Gavi NVS Application Form

Submitted by

The Government of

São Tomé and Principe

Date of submission: **15 January 2016**

Deadline for submission:

i. **19 January 2016**
ii. 1st May 2015
iii. 9 September 2015

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

Start Year	2016	End year	2020

Form revised in 2015

(To be used with guidelines dated November 2015)

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

Gavi GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by 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 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 Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application. Gavi 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 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 Gavi, within sixty (60) days after the Country receives Gavi's request for a reimbursement and be paid to the account or accounts as directed by Gavi.

SUSPENSION/ TERMINATION

Gavi 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-approved amendment to this application. Gavi reserves the right to terminate its support to the Country for the programme(s) described in this proposal if Gavi receives confirmation of misuse of the funds granted by Gavi.

ANTI-CORRUPTION

The Country confirms that funds provided by 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 Gavi, as requested. 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 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 Gavi's TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with 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 Gavi arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either 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 Gavi . For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: 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.

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 the type of Gavi support you would like to apply for.

Type of Support	Vaccine	Start Year	End year	Preferred second presentation[1]
Preventive campaign support	MR, 10 dose(s) per vial, LYOPHILISED	2016	2016	

[1] If, for a variety of reasons, the country's first product preference might only be available in limited quantities or be unavailable in the short term, Gavi will contact the country and its partners to explore alternative options. A country will not be obliged to accept its second or third preference; however, Gavi will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine. If a country does not indicate a second or third preference, it will be assumed that the country prefers to postpone introduction until the first preference is available. It should be noted that this may delay the introduction in the country.

2. Table of Contents

3. Executive Summary

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

- For each specific request, NVS routine support or NVS campaign:
  - Duration of support
  - The total amount of funds requested
  - Characteristics of vaccine(s), if necessary, and the reason for presentation choice
  - Month and year planned for vaccine introduction (including campaigns and routine immunisations)
- Relevant baseline data, including:
  - DTP3 and measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Target population determined based on the evaluation of yellow fever and meningitis A risk
  - Birth cohort, targets and immunisation coverage by vaccines
- Country preparedness
  - Summary of planned activities to prepare vaccine launch, including EVM assessments, progress with regard to EVM improvement plans, communication plans, etc.
  - Summary of the EVM assessment report and progress report on the implementation of improvement plan
- How stakeholders participated in developing this proposal
  - Interagency Coordination Committee (ICC)
  - Partners, including CSO involvement

This is a request for support for the NVS campaign.

The duration of support is initially one-time support for the campaign for children 9 months to 14 years of age, and continual for the rubella part only for the second dose of MR.

The funding amount for the campaign is US$ 162,510.47.

The vaccine is the lyophilised, 10-dose MR.

The estimated number of live births anticipated in 2016 is 5,831. The DTP-HepB-Hib3 and measles1 targets are 5,637 and the measles2 target is 4,792. Their respective coverages are: 95.3%, 92% and 71.2% according to the 2014 Joint Reporting Form.

The last EVM evaluation occurred in 2015.

Summary of the EVM evaluation report:

The results from interviews, observation and document reviews that were done at each level were given as a percentage per criterion and per category.

The EVM evaluation showed that five variables were above the standard (80%): E2 (vaccine storage temperature) - 87%; E3 (storage capacity) 88%; E6 (stock management) 92%; E7 (distribution) 92%; E9 (GIS and support operations) 89%. The score for vaccine management was 74%.

The criteria that were above include: E1 (Vaccine receiving and entry): 67%, E4 (buildings, transportation equipment; 69%); E5 (upkeep: 68%).

Progress implementing the 2011 EVM recommendations

The assessment of the implementation of the June 2011 EVM evaluation recommendations is shown in the table below. Table 2: 2011 EVM and 2015 EVM results

EVM Criteria	Objectives	2011	2015
E1: Vaccine receiving/arrival	**80%**	**6%**	**67%**
E2: Temperature	**80%**	**57%**	**87%**
E3: Storage capacity	**80%**	**87%**	**88%**
E4: Buildings, equipment, transportation	**80%**	**79%**	**69%**
E5: Maintenance	**80%**	**63%**	**68%**
E6: Stock management	**80%**	**59%**	**92%**
E7: Distribution	**80%**	**76%**	**92%**
E8: Vaccine management	**80%**	**75%**	**74%**
E9: GIS, support operations	**80%**	**37%**	**89%**

Implementation status for the recommendations:
- Supervision of on-site stakeholders through training and retraining
- Developing educational and management materials suitable for each level: Nine were 100% completed, two were not completed
- Regular and supportive supervision (using appropriate grids for specific objectives), creating posters and modules
- Periodic reviews to monitor management and refocus actions Defining the information chain, reporting frequency, as well as the nature of data to be collected upstream and downstream
- Reinvigorating the ICC to monitor consumption of vaccines, equipment and systematic losses
- Multisector collaboration with ministries and departments involved in immunisation and vaccine quality (Ministry of the Interior, Planning, Budget and Finances, customs, etc)
- Implementation rate for the 2011 EVM recommendations: 67% completed and 33% incomplete.

The 2015 EVM recommendations are:
- Begin daily temperature readings at all levels of the supply chain.
- Use freeze indicators for vaccine transport when cooled water is not used during transport.
- At all levels, begin inventory management registries for vaccines, diluents and injection supplies.
- Define a national maintenance policy (both preventive and repair) for buildings, equipment and means of transport.
- Develop maintenance contracts that define each contractor's responsibilities.
- Procure four fire extinguishers for the central store.
- Procure four sets of warm clothing for staff at the central store who work in the cold room.
- Establish traceability for lots of vaccines and injection supplies by using purchase orders and receipts for antigens and inventory management registries at all levels.
- Recruit and train a store manager so that the logistician can focus on other activities.

- Develop standardised operations procedures for treating ice packs, administration of the shake test, disposal of damaged or expired vaccines, disposal of empty vials, and vaccine transport.
- Support the Ministry of Health in implementing and monitoring the recommendations resulting from this assessment.

Parties that have contributed their technical support to the proposal are Ministry of Health officials, the Health Care Directorate, the EPI, HSS, the Health Promotion Directorate, chief physicians for two districts, and technical and financial partners: WHO, UNFPA and UNICEF

4. Signatures

4.1. Signatures of the Government and national coordinating bodies

4.1.1. The Government and the Interagency Coordination Committee (ICC) for immunisation

The Government of São Tomé and Principe wishes to consolidate the existing partnership with Gavi to strengthen its national routine childhood immunisation programme and is specifically requesting Gavi support for:

MR, 10 dose(s) per vial, lyophilised, preventive campaigns

The Government of São Tomé and Principe agrees to develop national immunisation services on a sustainable basis in accordance with the comprehensive multi-year plan presented with this document. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunising children as outlined in this application.

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 Review Committee (IRC). These signatures appear in Documents Nos.: 2 and 1 in Section 10. Attachments

Minister of Health (or authorised representative)		Minister of Finance (or authorised representative)	
Name	Maria de Jesus Trovoada dos Santos	**Name**	Américo Oliveira Ramos
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	Position	Telephone	E-mail
Amadeu Mendes Maia	Health Care Director	00239 9903920	maia95@live.com
Ednilza Solange G.Barros	EPI/PSR Manager	00239 9991665	sovilanova@yahoo.com.br

4.1.2. National Coordinating Body/Interagency Coordination Committee for Immunisation

Agencies and partners (including development partners and civil society organisations) supporting immunisation services are coordinated 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 proper use of the Gavi ISS and NVS routine support and/or campaign support. Please provide information about the ICC, HSCC, or equivalent committee in your country in the table below.

Profile of the ICC, HSCC, or equivalent committee

Name of the committee	ICC
Year of constitution of the current committee	2003
Organisational structure (e.g., sub-committee, stand-alone)	Thematic groups
Frequency of meetings	Quarterly

The Terms of Reference or Standard Operating Principles for the ICC, including details on the ICC membership, quorum, dispute resolution process and meeting schedules are presented in the attached document (Document No.: 4)

Major functions and responsibilities of the ICC/HSCC:

The ICC's main objective is to support the Ministry of Health in the planning, implementation, monitoring and evaluation of the national policies and strategies for sustainable health development.

Please describe the type of support offered by the different partners in preparing this application:

Support for developing a high-quality application document

4.1.3. 4.1.3. Signature Table for the Coordination Committee on Immunisation

We, the undersigned members of the ICC, HSCC or equivalent committee [1] met on **14/01/2016** to review this proposal. At that meeting, we approved this proposal on the basis of the attached supporting documentation. The minutes of this meeting are attached as document number 5. The signatures confirming the request appear in document 7 (please use the list of signatures in the section below).

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

Position	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 endorsement of the minutes of the meeting during which the proposal was discussed.
Chair	Minister of Health	Maria de Jesus Trovoada dos Santos		
Secretary	Health Care Directorate	Dr Amadeu Mendes da Maia		
Members	FHP/EPI/WHO	Maria Quaresma dosAnjos		
	WHO Representative	Dr Réné Zitsamalé-Coddy		
	UNICEF Deputy Representative	Ainhoa Jaureguibeitia		
	Ministry of the Economy	Sleid Costa		
	DAF/ Ministry of Health	Apolibio dos Santos Correia		
	Assistant to the Representative	Victoria d`Alva		
	PSR/EPI/STP Manager	Ednilza Solange G.Barros		
	Representing the Portuguese Embassy	Maria Rodrigues		
	Representing the NGO Marques Valle Flor Institute	Edgar Agostinho das Neves		
	National Society of the Red Cross	Ana Paula Antunes		
	UNICEF	Luís Bonfim		
	EPI/STP Logistician	Vladimir Costa e Sousa		
	Cabinet of the Minister of Health	Lucio Gomes Dias		
	EPI/PSR	Elizabeth Carvalho		

By submitting the proposal we confirm that a quorum was present. **Not selected**

The minutes from the three most recent ICC meetings are attached as DOCUMENT NUMBER: 6)

4.2. National Immunisation Technical Advisory Group (NITAG)

Has a NITAG been established in your country? **Not selected**

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

5. Data on the immunisation programme

5.1 Reference material

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

- Please refer to the Comprehensive Multi-Year Plan (cMYP) for Immunisation (or equivalent plan), and attach a complete copy with an executive summary (DOCUMENT NUMBER 9). Please also attach the cMYP costing tool (DOCUMENT NUMBER 10).
- Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NUMBER : 12
- 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 meningitis A mass preventive campaigns.

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

	Figure	Year	Source
Total population	196,909	2016	GPHC 2012
Birth cohort	5,831	2016	GPHC 2012
Infant Mortality Rate	361,000	2014	2014 MICS
Surviving infants *[1]*	5,637	2016	GPHC 2012
GNI per capita (US$)	1,456	2015	INE (National Institute of Statistics)
Total Health Expenditure (THE)	12,498,803	2014	Ministry of Finance 2015
General government expenditure on health (GGHE) as % of general government expenditure	11	2014	Ministry of Finance 2

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

5.1.1 Lessons learned

Support for new routine vaccines

Preventive campaign support

If vaccine campaigns [0] have already been carried out in your country, please complete in detail the lessons learned, specifically for: storage capacity, protection against accidental freezing, personnel training, cold chain, logistics, coverage, wastage rates, etc. and propose areas of action or indicate the measures taken to address them. If they are included in the introduction or the action plan, please cite the section only. If this information is already included in the NVIP/AP, please refer to the document and the section/page where this information can be found.

