Application Form for Gavi NVS support

Submitted by

The Government of

Ethiopia

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	2016	End Year	2020

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	Measles, 10 dose(s) per vial, LYOPHILISED in second dose	2018	2020	

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

If applying for any type of measles and/or MR support, summarise in the text box below the indicative major measles and rubella activities planned for the next 5 years (e.g. MCV2 introduction, measles or MR follow-up campaign, etc.).

- Update the measles elimination strategic document focusing on major activities in the next five years by Q3 2017
- Revise and update the immunization policy to provide clear guidance on MCV2 vaccination as well as providing MCV1 in the second year of life for children who missed their MCV1 dose by Q3, 2017.
- Introduce Measles second dose by Q1, 2018.
- Conduct follow-up measles SIAs for 9-59-month-old children by end of 2019.
- Strengthen measles case-based and laboratory surveillance to monitor the impact of measles vaccination.
- Strengthen measles case management using IMNCI approach.
- Document the burden of CRS in Ethiopia by strengthening the existingCRS sentinel surveillance in the two hospitals and expanding the sentinel surveillancein 4-5 additional areas with consideration for geographic representativeness by Q4 2018.
- Review the finding of CRS sentinel surveillance and other considerations for introduction of Rubella vaccine Q2 2019.

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 2012, Ethiopia endorsed the measles elimination 2012-2020 plan and developed measles elimination plan. The Federal Ministry of Health of Ethiopia (FMOH) has implemented the four key strategies recommended for accelerating the control of measles namely strengthening routine immunization, supplemental immunization, enhanced case based measles surveillance, and appropriate case management.

WHO recommends that reaching all children with two doses of measles containing vaccine (MCV) should be the standard for all national immunization programmes. The Ethiopia immunization program provides two doses of measles vaccinations with MCV1 given at 9 months through routine immunization and second opportunity through supplemental immunization activities conducted every 2-3 years.

The MCV1coverage showed improvement over the last decade, from 63% in 2006 to 93% in 2016. The WHO-UNICEF National Immunization Coverage Estimate (WUNEIC) also reported similar improvement of MCV1 coverage, from 44% in 2006 to 78% in 2015. The country has conducted periodic follow-up measles SIAs including the last three in 2010, 2013 and 2016/17 with an average administrative coverage of >95%.

However, measles outbreaks continued to occur affecting children under the age of five years. A measles consultative workshop was conducted in October 2016 to review the progress of the measles elimination plan. It was concluded that Ethiopia is not on track to achieve the measles elimination goal and measles second dose introduction was recommended to accelerate the measles elimination.

In 2016, SAGE revised the recommendation on MCV2 introduction encouraging countries to introduce a second dose of measles vaccine in the routine immunization schedule (MCV2) irrespective of the first dose measles vaccine (MCV1) coverage levels, as MCV2 to children in their second year of life reduces the rate of accumulation of susceptible children and the risk of an outbreak. Additionally, MCV2 will help to break the barrier to receiving MCV1 after the first birthday; reduce vaccine wastage by increasing session size and provide the opportunity to opening a formal service delivery platform for a provision of integrated child survival interventions.

The country requests support for MCV2 introduction for a period of five years starting from 2018-2022. MCV2 will be introduced nationwide in Q1 of 2018 for children at the age of 15 months. The existing routine immunization delivery strategies (static, outreach and mobile) will be used to provide MSD vaccination. In

addition, other platforms for integration such as IMNCI and nutrition programs will be employed as a strategy to reach children who missed their measles doses. Moreover, other opportunities such as child day care centers and school entry screening will be used to vaccinate children.

The currently used 10 dose vial presentation is also the country's first preference for MSD introduction as this requires less cold chain space than the 5 dose vial. Wastage rate will be reduced up to 40% as some of the MCV2 doses will be administered using a vaccine that would have been previously "wasted" using a 1-dose schedule.

The Introduction of MCV2 into the routine immunization program requires can be accommodated with the available cold chain storage space at all levels. . The available storage space can accommodate required routine immunization vaccines including MSD vaccine. The FMOH in collaboration with partners has started implementing a cold chain rehabilitation plan (2014-2018) considering vaccine introductions such as MCV2, IPV, HPV and others. FMOH implement the cold chain expansion and rehabilitation plan which mainly involves the procurement and installation of 2134 SDD refrigerators at health facilities levels which is believed to increase the cold chain capacity it HFs. Moreover, FMOH is undertaking a new construction of cold room in the PFSA hubs that helps to improve the national cold chain capacity. Moreover, FMOH will continue to use SDG-PF and CCEOP support to further improve the cold chain capacity with optimal cold chain equipment. At the central level, the cold chain net storage capacity increased from 75 m3 in 2004 to 369 m3 in 2017. Currently, the net cold chain storage volume of vaccines required per fully immunized child at service delivery and woreda levels is 120.388 and 113.668/cm3 respectively. The MCV2 introduction will increase the storage volume by 8.645 cm3 at service delivery point and 3.325 cm3 at woreda level. The increment in cold chain space is minimum and can be accommodated with the currently available cold chain storage space at woreda and health facility level.

