Application Form for Gavi NVS support

Submitted by

The Government of

Eritrea

Date of submission: **22 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]
Initial Catch up	MR, 10 dose(s) per vial, LYOPHILISED	2018	2018	Not applicable
Routine New Vaccines Support	MR, 10 dose(s) per vial, LYOPHILISED in first dose	2018	2021	Not applicable
Routine New Vaccines Support	MR, 10 dose(s) per vial, LYOPHILISED in second dose	2018	2021	

[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.).

The country is plainning to introduce MR vaccine into routine immunization program starting 2018 on wards. Prior the introduciton of MR vaccine into RI, children 9 months to 14 years will need to have vaccineated in campaign form inorder to boost the herd immunity and decrease susceptible individuals after completion of the catch-up campaign introduction of MR vaccine into RI will be follwed by the switch plan of MCV 1 and MCV2 to MR1 and MR1 in the alreay existed immunization schedule.

The country has been providing MCV in two doses schedule and planned to eplace both doses of MCV currently given at 9 and 18 months on routine immunization schedule with MR vaccine, following the October, 2018 MR campaign in wide age range. The current policy recommends that children aged between 18 and 24 months are eligible for MCV2 if they have not received the second dose of measles vaccine. This policy will apply to MR Vaccine also. The program will have a unique opportunity to mobilize and re-sensitize the community to increase the vaccine dose uptake and vaccination demand of the second dose through training the health workers as well as mobilizing the community during the catch-up campaign and introduction process.

The introduction of MR will ensure equitable access to the vaccine across the country by making more focused on less accessible geographical areas and nomadic population groups where frequent outbreak of the disease can occurs. there are a number of approacched practicing inthe country to reach the unreached children in less accessible areas suchs Periodic Intensified Routine Immunization (PIRI) service and provideing routine outreach services and implemntaion of the RED/REC approach with community involvement during during the micro planning at district level to map the hard to reach areas. In the previous years Eritrea has successfully introduced a number of new vaccines in to routine immunization system without any major challenges and with high acceptance of the vaccine by the public such as Penta (2008), MCV2 (2012), Rotavirus vaccine (2014) and PCV-13 in August 2015. Lessons learnt from these past introduction plan post introduction evaluation activities will help to understand and address the challenges expected to face during the catch-up campaign and introduction of MR into routine. Furthermore, the country has and experience of community involvement during the introduction plan successful and program will make adequate preparation to resolve and challenges. A well-established structure for communication through community health workers, various media out lets and community leaders exists and has been successfully employed during introduction of new vaccines and SIAs. In addition the program has a firm support of the government.

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

Executive Summary

In light of the remaining global burden of Congenital Rubella Syndrome (CRS) and proven efficacy and safety of Rubella Containing Vaccines (RCVs), WHO recommends that countries should take the opportunity of implementing accelerated measles control and elimination activities to introduce RCV into Routine Immunization (RI) program. In this regard, conducting a wide age-range of MR campaign is recommended by WHO to boost and increase herd immunity in the community. This approach is also a requirement for introduction of MR vaccine into routine childhood vaccination program to prevent congenital rubella infections. Moreover, this opportunity will catalyse the effort of reducing CRS incidence among infants. Furthermore, WHO advised countries to introduce rubella in their routine immunization by switching the first and second doses of measles containing vaccines into the Measles/Rubella (MR) vaccines and to children at 9 and 18 months age as per the immunization schedule. Based on this, Eritrea is eligible and fulfills the required criteria to apply and use this opportunity.

Based on EPI coverage survey result of 2013 and the draft coverage survey of 2017, routine immunization coverage of MCV1 is found to be >90% and this encourages the country to carry out MR Catch-upcampaign for wide age range to decrease susceptibility and boost herd immunity of measles rubella among the age group in which subsequently will follow introduction of MR vaccine in to routine immunization program. In Eritrea routine vaccination service is provided in 295 health facilities at static of out of the 347 health facilities in the country and there are 450 outreach sites in less accessible geographical areas. Starting from 2006 onwards, Sustainable Outreach Services (SOS) and REC/RED approach has been implemented to to reach districts in less accessible geographical areas and address mobile population segments. This approach helped us to address low immunization coverage in these areas and minimize the number of unvaccinated children. In addition to the routine immunization services, supplementary immunization activities of measles has been conducted in high risk districts bordering to Sudan and Ethiopia to prevent importation of vaccine preventable diseases such as polio and measles. Biannual Vitamin "A" supplementation is also underway for children 6-59 months of age which supports children in immunity development and defualters tracing activities are carried out to minimize the vaccine dropout rates.

Measles Rubella (MR) surveillance system in Eritrea has demonstrated increased trend of confirmed rubella cases. In the past three years of surveillance (2013-1015), the country reported a total of 310

Measles/Rubella suspected cases and blood specimen was taken for lab investigation out of which 45% and 42% were found to be lab confirmed measles and rubella virus cases respectively.

The EPI cMYP 2012-2016 ended and the country has developed a new cMYP 2017-2021 which is also aligned to Health Sector Strategic Development Plan (HSSDP, 2017-2021) which is endorsed in December, 2016. The MR campaign and introduction of MR vaccine into RI have been incorporated in the current cMYP as measles rubella is a public health problem in the country. The WHO logistic forecasting tool was also applied to know the existing and required net storage capacity of cold chain for routine and SIAs . Based on the calculated results, the country has adequate storage capacity to accommodate all the vaccines for routine vaccination, MR campaign vaccine doses and for making a follow-up MR campaign in 2021 if needed. Moreover, based on the results of the situational analysis, introduction plan, objectives of the plan have been widely incorporated in the 5 years cMYP. Based on this, MR campaign is planned for the 4th quarter of 2018 and a total 1,562,025 children age 9 months – 14 years are expected to be vaccinated with MR vaccine. Moreover, the MR campaign will give us a good opportunity to strengthening the existed routine immunization services and increase community awareness on vaccination demand. This objective can be attained through conducting a pre-campaign assessment on all EPI logistics, conducting CCE preventive maintenance activities to secure adequate storage capacity at service level, training of EPI focal persons on vaccine and cold chain management and appropriate disposal of EPI wastes. Social mobilization activities will be conducted using various media outlets before and during the campaign to increase vaccine demand and timely uptake of the vaccine doses for SIAs and RI and Post campaign survey will be done by independent group to assess and verify the performance of the campaign and reveal the actual campaign coverage.

The Total for for MR campaign both operational, vaccine and injection safety materials is estimated to be $US 2, 272, 244. The operational cost for MR campaign is estimated to be US$1,387,994 out of which US$1,015,317 (0.65 cents per child) will be covered by GAVI. The remaining operational cost US$832,67 (0.3 cents per child) will be covered by the Government, local partners and Civil Society Organizations (CSO) through fund raising activities. The cost of MR vaccine and injection safety materials is estimated USD 884,250 [(vaccine, $736,651); (AD syringes cost $115,137); (reconstitution syringes $11,654) and (safety box 26,805)]. The government of the state of Eritrea have been co-financing 20% of all tradition vaccines and starting from 2018, the Government will be on a position to cover the cost of MCV1 and its injection safety materials and will keep on his obligation and commitment for the future.

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 Eritrea 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:

MR, 10 dose(s) per vial, LYOPHILISED in first dose; MR, 10 dose(s) per vial, LYOPHILISED in second dose routine introduction

MR, 10 dose(s) per vial, LYOPHILISED initial catch-up

The Government of Eritrea 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, 6.3.3, 6.3.4** 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, 6.3.3, 6.3.4** of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

Table(s) **7.2.2** in the Initial Catch up of this application shows the amount of support in either supply or cash that is required from the Gavi.

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 **April**.