Lessons learned	Actions

5.1.2 Planning and budgeting of health services

Please provide some additional information on the planning and budgeting context in your country:

Sao Tome and Principe's development strategy is based on the poverty reduction strategy that was adopted by the government in 2002. This strategy was revised in November 2008. It is in this context that the priority policy actions and the medium-term (four-year) programming strategy have been defined. The budget cycle is annual.

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

NHDP II 2012-2016

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

Yes

Please indicate the national planning budgeting cycle for health

It is:

- Ten years for the NHP (National Health Policy)
- Five years for the NHDP
- Three years for the medium-term expense framework

One year for the Annual Action Plan

Please indicate the national planning cycle for immunisation

The cMYP cycle is five years

The Annual Action Plan cycle is one year.

5.1.3 Gender and equity

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

In Sao Tome and Principe, we have not observed any obstacles to access and use of vaccination services between rich and poor residents, or between boys and girls. Free care for children under five and for pregnant women, as well as immunisation campaigns integrated into other health activities (African Immunisation Week and mobile and outreach strategies; door-to-door activities) have improved immunisation coverage.

Please examine whether questions of equity (socio-economic, geographic and gender-specific factors) 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).

For the moment, the Sao Tome and Principe EPI has not experienced any socio-economic obstacles. The country did not deem it necessary to include questions of equity and gender in the mobilisation strategy, because there is no difference in immunisation coverage between boys and girls, or between rich and poor.

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

In Sao Tome and Principe, routine immunisation reports show sex-disaggregated data.

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

No

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.

Annual reports on immunisation and the joint government-UNICEF-WHO report (JRF) show that national immunisation coverage and for all districts was around 95% for penta3 in 2014.

5.1.4 Data quality

Please attach a data quality assessment (DQA), report if one has been completed within the previous 48 months (DOCUMENT NUMBER: 27). If available, an improvement plan and progress report on the implementation of the improvement plan should also be submitted (DOCUMENT NUMBER: 11 DOCUMENT NUMBER: 28).

If DQA not available, please briefly describe plans to establish mechanisms for data quality assessment.

There is no report on the evaluation of immunisation data quality. But the Ministry of Health organises quarterly EPI data quality review meetings with all stakeholders (Health Care Director, Chief Health District Physicians, EPI coordinators at the central level and partners (WHO, UNICEF, UNFPA and CSO).

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.

Sao Tome and Principe does not yet have systematic independent assessment mechanisms for administrative data quality. The implementation process for the Technical Advisory group on EPI issues is in progress.

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 following surveys have been conducted, among others:

- Demographic and Health Survey (EDS), 2009;
- MICS survey, including the 2014 immunisation coverage survey;
- For the next five years, EDS 2017 is planned.

5.1.5 Measles vaccine coverage

Please provide information on measles vaccine coverage.

Table 5.1.5: RCV immunisation coverage

Coverage	2011		2012		2013	
	Administrative *(1)*	WUENIC *(2)*	Administrative *(1)*	WUENIC *(2)*	Administrative *(1)*	WUENIC *(2)*
Measles 1st dose (%)	91.3		91.6		90.1	
Measles 2nd dose (%)						

Coverage	2014		2015	
	Administrative *(1)*	WUENIC *(2)*	Administrative *(1)*	WUENIC *(2)*
Measles 1st dose (%)	92	88	91	
Measles 2nd dose (%)	71.4		74.2	

Coverage	2011		2012		2013	
	Administrative *(1)*	Coverage Survey	Administrative *(1)*	Coverage Survey	Administrative *(1)*	Coverage Survey
Supplementary Immunisation Activities (SIA) (%)			105			

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

Note:

(1) National administrative coverage reported

(2) Estimated national immunisation coverage according to WHO/UNICEF

Do the most recent supplementary immunisation activities (SIAs) relate to administrative coverage or an acceptable survey method?
Administrative coverage

5.2. Baseline data and annual objectives (NVS routine immunisation)

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

Number	Base Year	Baseline and Targets			
	2015	2016	2017	2018	2019
Total number of births	5,695	5,831	5,931	6,054	6,179
Total number of infant deaths	183	183	183	183	183
Total surviving infants	5,512	5,648	5,748	5,871	5,996
Total number of pregnant women	6,457	6,586	6,722	6,861	7,003

Number	Baseline and Targets
	2020
Total number of births	6,307
Total number of infant deaths	183
Total surviving infants	6,124
Total number of pregnant women	7,148

5.3. Target for the preventive campaign(s)

5.3.1 Targets (MR campaign)

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

MR begins: 9 months

MR ends: 14 years

Cohort population: population 9 months -14 years

Gavi only provides assistance to countries for the rubella vaccine catch-up campaign through providing MR vaccine doses for a target population of girls and boys 9 months to 14 years of age (the exact interval in the field of application from 9 months to 14 years will depend on MR in the country).

Table 5.3.1 Baseline NVS campaign figures for MR

Number	Data: objectives
	2016
Total target population	72,464
Wastage rate (%) for MR (campaign)	10
Maximum wastage rate for MR (campaign)	0 %

6. New and underused vaccines (routine NVS)

7. NVS Preventive campaigns

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

Disease	Title of the assessment	Date	Results
N/A	N/A	N/A	N/A

Please attach the Action Plan for each campaign as Document No. 29.23 in Section 10.

7.1.1 Epidemiology and disease burden for measles-rubella

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

Epidemiological information on the disease burden:

☑ 1 - Rubella data from the measles case-based surveillance system (including the age distribution of rubella cases)

☐ 2 - Rubella seroprevalence surveys

☐ 3- Information on congenital rubella syndrome morbidity, for example a retrospective study, modelled evaluations of CRS morbidity, prospective surveillance.

☐ 4 – Other

7.2 Requested 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 catch-up campaign? **October 2016**

When is the country planning to introduce MR into routine immunisation? **October 2016**

It should be noted that because of various factors, the launch date may vary compared to the date stipulated in the application. Gavi will work in close collaboration with the country and their partners to correct this problem.

Please summarise the sections of the cMYP and/or of the introduction plan for MR 10 dose(s) per vial, lyophilised that relate to the introduction of MR, 10 dose(s) per vial, lyophilised. Please describe the principal items that guided the decision-making process (data taken into consideration etc), and describe the social mobilisation and micro-planning plans, in particular the strategies for unsafe areas or areas difficult to reach. If these items are included in the introduction plan or plan of action, please cite the sections only.

Introduction plan 10.2

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 logistics requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. Please describe how peak capacity will be managed for the campaigns. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how this will be handled. The Independent Review Committee (IRC) requires assurances 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 action plan, please cite the section here). **All the proposals** that include Gavi funding for the cold chain intended for storing vaccines must provide equipment that is WHO-prequalified for its performance, quality and programme safety (PQS). The purchase of non-PQS equipment will only be considered in special cases, with documentation and prior approval 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.

5.8 Vaccine management

Because the measles/rubella vaccine is replacing a vaccine that is already in the schedule (MCV), the vaccine management plan will need to ensure this transition. The MR vaccine will be implemented into the country's existing schedule and use supply methods that are in compliance with procedures. Annual routine MR needs will be estimated and taken into account in the 2016 "forecast" plan. These needs will address the importance of creating a reserve stock, since this is the first time that the vaccine has been used in the country. Until then, the logistics office will oversee the following:

- Existing MCV supplies will be progressively reduced by absorbing reserve stock, so that there is no overstock of this vaccine at the end of 2016; MR stock must be established while avoiding excess MCV stock in the facilities.
- The residual quantity of MCV after the MR vaccine has been implemented into the routine schedule will be removed and safely stored outside the supply chain in order to avoid the presence of both antigens in the programme at the same time.
- As of 1 January 2017, all of the MCV stock remaining in health centres must be collected and sent to the districts. These stocks must be returned to the central level.
- These residual vaccines will be destroyed.

Once it has been introduced, the MR vaccine will follow the immunisation coverage and wastage rate trends of the measles vaccine (MCV).

5.9 Overview of cold chain capacity at central and health district levels

1. **Strengthening the cold chain**

Central level

Currently available equipment easily covers vaccine storage capacity needs until 2019.

Operation level - Districts

The country should procure three new **Dometic** brand refrigerators (model **TCW 2000 SDD**).

At the health outpost level, the country must plan to gradually replace gasoline-powered refrigerators now in use by **Dometic** brand solar equipment, model **TCW 40 SDD**.

1. **Vaccine procurement and distribution**

The MR vaccine is currently being sold in 10-dose vials in lyophilised form. It must be stocked at between +2 to + 8° C. The diluents and vaccines must be kept at between +2 and +8 °C at the points of service. Once reconstituted, these vaccines must be kept no longer than 6 hours maximum. For the first year, the quantity needed for both the introduction and following months will be delivered in one shipment. These vaccines need to arrive at the central level in August 2016.

Vaccine distribution from the central level to the health districts will be carried out by the EPI team at least two weeks before the campaign's official launch date. The health districts will, in turn, supply the health facilities within their respective jurisdictions. This activity requires that means of transportation be available at all levels. This transportation will be mobilised at the central and district levels.

Central vaccine storage capacity, 2015-2019 in Sao Tome and Principe

Please describe how the campaign activities will contribute to strengthening routine immunisation services. Refer to activities that will be completed in the context of planning the campaign, in order to evaluate the implementation of activities intended to strengthen routine immunisation services; refer also to the quality and level of immunisation coverage achieved during the campaign.

5.7 Introducing the MR vaccine into the routine immunisation programme

The MR vaccine will be introduced into the routine immunisation plan for children from 9 to 18 months of age, replacing the measles vaccine. The MR vaccine will be introduced simultaneously throughout the country. A widespread introduction will produce quicker effects, and it is easier to promote the event throughout the country. The MR vaccine will be administered at the same age when children currently receive their dose of measles vaccine: at 9 and 18 months.

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

V.12 Surveillance of measles, rubella and congenital rubella syndrome

The surveillance of EPI target diseases is carried out in the overall context of the integrated disease surveillance and response system. Eight diseases (measles, haemorrhagic fever, shigellosis, cholera, meningitis, AFP, yellow fever and MNT) are subject to weekly surveillance using the telephone network.

All districts have surveillance focal points (RDE), which have been made operational in the context of integrated disease surveillance and response implementation and use data collection tools that are available and are an integral part of the district monthly report. The completeness and promptness of these reports vary between 80% and 100%.

The last cases of measles date back to 1994. Surveillance of these diseases is case-based, with confirmation at the reference laboratory if necessary.

Surveillance of suspected measles cases began in 2014 with samples being sent to the reference laboratory (CPC).

Please produce the relevant documents to support the relative estimates of the size of the campaign's target population (DOCUMENT No.: 18).

7.2.2. Allocation of support for the operating costs of the MR campaign

Table 7.2.2: calculation of support for campaigns' operating costs

Year of MR support	Total target population (Table 5.3)	Gavi contribution per target person in US$	Total in US$
2016	72,464	0.65	47,102

[1] The grant will be based on a maximum gift of US$ 0.65 per person in the target population.

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

Please describe how the Introduction Grant will be used to facilitate the timely and effective implementation of immunisation campaigns for the target populations in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).

12. Bank form (accounting)

Name of Institution (Account Holder):

EPI

Address:

Avenue Kwame Nkruma

City, Country:

Sao Tomé – Sao Tome and Principe

Telephone no.:

+239 2242000

Fax no.:

Currency of the bank account:

$US

For credit to:

Bank account's title:

EPI

Bank account no.:

1110/154

Bank name:

BANCO INTERNACIONAL DE SAO TOMÉ E PRÍNCIPE (BISTP)

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

5.6 Vaccine affordability and financial sustainability

The government of Sao Tome et Principe is committed to long-term co-financing of the rubella vaccine portion of the first and second doses of the MR vaccine in the routine EPI. For the immunisation campaign for children and adolescents (9 months to 14 years) that will precede the introduction of the MR vaccine into routine EPI, Gavi support will procure the necessary vaccines. For the campaign's operational costs, Gavi funding will be evaluated at a cost of US$ 0.65 per person in the target population for this campaign (72,464 inhabitants x US$ 0.65 $), or US$ 47,174.06.

The 24% funding gap will be mobilised by the Government and its technical and financial partners.

The operational costs for the MR immunisation campaign include the cost of cold chain equipment in the amount of US$ 175,578.61

The primary budget items are distributed as follows:

- Management and planning: US$ 905, or 1% of the budget;
- Training (capacity building): US$ 16,791.22, or 10%;
- Procurement and transportation costs for vaccines: US$ 66,302.97, or 38% of the budget;
- Monitoring and evaluation: 20,000, or 11% of the budget;
- Logistics (maintenance and fuel): US$ 5.418, or 4% of the budget;
- Social mobilisation: US$ 14.862, or 8% of the budget;

The operational cost of the combined MR vaccine introduction into routine is estimated at US$ 171,630. Gavi will subsidise the vaccine's introduction into routine with a grant of US$ 100,000.

Please also complete the form entitled "Detailed budget for the vaccine introduction/operational costs grant" provided by Gavi. It must be attached in the annexes section.

Detailed budget attached as Document No. 22.

7.2.3 Evidence of introduction of MR in routine programme

Please provide evidence that the country can fund the introduction of Rubella-Containing-Vaccine (RCV) into the routine programme through one of the following:(Please attach available documents AS DOCUMENT NUMBER 17 in Section 10. Attachments).

☐ 1- A commercial contract for purchase of MR/MMR vaccine with or without shipping documents, invoice, etc.

☑ 2- Integration of RCV into the cMYP with a corresponding increase in the budget line for vaccines in the health sector budget adequate to cover purchase of RCV (please highlight the budget line in the cMYP costing or other document showing the corresponding increase to cover the purchase of RCV)

☐ 3- A MOU between government and donor(s) (or other written document) committing the donor(s) to support for at least one year, the purchase of RCV for use in the routine programme **OR** a letter from the Ministry of Finance or Budget ensuring additional funding for RCV purchase. In this case, the country must show additional evidence that the country will include MR vaccination in the routine immediately after the campaign.

7.2.4 RCV introduction schedule

Countries must describe their introduction plan for surveillance activities.

Does Sao Tome and Principe's cMYP include a plan for the introduction of RCV into the national programme? **No**

Please specify the timeline for updating the cMYP **January 2016**

Please attach the Introduction Plan for the introduction of RCV into the national programme as **Document number 13** in Section 10 and also attach the Plan of Action for the campaign as **Document number 29 in Section 10. Please refer to Gavi's guidelines on support applications, for the items that must be included in the Introduction Plan and the Action Plan.**

See the attached document

7.2.5 Rubella vaccine introduction grant (VIG)

Has a rubella vaccine already been introduced into the national routine immunisation programme? **No**

Calculation of the vaccine introduction grant for MR, 10 dose(s) per vial, lyophilised

Please indicate in the tables below how the one-time introduction grant ***[1]*** will be used to cover the costs inherent to vaccine introduction and to essential preparatory activities (refer to the cMYP). If Gavi support is insufficient to cover all the requirements, please indicate in the table below the additional amount required and who will supplement the total funding.

Year of New Vaccine Introduction	Birth cohort (from Table 5.1)	Gavi contribution per target person in US$	Total in US$
2016	5,831	0.80	100,000

[1] The grant will be based on a maximum award of US$ 0.80 per person in the birth cohort with a minimum starting grant award of US$ 100,000

Please explain how the introduction grant provided by Gavi will be used to facilitate the timely and effective implementation of the activities before and during the introduction of the new vaccine (refer to the cMYP and to the vaccine introduction plan).

5.4 Steps necessary to facilitate the introduction of the MR vaccine

The primary activities to be implemented in the context of introducing the MR vaccine are:

- preparing a MR vaccine campaign plan and introduction plan for December 2015;
- ICC approval of the funding request file in January 2016;
- file submitted to Gavi in January 2016;

- review management and communication tools in February-March 2016;
- preparing communication plan in March 2016;
- preparing training plan in May-June 2016;
- preparing micro-plans at the district level in July-August 2016;
- implementing communication plan in September 2016;
- receiving vaccines at the central level in July 2016;
- implementing cascade training plan in August and September 2016;
- distributing vaccines and injection supplies to health districts in October 2015;
- the introduction into routine EPI preceded by the official launch of an immunisation campaign for children aged 9 months to 14 years in October 2016;
- post-introduction supervision in November 2016;
- restoring the immunisation campaign for children aged 9 months to 14 years in January 2017;

post-introduction evaluation, 6 - 9 months after the introduction.

8. Procurement and management

8.1 Procurement and management of routine immunisation 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 purchase of vaccines (Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund):

Once the expenditure plan and the funds allocated to activities are approved, the EPI accounting group takes steps to release the funds and this includes issuing a check. The check must have 2 to 3 signatures. These signatures include that of the Director of Health Care, the Director of Planning and Finance in the Ministry of Health and the UNICEF representative. The beneficiaries are required to submit a technical and financial report of the activities carried out by the central EPI office. The central EPI office submits a summary financial report on all resources to the ICC for approval.

b) If an alternative mechanism for procurement and delivery of vaccine (financed by the country or 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 purchase of locally-produced vaccines directly from a supplier 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 with standards is assured by a National Regulatory Authority (NRA) with jurisdiction, as assessed by WHO in the countries of production and purchase.

N/A

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

The funds should be transferred by Gavi directly by a commercial bank (BISTP - Banco Internacinal de São Tomé e Príncipe)

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

The co-financing amounts will be paid by direct transfer from the Ministry of Finance to UNICEF.

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

N/A

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

8. Monitoring-Evaluation

8.1 Updating the monitoring instruments

Management tools (tally sheets/registration cards, vaccination registers, mother and child health cards, monthly activity reports, stock cards) as well as the EPI norms and standards document will be revised, in order to integrate all aspects of the MR vaccine. Training modules will also be prepared for service provider training/retraining and communication, then distributed to all levels before the vaccine is introduced.

Monitoring and evaluation will take place:

- at the operational level, through monthly coordination and self-evaluation meetings;
- at the central level, through monthly data review meetings to evaluate districts' performance and data quality.
- in quarterly workshops to review routine EPI data bringing together the central and district levels (DCS, PSR/EPI, CNES, Surveillance Department, WHO, UNICEF and UNFPA).

immunisation coverage, specific dropout rate, wastage rate and vaccine stockouts will be the indicators used for monitoring and evaluation.

A post-introduction evaluation will be conducted 6 -12 months after introduction to identify the impact of the programme's components, to correct all problems that arise, and review useful lessons learned, to be better prepared for the introduction of new vaccines in the future.

g) For request for support related to the measles vaccine second dose, does the country wish to receive donations in kind or in cash? **In kind**

8.2 Procurement and management for NVS preventive campaigns

8.2.1 Procurement and management for the MR campaign, 10 dose(s) per vial, lyophilised

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):

V.6.2 Receiving and distributing vaccines

Vaccine distribution from the central level to the health districts will be carried out by the EPI team at least two weeks before the campaign's official launch date. The health districts will, in turn, supply the health facilities within their respective jurisdictions. This activity requires that means of transportation be available at all levels. This transportation will be mobilised at the central level.

b) Please describe the financial management procedures applicable to the operating support for preventive immunisation campaigns, including the related procurement procedures.

Funding for the 2016 mass measles and rubella immunisation campaign in Sao Tome and Principe will be ensured as a result of the local mobilisation of resources; US$ 42,101.58, or 24% from the Government and its technical and financial partners, including Gavi who, in addition to vaccines and supplies, will fund operational costs at 76% of the budget, or US$ 133,477.03.

c) Please indicate whether the campaign will be carried out in multiple phases. If so, please specify how these different phases will be organised.

No.

d) Please explain how the campaign coverage will be monitored, publicised and evaluated (please refer to the cMYP and/or the introduction plan for the MR campaign, 10 dose(s) per vial, lyophilised).

Supervision tools will be developed at the central level and made available to supervisors at the various levels to conduct supervision during and after the campaign to ensure a quality, successful campaign.

During the campaign, monitoring will occur through the health information system through daily compiling and monitoring of immunisation coverage data, vaccine and other input management and monitoring wastage rates. Meetings will be held daily, between vaccinators and team supervisors at the health centre level, and between supervisors at the district level and the Principe Autonomous Region.

After the campaign:

- rapid convenience surveys are planned during the campaign to identify unvaccinated children and to take corrective actions.
- A post-campaign coverage survey three to four weeks after the end of the campaign
- a post-campaign restoration meeting within a period of two to three months.

The results of these evaluations will help assess:

1. the quality of campaign activity implementation
2. the proportion of the target population that has been immunised

These results will also provide lessons learned and a conclusion for the introduction of new vaccines and the immunisation campaign.

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 Action Plan.

Yes

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

Yes

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

N/A

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

It has not

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. This EVM should have been carried out in the course of the **five preceding years**.

When was the EVM conducted? **January 2015**

Please attach the most recent EVM assessment report (DOCUMENT NUMBER : 20, 19, 21) the corresponding EVM improvement plan (DOCUMENT NUMBER : 19) and the progress report on the EVM improvement plan (DOCUMENT NUMBER : 21). 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 post-introduction evaluations and external EPI reviews.

When is the next Effective Vaccine Management (EVM) Assessment planned? **January 2018**

See attachment

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), of equipment enabling the safe handling of immunisation materials, storage capacity, transportation and disposal of immunisation waste. Please describe the country's waste management plan for immunisation activities (including campaigns).

5.9.3 Waste management and injection safety

For routine immunisation and the campaign, instructions on waste management are the following:

- The systematic use of auto-disable (AD) syringes for each injection;
- The collection of used syringes and needles in safety boxes;
- Full safety boxes are disposed of through burial of slag in two-level pits in health facilities.
- The materials and equipment used to manage waste are the following:

1. 1. triage/waste separation: safety boxes are available and in sufficient quantities at all health facilities;

2. 2. pre-collection: waste bins are available;

3. 3. collection/transport: during immunisation campaigns, waste from outreach sites is collected and taken to health facilities to be destroyed;

4. final elimination: 5. final disposal: slag is collected and thrown into pits.

9. Additional comments and recommendations from the national coordinating body (ICC/HSCC)

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

The WHO representative, in order to strengthen the presentation, spoke about rubella cases, which are light for children and more dangerous for pregnant women. This is because children may be born with congenital rubella syndrome, and for this reason the government (Ministry of Health) asked the partners to substitute the combined measles-rubella vaccine for the measles vaccine. She asked for cooperation from all of the partners who were present to provide effective support to the country in that direction. The UNICEF representative added that there would not be a burden on the children, because now they have the measles vaccine, and they will continue to have one single combined vaccine, for measles and rubella. And she also called on the country's reaction time, because it had taken some time to take such action.

10. List of documents attached to this proposal

10.1. List of documents attached to this proposal

Table 1: Checklist for mandatory attachments

Document Number	Attachment	Section	File
Approvals			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	CCIA 1.pdf **File desc:** **Date/time** 15/01/2016 10:29:01 **Size:** 826 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	CCIA 1.pdf **File desc:** **Date/time** 15/01/2016 10:29:53 **Size:** 826 KB
4	ICC Terms of Reference	4.1.2	Acta CCIA 28_4_2014.pdf **File desc:** **Date/time** 15/01/2016 10:58:07 **Size:** 332 KB
5	Minutes of ICC/HSCC meeting endorsing Proposal	4.1.3	CCIA 2.pdf **File desc:** **Date/time** 15/01/2016 10:30:48 **Size:** 307 KB
6	Signatures of ICC or HSCC or equivalent in Proposal	4.1.3	CCIA 3.pdf **File desc:** **Date/time** 15/01/2016 10:33:13 **Size:** 297 KB
7	Minutes of the three most recent ICC/HSCC meetings	4.1.3	CCIA 1x.pdf **File desc:** **Date/time** 15/01/2016 10:35:21 **Size:** 185 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	São Tome et Príncipe il y a pas.docx **File desc:** **Date/time** 15/01/2016 11:03:25 **Size:** 12 KB
Vaccine management, planning and funding			
9	comprehensive Multi Year Plan - cMYP	5.1	PPAC.docx **File desc:** **Date/time** 15/01/2016 10:38:04 **Size:** 683 KB
10	cMYP Costing tool for financial analysis	5.1	PPAC.docx **File desc:** **Date/time** 15/01/2016 10:38:41 **Size:** 683 KB

11	M&E and monitoring plan in the countries with an existing monitoring plan	5.1.5	STP-Plan opérationel Introduction RR_18.12.2015.doc **File desc:** **Date/time** 15/01/2016 11:11:58 **Size:** 1 MB
12	Vaccine introduction plan	5.1	STP-Plan opérationel Introduction RR_18.12.2015.doc **File desc:** **Date/time** 15/01/2016 11:00:02 **Size:** 1 MB
13	Introduction Plan for the introduction of rubella / JE / Men A / YF combined vaccine into the national programme.	7.x.4	STP-Plan opérationel Introduction RR_18.12.2015.doc **File desc:** **Date/time** 15/01/2016 10:41:05 **Size:** 1 MB
17	Evidence of commitment to fund purchase of RCV for use in the routine system in place of the first dose of MCV	7.x.3	CCIA 1.pdf **File desc:** **Date/time** 15/01/2016 11:13:12 **Size:** 826 KB
18	Campaign target population documentation	7.x.1, 6.x.1	V.docx **File desc:** **Date/time** 15/01/2016 11:14:55 **Size:** 16 KB
19	EVM report	8.3	Rapport_GEV_2015_STP final.pdf **File desc:** **Date/time** 15/01/2016 10:42:22 **Size:** 1 MB
20	Improvement plan based on EVM	8.3	STP-Plan d'amélioration_GEV_DraftZero.xlsx **File desc:** **Date/time** 15/01/2016 10:42:55 **Size:** 89 KB
21	EVM improvement plan progress report	8.3	Rapport_GEV_2015_STP final.pdf **File desc:** **Date/time** 15/01/2016 11:07:59 **Size:** 1 MB
22	Detailed model budget for the vaccine introduction / operating costs grant	6.x,7.x.2, 6.x.2	5.docx **File desc:** **Date/time** 15/01/2016 11:19:37 **Size:** 16 KB
27	Data quality assessment (DQA) report	5.1.5	Il n.docx **File desc:** **Date/time** 15/01/2016 11:23:43 **Size:** 13 KB
29	Campaign action plan	7.1, 7.x.4	PLAN CAMPANHA RR_28.12.2015_ACTUAL.docx **File desc:** **Date/time** 15/01/2016 10:44:15 **Size:** 660 KB

Table 2: List of optional attachments

Document Number	Attachment	Section	File
3	MoH Signature (or delegated authority) of Proposal for HPV support	4.1.1	No file uploaded
15	HPV vaccine roadmap or strategy	6.1.1	No file uploaded
16	Summary of the HPV vaccine assessment methodology	5.1.6	No file uploaded
23	Risk assessment and MenA consensus meeting report If DPT was used instead, please specify	7.1	No file uploaded
25	A description of partner participation in preparing the applications	4.1.3	No file uploaded
26	Minutes of the NITAG meeting with specific recommendations on NVS introduction or the campaign	4.2	No file uploaded
28	DQA improvement plan	5.1.5	No file uploaded
30	Other documents		No file uploaded

11. Annexes

Annex 1 - NVS Routine Support

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

		2016	2017	2018	2019
Number of vaccine doses	#	8,900	7,300	7,500	7,700
Number of AD syringes	#	8,300	6,500	6,700	6,800
Number of reconstitution syringes	#	1,000	900	900	900
Number of safety boxes	#	125	100	100	100
Total value to be co-financed by Gavi	$	3,000	2,500	2,500	2,500

		2020
Number of vaccine doses	#	7,800
Number of AD syringes	#	7,000
Number of reconstitution syringes	#	900
Number of safety boxes	#	100
Total value to be co-financed by Gavi	$	3,000

Annex 2 – NVS Routine Support – Preferred second presentation

No NVS – routine immunisation – second preferred 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

ID		Data from		2016
	Total target population	Table 5.2	#	72,464
	Number of doses per person	Parameter	#	1
	Vaccine wastage rates	Table 6.4.1	#	10
	Estimated vaccine wastage factor	Table 5.2	#	1.11
	Number of doses per vial	Parameter	#	10
	AD syringes required	Parameter	#	Yes
	Reconstitution syringes required	Parameter	#	Yes
	Safety boxes required	Parameter	#	Yes
ca	**AD syringe price per unit**	Table Annexes 4A	$	0.041
cr	**Reconstitution syringe price per unit**	Table Annexes 4A	$	0.003
cs	**Safety box price per unit**	Table Annexes 4A	$	0.005
fv	**Freight cost as% of vaccines value**	Table Annexes 4B	%	2.48%
fd	**Freight cost as% of devices value**	Parameter	%	0

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	2016		
			Total	Government	Gavi
B	Gavi support	*Table 5.3.1*	72,464	0	72,464
C	Number of doses per person	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B X C*	72,464	0	72,464
E	Estimated vaccine wastage factor	*100 / (100 - Vaccine wastage rate)*	1.11		
F	Number of doses needed including wastage	*D X E*	80,436	0	80,436
G	Vaccines buffer stock	*0*	0	0	0
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	80,500	0	80,500
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	80,436	0	80,436
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	8,936	0	8,936
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 × 1.11*	993	0	993
N	Cost of vaccines needed	*I x * vaccine price per dose (g)*	48,783	0	48,783
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	3,278	0	3,278
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	28	0	28
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	6	0	6
R	Freight cost for vaccines needed	*N x freight cost as % of vaccines value (fv)*	1,208	0	1,208
S	Freight cost for devices needed	*(O+P+Q) x freight cost as% of devices value (fd)*	0	0	0
T	Total funding needed	*(N+O+P+Q+R+S)*	53,303	0	53,303

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

Annex 4

Table Annex 4A: Commodities Cost

Estimated prices of supplies are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Type of Vaccine	2016	2017	2018	2019
MR, 10 dose(s) per vial, LYOPHILISED	MM	2.48 %			

Table Annex 4C: Preparatory transition phase - Minimum country's co-payment per dose of co-financed vaccine

Table Annex 4D: Wastage rates and factors

The table below presents the wastage rates for the different vaccines (routine immunisation and campaigns) for 2016.

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

Observations:

* Sources: WHO recommended wastage rates

** Source: Country APRs and surveys, approved by WHO, UNICEF, and the Gavi Secretariat

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

Table Annex 4E: Vaccine maximum packed volumes

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)
BCG	BCG	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-HepB liquid + Hib freeze-dried	DTP+Hib	liquid	IM	3	10	2.5	
DTP-HepB liquid + Hib freeze-dried	DTP-HepB-Hib	liquid+lyop.	IM	3	1	22	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid+lyop.	IM	3	2	11	

DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	10	4.4	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	2	13.1	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	1	19.2	
DTP-Hib combined liquid	DTP+Hib	liquid+lyop.	IM	3	10	12	
DTP-Hib combined liquid	DTP+Hib	liquid	IM	3	1	32.3	
Hepatitis B	HepB	liquid	IM	3	1	18	
Hepatitis B	HepB	liquid	IM	3	2	13	
Hepatitis B	HepB	liquid	IM	3	6	4.5	
Hepatitis B	HepB	liquid	IM	3	10	4	
Hepatitis B Uniject	HepB	liquid	IM	3	Uniject	12	
Hib freeze-dried	Hib_lyo	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	HPV	liquid	IM	3	1	15	
Human Papillomavirus vaccine	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 freeze dried	MMR	lyophilised	SC	1	1	26.1	26.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	2	13.1	13.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	5	5.2	7
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	10	3	4
Measles-Rubella freeze dried	MR	lyophilised	SC	1	1	26.1	26.1
Measles-Rubella freeze dried	MR	lyophilised	SC	1	2	13.1	13.1
Measles-Rubella freeze dried	MR	lyophilised	SC	1	5	5.2	7
Measles-Rubella freeze dried	MR	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	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	IPV	liquid	IM	3	PFS	107.4	
Polio inactivated	IPV	liquid	IM	3	10	2.5	
Polio inactivated	IPV	liquid	IM	3	1	15.7	
Rota vaccine	Rota_liq	liquid	Oral	2	1	17.1	
Rota vaccine	Rota_liq	liquid	Oral	3	1	45.9	
Tetanus Toxoid	TT	liquid	IM	2	10	3	
Tetanus Toxoid	TT	liquid	IM	2	20	2.5	
Tetanus Toxoid Uniject	TT	liquid	IM	2	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

12. Banking form

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

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

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

By whom is the account audited?

Signature of Government's authorising official

		Seal
Name:		
Title:		
Signature:		
Date:		

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

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

The account must be signed jointly by at least (number of signatories) of the following authorised signatories:

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

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