Application Form for Gavi NVS support

Submitted by

The Government of

Gambia

Date of submission: **3 May 2017**

Deadline for submission:

i. **3 May 2017**
ii. 3 May 2017
iii. 1 September 2017

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 December 2016)

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	HPV quadrivalent, 1 dose(s) per vial, LIQUID	2017	2021	HPV bivalent, 2 dose(s) per vial, LIQUID

[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.

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 role of the Coordination Forum (ICC/HSCC or equivalent) and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal

In the Gambia, cervical cancer is the most common cancer among women and forms 33% of all cancers in women. A prevalence rate of 13% of HPV infection was reported from a study conducted in the country (Bah et al, 2013). If adjusted for age (i.e. to the world standard population as commonly done by population-based cancer registries) the annual age-adjusted incidence rate of cervical cancer is 18.9 per 100,000 person-years during the period reviewed (1990-2009).

The existing cervical cancer prevention and control activities comprise primary, secondary and tertiary prevention and control strategies. Primary prevention strategies consist of HPV vaccination, and health education. Secondary prevention method comprises screening programmes run by some health facilities at the primary, secondary and tertiary levels. Tertiary control measures comprise treatment and palliative care mainly done at the Edward Francis Small Teaching Hospital (EFSTH).

The objective of introducing the HPV vaccine is to reduce the prevalence of cervical cancer in The Gambia. The targeted age group for the vaccine will be girls in grade 3 aged 9 to 14 years old. A total of 30442 girls are targeted for vaccination in the routine cohort while 108132 girls for the multi age cohortin the introducyion year. In 2017, there are 88968 and 82127 annual live births and surviving infants respectively.

The 1-dose vial quadrivalent vaccine is the preferred choice of vaccine presentation. This decision was based on the fact that the country has had an experience with it during the HPV demonstration project from 2014 to 2016. This choice was made due to the fact that, it contains all the major serotypes that are prevalent in The Gambia including the most important serotypes 16 and 18 associated with cervical cancer as reported by Bah et al, 2013.

Compared to other countries within the sub region, The Gambia has a good track record of high immunization coverage. Key among these achievements include the continuous availability of vaccines and other supplies at all levels, geographical access (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) and committed health staff to deliver immunization services. The country had attained 95% and 97% coverage rates for Penta 3 and MCV1 respectively in 2016.

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 HPV vaccine.

The findings of the 2014 Effective Vaccine Management (EVM) assessment revealed that there is a 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.

Currently the country has adequate cold chain capacity at the Central, Regional and Health facility levels to accommodate introduction of the HPV vaccine. The supply chain consists of a National Vaccine Store of 40m3 which is based in Banjul at Central Medical Stores complex and is about 30 kilometres from the airport. The national vaccine store distributes vaccines and injection supplies to the regional cold stores. The country receives vaccine supplies twice yearly – March and September, and supply the regions on quarterly basis. The health facilities collect vaccines and injection supplies from the regional cold stores monthly.

With the switch from Rota Teq to Rota rix vaccine, in 2017, the country would gain additional cold chain storage space to accommodate more vaccines including HPV. The Rota Teq vaccine occupied about 60% of the total cold chain storage capacity (EVM, 2014). Coupled with that, the country will switch from PCV single dose to the multi dose before end of the third quarter of 2017; to garner additional storage space.

In addition to the above, there is provision for a Cold Room and 31 sets of TCW 2000 SDD in the approved HSS grant of the country that would facilitate the replacement and expansion of immunization service delivery points.

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

The VIG is based on a maximum award of $2.40 per girl in the routine cohort with a minimum starting grant award of $100,000. The total cost for the multi age cohort attracts a sum of $70285.67 ($0.65 per girl). A detailed budet for these two activities is attached.

A communication plan will be developed to guide the implementation of all communication related activities. There would be a national launching prior to the implementation of the HPV vaccination that aims to attract the involvement of the relevant stakeholders. Community health workers, supported with IEC support materials will engage communities to increase awareness. Print and electronic media, drama and traditional communicators, media briefing, pre-clinic health talks and launching of the HPV roll out will be used to emphasize awareness creation. In addition, Civil Society Organizations such as Health Promotion and Development Organization (HePDO) and The Gambia Red Cross Society, which have strong presence in communities, will be engaged to promote acceptance and demand generation.

The process of the HPV proposal development started from discussions at the Inter-Agency Coordinating Committee (ICC) for the Expanded Programme on Immunization (EPI). The country agreed that the National Cancer Prevention and Control Technical Committee will lead the proposal development.

The proposal formulation process was spearheaded by the Expanded Programme on Immunization (EPI), in collaboration with the Cervical Cancer Prevention and Control Technical Committee with membership from the Directorates of Human Resource for Health (HRH) and Planning & Information (DPI) of the Ministry of Health and Social Welfare (MOH&SW), The Teaching Hospital, MRC, WHO, UNICEF, UNFPA, Regional directorates Western 1 &2, Ministry of Basic and Secondary Education etc. The Technical Committee was charged with the responsibility of co-coordinating the proposal formulation process.

During the proposal development a workshop was organized at a retreat in Bwiam with all Development Partners, CSOs, NGOs and CBOs represented. UNICEF funded the workshops for the development of the proposal.

Members of the civil society organizations (Health Promotion and Development Organization – HePDO) , Technical partners such as WHO, UNICEF etc were also part of the TWG and actively participated in the proposal development

The ICC endorsed the HPV vaccine introduction application during a meeting on the 26th April, 2017 for submission. The duration of the HPV vaccination support would be from 2017 to 2021. The presentation

made at the meeting highlighted the rationale for HPV Vaccine introduction, programmatic as well as budgetary considerations.

This body is tasked with the responsibility of coordinating and monitoring activities that are implemented through 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 global drive of reducing the morbidity and mortality due to cancers in the country.

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:

HPV quadrivalent, 1 dose(s) per vial, LIQUID 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) **6.2.3, 6.2.4** in the Routine New Vaccines Support of this application shows the amount of support in either supply or cash that is required from the Gavi.Table(s) **6.2.3, 6.2.4** 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 **December**.

The payment for the first year of co-financed support will be around **December 2017** for HPV quadrivalent, 1 dose(s) per vial, LIQUID.

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 : 1 and 2 in Section 10. Attachments.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Hon. Safie Lowe Ceesay	**Name**	Hon. Amadou Sanneh
Date		**Date**	
Signature		**Signature**	

Proof of involvement of the Ministry of Education will also be required for HPV Routine Support. The Ministry of Education will either have to be involved in the ICC process (preferred option) and, for countries choosing schools as a location for vaccinations, or choosing a school link strategy, the Minister of Education (or delegated authority) must provide its signature. The signature is attached as DOCUMENT NUMBER : 3 in Section 10. Attachments.

Minister of Education (or delegated authority)	
Name	Hon. Claudia Cole
Date	
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
Alagie Touray	EPI	(+220) 2423006	tourayg910@gmail.com
Dr Adelard Ngabonziza	SOS Mother and Children Villages	(+220) 9966512	adelard.ngabonziza@sosgambia.org
Dr Alfred E. Yawson	Lead consultant	+233206301049	aeyawson@yahoo.com
Dr. Musa Marena	Edward Francis Small Teaching Hospital (EFSTH)	(+220) 3038157	valentinemusa@yahoo.c.uk
Dr. Mustapha Bittaye	Edward Francis Small Teaching Hospital (EFSTH)	(+220) 2388875	bittaye@yahoo.com
Dr. Ndack Diop	PATH	+221775436428	ndiop@path.org
Mbye Njie	EPI	(+220) 2422421	mbyenjie6@yahoo.co.uk
Mr. Abdoulie Janneh	EPI	(+220) 2423007	bambagulu@yahoo.com
Mr. Dawda Sowe	EPI	(+220) 2423001	dmsowe@yahoo.co.uk
Mr. Ebrima Bah	Directorate of Health Research	(+220) 7067335	ebah71608@gmail.com
Mr. Kebba Gibba	Kanifing	(+220) 9943842	jipson@yahoo.co.uk
Mr. Lamin Ceesay	EPI	(+220) 2423005	mlceesay210@yahoo.com
Mr. Malang Kuyateh	Regional Education Office-Region 2	(+220) 6266704	kuyatehmalang@yahoo.co.uk
Mr. Mamo Jatta	Regional Health Directorate, Western Region 2	(+220) 2422414	mamojatta@gmail.com
Mr. Mathew Baldeh	Brikama	(+220) 6305204	mathewbaldeh@gmail.com
Mr. Modou Njai	Directorate of Health Promotion and Education	(+220) 9939851	modounjai2002@yahoo.com
Mr. Musa Camara	Regional Health Directorate, Western Region 1	(+220) 2422425	musacamara30@yahoo.com
Mr. Omar Badjie	Directorate of Health Promotion and Education	(+220) 7044784	omarbadjie@yahoo.com
Mr. Omar Malleh Ceesay	Health Promotion and Development Organization (HePDO)	(+220) 9924895	omcsay@gmail
Mr. Sanjally Trawally	Directorate of Health Promotion and Education	(+220) 6432528	sanjally2000@yahoo.co.uk
Mr. Sarjo B. Gassama	EPI	(+220) 2422946	gassama85@yahoo.com
Mr. Sidat Fofana	EPI	(+220) 2423004	sidatfofana@yahoo.co.uk
Ms Iris Casell	Ministry of Basic and Secondary Education	(+220) 9835229	mauricevickris@hotmail.co.uk

4.1.2. National Coordination Forum (Interagency Coordinating Committees (ICCs), Health Sector Coordinating Committees (HSCCs), and other equivalent bodies)

To be eligible for support, Gavi asks countries to ensure a *basic* functionality of their Coordination Forum (ICC/HSCC or equivalent body). Countries can demonstrate this by adhering to the requirements listed in section 5.2 of the General Guidelines. The information in this section and a set of documents submitted along with this application will help the Independent Review Committee (IRC) to assess adherence.

Profile of the Coordination Forum

Name of the Forum	Inter-Agency Coordinating Committee(ICC)
Organisational structure (e.g., sub-committee, stand-alone)	Stand alone

The Terms of Reference for the Coordination Forum is attached as DOCUMENT NUMBER : 4. The Terms of Reference should include all sections outlined in Section 5.2 of the General Guidelines..

Please describe the role of the Coordination Forum and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal:

The process of the HPV proposal development started from discussions at the Inter-Agency Coordinating Committee (ICC) for the Expanded Programme on Immunization (EPI). The country agreed that the National Cancer Prevention and Control Technical Committee to lead the proposal development.

The proposal formulation process was spearheaded by the Expanded Programme on Immunization (EPI), in collaboration with the Cervical Cancer Prevention and Control Technical Committee with membership from the Directorates of Human Resource for Health (HRH) and Planning & Information (DPI) of the Ministry of Health and Social Welfare (MOH&SW), The Teaching Hospital, MRC, WHO, UNICEF, UNFPA, Regional directorates Western 1 &2, Ministry of Basic and Secondary Education etc.The Technical Committee was charged with the responsibility of co-ordinating the proposal formulation process.

