REPUBLIC OF TOGO

MINISTRY OF HEALTH

DOCUMENT TO BE SUBMITTED TO THE GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION TO SUPPORT REINFORCEMENT OF IMMUNISATION SERVICES IN TOGO

(15 July 2007 Form)

Please return one signed copy of this document to
GAVI Alliance Secretariat, c/o UNICEF, Palace of Nations, 1211 Geneva 10, Switzerland

For all inquiries, please go to Dr. Ivone Rizzo irizzo@gavialliance.org or to representatives of a GAVI partner institution. All documents and appendices must be submitted in English or French.

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Analytical Summary

In 2002, the Expanded Programme for Immunisation (EPI) of Togo benefited from support from the GAVI Fund for the implementation of the Reach Each District (RED) approach in 23 pilot districts selected based on their lower than 50% DTC3 coverage and their systematic EPI target population over 5,000 children.

This support, extended to 35 districts since 2003, is strengthened by support from traditional partners (WHO, UNICEF, GTZ, Plan Togo, Togolese Red Cross, Coopération Française, European Union) and a great deal of involvement by political, administrative, and technical authorities.

The programme, which is strong due to this favourable environment, has advanced immunisation coverage year after year. Thus, DTC3 coverage of children from 0-11 months and VAT2+ of pregnant women went respectively from 43% to 88% and from 40% to 85% from 2001 to 2007. The loss rate of vaccines, the vaccine drop-out rate, and the indicators of monitoring of EPI target diseases are also progressively improving even though much work remains to be done to meet the new requirements.

In 2004, also due to support from the GAVI Fund, the yellow fever vaccine was introduced into systematic immunisation.

In March-May 2006, Togo reviewed the Programme, and it appears from its results that efforts have been made in comparison to the 2001 review. In the same process, Togo has prepared its Complete Multiyear Plan (cMYP) of the Expanded Program for Immunisation for the next five years (2007-2011).

The vision of our cMYP is a part of the vision of the world-wide strategy for vaccines and immunisation. It comes under 5 strategic areas :

- to immunise additional persons regardless of the social and health environment
- to integrate immunisation into other work by the health system
- to reinforce monitoring and control of diseases
- to develop a long-term and varied partnership for financing and management of the EPI
- to define and implement viable strategies for the EPI.

In order to increase the spectrum of protection of Togolese children against preventable diseases by immunisation, in 2007 the Ministry of Health requested and obtained the support of the GAVI Fund to integrate two new vaccines, the vaccines against viral hepatitis B and hemophilus influenzae type B (pentavalent DTC-HepB-Hib vaccine) into systematic immunisation. This introduction is planned for July 2008.

The implementation of the cMYP requires a large amount of additional resources and the financing not ensured exceeds 35% of the total planned financing. The requirements for future resources for the five years of the Plan total more than 45 million dollars.

Togo would like to seize the opportunities that the GAVI Fund offers in its phase 2 to member countries, in order to ensure the financing of certain activities in the plan. Within this framework, the government is requesting GAVI support to strengthen the immunisation services support (ISS) in phase 2. After having benefited from the initial ISS support, the second phase will be done in the form of reimbursement based on EPI performance in DTC3 coverage. The duration of this support takes account of the time frame of our cMYP, which will expire at the end of 2011.

The basic data in 2007 and the objectives in the area of immunisation coverage and the number of children to be immunised by year, from 2008 to 2011, are summarised in the table below :

Table summarising reference data and annual objectives

Number of		Reference Year	Reference Data and Objectives			
		2007	Year 1 2008	Year 2 2009	Year 3 2010	Year 4 2011
Births		245,925	251,979	258,177	264,529	271,036
Infant deaths		19,674	12,038	11,458	10,907	10,382
Surviving infants		226,251	239,941	246,719	253,622	260,654
Pregnant women		245,925	251,979	258,177	264,529	271,036
Target population immunised with BCG		224,006	239,380	247,850	253,947	262,905
Coverage by BCG*		91%	95%	96%	96%	97%
Target population immunised with VPO3		175,522	213,548	222,048	230,796	247,622
Coverage by VPO3**		78%	89%	90%	91%	95%
Target population immunised with DTC3***		199,649				
Coverage by DTC3**		88%				
Target population immunised with DTC1***		212,555				
Target population immunised with a **3rd dose** of		8%				
Target population immunised with a **3rd dose** of DTC-Hep B-Hib…….			213,548	222,048	230,796	247,622
……. Coverage**			89%	90%	91%	95%
Target population immunised with a **1st dose** of DTC-Hep B-Hib…….			227,944	234,383	240,941	247,621
Loss rate[1] over the course of the reference year and rate expected as a result			10%	5%	5%	5%
Target population immunised with a **1st dose** of anti-measles vaccine		181,369	206,623	214,287	215,578	234,589
Target population immunised with a **2nd dose** of anti-measles vaccine		NA	NA	NA	NA	NA
Coverage by anti-measles vaccine**		80%	82%	83%	85%	90%
Pregnant women immunised with Tetanus anatoxin+(VAT2+)		209,237	219,222	227,196	235,430	243,932
Coverage by Tetanus anatoxin+(VAT2+) ****		85%	87%	88%	89%	90%
Vitamin A supplement	Mothers, (<6,weeks,after,birth)	149,759	162,902	171,343	176,974	185,518
	Infants,,(>6,weeks)	182,613	213,548	222,048	230,796	247,622
Annual DTC dropout rate [(DTC1-DTC3)/DTC1] x100		6%	6%	5%	5%	5%

