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All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds. | | **AMENDMENT TO THE APPLICATION** | | The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application. GAVI Alliance will provide the necessary documents for the approved change, and the country's request will be duly amended. | | **RETURN OF FUNDS** | | The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance. | | **SUSPENSION/ TERMINATION** | | The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purposes other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. GAVI Alliance reserves the right to terminate its support to the Country for the programs described in this proposal if GAVI Alliance receives confirmation of misuse of the funds granted by GAVI Alliance. | | **ANTICORRUPTION** | | The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice. | | **AUDITS AND RECORDS** | | The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country. | | The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the Gavi Alliance in connection with any audit. | | **CONFIRMATION OF LEGAL VALIDITY** | | The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations 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 ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY** | | The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein. | | **Use of commercial bank accounts** | | The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event. | | **ARBITRATION** | | Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. | | The languages of the arbitration will be English or French. | | For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The Gavi Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson. | | The GAVI Alliance will not be liable to the country for any claim or loss relating to the 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. | | | |

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Banking form*](#BankingForm) | | | | |  | | |

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Executive Summary** | | |  | | |  |  |  |  | | --- | --- | --- | --- | | [Please provide a summary of your country's proposal, including the following the information:](#ApplicationSpecification) | | | | |  |  |  |  | |  | [For each specific request, NVS routine support or NVS campaign :](#ApplicationSpecification) | | | |  |  | Duration of support | | |  |  | The total amount of funds requested | | |  |  | Characteristics of vaccine(s), if necessary, and the reason for the choice of the format | | |  |  | Month and year of planned introduction of the vaccine | | |  | | | | |  | Relevant baseline data, including: | | | |  |  | DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form) | | |  |  | Birth cohort, targets and immunisation coverage by vaccines | | |  | | | | |  | Country preparedness | | | |  |  | Summary of the EPI assessment report and progress report on the implementation of the planned improvements | | |  | | | | |  | The nature of stakeholders' participation in developing this proposal | | | |  |  | Inter-Agency Coordinating Committee | | |  |  | Partners, including CSO involvement | | |  | | | | | **EXECUTIVE SUMMARY**  Vaccine-preventable diseases remain a major public health problem in several developing countries, including CAR. CAR has recorded seasonal epidemics of Meningococcal A meningitis (NmA) with a mortality rate of between 12 and 19%.  In order to fight these epidemics, in 2016 the country will conduct a preventive campaign using MenAfriVac® throughout domestic territory. It will cover the population from 1 to 29 years of age.  This campaign will be followed by the implementation of a case by case bacterial meningitis surveillance system at the national level.  In order to prevent recurring Meningococcal A meningitis epidemics, CAR, with the support of its technical and financial partners, specifically Gavi Alliance, WHO and UNICEF, decided to introduce the MenAfriVac® vaccine into its routine immunisation program in February 2017.  The purpose of introducing this vaccine is to contribute to the elimination of Meningococcal A meningitis as a public health issue in CAR.  The overall objective is to strengthen the immunity of the population to Meningococcal A meningitis.  The specific objectives are:   * To organise a catch-up campaign in order to immunise at least 95% of the population 1 to 29 years of age in November 2016; * To introduce MenAfriVac into routine immunisation in February 2017 and to immunise at least 60% of children 9-11 months old.   The target population for the mass campaign represents 71% of the total population, i.e. 3,604,558. The target population for routine immunisation is children 9-11 months old, i.e. a cohort of surviving infants (158,195).  The vaccine will be administered simultaneously with the measles and yellow fever vaccines (VAA).  The program will also seek to achieve 100% vaccine supply at all levels during the specified period.  Before introduction of the vaccine, the EPI administrative forms were revised as of August 2015, following the introduction of the inactivated polio vaccine (IPV)  The official launch and introduction of MenAfriVac® into routine immunisation is planned for February 2017.  The CAR has good experience in introducing new vaccines. For example, as part of Gavi's support to the introduction of new vaccines in routine EPI, the CAR introduced the pentavalent vaccine (DTP-HepB-Hib) in 2008 and the Pneumococcal vaccine (PCV13) in 2011. The conclusions and recommendations of the external review of the EPI conducted in 2012, as well as the various Post-introduction Evaluations will be taken into account in the framework of the MenAfriVac introduction.  Cold-chain capacity has been increased at the national level thanks to the purchase and installation of a new positive cold room with gross capacity of 30m3. Two hundred (200) solar refrigerators (150 from UNICEF and 50 from WHO) are currently being deployed at the Health Region and District level. Absorption refrigerators are gradually being replaced with solar refrigerators with a high capacity for vaccine storage, so that the introduction of new vaccines may continue. Reprogramming of the GAVI-HSS 2014-2015 support plan towards the strengthening of the EPI will help improve the provision of immunisation services.  In order to achieve the objectives for introducing this new vaccine, the following strategies have been defined:   * Improving the skills of health workers; * Reinforcing the logistical capabilities of the EPI; * Improved vaccine and supply management; * Improving the management of waste; * Revising the EPI management tools; * Improving communication to benefit the EPI; * Strengthening of AEFI surveillance; * Improving meningitis surveillance data; * Improving the partnership.   Monitoring-evaluation of the introduction of MenAfriVac® will be carried out at all levels of the health system (central, regional and district). It will consist of monitoring vaccine coverage, monitoring the evolution of non-immunised children and conducting an evaluation post-introduction of the vaccine.  The estimated budget for the immunisation campaign totals 2,979,558,265 CFA francs, i.e.4,965,930.44 **$US** including  2,342,948.50 **$US** for operating expenses and 2,622,981.94 **$US** for the cost of vaccines and injection supplies.  