In summary, a total of USD 17,901,741.28 is requested for GAVI in the coming five years for measles SIAs and MSD introduction, out of which USD 6,726,527.81 is for vaccines and supplies and USD 11,175,213.47 is for operational cost. A total of USD 4,540,274 (1,868,004 vaccine &injection material cost and 2,672,270 Vaccine introduction grant) is requested to vaccinate a total of 15,061,111 in 5 years for MSV2. One supplemental immunization activity is planned for early 2020 and a total of USD 13,361,467.33 is requested out of which USD 8,502,947.07 is for operation cost while 4,858,524.26 is for vaccine and injection supplies cost. With an average annual increment of about 3%, in 2017, a total of 3,118,951 surviving infants are targeted for the routine immunization nationally with 11 antigens.

This application proposal was prepared with the participation of different stakeholders like the different units at the MoH, EPI partners, and CSOs under the coordination of the Ministry. The Inter-Agency Coordinating Committee has actively reviewed the critical sections of the application document and endorsed the application for MCV2 introduction.

MCV2 introduction activities will be coordinated by a technical working group and all preparatory activities needed for new vaccine introduction will be followed up. Particular emphasis will be given for planning allowing adequate time for preparatory activities including assessment of cold chain capacity, revision of data recording and reporting formats, preparing guidelines and organizing trainings for staffs at all levels of the health system. Due consideration will be given to raise community awareness and develop new communication messages. Attention will be given for timely securing resources and procurement of supplies.

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 Ethiopia 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:

Measles, 10 dose(s) per vial, LYOPHILISED in second dose routine introduction

The Government of Ethiopia 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 **July**.

The payment for the first year of co-financed support will be around **November 2018** for Measles, 10 dose(s) per vial, LYOPHILISED in second dose.

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	Yifru Berhan Mitke (Professor)	**Name**	Abraham Tekeste (PhD)
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
Dr Ephrem TEKLE/Liya Woldegiorigis	Director, MCH Directorate/EPI coordinator	+251-912-615651/+251-911-191928	mchdirector.fmoh@gmail.com/epicoordinator.mch@mail.com

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 main goal of the ICC is to support and capacitate the MOH to coordinate the immunization program of the country effectively and efficiently. Hence, key elements of collaboration for the functionality of the ICC include:

- Broad-based organization representation, support and commitment (financial and technical) that enables harmonization of priorities and alignment of key activities

- Leadership and active participation from the MOH including technically qualified and well defined EPI unit. This facilitates country owned and led programming, encourages partnership, provides institutional memory and enables consistency. The MOH has demonstrated a strong leadership by establishing EPI case team staffed with sizable number of staff and keeping immunization among its prioritized high impact interventions.

- Clearly defined and jointly agreed terms of reference for providing support to immunization activities. Partner's input in strategic directions ensures greater acquiescence and allows them an in-depth understanding of the technical choices and existing capacity that influences important decisions. However, member organization should stay away from agency specific agenda that could cause complexity in the coordination of activities and compete with technical and epidemiological priorities.

- Mutual respect and acknowledgment of each organization and individual's roles and commitment. As long as partners harmonized their priorities and aligned their major activities with the immunization program of the country, it is assumed that all partners are contributing to the success and failure of the program. Trying to link specific contribution to a picky result in an effort to gauge the greatest share of credit can create considerable tension between partner organizations. For this reason, all stakeholders should be sensitive to such demands so that the spirit of collaboration and active participation will not be endangered.

- Collective monitoring and evaluation of activities: It is believed that a multi-organization input and analysis of problems provides a better perspectives and insights beyond those of any single organization. Hence, collective monitoring and evaluation of performances strengthen future planning, implementation, monitoring and evaluation efforts.

- Collective ownership of the immunization program: full engagement and ownership will allow having a shared understanding and creating individual accountability to the program.