The payment for the first year of co-financed support will be around **April 2018** for MR, 10 dose(s) per vial, LYOPHILISED in first dose, MR, 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	HE Minister AMINA NURHUSSIEN	**Name**	HE Minister BERHANE HABTEMARIAM
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
TEDROS YEHDEGO	EPI Manager	2917184525	tedrosmy@gmail.com
YODIT HIRUY	CHILD HEALTH SPECIALIST	2917133256	yhiruy@unicef.org

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	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:

Roles of ICC

1. Advise the Ministry of Health on policy matters pertaining to the immunization programme,

2. Review and endorse all immunization documents (CMYP, annual plans and reports, proposals for the introduction of new vaccines, new technologies, and changing in vaccine formulation and presentation.

3. Mobilize resources from local and international partners/agencies for successful implementation of the national immunization programme and ensure transparency & accountability in utilization of the received funds.

4. Review programme performance reports and advising programme leadership for equitable and accessible immunization services especially for segregated population groups and people living in less accessible geographical areas.

5. Monitoring programme implementation of planned activities and reporting to the partners, e.g. GAVI, JICA, WHO, UNICEF and other agencies providing financial and technical support for the program.

6. Promote integration with other initiatives/programmes within and outside the health sector that may be supported by ICC partners.

7. Provide guidance, advices and technical support for national immunization days organized by the program and

advocate for resources mobilization from local CBO and international agencies.

8. Advise the program on prioritization of vaccine preventable diseases, EPI target diseases surveillance and follow up and periodically monitor implementation of the planned activities by the program.

9. Approve comprehensive multi-year plan and budget of the immunization program of five years.

10. Advise the program on program capacity management, coordination and financial sustainability in immunization service to focus on self-reliance.

11. Advocate Government officials and other partners for leveraging of resources for supplementary immunization activities and introduction of new technologies for immunization program to exceed their contribution to vaccination service.

Memberships for ICC include:

Representative of the following organization/agencies/CBO…constitute the ICC.

- Representative from WHO country office
- Representative from UNICEF county office
- Japan International Cooperation Agency (JICA) office in Asmara
- National Union of Eritrean Youth and Students (NUEYS)
- National Union of Eritrean Women's Association (NUEWA)
- Representative from Ministry of Education
- Representative from College of Health Science
- Representative from Religious Affairs
- Director General of Public Health Department
- Director of Health Care Service Delivery Division
- Director of Family and Community Health Division
- Manager of Expanded program on immunization
- Integrated diseases surveillance and respond officer
- Director of National Paediatric Hospital
- Director National Medicines and Food Administration
- Director of National Gb/Gyn Hospital

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 **28/04/2017** 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	DIRECTOR of HEALTH SERVICE-MoH	Dr. GOITOM MEBRAHTOM		
Secretary	EPI MANAGER/MOH	Mr. TEDROS YEHDEGO		
Members	IDSR MANAGER/MOH	Dr. FIKREMARIAM GHILAMICHAE		
	DIRECTOR FCH/MOH	Dr. BERHANA HAILE		
	OIC REPRESENTATIVE-JICA ERITREA	Mr. GEBREMICHAEL ESTIFANOS		
	EPI FOCAL PERSON-WHO	Mr. TSEGGAI YEHIDEGO		
	PROJECT OFFICER GAVI HSS/MO-	Mr.ROBEL ZEKRSITOS		
	CHILD HEALTH SPECIALIST-UNICEF	Ms.YODIT HIRUY		

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.
- 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	3,798,702	2017	NSO 2015
Birth cohort	113,961	2017	NSO 2015
Infant mortality rate (per 1000)	36	2016	CHERG 2016
Surviving infants*[1]*	106,364	2017	NSO2015
GNI per capita (US$)	480	2011	WORLDBANK
Total Health Expenditure (THE) as a percentage of GDP	3	2017	WHO 2014
General government expenditure on health (GGHE) as % of General government expenditure	3.6	2012	WHO 2014

[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
Proper orientation and training of health care providers is very necessary for successful introduction of new vaccine as well as for Switch of one vaccine to another to make them aware and have approriate management of vaccine and CCE	The MOH has developed a comprehensive training package and is planning to provide the training before two months at all levels and training will continue in each zoba two rounds per year as previous practice
Appropriate temperature monitoring is very vital to avoid freezing of vaccine at all supply chain levels.	The MoH has strengthened the capacity of all EPI service delivery points to use temperature monitoring devices (Fridge Tags and Temperatures loggers) to have continuous monitoring records so that to confirm that the potency of the vaccine will guaranteed and keep its potency.
Involve the community members so that they will feel as having owner ship of the plan	Community involvement during micro planning at district level to reach children in less accessible areas.

Preventive campaign support

If campaigns with MR, 10 dose(s) per vial, LYOPHILISED vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. If they are included in the Introduction Plan or Plan of Action, 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 National and subnational AEFI committees need to be updated and actively search and respond tor potential AEFI cases.	The Ministry of health has established and trained immunization safety advisory committees at national and subnational levels.
Adequate storage capacity at all levels is necessary for rolling out campaign successfully.	Cold chain inventory has been done and improvement plan has been developed and addressed.

5.1.2 Health planning and budgeting

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

The planning and budgeting cycle of Eritrea is from January 1st to December 31st of each year. Proposal of annual work of each ministry is prepared. The budget is reviewed and cleaned at national level and feedback is provided to make amendments before submitting to the MoF. Annual budget of all the ministry and other sectors is submit to Ministry of Finance. Budget reading and hearing is done at governmental level chaired by the Ministry of Finance for more verification defending. Finally the consolidated annual budget is present to the Ministerial Meeting for approval and endorsement in order to implement it at various levels and sectors of the government.

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

Health Sector Strategic Development Plan (HSSDP). A new HSSDP 2017-2021 is developed and endorsed in Dec. 2016

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

Yes the CMYP has been developed to cover 2017-2021 and it is alligned with this proposal. Please refer page 21-25 of cMYP. . Furthermore information included in the cMYP addendum iis attached. The epidemiological trend of rubella cases and the need to introduce rubella vaccine is clearly discussed and presented in the cMYP.. The cMYP incliuded and discussed back ground information of activities carried out to starting from 2006 to conrol measles disease and consecutive catch-up and follow-up campaign to controll measles. Furthermore, the 5 years multiy ear plan of MR control strategies and activties also in the cMYP.

Please indicate the national planning budgeting cycle for health

The planning and budgeting cycle for health is similar to the country planning cycle which is from January 01 to December 31.

In order to set objectives, a situational analysis of the services providing at lower level is carried. After the

existed problems have determined prioritization of the identified problems of the districts and zobas is done. At regional level annual work plan is developed to address the problem. The annual work plan is accompanied with specific objectives, strategies and activity lines. Each activity line is budgeted and compiled at zoba level and submit to the Ministry at the national level. At national level the budget proposals are reviewed evaluated and feedback is provided to zobas to make some amendments based on the recommendations. After that the annual budget of the Ministry is shared to Ministry of Finance and budget hearing and defending is arranged at governmental level for more verification and consolidation. At the end a budget summary is prepared and present to the ministerial meeting for its approval and endorsement at governmental level.

After that the budget is disburse to sub nationals for their implementation and every quarter liquidation of the utilized budget is done and report is submitted to national level. Mid-year review meeting is also done to monitor and evaluate the status of the budget utilization and to observe the progress made in achieving the specific targets and objectives.

Please indicate the national planning cycle for immunisation

The national planning cycle for immunisation is the same as the national planning and budgeting cycle for health, January 1 to December 31.Situational analysis, of available services of the EPI program is done at lower level and problems are identified and prioriitized. Based on them objectives, strategies and activity lines are developed and costed. Proposal for their implementstion is developedd The annual work plais sent to the national level and follows the same procedure as of the the national planning and budgetng of heealth sectors and sent to ministry of finance for its approval and endorcement.