These immunisation coverages will be achieved by applying the following strategies :

[1] Formula enabling the loss rate of a vaccine to be calculated (in percentage): [(A-B)] x 100. A being equal to the number of doses distributed in accordance with the supply registries, with correction of all of the stocks at the end of the supply period; B being equal to the number of immunisations carried out with the same vaccine over the course of the same period. For new vaccines, see **table α** after table 7.1.

- Reduction of DTC-HepB-Hib1/DTC-HepB-Hib3 dropout rate
- Reduction of DTC-HepB-Hib vaccine dropout rate
- Staff training
- Strengthening the advanced strategy
- Strengthening supervision and monitoring
- Strengthening monitoring of adverse effects following immunisation (AEFI)
- Strengthening storage capacities and maintenance
- Strengthening communication in favour of EPI by using different channels of communication (mass media, opinion leaders, associations/NGOs) to obtain participation by the population, especially by mothers, in immunisation of children against hepatitis B and hemophilus influenzae type B
- Implementation of the safe injection policy
- Empowering the Interagency Co-ordinating Committee with respect to its membership and operation.

The following table describes :

- objectives in terms of coverage by year,
- the number of infants declared immunised or who must be immunised with DTC-HepB-Hib3
- the number of additional infants who must be immunised with DTC-HepB-Hib3
- the amount of funds requested from GAVI, corresponding to the number of additional infants, for reinforcing immunisation services over the 2009-2011 period.

Table summarising the amount of funds requested from GAVI

	Reference Year 2007	**Year 1 2008…**	**Year 2 2009…**	**Year 3 2010…**	**Year 4 2011…**
Rate of DTC3 coverage	88%	89%	90%	91%	95%
Number of infants declared immunised / who must be immunised with DTC3 (according to table 3.4)	199,649	213,548	222,048	230,796	247,622
Number of *additional* infants declared immunised / who must be immunised each year with DTC3	-	13,899	8,500	8,748	16,826
Funds expected (US $20 per additional infant)	**-**	**277,980**	**170,000**	**174,960**	**336,520**

2. Signatures by the Government and National Co-ordinating Entities

Government and Interagency Co-ordinating Committee for Immunisation

The Government of Togo wishes to make the existing partnership with the GAVI Alliance closer in order to improve the national programme for systematic infant immunisation, and therefore, specifically requests the support of GAVI to strengthen immunisation services in Togo.

The Government of Togo agrees to develop the national immunisation services on a long-term basis, in accordance with the overall multiyear plan submitted with this document. The Government requests that the GAVI Alliance and its partners to contribute financial and technical assistance to support child immunisation as presented in this proposal.

Table **No. 4.1 on page 28** of this proposal gives the amount of the support (in kind or in cash) which is requested from GAVI Alliance.

Minister of Health (or Senior Official):	**Minister of Finances (or Senior Official):**
Professor Kondi Charles Agba	**Mr. Adji Otêth Ayassor**
Signature:	Signature:
Title: Minister of State, Minister of Health	Title: Minister of Finances, Budget and Privatisation
Date:	Date:

National Co-ordinating Entity: Interagency Co-ordinating Committee For Immunisation

We, the undersigned members of the ICC,[2] met on 15 April 2008 to review this proposal. At this meeting, we adopted this proposal based on the attached supporting documents:

- The approved minutes of this meeting appear in the appendix as **document number: 01**

[2] Interagency coordination committee

Name/Title	Institution/Organisation	Signature
Professor Kondi Charles Agba Minister of State, Minister of Health	Ministry of Health	
Dr. Kadri Tankari Representative	World Health Organisation (WHO)	
Ms. Una McCauley	United Nations Children's' Fund (UNICEF)	
Dr. Koku Sika Dogbe General Director for Health	General Directorate for Health	
Mr. Jean H. Djossou Administrator for Finances Director, State Subsidies Section, EPI Focus Area in Ministry of the Economy and Finances	Ministry of the Economy and Finances	
Mr. Issaka Laguebande Attaché de Cabinet	Ministry for Development and Territorial Development	
Mr. Gbehomilo - Nyelolo Tomegah Assistant Chairman	Rotary International	
M. Joseph Baah-Dwomoh	World Bank	
M. Olivier Boucher	Coopération Française Mission	
Ms. Rosine Sori Coulibaly	United Nations Development Programme	
Dr. Aristide Aplogan	Agency for Preventive Medicine (APM)	
Mr. Bell' Aube Houinato	Plan-Togo	
Dr. Alpha Oumar Barry	EU / ADSS	

Dr. Kuami Guy Battah	Togolese Red Cross	
Dr. Atayi Komlangan Director, Primary Health Care	Directorate for Primary Health Care	
Dr. Afefa Amivi Baba Director, Health Care Establishments	Directorate for Health Care Establishments	
Dr. Atany Nyansa Director, Pharmacies, Laboratories, and Technical Equipment	Directorate of Pharmacies, Laboratories, and Technical Equipment	
Mr. Hokameto Edorh Director for Planning, Training, and Research of the Ministry of Health	Directorate for Planning, Training and Research	
Mr. Okaté Akpo-Gnandi Director of Community Affairs of the Ministry of Health	Directorate for Community Affairs	
Dr. Danladi Nassoury EPI Co-ordinator	Division of Epidemiology	
Mr. Edem Koffi-Kuma Department Director	National Information, Education, and Communication Service	
Dr. Kassouta Komlan Tchiguiri N'TAPI Division Director	Family Health Division	

If the GAVI Secretariat has any questions concerning this proposal, the contact person is:

Name: Dr. **I. Danladi Nassoury**

Title: **Director, Division of Epidemiology**

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The GAVI Secretariat cannot return any documents and papers sent to the Secretariat to various countries. Unless otherwise indicated by the country, the documents may be sent to GAVI partners and co-operating entities.

Interagency Co-ordinating Committee for Immunisation

The institutions and partners (including the development partners and civil society organisations) that contribute their support to immunisation services are co-ordinated and organised through an interagency co-ordinating mechanism (ICC). The ICC is responsible for co-ordinating and the proper use of ISS and SIA support from GAVI. Please provide information on the ICC in your country in the spaces provided below.

ICC Profile

Name of ICC: ***Interagency Co-ordinating Committee for Immunisation (ICC) Togo***
……

Date of establishment of current ICC: 19 January 2001
:……..

Structure (for example, subcommittee, independent entity): The ICC is made up of three technical sub-committees:

- Technical sub-committee for EPI programme management
- Technical sub-committee for EPI logistics management
- Technical sub-committee for communication for the EPI.

Meeting frequency: One ordinary meeting per quarter and special meetings as appropriate

Members:

Position	**Title / Organisation**	**Name**
Chairman	**Minister of State Minister of Health**	**Kondi Charles Agba**
Secretary	**Division of Epidemiology**	**Dr. Danladi I. Nassoury**
Members	• WHO Representative	Dr. Kadri Tankari
	• UNICEF Representative	Ms. Una McCauley
	• General Director for Health	Dr. Koku Sika Dogbe
	• Administrator for Finances, Director, Department of State Subsidies, EPI Focus Area in the Ministry of Economy and Finances	Mr. Jean H. Djossou
	• Attaché de Cabinet in the Ministry of Co-operation of Development and Territorial Development	Mr. Issaka Laguebande
	• Assistant Chairman Rotary International	Mr. Gbehomilo - Nyelolo Tomegah

	• World Bank	Mr. Joseph Baah-Dwomoh
	• Coopération Française Mission	Mr. Olivier Boucher
	• United Nations Development Programme	Ms. Rosine Sori Coulibaly
	• Agency for Preventive Medicine (APM)	Dr. Aristide Aplogan
	• Plan-Togo	Mr. Bell' Aube Houinato
	• EU / ADSS	Dr. Alpha Oumar Barry
	• Togolese Red Cross	Dr. Kuami Guy Battah
	• **EPI Co-ordinator Division of Epidemiology**	Dr. Danladi I. Nassoury
	• Director National Information Education Communication for Health	Mr. Edem Koffi-Kuma
	• Director, Primary Health Care	Dr. Atayi Komlangan
	• Director of Community Affairs in the Ministry of Health	Mr. Okaté Akpo-Gnandi
	• Director of Planning, Training and Research in the Ministry of Health	Mr. Hokameto Edorh
	• Director of Pharmacies, Laboratories and Technical Equipment	Dr. Atany Nyansa
	• Director of Health Establishments	Dr. Afefa Amivi Baba
	• Division Chief Family Health Division	Dr. Kassouta Komlan Tchiguiri N'tapi

Duties and responsibilities of the ICC:

The Interagency Co-ordinating Committee is responsible for:

- approving the multiyear and annual EPI strategic plans;
- evaluating the implementation of multiyear and annual plans;
- assisting the EPI to mobilise internal and external resources for performing programme activities;
- ensuring the co-ordination of contributions of national and international resources to reinforce the EPI;
- contributing its support for the review and approval of strategies related to the National Days of Immunisation (NDI) and to the EPI;
- guaranteeing transparent management of funds for the EPI;
- ensuring technical and political support for national co-ordination of EPI;
- supporting and encouraging the exchange of information and background information with external partners about immunisation activities;
- assisting to find short, medium, and long-term solutions to problems raised to the EPI.

Three major strategies intended to reinforce the role and functions of the ICC over the next 12 months:

1. Involvement of ICC members in the presentation to the partners to mobilise the resources necessary to finance the EPI and supplemental immunisations;
2. Reinforcement of the information system between the ICC and technical and administrative authorities involved in the EPI;
3. Renewal of subcommittees.

3. Data related to the immunisation programme

Please fill out the table below, using data from available sources, giving the source of the data and the date. If possible, use the most recent data and attach the document from which the data is taken.

- Please refer to the overall multiyear plan for immunisation (or the equivalent plan) and attach a complete copy (with an analytical summary) as **document number 02;**
- Please refer to the two most recent attached forms for WHO/UNICEF declarations on diseases preventable by immunisation and attach them as **documents number 03 and 04**.
- Please refer to health sector strategy documents, to budgetary documents, and to other reports, surveys, etc., as needed.

Table 3.1: Basic Information for 2007 ... (the most recent, indicate the dates of data provided)

	Number	Date	Source
Total population	5,465,000	2007	National Statistics Directorate (1981 updated census)
Infant mortality rate (per 1,000)	80	1998	Demographic and Health II Survey (1998)
Surviving infants*	226,251	2007	National Statistics Directorate (1981 updated census)
Gross national income per inhabitant (US$)	ND	-	-
GDP	320	1999	World Bank Report
Percentage of GDP allocated to health	6.64%	2000	GDP Committee
Percentage of government expenditures allocated to health	6.64%	2000	GDP Committee

* Infants still living at 12 months of age.

Please give additional information on the context of planning and budgeting in your country:

Indicate the name and date of the planning document in effect for health:
National Plan for Health Development (NPHD) 2008-2012

Is the cMYP (or complete Multiyear Plan) aligned with this document (schedule, contents, etc.)?
Yes

Describe the national cycle for planning and budgeting for health:

In March of this year, the various operational and decentralised offices of the Ministry of Health are planning and budgeting for activities to be conducted next year based on the guidance in the National Health Policy (NHP) and the National Health Development Plan (NHDP).
Annual plans prepared in each of these decentralised departments go through an initial review in each Division in order to be consolidated before being sent to their respective central management offices the Central Managers and their teams conduct a second review.
The Central Management Offices co-ordinate the requirements and create the budgets.
The various budgets by management are sent to the Directorate for Community Affairs of the Ministry of Health.
The DCA centralises all of the budgets according to the official plan.
A budget session is organised in September of this year at the Ministry of Finances for the justification of the allocated lines.
A second budget review session approves the budget line items in order to complete a first draft of the law on finances for the following year.
This first draft law is submitted to the Government, which adopts it in a draft law on finances, which would be sent to the National Assembly for adoption.
The National Assembly adopts the law on finances. The Government authorises the expenditures according to the line items in the budget.
The Ministry of Health makes the obligations of expenditures.
The operational departments order goods or services from suppliers, after consultations with suppliers, if the amount of the order is below 15 million CFA francs (US $30,000). If the amount is over $30,000, a public call for bids is issued, following the government procurement procedure in effect in Togo.
Upon delivery of goods or services, a committee for acceptance of the goods comprised of members of an auditing firm, the Ministry of Finances, the DAC, and the affected Department accepts the delivery. The committee prepares the Report and authorises the supplier to send its invoice to the Treasury for payment. The payment is always made by bank transfer.

Describe the national cycle for planning for immunisation:

Immunisation is planned through the 2007-2011 Multiyear Plan (cMYP). The vision for Togo is the same as the vision for the world-wide strategy for vaccines and immunisation. Thus, by 2015:

- Immunisation is a priority to reinforce the health system in general and to achieve the Millennium Objectives for Development (MOD);
- More persons are immunised against a greater number of diseases;
- Fairness and equal access to immunisation based on the national schedule are guarantees to all children, adolescents, and adults;
- Integration of immunisation activities with priority health care development work is a reality regardless of the social, political, and economic environment.

This vision comes under 5 strategic areas:

1. to immunise additional persons regardless of the social and health environment;
2. to integrate immunisation into other work by the health system;
3. to reinforce monitoring and control of diseases;
4. to develop a long-term and varied partnership for financing and management of the EPI; and
5. to define and implement viable strategies for the EPI.

The coverages and activities are evaluated at the end of each year of the cycle. The cMYP is reviewed and updated taking any new contexts into account.

6. At the operational level (regions, districts, and health care organisations) monthly evaluations through monitoring of immunisation coverage are conducted. At the end of the year, annual microplans are prepared at the operational level and consolidated at the central level.

Table 3.2.a **Current immunisation schedule: traditional vaccines, new vaccines, and vitamin A supplementation** *(page 15 of the cMYP)*

Vaccine *(do not use brand name)*	**Ages for vaccine administration** *(by systematic vaccination services)*	**Mark with "x" if the vaccine is administered in:**		**Comments**
		the entire country	**only one part of the country**	
BCG	At birth	X		
POLIO 0	At birth	X		
DTC1-HepB-Hib 1/POLIO 1/ Vitamin A 1	after 6 weeks	X		
DTC-HepB-Hib 2/POLIO2/ Vitamin A 2	after 10 weeks	X		
DTC1-HepB-Hib 3/POLIO 3/ Vitamin A 3	after 14 weeks	X		
VAR / VAA/ Vitamin A 4	after 9 months	X		
VAT	Pregnant women	X		

Table 3.2.b: Immunisation schedule for pregnant women

VAT1	First contact	X		
VAT2	4 weeks after VAT1	X		
VAT3	6 months after VAT2	X		
VAT4	1 year after VAT3	X		
VAT5	1 year after VAT4	X		

Table 3.3: Changes in immunisation coverage and morbidity burden
(as described in the last two joint WHO/UNICEF reporting forms on diseases preventable by immunisation)

Change in immunisation coverage (in percentage)							Morbidity Burden of diseases preventable by immunisation		
Vaccine			Reported		Survey		Disease	Number of reported cases	
			2006	2007	EPI Review 2006	200…		2006	2007
BCG			96	91***	92		Tuberculosis*	2131	1791
DTC	DTC1		91	94	88		Diphtheria	0	0
	DTC3		87	88	76		Mumps	71	27
Polio 3			87	78	76		Poliomyelitis	0	0
Measles (first dose)			83	80	64		Measles	26	171
VAT2+ (pregnant women)			80	85	80		Neonatal Tetanus **	15	18
Hib3							Hib ***	08	07
Yellow fever (added to systematic immunisation in December 2004)			81	77			Yellow Fever	03	454
HepB3							Seroprevalence Hepatitis B*	853	1980
Vitamin A supplement	Mothers (<6 weeks after childbirth)		47	58					
	Infants (>6 weeks)	1st dose	70	84					
		2nd dose	68	81					
		3rd dose	64	74					
		4th dose	48	71					

* If available.
** Note: the joint reporting form asks for Hib meningitis.
***The reduction of BCG coverage in 2007 is due to the modification of the denominator (live birth was used in 2007 as the denominator as opposed to live infants in earlier years).

If survey data is provided in the table above, please indicate the year when these surveys were conducted, their full title and, if applicable, the relevant age groups.

A 2006 internal EPI review was conducted in the 1st half of 2006. It included an immunisation coverage survey of children from 12-18 months old.

Table 3.4: Reference data and annual objectives *(page 32 of the cMYP)*

Number of		Reference Year	Reference data and objectives			
		2007	Year 1 2008	Year 2 2009	Year 3 2010	Year 4 2011
Births		245,925	251,979	258,177	264,529	271,036
Infant deaths		19,674	12,038	11,458	10,907	10,382
Surviving infants		226,251	239,941	246,719	253,622	260,654
Pregnant women		245,925	251,979	258,177	264,529	271,036
Target population immunised with BCG		224,006	239,380	247,850	253,947	262,905
Coverage by BCG*		91%	95%	96%	96%	97%
Target population immunised with VPO3		175,522	213,548	222,048	230,796	247,622
Coverage by VPO3**		78%	89%	90%	91%	95%
Target population immunised with DTC3***		199,649				
Coverage by DTC3**		88%				
Target population immunised with DTC1***		212,555				
Loss rate[3] during the reference year and rate expected as a result		8%				
Target population immunised with a **3rd dose** of DTC-Hep B-Hib……..			213,548	222,048	230,796	247,622
……. Coverage**			89%	90%	91%	95%
Target population immunised with a **1st dose** of DTC-Hep B-Hib……..			227,944	234,383	240,941	247,621
Loss rate[1] during the reference year and rate expected as a result			10%	5%	5%	5%
Target population immunised with a **1st dose** of anti-measles vaccine		181,369	206,623	214,287	215,578	234,589
Target population immunised with a **2nd dose** of anti-measles vaccine		NA	NA	NA	NA	NA
Coverage of anti-measles vaccine**		80%	82%	83%	85%	90%
Pregnant women immunised with Tetanus Anatoxin +(VAT2+)		209,237	219,222	227,196	235,430	243,932
Coverage by Tetanus Anatoxin+(VAT2+) ****		85%	87%	88%	89%	90%
Vitamin A Supplement	Mothers, (<6,weeks,after,childbirth)	149,759	162902	171,343	176,974	185 518
	Infants,,(>6,weeks)	182,613	213,548	222,048	230,796	247 622
Annual dropout rate for DTC [(DTC1-DTC3)/DTC1] x100		6%	6%	5%	5%	5%

* Number of infants immunised in comparison to total births

** Number of infants immunised in comparison to surviving infants

[3] Formula which allows the vaccine loss rate (in percentage) to be calculated: [(A – B) / A] x 100. A being equal tot he number of doses distributed in accordance with the registries of supply, with correction of the entire stock at the end of the supply period ; B being equal to the number of immunisations done with the same vaccine over the same period. For new vaccines, see **table α** after table 7.1.

*** Indicate the total number of children immunised with simple DTC or DTC in combination
**** Number of pregnant women receiving tetanus anatoxin + in comparison to total number of pregnant women

Table 3.5: Summary of current and future immunisation budget (*pages 67-72 and 79-83 of the cMYP)*

Table 3.5.a: Recurring costs specific to systematic immunisation

Budget line items	**Expenditures**	**Need for Future Resources**				**Total 2008 - 2011**
	2007	**2008**	**2009**	**2010**	**2011**	
Recurring costs for systematic immunisation	**US$**		**US$**	**US$**	**US$**	**US$**
Vaccines (only for systematic immunisation)	296 044.6	2 520 848	3558001	3 667 141	3759424	13 505 414
- Traditional vaccines	286320.6	453261	309745	317265	327800.00	1408071
- New or under-utilised vaccines	9724	2 067 587	3 248 256	3 349 876	3 431 624	12 097 343
Injection supplies	7811.7	367 419	331 319	347 300	360 941	1 406 979
Personnel	Not available	301 566	319 169	334 607	348 621	1 303 963
- Salaries of personnel employed full-time by the national immunisation programme (and who work on immunisation exclusively)	Not available	99843	100841	103 556	107 180	411420
- Subsistence payments for mobile/outreach vaccinators	223461	201 723	218 328	231 051	241 441	892543
Transportation	141279	70 030	99 314	139 894	107 545	416 783
Maintenance and general costs	11947	473 192	545 188	604 935	595 515	2 218 830
Training	32938	452 892	353 478	254 250	223 453	1 284 073
Social mobilisation and IEC		16 480	18 080	19 836	21 762	76 158

	5429					
Epidemiological monitoring	32006	160 539	165 495	141 704	153 774	621 512
Programme administration	39650	163 314	171 906	195 251	229 332	759 803
Monitoring	113440	200 000	250 000	250 000	250 000	
Sub-total recurring costs	**608258.146**	**4726280**	**5 811 950**	**5 954 918**	**6 050 367**	**22 543 515**
Cost of equipment for systematic immunisation						
Vehicles	115555	69595	103097	-	59800	232492
Cold chain equipment	409870	227477	147975	185947	0	561399
Sub-total equipment costs	**525425**	**297072**	**251071**	**185947**	**59800**	**793890**

Table 3.5.b: Recurring costs specific to immunisation campaigns

Campaigns	**Expenditures (in $)**	**Need for Future Resources (in $)**				**Total 2008 – 2011 (in $)**
	2007	**2008**	**2009**	**2010**	**2011**	
Poliomyelitis (localised response in case of importation)	-	175 000	200 000	250 000	300 000	925 000
Measles	637107	-	-	948 006	-	948 006
Yellow fever	7136140	-	-	-	-	-
Maternal and neonatal tetanus	1669	-	-	-	-	-
Sub-total Campaign costs	**7 774916**	**175000**	**200000**	**1198006**	**300000**	**1873006**

Table 3.5.c Total costs related to immunisation

Budget line items	**Expenditures**	**Need for future resources**				**Total 2008 - 2011**
	2007	**2008**	**2009**	**2010**	**2011**	
Sub-total Recurring costs	608258,146	4726280	5 811 950	**5 954 918**	**6 050 367**	**22 543 515**
Sub-total Equipment costs	525425	297072	251071	185947	59800	793890
Sub-total Campaign costs	7 774916	175000	200000	1198006	300000	1873006
TOTAL GENERAL	**8 908 599,146**	**5198352**	**6 263 021**	**7338 871**	**6 410 167**	**$ 25210411**

In the tables below, please give the sources of financing for each budget line item (if known). Try to indicate which line items are covered by the Government budget and which costs are covered by development partners (or GAVI Alliance) and give the name of the partners.

Table 3.6: Summary of current and future financing and sources of funds *(pages 67-72 and 79-83 of the cMYP)*

Budget line item	Source of funds	Expenditures	Needs for future resources				Total 2009-2011…
		Reference Year	2008	2009	2010	2011	
		2007					
Recurring Costs							
1. Vaccines (only for systematic immunisation)	1. Government/ GAVI	**296 044.6**	**2 520 848**	**3 558 001**	**3667141**	**3759424**	**13 505 414**
1.1 Traditional vaccines	1. Government	**286320.6**	453 261	309 745	317 265	327 800	1 408 071
1.2 New or under-utilised vaccines	GAVI	**9724.0**	1984883	2990344	2847395	2637203	10 459 826
	Community	-	82703	-	-	-	82 703
	Government	-	-	257912	502481	794421	1 554 814
2. Injection supplies	Government	7811.7	271890	246236	261829	281461	1 061 418
	Plan Togo	-	36962	32436	33340.8	33026	135 765
	GAVI	-	58567	52647	52130	46453	209 796

3. Personnel	**Government/ Community**	Not available	**301 566**	**319 169**	**334 607**	**348 621**	**1 303 963**
3.1 Salaries of personnel employed full-time by the national immunisation programme (and who work on immunisation exclusively)	Government	-	88 706	86 339	93 200	107 180	375425
	Community	-	-	9 593	10 356	-	19949
3.2. Subsistence payments for mobile/outreach vaccinators	Government	-	-	-	-	-	-
	GAVI	133003	106430	111619	115526	120721	454295
	UNICEF	51847	44339	46500	47666	49809	188314
	WHO	-	21286	21208	22551	23565	87544
	Plan Togo	-	24053	25226	25855	27017	102151
	EU/Decentralised Support to Health Sector	38611	17816	18685	19454	20329	76285
4. Transportation	Government	-	5252	7449	10492	8066	31259
	GAVI	90255	31514	44691	62952	48395	187552
	UNICEF	29247	21814	30936	43577	33500	129827
	WHO	-	8649	12265	17277	13282	51473

	Plan Togo	-	2800	3973	5596	4302	16671
	EU/Decentralised Support to Health Sector	21777	-	-	-	-	-
5. Maintenance and general costs	Government	-	177021	203955	226306	222782	830064
	GAVI	10664	118298	136297	151234	148879	554708
	EU/Decentralised Support to Health Sector	463	47319	54519	60494	59551	221883
	Plan Togo		47508	54737	60735	59791	222771
	Community	Not available	83045	95680	106166	104513	389404
	UNICEF	622	-	-	-	-	-
6. Training	Government	-	-	-	50850	44691	95541
	WHO	5664	133060	175396	30637	28669	367762
	UNICEF	-	47327	154010	126032	117961	445330
	EU/Decentralised Support to Health Sector	-	68704	-	-	-	68704
	AFD (French Development Agency)	-	135868	-	-	-	135868

	Plan Togo		67934	24072	46731	32132	170869
	GAVI	27274	-	-	-	-	-
7. Social mobilisation and IEC	Government	-	-	-	-	-	-
	WHO	-	1183	1298	1424	1563	5469
	GAVI	3258	3626	3978	4364	4788	16756
	UNICEF	1244	8240	9040	9918	10881	38079
	Plan Togo	-	1533	1681	1845	2024	7083
	EU/Decentralised Support to Health Sector	927	1898	2083	2285	2507	8773
8. Epidemiological monitoring	Government	-	-	-	-	-	-
	WHO	23422	60860	74738	60153	61510	257261
	GAVI	-	51517	-	21610	23451	96578
	UNICEF	-	48162	41374	42511	46132	178179
	Community	-	-	39719	5694	7689	53102
	Plan Togo	-	-	9665	11736	14993	36394
	EU/Decentralised Support to Health Sector	8584	-	-	-	-	-

9. Programme administration	Government	5378	16331	17191	29288	34400	97210
	WHO	-	106203	104330	106958	87054	404545
	UNICEF	-	16331	24067	29112	49834	119344
	GAVI	34272	24448	26319	29893	58044	138704
Monitoring	EU/Decentralised Support to Health Sector	33333	-	-	-	-	-
	WHO	65877	120 000	150 000	150 000	150 000	570 000
	UNICEF	14230	80 000-	100 000	100 000	100 000	380 000
Total recurring costs		**608258.146**	**4762680**	**5 561 950**	**5 704 918**	**5 00367**	**22 543 515**

Equipment costs							
1. Vehicles	Government	91111	-	20509	-	59800	80309
	GAVI	24444					
	WHO	-	69595	38864	-	-	108459
	UNICEF	-	-	43724	-	-	43724
2. Cold chain equipment	Government	12534	38416	26448	51691	-	116555
	GAVI	177394	109760	-	-	-	109760

	UNICEF	23787	79301	77448	102569	-	259318
	WHO	196155	-	-	-	-	-
	Plan Togo	-	-	44079	31688	-	75767
Sub-total Equipment		**525425**	**297072**	**251071**	**185947**	**59800**	**793891**
Campaigns							
1. Poliomyelitis (localised response in case of importation)	Government	-	20353	23260	37500	45000	126113
	GAVI	-	-	-	-	-	0
	WHO	-	70000	80000	100000	102000	352000
	UNICEF	-	82897	94740	100000	135000	412637,5
	Plan Togo	-			10000	18000	28000
	EU/Decentralised Support to Health Sector	-	1750	2000	2500		6250
2. Measles	Government	86035	-	-	208561	-	208561
	GAVI	-	-	-	-	-	-
	WHO	143810	-	-	379202	-	379202
	UNICEF	407262	-	-	284402	-	284402

	Plan Togo	-	-	-	75840	00	75840
3. Yellow fever	Government	245072	-	-	-	-	-
	GAVI-WHO	6635982 6659 064	-	-	-	-	-
	UNICEF	193804	-	-	-	-	-
	EU/Decentralised Support to Health Sector	4444	-	-	-	-	-
	Coopération Française	13340	-	-	-	-	-
	APM	20416					
4. Maternal and neonatal tetanus		0	-	-	-	-	-
	UNICEF	1669	-	-	-	-	-
Total Campaign		**7,774,916**	**175000**	**200000**	**1198006**	**300000**	**1873006**
TOTAL GENERAL			**4998352**	**6013021**	**7088871**	**6160167**	**25210411**

4. Immunisation Services Support (ISS)

Please indicate below the total amount of the funds that you expect to receive as ISS:

Table 4.1: Estimate of funds expected as ISS

	Reference Year 2007	Year 1 2008…	Year 2 2009…	Year 3 2010…	Year 4 2011…
DTC3 Coverage rate	88%	89%	90%	91%	95%
Number of infants reported immunised / who must be immunised with DTC3 (according to table 3.4)	199,649	213,548	222,048	230,796	247,622
Number of *additional* infants reported immunised / who must be immunised each year with DTC3	-	13,899	8,500	8,748	16,826
Funds expected (US $20 per additional infant)	**-**	**277,980**	**170,000**	**174,960**	**336,520**

* Projections
** According to the duration of the cMYP

If you have previously benefited from GAVI support as ISS, please discuss below the lessons learned from the experience and the effect they will have on the future use of ISS funds.

Indicate the use of the funds, at what level they were used, and if you believe that flexible funds could have been better utilised. Note management and monitoring provisions, and the person who was responsible for authorising payments and approving programmes of expenditures. Indicate whether this system will be renewed.

Main lessons learned from phase 1	**Consequences for phase 2**
1. The financing of immunisation activities and the availability of resources ensures a noticeable improvement in EPI indicators.	In order to be effective and efficient, immunisation must be ensured permanent and sufficient financing.
2. The duration of phase 1 of GAVI (5 years) has not been sufficient to cause a resulting change of the indicators.	The 2nd phase must be longer than the 1st (at least 10 years).
3. The plan to reduce vaccine prices has not been carried out.	Increase in recurring costs of immunisation due to the introduction of new vaccines and to the increase in the coverage of various vaccines. The presentation must be reinforced with pharmaceutical firms to reduce vaccine costs at the end of the GAVI cycle.

4. Phase 1 only addressed immunisation, without taking into account other elements of the health system.	Integrate the other elements of the health system into GAVI financing.
5. The environment outside of immunisation (civil society, NGOs, leaders and authorities) has not been sufficiently involved.	Support mobilisation of the community in activities which might improve immunisation coverage.

If you have never received an ISS, please indicate: **irrelevant**

a) when the support should start:
b) when the first DQA should occur:
c) how you plan to transfer GAVI funds in the country:
d) how you plan to manage the funds within the country:
e) who will be responsible for authorising and approving expenditures:

- Please complete the bank form (Appendix 1), if necessary.

5. Additional comments and recommendations by the Interagency Co-ordinating Committee (ICC)

The Expanded Programme for Immunisation (EPI), established in Togo since 1980, is a priority of the National Health Programme. It is a key element in the arsenal established by the Government to promote the reduction of maternal and infant morbidity and mortality.

Thus, facing the new challenges of a world in a state of perpetual change, with improved control over the dangers that threaten children, due to the discovery of new vaccines, the cost of quality services continues to increase. At the end of 2007, Togo requested and obtained the support of GAVI to introduce two new pentavalent vaccines (DTC-Hep-Hib). In order to provide Togolese children guaranteed access to these services which are the basis for supporting their survival, the Ministers for Health and Finance prepared, in close collaboration with development Partners, an offer of assistance to reinforce immunisation services. The introduction of the systematic EPI, of the vaccine against Hepatitis B and Hib combined with DTC (DTC-Hep-Hib).

Since 2002, the Togolese Government has continued to increase the portion of the budget allocated to the purchase of EPI systematic vaccines (120,000,000 CFA francs in 2003 and in 2004 and 261,326,757 CFA francs in 2005, 225,000,000 in 2006 and 300,000,000 in 2007). But all of these funds are used only to purchase vaccines. The other elements of the immunisation system are adversely affected by a lack of financing.

The multiyear plan (cMYP) which was approved in October 2006 by the partners involved in the ICC took the introduction of this new vaccine into account. The Government prepared the plan very carefully. It was discussed in the Interagency Co-ordinating Committee (ICC). An economist from the Agency for Preventive Medicine (AMP) provided technical support.

Conscious of the urgent need to ensure the long-term success of immunisation services, the Togolese Government respectfully requests that GAVI continue its work in order to support the reinforcement of immunisation services during its second phase.

In light of the foregoing, the Interagency Co-ordinating Committee (ICC) supports the Government of Togo and congratulates the Government for agreeing to continue the work started during the first phase of GAVI to improve EPI performance.

The ICC desires flexibility in the negotiation with GAVI to extend compensation until the end of the Multiyear Plan in 2011.

The ICC fervently hopes that the documents submitted will be evaluated positively so that Togo can again receive support to reinforce vaccination services.

The ICC agrees to assist Togo in this process.

6. Documents provided to support reinforcement of immunisation services

DOCUMENTS	DOCUMENT NUMBER	DURATION*
Joint WHO/UNICEF reporting form (the last two)		
Complete multiyear plan (cMYP)		
Approved minutes of meetings of the national co-ordinating entity during which the GAVI assistance application was approved		
Approved minutes of ICC meetings during which the GAVI assistance application was examined		
Minutes of the last three ICC meetings		
ICC work plan for next 12 months		

** Please indicate the duration of the plan, the document, or the evaluation, if applicable.*