APPLICATION FORM FOR GAVI NVS SUPPORT

Submitted by
The Government of Chad
for
Measles 1st and 2nd dose routine

Gavi
The Vaccine Alliance

Reach Every Child
www.gavi.org

1 Gavi Grant terms and conditions

1.2 Gavi terms and conditions

1.2.1 Gavi terms and conditions

The terms and conditions of the Partnership Framework Agreement (PFA) between Gavi and the Country, including those provisions regarding anti-corruption and anti-terrorism and money laundering, remain in full effect and shall apply to any and all Gavi support made pursuant to this application. The terms and conditions below do not create additional obligations or supersede those of the PFA. In the event the Country has not yet executed a PFA, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

GAVI GRANT APPLICATION TERMS AND CONDITIONS

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

AMENDMENT TO THE APPLICATION
The Country will notify Gavi in its Joint Appraisal, or in any other agreed annual reporting mechanism, if it wishes to propose any change to the programme(s) description in its application. Gavi will document any change approved by Gavi according with its guidelines, and the Country's application will be amended.

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

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

NO LIABILITY
The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programme(s) in the Country; and (ii) the use or distribution of vaccines

and related supplies after title to such supplies has passed to the Country.
Neither party shall be responsible for any defect in vaccines and related supplies, which remain the responsibility of the relevant manufacturer. Gavi shall not be responsible for providing any additional funding to replace any vaccines and related supplies that are, or became, defective or disqualified for whatever reason.

INSURANCE
Unless otherwise agreed with Gavi, the Country shall maintain, where available at a reasonable cost, all risk property insurance on the Programme assets (including vaccines and vaccine related supplies) and comprehensive general liability insurance with financially sound and reputable insurance companies. The insurance coverage will be consistent with that held by similar entities engaged in comparable activities.

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

ANTI-TERRORISM AND MONEY LAUNDERING
The Country confirms that funds provided by Gavi shall not be used to support or promote violence, war or the suppression of the general populace of any country, aid terrorists or their activities, conduct money laundering or fund organisations or individuals associated with terrorism or that are involved in money-laundering activities; or to pay or import goods, if such payment or import, to the Country’s knowledge or belief, is prohibited by the United Nations Security Council.

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with Gavi, as requested. Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the Country confirm that its application, or any other agreed annual reporting mechanism, is accurate and correct and forms legally binding obligations on the Country, under the Country's law, to perform the programme(s) described in its application, as amended, if applicable.

COMPLIANCE WITH GAVI POLICIES
The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant

to the programme(s), including without limitation the Transparency and Accountability Policy (TAP) and complies with the requirements therein. All programme related policies, guidelines and processes are available on Gavi's official website and/or sent to the Country.

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

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

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

1.3 Gavi Guidelines and other helpful downloads

Guidelines and documents for download

Please refer to the relevant guidelines concerning your request for support.

Please ensure to consult and download all documents. It is important to note that some documents must be completed offline, and will need to be uploaded in the final steps of your application.

This application form is designed to collect information needed by Gavi to process requests for support, plan procurement of vaccines, plan technical assistance, track data for future reporting, and more.

A key component of the application is a solid operational plan (New Vaccine Introduction Plan for routine support, or Plan of Action for campaign support), explaining how the country will

introduce the vaccine or conduct the envisaged campaign, with a corresponding budget. The New Vaccine Introduction Plan or Plan of Action must be submitted together with this application form and will be considered as the foundation of the support request.

For more information on the documents to submit with your application and what they should contain, please refer to the appropriate guidelines: http://www.gavi.org/support/process/apply/

2 Review and update country information

2.1 Country profile

2.1.1 Country profile

Eligibility for Gavi support

Eligible

Co-financing group

Initial self-financing

Date of Partnership Framework Agreement with Gavi

24 July 2013

Country tier in Gavi's Partnership Engagement Framework

1

Date of Programme Capacity Assessment

June 2016

2.1.2 Country health and immunisation data

Please provide the following information on the country’s health and immunisation budget and expenditure.

What was the total Government expenditure (US$) in 2016?

888,888,888 USD

What was the total health expenditure (US$) in 2016?

179,642,443 USD

What was the total Immunisation expenditure (US$) in 2016?

1,026,786 $

Please indicate your immunisation budget (US$) for 2016.

33 24 527

Please indicate your immunisation budget (US$) for 2017 (and 2018 if available).

USD 34,841,945 in 2017 and USD 24,248,858 in 2018

2.1.3 National health planning and budgeting cycle, and national planning cycle for immunisation:

The government planning cycle starts on the

1 January

The current National Health Sector Plan (NHSP) is

From	2019
To	2022

Your current Comprehensive Multi-Year Plan (cMYP) period is

2015-2017

Is the cMYP we have in our record still current?