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	FMOH	Dr Kebede Worku		
Secretary	FMOH	Dr Eprem Tekle		
Members	WHO	Akpaka A.Kalu		
	UNICEF	Gillian Mellsop		
	CHAI	Yigeremu Ababe		
	BMGF	Solmon Zewedu		
	UI-FHS	Zenaw Adam		
	Rotary International	Tadesse Alemu		
	L10K	Kassahun Mitiku		
	CORE Group	Filimona Bisrat		
	PATH	Tirsit Girshaw		
	USAID	Samita Kumar		
	DFID	Kassahun Mohammed		
	IFHP	Tesfaye Bulto		

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 ? **Yes**

We the members of the NITAG met on the to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation describing the decision-making process through which the recommendations were reached, attached as Document number 31.

4.2.1. The NITAG

Profile of the NITAG

Name of the NITAG	Ethiopian NITAG
Year of constitution of the current NITAG	2016
Organisational structure (e.g., sub-committee, stand-alone)	Stand alone
Frequency of meetings	Minimum twice per year

Function	Title / Organisation	Name
Chair	Professor, Epidemiologist and Public Health expert, Addis Continental School of Public health	Professor Yemane Behan Tsehay
Secretary	National EPI Coordinator; Ministry of Health	Liya Woldegiorigis
Members	Paediatrician and Infectious Disease, Nutrition & Vaccine specialist; Addis Ababa University	Professor Telahun Teka Wolde
	New born and Child health specialist; Addis Ababa University	Professor Bogale Worku Feye
	Infectious disease and Vaccinology specialist; Addis Ababa University	Prof Amha Mekasha Wondimagegnehu
	1. IImmunologist and Researcher at Armaur Hansen's research institute	Dr Liya Wassie
	Gynecologist and Obstetrician; Addis Ababa University	Dr. Yirgu Gebrehiwot

Major functions and responsibilities of the NITAG

1. Conduct policy analysis and determine the optimal national immunization policies
2. Guide the national government and the national immunization programme (NIP) on the formulation of short and long-term strategies for the control of vaccine preventable diseases through immunization
3. Advise the national authorities in the monitoring and evaluation of the national immunization programme and provide recommendations on the continuation or modification of existing programmatic activities.
4. Identify the need for further data for policy-making and advise the government in the collection of these data.
5. Help to keep the national authorities and the immunization programme updated on the latest scientific developments in the area of vaccines and vaccine-preventable diseases.

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.
- If applying for measles or measles rubella support, please check that the current cMYP includes all the information described in Annex 2 of the Measles and Rubella 2017 Application Guidelines. If this information is not included in the cMYP, please submit a cMYP addendum that covers the missing information and attach it as document number 40.
- 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	94,440,104	2016	projected from 2007 census
Birth cohort	3,173,187	2016	projected from census 2007
Infant mortality rate (per 1000)	48	2016	EDHS
Surviving infants*[1]*	2,984,307	2016	projected from 2007 census
GNI per capita (US$)	762	2016	national health account
Total Health Expenditure (THE) as a percentage of GDP	4.56	2016	HSTP 2015-2020
General government expenditure on health (GGHE) as % of General government expenditure	9.6	2016	HSTP 2015-2020

[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
The support of political and community leaders was critical for successful introduction of Rota and PCV as well as HPV in the demo districts. The technical working groups including logistics, communication and monitoring and evaluation working groups, played important role.	Engage political and community leaders at all level and get their commitment for the successful implementation of MSD Employ similar coordination mechanism to monitor preparedness and implementation of MSD introduction through TWG and sub-working groups
Establishment of new vaccine sentinel surveillance sites such as Rota and PBM helped to monitor impact of the vaccines introduced	strengthen measles case based supported by laboratory surveillance to monitor disease burden and progress towards measles elimination
Use of RED approach, immunization improvement plan in high priority zones and use of enhanced defaulter tracing mechanism through community involvement increased service utilization	Introduce adapted RED approach; enhance the use of different defaulter tracing mechanisms at the community, health facility contacts and school entry
The presence of decentralized and strong health system in the country, enabled Ethiopia to successfully introduce new vaccines	Strengthen and use the existing health system for the MCD2 introduction
Strong collaboration with partners with in the health and outside the health sector was critically required during new vaccine introduction and this was observed when PCV and Rota vaccine commenced	Enhance collaboration of stakeholders ,leveraging additional resources, and sharing responsibility for MSD introduction
Storage capacity and cold chain equipment assessment and projection plans done to fit the traditional as well as newly introduced vaccines	Conduct cold chain equipment and storage capacity assessment
The presence of community structure and partnership such as women development army helped to raise community awareness and disseminate information on the newly	Strengthen Community partnership and engagement through use of existing structure like Women development Army, develop key communication messages to increase community awareness and

introduced vaccines	demand for MSD
Capacity building for Health workers, and HEWs at different levels helped to improve the skills and knowledge on traditional as well as newly introduced vaccines.	Provide pre-introduction training for health workers and HEWs at all levels