The estimated budget for the introduction of the MenAfriVac vaccine into the routine EPI totals 492,642.26 $US broken down to 333,259.89 $US for operating expenses and 159,382 $US for the cost of vaccines and injection supplies.  - Duration of funding: 2016 - 2017  - Total amount of funds requested   2,342,948.50 **$US** for operating expenses of the campaign and 126,556 **$US** for the introduction of the vaccine into the routine EPI  **Features of the vaccine**:  The company chose two types of vaccine, MenAfriVac® 5 µg which will be used in the routine EPI and MenAfriVac® 10 µg for preventive campaigns.  MenAfriVac®, a conjugated Meningococcal A vaccine manufactured by the Serum Institute of India (SIL) Ltd. laboratory is a lyophilised purified polysaccharide vaccine, covalently bonded to the tetanus anatoxin (TA) which acts as a carrier protein.  The vaccine contains bacterial polysaccharide specific to the Group from Neisseria meningitidis A. The TA is prepared by extraction, purification with ammonium sulfate and deactivation of the toxin with formalin from the Clostridium tetani culture.  - Month and year of introduction: For the mass campaign:  October 2016 and April 2017 for introduction into the routine EPI  - Reference data  - CV Penta 3 in 2014: 45%  Birth cohort, targets and immunisation coverage by vaccine:  In 2017 routine EPI: Birth cohort: 182,132  target: 158,195  and vaccine coverage: 60%  For the 2016 preventive campaign: Population 1-29 years, target: 3,604,558 and vaccine coverage: 95%  - Summary of preparations in the country: summary of EVM evaluation and progress report on the implementation of the planned improvements  The Effective Vaccine Management Assessment (EVMA) of the national vaccine depots was conducted from August 22 to September 18, 2011 through the efforts of external evaluators from UNICEF/WCARO and UNICEF/CAR and a survey team from the Ministry of Health and Prevention. Recommendations have been made during this external evaluation and they are currently being implemented. A new evaluation will be conducted in November 2015.  Types of stakeholders:  The CAR will introduce MenAfriVac into CAR with the support of its technical and financial partners, in particular the Gavi Alliance, WHO, AMP and UNICEF, CSOs and community participation. | | | | | | |

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Signatures** | | | | | |  | | --- | | **4.1. Signatures of the Government and National Coordinating Body** | | | | | |  | | --- | | **4.1 1 The Government and the Inter-Agency Coordinating Committee (ICC) for immunisation** | | | | | |  | | --- | | The Government of Central African Republic wishes to consolidate the existing partnership with Gavi to strengthen its national routine infant immunisation program and is specifically requesting Gavi funding for: | | | | |  |  |  | |  | |  | | --- | | Meningococcal A, 10 dose(s) per vial, LYOPHILISED systematic introduction | |  | |  |  |  | | |  | | --- | | The Government of Central African Republic 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 Alliance and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application. | | | | |  |  |  | | |  | | --- | |  | | |  | | --- | | Table(s) 6.2.4 in the systematic NVS section of this application shows the amount of support in either supply or cash that is required from the Gavi Alliance. Table(s) 6.2.3 of this application shows the Government financial commitment for the procurement of this new vaccine (NVS funding only). | | |  | | |  | | --- | | Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of **December**. | | |  | | |  | | --- | | The payment of the first year of co-financed support will be due around**December** **2017** for Meningococcal A, 10 dose(s) per vial, LYOPHILISED. | | |  | | | | |  |  |  | | |  | | --- | | It should be noted that any request not signed by the Ministers of Health and Finance, or by their authorised representatives, will not be examined or recommended for approval by the Independent Examination Committee (IEC). These signatures appear in Documents Nos.: 1 and 2 in Section 10. Attachments | | | | |  |  |  | | |  |  |  |  | | --- | --- | --- | --- | | **Minister of Health (or delegated authority)** | | **Minister of Finance (or delegated authority)** | | | **Name** | Dr Marguerite SAMBA MALIAVO | **Name** | Mr Abdallah KADRE | | **Date** |  | **Date** |  | | **Signature** |  | **Signature** |  | | | | |  |  |  | | |  | | --- | | *This report has been compiled by (these persons may be contacted by the GAVI Secretariat if additional information related to this proposal is required):* | | | | |  |  |  | | |  |  |  |  | | --- | --- | --- | --- | | **Full name** | **Title** | **Telephone** | **E-mail** | | Dr Alain Jean Michel ASSANA | AMP, Gavi, CAR Coordinator | [+236 72777760 | assana\_alain2002@yahoo.fr | | Dr BOSSOKPI PASSI Ptakilnam Prisca | EPI-UNICEF Team Member | +(00236) 70 55 60 79 | pbossokpipassi@unicef.org | | Dr Casimir MANENGU | WHO EPI Focal Point | +236 70171520 | manenguc@who.int | | Dr Déogratias MANIRAKIZA | Focal point for EPI/UNICEF | + 236 70550233 | dmanirakiza@unicef.org | | Dr Emmanuel FANDEMA | EPI Assistant Director | (00236) 75200066 | fandema\_emmanuel@yahoo.fr | | Dr Florentine Sylvie MBERYO YAAH | EPI-WHO Team Member | +236 75501060 | mberyosy@who.int | | Dr Rock OUAMBITA MABO | EPI Director | +236 75649052 | ouambita\_mr@outlook.com | | Ms. GUEGBELET Lydie Flore | Manager, EPI Directorate | (00236) 75056260 | guegbelet@yahoo.fr | | Mr David Melvin GONI | Head, Data Management Section; | (00236) 75616181 | davidmelvingoni@yahoo.fr | | Mr Jean Daniel LEPPA | UNICEF logistics supervisor | (00236) 75505982 | jdlepa@unicef.org | | Mr SATHE Antoine | Head of Monitoring and Planning Service | (00236) 75501414 | satheanto@yahoo.fr | | Mr Urbain BENZA | IVE WHO Country Team Member | (00236) 75506777 | benzaur@.who.int | | | | |  |  |  | | |  | | --- | | **4.1 2 National Coordinating Body/Inter-Agency Coordinating Committee for Immunisation** | | | | |  |  |  | | |  | | --- | | Agencies and partners (including development partners and NGOs) supporting immunisation services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC, Health Sector Coordinating Committee (HSCC), or equivalent committee). The ICC, HSCC, or equivalent committee is responsible for coordinating and guiding the use of the Gavi NVS routine support and/or campaign support. Please provide information about the ICC, HSCC, or equivalent committee in your country in the table below. | | | | |  |  |  | | |  | | --- | | **Profile of the ICC, HSCC, or equivalent committee** | | | | |  |  |  | | |  |  | | --- | --- | | **Name of the committee** | EPI Inter-Agency Coordinating Committee | | **Year of constitution of the current committee** | 2002 | | **Organisational structure (e.g., sub-committee, stand-alone)** | Technical Advisory Committee to the EPI (TAC-EPI) | | **Frequency of meetings** | Quarterly (4 times per year) | | | | |  |  |  | | |  | | --- | | The Terms of Reference or Standard Operating Principles for the ICC, including details on the ICC membership, quorum, dispute resolution process and meeting schedules are presented in the attached document (Document No.: 4) . | | | | |  |  |  | | |  | | --- | | Major functions and responsibilities of the ICC/HSCC: | | | | |  |  |  | | |  | | --- | | 1. To coordinate partner activities; 2. To contribute to the review and approval of routine EPI plans, National/Local Immunisation Days and integrated epidemiological surveillance of diseases; 3. To mobilise the internal and external resources necessary to conduct activities; 4. To ensure transparent and responsible management of resources by working with the EPI team to conduct regular audits of the use of program resources; 5. To foster and support the exchange of information, at the domestic as well as the foreign operational level; 6. To ensure the proper performance of the program;   7.  