During the proposal development a workshop was organized at a retreat in Bwiam with all Development Partners, CSOs, NGOs and CBOs represented. UNICEF funded the workshops for the development of the proposal.

Members of the civil society organizations (Health Promotion and Development Organization – HePDO) , Technical partners like WHO, UNICEF etc were also part of the TWG and actively participated in the proposal development.

4.1.3. Signature Table for the Coordination Forum (ICC/HSCC or equivalent body)

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **26/04/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 7 (please use the list for signatures in the section below).

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	Minister of Health and Social Welfare	Hon Safie Lowe CEESAY		
Secretary	Programme Manager Expanded Programme on Immunization Ministry of Health and Social Welfare	Mr. Dawda SOWE		
Members	Directorate of Public Health Services	Dr. Buba MANJANG		
	Director of Health Services	Dr. Momodou Lamin WAGGEH		
	WHO Representative/OIC	Mr Momodou CEESAY		
	Epidemiology and Disease Control	Mr. Abdoulie CAMARA		
	Regional Health Director Western 1	Mr. Alhagie SANKAREH		
	Head reproductive and child Health	Mr. Bafoday JAWARA		
	Permanent Secretary	Mr. Dawda L CEESAY		
	Regional Health Directorate Western 2	Mr. Gibril SANNEH		
	Child FUND-THe Gambia	Mr. Kebba CONTEH		
	Deputy Directorator Of Nursing Services	Mr. Lamin MARONG		
	Health Promotion and Development (HePDO)-Director	Mr. Omar Malleh CEESAY		
	Ag. Director of Human Resources for Health	Mr. Sana JARJU		
	Deputy Director of Health	Mr. Sanially TRAWALLY		

	Promotion and Education			
	President Rotary Club of Fajara-Rotary International	Ms Adam WADDA		
	UNICEF Representative	Ms Sara Beysolow NYANTI		
	Directorate of Planning and Information	Ms. Kaddijatou FAYE		
	Directorate of Basic and Secondary Education	Ms.Iris CASSELL		

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

The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached are attached as DOCUMENT NUMBER : 6.

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 the most recent data from available sources. Please identify the source of the data, and the date and attach the source document, where possible. The following documents should be referred to and/or attached:

- Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan). Please attach as DOCUMENT NUMBER 9.
- New Vaccine Introduction Plan(s) / Plan of Action. Please attach as DOCUMENT NUMBER 12.
- New Vaccine Introduction Checklist, Activity List and Timeline. Please attach as DOCUMENT NUMBER 12.
- Effective Vaccine Management (EVM) assessment. Please attach as DOCUMENT NUMBER 20.
- Two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases.
- Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.
- In the case of Yellow Fever and Meningitis A mass preventive campaigns, the relevant risk assessments. Please attach as DOCUMENT NUMBER 24 and DOCUMENT NUMBER 25.

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

	Figure	Year	Source
Total population	1,932,151	2017	2013 census
Birth cohort	88,639	2017	2013 census
Infant mortality rate (per 1000)	34	2013	DHS 2013
Surviving infants*[1]*	81,991	2017	Census 2013
GNI per capita (US$)	27	2013	National Health Accounts
Total Health Expenditure (THE) as a percentage of GDP	5.6	2013	National Health Accounts
General government expenditure on health (GGHE) as % of General government expenditure	12.48	2013	National Health Accounts

[1] 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
Vaccine Supply and cold chain □ Government has been able to fully meet its co-financing obligations thereby ensuring the continuous availability of vaccines □ There is sufficient storage capacity at all levels which is key in new vaccine introduction. □ Reliable power supply (e.g. Solar system) enhances proper cold chain system. □ Proper planning and forecasting of logistics and supplies are prerequisites for effective cold chain management	□ Adequate and sustainable vaccine financing plan should be in place □ Strengthen continuous enlightenment of policy makers on the importance of immunisation. □ Provision of adequate cold chain capacity. □ Cold chain assessment conducted prior to new vaccine introduction. □ Cold chain equipment in all public health facilities solar-powered □ Additional cold chain equipment and spare parts procured and installed
Monitoring and supervision □ Strong surveillance system with laboratory components facilitate effective monitoring of AEFIs □ Vaccine wastage and drop-out not monitored □ Irregular supervision of service providers at all levels.	□ Improved coordination with stakeholders for effective monitoring of AEFIs □ Strengthened AEFI Surveillance and monitoring. □ Development of a national immunisation registry. □ Training of health staff in surveillance of AEFI □ Training of health workers on effective vaccine management □ Strengthen regular supportive supervision at all levels.
Capacity Building □ Orientation and training of immunisation service providers is key to successful introduction of new vaccines.	□ Standardized training of immunisation service providers conducted in all the regions
Political Support □ There is a budget line for immunisation financing. □ Physical participation of politicians during immunisation activities (e.g. Launching) □ Availability of evidence-based immunisation interventions for advocacy and co-financing support	□ Immunisation data used for decision making and mobilize more resources. □ Continuous advocacy for increased budgetary allocation. □ Continuous advocacy for increased participation of politicians. □ Improved health research on immunisation with specific topics on immunisation coverage, timeliness, etc.
Community sensitization □ Community sensitization creates awareness and demand for immunisation services □ High community acceptance of immunisation services	□ Develop and adopt key messages for new vaccines . □ Strengthen Inter-personal and mass communication campaigns skills for new vaccine. introduction
Waste Management □ Improved waste management enhances proper injection safety practices	□ Rehabilitation and expansion of incinerators

5.1.2 Health planning and budgeting

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

A budgeted Annual Operational Plan (AOP) of the Ministry of Health and Social Welfare (MOHSW) is annually collected and combined from all programmes, sub-programmes in the health sector, which will be implemented by Departments/Institutions at national and sub-national levels as well as activities implemented by Development Partners and Non-Government Organizations. The planning cycle for the ministry of health is from January to December

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

The current plan is called The National Health Sector Srategic Plan (2014-2020)

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

Yes. This proposal is aligned the cMYP 2017 to 2021

Please indicate the national planning budgeting cycle for health

January to December

Please indicate the national planning cycle for immunisation

Januray to December

5.1.3 Coverage and equity

Please describe any health systems bottlenecks or barriers to access, utilisation and delivery of immunisation services at district level (or equivalent), for example geographic, socio-economic and/or gender-related barriers. Please indicated if there are specific populations of concern. If available, please provide subnational coverage and equity data highlighting geographic, socio-economic, gender-related, or other barriers and any other relevant categories of vulnerable or high-risk populations.

The DHS 2013 report did show variations in immunisation coverage even though the reasons for these variances in coverages between urban and rural areas were not elicited in detail. Variations in the fully immunized coverage and drop-out rate between rural and urban areas, demonstrate challenges that the immunisation programme is faced with. The proportion of children who were fully immunized was higher in rural areas than in urban areas (84% compared with 67% respectively). It was also higher among children whose mothers have no education (78.2%) or who only reached primary level than among children whose mothers reached secondary level or higher (68.3%). The DHS 2013 data shows that the literacy level is higher in urban areas than in rural areas, and that Banjul (58.8%), Brikama (69.5%) and Kanifing (70.9%) which are mainly urban settlements, have lower fully immunized coverages.

The lower immunisation coverage in urban areas reported in the DHS 2013 could be due to issues relating to **Health system/services, Community related, Economic/Family and Individual factors**.

1. **Health systems/ Service related issues:**

- Over the past ten years, there has been population expansion in urban areas, with the 2013 census reporting the highest increase in Brikama LGA (79%) which is predominantly an urban settlement.Despite this population increase, health service delivery points remain unchanged leading to health facilities becoming increasingly overcrowded.
- Health facility density in urban areas is comparatively lower than in rural areas. (See above). As the health worker per population density and other service inputs have not correspondingly increased, availability, access and quality of Reproductive Health Services is inadvertently affected. In addition, overcrowding of RCH clinics contributes to inappropriate working environment for inter-personal communication between service providers and clients. Service providers interviewed and observed

during monitoring visits revealed inadequate knowledge and skills in delivering immunisation services.

- Social mobilization for EPI services needs improvement. The previous EPI communication plan 2007 – 2012 was not well implemented due to low availability of funds. Implementation of the current plan 2014 – 2019 is yet to be fully implemented. There is thus no well-organized system for mass community mobilization and sensitization activities by the EPI programme. The presence of mass communication media in the urban area is not well utilized for immunisation services.

1. **Community related issues**:

- High density urban settlements such as Brikama and Kanifing Municipal Council have communities with low income families that live far away from service delivery points, which has cost implications in accessing routine immunisation services. In addition, competing social activities such as naming ceremonies and religious feasts are more prominent among urban populations. These are given precedence over RCH clinic attendance especially when immunisation days coincide with such feasts or activities. (.

1. **Economic/ Family/Individual Related Issues**

- Literacy levels are higher in urban areas than in rural areas. Mothers and caregivers in urban settings tend to be more engaged in economic activities that distract them from attending immunisation sessions. In addition there are many working class mothers whose work schedules do not permit them to take their children for routine immunisation. These busy mothers mostly visit RCH clinics when the child is sick. Furthermore, working mothers are more likely to use private clinics which reportedly offer lower quality of immunisation services. Similarly, low income mothers in urban areas, tend to be too busy with domestic and other socio-economic activities and therefore have little time to take their children for immunisation as scheduled.

Overcrowded immunisation clinics, inadequate community awareness and involvement in immunisation services as well as low uptake of immunisation services by working mothers are possible factors, which can be attributed to the relatively low immunisation coverage in urban areas.

Please explain how the proposed NVS support (activities and budget) will be used to improve coverage and equity of routine immunisation with reference to specifically identified health systems bottlenecks and/or specific populations of concern. For countries that will be receiving Gavi HSS and/or CCEOP funding concurrently with NVS funds, please also highlight how NVS funds will support/complement/leverage specific activities or investments included in those other grants.

The Gambia was approved for HSS support in 2016. The proposal aims to address low immunisation coverage in urban areas and sustain high coverage in rural areas. The new vaccine support will compliment the HSS grant in trying to address bottle necks highlighted above.Altough immunisation coverage is higher in rural areas than in urban areas for routine infant vaccination , however the HPV vaccination will be using a different startegy through a school based vaccination. Though coverage diffrences between rural and urban areas are evident in the routine immunisation for infants, this was not observed during the HPV demonstration project that was piloted in a region with both rural and urban characteristics. This could be attributed to the vaccnators meeting the target girls in schools were 98% of them are found.

Training of service providers: The new vaccine support will facilitate the training of 200 health staff on immunisation to compliment the scheduled training in the HSS. With this additional numbers, there will be an increased number of vaccinators per immunisation session to mitigate overcrowding.