5.1.2 Health planning and budgeting

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

The country is implementing the second Growth and transformation plan (GTP II), 2015 - 2020.The midterm strategic planning and budgeting cycle of health sector strategic plan is in line with national growth and transformation plan and rolling every five years. The annual planning and budgeting cycle for Ethiopia is from July to June every year

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

The strategic document for health sector is the Health Sector Transformation Plan (HSTP) from 2015/16 to 2019/20. The Cmyp 2016-2020 is the immunization program strategic document which is aligned with the HSTP in time and priorities

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

Yes, the cMYP (2016-2020) is updated and aligned with the MCV2 introduction proposal in terms of content and timing

Please indicate the national planning budgeting cycle for health

The national health sector planning and budgeting cycle runs annually from July 8 to July 7 of the following year

Please indicate the national planning cycle for immunisation

The national planning cycle for immunization is the same as the health sector planning cycle i.e. July 8 to July 7 of the following year

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.

Measles immunization coverage has increased over the years, from 63% in 2006 to 93% in 2016. However there is variation in the immunization performance among regions and among districts within the same region. The coverage is markedly low in pastoralist regions and semi agrarian zones of other big regions.

The specific challenges faced by the immunization program in Ethiopia have been well-documented in the past three years with a variety of high-quality, formal program evaluations, assessments and surveys. Most notably, the National Immunization Coverage Survey (2012); the Post Introduction Evaluation of Pneumococcal Vaccine (2013); the survey on Socio-economic, Behavioral and Health Services Determinants of Immunization Service Utilization (2012); the JSI/ARISE Evaluation of the Drivers of Routine Immunization System Performance in Ethiopia (2012); and the Effective Vaccine Management Assessment (2013), Logistics and Cold Chain Report (2011 & 2013) which reflect major problems in the various immunization delivery system and components.

The sited problems and solutions include, but are not limited to:

- Infrastructure problems :especially transport and inputs for cold chain equipment in most rural agrarian and pastoralist regions including high skilled human resource attrition as the major challenges for health programme.

- SDDs refrigerators for hard to reach areas procured and installed.

- The pastoralist health programme recruited, trained HEWs and to be functioning optimally in certain pastoralist and agro-pastoralist woredas.

- The women health development army were equipped with necessary information on vaccination program including the new vaccines information and supported the introduction and continuing their support for the routine immunization.

- Geographic disparities; studies has shown that there are coverage disparities among pastoralist communities, due to limited infrastructure, high population mobility, inadequate trained manpower suboptimal community awareness
- Service delivery: fear of vaccine wastage particularly measles, irregularity of immunizationsessions, transportation for outreachs and shortage operation funds.

Logistics and vaccine management :Cold chain breakage, shortage of EPI communication focal persons at all levels; including lack of pastoralist tuned communication strategy; high dropout rate, where 80% attributed to problem of communication (including time of immunization unknown, fear of side effects and child crying, unaware of the need to return for the next vaccination, rumors and community/family/elders influence); poor interpersonal communication between health service provider and caretakers; and low level of knowledge of communities on immunization including diseases surveillance

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 introduction of MCV2 support will provide good opportunity to strengthen the immunization program and thereby to reduce inequity ,increase access and improve service utilization through:

- Training of immunization staffs on MCV2 introduction: this will provide an opportunity to update all staffs on existing vaccines and basics of immunization.
- Use MSD grant to leverage the cold chain system: the grant will be used to conduct rapid cold chain assessment and maintenance of refrigerators supporting the ongoing effort of cold chain rehabilitation plan
- The new vaccine coordination committee will be revitalized at all levels and to monitor preparatory activities for MSD as well as support routine immunization program
- MSD will provide an opportunity to strengthen community engagement, increase awareness and increase demand for the new and existing vaccines through IEC/BCC and social mobilization activities.
- MSD will create opportunity to enhance coordination, partnership and monitoring of EPI program,

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.

In Ethiopia immunization coverage survey and DHS are done every 3 and 5years respectively. Both surveys assess barriers to utilization of immunization service by sex and socio-economic determinants.

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

Sex disaggregated data is not collected regularly for immunization in the routine administrative reporting system. However, as indicated above it is assessed during immunization coverage surveys. And DHS. In the past these studies showed no significant difference in the uptake of immunization by sex

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.