Research the paths and means for resolving constraints that are likely to endanger the proper performance of the program. | | | | |  |  |  | | |  | | --- | | Please describe the type of support offered by the different partners in the preparation of this request: | | | | |  |  |  | | |  | | --- | | The various partners have provided technical and financial support for the preparation and validation of the documents for this proposal (Introduction and operational plans for the prevention campaign). They participated in the peer proposal review workshop held in Ouagadougou, Burkina Faso, on August 23-28, 2015. | | | | |  |  |  | | |  | | --- | | **4.1 3 4.1.3. Signature Table for the Coordinating Committee for Immunisation** | | | | |  |  |  | | |  | | --- | | We, the undersigned members of the ICC, HSCC or equivalent committee *[1]* met on **September 4, 2015** to review this proposal. At that meeting, we approved this proposal on the basis of the supporting documentation attached. The endorsed minutes of this meeting are attached as document number 5. The signatures confirm the request presented in Document 6 (please use the list of signatures in the following section). | | | | |  |  |  | | |  | | --- | | Please refer to Annex C of the ‘Gavi HSS and NVS General Guidelines’ for more information on ICCs. | | | | |  |  |  | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Title** | **Title / Organisation** | **Name** | **Please sign below to indicate your attendance at the meeting during which the proposal was discussed.** | **Please sign below to indicate your approval of the minutes of the meeting during which the proposal was discussed.** | | **Chair** | World Health Organization | Dr YAO N'da Konan Michel |  |  | | **Secretary** | Ministry of Health and Population | Dr Thomas d'Aquin KOYAZEGBE |  |  | | **Members** | Ministry of Finance | Patrice NGOUPENDE |  |  | | Ministry of the Economy and Planning | Jonas NAGOLA |  |  | | Ministry of the Administration of Territory | Mélanie WAKODO |  |  | | Bangui Pasteur Institute | Ionela GOUNDJIKA |  |  | | Ministry of Defense | Dr Bruno IZAMO |  |  | | SOS Children's Village | Dr Rodrigue DOYAMA-WOZA |  |  | | PU-AMI | Dr Materne CIRIBWANWA |  |  | | MSF/Medical Coordinator | Dr Emmanuel FANDEMA |  |  | |  |  |  |  | | | | |  |  |  | | |  | | --- | | By submitting the proposal we confirm that a quorum was present. **Yes** | | | | |  |  |  | | |  | | --- | | The minutes from the three most recent ICC meetings are attached as DOCUMENT NUMBER: 7) . | | | | |  |  |  | | |  | | --- | | **4.2. National Immunisation Technical Advisory Group** **NITAG** | | | | |  |  |  | | |  | | --- | | Has a NITAG been established in your 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 | | | | | |

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Please identify the source of the data, and the date. Where possible use the most recent data and attach the source document. | | |  | | |  |  | | --- | --- | | ▪ | Please refer to the Comprehensive Multi-Year Plan for Immunisation (or equivalent plan), and attach a complete copy with an executive summary (DOCUMENT NUMBER 11). Please attach the cMYP costing tool (DOCUMENT NUMBER 12). | | ▪ | Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NUMBER : 14 | | ▪ | Please refer to the two most recent joint WHO/UNICEF reports on immunisation activities. | | ▪ | Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate. | | ▪ | Please refer to the attached risk assessments in the case of yellow fever and meningitis A mass preventive campaigns. | | |  | | |  | | --- | | Please use the most recent data available and specify the source and date. | | |  | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **Figure** | | **Year** | **Source** | | Total population | 4,953,015 |  | 2015 | GPHC 2003 Projection | | Birth cohort | 173,356 |  | 2015 | GPHC 2003 Projection | | Infant Mortality Rate | 116 |  | 2010 | 4 MICS | | Surviving infants*[1]* | 150,572 |  | 2015 | GPHC 2003 Projection | | GNI per capita (US$) | 333 | % | 2013 | HDI | | Total Health Expenditure (THE) as a percentage of GDP | 25,114,169,655 | % | 2014 | Health Sector Transition Plan (2015-2016) | | General government expenditure on health (GGHE) as % of General government expenditure | 11 | % | 2014 | Health Sector Transition Plan (2015-2016) | | |  | | |  | | --- | | *[3]* Surviving infants = infants that survived the first 12 months of life | | |  | | |  | | --- | | **5.1.1 Lessons learned** | | |  | | |  | | --- | | **Support for new routine vaccines** | | |  | | |  | | --- | | 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 to address them. Please refer to prior post-introduction evaluations, as applicable. If they are included in the Introduction Plan, please cite the section only. | | |  | | |  |  | | --- | --- | | **Lessons Learned** | **Action Points** | | The CAR has good experience in introducing new vaccines. For example, as part of Gavi's support to the introduction of new vaccines in routine EPI, the CAR introduced the pentavalent vaccine (DTP-HepB-Hib) in 2008 and the Pneumococcal vaccine (PCV13) in 2011 and the IPV on September 1, 2015.  The conclusions and recommendations of the external review of the EPI conducted in 2012, as well as the various Post-introduction Evaluations and the EVM evaluation which will take place in November 2015 will be taken into account in the framework of the MenAfriVac introduction. | Cold-chain capacity has been boosted at the national level thanks to the purchase and installation of a new positive cold room with gross capacity of 30m3. Two hundred (200) solar refrigerators (150 from UNICEF and 50 from WHO) are currently being deployed at the Health Region and District level. Absorption refrigerators are gradually being replaced with solar refrigerators with a great capacity for vaccine storage, ahead of the introduction of new vaccines.  Reprogramming of the GAVI-HSS 2014-2015 support plan towards the strengthening of the EPI will help improve the provision of immunisation services. | | |  | | |  | | --- | | **5.1.2 Planning and budgeting of health services** | | |  | | |  | | --- | | Please provide some additional information on the planning and budgeting context in your country: | | The planning and budgeting cycle for CAR is 10 years. This planning is specified in the "Poverty Reduction Strategy Documents (PRSD 1 and 2)". In order to effectively respond to the crisis currently being experienced by the country, the Government has established a road map for the 2014-2015 period. | | Please indicate the name and date of the relevant planning document for health | | Health Sector Transition Plan for Central African Republic (2015-2016). | | Is the cMYP (or updated Multi-Year Plan) aligned with this document (timing, content etc)? | | The cMYP complies with the Health Sector Transition Plan and has a 3-year planning period (2015-2017). | | Please indicate the national planning budgeting cycle for health | | The national planning budgeting cycle for health is 10 years (NHDP II 2006-2015). | | Please indicate the national planning cycle for immunisation | | The national planning cycle for immunisation is 5 years, but due to the fragility of the current system it was revised to 3 years. The operational planning period is one year. | | |  | | |  | | --- | | **5.1.3 Preparatory activities** | | |  | | |  | | --- | | Please provide a summary of all the **preparatory** activities for the introduction of the vaccine(s) or the campaigns. If they are included in the introduction plan or plan of action, please cite the sections only. | | Refer to section **V** of the Introduction Plan. | | |  | | |  | | --- | | **5.1.4 Gender and equity** | | |  | | |  | | --- | | Please describe any barriers to access, utilisation and delivery of immunisation services at district level (or equivalent) that are related to geographic, socio-economic and/or gender equity. Please describe actions taken to mitigate these barriers and highlight where these issues are addressed in the vaccine introduction plan(s). | | Equity analysis based on data from the MICS 4 (2010) considering the DTC3/Penta3 coverage indicator, showed huge vaccine coverage discrepancies compared to the national average, as follows:   * Discrepancy between regions/prefectures (4.64 coverage ratio); * Discrepancy between rich and poor (3.33 coverage ratio); * Discrepancy based on mother's educational level: 2.61 coverage ratio); * Discrepancy between urban and rural environments (2.32 coverage ratio); * NB: The analysis did not show gender discrepancy. | | Please examine whether questions of equity (socio-economic, geographic and gender-specific) factor have been taken into consideration in the process of preparing social mobilisation strategies, among other things, to improve immunisation coverage. Specify whether these issues are addressed in the vaccine introduction plan(s). | | Immunisation equity has been designated a priority for the program, therefore:   * the equity component was included in the cMYP and in financing proposals (e.g. HSS/Gavi); * a review of the micro planning guide based on (FOSA) * training of health agents in micro-planning according to the RED/equity approach and EPI management; * The review of data collection tools considered sex-specific aspects of immunisation. * it was integrated into the C4D strategy in the operating plans to ensure autonomy and community participation. | | Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems. | | Data broken down by sex were collected during the surveys. Routine immunisation reports included the breakdown of data by sex during the review of data collection tools for introduction of the IPV conducted in August 2015. | | 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 currently in a fragile situation, and as a result:   * Destruction/looting of health care facilities: 45% of health care facilities are operational, 28% of health care facilities have been destroyed, 75% of health care facilities in health region 3 have halted immunisation; * Loss of personnel (80% of health agents unaccounted for); * Significant movement of the population (IDP, in towns and in the brush, refugees); * Drastic drop in DTC3/Penta 3 vaccine coverage: 27% (2013); * Birth of high-risk communities (refugees due to war, persons displaced from enclaves, difficult access regions, etc.).   The following strategies were adopted in response to the crisis   * Restoration of basic health services and mobile clinics along axes, IDP sites, enclaves, free care and incentives for personnel; * Restoration of routine immunisation services, including catch-up activities (12-23 months), organisation of measles and polio immunisation campaigns, integrated with Vitamin A supplementation and deworming with priority for IDP sites and enclaves; * Strengthening epidemiological surveillance and response to epidemics. | | If possible, please provide additional information and documents on the data relative to sub- national coverage, for example comparisons between urban and rural districts, or between districts with the highest and lowest coverage etc. | | Administrative data from joint reports (JRF), EPI, show disparities in vaccine coverage between urban and rural districts. Districts of the capital of Bangui have better vaccine coverage than rural districts. | | Please describe what national surveys are routinely conducted in the country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers. | | The equity evaluation conducted in CAR in 2014 was based on data from the MICS 4 (2010) considering the DTC3/Penta3 coverage indicator and the EPI environment in the context of the crisis. It encountered no obstacles/bottlenecks related to equality between men and women with regard to immunisation. | | |  | | |  | | --- | | **5.1.5 Data quality** | | |  | | |  | | --- | | Please attach a data quality assessment (DQA), report if one has been completed within the previous 48 months (DOCUMENT NUMBER: 13) If available, an improvement plan and progress report on the implementation of the improvement plan should also be submitted (DOCUMENT NUMBER: 16 DOCUMENT NUMBER: 17) | | If DQA not available, please briefly describe plans to establish mechanisms for data quality assessment. | | Central African Republic's EPI set up self-assessment of the quality of immunisation data thanks to the DQS tool in 2011.  The external review of the EPI completed in 2012 led to a data quality evaluation (DQS) in 14 Health Prefectures, or 58.3%. It showed data quality weaknesses in terms of reporting the doses administered and recommendations formula. The country established a data quality improvement plan, the primary measures of which are as follows:   * Use of the DQS tool to back up supervision * Immunisation Coverage Surveys * Monthly meetings for harmonisation and review on surveillance, immunisation and laboratory data at the national level * Independent monitoring of campaign data; * Quarterly regional coordination meetings, semi-annual national ones; * Monthly meetings for monitoring immunisation data at the Health Prefecture level. | | Please indicate what routine mechanisms to independently assess the quality of administrative data are in place, and if so what these mechanisms are and how they enable the country to track changes in data quality over time. | | Monitoring of immunisation data is carried out monthly at the national level (national committee for review and standardisation of immunisation, surveillance and laboratory data). However, it is not entirely functional at the local and regional level.  In the context of the evaluation of surveillance of diseases targeted by the EPI and the routine EPI, quarterly and semi-annual meetings are organised at the health regions and national levels, respectively.  Furthermore, formative supervisions are conducted periodically using the self-evaluation tool for data quality (DQS). | | Please detail what household surveys have been conducted in recent years to independently assess immunisation coverage and equity, and describe any survey plans for the coming five year period. | | The analysis based on the survey was conducted in 2014, considering the DTC-Heb-Hib3 coverage indicator. A new MICS V survey is currently being prepared and will be conducted in 2016. | | |  | | |

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Waterfall effect briefing sessions will be conducted for this purpose. After introduction, waterfall effect supervisions will allow the monitoring and implementation at all levels.  **- improving logistical capabilities of the EPI**  The introduction of the MenAfriVac® vaccine will require improvement of storage capacities at all levels. Assessment of effective vaccine management is planned for 2015 and its results will be leveraged.  **- vaccine and consumables management**  The funds will be used to supply vaccines to the various districts. MenAfriVac® will be integrated into the existing procurement plan.  **- waste management**  The introduction of the vaccine will trigger the production of additional immunisation waste to be eliminated in accordance with the national waste management policy. This requires improvement of the waste destruction device. However it is possible to contract with private foundries that could be used during the catch-up campaign.  **- revising the EPI management tools**  The management tools will be revised to include the new vaccine.  **- improving communication to benefit the EPI**  A communication plan for introduction and the catch-up campaign will be developed and implemented. Communication messages to encourage participation and the use of various actors in support of the MenAfriVac® introduction and the continuation of the programme will be prepared.  **- AEFI monitoring**  This will involve reporting and investigating minor, major and serious cases of AEFIs related to immunisation. The country does not yet have a system of pharmacovigilance or a committee of AEFI experts. An Institutional Development Plan (IDP) was developed in 2011 but has not yet been implemented due to lack of funding. The AEFI Experts Committee will be set up.  A national notification sheet of undesirable effects has been adopted and will have to be used for AEFI notification. AEFI reporting is conducted only during SIAs and routine immunisation. The process and procedures of monitoring undesirable symptoms following IPV introduction at the district level, as well as at the local level, will be made with the implementation of the IDP and the setting up of the pharmacovigilance system.  Surveillance tools, case definitions and monitoring procedures for serious cases of AEFI will be prepared during a workshop and distributed.  The personnel in charge of disease monitoring will be trained in AEFI management via cascade-type training.  **- meningitis surveillance**  Meningitis surveillance has been integrated into the routine surveillance system. It is conducted on a case-by-case basis according to the IMDR. A plan for strengthening surveillance will be established. This strengthening will be carried out through training, equipment and technical support.  **- improving the partnership**  The involvement of technical and financial partners, other ministerial sectors, civil society, the private sector and the community will be an indicators of the success of the introduction. Awareness and mobilisation sessions will be conducted. | | |  |  | |  | |  | | --- | | 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. 28. | | |  |  | | |  | | --- | | if the GAVI support does not cover all of the requirements, please describe the other sources of funding and the amounts projected, if available, to cover your requirements | | | |  |  | | |  | | --- | | Gavi funding will of course not cover all needs related to introduction of the new vaccine. The traditional technical and financial partners will be requested to make up the financing gap. | | | |  |  | | |  |  | | --- | --- | | |  | | --- | | **6.2.6.Technical assistance** | | |  | | |  | | --- | | Please describe any specific area for which the Minister would need technical assistance with the introduction of the Meningococcal A vaccine. | | |  | | |  | | --- | | The introduction of MenAfriVac will be preceded by a mass preventive immunisation campaign covering the population from 1 to 29 years of age, i.e. 3,604,588 individuals. In order to conduct this campaign and have quality results, the country will require technical assistance in operational planning and cold chain management and logistics. An international consultant specialising in MenAfriVac campaigns and a cold chain specialist will be required. | | |  | | | | | | |

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Procurement and management** | | | |  |  | | |  | | --- | | **8.1 Procurement and management of routine vaccination with new or underused vaccines** | | | |  |  | | |  | | --- | | **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): | | | | The vaccines for CAR are purchased through UNICEF Copenhagen's procurement centre. The forwarding agent takes care of customs procedures as soon as they arrive at the airport. The vaccines enjoy exemption by the CAR government, through the Ministry of Finances.  However transportation expenses are paid by the national party through partner financing: Unicef, HSS/Gavi rescheduled. The support of the same partners will always be requested while waiting for the government to have sufficient resources to cover this category. Supplying the health districts [is] also ensured through the support of partners. | | | | b) If another vaccine procurement and administration mechanism (financed by the country or by Gavi) is requested, please provide justification. | | | |  |  | 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 pre-qualified 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. | | Vaccines purchased via the Unicef Procurement Center in Copenhagen are pre-qualified by WHO. | | | | 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. | | | | As soon as the proposal is approved by the Gavi IRC, the funds related to operating costs for introduction of new vaccines will be deposited into the Gavi account of the CAR EPI opened with ECOBANK Bangui by the Ministry of Health and Population. | | | | e) Please indicate how the co-financing amounts will be paid (and who is responsible for this) | | | | Co-financed amounts are collected weekly as agreed by the Gavi Alliance and the government of Central African Republic. The funds collected are deposited into the Unicef country fund, which transfers them to the Gavi Alliance account in Copenhagen. | | | | e) Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including procurement. | | | | The management mechanism is proposed as follows:   1. Gavi sends the funds to the government, which receives them into the Gavi EPI account. 2. A disbursement schedule is established in function of the plan of action for the program, and it is submitted for approval by the ICC and all the partners. 3. A funds disbursement request is cosigned by the EPI Management based on requests. 4. After the favorable opinion of the Minister (Chairman of the ICC),regarding the disbursement request, a check is prepared to be signed by the authorised cosignatories, in this case the Minister and the WHO representative. A list of alternatives is provided in the event the regular signatories are not available.   If Gavi decides to entrust the management of funds to one of the partners in place (WHO, Unicef), the receiving member shall carry out the project in accordance with its rules for administrative and financial management and shall report on the results obtained and the financial management.  In this case:  Requests shall be prepared by the EPI Management for the financing of activities, and are forwarded to the Partner by the Office of the MSP.  The partner will draw the funds on the EPI account performing the activities, conducts a technical and financial report that is submitted to the partner receiving the funds. | | | | f) Please outline how coverage of the introduced vaccine will be monitored, reported and evaluated (refer to cMYP and Introduction Plan). | | | | Vaccine coverage will be assessed monthly through monthly health district reports sent to the EPI. A joint report (JRF) from the Ministry of Public Health with the partners (WHO, Unicef) will be prepared at the end of each year. | | | | g) For a funding application regarding the second dose of the measles vaccine, does the country wish to receive its grants in kind or in cash. **N/A** | | | | | |  |  | | |  | | --- | | **8.2 Procurement and management for NVS preventive campaigns** | | | |  |  | | |  | | --- | | No NVS Prevention Campaign Support this year | | | |  |  | | |  | | --- | | **8.3. Product licensure** | | | |  |  | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | |  | | --- | | For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO pre-qualification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-pre-qualified 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.* | | | | | |  |  |  | |  | | --- | | This role is currently handled by the Division of Pharmaceutical Services, Laboratories and Traditional Medicine, as well as by the Pharmaceutical and Laboratory Inspection services.  After validation of the MenAfriVac Introduction Plan and its approval by the ICC, procedures will be undertaken with the Division of Pharmaceutical Services, Laboratories and Traditional Medicine and with the Pharmaceutical and Laboratory Inspection services, which carry out an NRA role of registering this new vaccine pre-qualified by WHO before it enters the country. This may take one (1) month.  National licensure is necessary for MenAfriVac, in addition to pre-qualification by WHO. | | | | |  |  |  |  |  |  | |  | |  | | --- | | 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 MenAfriVac vaccine is not yet licensed by the CAR RNA. This licensure will be carried out before it is introduced. The vaccine requested is MenAfriVac ® 5 µg for routine  and MenAfriVac® 10 µg for the campaign. MenAfriVac® is delivered in 10 dose per vial format. | | |  |  |  |  |  |  | |  |  |  | |  | | --- | | 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. | | | | |  |  |  |  |  | |  | | --- | | The vaccines enjoy exemption by the CAR government, through the Ministry of Finances. The forwarding agent takes care of customs procedures as soon as they arrive at the airport. Transportation expenses are paid by the national party through partner financing: Unicef, HSS/Gavi rescheduled. The support of the same partners will always be requested while waiting for the government to have sufficient resources to cover this category. | | |  |  |  |  |  |  | |  |  |  |  | |  | | --- | | 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 CAR does not have a formal National Regulatory Authority (NRA). This role is currently fulfilled by the Division of Pharmaceutical Services, Laboratories and Traditional Medicine, as well as by the Pharmaceutical and Laboratory Inspection services. | | |  |  |  |  |  |  | | | | |  |  | |  | |  | | --- | | **8.4 Vaccine Management (EVSM/EVM/VMA)** | | |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | |  | | --- | | It is mandatory for a country to conduct an assessment of effective vaccine management (EVM) before requesting support for the introduction of a new vaccine. The EVM a must have been conducted within the preceding 36 months. Please note that this assessment is recommended but not mandatory for requests for operational support to supplemental immunisation campaigns/activities (AVS). | | |  | | |  | | --- | | When was the EVM conducted? **August 2011** | | |  | | |  | | --- | | Please attach the most recent EVM assessment report (DOCUMENT NUMBER : 25.26, 27) the corresponding EVM improvement plan (DOCUMENT NUMBER : 26) and the progress report on the EVM improvement plan (DOCUMENT NUMBER : 27) The improvement plan should include a timeline, budget of committed resources for these activities and funding gaps, if any, as well as M&E indicators to monitor progress of implementation. | | |  | | |  | | --- | | If any of the above mandatory documents (EVM Assessment Report, EVM Improvement Plan, Progress on the EVM Improvement Plan) are not available, please provide justification and reference to additional documents such as PIE and External EPI Reviews. | | |  | | |  | | --- | | When is the next Effective Vaccine Management (EVM) Assessment planned? **November 2015** | | |  | | |  | | --- | | The country has scheduled an assessment of vaccine management for November 2015. The resources are already available at the country level and are prepositioned in the Unicef CAR account. An international consultant is currently being recruited to conduct this evaluation. | | | | |  |  | |  | |  | | --- | | **8.5 Waste management** | | |  |  | |  | |  | | --- | | Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), the safe handling, storage, transportation and disposal of immunisation waste, as part of a health care waste management strategy. Please describe the country’s waste management plan for immunisation activities (including campaigns). | | The country's directives recommend utilizing auto-disabling syringes and safety boxes as much for routine immunisation as for the supplementary immunisation activities (SIAs).  As part of routine activities, the wastes collected at the immunisation centres are destroyed, either in incinerators built by the NGOs (there where they exist) or by burning and burial.  For the mass campaigns, the waste is collected in the Health Districts/Prefectures that do not have incinerators, and they are sent by convoy to Bangui for destruction in the "HUSACA" soap factory, at the Bangui Pediatrics Complex, or the Bangui Pasteur Institute. Some Health Facilities of the Health Regions (Health Regions nos. 1, 2, 3, 4, 5 and 6) have seen the construction of incinerators thanks to support from NGOs.  In 2010, a biomedical waste management plan was developed and validated. This plan will be revised so as to adapt it to the current situation. | | | |