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.

In Eritrea Southern Red Sea (SRS), Gash Barka (G/Barka), Northern Red Sea (NRS) and Debub have challenging areas with consistently limited access to EPI services as well as limited access to other priority health services. Valid immunization coverage is below the target of 90% in SRS, G/Barka and NRS for all antigens, while the remaining three regions had coverage of 90% and above. Generally, up to 40% of the population does not have a health facility within 10 kms radius of their residences (HSSDP, 2012). Details in access can be found in the following sources: **EPI Coverage Survey Eritrea, 2013 (pgs. 13, 20-24 & 31-42);**

As per the joint assessment report 2016, 'The life style of the nomadic population at the coastal districts, there is high dropout rate between BCG – Measles, limited community empowerment, inequitable access to health services' is just a glimpse of inequity of access to EPI/VPD and other priority health services. However, it is worth noting that there is no gender related inequity in the country especially as related to EPI services.

Lowest access to EPI/VPD and other priority services is found in the lowest and second lowest socio-economic quintiles, putting at risk children of mothers and or families in remote/rural and Hard To Reach (HTR) areas, HTR (mostly nomadic) populations as well as children in households with young mothers below 24 years and aged mothers 35 years and above. The region with some inequities and that deserve remedial approaches are: Zoba SRS, NRS, Debub and G/Barka. Details can be accessed in the following resources: **EPHS, 2010 (pgs. 197-201); EPI Coverage Survey Eritrea, 2013 (pgs. 19, 20-24, 29, 31-42); JAR cMYP Eritrea, 2015 (pgs. 4-5, 15); MTR HSSDP, 2014 (24).**

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.

With the proposed NVS support, the country will be able to develop detailed micro plans to reach every child in less accessable areas which will be an opportunity for increasing immunization coverage. The country has

recieved support from GAVI HSS grant for outreach immunization servs and this will assist to solve the problem in less accessible areas by strengthening outreach services, and human resource for health at facility and community level. The proposed CCEOP application and aoval will improve the cold chain challenges at all levels to maintain continous avaialblity of vaccine even in less accessible areas and hence improve coverage and equity more.

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.

The EPI coverage survey is conducted every five years to assess any gender and equity related barriers. In 2017 EPI coverage survey has been conducted and draft report is being compiled. The health management information system generates routine data every month. The national EPI program analyse the data and conduct further assessment in districts that report low immunization coverage. This year equity assessment is planned to understand the barriers to access and utilizaiton of EPI services.This application has also included assessments during and after the campaign to assess gender and equity related barriers.

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

No the health management information system doesnot collect sex disaggregated data however the EPI coverage survey reveals that there is no difference of immunization coverage by gender.

Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought 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 country is not in a situaiton of fragility situation.

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

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

Table 5.1.5: MCV Immunisation coverage

Coverage	2014		2015		2016	
	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*
Measles 1*st* dose (%)	72	90	78	85	80	0
Measles 2*nd* dose (%)	0	87	72	0	62	0

Coverage	2014		2015		2016	
	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey	Administrative*(1)*	Coverage survey
Supplementary Immunisation Activities (SIA) (%)	0	0	82	0	0	0

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 **Administrative coverage**

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	2021
Total births	110,857	117,152	120,381	123,752	127,217
Total infants' deaths	7,390	7,810	8,025	8,250	8,481
Total surviving infants	103,467	109,342	112,356	115,502	118,736
Total pregnant women	147,809	156,203	160,508	165,003	169,623
Target population (routine cohort) vaccinated with OPV3*[1]*	83,322	91,000	96,626	101,642	106,862
OPV3 coverage*[2]*	81 %	83 %	86 %	88 %	90 %
Target population (routine cohort) vaccinated with DTP1*[1]*	88,098	92,941	97,750	103,952	109,237
Target population (routine cohort) vaccinated with DTP3*[1]*	83,322	91,000	96,626	101,642	106,862
DTP3 coverage*[2]*	81 %	83 %	86 %	88 %	90 %
Wastage*[3]* rate in base-year and planned thereafter (%) for DTP	5	5	5	5	5
Wastage*[3]* factor in base-year and planned thereafter for DTP	1.05	1.05	1.05	1.05	1.05
Target population (routine cohort) vaccinated with MCV2*[1]*	62,256	87,474	92,132	98,177	104,488
MCV2 coverage*[2]*	60 %	80 %	82 %	85 %	88 %
First Presentation: MR, 10 dose(s) per vial, LYOPHILISED in second dose					
Wastage*[3]* rate in base-year and planned thereafter (%)	40	40	40	40	40
Wastage*[3]* factor in base-year and planned thereafter (%)	1.67	1.67	1.67	1.67	1.67
Maximum wastage rate value for MR, 10 dose(s) per vial, LYOPHILISED in second dose	40 %	40 %	40 %	40 %	40 %
Target population (routine cohort) vaccinated with 1st dose of MCV	82,921	92,941	96,626	101,642	106,862
MCV coverage*[2]*	80 %	85 %	86 %	88 %	90 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	5 %	2 %	1 %	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)

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.

5.3.1 Targets (MR campaign)

Please specify cohort for rubella-containing vaccines (RCV):

MR Start **9 months**

MR End **14 years**

Cohort population = population 9 months - 14 years old

Gavi will only provide support to countries for Rubella Containing Vaccine catch-up campaign by providing doses of MR vaccine for a target population of males and females aged 9 months to 14 years (the exact range in the scope of 9 months to 14 years old will depend on MR in the country).

Table 5.3.1 Baseline NVS preventive campaign figures for MR

Number	Targets
	2018
Total target population	1,562,025
Wastage rate (%) for MR (campaign)	15
Maximum wastage rate value for MR (campaign)	15 %

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
Rubella	No assessment has been done but in the plan of action the disease burden is discussed	03/05/2017	The national lab reported confirmed rubella cases 25 rubella cases in 2010; 18 in 2011; 16 in 2012; 121 in 2013, 33 cases in 2014 and 222 cases in 2015.

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

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

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

Cold chain status

The EPI unit has a central cold chain store, and cold chain stores are also available at each of the Zoba. There are four immunization supply chain levels in the country, at national, subnational, district and service delivery points (health facilities). The Zoba cold chain stores collect vaccines from the National Vaccine Store quarterly and all health facilities collect vaccines from Zoba cold chain stores in monthly base. This scheduled delivery of vaccine and availability of well utilized and managed SMT at national and sub national levels helped us to monitor stock balance of the vaccines easily. Procurement of vaccines and injection safety materials is done by UNICEF SD from WHO prequalified serum institutes and the country has planned to use the same process in the future

The Immunization program has regular continuous planning activities on renewal, rehabilitation and maintenance of cold chain equipment at all levels. Vaccine stock management training activities at lower levels are part of the EPI routine plan. Vaccine ledgers and recording forms are standard and all health workers are trained on recording the vaccines. Using the WHO tools, quantity of the new vaccine is calculated considering that vaccine will be shipment from abroad in two phases. The country have installed additional one cold room at central level to have additional storage capacity. Currently, there is a net storage capacity of 19,414 meter cube liters at national level and 25,240 capacity at zonal levels. Hence, the country has a total of 44,654 Lts which is estimated to be enough storage capacity to store all vaccine of the routine and including the measles/rubella campaign doses.

In accordance with five year plan, the EPI program has renewed efforts to reduce wastage of EPI vaccines since the cost of new vaccines and quantity of the vaccines in the routine program are increasing. In particular

during the plan of introducing of new vaccines we have included which focuses on open vial policies to be used when appropriate in order to reduce wastages.