The 2015-2016 El Nino effect caused large areas in the country to be food insecure with high vulnerability of children acquiring measles which may result with complications death with underlying cause of malnutrition. The Government of Ethiopia, together with partners designed the emergency preparedness plan and its implantation is on progress and no significant challenge for both the new introduction and routine immunization activities faced.

Refugees from South Sudan, Eretria, Yemen and Somalia fostered in Ethiopia. FMOH, ARRA with partner instituted the refugee vaccination programme and thus the new vaccine introduction will be integrated with the routine programme as planned

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 MCV Immunisation coverage

Evidence of self-financing MCV1

If the country is not currently fully financing with domestic resources the measles mono-valent vaccine component of routine measles first dose (MCV1), please provide evidence that the country can meet this requirement from 2018 onwards through a decision recorded in the ICC minutes AND a signed letter from the Minister of Health and the Minister of Finance (Please attach available documents AS DOCUMENT NUMBER 37 and 38 -- in Section 10. Attachments).

Please provide information concerning immunisation coverage related to measles-containing vaccines (MCV)

Coverage	2014		2015		2016	
	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*
Measles 1*st* dose (%)	84	70	92	78	93	
Measles 2*nd* dose (%)						

Coverage	2014		2015		2016	
	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey
Supplementary Immunisation Activities (SIA) (%)	106	88	98	91	97	94

Note:

(1) National reported Administrative Coverage

(2) WHO/UNICEF estimates of national immunization coverage

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

Please describe survey methodology and attach the post campaign coverage survey report, if available, as document number 40.

This study employed cluster survey method as recommended by the World Health Organization(WHO).

5.2. Baseline and Annual Targets for Routine Vaccines

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	2018	2019	2020
Total births	3,173,187	3,340,338	3,427,187	3,516,294
Total infants' deaths	114,235	86,849	78,825	70,326
Total surviving infants	3,058,952	3,253,489	3,348,362	3,445,968
Total pregnant women	3,173,187	3,340,338	3,427,187	3,516,294
Target population (routine cohort) vaccinated with OPV3*[1]*	2,643,796	3,090,815	3,214,427	3,308,129
OPV3 coverage*[2]*	86 %	95 %	96 %	96 %
Target population (routine cohort) vaccinated with DTP1*[1]*	3,014,557	3,155,885	3,281,395	3,377,049
Target population (routine cohort) vaccinated with DTP3*[1]*	2,844,144	3,090,815	3,214,427	3,308,129
DTP3 coverage*[2]*	93 %	95 %	96 %	96 %
Wastage*[3]* rate in base-year and planned thereafter (%) for DTP	5	5	5	5
Wastage*[3]* factor in base-year and planned thereafter for DTP	1.05	1.05	1.05	1.05
Target population (routine cohort) vaccinated with 1st dose of MCV	2,751,636	2,993,210	3,147,460	3,273,670
Target population (routine cohort) vaccinated with 2nd dose of MCV	0	2,993,210	3,147,460	3,273,670
MCV coverage*[2]*	0 %	92 %	94 %	95 %
First Presentation: Measles, 10 dose(s) per vial, LYOPHILISED in second dose				
Wastage*[3]* rate in base-year and planned thereafter (%)	25	25	25	25
Wastage*[3]* factor in base-year and planned thereafter (%)	1.33	1.33	1.33	1.33
Maximum wastage rate value for Measles, 10 dose(s) per vial, LYOPHILISED in second dose	40 %	40 %	40 %	40 %

Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	6 %	2 %	2 %	2 %

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

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

[3] The formula to calculate a vaccine wastage rate (in percentage): [(A - B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

5.3. Targets for Preventive Campaign(s)

No NVS Prevention Campaign Support this year

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

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

6.2. Requested vaccine (Measles, 10 dose(s) per vial, LYOPHILISED in second dose)

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

When is the country planning to introduce this vaccine? **January 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.

Currently the Measles 5-dose vial presentation is not available, but please indicate if the country would prefer this presentation if it becomes available. **Yes**

If the country is introducing measles-rubella (MR) in the routine system, is the country planning to switch the second dose of measles to MR as well, in addition to the first MR dose? **No**

If [YES], when? **January**

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

The country has cold rooms in 20 locations with 974 cubic meters net positive storage capacity and 40 m3 freezer; 477 cubic meters positive storage and 20 m3 freezers at central PFSA and 487 m3 distributed in regions and sub-regions. The distribution is supported by 20 Refrigerated trucks.