Engagement of CSOs and NGOs in community mobilization and sensitization:

The engagement of CSOs and NGOs in promoting RCH including immunisation services, especially in the urban areas, is an opportunity in addressing this challenge. Specific strategies in the current EPI communication plan that aim to raise community awareness will be implemented through CSOs and NGOs. The new vaccine communication component of this NVS will complement the implementation of the EPI communication Plan. This will support sensitization of over 1000 teachers and regional education staff nationwide on HPV vaccination.

Monitoring and supervision: Routine monitoring and supervision of health workers will be strengthened and made more regular as outlined in the HSS proposal. The NVS will support Cervical Cancer Prevention and Control Committee to conduct quarterly monitoring and supervision of HPV vaccination activities.

Please describe what national surveys take place routinely in country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers.

There has been no specific gender and equity studies conducted in country, however the DHS 2013 report identified inequities- a variations in immunisation coverage between urban and rural areas. Though The Gambia do conduct DHS and MICS which highlight gender and equity issues. These surveys are planned every ten years depending on availability of funding, the last DHS was in 2013 and MICS in 2010.

One key activity in this new vaccine support will be a study on gender sagregation and identifying inequilties on immunisation of adolescent.

Social mbilisation activities in the new vaccination introduction support will focus more on urban areas were immunisation is under utised in an attempt to abridge the identified equity gaps.

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

Routine immunisation data collection tools at facility level have been reviewed to capture sex dis-aggregated data. The challenge is that, it is not analyzed for use at the central level.

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, The Gambia is currently stable.

5.1.4 Data quality

To support country efforts to strengthen the availability, quality and use of vaccination coverage data for strengthened programme management, Gavi requires that countries applying for all types of Gavi support to undertake routine monitoring of vaccination coverage data through an annual desk review; conduct periodic (once every five years or more frequently where appropriate) in-depth assessments of routine administrative vaccination coverage data; conduct periodic (at least once every five years) nationally representative vaccination coverage surveys; and develop and monitor plans for improving vaccination coverage data quality as a part of their own core work plans.

5.1.5 HPV specific facts

Countries applying for HPV that have already conducted a demonstration or pilot programme, should include details on specific lessons learned for HPV vaccine delivery.

Key programmatic areas	Lessons Learned	How these areas have been addressed in a National Plan
Preparation & planning	1. Formation of a functional HPV technical committee facilitated regular coordination meetings and information sharing. 2. Some health facilities did not have operational plans to guide implementation 3. Close collaboration with Ministry of Basic and Secondary Education and all relevant stakeholders facilitated the availability of required data and resources for planning and implementation 4. Some vaccinators trained for administering the first dose were transferred from the demonstration project area and their replacements had limited knowledge on HPV □ Weak coordination and communication resulting in low awareness and preparedness of teachers, health staff and communities.	The HPV technical committee in collaboration with Regional Health Directorates will support health facilities to develop operational plans Follow-up schedules with checklists would be developed and rigorously monitored. 1. Communication support materials will be developed and distributed to schools and communities 2. A comprehensive communication plan with measurable indicators will be developed and implemented in close collaboration with relevant stakeholders 3. Coordination mechanisms with clear Terms of Reference will be developed to enhance effective multi-sectoral participation. 4. Community mapping of out of school girls by community health workers will be conducted. 5. The number of health workers trained be increased and not limited to only vaccination teams 6. HPV training will be integrated into the annual EPI orientation trainings for new staff

		from the training schools .
Communication & social mobilization	1. Low awareness of teachers on general HPV vaccination (this was revealed in the PIE during the HPV demonstration project)	1. Fully implement the HPV communication plan
Delivery strategies	1. In private schools, parental consent was required for vaccination. This caused delay and missed opportunities as parents were late in responding to give consent for their children to be vaccinated 2. The existing cold chain was able to adequately accommodate the HPV vaccine for the demonstration project 3. Inadequate incinerators to handle the extra volume of waste generated during the demonstration project	1. Parent-teacher association members will be involved early during the planning stage. 2. The country has planned to switch to PCV multi dose vial (75% volume reduction) as well as from 3 dose Rota Teq schedule to a 2 dose Rota Rix schedule (36% volume reduction) that will create additional capacity to accommodate HPV vaccine and related logistics 3. In the National Health Strategic Plan, Ministry of Health and Social Welfare in collaboration with World Bank will build incinerators at designated areas as part of a national programme which will facilitate waste management.
Coverage	1. Difficulties in identifying all eligible out of school girls and tracing them , this could be attributed to the inadequate social mobilization coupled with the lack of a mini census for the out of school girls prior to the HPV vaccination during the first year of the Demonstration project	1. A mini census for in and out of school girls will be conducted to provide the required baseline data. 2. Using community based health nurses, a house to house mapping exercise will be undertaken to identify and register out of school girls.
Reporting & monitoring	1. Daily monitoring and supervision conducted by both the Regional Health Directorates and The Cancer technical committee. 2. Development and use of data collection tools for smooth tracing of defaulters.	1. There would be continuous integrated routine monitoring and supervision of immunization related activities
Sustainability	1. There is a budget line for immunization financing.	1. Continue advocacy for increased participation of politicians and decision makers

For each district in which the demonstration/ pilot programme was implemented, please complete the following:

District Information	
Name of the district	Brikama Local Government Area(West Coast Region)
Size of target population of the district	9,432
Describe how the district is divided into rural and urban areas:	This is the fastest growing Local Government Area (LGA) in the country which presents urban, semi-urban and rural characteristics. The capital of the local government area (Brikama) is considered to be urban mainly due to population and availability of social amenities whilst surrounding community settlements are considered to be rural.
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	The school-based strategy was used for the HPV vaccine delivery as 98% of the targeted population were enrolled in schools within the region. This required vaccination teams to visit schools and vaccinate the girls. For the out-of-school girls, there were fixed vaccination teams in public places like markets and 'Bantabas' whilst mobile teams were deployed into ferry crossings, car parks etc. to vaccinate out of school girls.

5.2. Baseline and Annual Targets for Routine Vaccines

For HPV, Gavi supports the vaccination of girls aged 9-14 years, based on the following cohorts:

- Routine cohort – countries are required to identify a single year cohort of girls to be immunised on a routine basis. (e.g. 9 years old)
- Additional multi-age cohort – in the first year of introduction (or initial year of each phase, if country choose phased introduction), countries also have the option to immunise additional girls within the recommended age groups (e.g. 10-14 years), that are older than the routine cohort.

Note: Countries may choose proxy age of girls based on a school grade (e.g. grade 5 corresponds to approximately 10 year olds). However, grades usually have a range of different aged girls so it is important to keep in mind that girls under 9 years should not be vaccinated, and doses for girls older than 14 years are not provided by Gavi.

Please specify the chosen age for the routine cohort HPV vaccination: e.g. 9 years

If relevant, please specify the chosen age range for the additional multi-age cohort in the year of introduction: e.g. 10, 11, 12, 13, 14 years
From :

9 years

To :

14 years

Will a phased introduction approach be adopted?

No

If a phased approach will be adopted, please provide an explanation for this approach.

Natioal roll out will be conducted simultaneously to all regions in the country.

Please refer to cMYP pages to assist in filling-in this section. For HPV, please also refer to Annex 3 of the HPV Guidelines.
The Base year information should be completed for the year in which the application is being completed.

Table 5.2: Baseline NVS routine figures

Number	Base Year	Baseline and Targets			
	2016	2017	2018	2019	2020
Total births	88,639	90,678	92,763	95,546	98,412
Total infants' deaths	6,648	6,801	6,957	7,166	7,381
Total surviving infants	81,991	83,877	85,806	88,380	91,031
Total pregnant women	88,639	90,678	92,763	95,546	98,412
Target population (routine cohort) vaccinated with OPV3*[1]*	76,178	83,038	84,948	87,496	90,121
OPV3 coverage*[2]*	93 %	99 %	99 %	99 %	99 %
Target population (routine cohort) vaccinated with DTP1*[1]*	79,698	83,038	84,948	87,496	90,121
Target population (routine cohort) vaccinated with DTP3*[1]*	75,788	83,038	84,948	87,496	90,121
DTP3 coverage*[2]*	92 %	99 %	99 %	99 %	99 %
Wastage*[3]* rate in base-year and planned thereafter (%) for DTP	5	4	4	4	4

Wastage*[3]* factor in base-year and planned thereafter for DTP	1.05	1.04	1.04	1.04	1.04
Routine Cohort					
Number of girls in the routine cohort		29,758	30,442	31,142	31,859
Target population (routine cohort) vaccinated with 1st dose of HPV	23,272	23,806	24,963	25,537	27,080
Target population (routine cohort) vaccinated with 2nd dose of HPV	20,363	20,830	22,223	22,734	24,531
HPV quadrivalent coverage 1st dose	80 %	80 %	82 %	82 %	85 %
HPV quadrivalent coverage 2nd dose	70 %	70 %	73 %	73 %	77 %
Additional multi-age cohort					
Number of girls in the additional multi-age cohort	0	108,132			
Target population (additional multi-age cohort) vaccinated with 1st dose of HPV quadrivalent	0	90,327			
Target population (additional multi-age cohort) vaccinated with 2nd dose of HPV	0	81,148			
HPV quadrivalent coverage*[2]*	0%	84%	0%	0%	0%
HPV quadrivalent coverage 2nd dose	0%	75%	0%	0%	0%
First Presentation: HPV quadrivalent, 1 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI_AGE COHORT					
Wastage*[3]* rate in base-year and planned thereafter (%)	5	5	5	5	5
Wastage*[3]* factor in base-year and planned thereafter (%)	1.05	1.05	1.05	1.05	1.05
Maximum wastage rate value for HPV quadrivalent, 1 dose(s) per vial, LIQUID	5 %	5 %	5 %	5 %	5 %
Second Presentation: HPV bivalent, 2 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI_AGE COHORT					
Wastage*[3]* rate in base-year and planned thereafter (%)	10	10	10	10	10
Wastage*[3]* factor in base-year and planned thereafter (%)	1.11	1.11	1.11	1.11	1.11
Maximum wastage rate value for HPV bivalent, 2 dose(s) per vial, LIQUID	10 %	10 %	10 %	10 %	10 %
Target population (routine cohort) vaccinated with 1st dose of MCV	77,563	79,683	81,516	83,961	86,480
MCV coverage*[2]*	95 %	95 %	95 %	95 %	95 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	5 %	0 %	0 %	0 %	0 %

[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	101,364
Total infants' deaths	7,602
Total surviving infants	93,762
Total pregnant women	101,364
Target population (routine cohort) vaccinated with OPV3*[1]*	92,825
OPV3 coverage*[2]*	99 %
Target population (routine cohort) vaccinated with DTP1*[1]*	92,825
Target population (routine cohort) vaccinated with DTP3*[1]*	92,825
DTP3 coverage*[2]*	99 %
Wastage*[3]* rate in base-year and planned thereafter (%) for DTP	4
Wastage*[3]* factor in base-year and planned thereafter for DTP	1.04
Number of girls in the routine cohort	32,591
Target population (routine cohort) vaccinated with 1st dose of HPV	27,703
	25,095
HPV quadrivalent coverage 1st dose	85 %
HPV quadrivalent coverage 2nd dose	77 %
Additional multi-age cohort	
Number of girls in the additional multi-age cohort	
Target population (additional multi-age cohort) vaccinated with 1st dose of HPV quadrivalent	
Target population (additional multi-age cohort) vaccinated with 2nd dose of HPV	
HPV quadrivalent coverage*[2]*	0
HPV quadrivalent coverage 2nd dose	0
First Presentation: HPV quadrivalent, 1 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI_AGE COHORT	
Wastage*[3]* rate in base-year and planned thereafter (%)	5
Wastage*[3]* factor in base-year and planned thereafter (%)	1.05
Maximum wastage rate value for HPV quadrivalent, 1 dose(s) per vial, LIQUID	5 %
Second Presentation: HPV bivalent, 2 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI_AGE COHORT	
Wastage*[3]* rate in base-year and planned thereafter (%)	10
Wastage*[3]* factor in base-year and planned thereafter (%)	1.11
Maximum wastage rate value for HPV bivalent, 2 dose(s) per vial, LIQUID	10 %
Target population (routine cohort) vaccinated	89,074

with 1st dose of MCV	
MCV coverage*[2]*	95 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %

[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.

5.2.1 Description of routine and additional multi-age cohorts

Provide the percentage of primary school enrolment

The country plans to use the grade-based strategy for reaching eligible girls. Those in grade three (corresponding to 9 years) will be used as the routine target each year. The additional multi-age cohort i.e those girls presently (2017) in grades 3 ,4 and 5 will be in grades 4, 5 and 6 in the first year of implementation (2018). Therefore, in the first year of implementation girls in grade 3,4,5, and 6 will be targeted for vaccination. During implementation, girls in grade 3 who are not yet nine years will be targeted in the subsequent years. The targets are all derived from the Ministry of Basic and Secondary Education records for 2016. Figures are projected to determine the targets for subsequent years.

School enrolment is estimated at 98% with out of school girls estimated at 2%.

Provide the percentage of secondary school enrolment

The percentage of girls in secondary school is 51%

Provide the average age of entry for secondary school

15 years

Please provide a source for the enrolment data (e.g., national statistics office, MOE, recent census, school registers, etc.)

These targets were derived from the Ministry of Basic and Secondary Education Year Book, 2016.This is an annual statistical publication of the Ministry.

http://www.edugambia.gm/data-area/publications/year-book-2016.html

Please provide a source for the enrolment data (e.g., national statistics office, MOE, recent census, school registers, etc.)

These targets were derived from the Ministry of Basic and Secondary Education Year Book, 2016.This is an annual statistical publication of the Ministry.

http://www.edugambia.gm/data-area/publications/year-book-2016.html

5.2.2 HPV specific targets

Girls to be vaccinated with HPV should be within the WHO-recommended target population of 9-14 years old girls

Please specify the source of data that was used to estimate the number of girls in the routine and, if relevant, additional multi-age cohorts and reported in the above table under "Target population (routine cohort) vaccinated with HPV" and "Target population (additional multi-age cohort) vaccinated with HPV"

These targets were derived from the Ministry of Basic and Secondary Education Year Book, 2016.This is an annual statistical publication of the Ministry.

http://www.edugambia.gm/data-area/publications/year-book-2016.html

5.3. Targets for Preventive Campaign(s)

No NVS Prevention Campaign Support this year

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

No One time mini-catchup campaign this year

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

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
Crevical Cancer	Cervical Human Papilloma Virus Infection and squamous intraepithelial lesions in rural Gambia, West Africa: Viral Sequence Analysis and Epidemiology	2005	1. Overall prevalence rate of 13% for all forms of cervical HPV infection among rural women. 2. There were age variations (specifically among 25 – 44 years had a higher prevalence of cervical pre-cancer than the older or younger subjects).
Cervical Cancer	20-years of Population-based Cancer Registration in Hepatitis B and Liver Cancer Prevention in the Gambia, West Africa	2013	1. Revealed 33.0% of all female cancers in The Gambia were found to be cervical cancer. 2. The annual age-adjusted incidence rate of cervical cancer is 18.9 per 100,000 person-years during the period reviewed (1990-2009).

6.1.1 HPV burden specific information

Has the country undertaken an assessment of the burden of cervical cancer? If so, describe the burden, and when and how the assessment was done. If not, countries may report on Globocan data (available on the WHO HPV information Centre website at http://www.who.int/hpvcentre/en).

ASSESSMENT OF THE BURDEN OF CERVICAL CANCER

In the Gambia, cervical cancer is the most common cancer among women and forms 33% of all cancers in women. A prevalence rate of 13% of HPV infection was reported from a study conducted in the country. If adjusted for age (i.e. to the world standard population as commonly done by population-based cancer registries) the annual age-adjusted incidence rate of cervical cancer is 18.9 per 100,000 person-years during the period reviewed. The various HPV subtypes including the most important serotypes 16 and 18 associated with cervical cancer have also been reported. There is now an effective vaccine that can prevent HPV infection when given early to girls before they become sexually active.

There is a National Cancer Registry in operation in The Gambia (NCR). It was established as a population-based cancer registry (PBCR) within The Gambia Hepatitis Intervention Study (GHIS) project (a joint project between the Government of The Gambia via the Ministry of Health and Social Welfare (MoH&SW), Medical Research Council of the UK, The Gambia Unit (MRC) and WHO's International Agency for Research on Cancer (WHO-IARC)); to register the diagnoses of all cancers and chronic liver disease, specifically primary hepatocellular carcinoma (HCC) and liver cirrhosis (LC) in The Gambia (GHIS Group, 1987). In sub-Saharan Africa, the NCR of The Gambia is the only PBCR that achieved nation-wide coverage including a substantial rural population.

WHEN AND HOW THE STUDY WAS CONDUCTED

In the latest study of the NCR data which is being described, the data collected over the 20-year period, i.e. 1990-2009 was grouped into four by 5-year strata, namely,1990-1994, 1995-1999, 2000-2004 and 2005-2009 (denoted as period 1, 2, 3 and 4, respectively). The relative frequency (%) and crude incidence rates were computed for these periods. In order to compute incidence rates and the 95% confidence intervals, the population at risk for each period were estimated, using standard formula of population interpolation and extrapolation of the census figures of the Gambia for 1983,1993 and 2003.(period 1 and 2 were based on census figures of 1983 and 1993, while that of period 3 and 4 used the 2003 census figures). The rates were

adjusted for age using the world standard population for comparison of cancer registry data. Similarly, the corresponding 95% confidence intervals (95% CI) for each age-adjusted rate (ASR(W)) and differences in incidence between periods were determined using standard statistical formula.

Describe the existing cervical cancer prevention and control activities.

The existing cervical cancer prevention and control activities comprises primary, secondary and tertiary prevention and control strategies. Primary prevention strategies consists of HPV vaccination, and health education. The MOHSW in collaboration with Ministry of Basic and Secondary Education (MOBSE) implemented a two-year HPV demonstration project (2014-2016) to assess the feasibility and acceptability of HPV vaccination using the school based and community outreach strategy. The HPV vaccination demonstration project targeted girls aged 9-13 years using the school base and community outreach strategy. The successful outcome of the demonstration will guide the national rollout.

Secondary prevention method comprises screening programmes run by some health facilities at the primary, secondary and tertiary levels. SOS Mother and Child Clinic, a project of SOS Children's Villages, collaborates with seven public health facilities in the implementation of cervical cancer prevention through Visual Inspection with acetic acetic(VIA) screening methods and cryotherapy in a single visit approach (called see and treat approach). The Edward Francis Small Teaching Hospital (EFSTH) and BAFROW provide screening using pap smear screening method. Last year, the Association of Gynaecologist provided equipment and training to nine Doctors (at least one from each regional Hospital) to conduct colposcopy .The HPV accine introduction can also be used to raise awarenss of cervica cancer screening in communities.

Tertiary control measures comprise treatment and palliative care mainly done at the EFSTH. Clinical and laboratory staff were trained on cytology and ultrasound examination, biopsy, histopathology and performing laboratory test to support the diagnosis of cervical cancer.

Has the country developed a strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control? **Yes**

If Yes, please attach and refer to section 10. Attachments. (Document N°**15,16**)

If No, are there plans for the country to develop such a roadmap or strategy in the future? Please describe- when, who will be leading the development of the plan, and which agencies will be involved.

N/A

6.1.2 Description of province/ region profile

Countries are required to attach a description of the profile for each province/ region, using the template provided by Gavi

Please attach the relevant documents "HPV Region/ Province profile " template provided by Gavi and attach as a mandatory document in the Attachment section. Document number **16**)

6.1.3 Delivery strategies for HPV vaccine

Please provide information on each of the following **delivery strategies** that will be:

- Using outreach to schools as a location for vaccinations
- Using health facilities as a location for vaccinations
- Using community outreach as locations for vaccinations
- Campaign

Using schools as a location for vaccinations

Please describe why this delivery strategy has been chosen for the selection region/ district(s). Will this delivery strategy be used for every year? If so, please describe how this strategy will be financed in future years.

The school-based strategy was chosen because 98% of the target population are enrolled in schools and offered the best opportunity to reach a large number at a particular place. The same strategy was successfully used during HPV demonstration project in the country. For out of school girls community

outreach is the best strategy to reach them as they are found in the community.

The same approach for the school and community outreach strategies will be used every year to reach both in- and out-of-school girls. HPV vaccination will be integrated into the routine immunisation system. Existing resources in terms of personnel and transport will be utilized. 'Riders for Health', a Non Governmental Organization that manages transport resources for the Ministry of Health and Social Welfare will continue to provide the transport requirements for all vaccination activities including HPV.All services provided by Riders for Health are paid for by the Gambia government.

Government already fully finances the cost of traditional vaccines, and the co-financing of new vaccines; HPV vaccine component will be integrated into the current immunisation budget.

Please specify whether girls will be vaccinated by selection of a specific age or a specific school grade

The country planned to use the same strategies used during the HPV demonstration project (Grade based) targeting those in grade 3 for the routine cohort and grade 4 for the multi age cohort. It is important to note that girls inthis grades, who are less than 9 years or more than 14 years of age will not be vaccinated.

Please complete table 6.1.3a vaccination by specific age or table 6.1.3b by specific school grade, depending on above choice

Table 6.1.3 a: Vaccination by specific age

Routine Cohort	
Specific age chosen	9 years
Target population of girls in chosen age	0
Girls of chosen age enrolled in schools	0

Aditional multi-age cohort	
Specific age-range chosen	Start 9 years End 14 years
Target population of girls in chosen age	0
Girls of chosen age range enrolled in schools	0

Table 6.1.3 b: Vaccination by specific school grade

Routine Cohort		
School grade	**Average age of girls on school grade**	**Number of girls in grade**
Grade 3	10 years	30442

Aditional multi-age cohort		
School grade	**Average age of girls on school grade**	**Average age of girls on school grade**
Grades 4,5 ,6	12 years	108132

If you are vaccinating by grade, provide information on how you will ensure girls under 9 or over 14-years will not be vaccinated

The following strategies will be employed to ensure adherence to the target age group in the targeted grade.

- Verification of the ages of the school girls in grade 3 from the class registers with support from their teachers.
- Verification of the ages of out-of-school girls using infant welfare cards, birth certificates or parental information.
- Sensitization of the general public and school authorities on the age requirements for HPV vaccination.
- Vaccination registers will be structured to ensure that only girls between the ages 9 to14 will be captured.

Please describe when vaccinations will be scheduled (school year, holidays, examinations), where vaccinations will be administered, who will do vaccinations, how will the vaccine logistics be assured when using schools as a location for vaccination.

HPV vaccination will be conducted once in every school year during the fisrt school term (October/November). The Ministry of Health and Social Welfare will collaborate with the Ministry of Basic and Secondary Education through their representative in the HPV Technical Committee to ensure that vaccination period does not coincide with examination and school holidays. Vaccination will take place in the school venues and in the communities by trained health workers. Vaccines and logistic will be delivered to beneficiaries by health facilities serving the catchment area as was done during the HPV demonstration project.

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

There will be no need to hire additional personnel for the vaccination. The existing personnel conducting routine immunisation services are adequate to conduct the HPV vaccination. However, additional operational cost may be incurred to cover the multi-age cohorts.

Please describe the strategy to capture girls who may miss the initial vaccination session or any of the remaining doses

Vaccination will be done within a period of time during the school calendar year. The HPV Technical Committee with representation from MoHSW and MoBSE will collaborate to schedule the period for vaccination suitable to all parties.

Mop-up exercise will be conducted to reach missing girls. This will be supported by community re-sensitization and house-to-house mapping and recording of addresses of out-of-school girls.Girls who missed the first vaccination visits will either be reached by revisiting schools/community or ask to report to te nearest health faciity for vaccination.

Will the vaccination strategy need to be adapted for at private or religious schools? If so, please elaborate.

The same strategy will be used for both private and public schools including religious ones. All private and religious schools are registered with the Ministry of Basic and Secondary Education which enhanced smooth collaboration during the demonstration project. The same strategy will be employed during the national roll out of HPV vaccination.

Using health facilities as a location for vaccination

Please describe why this approach has been chosen for the selection region/ district(s). Will this approach be used every year?

Not applicable

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

There will be no need to hire additional personnel for the vaccination. The existing personnel conducting routine immunisation services are adequate to conduct the HPV vaccination. However, additional operational cost may be incurred to cover the multi-age cohorts.

Please provide details of demand generation activities to encourage girls to come to the health facility?

Health and other related services targeting mostly adolescent girls and their male counterparts are currently carried out by several actors notably; MoH&SW, Catholic Relief Service (CRS), Gambia Family Planning Association(GFPA), HePDO and MoBSE. Major activities in these interventions include:

- Institutional systems strengthening
- Training of service providers
- Information Education and Communication(IEC) and social mobilization
- Advocacy forpartnerships for increased participation
- Sustained demand for service delivery

Print and electronic media (Radio FMs) with free air time for health slots will also be used to create more awareness and demand generation. There were few refusals from some private schools due to delay in receiving information about the vaccination. This was addressed as a result of strong collaboration with MOB&SE to mobilize and inform schools prior to the vaccinations.

Please provide details on how the country plans to link with schools. Some examples of how schools can be leveraged to increase HPV vaccine uptake include facilitating sensitization and mobilization of parents/communities, identification/validation of the target population (i.e. use of school enrolment lists), and assisting with vaccination call/recall mechanisms. If the country does not plan to link with schools please provide a justification for this decision (i.e. low school enrolment).

HPV vaccination will be conducted once in every school year. The Ministry of Health and Social Welfare (MoHSW) will collaborate with the Ministry of Basic and Secondary Education (MoBSE) through their representative in the HPV Technical Committee to ensure that the vaccination period does not coincide with examination and school holidays.The vaccination will take place in school venues and in the communities by trained health workers. Vaccines and logistic will be delivered to beneficiaries by health facilities serving the catchment area as was done during the HPV demonstration project.

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls.

There are no “hard to reach” areas in the Gambia in delivering immunisation services. However, Community health workers will be used to conduct house to house mapping exercise to identify out-of-school girls (vulnerable group) and document their contacts and home addresses for improved follow -up.

Describe what follow-up mechanism will be used to ensure girls receive their second dose.

HPV vaccination will be conducted once in every school year during the fisrt school term (October/November). The second dose would be given in the subsequent year (October/November) when the new cohort would be receiving their first dose and the previous cohort willl be recieving their seocond dose. The HPV Technical Committee with representation from MoH&SW and MoBSE will collaborate to schedule the period for vaccination suitable to all parties.

Mop-up exercise will be conducted to reach missing girls. This will be supported by community re-

sensitization.

Using community venues as locations for vaccinations

Please describe why this approach has been chosen for the selection region/ district(s).

The out -of –school girls are found in the communities, thus the reason for choosing the community venue approach. This is to ensure that no eligible girl is left unvaccinated.

Will this approach be used for every year? If so, please describe how this strategy will be financed in future years.

The same approach for the school and community outreach strategies will be used every year to reach both in- and out-of-school girls. HPV vaccination will be integrated into the routine immunisation system. Existing resources in terms of personnel and transport will be utilised. 'Riders for Health', a Non Governmental Organization that manages transport resources for the Ministry of Health and Social Welfare will continue to provide the transport requirements for all vaccination activities including HPV. The cost of this is borne by the government .

Government already fully finances the cost of traditional vaccines, and the co-financing of new vaccines; HPV vaccine component will be integrated into the current immunisation budget.

Please describe how your community health care workers/ volunteers will be involved with this strategy

Community health workers and volunteers will be utilised in crowd control and sensitization activities to inform communities about the date and time of vaccination. In addition, community health workers will be engaged to conduct house-to-house mapping exercise to identify out-of-school girls and document their home addresses

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

There is no need to hire additional personnel to do the vaccination. The existing personnel conducting routine immunisation services are adequate to conduct the HPV vaccination.

Where in the community will the girls be vaccinated? E.g. schools, fixed outreach sites, streets, parks, malls, markets

The girls will be vaccinated in strategically located places in the communities such as public places ("bantabas"),community centers, car parks, markets, etc.

What interventions will be established to increase community based acceptance and increase community support?

Community health workers, supported with IEC support materials will engage communities to increase

awareness. Print and electronic media, drama and traditional communicators, media briefing, pre-clinic health talks and launching of the HPV roll out will be used to emphasize awareness creation. In addition, Civil Society Organizations such as Health Promotion and Development Organization (HePDO) and The Gambia Red Cross Society, which have strong presence in communities will be engaged to promote acceptance and demand generation.

Please provide details of demand generation activities e.g. awareness building and information dissemination via community or education sector and/or mass media, including through youth clubs and street theatre

Health and other related services targeting mostly adolescent girls and their male counterparts are currently carried out by several actors notably; MoH&SW, Catholic Relief Service (CRS), Gambia Family Planning Association(GFPA), HePDO and MoBSE. Major activities in these interventions include:

- Institutional systems strengthening
- Training of service providers
- Information Education and Communication(IEC) and social mobilization
- Advocacy forpartnerships for increased participation
- Sustained demand for service delivery

Print and electronic media (Radio FMs) with free air time for health slots will also be used to create more awareness and demand generation.

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls?

There are no “hard to reach” areas in the Gambia in delivering immunisation services. However, Community health workers will be used to conduct house to house mapping exercise to identify out-of-school girls (vulnerable group) and document their contacts and home addresses.

Describe what follow-up mechanism will be used to ensure girls receive their second dose.

Vaccination will be done within a period of time during the school calendar year. The HPV Technical Committee with representation from MoHSW and MoBSE will collaborate to schedule the period for vaccination suitable to all parties. The second dose will also apply the same mechanism to reach eligible girls.

Using campaigns to deliver HPV vaccines

Please describe why this approach has been chosen for the selection region/ district(s).

This is not applicable in our case(NA).

What type of campaign will be used for HPV vaccine delivery e.g. Child Health Days/ Weeks, Measles Rubella or tetanus containing vaccines, supplementary immunisation activities, health education activities? If the campaign is planned to be standalone, please explain why?

NA

How will this campaign impact routine service delivery? For example, will health facility personnel be used for this campaign?

NA

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

NA

What location(s) will be used to deliver vaccinations during the campaign?

NA

Will this delivery strategy be used for every year? If so, please describe how this strategy will be financed in future years.

NA

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls?

NA

6.1.4 Social Mobilisation

Please complete the table below to provide details on the types of information and/ or materials that will be used/ disseminated, to which audience, by which mechanism and the frequency of each.

Types of information or materials	**Audience receiving material**	**Method of delivery**	**Who delivers**	**Frequency & Timing**
e.g., leaflet, poster, banner, handbook, radio announcement, etc.	**e.g., girls, parents, teachers, health workers, district officials, community groups, etc.**	**e.g., parent meetings, radio, info session at school, house visit, etc.**	**e.g., teachers, health workers, district official, etc.**	**e.g., daily, weekly, twice before programme starts; day of vaccination, two weeks before programme begins, etc.**
Leaflets, school meetings	Girls, parents, teachers, health workers, district officials/authorities, community groups, opinion leader	School health talks, meetings, Peer health education sessions, house visits, media briefings	Teachers, health workers, community health workers (CHWs), media personnel and CSOs.	Daily, weekly, monthly, day of vaccination, two weeks before programme begins
Posters	Girls, parents, teachers, health workers, district officials/authorities, community groups, opinion leaders.	School health talks, meetings, Peer health education sessions, house visits, media briefings.	Teachers, health workers, community health workers (CHWs), media personnel, CSOs and opinion leaders Health workers	Before and during the period of vaccination
Banner	Girls, parents, teachers, health workers, district officials/authorities, community groups, opinion leaders.	Meetings, during launching.	Teachers, health workers Moderators and Health Workers	During the period of vaccination, and launching
Hand Book	Health workers, Peer	School health talks, Peer health education sessions, house visits	Moderators and Health	Before/During period of vaccination

Radio and TV Spots	Health Educators and teachers General public	Radio and TV shows, Panel discussion	Workers	Daily; Before/During period of vaccination

Please describe a crisis communication plan to response to rumors and misconceptions to HPV vaccination.

The HPV communication plan has captured an area on the crisis communication approach . A team comprising representatives from the central, regional and health facility levels together with the Ministry of Basic and Secondary Education, and opinion leaders is set to respond to any rumor and misconception about the HPV Vaccination. This will be done in the form of investigating the source of rumor or misconception and instititing immediate measures to address it. The crisis communication team will identify a spokesperson who will speak on behalf of the team to ensure consistency in the message to be delivered.

Community sensitization will be instituted to prevent further spread of the rumor or misconception. These measures had worked well in The Gambia in 1995 during a nationwide Tetanus Toxoid mass vaccination campaign targeting women of child bearing age. There were some community resistance as the vaccination was perceived to be associated with family planning . Similar methods would be adopted to deal with future crisis.This will be guided by a crisis communication plan as part of the overall communication strategy for immunization.

6.1.5 Adolescent health integration

Irrespective of the strategies, provide a description of existing health services and/or health education currently being provided to young adolescents (both girls and/or boys) within the 9-14 year old age group and indicate and potential synergy by integrating with HPV vaccination:

a. For health services (this can include: what health services are provided, to which age/sex group, whether it's mandatory or voluntary, regularly or ad-hoc, in school or out of school, who provides these (government, NGOs), how often, what is the uptake in the community, how is it perceived by the community.)

DEWORMING OF SCHOOL CHILDREN

In 2010, the Ministry of Basic and Secondary Education developed a formal deworming programme and set up a multi-sectoral working group which included personnel from Education, Health and other relevant Ministries in addition to development partners including UNICEF, WFP, WHO and FAO. This well-coordinated group is responsible for monitoring the implementation of this and other health programmes in schools. Between 2011 and 2013, a total of 1.6 million children inclusive of pre-school age and those from Lower Basic Schools, Madrassas, and out-of-school children aged 6 – 13 years were dewormed.

The objectives of the nationwide school de-worming programme in the country are to reduce the rate of worm infestation in children, improve school attendance and performance. These services are provided countrywide with good coverage.

On the other hand for almost a decade, EPI of the MoH&SW has consistently undertaken twice yearly de-worming of children aged 1 – 5 years countrywide, along with Polio and Vitamin A using the house-to-house strategy. However, given the relatively low cost of de-worming in schools, these two key government Ministries; MOH&SW and MoBSE are well positioned to advocate for sustained government funding for co-delivery of de-worming with the HPV vaccine. With several years experience of practical implementation both at the school and community outreach levels, extensive infrastructure of the education sector, the tremendous amount of manpower and overwhelming commonalities of de-worming and HPV (same targets, same regions, same frequency and intervals of dosing), the school system provides an excellent entry point for co-delivering de-worming with the HPV vaccine.

The prevention of helminthic infestations, through school-based and community outreach de-worming has been the recommended intervention for co-delivery with HPV vaccination and this was implemented during the second year of the HPV demonstration project.

HAND WASHING IN SCHOOLS

The MoH&SW, MoBSE in collaboration with UNICEF supported a five year pilot programme (2012-2016) in 150 schools (30150 students) in three regions of the country; namely Central River, North Bank East and Upper River regions. The main purpose of this programme was to improve hygiene and sanitation in Lower Basic Schools and eventually, reduce the incidence of water-borne diseases, improve student performance and retention at school, especially for girls.

Delivery strategies included teaching and learning, tippy taps construction, demonstration of hand washing, latrine construction and training of teachers and school management committees.

At the community level, school cluster monitors and Village Support Groups (VSGs) use posters and hand washing demonstration to support in community mobilization and participation. Although there has not been any impact assessment, schools have reportedly noted increased enrolment, retention and contact hours particularly among school girls. This programme was unique in that it also addressed gender and equity issues such as separate toilets for boys and girls and increased enrolment and retention of girls. However, in relation to co-delivery with HPV, this intervention may not be suitable because it is still in its pilot phase and secondly it has several lingering issues of sustainability due to high costs.

b. For health education (this can include: the topic, whether it is national, sub-national, in school or out of school, who provides the education, how often, is it in the school curriculum, are there NGOs providing these? How is it perceived by the community? Has there been an evaluation and if so, how was it evaluated and what were the findings?)

HEALTH EDUCATION ON DEWORMING

This programme uses multiple IEC and social mobilization media channels such as radio, TV, posters and community based traditional communicators to reach targeted communities. At the school level, teaching and learning materials were developed and taught in the targeted classes. The other key actors in intestinal helminths control through de-worming are the MoH&SW and Catholic Relief Services (CRS), with financial support from the UN World Food Programme, WHO and UNICEF.

c. For improving adolescent immunization platform (this can include integration with: other vaccines provided to adolescents (e.g. measles-rubella, tetanus containing vaccines or Dengue), broader health education services)

There is no adolescent immunisation intervention platform in the Gambia.

6.1.6 CSO engagement

Please describe how and which CSOs will be included in the delivery of HPV vaccines e.g. demand generation activities, increase coverage of "hard to reach" girls.

CSOs such as HePDO and Gambia Red Cross Society work directly with communities nationwide to deliver services. Their involvement will be crucial in promoting acceptance of immunisation services through awareness activities such as house to house visits, open field days, drama performances etc.

6.1.7 Key stakeholder and technical partner roles and responsibilities

Please complete the Gavi provided template, to define the respective roles and responsibilities of all in-country stakeholders and technical partners.

Please attach the relevant documents and refer to section 10. Attachments. (Document N°**17**)

6.2. Requested vaccine (HPV quadrivalent, 1 dose(s) per vial, LIQUID)

As reported in the cMYP, the country plans to introduce HPV quadrivalent, using HPV quadrivalent, 1 dose(s) per vial, LIQUID.

When is the country planning to introduce this vaccine? **October 2018**

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.

Currently the country has adequate cold chain capacity at the Central, Regional and Health facility levels to accommodate introduction of the HPV vaccine. The supply chain consists of a National Vaccine Store of 40Cubic meter which is based in Banjul at Central Medical Stores complex and is about 30 kilometres from the airport. The national vaccine store distributes vaccines and injection supplies to the regional cold stores. The country receives vaccine supplies twice yearly – March and September, and supply the regions on quarterly basis. The health facilities collect vaccines and injection supplies from the regional cold stores monthly.

With the switch from Rota Teq to Rota rix vaccine, in 2017, the country would gain additional cold chain storage space to accommodate more vaccines including HPV. The Rota Teq vaccine occupied about 60% of the total cold chain storage capacity (EVM, 2014). Coupled with that, the country will switch from PCV single dose to the multi dose before end of the third quarter of 2017; to garner additional storage space.

In addition to the above, there is provision for a Cold Room and 31 sets of TCW 2000 SDD in the approved HSS grant that would facilitate the replacement and expansion of immunisation service delivery points.

6.2.1. Vaccine Prices

Vaccine	Presentation	2017	2018	2019	2020	2021
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	4.550	4.550	4.550	4.550	4.550

6.2.2. Co-financing information

The co-financing requirement applies to vaccines for the **routine cohort** (i.e. the cohort that will be routinely vaccinated on an annual basis for the routine immunisation programme). However, Gavi will fully finance vaccines for the **additional multi-age cohort** during the introduction year.

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**	**2020**
minimum co-financing per dose	0.20	0.20	0.20	0.20
your co-financing per dose (please change if higher)	0.20	0.20	0.20	0.20

	2021
minimum co-financing per dose	0.20
your co-financing per dose (please change if higher)	0.20

6.2.2.1.Specifications of vaccinations with new vaccine for routine cohort

	Source		2017	2018	2019	2020
Number of girls in routine cohort to be vaccinated with the first dose	Table 5.2	#	23,806	24,963	25,537	27,080

Number of girls in routine cohort to be vaccinated with the second dose	Table 5.2	#	20,830	22,223	22,734	24,531
Immunisation coverage with the second dose	Table 5.2	%	70%	73%	73%	77%
Country co-financing per dose	Table 6.2.2	$	0.2	0.2	0.2	0.2

	Source		**2021**
Number of girls in routine cohort to be vaccinated with the first dose	Table 5.2	#	27,703
Number of girls in routine cohort to be vaccinated with the second dose	Table 5.2	#	25,095
Immunisation coverage with the second dose	Table 5.2	%	77%
Country co-financing per dose	Table 6.2.2	$	0.2

6.2.2.2.Specifications of vaccinations with new vaccine for additional multi-age cohort

	Source		**2017**	**2018**	**2019**	**2020**
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	90,327	0	0	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	81,148	0	0	0
Immunisation coverage with the second dose	Table 5.2	%	75.05%	0	0	0

	Source		**2021**
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	0
Immunisation coverage with the second dose	Table 5.2	%	0

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

		2017	**2018**	**2019**	**2020**
Number of vaccine doses	**#**	1,922	2,032	2,079	2,228
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]***	**$**	11,721	10,061	10,201	11,021

[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.

		2021
Number of vaccine doses	**#**	2,279
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]*	**$**	11,161

[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.

6.2.3.1 Portion of supply for routine cohort to be procured by Gavi (and cost estimate, US$)

		2017	2018	2019	2020
Number of vaccine doses	#	42,714	45,154	46,192	49,383
Number of AD syringes	#	61,989	52,642	53,412	57,737
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	682	580	588	636
Total value to be co-financed by Gavi	$	263,046	225,767	228,908	246,741

		2021
Number of vaccine doses	#	50,519
Number of AD syringes	#	58,422
Number of re-constitution syringes	#	0
Number of safety boxes	#	643
Total value to be co-financed by Gavi	$	249,874

6.2.3.2 Portion of supply for additional multi-age cohort to be procured by Gavi (and cost estimate, US$)

		2017	2018	2019	2020
Number of vaccine doses	#	111,157	22,223	22,734	24,531
Number of AD syringes	#	122,273	24,446	25,008	26,985
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	1,346	269	276	297

		2021
Number of vaccine doses	#	25,095
Number of AD syringes	#	27,605
Number of re-constitution syringes	#	0
Number of safety boxes	#	304

6.2.4 New and Under-Used Vaccine Introduction Grant

Calculation of Vaccine Introduction Grant for the HPV quadrivalent, 1 dose(s) per vial, LIQUID

Year of New Vaccine Introduction	Girls in routine cohort (From Table 5.2)	Share per Girls in routine cohort in US$	Total in US$
2017	29,758	2.40	100,000

The Grant will be based on a maximum award of $2.4 per girl in the routine 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 main objective of this proposal is to ensure that girls (grade 3 girls and their peers out of school) are vaccinated with 2 doses of HPV vaccine countrywide. The programme will target a total of 30442 girls (projected from the MOBSE year book 2016) in the first year for the routine cohort using the school-based system.

Activities to be implemented prior to vaccine introduction will include micro planning , training of health workers, development of a comprehensive communication plan, production of communication support materials ,sensitization of teachers, parents, faith-based and community leaders as well as development and printing of data collection tools and training manual.

In the implementation phase, activities would include; transportation of vaccinators and logistics to vaccination sites and monitoring and supervision of vaccination sessions.

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.

Resources will be mobilized locally from the Government Local Fund (GLF) through the Inter-Agency Coordinating Committee (ICC). The ICC have already been engaged to advocate for HPV financial support from government and partners after the HPV demonstration project. In addition WHO, UNICEF and UNFPA will be contacted to supplement the amount provided by Government through the Ministry of Health and Social Welfare. The current health master plan (2014-2020) and the EPI cMYP(2017-2021) will both be used for resource mobilization to support immunisation services

6.2.5.New and Under-Used Operational support

Calculation of Operational Support for the HPV quadrivalent, 1 dose(s) per vial, LIQUID

Year of New Vaccine Introduction	Girls in additional multi-age cohort (From Table 5.2)	Share per Girls in additional multi-age cohort in US$	Total in US$
2017	108,132	0.65	100,000

Please describe how the Gavi Operational support will be used to reach the additional multi-age cohorts? How will these funds be used to strengthen routine activities e.g. reinforcing routine outreach activities, additional personnel, additional demand generation activities?

Note: These funds can be used over a longer period than the introduction year in order to strengthen routine immunisation. For example to reinforce routine outreach activities in difficult to access districts.

The main objective of this proposal is to ensure that girls (grade 3 girls and their peers out of school) are vaccinated with 2 doses of HPV vaccine countrywide. The programme will target a total of 30442 girls (projected from the MOBSE year book 2016) in the first year for the routine cohort using the school-based system. There will be girls in oter grades(within the ages of 9 -14years) also known as the multi age cohort

which will also be targeted for vaccination. The Gavi operational support will be used to complement the VIG support in training of health workers, transportation, production of communication support materials ,sensitization of teachers, parents, faith-based and community leaders as well as development and printing of data collection tools, training manual and monitoring and supervision of vaccination sessions.

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.

Resources will be mobilized locally from the Government Local Fund (GLF) through the Inter-Agency Coordinating Committee (ICC). The ICC have already been engaged to advocate for HPV financial support from government and partners after the HPV demonstration project. In addition WHO, UNICEF and UNFPA will be contacted to supplement the amount provided by Government through the Ministry of Health and Social Welfare. The current Health Master Plan (2014-2020) and the EPI cMYP(2017-2021) will both be used for resource mobilization to support immunisation services

6.2.6.Technical assistance

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

Technical assistance would be needed in the following areas

1. Gender and Equity Assessment
2. Post introduction Evaluation
3. Training ofhealth staff on surveillance, including AEFI
4. Coverage survey

7. NVS Preventive Campaigns

No NVS Prevention Campaign Support this year

8. NVS Follow-up Campaigns

No NVS Follow-up Campaign Support this year

9. Procurement and Management

9.1 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 HPV vaccine introduction .

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 Financial Management Assessment (FMA) recommendations, the country is suggesting the VIG to be channeled through UNICEF. However, if the FMA recommendations are resolved before the VIG disbursement, then the country would prefer the funds to be disbursed to government.

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 have 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 utilised 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 HPV 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 Permanent Secretary of the Ministry of Health and social Welfare for approval. The approved memoradum is processed by the accounts Unit of the Ministry of Health and Social Welfare through the National Treasury before funds are received at the Central Bank of The Gambia. All procurements will be done through UNICEF.

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 HPV vaccination coverage after updating the data collection tools.

The following systems will also be used.
-Supportive supervisory visits conducted by the Cervical Cancer Prevention and Control Technical Committee

members to all the regions and health facilities, whilst regional health teams visit each health facility monthly to assess progress.
- Biennial cluster survey conducted using standard WHO EPI survey tools to validate the routine administrative data.
-Annual GAVI Progress Reports, Joint Appraisal Report and Joint Reporting Form(JRF) 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**

9.2 Procurement and Management for NVS Preventive Campaign(s)

No NVS Prevention Campaign Support this year

9.3 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 Agency (NRA) mandated to certify and license vaccines and pharmaceuticals. The MCA would require documentation from the manufacturers before any new vaccine is shipped into the country. To ensure quality and mainain standards, 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 final licensing. Fast tracking method is sometimes used, which is based on WHO prequalification.

It is important to note that HPV vaccine has already been licensed in The Gambia during the demonstration project.

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 quadravalent HPV vaccine has been the preferred choice of presentation and has already been licensed in 2014.

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&SW. The clearing officer is notified prior to the arrival of the goods to ensure all the necessary paper transactions are completed. The clearing officer for the Ministry of Health and Social Welfare clears all vaccines, drugs and injection supplies on behalf of the Ministry. The Officer liaises with the Customs Department and follows all local custom regulations. There are no special documentation protocols that can cause delay for vaccine handling. Pre-delivery is not required, since the vaccine come 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 National Medicine Control Agency (MCA) is mandated to certify and license vaccines and pharmaceuticals. To ensure quality and maintain standards, procurement of vaccines and supplies would 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 final licensing**.** Fast tracking method is sometimes used, based on WHO prequalification.

Name: Makieu Kaira Janneh

Title; Executive Director of the MCA

Telephone: (+220) 9950777

E-Mail: makieu@yahoo.co.uk or mjkaira@moh.gov.gm

9.4 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. The Africa Development Bank (ADB) project and WHO have provided some incinerators to strengthen the waste management system. Health facilities transport immunization waste to incineration sites for final disposal.

Injection Safety is assured by the use of AD Syringes. Bundling will continue to be implemented at all levels.

9.5 Procurement and Management for Follow up Campaign(s)

No NVS Follow-up Campaign Support this year

10. 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	HPV_MoHSW&MoFEA Signature.pdf **File desc:** **Date/time :** 02/05/2017 12:13:13 **Size:** 238 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	HPV_MoHSW&MoFEA Signature.pdf **File desc:** **Date/time :** 02/05/2017 12:13:37 **Size:** 238 KB
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	MoBSE Signature.pdf **File desc:** **Date/time :** 01/05/2017 01:08:54 **Size:** 250 KB
4	Terms of Reference for the Coordination Forum (ICC/HSCC or equivalent) including all sections outlined in Section 5.2 of the General Application Guidelines (Note: countries applying before May 2017 can submit their existing Terms of Reference)	4.1.2	ToR - ICC.doc **File desc:** **Date/time :** 14/04/2017 10:22:54 **Size:** 37 KB
5	Minutes of Coordination Forum meeting endorsing Proposal	4.1.3	ICC MINUTES_endorsing HPV proposal and NVS Renewal.docx **File desc:** **Date/time :** 03/05/2017 12:40:59 **Size:** 18 KB
6	Signatures of Coordination Forum members in Proposal	4.1.3	HPV_ICC Signature.pdf **File desc:** **Date/time :** 02/05/2017 12:14:05 **Size:** 733 KB
7	Minutes of the Coordination Forum meetings from the past 12 months before the proposal	4.1.3	MINUTES OF THE _OF THE ICC meetings last 12 months.pdf **File desc:** **Date/time :** 01/05/2017 01:09:55 **Size:** 307 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	NITAG Membership.pdf **File desc:** **Date/time :** 27/04/2017 02:55:39 **Size:** 339 KB
31	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	FORMATION OF NITAG.docx **File desc:** **Date/time :** 02/05/2017 12:23:01 **Size:** 10 KB
Planning, financing and vaccine management			

9	Comprehensive Multi Year Plan - cMYP	5.1	Draft Gambia cMYP 2017 2021.docx **File desc:** **Date/time :** 14/04/2017 10:28:04 **Size:** 651 KB
10	cMYP Costing tool for financial analysis	5.1	The Gambia_EPI cMYP Costing Tool.xlsx **File desc:** **Date/time :** 14/04/2017 10:31:51 **Size:** 4 MB
11	M&E and surveillance plan within the country's existing monitoring plan	5.1.4	MOHSW_FINAL_M_E Plan the Gambia NHSP 07-05-15 - Copy.pdf **File desc:** **Date/time :** 20/04/2017 10:28:56 **Size:** 1 MB
12	New vaccine introduction plan (NVIP), New Vaccine Introduction Checklist and Activity List & Timeline for routine vaccines or Plan of Action (PoA) for campaign vaccines	5.1,7.2.3	HPV IMPLEMENTATION PLAN_EDITS-AEY 21-4-2017.doc **File desc:** **Date/time :** 24/04/2017 03:12:35 **Size:** 733 KB
15	HPV Region/ Province profile	6.1.1	HPV Application_Region Profile working document.xlsx **File desc:** **Date/time :** 14/04/2017 12:40:21 **Size:** 38 KB
16	HPV Key Stakeholder Roles and Responsibilities	6.1.1,6.1.2	HPV Application_Stakeholder roles 11.04.17.xlsx **File desc:** **Date/time :** 14/04/2017 10:34:40 **Size:** 25 KB
19	EVM report	9.3	6. The Gambia EVM Assessment.doc **File desc:** **Date/time :** 14/04/2017 10:35:38 **Size:** 3 MB
20	Improvement plan based on EVM	9.3	7. Gambia EVM Improvement Plan_2014.xlsx **File desc:** **Date/time :** 14/04/2017 10:37:00 **Size:** 98 KB
21	EVM improvement plan progress report	9.3	8. GAM EVM IMPROVEMENT PLAN 2014_STATUS OF IMPLEMENTATION.xls **File desc:** **Date/time :** 19/04/2017 12:28:12 **Size:** 218 KB
22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2,6.x.2,8.2.3	HPV_Detailed Budget template_VIG & Op HPV final.xlsx **File desc:** **Date/time :** 19/04/2017 12:28:55 **Size:** 61 KB
32	Data quality assessment (DQA) report	5.1.4	LRR DQA Gambia.doc **File desc:** **Date/time :** 19/04/2017 02:48:27 **Size:** 242 KB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
14	Annual EPI Plan with 4 year forward view for measles and rubella		No file loaded
17	Evidence of commitment to fund purchase of RCV (in place of the first dose of MCV) / for use in the routine system	5.1.6, 6.1.7	No file loaded
18	Campaign target population documentation	8.x.1, 6.x.1	No file loaded
24	Risk assessment and consensus meeting report for Yellow Fever, including information required Section 5.3.2 in the General Guidelines on YF Risk Assessment process	5.1	No file loaded
25	Risk assessment and consensus meeting report for Yellow Fever, including information required in the NVS guidelines on YF Risk Assessment process	5.1	Yellow Fever_assessment report.docx **File desc:** **Date/time :** 24/04/2017 03:09:33 **Size:** 10 KB
26	List of areas/districts/regions and targets to be supported for meningitis A mini catch up campaigns		Target for mini catch up campaign.docx **File desc:** **Date/time :** 24/04/2017 03:08:16 **Size:** 32 KB
27	National Measles (& Rubella) elimination plan if available		No file loaded
28	A description of partner participation in preparing the application	4.1.3	No file loaded
30	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, ICC minutes committing to finance from 2018 onwards.		financing of MVC1.docx **File desc:** **Date/time :** 19/04/2017 03:04:53 **Size:** 10 KB
33	DQA improvement plan	5.1.4	No file loaded
34	Plan of Action for campaigns	8.1, 8.x.4	No file loaded

35	Other		No file loaded
36	Strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control		The Gambia_Crevical Cancer Strategic plan-2016 – 2020 Final.pdf **File desc:** **Date/time :** 14/04/2017 10:39:33 **Size:** 693 KB
37	Evidence of self-financing MCV1	5.1.5	No file loaded
38	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, a signed letter from the Minister of Health and the Minister of Finance committing to finance from 2018 onwards.		No file loaded
39	Epidemiological analysis/evidence	8.3.1	No file loaded
40	Post Campaign Coverage Survey report for MR catch-up applications	5.1.x	No file loaded
41	cMYP addendum on measles and rubella		No file loaded

11. Annexes

Annex 1 - NVS Routine Support

Annex 1.1 HPV quadrivalent, 1 dose(s) per vial, LIQUID

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	#	1,922	2,032	2,079	2,228
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]*	$	11,721	10,061	10,201	11,021

		2021
Number of vaccine doses	#	2,279
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]*	$	11,161

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

Portion of supply for routine cohort to be procured by Gavi (and cost estimate, US$)

		2017	2018	2019	2020
Number of vaccine doses	#	42,714	45,154	46,192	49,383
Number of AD syringes	#	61,989	52,642	53,412	57,737
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	682	580	588	636
Total value to be co-financed by Gavi	$	263,046	225,767	228,908	246,741

		2021
Number of vaccine doses	#	50,519
Number of AD syringes	#	58,422
Number of re-constitution syringes	#	0
Number of safety boxes	#	643
Total value to be co-financed by Gavi	$	249,874

Portion of supply for additional multi-age cohort to be procured by Gavi (and cost estimate, US$)

		2017	2018	2019	2020
Number of vaccine doses	#	111,157	22,223	22,734	24,531
Number of AD syringes	#	122,273	24,446	25,008	26,985
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	1,346	269	276	297

		2021

Number of vaccine doses	#	25,095
Number of AD syringes	#	27,605
Number of re-constitution syringes	#	0
Number of safety boxes	#	304

Table Annex 1.1 C: Summary table for vaccine HPV quadrivalent, 1 dose(s) per vial, LIQUID

	Source		2017	2018	2019	2020
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	90,327	0	0	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	81,148	0	0	0
Immunisation coverage with the second dose	Table 5.2	%	75.05%	0	0	0

	Source		2021
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	0
Immunisation coverage with the second dose	Table 5.2	%	0

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

		Formula	2017		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	23,806	1,025	22,781
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	20,830		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	44,636	1,922	42,714
E	Estimated vaccine wastage factor	*Table 5.2*	1.05		
F	Number of doses needed including wastage	*D x E*	46,868	2,018	44,850
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]*	11,717	505	11,212
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	58,600	2,523	56,077
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	61,989	0	61,989
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	682	0	682
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	266,630	11,480	255,150
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	2,232	0	2,232
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	315	0	315
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	5,590	241	5,349
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)*	274,767	11,721	263,046
U	Total country co-financing	*I x country co-financing per dose (cc)*	11,720		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 2)

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	24,963	1,075	23,888
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	22,223		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	47,186	2,032	45,154
E	Estimated vaccine wastage factor	*Table 5.2*	1.05		
F	Number of doses needed including wastage	*D x E*	49,546	2,134	47,412
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]*	670	29	641
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	50,300	2,166	48,134
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	52,642	0	52,642
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	580	0	580
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	228,865	9,854	219,011
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	1,896	0	1,896
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	268	0	268
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	4,799	207	4,592
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)*	235,828	10,061	225,767
U	Total country co-financing	*I x country co-financing per dose (cc)*	10,060		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 3)

		Formula	2019		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	25,537	1,100	24,437
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	22,734		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	48,271	2,079	46,192
E	Estimated vaccine wastage factor	*Table 5.2*	1.05		
F	Number of doses needed including wastage	*D x E*	50,685	2,183	48,502
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]*	285	13	272
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	51,000	2,196	48,804
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	53,412	0	53,412
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	588	0	588
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	232,050	9,991	222,059
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	1,923	0	1,923
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	271	0	271
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	4,865	210	4,655
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)*	239,109	10,201	228,908
U	Total country co-financing	*I x country co-financing per dose (cc)*	10,200		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 4)

		Formula	2020		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	27,080	1,169	25,911
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	24,531		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	51,611	2,228	49,383
E	Estimated vaccine wastage factor	*Table 5.2*	1.05		
F	Number of doses needed including wastage	*D x E*	54,192	2,339	51,853
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]*	877	38	839
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	55,100	2,378	52,722
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	57,737	0	57,737
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	636	0	636
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	250,705	10,818	239,887
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	2,079	0	2,079
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	294	0	294
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	4,684	203	4,481
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)*	257,762	11,021	246,741
U	Total country co-financing	*I x country co-financing per dose (cc)*	11,020		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 5)

		Formula	2021		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	27,703	1,196	26,507
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	25,095		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	52,798	2,279	50,519
E	Estimated vaccine wastage factor	*Table 5.2*	1.05		
F	Number of doses needed including wastage	*D x E*	55,438	2,393	53,045
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]*	312	14	298
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	55,800	2,408	53,392
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	58,422	0	58,422
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	643	0	643
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	253,890	10,956	242,934
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	2,104	0	2,104
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	297	0	297
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	4,744	205	4,539
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)*	261,035	11,161	249,874
U	Total country co-financing	*I x country co-financing per dose (cc)*	11,160		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Annex 2 - NVS Routine – Preferred Second Presentation

Annex 2.1 - NVS Routine Support (HPV bivalent, 2 dose(s) per vial, LIQUID)

Table Annex 2.1 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	#	1,922	2,032	2,079	2,228
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]*	$	12,401	10,621	10,781	11,661

		2021
Number of vaccine doses	#	2,279
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]*	$	11,801

Table Annex 2.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$

Rounded up portion of supply for the additional cohort that is procured by Gavi and estimate of relative costs in US$

		2017	2018	2019	2020
Number of vaccine doses	#	42,714	45,154	46,192	49,383
Number of AD syringes	#	62,726	52,684	53,430	57,792
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	690	580	588	636
Total value to be co-financed by Gavi	$	278,191	238,215	241,801	260,935

		2021
Number of vaccine doses	#	50,519
Number of AD syringes	#	58,441
Number of re-constitution syringes	#	0
Number of safety boxes	#	643
Total value to be co-financed by Gavi	$	264,066

Table Annex 2.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$ ADDITIONAL COHORTS

		2017	2018	2019	2020
Number of vaccine doses	#	20,830	22,223	22,734	24,531
Number of AD syringes	#	22,914	24,446	25,008	26,985
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	253	269	276	297

		2021

Number of vaccine doses	#	25,095
Number of AD syringes	#	27,605
Number of re-constitution syringes	#	0
Number of safety boxes	#	304

Table Annex 2.1 C: Summary table for vaccine HPV bivalent, 2 dose(s) per vial, LIQUID

	Source		2017	2018	2019	2020
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	0	0	0	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	0	0	0	0
Immunisation coverage with the second dose	Table 5.2	%	0	0	0	0

	Source		2021
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	0
Immunisation coverage with the second dose	Table 5.2	%	0

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

		Formula	2017		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	23,806	1,025	22,781
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	20,830		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	44,636	1,922	42,714
E	Estimated vaccine wastage factor	*Table 5.2*	1.11		
F	Number of doses needed including wastage	*D x E*	49,546	2,134	47,412
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]*	12,387	534	11,853
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	62,000	2,670	59,330
J	Number of doses per vial	*Vaccine parameter*	2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	62,726	0	62,726
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	690	0	690
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	282,100	12,146	269,954
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	2,259	0	2,259
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	318	0	318
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	5,915	255	5,660
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)*	290,592	12,401	278,191
U	Total country co-financing	*I x country co-financing per dose (cc)*	12,400		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 2)

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	24,963	1,075	23,888
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	22,223		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	47,186	2,032	45,154
E	Estimated vaccine wastage factor	*Table 5.2*	1.11		
F	Number of doses needed including wastage	*D x E*	52,377	2,256	50,121
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]*	708	31	677
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	53,100	2,287	50,813
J	Number of doses per vial	*Vaccine parameter*	2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	52,684	0	52,684
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	580	0	580
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	241,605	10,402	231,203
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	1,897	0	1,897
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	268	0	268
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	5,066	219	4,847
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)*	248,836	10,621	238,215
U	Total country co-financing	*I x country co-financing per dose (cc)*	10,620		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 3)

		Formula	2019		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	25,537	1,100	24,437
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	22,734		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	48,271	2,079	46,192
E	Estimated vaccine wastage factor	*Table 5.2*	1.11		
F	Number of doses needed including wastage	*D x E*	53,581	2,307	51,274
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]*	301	13	288
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	53,900	2,321	51,579
J	Number of doses per vial	*Vaccine parameter*	2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	53,430	0	53,430
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	588	0	588
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	245,245	10,559	234,686
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	1,924	0	1,924
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	271	0	271
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	5,142	222	4,920
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)*	252,582	10,781	241,801
U	Total country co-financing	*I x country co-financing per dose (cc)*	10,780		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 4)

		Formula	2020		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	27,080	1,169	25,911
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	24,531		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	51,611	2,228	49,383
E	Estimated vaccine wastage factor	*Table 5.2*	1.11		
F	Number of doses needed including wastage	*D x E*	57,289	2,473	54,816
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]*	927	40	887
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	58,300	2,516	55,784
J	Number of doses per vial	*Vaccine parameter*	2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	57,792	0	57,792
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	636	0	636
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	265,265	11,447	253,818
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	2,081	0	2,081
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	294	0	294
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	4,956	214	4,742
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)*	272,596	11,661	260,935
U	Total country co-financing	*I x country co-financing per dose (cc)*	11,660		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 5)

		Formula	2021		
			Total	Government	Gavi
A	Country co-finance	*V*	4.31 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	27,703	1,196	26,507
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	25,095		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	52,798	2,279	50,519
E	Estimated vaccine wastage factor	*Table 5.2*	1.11		
F	Number of doses needed including wastage	*D x E*	58,606	2,529	56,077
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]*	330	15	315
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	59,000	2,546	56,454
J	Number of doses per vial	*Vaccine parameter*	2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	58,441	0	58,441
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	643	0	643
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	268,450	11,584	256,866
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	2,104	0	2,104
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	297	0	297
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	5,016	217	4,799
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)*	275,867	11,801	264,066
U	Total country co-financing	*I x country co-financing per dose (cc)*	11,800		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	4.31 %		

Annex 3 - NVS Preventive campaign(s)

No NVS Prevention Campaign Support this year

Annex 4

Table Annex 4A:Commodities costs

Estimated prices of supply are not disclosed

Vaccine	Presentation	2017	2018	2019	2020
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	4.550	4.550	4.550	4.550

Supply	Form

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

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2017	2018	2019	2020
HPV quadrivalent, 1 dose(s) per vial, LIQUID	HPV	2.10 %	2.10 %	2.10 %	1.87 %

Vaccine Antigen	Vaccine Type	2021
HPV quadrivalent, 1 dose(s) per vial, LIQUID	HPV	1.87 %

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

Vaccine	2017	2018	2019	2020
HPV quadrivalent, 1 dose(s) per vial, LIQUID	0.2	0.2	0.2	0.2

Vaccine	2021
HPV quadrivalent, 1 dose(s) per vial, LIQUID	0.2

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: