Application Form for Gavi NVS support

Submitted by

The Government of

Cameroon

Date of submission: **2 June 2017**

Deadline for submission:

i. **3 May 2017**
ii. 3 May 2017
iii. 1 September 2017

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

Start Year	2015	End Year	2019

Form revised in 2016

(To be used with Guidelines of December 2016)

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

Gavi
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the Gavi will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the Gavi. All funding decisions for the application are made at the discretion of the Gavi Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application.The Gavi will document any change approved by the Gavi, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the Gavi all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the Gavi, within sixty (60) days after the Country receives the Gavi's request for a reimbursement and be paid to the account or accounts as directed by the Gavi.

SUSPENSION/ TERMINATION

The Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any Gavi-approved amendment to the application. The Gavi retains the right to terminate its support to the Country for the programmes described in its application if a misuse of Gavi funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the Gavi, as requested. The Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the Gavi Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the Gavi or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland

. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The Gavi and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The Gavi will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

1. Type of Support requested

Please specify for which type of Gavi support you would like to apply to.

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]
Routine New Vaccines Support	HPV quadrivalent, 1 dose(s) per vial, LIQUID	2018	2019	HPV bivalent, 2 dose(s) per vial, LIQUID

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

2. Table of Contents

3. Executive Summary

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

- For each specific request, NVS routine support or NVS campaign :
  - The duration of support
  - The total amount of funds requested
  - Details of the vaccine(s), if applicable, including the reason for the choice of presentation
  - Projected month and year of introduction of the vaccine (including for campaigns and routine)

- Relevant baseline data, including:
  - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Target population from Risk Assessments from Yellow Fever and Meningitis A
  - Birth cohort, targets and immunisation coverage by vaccines

- Country preparedness
  - Summary of planned activities to prepare for vaccine launch, including EVM assessments, progress on EVM improvement plans, communication plans, etc.
  - Summary of EVM assessment and progress on EVM improvement plan

- The role of the Coordination Forum (ICC/HSCC or equivalent) and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal

The Government of Cameroon wishes to apply for nationwide introduction from October 2018 of the vaccine against human papillomavirus (HPV) infection.

Cameroon has benefited from Gavi fund support for strengthening the following services: immunisation since 2001; injection safety support from 2003 to 2005; and introduction of new and underused vaccines in the EPI, including yellow fever tetravalent vaccine in 2004, viral hepatitis B tetravalent vaccine (DTP-HebB) in 2005, haemophilus influenzae type b pentavalent vaccine (DTP3-HepB + Hib) in February 2009, pneumococcal vaccine in July 2011, rotavirus vaccine in 2014 and Inactivated Polio Vaccine in 2016. Cameroon also benefited from support for immunisation using the MenAfriVac vaccine in 2011 and 2012, within the framework of the fight against meningococcal A epidemics.

This Gavi support has helped improve EPI performances, both qualitatively and quantitatively. National administrative immunisation coverage (IC) for DTP3 rose from 43% in 2001 to 85% in 2016. The percentage of health districts reaching IC superior to 80% is on a constant increase, having risen from 56% in 2007 to 64% in 2016. The last Effective Vaccine Management Assessment (EVMA) was carried out in October 2013. A vaccine management improvement plan was then developed. Implementation is in process. The report and state of the plan's implementation of activities are appended to this document. The next Effective Vaccine Management Assessment (EVMA) is planned for 2018.

According to Globocan 2012, the incidence of cervical cancer in Cameroon is 2000 cases per year. This makes it 2nd place among cancers in women. The standardised incidence of cervical cancer is 30 per 100,000 women in Cameroon, compared to a world average of 15 per 100,000. This cancer is caused in more than 99% of cases by the oncogenic genotypes of HPV.

Cervical cancer care in Cameroon has been coordinated by the National Committee for the Fight Against Cancer (CNLCa) since 2003. The CNLCa has developed an action plan, the objectives of which are to propose and coordinate the cancer-prevention policies and strategies, screen for cases, and provide treatment and palliative care for patients.

Within the framework of cervical cancer prevention, between 2014 and 2016 Cameroon conducted a demonstration phase for HPV vaccine introduction, in two health districts (Foumban and Edéa). This vaccine was administered to girls age 9 to 13. Assessment of the first year of implementation of the demonstration showed immunisation coverage of around 64.7%. The assessment also revealed the

acceptance of the vaccine by both beneficiaries and healthcare personnel, as well as the capacity of the health system to deal with integrating this vaccine into its routine immunisation programme.

This is the context in which Cameroon has planned to introduce the HPV vaccine into routine immunisation. The country has chosen the quadrivalent HPV vaccine. This vaccine has been chosen because it protects against 4 genotypes (16 and 18, responsible for 70% of cervical cancers, as well as 6 and 11, responsible for condylomata acuminata) and gives cross-protection against the oncogenic genotypes 31 and 45. Genotype 45 as been identified in cytological samples of women with cervical cancer in Cameroon.

Introduction will take place in September 2018 in all health districts of the country. The target population in 2018 is composed of girls age 9 for the routine cohort and age 10 to 14 for the multi-age cohort. The estimates of the target according to the demographic projections provided by the Ministry of Public Health are 1,812,789 girls for 2018. The immunisation coverage target for the first year is 70%.

Cameroon has adopted a mixed strategy (schools, healthcare facilities and communities) for the immunisation of both in-school and out-of-school girls. This mixed approach consists in organising fixed and outreach strategies at schools, fixed strategies at healthcare facilities and outreach strategies within communities; the goal is to reach the maximum number of girls. Special communication strategies will be developed to reach in-school girls at schools and out-of-school girls in their communities. Introduction of the HPV vaccine will be an opportunity to strengthen educational messages on various issues relating to adolescent health (HIV/AIDS prevention, adolescent sexuality, hand washing).

A Technical Advisory Group (TAG) for HPV immunisation has been established by the Ministry of Public Health for the HPV vaccine demonstration phase. This group is composed of representatives from: directorates of the Ministry of Public Health; the Ministries of Secondary Education, Basic Education, Finance, and Women's Empowerment and Family; the National Committee for the Fight Against Cancer; the EPI; and the various partners of the EPI. The TAG will take care of monitoring the preparatory activities. Monitoring meetings will be held bimonthly from six months before the probable introduction date, and weekly from two months before introduction. Implementation of the preparatory activities at the regional level will be monitored through monthly and then weekly telephone conferences with the EPI Regional Unit. The challenges will be discussed during these telephone conferences, and suitable solutions proposed.

The challenges that will be faced by Cameroon in this vaccine introduction are: management of a new target by the EPI, organisation and coordination of vaccine delivery to schools and communities, the storage capacity of the vaccines at the operational level during the year of introduction, and communication in order to prevent the occurrence of rumours or pockets of refusal. The training of service providers as well as the awareness-raising of communities will help address some of these challenges.

The budget estimate for the introduction of the HPV vaccine is US$ 1,907,517, made up of a government contribution of US$ 80,308, US$ 1,743,131 from Gavi, US$ 34,410 from WHO, US$ 14,668 from UNICEF and US$ 35,000 from CHAI. This amount does not include the vaccine purchase cost.

4. Signatures

4.1. Signatures of the Government and National Coordinating Bodies

4.1.1. Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of Cameroon would like to expand the existing partnership with the Gavi for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests Gavi support for:

HPV quadrivalent, 1 dose(s) per vial, LIQUID routine introduction

The Government of Cameroon commits itself to developing national immunisation services on a sustainable basis in accordance with the Comprehensive Multi-Year Plan presented with this document. The Government requests that the Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Table(s) **6.2.3, 6.2.4** in the Routine New Vaccines Support of this application shows the amount of support in either supply or cash that is required from the Gavi.Table(s) **6.2.3, 6.2.4** of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of **December**.

The payment for the first year of co-financed support will be around **Not selected 2018** for HPV quadrivalent, 1 dose(s) per vial, LIQUID.

Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NUMBER : 1 and 2 in Section 10. Attachments.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	M. André MAMA FOUDA	**Name**	M. Alamine OUSMANE MEY
Date		**Date**	
Signature		**Signature**	

Proof of involvement of the Ministry of Education will also be required for HPV Routine Support. The Ministry of Education will either have to be involved in the ICC process (preferred option) and, for countries choosing schools as a location for vaccinations, or choosing a school link strategy, the Minister of Education (or delegated authority) must provide its signature. The signature is attached as DOCUMENT NUMBER : 3 in Section 10. Attachments.

Minister of Education (or delegated authority)	
Name	Youssouf née Adidja Alim
Date	
Signature	

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

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4.1.2. National Coordination Forum (Interagency Coordinating Committees (ICCs), Health Sector Coordinating Committees (HSCCs), and other equivalent bodies)

To be eligible for support, Gavi asks countries to ensure a *basic* functionality of their Coordination Forum (ICC/HSCC or equivalent body). Countries can demonstrate this by adhering to the requirements listed in section 5.2 of the General Guidelines. The information in this section and a set of documents submitted along with this application will help the Independent Review Committee (IRC) to assess adherence.

Profile of the Coordination Forum

Name of the Forum	Inter-agency Coordinating Committee for immunisation (ICC)
Organisational structure (e.g., sub-committee, stand-alone)	Independent committee

The Terms of Reference for the Coordination Forum is attached as DOCUMENT NUMBER : 4. The Terms of Reference should include all sections outlined in Section 5.2 of the General Guidelines..

Please describe the role of the Coordination Forum and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal:

In this regard, the ICC shall in particular be responsible for:

- Preparing and implementing the national Expanded Program on Immunisation policy
- Coordinating, harmonizing and overseeing the consistency of all the actions of the various partners
- Adopting the Expanded Program on Immunisation's annual action plans and the associated budgets
- Mobilizing the resources necessary for the Expanded Program on Immunisation's activities
- Coordinating and tracking the implementation of the activities from the various Expanded Program on Immunisation's components
- Tracking the performance of the action plans
- Evaluating the implementation of the Expanded Programme on Immunisation.

4.1.3. Signature Table for the Coordination Forum (ICC/HSCC or equivalent body)

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **12/05/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 7 (please use the list for signatures in the section below).