Additional to the central and sub-regional cold storage capacity, as of the 2012 cold chain equipment inventory about 20,500 refrigerators (about 75% were reported functional) - available in districts and health facilities and since the inventory, the country procured and distributed 376 ice lined reflectors (ILR,) 2,244 Solar Direct Drive (SDD) refrigerators to replace the nonfunctional/ obsolete cold equipment and expand the cold chain capacity at different levels including the hard to reach areas. Moreover, a total of 8,134 SDD refrigerators procurement process is in progress and even without these the available storage space in the different health administration levels make the cold storage space sufficient for the MC2 introduction and periodic supplementary immunization activities.

Currently, Ethiopia has adequate cold chain space for newly introduced MCV2 vaccine. The MCV 2 grant will be utilized for cold chain maintenance and vaccine and cold chain management training.

6.2.1. Vaccine Prices

Vaccine	Presentation	2017	2018	2019	2020
Measles, 10 dose(s) per vial, LYOPHILISED in second dose	10	0.280	0.280	0.280	0.280

6.2.2. Co-financing information

If you would like to co-finance an amount higher than the minimum, please provide information in Your co-financing row.

Country group	Initial self-financing phase

	2018	2019	2020
minimum co-financing per dose	0.20	0.20	0.20
your co-financing per dose (please change if higher)	0.20	0.20	0.20

6.2.2.1.Specifications of vaccinations with new vaccine for routine cohort

	Source		2018	2019	2020
Number of girls in routine cohort to be vaccinated with the first dose	Table 5.2	#	2,993,210	3,147,460	3,273,670
Number of girls in routine cohort to be vaccinated with the second dose	Table 5.2	#	2,993,210	3,147,460	3,273,670
Immunisation coverage with the second dose	Table 5.2	%	92%	94%	95%
Country co-financing per dose	Table 6.2.2	$	0.2	0.2	0.2

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

		2018	2019	2020
Number of vaccine doses	#			
Number of AD syringes	#			
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#			
Total value to be co-financed by the Country *[1]*	**$**	1,990,501	1,694,981	1,758,381

[1] The co-financing amount for initial self-financing countries indicates costs for the vaccines and any freight charges. The total co-financing amount does not contain the costs and fees of the relevant Procurement Agency, such as contingency buffer and handling fees. Information on these extra costs and fees will be provided by the relevant Procurement Agency as part of the cost estimate to be requested by the Country.

6.2.4 New and Under-Used Vaccine Introduction Grant

Calculation of Vaccine Introduction Grant for the Measles, 10 dose(s) per vial, LYOPHILISED in second dose

Year of New Vaccine Introduction	Births (from Table 5.2)	Share per Birth in US$	Total in US$
2018	3,340,338	0.80	2,672,270

This is a one-time cash grant of US$0.80/child in a single birth cohort or a lump sum of $100,000 (whichever is higher). It should be noted that for introduction applications submitted from January 2017 onwards and for all Gavi vaccine introductions planned for implementation in 2018 onwards, this grant will be adjusted according to transition stage of the country. Countries in preparatory transition phase (Phase 1) will be provided with $0.70 per targeted person in a single birth cohort, and countries which have entered accelerated transition phase (Phase 2) $0.60 per targeted person in a single birth cohort. For low income

countries, the amount will remain at $0.80 per targeted person.

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 budget will be used for the following activities;

Training EPI managers and health workers

Printing of policy guideline, training, communication, revised HMIS tools

Advocacy and communication and social mobilization (advocacy workshop, media orientation workshop, national and regional launching, radio and TV message production and transmission

Cold Chain Equipment & Maintenance, cold chain inventory

vaccine distribution ,Vehicles and Transportation

Program Management(planning, supervision, monitoring, review meeting and post introduction evaluation)

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.

Additional amounts will be mobilized from government and EPI partners

6.2.5.Technical assistance

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

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):

Measles vaccine will be procured through UNICEF

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.

N/A

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.

The usual procedure will be followed to transfer Operational budget for VIG directly to FMOH account stated in annex 12(banking form)

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

The Government (FMOH) – through UNICEF

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

The allocated budget will be utilized as per the VIG breakdown and this will be jointly monitored by the finance and program(MCH/EPI) unit in collaboration with implementing regions. Statement of expenditure will be issued in the agreed time frame

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

The HMIS is under revision and Measles second Dose (MSD) will be captured as data element.

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.

N/A

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

MCV 10 dose vial is licensed in Ethiopia

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.

N/A

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.

N/A

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).

Injection safety and safe disposal of materials training will be conducted for health workers in general and peripheral level health workers in particular. Immunization safety will be included in all supervision and monitoring activities.

Nearly all health centers have incinerators, where sharps and other healthcare wastes are disposed by burning. The remaining health facilities use dug pits as a means of waste disposal. Training, sensitization and supervision will continue at all levels to improve waste management. All personnel will be well trained on immunization safety with inclusion of waste management in the curricula of the national training package for the MSD introduction training. In addition, the training will include education on health risks and on safe practice for waste management.