Yes☐	No☒

If you selected “No”, please specify the new cMYP period, and upload the new cMYP in country documents section.

Note 1

From	2019
To	2022

If any of the above information is not correct, please provide additional/corrected information or other comments here:

As the 2015-2017 cMYP has now expired, the country has developed a new cMYP covering the period 2018-2022.

2.1.4 National customs regulations

Please describe local customs regulations, requirements for pre-delivery inspection, and special documentation requirements that are instrumental for the delivery of the vaccine.

For the acquisition of vaccines and injection equipment, Chad uses UNICEF services benefiting from vaccine and injection equipment credit in accordance with the memorandum signed between the Ministry of Health and UNICEF and the guarantee letter signed by the Minister of Finance. As part of the vaccine independence initiative, funds for the acquisition of vaccines and injection equipment are transferred by the Government to the UNICEF division supply accounts. For more than 20 years, vaccines sent by UNICEF have been delivered to the airport and collected by the customs EPI on the basis of documents accompanying the batches (invoices, BL, ETA, freight forwarder's dispatch notice, copy of the dispatch note and other related documents). Analysis of the parcels is done in the presence of an agent of the Department of Pharmacy and Laboratories.

2.1.5 National Regulatory Agency

Please provide information on the National Regulatory Agency in the country, including status (e.g. whether it is WHO-certified). Please mention a point of contact with phone number and e-mail address. UNICEF will support the process and may need to communicate licensing requirements to the vaccine manufacturers where relevant.

At the Chad level, there is a National Regulatory Authority (NRA) certified by the WHO. Efforts are underway to strengthen the functions of this authority, including the systematic recording of vaccines and pharmacovigilance of vaccines. These functions are provided by the Department of Pharmacy and Laboratories (DPL). Dr Colette Ngaberé, Tel. 00235 62396364 Email: cngabere@yahoo.fr

2.2 National Immunisation Programmes

2.2.2 Financial Overview of Active Vaccine Programmes

IPV Routine

Note 2

	2018	2019	2020	2021	2022
Country Co-financing (US$)					
Gavi support (US$)	1,169,000	1,300,390	1,341,030	1,381,838	1,422,826

MenA Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	232,552		289,767	239,355	246,778
Gavi support (US$)	421,000		508,221	419,804	432,822

Pentavalent Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	385,600	414,737	424,738	437,579	450,477
Gavi support (US$)	1,134,000	1,051,055	1,076,402	1,108,942	1,141,629

YF Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	110,367	154,859	159,809	164,783	169,784
Gavi support (US$)	528,000	735,606	759,121	782,749	806,505

Summary of active Vaccine Programmes

	2018	2019	2020	2021	2022
Total country co-financing (US$)	728,519	569,596	874,314	841,717	867,039
Total Gavi support (US$)	3,252,000	3,087,051	3,684,774	3,693,333	3,803,782
Total value (US$) (Gavi + Country co-	3,980,519	3,656,647	4,559,088	4,535,050	4,670,821

financing)

2.3 Coverage and Equity

2.3.1 Coverage and equity situation analysis

Note: If a recent analysis of the coverage and equity analysis is already available, for example as part of a Joint Appraisal report, you may simply reference the report and section where this information can be found.

Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement. In particular, identify the areas and groups of low coverage or high inequity linked to geographic, socioeconomic, cultural or female literacy considerations, as well as systematically marginalized communities. Specify both the areas and/or populations with low coverage (%) and those with the largest absolute numbers of un-/under-vaccinated children. Among data sources, consider administrative data, coverage surveys, DHS/MCS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles.

Describe the challenges underlying the performance of the immunisation system, such as:

- Health work force: availability and distribution;
- Supply chain readiness;
- Gender-related barriers: any specific issues related to access by women to the health system;
- Data quality and availability;
- Demand generation / demand for immunisation services, immunisation schedules, etc;
- Leadership, management and coordination: such as key bottlenecks associated with the management of the immunisation programme, the performance of the national/ regional EPI teams, management and supervision of immunisation services, or broader sectoral governance issues;
- Financing issues related to the immunisation programme that impact the ability to increase coverage, including bottlenecks related to planning, budgeting, disbursement and execution of resources;
- Other critical aspects: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports.

Describe lessons learned and best practices on the effectiveness of implemented activities to improve coverage and equity; recommendations on changes or new interventions that might be required to accelerate progress (include data to support any findings or recommendations).