The wastage rates among new and traditional vaccines have been developed and will be monitored wastage rates according to the WHO recommended estimates. EPI monitoring tools are also in place. Consumption and wastage of the vaccine will be calculated after the introduction of the new vaccines regular base.

In some places of the country aging of solar and electrical refrigerators, lack of timely replacement plan, shortages of solar batteries and spare parts frequent failure of cold chain equipment were occurring especially in Western and Eastern low lands of the country. Shortage of trained and skilled cold chain technicians was a major problems at sub national level. But nowadays, the identified cold chain gaps have already addressed by making cold chain assessment and developing replacement plan by procuring solar & electrical refrigerators using JICA “Cold chain equipment and material supply” project of 5 years and the country has applied for CCEOP. To make effective and close follow-up of the cold chain equipment at service level, at least two trained solar and electrical technicians are available in each zoba. Refreshment training has been providing annually at national level by Biomedical Engineering division.

To keep-up monitoring of potency of vaccines, 30 days continuous temperature monitoring devices were also procured and distributed to each health facility and are on use. Temperature monitoring and recording activity for the refrigerators is in place in regularly bases twice per day. At national level, walk-in cold rooms are monitored using multi log sensor type monitoring is working in a centralized manner using a computer software .

6.2.1. Vaccine Prices

Vaccine	Presentation	2017	2018	2019	2020	2021
MR, 10 dose(s) per vial, LYOPHILISED in second dose	10	0.659	0.659	0.659	0.659	0.659

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	0.30	0.30	0.30
your co-financing per dose (please change if higher)	0.30	0.30	0.30

	2021
minimum co-financing per dose	0.30
your co-financing per dose (please change if higher)	0.30

6.2.2.1.Specifications of vaccinations with new vaccine for routine cohort

	Source		2018	2019	2020	2021
Number of girls in routine cohort to be vaccinated with the first dose	Table 5.2	#	92,941	96,626	101,642	106,862
Immunization coverage	Table 5.2	%	80%	82%	85%	88%
Number of girls in routine cohort to be vaccinated with the second dose	Table 5.2	#	87,474	92,132	98,177	104,488
Country co-financing per dose	Table 6.2.2	$	0.3	0.3	0.3	0.3

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]*	**$**	113,011	95,641	101,521

[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	#	
Number of AD syringes	#	
Number of re-constitution syringes	#	0
Number of safety boxes	#	
Total value to be co-financed by the Country *[1]*	**$**	107,341

[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 MR, 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	117,152	0.80	100,000

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).

Training

MR introduction will leverage on the milestones achieved during the MR catch up campaign to strengthen routine immunization. All health workers will be oriented on the new vaccine as well as the EPI operational areas, ensuring adequate supplies and logistics. Supportive visits will focus on routine aspects of the programme.

All EPI personnel will be trained on MR disease and the new vaccine through a standard program. Training for the new vaccine introduction will include aspects related to:

- Details of the disease and the new vaccine including (safety, efficacy, AEFI, etc.).

- The immunization schedule.
- Storage, preparation, and administration of the vaccine
- Recording and reporting using the new tools
- Monitoring of coverage, wastage, drop-out rates, etc.
- Immunization safety practices

Surveilance

Surveillance network has been established in the country within the EPI programmer since 2007 with technical financial support from WHO. Case based surveillance system will be strengthened to fill the gabs. The MR surveillance will be strengthened and expanded to cover more sites. The surveillance data will be used to evaluate the impact of the introduction of the new vaccine. Case based surveillance system will be strengthened to cover all the districts. This system is working in coordination with the Central National Lab.

Advocacy communication social mobilization

A communication and social mobilization plan will be developed with details on activities, timelines, responsibilities and a budget. Mutually reinforcing approaches of advocacy, social mobilization and behaviour change communication will be used for communication and social mobilization. The Advocacy, Communication and Social Mobilization (ACSM) sub-committee will also be responsible for addressing any rumours or adverse events reports that may arise about the vaccines. Public information and education on the introduction of rubella vaccines will be critical to the success of the introduction. The program in conjunction with UNICEF a vaccine awareness study aimed at establishing caregiver's knowledge of the EPI vaccine schedule and when to come for the next dose of the vaccine. The results showed a high level of awareness of the benefits of polio vaccine relative to the other interventions since much was done for polio eradication and the same model will be applied to raise the community awareness on the introduction of the new vaccines and strengthen the existed structures of the immunization services over all.

Supervision and monitoring

- The coverage of the MR vaccines will be reported through the existing EPI information system along with the other traditional vaccines starting from the service delivery site, districts, states to the National level, using the updated monthly reporting formats. Continuous monitoring for timely, complete reporting and regular feedback is routinely implemented in the EPI (identified deadlines date for reporting and feedback). Regular supervision visits will be implemented for all levels as planned using the updated Data Quality Self-assessment Tool (DQS) to monitor the quality index of the services and to verify the accuracy of the reported data at each level. Monitoring charts will be updated to include the new vaccines through which coverage is monitored against the planned coverage and drop-out rates are calculated. Supportive supervision visits using special check list will be performed regularly and according to a plan. The DQS tool will be updated to include the new vaccine.

  The new vaccine introduction monitoring will be through:

- Monitoring the immunization coverage of the second dose of the vaccine
- Drop-out rates between doses
- < >

  Disease impact overtime using surveillance data.

- Post introduction evaluation (PIE)
- Regular evaluation meetings with sub national Zonal Management Team (ZMT) to evaluate the plan implementation, coverage, revision and update of the plan.

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

Detailed budget attached as Document No. 22.

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

The Government and partners will work in partnership to mobilise 21,748USD to cover the cost for implementation of activities for MR vaccine introuduction.

6.2.5.Technical assistance

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

The country doesnot envisage any need for technical assistance as this vaccine is a switch plan from MCV1 to MR1 and MCV2 to MR2

7. NVS Preventive Campaigns

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

Disease	Title of the assessment	Date	Results
Measles Rubella	Assessment not done	not done	not done

Please attach the Plan of Action for each campaign as Document No. 34 in Section 10.

7.1.1 Epidemiology and disease burden for Measles-Rubella

Please select at least one of the following information sources to justify RCV diseases burden results:

Epidemiological information on burden of disease:

- ☑ 1 - Rubella data from the measles case-based surveillance system (including the age distribution of rubella cases)
- ☐ 2 - Rubella seroprevalence surveys
- ☐ 3 - Congenital Rubella Syndrome (CRS) burden information, e.g. retrospective search, modelled estimates for CRS burden, prospective surveillance
- ☐ 4 - Other

7.2.Request for MR, 10 dose(s) per vial, LYOPHILISED campaign support

7.2.1. Summary for MR campaign support

When is the country planning to conduct the MR catchup campaign? **October 2018**

When is the country planning to introduce MR into routine immunisation? **December 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 this issue.

Please give a summary of the cMYP and/or the MR, 10 dose(s) per vial, LYOPHILISED introduction plan sections that refer to the introduction of MR, 10 dose(s) per vial, LYOPHILISED. Outline the key points that informed the decision-making process (data considered etc) and describe the plans for social mobilisation and microplanning, including strategies for insecure or hard-to-reach areas. If they are included in the introduction plan or plan of action, please cite the sections only.

In spite of the high measles vaccination coverage in the country (70-84%), there were measles outbreaks with lab confirmed measles and rubella cases detected at age group above 5 years old but no measles case associated deaths were reported in all Zobas. There were 145 measles cases in 2011; 304 in 2012, 418 in 2013, zero cases in 2014. As of September 2015, 87 suspected measles cases were reported to the national Lab, out of which 34 were positive for measles Igm (confirmed cases). These cases were thoroughly investigated; more than 80% of the reporting zobas have sent blood specimens to the National laboratory.