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List of documents attached to this proposal** | | |  | | |  | | --- | | **10.1. List of documents attached to this proposal** | | |  | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Document Number** | **Document** | **Section** | **Mandatory** | **File** | | 1 | MoH Signature (or delegated authority) of Proposal | 4.1.1 | ..\bl.jpg | Signatures Ministres.pdf  **File desc:**  **Date/time** 07/09/2015 02:35:38  **Size:** 367 KB | | 2 | MoF Signature (or delegated authority) of Proposal | 4.1.1 | ..\bl.jpg | Signatures Ministres.pdf  **File desc:**  **Date/time** 07/09/2015 2:36:28 AM  **Size:** 367 KB | | 3 | MoH Signature (or delegated authority) of Proposal for assistance to the VPH | 4.1.1 | ..\bl.jpg | No file loaded | | 4 | IACC Terms of Reference | 4.1.2 | ..\bl.jpg | TDRs CCIA.zip  **File desc:**  **Date/time** 07/09/2015 2:55:47 AM  **Size:** 1 MB | | 5 | Minutes of ICC/HSCC meeting endorsing Proposal | 4.1.3 | ..\bl.jpg | Rapport CCIA 4septembre 2015.pdf  **File desc:**  **Date/time** 08/09/2015 7:10:45 AM  **Size:** 371 KB | | 6 | Signatures of ICC or HSCC or equivalent in Proposal | 4.1.3 | ..\bl.jpg | Liste de presence CCIA 4 sept 2015.pdf  **File desc:**  **Date/time** 08/09/2015 7:14:10 AM  **Size:** 851 KB | | 7 | Minutes of the three most recent IACC/HSCC meetings | 4.1.3 | ..\bl.jpg | CR reunions CCIA.zip  **File desc:**  **Date/time** 08/09/2015 7:16:21 AM  **Size:** 442 KB | | 8 | A description of partner participation in preparing the application | 4.1.3 | ..\bl.jpg | No file loaded | | 9 | Minutes of the meeting of the NITAG with specific recommendations on the introduction of the NVS or the campaign | 4.2 | ..\bl.jpg | No file loaded | | 10 | Role and functioning of the advisory group, description of plans to establish a NITAG | 4.2.1 | ..\bl.jpg | Organes de coordination du PEV\_RCA.docx  **File desc:**  **Date/time** 08/09/2015 7:59:11 AM  **Size:** 18 KB | | 11 | comprehensive Multi Year Plan - cMYP | 5.1 | ..\bl.jpg | PPAC 2015-2017 RCA.doc  **File desc:**  **Date/time** 07/09/2015 3:07:22 AM  **Size:** 1 MB | | 12 | cMYP Costing tool for financial analysis | 5.1 | ..\bl.jpg | cMYP\_V3.6.8\_RCA-20-06-15.xlsx  **File desc:**  **Date/time** 08/09/2015 4:41:53 AM  **Size:** 2 MB | | 13 | Monitoring and evaluation and surveillance (M&E) plan for the support requested, within the context of the country’s existing monitoring plan for the EPI programme | 5.1.5 | ..\bl.jpg | Cadre de Suivi Evaluation du PPAc 2015-2017 de la RCA.docx  **File desc:**  **Date/time** 08/09/2015 7:37:14 AM  **Size:** 18 KB | | 14 | Vaccine introduction plan | 5.1 | ..\bl.jpg | Plan\_Introduction MenAfriVac\_RCA..docx  **File desc:**  **Date/time** 15/10/2015 08:46:55 AM  **Size:** 538 KB | | 15 | Introduction Plan for the introduction of RCV / JE / Men A into the national programme | 7.x.4 | ..\bl.jpg | No file loaded | | 16 | Data quality assessment (DQA) report | 5.1.5 | ..\bl.jpg | Rapport\_final\_DQS RCA\_24\_01\_2013[1].doc  **File desc:**  **Date/time** 07/09/2015 3:18:51 AM  **Size:** 2 MB | | 17 | DQA improvement plan | 5.1.5 | ..\bl.jpg | No file loaded | | 19 | HPV vaccine roadmap or strategy | 6.1.1 | ..\bl.jpg | No file loaded | | 20 | Introduction Plan for the introduction of RCV into the national programme | 7.x.4 | ..\bl.jpg | No file loaded | | 21 | Summary of the methodology of the assessment of the HPV vaccine | 5.1.6 | ..\bl.jpg | No file loaded | | 22 | Evidence of commitment to fund purchase of RCV for use in the routine system in place of the first dose of MCV | 7.x.3 | ..\bl.jpg | No file loaded | | 23 | Campaign target population documentation | 7.x.1 | ..\bl.jpg | Populations cibles de la Campagne \_RCA.docx  **File desc:**  **Date/time** 08/09/2015 8:08:15 AM  **Size:** 21 KB | | 24 | Road map or strategy for strengthening a comprehensive approach to pneumonia and/or diarrhea prevention and treatment | 6.x.6 | ..\bl.jpg | No file loaded | | 25 | EVM report | 8.3 | ..\bl.jpg | RCA\_Rapport d'evaluation de la GEV en RCA 2011.docx  **File desc:**  **Date/time** 08/09/2015 7:48:09 AM  **Size:** 212 KB | | 26 | Improvement plan based on EVM | 8.3 | ..\bl.jpg | RCA\_EGEV\_PlanDameliorationV2.docx  **File desc:**  **Date/time** 08/09/2015 7:33:33 AM  **Size:** 35 KB | | 27 | EVM improvement plan progress report | 8.3 | ..\bl.jpg | Mise a jour\_Evaluation\_Plan\_Amelioration\_13 07 15.doc  **File desc:**  **Date/time** 07/09/2015 3:20:58 AM  **Size:** 102 KB | | 28 | Detailed model budget for the grant for the introduction of a vaccine / operating costs | 6.x,7.x.2 | ..\bl.jpg | Copie de Detailed Budget template\_VIG and Op Cost NVS 2015 01 sept 15.xls  **File desc:**  **Date/time** 07/09/2015 3:23:20 AM  **Size:** 82 KB | | 29 | Risk assessment and consensus meeting report for Meningitis / Yellow Fever: (for yellow fever please include information required in the NVS guidelines on YF Risk Assessment process) | 7.1 | ..\bl.jpg | Rapport CCIA 04 Septembre 2015.docx  **File desc:**  **Date/time** 08/09/2015 7:51:18 AM  **Size:** 218 KB | | 30 | Plan of Action for campaigns | 7.1, 7.x.4 | ..\bl.jpg | PLAN D ACTION POUR LA CAMPAGNE PREVENTIVE MENAFRIVAC RCA.doc  **File desc:**  **Date/time** 15/10/2015 08:%1:05 AM  **Size:** 555 KB | |  | Other documents |  | ..\bl.jpg | No file loaded | |  |  |  |  |  | | |  | | |

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Non | | **cc** | **Country co-financing per dose** | Table 6.4.1 | $ | 0.2 | | **ca** | **AD syringe price per unit** | Table Annexes 4A | $ | 0.448 | | **cr** | **Reconstitution syringe price per unit** | Table Annexes 4A | $ | 0.035 | | **cs** | **Safety box price per unit** | Table Annexes 4A | $ | 0.0054 | | **fv** | **Freight cost as a % of vaccines value** | Table Annexes 4B | % | 6.00 % | | **fd** | **Freight cost as a % of devices value** | Parameter | % | 0 | | |  | |  | |  |  | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | 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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | |  | | --- | | **Table Annex 1.1 D: Table Annex 1.1 D Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 1)** | | |  | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | | **Formula** | **2017** | | | |  | **Total** | **Government** | **Gavi** | | **A** | **Country co-financing** | *V* | 30.16 % |  |  | | **B** | **Number of children to be vaccinated with the first dose** | *Table 5.2* | 94,917 | 28,626 | 66,291 | | **C** | **Number of doses per child** | *Vaccine parameter (schedule)* | 1 |  |  | | **D** | **Number of doses needed** | *B X C* | 94,917 | 28,626 | 66,291 | | **E** | **Estimated vaccine wastage factor** | *Table 5.2* | 1.11 |  |  | | **F** | **Number of doses needed including wastage** | *D X E* | 105,358 | 31,774 | 73,584 | | **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]* | 26,340 | 7,944 | 18,396 | | **I** | **Total vaccine doses needed** | *Round up((F + G) / Vaccine package size) \* Vaccine package size* | 132,000 | 39,809 | 92,191 | | **J** | **Number of doses per vial** | *immunisation parameter* | 10 |  |  | | **K** | **Number of AD syringes (+ 10% wastage) needed** | *(D + G) x 1.11* | 134,596 | 0 | 134,596 | | **L** | **Reconstitution syringes (+ 10% wastage) needed** | *(I / J) x 1.11* | 14,653 | 0 | 14,653 | | **M** | **Total of safety boxes (+ 10% of extra need) needed** | *(K + L) / 100 × 1.11* | 0 | 0 | 0 | | **N** | **Cost of vaccines needed** | *I x \* vaccine price per dose (g)* | 82,918 | 25,007 | 57,911 | | **Y** | **Cost of AD syringes needed** | *K x AD syringe price per unit (ca)* | 60,300 | 0 | 60,300 | | **P** | **Cost of reconstitution syringes needed** | *L x reconstitution price per unit (cr)* | 513 | 0 | 513 | | **Q** | **Cost of safety boxes needed** | *M x safety box price per unit (cs)* | 0 | 0 | 0 | | **R** | **Freight cost for vaccines needed** | *N x freight cost as a % of vaccines value (fv)* | 4,621 | 1,394 | 3,227 | | **S** | **Freight cost for devices needed** | *(O+P+Q) x freight cost as % of devices value (fd)* | 0 | 0 | 0 | | **T** | **Total fund needed** | *(N+O+P+Q+R+S)* | 148,352 | 26,400 | 121,952 | | **U** | **Total country co-financing** | *I \* country co-financing per dose (cc)* | 26,400 |  |  | | **V** | **Country co-financing % of Gavi supported proportion** | *U / T* | 30.16 % |  |  | | |  | | | | | | | | |

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different vaccines (routine immunisation and campaigns) for 2017. | | |  | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Vaccine** | **dose(s) per vial** | **Maximum Wastage rate\*** | | **Benchmark Wastage Rate \*\*\*** | |  |  | **Routine** | **Campaign** |  | | Yellow Fever, 10 dose(s) per vial, LYOPHILISED | 10 | 40 % | 40 % |  | | Yellow Fever, 5 dose(s) per vial, LYOPHILISED | 5 | 10 % | 10 % |  | | Meningococcal A, 10 dose(s) per vial, LYOPHILISED | 10 | 50 % | 10 % |  | | Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID | 2 | 10 % | 10 % |  | | Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | 1 | 5 % | 5 % |  | | Rotavirus, 2-dose schedule | 1 | 5 % | 5 % |  | | Rotavirus, 3-dose schedule | 1 | 5 % | 5 % |  | | Measles, 2nd dose, 10 dose(s) per vial, LYOPHILISED | 10 | 40 % | 40 % |  | | JE, 5 dose(s) per vial, LYOPHILISED | 5 | 10 % | 10 % |  | | HPV bivalent, 2 dose(s) per vial, LIQUID | 2 | 10 % | 10 % |  | | HPV quadrivalent, 1 dose(s) per vial, LIQUID | 1 | 5 % | 5 % |  | | MR, 10 dose(s) per vial, LYOPHILISED | 10 | 15 % | 15 % |  | | |  | | |  | | --- | | Observations: | | | |  | | --- | | Sources WHO recommended wastage rates | | | |  | | --- | | \*\* Source: \*\*\* Country APRs and studies, approved by WHO, UNICEF, and the Gavi Secretariat | | | |  | | --- | | Note: HPV demonstration project wastage rates are the same as for the vaccine | | |  | | |  | | --- | | **Table Annex 4E: Vaccine maximum packed volumes** | | |  | | |  | | --- | | **Please note that this table is used solely for reference and includes both the vaccines supported by GAVI as well as vaccines not supported.** | | |  | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Vaccine product** | **Designation** | **Vaccine formulation** | **Admin route** | **No. Of doses in the schedule** | **Presentation (doses/vial, prefilled)** | **Packed volume vaccine (cm3/dose)** | **Packed volume diluents (cm3/dose)** | | IC | IC | lyophilised | ID | 1 | 20 | 1.2 | 0.7 | | Diphtheria-Tetanus | DT: | liquid | IM | 3 | 10 | 3 |  | | Diphtheria-Tetanus-Pertussis | DTP | liquid | IM | 3 | 20 | 2.5 |  | | Diphtheria-Tetanus-Pertussis | DTP | liquid | IM | 3 | 10 | 3 |  | | DTP liquid + Hib freeze-dried | DTP+Hib | liquid+lyop. | IM | 3 | 1 | 45 |  | | DTP-HepB combined | DTP-HepB | liquid | IM | 3 | 1 | 9.7 |  | | DTP-HepB combined | DTP-HepB | liquid | IM | 3 | 2 | 6 |  | | DTP-HepB combined | DTP-HepB | liquid | IM | 3 | 10 | 3 |  | | DTP liquid + Hib freeze-dried | DTP+Hib | liquid | IM | 3 | 10 | 2.5 |  | | DTP liquid + Hib freeze-dried | DTP-HepB-Hib | liquid+lyop. | IM | 3 | 1 | 22 |  | | DTP-HepB-Hib liquid | DTP-HepB-Hib | liquid+lyop. | IM | 3 | 2 | 11 |  | | DTP-HepB-Hib liquid | DTP-HepB-Hib | liquid | IM | 3 | 10 | 4.4 |  | | DTP-HepB-Hib liquid | DTP-HepB-Hib | liquid | IM | 3 | 2 | 13.1 |  | | DTP-HepB-Hib liquid | DTP-HepB-Hib | liquid | IM | 3 | 1 | 19.2 |  | | DTP-Hib combined liquid | DTP+Hib | liquid+lyop. | IM | 3 | 10 | 12 |  | | DTP-Hib combined liquid | DTP+Hib | liquid | IM | 3 | 1 | 32.3 |  | | Hepatitis B | HepB | liquid | IM | 3 | 1 | 18 |  | | Hepatitis B | HepB | liquid | IM | 3 | 2 | 13 |  | | Hepatitis B | HepB | liquid | IM | 3 | 6 | 4.5 |  | | Hepatitis B | HepB | liquid | IM | 3 | 10 | 4 |  | | Hepatitis B UniJect | HepB | liquid | IM | 3 | Uniject | 12 |  | | Hib freeze-dried | Hib\_lyo | lyophilised | IM | 3 | 1 | 13 | 35 | | Hib freeze-dried | Hib\_lyo | lyophilised | IM | 3 | 2 | 6 |  | | Hib freeze-dried | Hib\_lyo | lyophilised | IM | 3 | 10 | 2.5 | 3 | | Hib liquid | Hib\_liq | liquid | IM | 3 | 1 | 15 |  | | Hib liquid | Hib\_liq | liquid | IM | 3 | 10 | 2.5 |  | | Human Papillomavirus vaccine | Anti HPV | liquid | IM | 3 | 1 | 15 |  | | Human Papillomavirus vaccine | Anti HPV | liquid | IM | 3 | 2 | 5.7 |  | | Japanese Encephalitis | JE\_lyo | lyophilised | SC | 1 | 5 | 2.5 | 2.9 | | Measles | Measles | lyophilised | SC | 1 | 1 | 26.1 | 20 | | Measles | Measles | lyophilised | SC | 1 | 2 | 13.1 | 13.1 | | Measles | Measles | lyophilised | SC | 1 | 5 | 5.2 | 7 | | Measles | Measles | lyophilised | SC | 1 | 10 | 3.5 | 4 | | Measles-Mumps-Rubella lyophilised | MMR | lyophilised | SC | 1 | 1 | 26.1 | 26.1 | | Measles-Mumps-Rubella lyophilised | MMR | lyophilised | SC | 1 | 2 | 13.1 | 13.1 | | Measles-Mumps-Rubella lyophilised | MMR | lyophilised | SC | 1 | 5 | 5.2 | 7 | | Measles-Mumps-Rubella lyophilised | MMR | lyophilised | SC | 1 | 10 | 3 | 4 | | Measles-Rubella lyophilised | RR | lyophilised | SC | 1 | 1 | 26.1 | 26.1 | | Measles-Rubella lyophilised | RR | lyophilised | SC | 1 | 2 | 13.1 | 13.1 | | Measles-Rubella lyophilised | RR | lyophilised | SC | 1 | 5 | 5.2 | 7 | | Measles-Rubella lyophilised | RR | lyophilised | SC | 1 | 10 | 2.5 | 4 | | Meningitis A conjugate | Men\_A | lyophilised | IM | 1 | 10 | 2.6 | 4 | | Meningitis A/C | MV\_A/C | lyophilised | SC | 1 | 10 | 2.5 | 4 | | Meningitis A/C | MV\_A/C | lyophilised | SC | 1 | 50 | 1.5 | 3 | | Meningitis W135 | MV\_W135 | lyophilised | SC | 1 | 10 | 2.5 | 4 | | Meningococcal A/C/W/ | MV\_A/C/W/Y | lyophilised | SC | 1 | 50 | 1.5 | 3 | | Meningococcal A/C/W/Y | MV\_A/C/W/Y | lyophilised | SC | 1 | 10 | 2.5 | 4 | | Monovalent OPV-1 | mOPV1 | liquid | Oral |  | 20 | 1.5 |  | | Monovalent OPV-3 | mOPV3 | liquid | Oral |  | 20 | 1.5 |  | | Pneumo. conjugate vaccine 10-valent | PCV-10 | liquid | IM | 3 | 1 | 11.5 |  | | Pneumo. conjugate vaccine 10-valent | PCV-10 | liquid | IM | 3 | 2 | 4.8 |  | | Pneumo. conjugate vaccine 13-valent | PCV-13 | liquid | IM | 3 | 1 | 12 |  | | Polio | OPV | liquid | Oral | 4 | 10 | 2 |  | | Polio | OPV | liquid | Oral | 4 | 20 | 1 |  | | Polio inactivated | Le VPI | liquid | IM | 3 | PFS | 107.4 |  | | Polio inactivated | Le VPI | liquid | IM | 3 | 10 | 2.5 |  | | Polio inactivated | Le VPI | liquid | IM | 3 | 1 | 15.7 |  | | Rota vaccine | Rota\_liq | liquid | Oral | 2 | 1 | 17.1 |  | | Rota vaccine | Rota\_liq | liquid | Oral | 3 | 1 | 45.9 |  | | Tetanus Toxoid | TT | liquid | IM | 2 | 10 | 3 |  | | Tetanus Toxoid | TT | liquid | IM | 2 | 20 | 2.5 |  | | Tetanus Toxoid UniJect | TT | liquid | IM | 2 | Uniject | 12 |  | | Tetanus-Diphtheria | Td | liquid | IM | 2 | 10 | 3 |  | | Yellow fever | YF | lyophilised | SC | 1 | 5 | 6.5 | 7 | | Yellow fever | YF | lyophilised | SC | 1 | 10 | 2.5 | 3 | | Yellow fever | YF | lyophilised | SC | 1 | 20 | 1.5 | 2 | | Yellow fever | YF | lyophilised | SC | 1 | 50 | 0.7 | 1 | |  | | | | | | | | | | |

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