Function	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Ministry of Public Health	M. André MAMA FOUDA		
Secretary	Permanent Secretary of the CTG-EPI	EKOMANE Ename Ename Christine Harmelle		
Members	ICC Director of Family Health	Pr.Robinson MBU		
	WHO-Cameroon Representative / Vice-President	Dr ROUNGOU Jean Baptiste		
	UNICEF-Cameroon representative	Mme Félicité TCHIBINDAT		
	Health Advisor/French Embassy	Mme Caroline COMITI		
	Country Director, CHAI	M. Divine NZUOBONTANE		
	CDC	Dr Omer PASI		
	Red Cross, Cameroon	M. William ETEKI MBOUMOUA		
	Pasteur Centre in Cameroon	Dr. GUY VERNET, Directeur		
	National Polio Experts Committee	Pr. TETANYE EKOE		
	Catholic Organisation for Health in Cameroon	Dr. Marius Macaire BILOA		
	Association Culturelle Islamique in Cameroun	M. ISSA DANAMOU		
	Platform of the civil society organisation for the Promotion of Immunisation and Health System Strengthening	M. Bertrand KAMPOER		

By submitting the proposal we confirm that the quorum has been met. **Yes**

The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached are attached as DOCUMENT NUMBER : 6.

4.2. National Immunization Technical Advisory Group (NITAG)

Has a NITAG been established in the country? **No**

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as **(Document Number: 8)**

5. Immunisation Programme Data

5.1 Background information

Please complete the table below, using the most recent data from available sources. Please identify the source of the data, and the date and attach the source document, where possible. The following documents should be referred to and/or attached:

- Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan). Please attach as DOCUMENT NUMBER 9.
- New Vaccine Introduction Plan(s) / Plan of Action. Please attach as DOCUMENT NUMBER 12.
- New Vaccine Introduction Checklist, Activity List and Timeline. Please attach as DOCUMENT NUMBER 12.
- Effective Vaccine Management (EVM) assessment. Please attach as DOCUMENT NUMBER 20.
- Two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases.
- Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.
- In the case of Yellow Fever and Meningitis A mass preventive campaigns, the relevant risk assessments. Please attach as DOCUMENT NUMBER 24 and DOCUMENT NUMBER 25.

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

	Figure	Year	Source
Total population	24,253,757	2017	General Survey of Housing and Population (GSHP 2005)
Birth cohort	1,091,419	2017	GSHP 2005
Infant mortality rate (per 1000)	60	2014	MICS 2014
Surviving infants*[1]*	840,654	2017	GSPH 2005
GNI per capita (US$)	2,770	2013	World Bank
Total Health Expenditure (THE) as a percentage of GDP	728,108	2012	National Health Accounts - 2012 (CNS)
General government expenditure on health (GGHE) as % of General government expenditure	5	2012	National Health Accounts - 2012 (CNS)

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

5.1.1 Lessons learned

Routine New Vaccines Support

If new or under-used vaccines have already been introduced in your country, please give details of the lessons learned from previous introduction(s) specifically for: storage capacity, protection from accidental freezing, staff training, cold chain, logistics, coverage and drop-out rates, wastage rate, etc., and suggest action points or actions taken to address them. Please refer to previous Post Introduction Evaluations (PIE), if applicable. If they are included in the Introduction Plan, please cite the section only. If this information is already included in NVIP/POA, please reference the document and in which section/page this information can be found.

Lessons Learned	Action Points
Planning and Coordination - the need to involve all the stakeholders (government ministries, civil society, development partners, etc.); - the need to mobilise the funds and to make them available in time to the actors at all levels.	To prepare for HPV vaccine introduction, the Minister of Public Health will set up a Technical Advisory Group composed of all the stakeholders (representatives of the MoPH directorates and programs concerned, Ministry of Finance, Ministry of Basic Education, Ministry of Secondary Education, Ministry of Women's Empowerment and Family, Ministry of Youth and Civic Education, civil society organisations and development partners) with a view to the introduction of the HPV vaccine. - Involvement by the regional coordination committees in the planning and implementation of HPV vaccine introduction activities; - Advocacy for the mobilisation and timely provision of funds.
Training Capacity building for all actors, at all levels.	Involvement by teachers and community leaders in training for HPV vaccine introduction.
Communication/social mobilisation - Involvement by local leaders helps make parents and young girls support immunisation, in contrast to the means of communication implemented (leaflets and posters), which seem to be more or less effective for reaching the target group. - Anticipating rumours and the occurrence of pockets of refusal.	Strengthening grassroots communication with parents, community leaders and the educational community; - prepare a crisis plan in advance.
Supply chain/cold chain - Evaluating and strengthening storage capacities; - Capacity building for actors, on vaccines and input management.	Inventory of the cold chain equipment was conducted in January 2016; annual updating has been proposed. - Strengthening of storage capacity at all levels, through the 2017-2021 plan for expansion and rehabilitation of the cold chain; - Supportive supervision of the immunisation actors at all levels.
Waste management and injection safety - Making waste disposal equipment available to service providers;	- Set up a plan for the collection and transport of waste to the incineration sites; - Capacity building for immunisation waste management service providers.
Monitoring and evaluation - The importance of a rapid post-introduction assessment to readjust the implementation.	Implementation of rapid assessments 4 to 8 weeks after the vaccine introduction.

5.1.2 Health planning and budgeting

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

The 2010-2020 Strategy Document for Growth and Employment (SDGE) is the frame of reference for government action.

The national cycle of budgeting is annual (January to December).

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

The 2016-2027 Health Sectoral Strategy (in French: SSS)

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

Yes, the proposal is consistent with the cMYP (2015-2019).

Please indicate the national planning budgeting cycle for health

Health planning in Cameroon is based on the 2016-2027 Health Sectoral Strategy (SSS) and the 2016-2020 National Health Development Plan (NHDP), which define the broad strategic directions in the area of health. Taking into account the NHDP, each technical directorate or priority programme develops multi-year plans and annual plans.

The budget is worked out on an annual basis. It is adopted by Parliament.

The national planning and budgeting cycles for action plans in health are five years (NHDP) and annual

(MoPH AWP).

Please indicate the national planning cycle for immunisation

The national planning cycle for immunisation is five years and annual. It is based on the comprehensive Multi-Year Plan of the EPI and on annual work plans.

5.1.3 Coverage and equity

Please describe any health systems bottlenecks or barriers to access, utilisation and delivery of immunisation services at district level (or equivalent), for example geographic, socio-economic and/or gender-related barriers. Please indicated if there are specific populations of concern. If available, please provide subnational coverage and equity data highlighting geographic, socio-economic, gender-related, or other barriers and any other relevant categories of vulnerable or high-risk populations.

There are various obstacles to the access and use of immunisation services:

Weak implementation of the "Reach Every District" approach can be observed (2013 EPI external review report); the direct consequence of this is an irregular immunisation service offer. Indeed, less than 50% of the healthcare facilities carry out immunisation on a daily basis or offer immunisation services using the outreach strategy.

Analysis of immunisation coverage on a socio-economic basis shows that the wealthiest quintile enjoys higher DTP3 coverage than the poorest quintile (95.1% vs. 57.6%), 2014 MICS. Likewise, place of residence can also be an obstacle to immunisation services access. For example, immunisation coverage (DTP3) in urban areas is 91% compared to 75% in rural areas.

The rates of immunisation coverage do not indicate the existence of gender-specific barriers to immunisation access.

At the geographical and socio-cultural level, there are special population groups of remote and marginalised people in Cameroon. They are characterised by their lifestyles, their cultures, or by the fact that they live in particularly isolated areas. The health indicators of these areas reflect difficult access to health services in general and to immunisation in particular.

The implementation of temporary fixed strategies in schools, the involvement of the educational community and community leaders in awareness-raising, the outreach strategies within communities, as well as involvement of the security forces and humanitarian NGOs will help in reaching the maximum number of girls in school and out of school. The monitoring of HPV vaccine immunisation performances will help identify the weaknesses and correct them.

Please explain how the proposed NVS support (activities and budget) will be used to improve coverage and equity of routine immunisation with reference to specifically identified health systems bottlenecks and/or specific populations of concern. For countries that will be receiving Gavi HSS and/or CCEOP funding concurrently with NVS funds, please also highlight how NVS funds will support/complement/leverage specific activities or investments included in those other grants.

Questions of equity have been taken into consideration in the process of preparing social mobilisation strategies, among other things, to improve immunisation coverage via: (i) using community health liaisons to facilitate searching for dropouts; (ii) promotion of immunisation and other disease prevention interventions in children, in partnership with community health liaisons and Civil Society Organisations; (iii) advocacy initiated by the EPI directed at government, traditional, religious leaders and certain elected officials to serve as spokespersons appointed to guide decision-making and actions in order to improve their respective municipalities, community participation and local funding of primary health care, including immunisation.

With regard to introduction of the HPV vaccine, immunisation concerns girls only. Specific strategies to ensure equity between in-school and out-of-school girls have been proposed in the introduction plan. Special efforts will be made to immunise girls in the remote and insecure zones, for example by involving security forces and humanitarian NGOs. Special attention will be paid to vulnerable girls (HIV-positive girls who will need three doses of vaccine and girls with reduced mobility or who are hearing or sight impaired). This will be done by working with the centres that treat these girls.

All these issues are addressed in the appended introduction plan.

Please describe what national surveys take place routinely in country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers.

Several studies conducted in Cameroon highlight the problems and obstacles related to gender equality and equity. The Gender Inequality Index (GII) is a composite index that identifies discrimination against girls and women. This index reflects the disadvantages of girls and women regarding three aspects: reproductive health, empowerment/education and economic activity. In Cameroon, this index shows that:

- Maternal mortality remains high (782 per 100,000 live births) and access to healthcare for women in some regions and especially the northern regions remains low.
- The gender gaps have considerably decreased with regard to primary schooling but have not changed in secondary education.
- With regard access to jobs, the situation of women has improved slightly overall, but disparities persist in some regions. However, women encounter more difficulties in access to positions of responsibility, to credit, to land and to production goods generally. Access to land continues to remain one of the crucial problems facing women.
- Certain provisions of legislation or customary laws still deprive women the same rights as men and do not provide for equal treatment with men in terms of marriage, divorce and widowhood.
- Only 32% of companies are managed by women.

The main studies that have been carried out are:

(1) National Institute of Statistics (INS) and ICF International, 2012. Demographic and Health Survey - Multiple Indicator Survey of Cameroon, 2011. Calverton, Maryland, USA: INS and ICF International.

(2) National Report on progress in the Millennium Development Goals (MDGs 2012).

(3) The Rights of Indigenous Peoples in Cameroon, supplementary report submitted following the third periodic report of Cameroon, 54th ordinary session, October 2013, Banjul, Gambia.

(4) Monitoring of the situation of children and women, multiple indicator cluster survey (MICS) 2014.

(5) National Report on the state of the population (Central Bureau of Census and Population Studies, 2014)

The introduction plan provides for assessments at the end of one year of HPV vaccine delivery. These assessments take into account indicators of fairness in terms of socio-economic and geographical status and of access to immunisation services. The awareness-raising and communication activities carried out will target all adolescents regardless of gender.

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

Immunisation data have been collected and disaggregated by sex since 2015. However no significant difference is noted between the sexes with regard to immunisation.

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

Certain zones of the country are currently suffering a situation of fragility (insecurity at the borders with the CAR and Nigeria, refugees and/or displaced persons due to the violence of the Boko Haram sect in the three northernmost regions). Access in these areas is difficult, and most basic health infrastructure has been destroyed or is closed due to lack of personnel. These areas comprise 11 health districts of the Far North Region (Kousseri, Goulfey, Mada, Makary, Mora, Kolofata, Koza, Mokolo, Mogodé and Bourha) and six health districts in the East Region, on the border with the CAR (Garoua Boulaï, Kette, Ndelele, Batouri, Yokadouma, and Moloundou).

The planning and implementation of the HPV vaccine introduction in these areas could be disturbed by

insecurity and by the displacements or the influx of populations. The lack of healthcare providers there represents a challenge to the immunisation of girls at the time when the vaccine is introduced in these areas. Involvement by the security forces and humanitarian NGOs in vaccine delivery will help meet the immunisation challenges in these areas. These strategies are used with success during supplementary immunisation activities.

5.1.4 Data quality

To support country efforts to strengthen the availability, quality and use of vaccination coverage data for strengthened programme management, Gavi requires that countries applying for all types of Gavi support to undertake routine monitoring of vaccination coverage data through an annual desk review; conduct periodic (once every five years or more frequently where appropriate) in-depth assessments of routine administrative vaccination coverage data; conduct periodic (at least once every five years) nationally representative vaccination coverage surveys; and develop and monitor plans for improving vaccination coverage data quality as a part of their own core work plans.

5.1.5 HPV specific facts

Countries applying for HPV that have already conducted a demonstration or pilot programme, should include details on specific lessons learned for HPV vaccine delivery.

Key programmatic areas	Lessons Learned	How these areas have been addressed in a National Plan
Preparation & planning	Expert planning and quality coordination among health workers, civil society organisations, the educational sector and other related sectors are essential. Micro-planning that includes a counting of the target is an essential element for successful introduction. Plan vaccine delivery according to the school calendar and the season.	Establishment of a Technical Advisory Group by the Minister of Public Health. This TAG is made up of all stakeholders, with a view to introducing the HPV vaccine. Development of a detailed introduction plan with a timeline for monitoring activities implementation.
Communication & social mobilization	- Government commitment is crucial for guaranteeing its success. - The messages issued by trusted sources (traditional and religious authorities) strengthen its acceptability. - Good communication and consent requests reassure parents and girls.	Involvement by administrative, political, traditional and religious authorities in launching the vaccine introduction. Development of a detailed communication plan that involves community leaders in order to improve acceptability.
Delivery strategies	Several strategies for vaccine delivery have been used. This mixed strategy includes schools as well as health and community facilities. Involvement and adherence by the educational community and community leaders via this strategy has facilitated the implementation of the activity.	Cameroon has opted for the mixed strategy of service provision.
Coverage	A good estimate of the target is essential for proper assessment of the coverage outcome obtained.	A count of the target will be conducted prior to the implementation of the activity.
Reporting & monitoring	It is essential to make updated tools for data collection available at the immunisation posts. Administer the DQS monthly during the post-introduction supportive supervisions. Ensure AEFI reporting and AEFI care.	The data collection tools have already been updated. They will be produced and distributed two months prior to introduction. Supportive supervision with DQS administration will be carried out in an integrated way and will therefore include the aspects specific to the data management of HPV vaccine delivery. AEFI reporting and its treatment will be taken care of in an integrated way, as part of the AEFI surveillance of MAPI already established.
Sustainability	Strengthen collaboration between the healthcare facilities and schools in all	The TAG has proposed that, in the introduction plan, immunisation of girls in

	health areas, in order to facilitate vaccine delivery at healthcare facilities.	school be carried out at healthcare facilities after the first year of HPV vaccine delivery. This will require close collaboration between the Ministry of Basic Education and the Ministry of Health.

For each district in which the demonstration/ pilot programme was implemented, please complete the following:

District Information	
Name of the district	DS Edéa
Size of target population of the district	8,678
Describe how the district is divided into rural and urban areas:	Urban (ville d'Edéa), semi-urban and rural
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	School-based strategy (98%) Health and Community Centre (2%)
District Information	
Name of the district	DS Foumban
Size of target population of the district	10,706
Describe how the district is divided into rural and urban areas:	Urban (ville de Foumban), semi-urban and rural
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	School-based strategy (99%) Health and Community Centre (1%)

5.2. Baseline and Annual Targets for Routine Vaccines

For HPV, Gavi supports the vaccination of girls aged 9-14 years, based on the following cohorts:

- Routine cohort – countries are required to identify a single year cohort of girls to be immunised on a routine basis. (e.g. 9 years old)
- Additional multi-age cohort – in the first year of introduction (or initial year of each phase, if country choose phased introduction), countries also have the option to immunise additional girls within the recommended age groups (e.g. 10-14 years), that are older than the routine cohort.

Note: Countries may choose proxy age of girls based on a school grade (e.g. grade 5 corresponds to approximately 10 year olds). However, grades usually have a range of different aged girls so it is important to keep in mind that girls under 9 years should not be vaccinated, and doses for girls older than 14 years are not provided by Gavi.

Please specify the chosen age for the routine cohort HPV vaccination: e.g. 9 years

9 years

If relevant, please specify the chosen age range for the additional multi-age cohort in the year of introduction: e.g. 10, 11, 12, 13, 14 years
From :

10 years

To :

14 years

Will a phased introduction approach be adopted?

No

If a phased approach will be adopted, please provide an explanation for this approach.

NA

Please refer to cMYP pages to assist in filling-in this section. For HPV, please also refer to Annex 3 of the HPV Guidelines.
The Base year information should be completed for the year in which the application is being completed.

Table 5.2: Baseline NVS routine figures

Number	Base Year	Baseline and Targets	
	2015	2018	2019
Total births	986,292	1,062,129	1,088,682
Total infants' deaths	153,423	165,214	169,345
Total surviving infants	832,869	896,915	919,337
Total pregnant women	1,095,880	1,178,963	1,208,437
Target population (routine cohort) vaccinated with OPV3*[1]*	690,881	816,193	845,790
OPV3 coverage*[2]*	83 %	91 %	92 %
Target population (routine cohort) vaccinated with DTP1*[1]*	763,957	870,008	900,950
Target population (routine cohort) vaccinated with DTP3*[1]*	702,407	816,193	845,790
DTP3 coverage*[2]*	84 %	91 %	92 %
Wastage*[3]* rate in base-year and planned thereafter (%) for DTP	5	6	6

Wastage*[3]* factor in base-year and planned thereafter for DTP	1.05	1,06	1,06
Routine Cohort			
Number of girls in the routine cohort		322,757	327,362
Target population (routine cohort) vaccinated with 1st dose of HPV	0	225,930	235,701
Target population (routine cohort) vaccinated with 2nd dose of HPV	0	209,792	222,606
HPV quadrivalent coverage 1st dose	0 %	70 %	72 %
HPV quadrivalent coverage 2nd dose	0 %	65 %	68 %
Additional multi-age cohort			
Number of girls in the additional multi-age cohort	0	1,490,022	
Target population (additional multi-age cohort) vaccinated with 1st dose of HPV quadrivalent	0	1,043,015	
Target population (additional multi-age cohort) vaccinated with 2nd dose of HPV	0	968,514	
HPV quadrivalent coverage*[2]*	0%	70%	0%
HPV quadrivalent coverage 2nd dose	0%	65%	0%
First Presentation: HPV quadrivalent, 1 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI_AGE COHORT			
Wastage*[3]* rate in base-year and planned thereafter (%)	0	0	0
Wastage*[3]* factor in base-year and planned thereafter (%)	1.00	1,00	1,00
Maximum wastage rate value for HPV quadrivalent, 1 dose(s) per vial, LIQUID	5 %	5 %	5 %
Second Presentation: HPV bivalent, 2 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI_AGE COHORT			
Wastage*[3]* rate in base-year and planned thereafter (%)	0	0	0
Wastage*[3]* factor in base-year and planned thereafter (%)	1.00	1,00	1,00
Maximum wastage rate value for HPV bivalent, 2 dose(s) per vial, LIQUID	10 %	10 %	10 %
Target population (routine cohort) vaccinated with 1st dose of MCV	0	0	0
MCV coverage*[2]*	0 %	0 %	0 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	8 %	6 %	6 %

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

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

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

5.2.1 Description of routine and additional multi-age cohorts

Provide the percentage of primary school enrolment

The rate of primary school enrolment is 83.5% among girls and 87.3% among boys.

Provide the percentage of secondary school enrolment

The rate of school enrolment is 55.0% among girls and 50.4% among boys.

Provide the average age of entry for secondary school

11 years

Please provide a source for the enrolment data (e.g., national statistics office, MOE, recent census, school registers, etc.)

Ministry of Basic Education, Ministry of Secondary Education;

Please provide a source for the enrolment data (e.g., national statistics office, MOE, recent census, school registers, etc.)

Ministry of Basic Education, Ministry of Secondary Education;

5.2.2 HPV specific targets

Girls to be vaccinated with HPV should be within the WHO-recommended target population of 9-14 years old girls

Please specify the source of data that was used to estimate the number of girls in the routine and, if relevant, additional multi-age cohorts and reported in the above table under "Target population (routine cohort) vaccinated with HPV" and "Target population (additional multi-age cohort) vaccinated with HPV"

The demographic estimates of the Ministries of Public Health and the National Institute of Statistics (INS) have been used in estimating the targets (MoPH/INS, 2014).

5.3. Targets for Preventive Campaign(s)

No NVS Prevention Campaign Support this year

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

No One time mini-catchup campaign this year

6. New and Under-Used Vaccines (NVS Routine vaccines)

6.1. Assessment of burden of relevant diseases (if available)

If already included in detail in the Introduction Plan or Plan of Action, please cite the section only.

Disease	Title of the assessment	Date	Results
HPV infections, cervical cancers, pre-cancerous lesions	Human Papillomavirus and Related Diseases in Cameroon.	2012	- 1993 new cases of cervical cancer diagnosed every year in Cameroon - 2nd leading cause of cancer among women aged 15-44 in Cameroon - 1120 deaths a year are caused by cervical cancer in Cameroon - 2nd cause of cancer death in women
All types of Cancers	Current cancer incidence and trends in Yaounde, Cameroon	2012	- Cervical cancer accounts for 14% of all cancers recorded in the cancer registry of the city of Yaoundé between 2004 - 2006 and 2010 - 2011.
Invasive Cervical Cancers of the utérus	Human papillomavirus genotype distribution among Cameroonian women with invasive cervical cancer: a retrospective study	2014	- On a sample of 181 biopsy samples of women with cervical cancer: o The most commonly identified oncogenic genotypes were HPV 16 (88%), 45 (32%) and 18 (15%). o Multiple infections: 45%
Invasive Cervical Cancers	Risk factors associated with human papillomavirus prevalence and cervical neoplasia among Cameroonian women.		- 838 women aged 25 to 65 years - Prevalence of HPV: 39% - Risk factors for HPV infection: housewives, HIV co-infection, hormonal contraception
Col, pre-cancerous lesions	Prevalence, Predictors, and Same Day Treatment of Positive VIA Enhanced by Digital Cervicography and Histopathology Results in a Cervical Cancer Prevention Program in Cameroon.	2007-2014	- Screening of 44,979 women, 9% with pre-cancerous lesions - Risk factors: HIV +, early sexual intercourse, low level of education, high number of pregnancies, number of sexual partners

6.1.1 HPV burden specific information

Has the country undertaken an assessment of the burden of cervical cancer? If so, describe the burden, and when and how the assessment was done. If not, countries may report on Globocan data (available on the WHO HPV information Centre website at http://www.who.int/hpvcentre/en).

Several studies on the estimation of the prevalence of HPV, pre-cancerous lesions and invasive cervical cancer of the uterus have been carried out in the country.

- HPV prevalence is estimated to be 39% (Catarino R et al. 2016): Screening by HPV tests in communities.
- Prevalence of precancerous lesions: 9% (De Gregorio and al. 2016); screening in hospitals, by staining and visual examination.
- Prevalence of oncogenic genotypes of HPV: HPV 16 (88%), 45 (32%) and 18 (15%).(Pirek et al., 2015): Genotyping on biopsy specimens of women with cervical cancer.
  Globocan estimates in 2012 show that the incidence of cervical cancer in Cameroon is 2,000 new cases per year; mortality is estimated to be 1,120 deaths per year.

Describe the existing cervical cancer prevention and control activities.

Cervical cancer prevention and control activities carried out in Cameroon can be classified into three categories:

- Primary prevention through awareness-raising and immunisation with the HPV vaccine. Two mass HPV immunisation campaigns were organised in 2010 (in three regions) and 2014. In 2014, the campaign was conducted in two health districts (Foumban and Edéa). This vaccine was administered to girls age 9 to 13. Assessments of the first year of implementation of the demonstration showed immunisation coverage of around 64.7% for the second dose.
- Secondary prevention activities: services to screen for pre-cancerous lesions and cervical cancer via visual examination are provided by some healthcare facilities at costs that are unaffordable for the majority of people. Furthermore, awareness-raising as well as screening and immediate treatment campaigns are organised on various occasions (International Women's Day, Fight Against Cancer Week, etc.) and by several health institutions across the country. Unfortunately no organised system has been set up by the government for taking charge of screening.
- The treatment of cancer, depending on the stage of the disease and the state of the patient, is based on surgery, radiotherapy and chemotherapy. Access to treatment is currently poor for all strata of the population. It is not available in all regions of the country, and its cost remains high. Not all the therapeutic options are available in the country.

Has the country developed a strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control? **Yes**

If Yes, please attach and refer to section 10. Attachments. (Document N°**15,16**)

If No, are there plans for the country to develop such a roadmap or strategy in the future? Please describe- when, who will be leading the development of the plan, and which agencies will be involved.

NA

6.1.2 Description of province/ region profile

Countries are required to attach a description of the profile for each province/ region, using the template provided by Gavi

Please attach the relevant documents "HPV Region/ Province profile " template provided by Gavi and attach as a mandatory document in the Attachment section. Document number **16**)

6.1.3 Delivery strategies for HPV vaccine

Please provide information on each of the following **delivery strategies** that will be:

- Using outreach to schools as a location for vaccinations
- Using health facilities as a location for vaccinations
- Using community outreach as locations for vaccinations
- Campaign

Using schools as a location for vaccinations

Please describe why this delivery strategy has been chosen for the selection region/ district(s). Will this delivery strategy be used for every year? If so, please describe how this strategy will be financed in future years.

- The choice to use schools for vaccine delivery is based on the high school enrolment rates in Cameroon. The average school enrolment rate for the routine cohort in Cameroon is 83.7%.
- The HPV vaccine demonstration phase has shown that immunisation coverage as well as vaccine acceptability were highest at the school level.

Please specify whether girls will be vaccinated by selection of a specific age or a specific school grade

The girls will be vaccinated by selection of a specific age: the girls of the routine cohort are age 9, and girls of the multi-age cohort are age 10 to 14.

Please complete table 6.1.3a vaccination by specific age or table 6.1.3b by specific school grade, depending on above choice

Table 6.1.3 a: Vaccination by specific age

Routine Cohort	
Specific age chosen	9 years
Target population of girls in chosen age	322,757
Girls of chosen age enrolled in schools	302,145

Aditional multi-age cohort	
Specific age-range chosen	Start 10 years End 14 years
Target population of girls in chosen age	1,490,022
Girls of chosen age range enrolled in schools	747,991

Table 6.1.3 b: Vaccination by specific school grade

Routine Cohort		
School grade	**Average age of girls on school grade**	**Number of girls in grade**
	9 years	

Aditional multi-age cohort		
School grade	**Average age of girls on school grade**	**Average age of girls on school grade**
	9 years	

If you are vaccinating by grade, provide information on how you will ensure girls under 9 or over 14-years will not be vaccinated

NA

Please describe when vaccinations will be scheduled (school year, holidays, examinations), where vaccinations will be administered, who will do vaccinations, how will the vaccine logistics be assured when using schools as a location for vaccination.

Organisation of the immunisation will use a fixed/outreach strategy at schools (in September – October 2018 and March – April 2019, during the school year). The organisation of the immunisation will be planned according to the school holidays and exam periods.

The fixed strategies in the healthcare facilities and the outreach strategies within communities will occur throughout the year.

The vaccine will be administered by trained health workers for this purpose. The health personnel will travel to schools and to communities to immunise the girls.

The vaccines, packed in vaccine carriers with ice packs, will be transported from the healthcare facilities to the immunisation sites (schools, communities). The quantity of vaccines will be based on the needs for each immunisation site.

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

Additional staff will not be hired.

On the other hand, during the 1st year of introduction, the country will call on a team of volunteers (retired

healthcare personnel, medical school and nursing students), who will receive transportation and meal allowances.

These costs will be included in the operational costs.

Please describe the strategy to capture girls who may miss the initial vaccination session or any of the remaining doses

The teams at the operational level will work in collaboration with the educational community and with community leaders on awareness-raising and on steering girls who missed the first immunisation session to healthcare facilities.

Will the vaccination strategy need to be adapted for at private or religious schools? If so, please elaborate.

There will be no special strategy adapted to private schools or denominational schools. However, those responsible for these different sectors will be involved in all stages of the introduction process.

Using health facilities as a location for vaccination

Please describe why this approach has been chosen for the selection region/ district(s). Will this approach be used every year?

The healthcare facilities are the traditional immunisation sites. The personnel and supply chain are present and available. These healthcare facilities will be used for the catch-up of girls missed during immunisation at schools and in the community.

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

Additional staff will not be hired.

Please provide details of demand generation activities to encourage girls to come to the health facility?

To generate demand, the following strategies will be developed: advocacy, social mobilisation and grassroots communication.

- Advocacy will be carried out, targeting administrative, traditional and religious authorities as well as head physicians of the inspectorates for health at schools (*Inspections médico-scolaires*).
- Formal collaboration will be developed with organised womens groups and institutions working in education, women's empowerment and the family.
- For girls in school, school principals and teachers will be involved in the activities to mobilise the educational community.
  For out-of-school girls, community health workers will be put to work to identify [the girls] in households and to steer them towards immunisation posts.

Please provide details on how the country plans to link with schools. Some examples of how schools can be leveraged to increase HPV vaccine uptake include facilitating sensitization and mobilization of parents/communities, identification/validation of the target population (i.e. use of school enrolment lists), and assisting with vaccination call/recall mechanisms. If the country does not plan to link with schools please provide a justification for this decision (i.e. low school enrolment).

- Involvement by the Ministry of Basic Education and of Secondary Education in the coordinating committee to prepare and implement the introduction.
- Involvement by teachers in immunisation training and micro-planning.
- School principals and teachers will be involved in the activities to mobilise the educational community.

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls.

The outreach strategies will be carried out at schools in remote areas.

In the insecure areas, special strategies to immunise the girls (displaced persons, nomads, etc.) will be

carried out in collaboration with the security forces and humanitarian NGOs there.

Collaboration with schools specializing in training girls with reduced mobilities and other vulnerable girls (hearing and sight impaired, etc.) will help in immunising this target.

Collaboration with centres treating HIV-positive people will be set up to help steer the girls living with HIV towards immunisation centres.

Describe what follow-up mechanism will be used to ensure girls receive their second dose.

Immunisation registries will be produced and distributed at the immunisation sites and healthcare facilities. These registries will include information such as the contact details and addresses of parents, in order to carry out follow-up for the second dose.

The girls' immunisation cards will be kept at the schools by the teachers after the 1st dose. The cards will be returned to the girls just after the 2nd dose.

Using community venues as locations for vaccinations

Please describe why this approach has been chosen for the selection region/ district(s).

Immunisation at the community sites provides the best way to reach the maximum number of out-of-school girls in the communities.

Will this approach be used for every year? If so, please describe how this strategy will be financed in future years.

This approach will be used every year. This approach uses the outreach strategies, which are a routine immunisation activity. Its implementation will not require additional funding.

Please describe how your community health care workers/ volunteers will be involved with this strategy

A team of volunteers (retired personnel, medical school and nursing students) will provide support for immunising the multi-age cohort during the introduction year. These volunteers will be recruited and trained in HPV immunisation and will be made available to the healthcare facilities.

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

No, additional staff will not be hired to immunise the multi-age cohort girls. A team of volunteers (retired personnel, medical school and nursing students) will provide support for immunising the multi-age cohort during the introduction year.

Where in the community will the girls be vaccinated? E.g. schools, fixed outreach sites, streets, parks, malls, markets

Sites fitted out in communities such as public spaces (markets, stadiums, parks, etc.), community halls and traditional chiefdoms will serve as immunisation sites. These sites will be selected in collaboration with community leaders and local authorities.

What interventions will be established to increase community based acceptance and increase community support?

- The community and religious leaders will be put to work to raise people's awareness and to spread the messages about HPV in the communities.
- Specific activities such as grassroots awareness via educational discussions and home visits will be implemented in the communities, with involvement from the community leaders.
- The dissemination of essential messages in local languages on community radios, at places of worship and other places where people meet will take place on a continual basis.

- Advocacy will be carried out, targeting administrative, traditional and religious authorities to ensure their commitment.
- Formal collaboration will be developed with organised groups related to women, women's empowerment and the family.

Please provide details of demand generation activities e.g. awareness building and information dissemination via community or education sector and/or mass media, including through youth clubs and street theatre

To generate demand, the following strategies will be developed: advocacy, social mobilisation and grassroots communication:

- Advocacy will be carried out, targeting administrative, traditional and religious authorities.
- Formal collaboration will be developed with organised groups related to women, women's empowerment and the family.
- The dissemination of essential messages in local languages on community radios, at places of worship and other places where people meet will take place on a continual basis.
- The community and religious leaders will be put to work to raise people's awareness and to spread the messages about HPV in the communities.

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls?

Community leaders, opinion leaders and the humanitarian NGOs of remote areas and insecure zones will be put to work to raise awareness among out-of-school girls.

Describe what follow-up mechanism will be used to ensure girls receive their second dose.

Immunisation registries will be produced and made available at the immunisation sites and healthcare facilities. These registers will include information such as contact details and addresses of parents. This information will be used by the healthcare personnel and the social mobilisers for the follow-up for the second dose.

Community leaders, women’s associations and peers will be involved in identifying and steering out-of-school girls towards the healthcare facilities.

Using campaigns to deliver HPV vaccines

Please describe why this approach has been chosen for the selection region/ district(s).

NA

What type of campaign will be used for HPV vaccine delivery e.g. Child Health Days/ Weeks, Measles Rubella or tetanus containing vaccines, supplementary immunisation activities, health education activities? If the campaign is planned to be standalone, please explain why?

NA

How will this campaign impact routine service delivery? For example, will health facility personnel be used for this campaign?

NA

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

NA

What location(s) will be used to deliver vaccinations during the campaign?

NA

Will this delivery strategy be used for every year? If so, please describe how this strategy will be financed in future years.

NA

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls?

NA

6.1.4 Social Mobilisation

Please complete the table below to provide details on the types of information and/ or materials that will be used/ disseminated, to which audience, by which mechanism and the frequency of each.

Types of information or materials	**Audience receiving material**	**Method of delivery**	**Who delivers**	**Frequency & Timing**
e.g., leaflet, poster, banner, handbook, radio announcement, etc.	**e.g., girls, parents, teachers, health workers, district officials, community groups, etc.**	**e.g., parent meetings, radio, info session at school, house visit, etc.**	**e.g., teachers, health workers, district official, etc.**	**e.g., daily, weekly, twice before programme starts; day of vaccination, two weeks before programme begins, etc.**
Leaflets	- Political leaders, administrative, municipal, traditional and religious leaders, - professional health associations - Educational Community - Parents - Girls	- Information Days - causeries - home visit -Educational Meetings	- Focal point for communication, MoH - Trainers at all levels (central, regional, operational) - Community leaders (religious, traditional) - Women’s associations	- Before and during the introduction day - On the day of vaccination
Posters	- communities - School establishments - Health facilities	Display	- Ministry of Health -Ministry of Basic Education - Ministry of Secondary Education	- Before and during the introduction day - On the day of vaccination
Banners	- communities - School establishments - Health facilities	Display	- Ministry of Health -Ministry of Basic Education - Ministry of Secondary Education	During the launch

Radio Spots	- Educational community - parents - girls - community leaders - traditional leaders	Broadcast on the radio	- Ministry of Health - Communication Focal Points, MoH - Journalists Association	before and during the launch

Please describe a crisis communication plan to response to rumors and misconceptions to HPV vaccination.

A crisis communication plan will be developed and will follow the following steps:

Pre-crisis:

- Establish a crisis management committee.
- Designate and train a spokesperson (in general the Minister of Public Health at the national level or opinion leaders).
- Identify credible media and journalists who can help contain the crisis if need be.
- Prepare a series of questions & answers.

During the crisis:

- Assess and weigh the words to be used.
- Communicate as simply as possible: illustrate rather than assert.
- Provide prospects for the future.

After the crisis:

- Assess the impact of the crisis.
- Restore the image of the health services.
- Evaluate, correct and improve crisis communication during and after the crisis.

6.1.5 Adolescent health integration

Irrespective of the strategies, provide a description of existing health services and/or health education currently being provided to young adolescents (both girls and/or boys) within the 9-14 year old age group and indicate and potential synergy by integrating with HPV vaccination:

a. For health services (this can include: what health services are provided, to which age/sex group, whether

it's mandatory or voluntary, regularly or ad-hoc, in school or out of school, who provides these (government, NGOs), how often, what is the uptake in the community, how is it perceived by the community.)

The following health services are provided at schools:

- Systematic consultations with the school doctor once per year, for primary school children (age 5–11);
- Control missions for hygiene and sanitary conditions, fight against cholera: occasional;
- Anti-parasite campaigns: once per year;

These services are mandatory and provided by the government.

Some NGOs occasionally offer health services to schools, e.g. screening for vision problems.

b. For health education (this can include: the topic, whether it is national, sub-national, in school or out of school, who provides the education, how often, is it in the school curriculum, are there NGOs providing these? How is it perceived by the community? Has there been an evaluation and if so, how was it evaluated and what were the findings?)

There are health clubs within primary schools. The members of these clubs are trained by teachers, the school doctor or NGOs on various subjects of adolescent health, and they are put in charge of educating their fellow students (peer education). These themes are:

- Adolescent reproductive health: puberty, family planning, prevention of unwanted pregnancies;
- HIV/AIDS prevention in the school environment: different methods of prevention;
- Oral hygiene: brushing teeth, education on the most common dental disorders;
- Teaching the WASH method: washing hands with soap, safe disposal of feces, drinking water, personal hygiene;
- Alcohol and tobacco dependencies;
- Malaria prevention in the school environment;

Educational discussions and health campaigns are organised on the occasion of various festivities (national holidays, fairs, international days of AIDS or malaria, etc.). These activities are funded by development partners (PLAN Cameroon, CAMNAFAW, UNICEF, UNESCO, etc.).

These services are well perceived by the community. No evaluation of these activities has been planned for now.

c. For improving adolescent immunization platform (this can include integration with: other vaccines provided to adolescents (e.g. measles-rubella, tetanus containing vaccines or Dengue), broader health education services)

All adolescents should normally receive a booster dose of tetanus vaccine. As part of its plan to maintain its maternal and neonatal tetanus-free country status, Cameroon has provided for the introduction of a dose of tetanus vaccine for adolescent girls. The success of the HPV vaccine introduction will facilitate the implementation of the tetanus immunisation for adolescent girls.

6.1.6 CSO engagement

Please describe how and which CSOs will be included in the delivery of HPV vaccines e.g. demand generation activities, increase coverage of "hard to reach" girls.

Involvement by non-state actors in the implementation of health activities is a firm policy option of the Cameroonian Government. This political choice, which seeks to develop the synergies of action and complementarity between the public and private health actors, is made operational through the partnership strategy in the health sector. Moreover, the Ministry of Public Health has defined the terms of community participation in health activities through the 1998 Order setting the terms for creating dialogue and community-participation bodies in the health districts.

Community participation in the health activities is based on collaboration and complementarity between the health system and the community health system organisations (decentralised local communities, COSA/COSADI, NGOs/CSOs, community associations or groups, religious organisations, private sector and universities). The main community-level actors working in immunisation activities are: the Community Health Workers (CHWs); the CSOs/associations and in particular the network of women's association MINPROFF

and the Civil Society Platform for the Promotion of Immunisation and Health System Strengthening (PROVARESSC), which is made up at the regional level of 10 CSO focal points that coordinate all the activities of CSOs working in the region. At the operational level, the main actors are 189 district CSOs that ensure the monitoring and evaluation of the CBO activities in villages and neighbourhoods; 1,766 CBOs of health areas; 1,766 dialogue bodies that carry out actions for awareness-raising, research and the steering of targets toward the immunisation posts in all the communities, with the support of 17,000 health workers; the dialogue bodies; the traditional leaders; and the religious leaders.

As part of introducing the HPV vaccine into routine immunisation, capacity building will be provided for these community actors and their terms of reference revised to provide for their active involvement in the activities of generation of demand, counting, research and steering the girls lost to follow-up toward the immunisation posts.

6.1.7 Key stakeholder and technical partner roles and responsibilities

Please complete the Gavi provided template, to define the respective roles and responsibilities of all in-country stakeholders and technical partners.

Please attach the relevant documents and refer to section 10. Attachments. (Document N°**17**)

6.2. Requested vaccine (HPV quadrivalent, 1 dose(s) per vial, LIQUID)

As reported in the cMYP, the country plans to introduce HPV quadrivalent, using HPV quadrivalent, 1 dose(s) per vial, LIQUID.

When is the country planning to introduce this vaccine? **September 2018**

Please note that, due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

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

In December 2015 and January 2016, Cameroon carried out an inventory of cold chain equipment. The ICF data were used to determine the current available capacity at the different levels of the cold chain system.

At the national level: Cameroon has three positive cold rooms of 40m3 and one of 30m3, making for a total net capacity of 35,714 litres. This existing capacity is less than the current needs of 70,000 litres. To fill in this gap at the national level, the country will purchase two cold rooms using the remaining funds of the MR [vaccine] introduction campaign and the HSS funds. Installation of these cold rooms will provide the capacity required for the HPV [vaccine] introduction, as well as for the other vaccines provided for in the cMYP.

With the goal of improving the management of vaccines and supplies, Cameroon is planning to build a modern warehouse thanks to Gavi funding. This warehouse will make it possible to put the cold rooms and consumables in a single location.

At the regional level: eight out of ten regions currently have the required storage capacity. The two other regions will benefit from new purchases through the HSS2 funds. For the year the HPV vaccine is introduced, there is no storage capacity problem at the region level.

At the district level: Cameroon has 189 district storage facilities that take care of supplying the healthcare facilities. The 2016 inventory revealed that 141 storage facilities will have a storage capacity deficit by 2021. In order to fill in this gap, Cameroon obtained a funding agreement from Gavi through the supply chain optimisation platform, implementation of which is planned for 2018. The installation of this equipment will provide the suitable storage capacity at the district level.

At the healthcare facility level: the 2016 inventory showed that Cameroon has 3,570 healthcare facilities that immunise. At this level, the estimated volume per fully immunised child (FIC) in 2016 is 133 cm3. With the introduction of the new vaccines, this volume will increase by 39%, rising to 186 cm3 in 2021. As in the case of the district storage facilities, these gaps will be filled in through the supply chain optimisation platform, whose planned implementation in 2018 also provides for equipping 629 new healthcare facilities. Including

these new healthcare facilities will help improve immunisation coverage and equity.

6.2.1. Vaccine Prices

Vaccine	Presentation	2017	2018	2019
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	4.500	4.500	4.500

6.2.2. Co-financing information

The co-financing requirement applies to vaccines for the **routine cohort** (i.e. the cohort that will be routinely vaccinated on an annual basis for the routine immunisation programme). However, Gavi will fully finance vaccines for the **additional multi-age cohort** during the introduction year.

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

Country group	Preparatory transition phase

	2018	2019
minimum co-financing per dose	0.76	0.87
your co-financing per dose (please change if higher)	0.76	0.87

6.2.2.1.Specifications of vaccinations with new vaccine for routine cohort

	Source		2018	2019
Number of girls in routine cohort to be vaccinated with the first dose	Table 5.2	#	225,930	235,701
Number of girls in routine cohort to be vaccinated with the second dose	Table 5.2	#	209,792	222,606
Immunisation coverage with the second dose	Table 5.2	%	65%	68%
Country co-financing per dose	Table 6.2.2	$	0.76	0.87

6.2.2.2.Specifications of vaccinations with new vaccine for additional multi-age cohort

	Source		2018	2019
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	1,043,015	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	968,514	0
Immunisation coverage with the second dose	Table 5.2	%	65,00%	0

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

		2018	2019
Number of vaccine doses	#	72,186	86,917
Number of AD syringes	#	99,256	96,787
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	1,092	1,065
Total value to be co-financed by the Country *[1]*	**$**	413,975	403,682

[1] The co-financing amount for intermediate and graduating countries indicates costs for the vaccines, related injection safety devices and any freight charges. The total co-financing amount does not contain the costs and fees of the relevant Procurement Agency, such as contingency buffer and handling fees.

Information on these extra costs and fees will be provided by the relevant Procurement Agency as part of the cost estimate to be requested by the Country.

6.2.3.1 Portion of supply for routine cohort to be procured by Gavi (and cost estimate, US$)

		2018	2019
Number of vaccine doses	#	363,536	371,390
Number of AD syringes	#	499,863	413,563
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	5,499	4,549
Total value to be co-financed by Gavi	$	2,084,823	1,724,907

6.2.3.2 Portion of supply for additional multi-age cohort to be procured by Gavi (and cost estimate, US$)

		2018	2019
Number of vaccine doses	#	2,011,529	0
Number of AD syringes	#	2,212,682	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	24,340	0

6.2.4 New and Under-Used Vaccine Introduction Grant

Calculation of Vaccine Introduction Grant for the HPV quadrivalent, 1 dose(s) per vial, LIQUID

Year of New Vaccine Introduction	Girls in routine cohort (From Table 5.2)	Share per Girls in routine cohort in US$	Total in US$
2018	322,757	2.40	774,617

The Grant will be based on a maximum award of $2.4 per girl in the routine cohort with a minimum starting grant award of $100,000

Please describe how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).

After approval of the request for HPV vaccine introduction and the disbursement of funds by Gavi, the funds will be allocated to different levels of the health system for the implementation of preparatory activities, in particular through:

- The production and distribution of training modules, communication tools and data management tools;
- Capacity building for the actors working to introduce the HPV vaccine at the national level;
- Support for outreach and mobile strategy immunisation;
- AEFI monitoring;
- Communication/social mobilisation
- Monitoring, evaluation and surveillance.

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

Detailed budget attached as Document No. 22.

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

The gap will be filled with contributions from the government and the local technical partners (WHO, UNICEF, CHAI, CDC…)

6.2.5.New and Under-Used Operational support

Calculation of Operational Support for the HPV quadrivalent, 1 dose(s) per vial, LIQUID

Year of New Vaccine Introduction	Girls in additional multi-age cohort (From Table 5.2)	Share per Girls in additional multi-age cohort in US$	Total in US$
2017	1,490,022	0.55	819,512

Please describe how the Gavi Operational support will be used to reach the additional multi-age cohorts? How will these funds be used to strengthen routine activities e.g. reinforcing routine outreach activities, additional personnel, additional demand generation activities?

Note: These funds can be used over a longer period than the introduction year in order to strengthen routine immunisation. For example to reinforce routine outreach activities in difficult to access districts.

Detailed budget attached as Document No. 22.

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

6.2.6.Technical assistance

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

The country will ask for technical assistance to support implementation of the communication activities, training at the national and regional levels on the HPV vaccine, the development of training modules and communication tools, and pre- and post-introduction assessments.

7. NVS Preventive Campaigns

No NVS Prevention Campaign Support this year

8. NVS Follow-up Campaigns

No NVS Follow-up Campaign Support this year

9. Procurement and Management

9.1 Procurement and Management of New and Under-Used Vaccines Routine

Note: The PCV vaccine must be procured through UNICEF to be able to access the price awarded by the Advance Market Commitment (AMC).

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

The funds for this proposal will be managed through the government standard expenditure procedures channel. The funds (Gavi share) for procurement of vaccines and other immunisation supplies will be sent directly to Unicef. The country procures the vaccines and other immunisation supplies through Unicef.

b) If an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or the Gavi) is requested, please document

- A description of the mechanism and the vaccines or commodities to be procured by the country
- Assurance that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. For the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, assurance should also be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

NA

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 will be transferred to the Gavi EPI account open in the EPI/CAA:

- Entitled: Independent Payment Fund EXPANDED PROGRAMME ON IMMUNISATION (EPI)-Gavi
- Bank Code : 10004
- Code counter : 00200
- N° de compte : 08021755974
- Clé de contrôle : 54
- Code Swift : SCBLCMCX
- In Euro :
- STANDARD CHARTERED BANK FRANFURT
- CODE SWIFT: SCBLDEFX
- En USD :
- STANDARD CHARTERED BANK FRANFURT
- CODE SWIFT : SCBLUS33

The signatories are as follows:

- For amounts < five million: The Director of Family Health and the EPI Permanent Secretary are cosignatories, with the approval of the Minister of Public Health
- For amounts ≥ five million: the Minister of Public Health is the sole signatory.

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

Co-financing funds are drawn by the Government via CAA from the central procurement account in Copenhagen or via Unicef.

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

The funds for this proposal will be managed through the government standard expenditure procedures channel. The Central Technical Group of the EPI (CTG-EPI) includes five technical sections, including an Administrative and Financial Section (SAF) directed by a qualified accountant. An internal controller was appointed by the Minister of Public Health, to work in collaboration with the Permanent Secretary of the CTG-EPI to monitor financial management. In addition, an annual audit of Gavi funds was conducted and the report should be shared with Gavi and other Partners, 6 months after the end of the fiscal year covered by the audit.

There is a Comprehensive Multi-Year Plan (cMYP) for the period 2015-2019, prepared with all the partners, covering all the activities to be carried out during the period. This cMYP aligns with the National Health Development Plan (NHDP) 2016-2020, which itself issued from the 2015-2017 Sectoral Health Strategy (SHS). From the 2015-2019 cMYP, an Annual Work Plan is prepared at the start of each year, and the quarterly work plans at the start of each quarter. The Annual Work Plan and the quarterly work plan are validated by the ICC.

To conduct these activities, technical sheets are prepared by the technical sections in collaboration with the SAF and the Internal Controller, which verify that: (i) activities are planned in the Annual Work Plan; (ii) the budget conforms to the budget set forth in the Annual Work Plan; (iii) the unit costs are the same. The technical sheets are then validated by the SAF, the Internal Controller and the Permanent Secretary and they are forwarded to the Minister of Health to be signed. At the central level the EPI has an accounting and financial management software package (TOMPRO) that will be replaced by software by TOM 2 PRO. In addition, the EPI has just been provided with an accounting, financial and administrative management procedures manual that describes the internal control system and operational procedures for financial management.

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

The immunisation coverage will be monitored via the monthly reports of the number of children who receive the 1st and the 2nd dose of HPV vaccine. Data on this vaccine will be included in the routine immunisation reports. A coverage survey to estimate the rates of immunisation coverage is planned for the year following the vaccine introduction. This survey will help measure the level of acceptability and ensure that the indicators on equity associated with the immunisation of in-school and out-of-school girls, geographical equity and delivery to vulnerable girls are taken into account.

g) If applying for measles second dose, does the country wish to have the support in cash or in-kind? **N/A**

9.2 Procurement and Management for NVS Preventive Campaign(s)

No NVS Prevention Campaign Support this year

9.3 Product Licensure

For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines.

Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.

The quadrivalent HPV vaccine is approved for use in Cameroon. (Provide the references by SPA.)

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

The quadrivalent HPV vaccine is Cameroon's preferred option. In the event the quadrivalent vaccine is unavailable on the market, the alternative presentation shall be the bivalent HPV vaccine.

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

Customs formalities and the transport of routine vaccines from the airport to the central warehouse will be handled by the government.

With regard to customs clearance for the vaccines and injection supplies for routine immunisation, each year the EPI requests and obtains custom fee exemption from the Ministry of Finance and Budget. However, the MoPH must pay the the payment of the data processing fees, the fees of the licensed customs forwarding agent, and transport. Once the pre-alert documents are received, the TAG-EPI transfers the file to the Department of Financial Resources and Assets (DRFP), which handles the formalities regarding pick-up of the vaccines and supplies.

Cameroon has a national regulatory authority for pharmaceutical products called the ANR (National Agency for Regulation). This authority releases vaccine lots based on documents received from the procurement centre for WHO-licensed vaccines. The process takes a maximum of two weeks.

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

The DPML (Direction of Pharmacy of the Pharmaceutical and Laboratories) acts as National Regulatory Authority (NRA). It is functional and meets three functions out of the six recommended functions, i.e:

- approval of products and granting market authorizations;
- releasing batches;
- post-sale surveillance, including monitoring of Adverse Post Immunization Manifestations (AEFIs).
- Dr Ateba Etoundi Aristide Tel: +237 677 60 42 62 e-mail: atebarisotto@yahoo.fr

9.4 Waste management

Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), the safe handling, storage, transportation and disposal of immunisation waste, as part of a healthcare waste management strategy. Please describe the country's waste management plan for immunisation activities (including campaigns).

The implementation of the immunisation activity using the fixed strategy in the healthcare facilities, schools and community immunisation sites will produce a significant amount of waste. For this reason there is a need to clearly define the waste management circuit in order to reduce the risk of contamination by sharp objects. Application of the bundling principle will ensure the availability of a sufficient quantity of safety boxes. Used syringes will be placed in safety boxes and the empty bottles in plastic bags. Just as in the implementation of the fixed and outreach strategies, waste from immunisation activities will be taken to destruction sites. The destruction will be by burning and burial, or by incineration. Waste management protocols will be developed and disseminated. In addition, the personnel in charge of the waste management will be briefed during training.

9.5 Procurement and Management for Follow up Campaign(s)

No NVS Follow-up Campaign Support this year

10. List of documents attached to this proposal

10.1. List of documents attached to this proposal

Table 1: Checklist of mandatory attachments

Document Number	Document	Section	File
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	Page signature Ministres.pdf **File desc:** Signature du Ministre de la Santé **Date/time :** 17/05/2017 04:18:37 **Size:** 637 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	Page signature Ministres.pdf **File desc:** Signature du Ministre des Finances **Date/time :** 17/05/2017 04:19:06 **Size:** 637 KB
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	Page signature Ministres.pdf **File desc:** Signature du Ministre de l'éducation base **Date/time :** 17/05/2017 04:19:41 **Size:** 637 KB
4	Terms of Reference for the Coordination Forum (ICC/HSCC or equivalent) including all sections outlined in Section 5.2 of the General Application Guidelines (Note: countries applying before May 2017 can submit their existing Terms of Reference)	4.1.2	ORGANIGRAMME PEV SIGNE DU 08-03-2011.pdf **File desc:** Organigramme PEV signé du 08-03-2011 intégrant les termes de référence du CCIA (voir Chapitre 2) **Date/time :** 17/05/2017 02:05:16 **Size:** 2 MB
5	Minutes of Coordination Forum meeting endorsing Proposal	4.1.3	Rapport CCIA du 12 Mai 2017 & Fiche de présence.rar **File desc:** Rapport CCIA du 12 mai 2017 avalisant la proposition et fiche de présence à ce CCIA **Date/time :** 17/05/2017 02:12:10 **Size:** 3 MB
6	Signatures of Coordination Forum members in Proposal	4.1.3	Pages Signatures Membres_CCIA-Soumission Introduction HPV Mai 2017.pdf **File desc:** Signatures du CCIA **Date/time :** 17/05/2017 04:20:35 **Size:** 1 MB
7	Minutes of the Coordination Forum meetings from the past 12 months before the proposal	4.1.3	3 derniers rapports CCIA 2016.rar **File desc:** Compte-rendus des trois dernières réunions du CCIA en 2016 **Date/time :** 17/05/2017 12:20:38 **Size:** 3 MB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	Cameroon_Décision Nomination Membres Comité Scientifique.docx **File desc:** Décision portant nomination des membres du GTCV/comité scientifique de la vaccination. **Date/time :** 17/05/2017 12:25:05 **Size:** 1 MB

31	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	Explication absence de compte rendu de la réunion du GTCV .docx **File desc:** Explication absence de compte rendu de la réunion du GTCV **Date/time :** 17/05/2017 12:37:03 **Size:** 12 KB
Planning, financing and vaccine management			
9	Comprehensive Multi Year Plan - cMYP	5.1	PPAC 2015-2019 -Version definitive du 24-01-2015-22h10.pdf **File desc:** Plan Pluriannuel Complet - PPAC 2015-2019 **Date/time :** 17/05/2017 12:40:24 **Size:** 4 MB
10	cMYP Costing tool for financial analysis	5.1	cmyp_costing_tool_3 version du 31-12-2014 Final.xlsx **File desc:** Outil d'analyse financière du PPAC 2015-2019 **Date/time :** 17/05/2017 12:41:52 **Size:** 3 MB
11	M&E and surveillance plan within the country's existing monitoring plan	5.1.4	Plan intégré de Suivi Evalution -PISE 2016-2020.docx **File desc:** Plan intégré de Suivi Evaluation 2016-2020 du Ministère de la Santé **Date/time :** 17/05/2017 01:11:02 **Size:** 353 KB
12	New vaccine introduction plan (NVIP), New Vaccine Introduction Checklist and Activity List & Timeline for routine vaccines or Plan of Action (PoA) for campaign vaccines	5.1,7.2.3	introplan HPV_150517.doc **File desc:** Plan d'introduction du vaccin **Date/time :** 17/05/2017 01:14:19 **Size:** 847 KB
15	HPV Region/ Province profile	6.1.1	HPV Application_Region Profile_FR.xlsx **File desc:** Feuille de route ou stratégie pour le vaccin anti-PVH **Date/time :** 17/05/2017 01:16:44 **Size:** 43 KB
16	HPV Key Stakeholder Roles and Responsibilities	6.1.1,6.1.2	introplan HPV_150517.doc **File desc:** Methodologie d'évaluation du vaccin anti-HPV décrite à la page 42 du plan d'introduction **Date/time :** 17/05/2017 10:50:57 **Size:** 847 KB
19	EVM report	9.3	Rapport_GEV_Cameroun_CM_06_10_2013.pdf **File desc:** Rapport sur la GEV **Date/time :** 17/05/2017 01:21:17 **Size:** 1 MB
20	Improvement plan based on EVM	9.3	GEV-Plan-Amélioration-CMR_Juillet_2014.xls **File desc:** Un plan d'amélioration basé sur le GEV **Date/time :** 17/05/2017 01:25:05 **Size:** 215 KB
21	EVM improvement plan progress report	9.3	Plan d'amélioration GEV et Rapport d'étape_CMR.doc **File desc:** Rapport de situation du plan d'amélioration de la GEV **Date/time :** 17/05/2017 01:25:44

			Size: 4 MB
22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2,6.x.2,8.2.3	MODELE DE PREVISIONS BUDGETAIRE_CMR fInal.rar **File desc:** Modèle détaillé de budget pour l'allocation d'introduction d'un vaccin/les coûts opérationnels **Date/time :** 17/05/2017 01:35:14 **Size:** 1 MB
32	Data quality assessment (DQA) report	5.1.4	DQA Rapport général.docx **File desc:** Rapport sur l'évaluation de la qualité des données **Date/time :** 17/05/2017 01:29:05 **Size:** 1 MB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
14	Annual EPI Plan with 4 year forward view for measles and rubella		PTA 2017 version finale du 02-03-2017.docx **File desc:** Plan annuel du PEV 2017 **Date/time :** 17/05/2017 01:30:16 **Size:** 626 KB
17	Evidence of commitment to fund purchase of RCV (in place of the first dose of MCV) / for use in the routine system	5.1.6, 6.1.7	No file loaded
18	Campaign target population documentation	8.x.1, 6.x.1	No file loaded
24	Risk assessment and consensus meeting report for Yellow Fever, including information required Section 5.3.2 in the General Guidelines on YF Risk Assessment process	5.1	No file loaded
25	Risk assessment and consensus meeting report for Yellow Fever, including information required in the NVS guidelines on YF Risk Assessment process	5.1	No file loaded
26	List of areas/districts/regions and targets to be supported for meningitis A mini catch up campaigns		No file loaded
27	National Measles (& Rubella) elimination plan if available		No file loaded
28	A description of partner participation in preparing the application	4.1.3	No file loaded

30	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, ICC minutes committing to finance from 2018 onwards.		No file loaded
33	DQA improvement plan	5.1.4	No file loaded
34	Plan of Action for campaigns	8.1, 8.x.4	No file loaded
35	Other		Autre documents HPV.rar **File desc:** Autres documents importants relatifs à cette demande de soutien au vaccin anti-HPV **Date/time :** 17/05/2017 01:44:45 **Size:** 4 MB
36	Strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control		No file loaded
37	Evidence of self-financing MCV1	5.1.5	No file loaded
38	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, a signed letter from the Minister of Health and the Minister of Finance committing to finance from 2018 onwards.		No file loaded
39	Epidemiological analysis/evidence	8.3.1	No file loaded
40	Post Campaign Coverage Survey report for MR catch-up applications	5.1.x	No file loaded
41	cMYP addendum on measles and rubella		No file loaded

11. Annexes
11. Annexes

Annex 1 - NVS Routine Support

Annex 1.1 HPV quadrivalent, 1 dose(s) per vial, LIQUID

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

		2018	2019	
Number of vaccine doses	#	72,186	86,917	
Number of AD syringes	#	99,256	96,787	
Number of re-constitution syringes	#	0	0	
Number of safety boxes	#	1,092	1,065	
Total value to be co-financed by the Country *[1]*	$	413,975	403,682	

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

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

		2018	2019	
Number of vaccine doses	#	363,536	371,390	
Number of AD syringes	#	499,863	413,563	
Number of re-constitution syringes	#	0	0	
Number of safety boxes	#	5,499	4,549	
Total value to be co-financed by Gavi	$	2,084,823	1,724,907	

Portion of supply for additional multi-age cohort to be procured by Gavi (and cost estimate, US$)

		2018	2019	
Number of vaccine doses	#	2,011,529	0	
Number of AD syringes	#	2,212,682	0	
Number of re-constitution syringes	#	0	0	
Number of safety boxes	#	24,340	0	

Table Annex 1.1 C: Summary table for vaccine HPV quadrivalent, 1 dose(s) per vial, LIQUID

	Source		2018	2019	
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	1,043,015	0	
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	968,514	0	
Immunisation coverage with the second dose	Table 5.2	%	65.00%	0	

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

	Formula	2018		
		Total	Government	Gavi

A	**Country co-finance**	*V*	16.57 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2*	225,930	37,430	188,500
B1	**Number of children to be vaccinated with the second dose**	*Table 5.2*	968,514		
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1		
D	**Number of doses needed**	*B + B1*	435,722	72,186	363,536
E	**Estimated vaccine wastage factor**	*Table 5.2*	1		
F	**Number of doses needed including wastage**	*D x E*	435,722	72,186	363,536
G	**Vaccines buffer stock**	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	108,931	18,047	90,884
I	**Total vaccine doses needed**	*Round up((F + G) / Vaccine package size) * Vaccine package size*	544,700	90,240	454,460
J	**Number of doses per vial**	*Vaccine parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G) x 1.10*	599,119	99,256	499,863
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*	6,591	1,092	5,499
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	2,451,150	406,079	2,045,071
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	21,569	3,574	17,995
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	3,038	504	2,534
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	23,041	3,818	19,223
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	2,498,798	413,975	2,084,823
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	413,972		
V	**Country co-financing % of Gavi supported proportion**	*U / T*	16.57 %		

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

		Formula	2019		
			Total	Government	Gavi
A	Country co-finance	*V*	18.96 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	235,701	44,700	191,001
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	0		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	458,307	86,917	371,390
E	Estimated vaccine wastage factor	*Table 5.2*	1		
F	Number of doses needed including wastage	*D x E*	458 307	86 917	371 390
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	5 647	1 071	4 576
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	464 000	87 997	376 003
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	510 350	96 787	413 563
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	5 614	1 065	4 549
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2 088 000	395 983	1 692 017
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	18 373	3 485	14 888
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	2 588	491	2 097
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	19 628	3 723	15 905
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	2 128 589	403 682	1 724 907
U	Total country co-financing	*I x country co-financing per dose (cc)*	403 680		
V	Country co-financing % of Gavi supported proportion	*U / T*	18,96 %		

Annex 2 - NVS Routine – Preferred Second Presentation

Annex 2.1 - NVS Routine Support (HPV bivalent, 2 dose(s) per vial, LIQUID)

Table Annex 2.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in US$

		2018	2019
Number of vaccine doses	#	70 632	85 046
Number of AD syringes	#	97 119	94 703
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	1 069	1 042
Total value to be co-financed by the Country *[1]*	$	413 974	403 683

Table Annex 2.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$

Rounded up portion of supply for the additional cohort that is procured by Gavi and estimate of relative costs in US$

		2018	2019
Number of vaccine doses	#	365 090	373 261
Number of AD syringes	#	502 000	415 647
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	5 522	4 572
Total value to be co-financed by Gavi	$	2 139 806	1 771 742

Table Annex 2.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$ ADDITIONAL COHORTS

		2018	2019
Number of vaccine doses	#	0	0
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0

Table Annex 2.1 C: Summary table for vaccine HPV bivalent, 2 dose(s) per vial, LIQUID

	Source		2018	2019
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	0	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	0	0
Immunisation coverage with the second dose	Table 5.2	%	0	0

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	*V*	16,21 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	225 930	36 624	189 306
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	0		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	435 722	70 632	365 090
E	Estimated vaccine wastage factor	*Table 5.2*	1		
F	Number of doses needed including wastage	*D x E*	435 722	70 632	365 090
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	108 931	17 658	91 273
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	544 700	88 297	456 403
J	Number of doses per vial	*Vaccine parameter*	2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	599 119	97 119	502 000
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	6 591	1 069	5 522
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2 505 620	406 166	2 099 454
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	21 569	3 497	18 072
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	3 038	493	2 545
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	23 553	3 818	19 735
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	2 553 780	413 974	2 139 806
U	Total country co-financing	*I x country co-financing per dose (cc)*	413 972		
V	Country co-financing % of Gavi supported proportion	*U / T*	16,21 %		

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 2)

		Formula	2019		
			Total	Government	Gavi
A	Country co-finance	*V*	18,56 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	235 701	43 738	191 963
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	0		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	458 307	85 046	373 261
E	Estimated vaccine wastage factor	*Table 5.2*	1		
F	Number of doses needed including wastage	*D x E*	458 307	85 046	373 261
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	5 647	1 048	4 599
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	464 000	86 102	377 898
J	Number of doses per vial	*Vaccine parameter*	2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	510 350	94 703	415 647
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	5 614	1 042	4 572
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2 134 400	396 068	1 738 332
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	18 373	3 410	14 963
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	2 588	481	2 107
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	20 064	3 724	16 340
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	2 175 425	403 683	1 771 742
U	Total country co-financing	*I x country co-financing per dose (cc)*	403 680		
V	Country co-financing % of Gavi supported proportion	*U / T*	18,56 %		

Annex 3 - NVS Preventive campaign(s)

No NVS Prevention Campaign Support this year

Annex 4

Table Annex 4A: Commodities Cost

Vaccine	Presentation	2017	2018	2019
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	4.500	4.500	4.500

Supply	Form

Note: WAP - weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Estimated prices of supply are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2018	2019
HPV quadrivalent, 1 dose(s) per vial, LIQUID	HPV	0.94 %	0.94 %

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

Vaccine	2018	2019
HPV quadrivalent, 1 dose(s) per vial, LIQUID	0.76	0.87

12. Banking Form

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

Name of Institution (Account Holder):	Caisse Autonome d'Amortissement (CAA)
Address:	B.P. 7167
City Country:	Yaoundé, Cameroun
Telephone no.:	(237) 242 22 26/242 22 01 87 **Fax no.:** (237) 242 22 01 29
	Currency of the bank account: XAF
For credit to:	
Bank account's title:	CAA-Programme Elargi de Vaccination (PEV) - GAVI
Bank account no.:	10004-00200-0802-1755974-54
Bank's name:	Standard Chartered Bank

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

By who is the account audited? CLS Audit Conseil

Signature of Government's authorizing official

		Seal
Name:	M. André MAMA FOUDA	
Title:	Ministre de la Santé Publique	
Signature:		
Date:	15/05/2017	

FINANCIAL INSTITUTION		CORRESPONDENT BANK (In the United States)	
Bank Name:	Standard Chartered Bank		Standard Chartered Bank
Branch Name:	Yaoundé		
Address:	B.P. 1784		
City Country:	Yaoundé, Cameroun		
Swift Code:	SCBLCMCX		
Sort Code:	00200		
ABA No.:	0802 1755974		
Telephone No.:	242227700		
FAX No.:	242222646		

I certify that the account No 10004 00200 0802 1755974-54 is held by CAA-Programme Elargi de Vaccination (PEV)-GAVI at this banking institution

The account is to be signed jointly by at least 2 (number of signatories) of the following authorized signatories:

1		
	Name:	M. André MAMA FOUDA
	Title:	Ministre de la Santé Publique
2		
	Name:	Pr. Robinson MBU
	Title:	Directeur de la Santé Familliale
3		
	Name:	Dr. ENAME Harmelle
	Title:	Secrétaire Permanent du GTC-PEV

Name of bank's authorizing official	
Dieudonné EVOU MEKOU (Directeur Géneral CAA)	
Signature:	
Date:	5/15/2017 12:00:00 AM
Seal:	