Most of the confirmed cases (78%) are in age group above 15 years, only 1 case was below 5 years. The majority of the positive cases were reported from Zoba Gash Gash Barka sub-zobas, Akordet and from Zoba NRS Afabet, kerkebet and Habero. Of the total cases more than 82% of the measles cases are adolescent's age groups. These are adults who were likely not immunized when the program was not well established and working in all areas or did not seroconvert after their vaccination.

Appropriate measures were put in place to control the outbreaks. The community was sensitized, mass immunization of children less than 15 years old was taken. Overall, the shift is indicative of the good performance of the EPI programme and measles vaccine potency is provided in good condition. Indeed these sub-zobas have low immunization coverage as compared to the national average. These indicates us the need to revise immunization target group for measles. In 2014 national level measles annualized investigation rate sustained at 2.5/100,000 population. As of September 2015, annualized measles detection rate was 4.3/100,000 and meets the minimum target 1 per 100,000 populations.The immunization program in Eritrea, aims to reduce infant mortality and morbidity from vaccine preventable diseases by integrating new vaccines into the national immunization services. **Refer cMYP page and attachment 34**

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. Please describe how the surge capacity for campaigns will be managed. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled. The Independent Review Committee requires assurance that the cold chain is ready or will be ready for the campaign, and evidence/plans need to be provided (if they are included in detail in the plan of action, please cite the section here). **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. Please note that all Gavi-financed cold chain equipment needs to be WHO pre-qualified. The purchase of non-PQS equipment will only be considered on exceptional basis, with justification and advance agreement from Gavi.

No changes are anticipated to the current cold chain capacity as the unit pack of MR vaccine is the same as MCV. A recent nationwide cold chain assessment (April, 2016) showed sufficient cold chain capacities at national, sub national stores and health facility level with few obsolete and none standard cold chain equipment. The country has applied a recent of cold chain equipment, operationalization platform application for GAVI support with main objective of replacing the obsolete and none standard ones at service level. In the updated cold chain inventory, there is adequate stoage capacity at district levels, At regional and National level in consideration of the new vaccines to be introduced namely HPV, IPV and vaccines for SIAs shortly the counry has prepared adeqae storage for these also.

The country need for routine MR vaccines and injection supplies are calculated according to the target population considering the number of doses, wastage rate and buffer stock for the vaccine. The same method

is also applied at the regions, districts and health facilities to come up with required amount of vaccines needed for a month or a quarter. Distribution of vaccines is done in pull system to lower level based on their request. But starting from 2018 onwards the program has planned to change it into push system to monitor the available stock valance of vaccines at sub level and to monitor overstock and stock out status of all the vaccines. After the first year of introduction, necessary revisions and updates will be considered on the vaccine management. The Immunization program has regular and continuous planning activities on renewal, rehabilitation and maintenance of cold chain equipment at all levels. Vaccine stock management training has been conducted at lower levels as part of the EPI routine plan. Vaccine ledgers and recording forms are standard and all health workers will be trained on recording the vaccines. Using the WHO tools, quantity of the new vaccine is calculated considering that vaccine will be shipment from abroad.

The country has installed additional one cold room at central vaccine store and zoba Maekel to have additional storage capacity and use it also as a back-up. Currently, there is a net storage capacity of 26,000L net positive storage at national level and 25,240 capacity at zonal levels. Hence, the country has a total of 51,240LLts which is estimated to be enough storage capacity to store all vaccine of the routine and including the measles/rubella campaign doses. In accordance with five year plan, the EPI program has renewed efforts to reduce wastage of EPI vaccines since the cost of new vaccines and quantity of the vaccines in the routine program are increasing. The wastage rates among new and traditional vaccines have been developed and will be monitored wastage rates according to the WHO recommended estimates. EPI monitoring tools are also in place. Consumption and wastage of the vaccine will be calculated after the introduction of the new vaccine in a regular base.

Please describe how the campaign activities will contribute to strengthening routine immunisation services. Please refer to specific activities to be undertaken during planning and implementation, to evaluate the implementation of the routine strengthening activities completed during the campaign, and to assess, via an independent survey, the quality and coverage achieved through the campaign.

Supervision

Supervisors from all levels will actively visit sites to monitor, assist, take corrective actions on spot and take up issues to the next level for further action if needed. Supervisors from the national level shall visit all zobas and at least 50% of the districts during the campaign and zonal supervisor will visit each districts in their respective zobas and vaccination sites in the districts.

Pre campaign Readiness Assessment for hard to reach communities

Hard to reach areas and nomadic population will be visited by the national and zonal teams. less accessib geogrphical areas will be cheked moniitored how they will be visted, means of transport for them and mapping where they especially for nomadic population groups. Several households, schools etc. will be interviewed 2–3 days before the campaign to ascertain parents' awareness about the campaign, dates, target group and the nearest site using a WHO standardized tool.

Assessment during the implementation phase

During the implementation of the campaign the supervisors will verify that campaign personnel at various levels understand their task, identify any constraints and work with campaign committee members and the local community to address them. Furthermore, the campaign supervisors shall discuss plans with coordinators every day and observe vaccination teams in action. In addition supervisors will conduct rapid convenience survey to determine awareness and participation in the campaign especially in hard to reach areas. The survey will also assess non-compliance or resistance to the campaign. Supervisors will also compile a daily report for the sites allocated which forms a regional report at the end of the exercise. During in process, Independent Monitors will be engaged to verify the immunization status of children in households and schools. A standardized monitoring tool will be used.

Monitoring of Adverse Events Following Immunization

It is anticipated that with any new vaccine introduction, increased awareness of the vaccine will contribute to an increase in reporting of adverse events, even if they are not serious. Nevertheless, healthcare providers should be aware of the probable AEFI and be prepared to manage them. Healthcare providers will be re-sensitized on AEFI reporting and management during pre-introduction trainings to reinforce knowledge and skills in this program area. Each adverse event will be investigated and efforts made to determine the cause and managed appropriately. A communication plan for managing and responding to any possible AEFI will be developed, including identification of focal points at various levels. The AEFI committee will be responsible for

the AEFI communication.

The existed system of reporting and investigating adverse events following immunization (AEFI) of vaccines will be used. During the training and orientation of health workers, EPI focal persons, participants from line ministries and local partners in the measles rubella campaign, particular attention will be given to adverse event identification and reporting. Suspected adverse events including injection abscess and encephalitis will be reported and managed appropriately; the AEFI forms will be made available at each post for reporting and investigation of AEFI during the campaign. Each team will be supplied with basic emergency kits for any unseen features during administration of MR vaccine to a child.

Evaluation of the Campaign

A post campaign coverage survey will be conducted by independent monitoring group (IM) to validate administrative reported coverage. This will also integrate and compare with routine overage survey. Training will be provided for the monitors of the end process evaluation. The qualitative and quantitative data collected will be analyzed and compiled into a reporting form. The Evaluation will be done during the campaign and also after the campaign. Zonal measles rubella campaign coordinating committee members and other observers will participate in a post campaign review meeting and a summary report will be prepared based on the tools used for assessment. The results will be used to evaluate the preparation and implementation process of the campaign. Furthermore, the lessons learned will be used to improve subsequent campaigns and routine immunization. A comprehensive report on the MR campaign with coverage, strengths, challenges, opportunities, financial expenditure will be produced and disseminated to ICC members and stakeholders at various staggered meetings to use it as reference.

Please describe any plans for expanding measles surveillance to include rubella and plans for the introduction of Congenital Rubella Syndrome (CRS) surveillance.

Sustaining measles rubella case based surveillance performance indicators is a challenge in maintaining the elimination status. In order to maintain the status quo, continuous training and sensitization of health workers including medical doctors, laboratory technician will be conducted to engage in activities to strengthen community based surveillance, supportive supervision and monitoring activities.

The training of the MR campaign will be used to update the skills awareness of the health workers by providing an opportunity to train on measles rubella case based surveillance plan and taking an appropriate response actions in case an outbreak happen.

The country has planned to introduce Congenital Rubella Syndrome (CRS) surveillance following the MR campaign and introduction.

Please submit relevant documentation to support the estimates of the size of the campaign target population (as DOCUMENT NUMBER : 18).

7.2.2. Grant Support for Operational Costs of the MR Campaign

Table 7.2.2: calculation of grant to support the operational costs of the campaigns

Year of MR support	Total target population (from Table 5.5)	Gavi contribution per target person in US$	Total in US$
2018	1,562,025	0.65	1,015,316

[1] The Grant is currently based on a maximum of US$0.65 per targeted person. It should be noted that for campaign applications submitted from January 2017 onwards and for all campaigns planned for implementation in 2018 onwards this grant will be adjusted according to transition stage of the country. Countries will be responsible for providing the balance of operational funds in excess of US$0.65 per child. Countries in preparatory transition phase (Phase 1) will be provided with $0.55 per targeted person, and countries which have entered accelerated transition phase (Phase 2) $0.45 per targeted person. For low income countries, the amount will remain at $0.65 per targeted person.

[2] Please add a line for each calendar year for SIAs being implemented over different years.

Please describe how the grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population (refer to the cMYP and the Vaccine Introduction Plan).

The grant will be used to facilitate the effective implementation of MR catch-up campaign by preparing detailed micro plans at sub national and sub national levels to identify and reach all children . The grant will be used to provide training to health workers, monitor cold chain status, conduct assessment before the start

of the campaign. The fund will also be used to mobilise the community to participate and utilize the services and to identify hard to reach areas and nomadic population. The grant will also be used to strengthen surveillence and AEFI , safe disposal of injection safety materials. Please refer to the MR introducion plan attached**.**

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

The transport cost of the campaign is expensive hence the Government will made fuel subsidy and transport support to cover especially the hard to reach and less accessible geographical areas**. Commiunity members and local CSO will give support on transport of camels to carry EPI logistics to less accsible areas also Refer attachment 34**

Please complete also 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.

7.2.3 Introduction planning for RCV

Countries should describe their plan for introduction including surveillance activities:

Does Eritrea's cMYP include a plan for the introduction of RCV into the national programme? **Yes**

Please attach the Introduction Plan for the introduction of RCV into the national programme as **Document number 12** in Section 10 and also attach the Plan of Action for the campaign as **Document number 34** in Section 10. Please refer to the Gavi application guidelines for required components in the introduction plan and plan of action.

The plan for introductoin of RCV into the national programme is attached as document number 34

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):

Like the other vaccines in the immunization program, the new MR vaccine will be procured through UNICEF supply division. The vaccine will be administered using the auto-disable syringes and safety boxes, these injection safety materials will be distributed along with the vaccine as a bundled supply. The EPI plan for injection safety includes among others the following major activities to ensure injection safety practices; The national policy of waste disposal is either incineration or burn and bury so all facilities will be required to follow this policy. All vaccines will be procured and bundled with adequate supply of AD syringes and safety boxes.

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.

The country has instituted a mechanism whereby any new vaccine is registered prior its introduction by the National Food and Drug Administration (NFDA) division of Ministry of health. Manufacturer registration or national vaccine licensure is not needed as the country procures vaccines through UNICEF from WHO prequalified vaccine manufacturers. Hence the country has accepted the expedited procedure for national registration of WHO prequalified vaccines. The MR vaccine is registered and is accepted for introduction in 2018 by NFDA of MoH.

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 financial support for campaign or VIG should be transfered to Ministry of health, Project Management Unit in the National bank. The banking informaiton is uploaded in item no. 12. the budget breake down will be prepared by the program manager and will be endorsed by Minister before trasfering it to the zobas to implement it according the activity line prepared at national level. some of the budget will remain at national level for microplaing and providing ToT for zonal management team.

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

The Ministry of health is responsible for transfer of the cofinancing amount to UNICEF account as of the procedure of new vaccine of GAVI support. It will follow the same protocol as the previous exercise.

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

The financial management procedure will follow the same financial management procedure as the existing GAVI HSS II grant and VIGs. The procurement procedure will also follow the existing GAVI HSS II grant and VIGs procedures.

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

The coverage of the MR vaccines will be reported through the existing EPI information system along with the other traditional vaccines starting from the service delivery site, districts, states to the National level, using the updated monthly reporting formats. Continuous monitoring for timely, complete reporting and regular feedback is routinely implemented in the EPI (identified deadlines date for reporting and feedback). Regular supervision visits will be implemented for all levels as planned using the updated Data Quality Self-assessment Tool (DQS) to monitor the quality index of the services and to verify the accuracy of the reported data at each level. Monitoring charts will be updated to include the new vaccines through which coverage is monitored against the planned coverage and drop-out rates are calculated. Supportive supervision visits using special check list will be performed regularly and according to a plan. The DQS tool will be updated to include the new vaccine.

The new vaccine introduction monitoring will be through:

- Monitoring the immunization coverage of the second dose of the vaccine
- Drop-out rates between doses
- Disease impact overtime using surveillance data.
- Post introduction evaluation (PIE)
- Regular evaluation meetings with sub national Zonal Management Team (ZMT) to evaluate the plan implementation, coverage, revision and update of the plan.

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)

9.2.1 Procurement and Management for MR, 10 dose(s) per vial, LYOPHILISED campaign

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

The Country will procure vaccines and injection supplies through UNICEF only.

b) Please describe the financial management procedures that will be applied for the management of the preventive campaign cash support, including any procurement to be incurred.

The existing financial management procedures applied for GAVI HSS II will be used to manage the catch-up campaign cash support including procurement campaign item. PMU wil use the same procedure as other GAVI and Global funds management protocol.

c) Please indicate if the campaign is going to be phased, and if so, how this will be done.

The campaign is going to be conducted at the same time. it is not going to be a phased approach.

d) Please outline how coverage of the campaign will be monitored, reported and evaluated (refer to the cMYP and/or the MR, 10 dose(s) per vial, LYOPHILISED campaign introduction plan)

A post campaign coverage survey will be conducted by independent monitoring group (IM) to validate administrative reported coverage. This will also integrate and compare with routine overage survey. Training will be provided for the monitors of the end process evaluators. The qualitative and quantitative data collected will be analyzed and compiled into a reporting form. The Evaluation will be done during the campaign and also after the campaign. Zonal measles rubella campaign coordinating committee members and other observers will participate in a post campaign review meeting and a summary report will be prepared based on the tools used for assessment. The results will be used to evaluate the preparation and implementation process of the campaign. Furthermore, the lessons learned will be used to improve subsequent campaigns. A comprehensive report on the MR campaign with coverage, strengths, challenges, opportunities, financial expenditure will be produced and disseminated to ICC members and stakeholders at various staggered

meetings to use it as reference.

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 country has instituted a mechanism where by any new vaccine is registered prior its introduction by the National Food and Drug Administration (NFDA)division of Ministry of health. Manufacurer registration or national vaccine licensure is not needed as the country procures vaccines through UNICEF from WHO prequalified vaccine manufacturers. Hence the country has accepted the expedited procedure for national registration of WHO prequalifed vaccines. The MR vaccine is registered and is accepted for introduction in 2018 by NFDA of MoH.

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 MR vaccine is registered and is accepted for introduction in 2018 by NFDA of MoH. MR 10 lypholised vaccine is registered by NFDA.