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

10.1. List of documents attached to this proposal

Table 1: Checklist of mandatory attachments

Document Number	Document	Section	File
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	01 FMOH_Signiture.pdf **File desc:** **Date/time :** 02/05/2017 11:55:59 **Size:** 514 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	02 MOFED_Signiture.pdf **File desc:** **Date/time :** 02/05/2017 12:01:09 **Size:** 514 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	04ICC TOR for coordination forum.pdf **File desc:** **Date/time :** 03/05/2017 08:50:40 **Size:** 567 KB
5	Minutes of Coordination Forum meeting endorsing Proposal	4.1.3	ICC meeting Minute April 26, 2017_Final.pdf **File desc:** **Date/time :** 03/05/2017 06:22:48 **Size:** 253 KB
6	Signatures of Coordination Forum members in Proposal	4.1.3	06 Signiture of ICC.pdf **File desc:** **Date/time :** 03/05/2017 06:13:34 **Size:** 141 KB
7	Minutes of the Coordination Forum meetings from the past 12 months before the proposal	4.1.3	ICC JA Meeting minutes 04 Nov 2016 previous 12 months.pdf **File desc:** **Date/time :** 02/05/2017 12:21:46 **Size:** 312 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	8 NITAG ToR_Final NITAG approved.pdf **File desc:** **Date/time :** 02/05/2017 12:22:45 **Size:** 253 KB
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.		Not Applicable.docx **File desc:** **Date/time :** 03/05/2017 09:05:52 **Size:** 12 KB
31	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	Not Applicable.docx **File desc:** **Date/time :** 03/05/2017 09:05:13 **Size:** 12 KB

Planning, financing and vaccine management			
9	Comprehensive Multi Year Plan - cMYP	5.1	Ethiopia cMYP 2016-2020.pdf **File desc:** **Date/time :** 02/05/2017 12:35:03 **Size:** 2 MB
10	cMYP Costing tool for financial analysis	5.1	Ethiopia_cMYP_Costing_Tool_V3 9 3_ December 2016.xlsx **File desc:** **Date/time :** 02/05/2017 01:31:21 **Size:** 2 MB
11	M&E and surveillance plan within the country's existing monitoring plan	5.1.4	09JRF Mortality and Morbidity data2014_2016.xlsx **File desc:** **Date/time :** 02/05/2017 12:38:00 **Size:** 20 KB
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	06Measles2nd dose introdcution plan Final.pdf **File desc:** **Date/time :** 03/05/2017 06:29:15 **Size:** 955 KB
14	Annual EPI Plan with 4 year forward view for measles and rubella		25 Ethiopian Measles Strategic Plan_2012-2020_Final.pdf **File desc:** **Date/time :** 02/05/2017 12:43:04 **Size:** 1 MB
20	Improvement plan based on EVM	9.3	21 EVM improvement plan Ethiopia 2014.pdf **File desc:** **Date/time :** 02/05/2017 12:47:22 **Size:** 485 KB
21	EVM improvement plan progress report	9.3	010_Effective Vaccine Management Improvement plan status.pdf **File desc:** **Date/time :** 02/05/2017 12:48:26 **Size:** 133 KB
22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2,6.x.2,8.2.3	10DetailedBudgetTemplate_VIG_OP_MSD_2018.xlsx **File desc:** **Date/time :** 02/05/2017 01:09:02 **Size:** 44 KB
32	Data quality assessment (DQA) report	5.1.4	Data quality Review.pdf **File desc:** **Date/time :** 03/05/2017 07:06:29 **Size:** 2 MB
37	Evidence of self-financing MCV1	5.1.5	Ethiopia cMYP 2016-2020.doc **File desc:** **Date/time :** 02/05/2017 01:50:55 **Size:** 4 MB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File

3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	No file loaded
15	HPV Region/ Province profile	6.1.1	No file loaded
16	HPV Key Stakeholder Roles and Responsibilities	6.1.1,6.1.2	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
19	EVM report	9.3	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	No file loaded
26	List of areas/districts/regions and targets to be supported for meningitis A mini catch up campaigns		No file loaded
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
33	DQA improvement plan	5.1.4	Information Revolution Roadmap.pdf **File desc:** **Date/time :** 03/05/2017 07:10:13 **Size:** 870 KB

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		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 Measles, 10 dose(s) per vial, LYOPHILISED in second dose

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

		2018	2019	2020
Number of vaccine doses	#			
Number of AD syringes	#			
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#			
Total value to be co-financed by the Country *[1]*	$	1,990,501	1,694,981	1,758,381

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$)

		2018	2019	2020
Number of vaccine doses	#	0	0	0
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by Gavi	$	1,384,932	1,159,683	1,202,787

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

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	*V*	67.80 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	2,993,210	2,029,294	963,916
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	2,993,210		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	5,986,420	4,058,588	1,927,832
E	Estimated vaccine wastage factor	*Table 5.2*	1.33		
F	Number of doses needed including wastage	*D x E*	7,961,939	5,397,922	2,564,017
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]*	1,990,485	1,349,481	641,004
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	9,952,500	6,747,455	3,205,045
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	8,774,596	0	8,774,596
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	1,094,775	0	1,094,775
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	108,564	0	108,564
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,786,701	1,889,288	897,413
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	315,886	0	315,886
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	33,575	0	33,575
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	50,033	0	50,033
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	149,288	101,213	48,075
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	39,950	0	39,950
T	Total fund needed	*(N+O+P+Q+R+S)*	3,375,433	1,990,501	1,384,932
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,990,500		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	67.80 %		

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

		Formula	2019		
			Total	Government	Gavi
A	Country co-finance	*V*	67.80 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	3,147,460	2,133,871	1,013,589
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	3,147,460		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	6,294,920	4,267,742	2,027,178
E	Estimated vaccine wastage factor	*Table 5.2*	1.33		
F	Number of doses needed including wastage	*D x E*	8,372,244	5,676,097	2,696,147
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]*	102,577	69,544	33,033
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	8,474,900	5,745,694	2,729,206
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	7,037,247	0	7,037,247
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	932,240	0	932,240
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	87,665	0	87,665
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,372,972	1,608,795	764,177
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	253,341	0	253,341
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	28,591	0	28,591
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	40,402	0	40,402
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	127,124	86,186	40,938
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	32,234	0	32,234
T	Total fund needed	*(N+O+P+Q+R+S)*	2,854,664	1,694,981	1,159,683
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,694,980		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	67.80 %		

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

		Formula	2020		
			Total	Government	Gavi
A	Country co-finance	*V*	67.80 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	3,273,670	2,219,437	1,054,233
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	3,273,670		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	6,547,340	4,438,873	2,108,467
E	Estimated vaccine wastage factor	*Table 5.2*	1.33		
F	Number of doses needed including wastage	*D x E*	8,707,963	5,903,701	2,804,262
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]*	83,930	56,902	27,028
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	8,791,900	5,960,607	2,831,293
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	7,294,398	0	7,294,398
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	967,110	0	967,110
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	90,877	0	90,877
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,461,733	1,668,971	792,762
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	262,599	0	262,599
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	29,660	0	29,660
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	41,882	0	41,882
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	131,879	89,410	42,469
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	33,415	0	33,415
T	Total fund needed	*(N+O+P+Q+R+S)*	2,961,168	1,758,381	1,202,787
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,758,380		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	67.80 %		

Annex 2 - NVS Routine – Preferred Second Presentation

No NVS Routine – Preferred Second Presentation requested this year

Annex 3 - NVS Preventive campaign(s)

No NVS Prevention Campaign Support this year

Annex 4

Table Annex 4A: Commodities Cost

Vaccine	Presentation	2017	2018	2019	2020
Measles, 10 dose(s) per vial, LYOPHILISED in second dose	10	0.280	0.280	0.280	0.280

Supply	Form	2017	2018	2019	2020
RECONSTIT-SYRINGE-YF	SYRINGE	0.031	0.031	0.031	0.031

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)

Estimated prices of supply are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2018	2019	2020
Measles, 10 dose(s) per vial, LYOPHILISED in second dose	MEASLES	5.36 %	5.36 %	5.36 %

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

Vaccine	2018	2019	2020
Measles, 10 dose(s) per vial, LYOPHILISED in second dose	0.2	0.2	0.2

12. Banking Form

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

Name of Institution (Account Holder):	Federal Ministry of Health		
Address:	Sudan Avenue		
City Country:	Addis Ababa, Ethiopia		
Telephone no.:	+251-11-551-7011	**Fax no.:**	+251-11-551-9366
		Currency of the bank account:	Ethiopian Birr
For credit to:			
Bank account's title:	MOH-MDG DESIGNATED pooled acc		
Bank account no.:	0100081040142(0160101352600)		
Bank's name:	NATIONAL BANK OF ETHIOPIA		

Is the bank account exclusively to be used by this program? No

By who is the account audited?

Signature of Government's authorizing official

Name:		**Seal**
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: