	Government	Gavi
A	Country co-finance	*V*	34.25 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	84,071	28,791	55,280
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	84,071	28,791	55,280
E	Estimated vaccine wastage factor	*Table 5.2*	1.18		
F	Number of doses needed including wastage	*D x E*	99,204	33,974	65,230
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	805	276	529
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	100,500	34,418	66,082
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	94,213	0	94,213
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	11,156	0	11,156
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.11*	0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	56,783	19,446	37,337
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	3,840	0	3,840
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	47	0	47
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	1,910	655	1,255
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	62,580	20,101	42,479
U	Total country co-financing	*I x country co-financing per dose (cc)*	20,100		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	34.25 %		

Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 4)

		Formula	2020		
			Total	Government	Gavi
A	Country co-finance	*V*	34.25 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	86,005	29,454	56,551
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	86,005	29,454	56,551
E	Estimated vaccine wastage factor	*Table 5.2*	1.18		
F	Number of doses needed including wastage	*D x E*	101,486	34,755	66,731
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	571	196	375
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	102,500	35,103	67,397
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	96,100	0	96,100
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	11,378	0	11,378
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.11*	0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	57,913	19,833	38,080
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	3,917	0	3,917
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	48	0	48
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	1,948	668	1,280
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	63,826	20,501	43,325
U	Total country co-financing	*I x country co-financing per dose (cc)*	20,500		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	34.25 %		

Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 5)

		Formula	2021		
			Total	Government	Gavi
A	Country co-finance	*V*	34.25 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	87,983	30,131	57,852
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	87,983	30,131	57,852
E	Estimated vaccine wastage factor	*Table 5.2*	1.18		
F	Number of doses needed including wastage	*D x E*	103,820	35,555	68,265
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	584	200	384
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	104,500	35,788	68,712
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	98,310	0	98,310
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	11,600	0	11,600
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.11*	0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	59,043	20,220	38,823
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	4,007	0	4,007
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	49	0	49
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	1,986	681	1,305
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	65,085	20,901	44,184
U	Total country co-financing	*I x country co-financing per dose (cc)*	20,900		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	34.25 %		

Annex 2 - NVS Routine – Preferred Second Presentation

No NVS Routine – Preferred Second Presentation requested this year

Annex 3 - NVS Preventive campaign(s)

No NVS Prevention Campaign Support this year

Annex 4

Table Annex 4A: Commodities Cost

Estimated prices of supply are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2017	2018	2019
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	MENINACONJUGATE	3.36 %	3.36 %	3.36 %

Vaccine Antigen	Vaccine Type	2020	2021
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	MENINACONJUGATE	3.36 %	3.36 %

Table Annex 4C: Initial self-financing phase - Minimum country co-payment per dose of co-financed vaccine

Vaccine	2017	2018	2019
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	0.2	0.2	0.2

Vaccine	2020	2021
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	0.2	0.2

Table Annex 4D: Wastage rates and factors

The following table shows the wastage rates for routine and campaign vaccines, set for 2017.

Vaccine	dose(s) per vial	Maximum Vaccine wastage rate*		Benchmark Wastage Rate**
HPV bivalent, 2 dose(s) per vial, LIQUID	2	10 %	0 %	
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5 %	0 %	
JE, 5 dose(s) per vial, LYOPHILISED	5	10 %	10 %	
Measles, 10 dose(s) per vial, LYOPHILISED in second dose	10	40 %	0 %	
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	10	50 %	10 %	
MR, 10 dose(s) per vial, LYOPHILISED in second dose	10	40 %	15 %	
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	10 %	0 %	
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	5 %	0 %	
Rotavirus, 2-dose schedule	1	5 %	0 %	
Rotavirus, 3-dose schedule	1	5 %	0 %	
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	40 %	0 %	
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	10 %	0 %	

Comments:

* Source - WHO indicative wastage rates

** Source - Country APRs and studies, approved by WHO, UNICEF, and the Gavi Secretariat

Note: HPV demonstration project wastage rates are the same as for the national introduction of the vaccine

Table Annex 4E: Vaccine maximum packed volumes

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

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	DT	liquid	IM	3	10	3	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	20	2.5	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	10	3	
DTP liquid + Hib freeze-dried	DTP+Hib	liquid+lyop.	IM	3	1	45	
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	
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	
DTP-Hib combined liquid	DTP+Hib	liquid+lyop.	IM	3	10	12	
DTP-Hib combined liquid	DTP-Hib	liquid	IM	3	1	32.3	
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 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
Hib liquid	Hib_liq	liquid	IM	3	1	15	
Hib liquid	Hib_liq	liquid	IM	3	10	2.5	
Human Papilomavirus vaccine	HPV	liquid	IM	3	1	15	
Human Papilomavirus vaccine	HPV	liquid	IM	3	2	5.7	
Japanese Encephalitis	JE_lyo	lyophilized	SC	1	5	2.5	2.9
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-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
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
Meningitis A conjugate	Men_A	lyophilized	IM	1	10	2.6	4
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
Meningitis W135	MV_W135	lyophilized	SC	1	10	2.5	4
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
Monovalent OPV-1	mOPV1	liquid	Oral		20	1.5	
Monovalent OPV-3	mOPV3	liquid	Oral		20	1.5	
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	OPV	liquid	Oral	4	10	2	
Polio	OPV	liquid	Oral	4	20	1	
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	
Rota vaccine	Rota_liq	liquid	Oral	2	1	17.1	
Rota vaccine	Rota_liq	liquid	Oral	3	1	45.9	
Tetanus Toxoid	TT	liquid	IM	2	10	3	
Tetanus Toxoid	TT	liquid	IM	2	20	2.5	
Tetanus Toxoid UniJect	TT	liquid	IM	2	Unijject	12	
Tetanus-Diphtheria	Td	liquid	IM	2	10	3	
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

12. Banking Form

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

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

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

By who is the account audited?

Signature of Government's authorizing official

		Seal
Name:		
Title:		
Signature:		
Date:		

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

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

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

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

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