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 Eritrea all vaccines are procured through UNICEF Supply Division. Any import by UNICEF is tax free and custom clearance is facilitated by the Government. THere is no requirement that may cause potential delaysin recieving the vaccine on time. Previous procurements through UNICEF were all tariff free.

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 NRA is under the Ministry of health refered as National food and drug adminstration division.

The Director is called Mr. Iyasu Bahta.

Telephone +291-1-125393 or +291-7321705

email= bahtassy@gmail.com

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).

Non-reusable auto-disable (AD) syringes will be used for all injections during the campaign. Disposal safety boxes will be supplied to all posts. Training will include use of auto-disable syringes and their safe disposal. Supervisory teams will monitor the correct use and disposal of the syringes during the campaign and post-campaign time. All used syringes will be kept in safety boxes and will be transported to where necessary and appropriate incineration, and places where there no incineration burning and burying of injection materials will made or will be transported to the areas where there is incinerators.

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
40	Post Campaign Coverage Survey report for MR catch-up applications	5.1.x	Document not available.docx **File desc:** **Date/time :** 05/05/2017 07:40:51 **Size:** 11 KB
41	cMYP addendum on measles and rubella		Addendum for cMYP for MR Introduction.docx **File desc:** **Date/time :** 19/05/2017 07:28:01 **Size:** 468 KB
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	GOE MOF signature.pdf **File desc:** **Date/time :** 05/05/2017 07:41:57 **Size:** 311 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	GOE MOF signature.pdf **File desc:** **Date/time :** 05/05/2017 07:42:37 **Size:** 311 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	ERI ICC ToR.pdf **File desc:** **Date/time :** 03/05/2017 02:57:27 **Size:** 167 KB
5	Minutes of Coordination Forum meeting endorsing Proposal	4.1.3	ICC Meeting 28 April 2017.docx **File desc:** **Date/time :** 03/05/2017 02:58:14 **Size:** 17 KB
6	Signatures of Coordination Forum members in Proposal	4.1.3	Untitled (009).pdf **File desc:** **Date/time :** 03/05/2017 02:59:19 **Size:** 91 KB
7	Minutes of the Coordination Forum meetings from the past 12 months before the proposal	4.1.3	ICC JA Endorsing_Meeting .doc **File desc:** **Date/time :** 03/05/2017 03:00:15 **Size:** 39 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	ERI NITAG.docx **File desc:** **Date/time :** 18/05/2017 06:25:14 **Size:** 33 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.		ICC Meeting 28 April 2017.docx **File desc:** **Date/time :** 03/05/2017 03:01:18 **Size:** 17 KB

31	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	No NITAG meeting conducted as NITAG not established.docx **File desc:** Selection of NITAG members is underway in consultation with Higher ofifcials and acadmicians. The Final ToR for them is attached for your referenc **Date/time :** 04/05/2017 01:11:00 **Size:** 11 KB
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.		Confirmation letter.pdf **File desc:** **Date/time :** 05/05/2017 07:38:30 **Size:** 151 KB
Planning, financing and vaccine management			
9	Comprehensive Multi Year Plan - cMYP	5.1	ERI cMYP 2017-2021.doc **File desc:** **Date/time :** 19/05/2017 07:21:41 **Size:** 1 MB
10	cMYP Costing tool for financial analysis	5.1	Eritrea Nov 23 cMYP_Costing_Tool_V3.9.3.xlsx **File desc:** **Date/time :** 04/05/2017 02:38:18 **Size:** 3 MB
11	M&E and surveillance plan within the country's existing monitoring plan	5.1.4	Attach # 5 HSS M&E Framework(Performance framework).xlsx **File desc:** **Date/time :** 05/05/2017 09:29:09 **Size:** 48 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	ERI Budgeting and Planning Template MR Catch-up Campaign.xlsm **File desc:** **Date/time :** 22/05/2017 08:12:25 **Size:** 1 MB
14	Annual EPI Plan with 4 year forward view for measles and rubella		MR 5 years plan.docx **File desc:** **Date/time :** 04/05/2017 02:42:50 **Size:** 14 KB
18	Campaign target population documentation	8.x.1, 6.x.1	Eritrea -Population Size 2000- 2022.xlsx **File desc:** **Date/time :** 05/05/2017 09:23:10 **Size:** 317 KB
20	Improvement plan based on EVM	9.3	Eritrea_CCEOP application_Progress report on EVM Improvement Plan and Work Plan.doc **File desc:** **Date/time :** 04/05/2017 03:12:33 **Size:** 258 KB
21	EVM improvement plan progress report	9.3	EVMA 2012 Recommondations Implementation Status March 2017.pdf **File desc:** **Date/time :** 05/05/2017 09:26:25 **Size:** 132 KB

22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2,6.x.2,8.2.3	ERI Budgeting and Planning Template MR Catch-up Campaign.xlsm **File desc:** **Date/time :** 22/05/2017 08:10:53 **Size:** 1 MB
32	Data quality assessment (DQA) report	5.1.4	Data Quality Audit.docx **File desc:** **Date/time :** 19/05/2017 07:13:24 **Size:** 13 KB
34	Plan of Action for campaigns	8.1, 8.x.4	ERI MR Campaign Proposal and Plan of Action for_2018.docx **File desc:** **Date/time :** 19/05/2017 07:17:44 **Size:** 183 KB
37	Evidence of self-financing MCV1	5.1.5	Confirmation letter.pdf **File desc:** **Date/time :** 05/05/2017 07:53:10 **Size:** 151 KB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	No file loaded
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
19	EVM report	9.3	EVM Report 2012.pdf **File desc:** **Date/time :** 22/05/2017 08:22:36 **Size:** 2 MB
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	No file loaded
35	Other		ERI HSSDP II.pdf **File desc:** **Date/time :** 22/05/2017 08:24:46 **Size:** 2 MB Minutes on_strenghening Rota and PBM sentinel site_21__06__2016.pdf **File desc:** **Date/time :** 22/05/2017 08:26:00 **Size:** 63 KB #14.1 ICC meeting attendace_Jan 2016.pdf **File desc:** **Date/time :** 22/05/2017 08:27:35 **Size:** 386 KB #14_Minutes of ICC meeting_Jan 2016.pdf **File desc:** **Date/time :** 22/05/2017 08:31:02 **Size:** 186 KB
36	Strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control		No file loaded
39	Epidemiological analysis/evidence	8.3.1	No file loaded

11. Annexes

Annex 1 - NVS Routine Support

Annex 1.1 MR, 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	2021
Number of vaccine doses	#				
Number of AD syringes	#				
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#				
Total value to be co-financed by the Country *[1]*	$	113,011	95,641	101,521	107,341

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	2021
Number of vaccine doses	#	0	0	0	0
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 Gavi	$	156,300	131,074	139,152	147,131

Table Annex 1.1 D: Estimated numbers for MR, 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*	44.32 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	92,941	41,194	51,747
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	87,474		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	180,415	79,965	100,450
E	Estimated vaccine wastage factor	*Table 5.2*	1.67		
F	Number of doses needed including wastage	*D x E*	301,294	133,542	167,752
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]*	75,324	33,386	41,938
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	376,700	166,964	209,736
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	281,313	0	281,313
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	41,437	0	41,437
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	3,551	0	3,551
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	248,190	110,005	138,185
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	10,128	0	10,128
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	1,271	0	1,271
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	1,637	0	1,637
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	6,781	3,006	3,775
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	1,304	0	1,304
T	Total fund needed	*(N+O+P+Q+R+S)*	269,311	113,011	156,300
U	Total country co-financing	*I x country co-financing per dose (cc)*	113,010		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	44.32 %		

Table Annex 1.1 D: Estimated numbers for MR, 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*	44.32 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	96,626	42,828	53,798
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	92,132		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	188,758	83,663	105,095
E	Estimated vaccine wastage factor	*Table 5.2*	1.67		
F	Number of doses needed including wastage	*D x E*	315,226	139,717	175,509
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]*	3,483	1,544	1,939
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	318,800	141,301	177,499
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	211,466	0	211,466
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	35,068	0	35,068
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	2,712	0	2,712
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	210,043	93,097	116,946
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	7,613	0	7,613
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	1,076	0	1,076
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	1,250	0	1,250
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	5,739	2,544	3,195
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	994	0	994
T	Total fund needed	*(N+O+P+Q+R+S)*	226,715	95,641	131,074
U	Total country co-financing	*I x country co-financing per dose (cc)*	95,640		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	44.32 %		

Table Annex 1.1 D: Estimated numbers for MR, 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*	44.32 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	101,642	45,051	56,591
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	98,177		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	199,819	88,565	111,254
E	Estimated vaccine wastage factor	*Table 5.2*	1.67		
F	Number of doses needed including wastage	*D x E*	333,698	147,904	185,794
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]*	4,618	2,047	2,571
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	338,400	149,988	188,412
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	224,881	0	224,881
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	37,224	0	37,224
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	2,884	0	2,884
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	222,956	98,820	124,136
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	8,096	0	8,096
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	1,142	0	1,142
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	1,330	0	1,330
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	6,092	2,701	3,391
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	1,057	0	1,057
T	Total fund needed	*(N+O+P+Q+R+S)*	240,673	101,521	139,152
U	Total country co-financing	*I x country co-financing per dose (cc)*	101,520		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	44.32 %		

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

		Formula	2021		
			Total	Government	Gavi
A	Country co-finance	*V*	44.32 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	106,862	47,365	59,497
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	104,488		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	211,350	93,676	117,674
E	Estimated vaccine wastage factor	*Table 5.2*	1.67		
F	Number of doses needed including wastage	*D x E*	352,955	156,439	196,516
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]*	4,815	2,135	2,680
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	357,800	158,587	199,213
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	237,782	0	237,782
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	39,358	0	39,358
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	3,049	0	3,049
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	235,738	104,486	131,252
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	8,561	0	8,561
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	1,208	0	1,208
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	1,406	0	1,406
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	6,441	2,855	3,586
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	1,118	0	1,118
T	Total fund needed	*(N+O+P+Q+R+S)*	254,472	107,341	147,131
U	Total country co-financing	*I x country co-financing per dose (cc)*	107,340		
V	Country co-financing % of Gavi supported proportion	*U / (N + R)*	44.32 %		

Annex 2 - NVS Routine – Preferred Second Presentation

No NVS Routine – Preferred Second Presentation requested this year

Annex 3 - NVS Preventive campaign(s)

Annex 3.1 - NVS Preventive campaign(s) (MR, 10 dose(s) per vial, LYOPHILISED)

Table Annex 3.1 C: Summary table for CAMPAIGN MR, 10 dose(s) per vial, LYOPHILISED

	Source		2018
Total target population	Table 5.2	#	1,562,025
Number of doses per persons	Parameter	#	1
Estimated vaccine wastage factor	Table 5.2	#	1.18
Wastage Rate	Table 6.2.2	#	15
Number of doses per vial	Parameter	#	10
AD syringes required	Parameter	#	Yes
Reconstitution syringes required	Parameter	#	Yes
Safety boxes required	Parameter	#	Yes
AD syringe price per unit	Table Annexes 4A	$	0.036

Reconstitution syringe price per unit	Table Annexes 4A	$	0.031
Safety box price per unit	Table Annexes 4A	$	0.461
Freight cost as % of vaccines value	Table Annexes 4B	%	2.73%
Freight cost as % of devices value	Parameter	%	10.00%

Table Annex 3.1 D: Estimated numbers for MR, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 1)

		Formula	2018		
			Total	Government	Gavi
B	Total target population	*Table 5.3.1*	1,562,025	0	1,562,025
C	Number of doses per persons	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	1,562,025	0	1,562,025
E	Estimated vaccine wastage factor	*100 / (100 - Vaccine wastage rate)*	1.18		
F	Number of doses needed including wastage	*D x E*	1,843,190	0	1,843,190
G	Vaccines buffer stock	*0*	0	0	0
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	1,843,200	0	1,843,200
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	1,718,228	0	1,718,228
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	202,753	0	202,753
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	21,131	0	21,131
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	1,214,399	0	1,214,399
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	61,857	0	61,857
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	6,219	0	6,219
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	9,739	0	9,739
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	33,178	0	33,178
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	7,782	0	7,782
T	Total fund needed	*(N+O+P+Q+R+S)*	1,333,174	0	1,333,174

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

Annex 4

Table Annex 4A:Commodities costs

Estimated prices of supply are not disclosed

Vaccine	Presentation	2017	2018	2019	2020
MR, 10 dose(s) per vial, LYOPHILISED	10	0.659	0.659	0.659	0.659
MR, 10 dose(s) per vial, LYOPHILISED in second dose	10	0.659	0.659	0.659	0.659

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)

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2018	2019	2020
MR, 10 dose(s) per vial, LYOPHILISED	MR	2.73 %		
MR, 10 dose(s) per vial, LYOPHILISED in first dose	MR1	2.73 %	2.73 %	2.73 %
MR, 10 dose(s) per vial, LYOPHILISED in second dose	MR2	2.73 %	2.73 %	2.73 %

Vaccine Antigen	Vaccine Type	2021
MR, 10 dose(s) per vial, LYOPHILISED in first dose	MR1	2.73 %
MR, 10 dose(s) per vial, LYOPHILISED in second dose	MR2	2.73 %

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

Vaccine	2018	2019	2020
MR, 10 dose(s) per vial, LYOPHILISED in second dose	0.3	0.3	0.3

Vaccine	2021
MR, 10 dose(s) per vial, LYOPHILISED in second dose	0.3

12. Banking Form

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

Name of Institution (Account Holder):	Proiect Management Unit (PMU) MoH		
Address:	Asmara Eritrea		
City Country:	As		
Telephone no.:	Asmara	**Fax no.:**	291-1-124357
	Currency of the bank account:		USD
For credit to:			
Bank account's title:	PMU/MoH GAVI HSS (c)		
Bank account no.:	1201220162		
Bank's name:	Bank of Eritrea		

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

By who is the account audited? Goeneral Auditor

Signature of Government's authorizing official

		Seal
Name:	Amina Nurhussine	
Title:	Minister of Health	
Signature:		
Date:	5/4/2017	

FINANCIAL INSTITUTION		**CORRESPONDENT BANK (In the United States)**
Bank Name:	Bank of Eritrea	GAZPRSTO of BANK (OPEN JOINT) STOCK CAMPANY
Branch Name:	-	
Address:	-	
City Country:	Asmara Eritrea	MOSCOW, RUSSA
Swift Code:	S.W.I.F.T.	GAZPRO OF XXX
Sort Code:	-	
ABA No.:	-	
Telephone No.:	00291 1 127991	
FAX No.:	00291 1 122091/98	

I certify that the account No 1201220162 is held by BANK OF ERITREA at this banking institution

The account is to be signed jointly by at least 3 (number of signatories) of the following authorized signatories:

1		
	Name:	Mr. Yemane Teadel
	Title:	Director General of Administration and Finance
2		
	Name:	Mr. Tsehaye Tsegay
	Title:	Adminstratio and Finance Head of PMU
3		
	Name:	Dr. Eyob Tekle
	Title:	Director of PMU

Name of bank's authorizing official	
ZERE SEYOUN	
Signature:	
Date:	5/4/2017
Seal:	