Healthcare staff: availability and distribution;
The density of healthcare staff at the national level is estimated at 0.58 per thousand inhabitants

in 2016 compared to 2.3 recommended by the WHO. This inadequate density of healthcare staff in Chad is exacerbated by disparity between the regions. The N'Djamena region has 52% of the country's doctors, 36% of its nurses and 40% of its midwives (see Table 4 of the NHP 3 page 25).
In addition, immunisation activities are carried out by unskilled staff in more than half of cases. This affects the use of management tools and communication with children's parents as these staff have a low level and are not always trained. There is also a lack of formative supervision and motivation of providers at all levels.

Supply chain preparation:
The cold chain inventory conducted in 2017 and updated in 2018 showed low coverage in approved cold chain equipment. Of the 1742 service delivery points, only 627 (or 36%) have an adequate cold chain.
According to the 2015 EVM evaluation, only 3 out of 9 criteria at the national level (all levels mixed together) recorded a score of more than 80%: vaccine management (83%), stock management (81%) and vaccine arrival/receipt. The lowest scores were vaccine distribution (51%) and maintenance (29%). The audit conducted in 2017 by GAVI showed stock discrepancies in the central level stock management tool (SMT) between 2014 and 2017.
Both the GAVI audit and the external programme review (2017), as well as the vaccine management tool analysis showed recurrent shortages of vaccines and injection equipment at the central and peripheral level for a number of years.
As part of the improvement of the vaccine supply chain and in accordance with the 2010 EVM recommendations, four sub-national warehouses have been created to bring vaccines and injection equipment closer to the healthcare facilities of the operational level. However, their effective implementation was related to the allocation of human resources and to the provision of maintenance kits, which unfortunately were delayed.
These warehouses are currently semi-functional with the allocation of vehicles, IT kits. Each one has been provided with a 4x4 vehicle purchased using HSS/GAVI funds in order to provide support to the Health Districts (HD) with regard to supervision and supply.
However, they are faced with some difficulties related to the lack of a reliable and permanent electrical power source and voltage fluctuation often causes frequent power failures. That is why the country has launched feasibility studies for solarisation of these warehouses. However, the push system is not yet functional between the sub-national warehouses and the HD.
Similarly, with regard to the supervision of activities at the operational level, 79 out of the 117 health districts (i.e. 68%) do not have functional vehicles.

Gender-related barriers: any problem concerning access to the health system for women;
Between 2012 and 2017 the country conducted three independent surveys: an immunisation coverage survey (ICS) in 2012 covering 19 regions, a Demographic and Health Survey and Multiple Indicators (DHS-MICS) in 2014-2015 and an ICS in 2017 covering the country's 23 regions. These various studies show the following findings:
- Low immunisation coverage: less than 80% for all antigens
- Data discrepancies between sources (survey data, WHO/UNICEF estimate, administrative data).
- Inequality in immunisation: Penta3 is 37% (gross dose), including 46% in urban areas, 33% in rural areas, 27% for out-of-school persons responsible for children (PRC) and 61% for PRC with secondary/higher education; fully immunised children (ICS) at 22%, including 28% in urban areas, 20% in rural areas, 16% for out-of-school PRC and 38% for PRC with secondary/higher education; according to the 2017 immunisation coverage survey (ICS), only 28% of community leaders are aware of all EPI antigens, 39% are aware of the EPI target and 63% link non-immunisation to parents' lack of information.

It should be noted that there are hard-to-reach areas (island, flood-prone, desert areas) and special populations (nomadic, refugee, returnee and displaced populations). According to the results of the second general census of population and habitat (GCPH2 of 2009), nomadic populations represent 3.5% of the total population, or 571,573 inhabitants.
Island populations represent 379,206 inhabitants (data extrapolated from the island SIA of Lac by the Task Team in 2018). The country also hosts 446,326 refugees and 126,755 persons who were internally displaced in late August 2018 (UNHCR sources 31/08/2018). The coverage survey showed that the regions of the far south are better immunised (56% in PENTA 3) than those of the north (19%) for the same antigen (see 2017 coverage survey). None of these surveys showed any difference in immunisation coverage by sex.

Data availability and quality;
The immunisation data transfer circuit goes from the periphery (healthcare centre) to the central level, via the district and the health delegation. At each level, an analysis of this data is normally carried out prior to transfer to the higher level. However, the quality of the data arriving at the central level is poor. Indeed, the various surveys conducted and the estimates (ICS, DHS-MICS, WUENIC, rapid survey) show large discrepancies between survey data and administrative immunisation coverage (55% DTP3 in 2016). The lateness of data transfer also does not facilitate analysis for timely decision-making. In order to correct deficiencies relating to the quality of data, a data quality improvement plan has been drawn up. This plan includes, among other things, the strengthening of formative supervision, monitoring and validation of data at each level of the health pyramid, the training of workers in rapid surveys, the carrying out of document reviews, the implementation and promotion of new technologies for the collection, analysis, transfer and archiving of data etc.
As part of the control of the populations who are targeted by health programmes in general and the Expanded Programme on Immunisation in particular, UNICEF is providing technical assistance to the Ministry of Public Health to develop a triangulation method to improve the estimate of populations targeted at the local level for the immunisation programme.

Generation of demand/demand for immunisation services, immunisation schedules etc.;
Communication-social mobilisation for the EPI is an important strategy for increasing immunisation coverage and encouraging communities to take ownership of the programme. Recent surveys have shown that the main reasons for non-immunisation/insufficient immunisation are lack of information (41%), lack of motivation (20%) and sociocultural barriers (39%). Based on the survey data, a 2018-2022 strategic communication plan for the EPI has been drawn up. This plan is divided into various communication activities and strategies to promote routine immunisation activities, campaigns, the introduction of new vaccines including the second dose of VAR and immunisation campaigns to encourage populations to accept these interventions.
In addition, the recommendations of the national immunisation forum, which put particular emphasis on multi-sectorality and the taking ownership of immunisation activities by the communities, will increase their level of information regarding immunisation and will therefore increase immunisation coverage at the country level.
Particular emphasis is placed on strengthening the capacity of health workers and civil society actors (women's groups and associations for the promotion of immunisation, the platform of civil society organisations supporting immunisation, opinion leaders, representatives of nomads, refugees/displaced persons etc.) with regard to communication for behavioural change and demand generation. Interpersonal communication, social mobilisation and advocacy will be implemented to support the preparation for and the carrying out of the campaign. Local communication activities will make it possible to directly reach the groups of people targeted for immunisation interventions.

Leadership, management and coordination: such as the main obstacles associated with management of the immunisation programme, the performance of national and regional EPI teams, the management and supervision of immunisation services or the broader issues of sectoral governance;
A lack of governance has been identified that is characterised by poor coordination at the central, regional and operational levels. In addition, there is low accountability/responsibility at all levels of the healthcare system;
The EPI Management's capacity for leadership and management is poor. It is characterised by an excessively large workforce and unsuitable profiles. However, a job description is in the process of being approved and an organisational audit is underway.
The ICC and TSC/EPI (coordinating bodies of the immunisation system) are inefficient and not very functional. This is evident in the absence of regular statutory meetings of the ICC and the lack of follow-up of recommendations. Management capacity at the regional level is inadequate (steering committees are not held regularly, human resources are inadequate from both a qualitative and quantitative perspective).
It should be noted that the National Forum recommended the revision of the ToR of the ICC to make it more efficient including multi-sectorality and high-level representatives.

Funding difficulties associated with the immunisation programme that have an impact on the ability to extend coverage, including obstacles related to planning, budgeting, disbursements and resource delivery;
The national health planning and budgeting cycle refers to the general state budget which is drawn up annually. The Ministry of Health allocates a lump sum to the programme without taking full account of its needs.
The general state budget since 2016 is affected by the fall in the price of oil leading to the reduction of the budget allocated to immunisation. Indeed, this budget changed from 2,900,000,000 CFA francs in 2013 to 1,100,000,000 CFA francs in 2014, 692,000,000 CFA francs in 2015, 575,000,000 CFA francs in 2016 and 650,000,000 CFA francs in 2017.
The rate of implementation of the budget for immunisation varies from 78% to 100% over the period 2013 to 2017. (See Appendix 9. 2018-2022 cMYP, page 39). Although delays are noted in disbursements, it should be noted that the resources provided are allocated by level and disbursements are also made through the use of local revenues.
With regard to disbursements related to partner support, some are made through the sub-offices which provide technical support to the Provincial Health Delegations. Others, however, use the administrative circuit of the State. Hence the difficulties encountered in the production of justifying documents.
The disbursement rates for 2016 and 2017 are as follows:
The main bottlenecks related to the implementation of immunisation expenditure include:
- Disbursement delay at all levels due to administrative burdens (commitment, control, scheduling, approval, payment);
- Low implementation rate of the national budget and the budget from Technical and Financial Partners as well as the varying availability of funding resulting in erratic control of vaccines;
- Insufficient follow-up of action plan implementation;
- Poor mobilisation of local resources;
- Poor control of administrative and financial procedures, yet the MPH has a procedure manual.

Other critical aspects: another point identified, for example, according to the cMYP, evaluation of the EPI, PPE, EVM or any other country-wide plan, or the findings of independent evaluation reports. Describe lessons learned and best practices on the effectiveness of activities to improve coverage and equity; recommendations on changes or new interventions that might be required to accelerate progress (include data to support findings and recommendations). In recent years the country has put in place certain strategies to strengthen routine immunisation,

including: the micro-planning of activities in districts; the implementation of the Reach Every District (RED) strategy in 60 HD, the community approach for the promotion of immunisation (CAPI) in 31 HD, mixed immunisation (human/livestock) organised jointly with the Ministry of Livestock, the strategy to reduce missed opportunities in 6 HD as well as the annual organisation of African Immunisation Week (AIW). Micro-planning has made it possible to identify the specific needs of every district and allocate resources in a rational way. In view of the shortcomings observed in the implementation of the community-related aspects, a CAPI approach has been introduced to strengthen this component. The CAPI consists in the use of a community register for the identification of lost children. It has enabled the immunisation of 80,056 unimmunised children. Mixed immunisation has helped to increase coverage of nomadic populations. The implementation of the missed opportunities strategy has also made it possible to catch drop-outs. It has enabled 80,375 lost children to be caught. As for the annual organisation of African Immunisation Week, it enabled awareness-raising among opinion leaders and communities, as well as the immunisation of lost children. In March 2018, the country organised the National Immunisation Forum. This Forum made it possible to obtain the commitment of the authorities to relaunch the routine EPI. With regard to the implementation of the commitments made by the authorities, a roadmap has been drawn up for this purpose. For the next 5 years, the country intends to develop a special strategy for immunisation in urban areas to be used in N'Djamena and other urban centres in selected priority districts.

2.4 Country documents

Upload country documents

Please provide **country documents** that are relevant for the national immunisation programme and for multiple vaccines, to be taken into account in the review of your application. If you have already provided one or more of these country documents, you do not need to upload it/them again unless the document version changed. If documents cannot be provided, please use the comment functionality to explain why, or by when they will be available.

Note that only general country documents are uploaded here; at the end of section 3 (sub-section "Upload new application documents") you will be required to provide those documents that are specific to the support requested (for example the new vaccine introduction plan and/or campaign plan of action, new budget, application endorsements etc.)

Country and planning documents

✓	**Country strategic multi-year plan** Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan	PPAc 20182022_05-10-18_15.39.36.pdf
✓	**Country strategic multi-year plan / cMYP costing tool**	cMYP_Costing_Tool_V3.9.4. TCHAD 2018_2022xlsx_12-01-18_10.38.21.xlsx

✓	**Effective Vaccine Management (EVM) assessment**	Plan_GEV_Tchad_16_07_2017 (1)_11-01-18_16.04.24.pdf
✓	**Effective Vaccine Management (EVM): most recent improvement plan progress report**	RAPPORT DE MISE OUEVRE DU PLAN DAMELIORATION 2 2_26-06-18_16.39.55.docx plan d'amelioration EGEV 2015 cIP-draft v8-30-4-16_07-07-16_12.37.34 (1)_12-01-18_10.40.30.xls
✓	**Data quality and survey documents: Final report from most recent survey containing immunisation coverage indicators**	Rapport final de lenquêteCVTchad2017_26-06-18_14.09.40.pdf
✓	**Data quality and survey documents: Immunisation data quality improvement plan**	PSNAQDTCHAD20182022_05-10-18_15.42.41.pdf
✓	**Data quality and survey documents: Report from most recent desk review of immunisation data quality**	REVUEDOCUMENTAIREDONNEESSISTCHAD_13-11-18_16.55.29.pdf
✓	**Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation**	RapportEvaluation approfondie de la qualité ds données_26-10-18_08.19.15.pdf

✓ **Human Resources pay scale**

If support to the payment of salaries, salary top ups, incentives and other allowances is requested

D14 PPAC Costing cMYPCostingToolV3.9.4.TCHAD 20182022 21072018xlsx 1_29-11-18_09.39.13.xlsx

D1212 Indemnites RH Santé_29-11-18_09.29.47.pdf

Coordination and advisory groups documents

✓ **National Coordination Forum Terms of Reference**

ICC, HSCC or equivalent

Arrete_CCIA_Tchad_12-01-18_10.09.04.pdf

✓ **National Coordination Forum meeting minutes of the past 12 months**

CR_CCIA_11-01-18_16.06.36.pdf

Other documents

Other documents (optional)

Please also provide other country documents to support the review of the applications, for example Health Facility Assessment Reports, Knowledge-Attitude-Practice surveys or other demand-related surveys, if available.

No file uploaded

3.2 Measles 1st and 2nd dose routine

3.2.1 Vaccine and programmatic data

Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.

Note 11

Measles 1st and 2nd dose routine

Preferred presentation	M, 10 doses/vial, lyo
Is the presentation licensed or registered?	Yes ☒ No ☐
2nd preferred presentation	
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	31 March 2020
Planned launch date	12 June 2020
Support requested until	2022

3.2.1.2 Vaccine presentation registration or licensing

If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines, and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.

Non applicable

3.2.1.3 Vaccine procurement

Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund.Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?

Yes☐ No☒

If you have answered yes, please attach the following in the document upload section:* A description of the mechanism, and the vaccines or commodities to be procured by the country through this mechanism.* A confirmation that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. OR, for the procurement of locally-produced vaccines directly from a manufacturer which may not have

been prequalified by WHO, a confirmation should 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.

3.2.2 Target Information

3.2.2.1 Targets for routine vaccination

Please describe the target age cohort for the Measles 1st dose routine immunisation:

Note 12

9	weeks ☐	months ☒	years ☐

Please describe the target age cohort for the Measles 2nd dose routine immunisation:

15	weeks ☐	months ☒	years ☐

	2020	2021	2022
Population in the target age cohort (#)	836,604	863,694	894,979
Target population to be vaccinated (first dose) (#)	771,039	796,006	824,839
Population in the target age cohort for last dose(#)	720,412	746,183	772,851
Target population to be vaccinated for last dose (#)	722,775	747,567	773,208
Estimated wastage rates for preferred presentation (%)	25	25	25

3.2.3 Co-financing information

3.2.3.1 Vaccine and commodities prices

Price per dose (US$) - Measles routine, 1st and 2nd dose

	2020	2021	2022
10 doses/vial, Lyophilised	0.32	0.32	0.32

Commodities Price (US$) - Measles routine, 1st and 2nd dose (applies only to preferred presentation)

	2020	2021	2022
AD syringes	0.04	0.04	0.04
Reconstitution syringes	0.04	0.04	0.04
Safety boxes	0.47	0.47	0.47
Freight cost as a % of device value	0.02	0.02	0.02

3.2.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support

Note 14

	2020	2021	2022
Country co-financing share per dose (%)	62.89	62.89	62.89
Minimum Country co-financing per dose (US$)			
Country co-financing per dose (enter an amount equal or above minimum)(US$)	0.2	0.2	0.2

3.2.3.3 Estimated values to be financed by the country and Gavi for the procurement of supply

Measles routine, 1st and 2nd dose

	2020	2021	2022
Vaccine doses financed by Gavi (#)	1,045,200	871,000	902,200
Vaccine doses co-financed by Country (#)	1,438,300	1,198,500	1,241,400
AD syringes financed by Gavi (#)	2,189,600	1,716,200	1,777,800

AD syringes co-financed by Country (#)			
Reconstitution syringes financed by Gavi (#)	273,200	227,700	235,800
Reconstitution syringes co-financed by Country (#)			
Safety boxes financed by Gavi (#)	27,100	21,400	22,150
Safety boxes co-financed by Country (#)			
Freight charges financed by Gavi ($)	30,833	25,506	26,419
Freight charges co-financed by Country ($)	42,427	35,096	36,352

	2020	2021	2022
Total value to be co-financed (US$) Country	497,000	414,000	429,000
Total value to be financed (US$) Gavi	474,500	390,500	404,500
Total value to be financed (US$)	971,500	804,500	833,500

3.2.3.4 Estimated projection of the required domestic financing for the measles monovalent component of MCV1

Countries are required to domestically finance the first dose in their measles containing vaccine routine (MCV1) in order to be able to receive Gavi support for any measles/ measles-rubella programmes. Below is the estimated projection of the required domestic financing for MCV1, based on the information provided in the previous sections.

Note 15

	2020	2021	2022
Minimum number of doses financed from domestic	1,205,705	1,039,305	1,001,512.5

resources			
Country domestic funding (minimum)	368,946	318,028	306,463

3.2.3.5 Co-financing payment

Please indicate the process for ensuring that the co-financing payments are made in a timely manner.

Co-financing will be paid in accordance with the memorandum of understanding signed between the Government and UNICEF for the acquisition of vaccines and injection equipment. The Ministry of Health will transfer funds to the UNICEF division supply account following receipt of vaccines and invoices.

If your country is in the accelerated transition phase for Gavi support, please answer the following question:

Please provide evidence that the co-financing obligations for the new introduction have been budgeted for, and elaborate on how the country plans to pay for the fully self-financing amounts. Please discuss the extent to which medium-term immunisation/health plans and medium-term expenditure frameworks incorporate the additional costs associated with this introduction. Discuss any co-financing defaults that may have happened in the last five years.

No Response

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:	March

The payment for the first year of co-financed support will be made in the month of:

Month	
Year	

3.2.4 Financial support from Gavi

3.2.4.1 Routine Vaccine Introduction Grant(s)

Measles-rubella 1st and 2nd dose routine

Live births (year of introduction)

836,604

Gavi contribution per live birth (US$)

0.8

Total in (US$)

669,283.2

Funding needed in country by 30 March 2020

3.2.4.2 Operational budget

Please complete the Gavi budgeting and planning template to document 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. Please ensure to upload the completed budgeting and planning template as part of this application.

If Gavi's support is not enough to cover the full needs please indicate how much and who will be complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.

Total amount - Gov. Funding / Country Co-financing (US$)

52011

Total amount - Other donors (US$)

00

Total amount - Gavi support (US$)

669283.2

Amount per target person - Gov. Funding / Country Co-financing (US$)

02

Amount per target person - Other donors (US$)

0

Amount per target person - Gavi support (US$)

08

3.2.4.3 Key Budget Activities

List the key budgeted activities to be undertaken in implementing the requested support. Please provide details on the key cost drivers, inputs and assumptions required for these activities.

- Coordination and programme management:
- Planning and training of the stakeholders involved in the introduction of VAR2;
- Training of stakeholders;
- Review and reproduction of EPI management tools;
- Formative supervision of workers;
- Transport and implementation of inputs and implementation of the introduction;
-
-

3.2.4.4 Financial management procedures

Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.

The funds will be managed in accordance with the administrative and financial management procedures manual approved by Gavi and the Government. The management of these funds will be audited upon completion of the activity.

3.2.4.5 Fiduciary management

Please indicate whether funds for operational costs should be transferred to the government or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the government. Please note that UNICEF and WHO will require administrative fees as follows.

- **UNICEF Tripartite Agreement: 5%**
- **UNICEF Bilateral Agreement: 8%**
- **WHO Bilateral Agreement: 7%.**

Once the submission has been accepted and the country has been informed, the Ministry will send details

of the bank account that has been opened for this purpose for fund transfer and will confirm receipt. The country suggests that the funds for the introduction of the second dose of VAR and the funds related to the campaigns should be received separately. These funds will then be transferred to the regions and then to the health districts for implementation of the activities.
However, if the deficiencies identified in the capacity management assessment are not resolved before the date of transfer of the funds (3 months prior to implementation of the introduction), the country suggests that the funds are transferred to the accounts of the WHO, which will then make them available to the EPI.

3.2.4.6 Use of financial support to fund additional Technical Assistance needs

Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the "One TA plan") with a view to assess that required support for the implementation of the new vaccine support is contained in the approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template. In addition, please indicate the programmatic areas for additional technical assistance needs and the respective agencies providing the technical assistance (if already identified) below.

Note 16

As support for the new vaccine, this submission provides for the carrying out of a VAR2 post-introduction assessment, post-campaign immunisation coverage survey and independent monitoring. None of these activities are provided for in the 2018-2020 TCA, and are budgeted for in the operational costs of these interventions.

3.2.5 Strategic considerations

3.2.5.1 Rationale for this request

Describe the rationale for requesting these new programme(s), including the burden of disease. If already included in detail in the Vaccine Introduction Plan or Campaign Plan of Action, please cite the sections only.

The reasons for this request are summarised in sections 3.4, 3.5, 3.6 and 3.7 of the plan to introduce the second dose of VAR into the routine EPI.

3.2.5.2 Alignment with country strategic multi-year plan / comprehensive multi-year plan (cMYP)

Please describe how the plans and key assumptions in this request align with the most recent country strategic multi-year plan (cMYP) and other national health and immunisation plans.

Through this submission, the country intends to strengthen the immunity level of children against measles

by offering them a second chance to receive the measles vaccine. This is fully in line with the national strategic measles elimination plan, which provides additional immunisation activities, enhanced epidemiological monitoring, responses to epidemics and the strengthening of routine immunisation through the introduction of the second dose of VAR. These two plans are also aligned with the 2018-2022 Comprehensive Multi-Year Plan and the 2014-2020 Regional Strategic Measles Elimination Plan.

3.2.5.3 Coordination Forum (ICC, HSCC or equivalent) and technical advisory committee (NITAG)

Provide a description of the roles of the national Coordination Forum (ICC, HSCC or equivalent body) and national immunization technical advisory group (NITAG) in developing this request.
If any of Gavi's requirements to ensure basic functionality of the relevant national Coordination Forum (ICC, HSCC or equivalent) were not met, please describe the reasons and the approach to address this. Requirements can be found in the general application guidelines.
In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG.

The ICC and TSC/EPI (coordinating bodies of the immunisation system) are inefficient and not very functional. This is evident in the absence of regular statutory meetings of the ICC and the lack of follow-up of recommendations (see Appendix 10 Assessment of Capacities of the 2017 GAVI and 2018-2022 cMYP programmes). It should be noted that the National Forum recommended the revision of the ToR of the ICC to make it more efficient including multi-sectorality and high-level representatives.
Management capacity at the regional level is inadequate (steering committees are not held regularly, human resources are inadequate from both a qualitative and quantitative perspective).
The establishment of the National Immunisation Technical Advisory Group (NITAG) and the Health Sector Coordinating Committee is provided for in the framework of the implementation of the NHP3 and the 2018-2022 cMYP. Currently it is the EPI Technical Support Committee that plays the role of the NITAG. The process of setting up the NITAG is underway.

3.2.5.4 Financial sustainability

Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?

Chad regularly pays its share of co-financing and all traditional vaccines up to the present day. There is a budget line on the State's own funds for the purchase of traditional vaccines and payment of the co-financing share. As part of the Vaccine Independence Initiative (VII), vaccines are delivered to the country based on available working capital and the country should pay invoices within 30 days of receipt. However, given the country's difficult economic situation, there has been a payment delay over the last two years and the 2017 co-financing was paid through budgetary support from France in the form of a loan. The National Immunisation Forum recommended the inclusion of vaccines on the list of strategic products of the State, which will secure the budget line and the head of State announced the grant of 3 billion CFA francs per year at the health meeting of 24 July 2018 for the strengthening of routine immunisation.

3.2.5.5 Programmatic challenges

Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.

Following analysis of the situation relating to performance of the immunisation system, the main bottlenecks have been identified in the following areas:
• Coverage and equity
The main bottleneck is linked to the inadequate supply of immunisation services. This stems from i) the weakness of fixed, outreach and mobile strategies (only 38% of healthcare centres achieve at least 80% of planned field visits), ii) the non-systematisation of tailored and sustainable strategies for reaching difficult-to-access populations (nomadic, island, desert populations), iii) poor geographical and physical accessibility (80% of the population lives more than 5 km from healthcare centres), iv) poor quality of service (absent vaccinator, poor reception, unsuitable immunisation time, long wait time, see 2017 immunisation coverage survey report p.34), v) missed opportunities for immunisation (42% in N'Djamena). This frequent absence of healthcare workers further disrupts the supply of immunisation services in a context of an overall shortage of human resource. An additional problem is payment for immunisation by location; although the national policy recommends free immunisation (6% of mothers claim to have paid according to the 2017 immunisation coverage survey).
• Healthcare staff: availability and distribution
The challenge is to improve the skills and availability of staff at the operational level, including in particular the redeployment of staff to peripheral facilities from the country's capital and major cities where there is a concentration of qualified staff. Actions will be taken by the HRD under the impetus of the Minister of Public Health to reallocate excess staff from urban centres to the periphery on the one hand and ensure the effectiveness of these allocations on the other hand. The recruitment of 2188 healthcare workers to strengthen the health system in general and the immunisation service in particular is promised by the country's highest authorities. Of these, 335 will be recruited by HSS funding for one year before being reverted to the Government account from the second year onwards. In addition, the plan to redeploy urban staff as well as the support of other partners will bridge the gap.
Good governance practices, accountability measures and the fight against impunity will accompany this human resources management process.
• Vaccine management, logistics and supply chain
The challenge is to adequately ensure the distribution of vaccines and consumables from the central level to the immunisation centres. Actions are being taken to strengthen the vaccine distribution system in terms of operationalisation of sub-national warehouses, strengthening of staff capacities, provision of tools for management, maintenance and vehicles.
In addition, only 35% of healthcare centres have solar-powered refrigerators and 38% have motorcycles to provide outreach strategies and ensure the supply of EPI inputs and vaccines at the district management level. The cold chain optimisation platform submission is a great opportunity for the country to seizes to improve cold chain coverage.
Another challenge, and not a small one, is the management of biomedical waste from immunisation. The current practice—which is unsatisfactory due to the lack of adequate incineration equipment—is the destruction of waste at the level of healthcare centres and health districts in incinerators (for the HC that have them) and/or in pits by the method of burning followed by burial. The National Malaria Control Programme, funded by the Global Fund, planned the construction of 9 high-level incinerators for the destruction of biomedical waste in 2018. These incinerators will be installed in (9) cities (N'Djamena, Bongor, Moundou, Sarh, Bol, Mongo, Abéché, Biltine and Fada). The sub-national warehouse teams responsible for the distribution of vaccines will collect the safety boxes in the HD in order for them to be destroyed in these incinerators. Every district is responsible for the collection of safety boxes in its healthcare centres. Non-sharp waste such as packaging and caps will be destroyed on-site at healthcare

centres.

• Generation of demand/mobilisation of the community
The challenge arises in terms of the ability to achieve ownership of staff, acceptance of immunisation by the population (quality of services), the involvement of civil society, opinion leaders, the acceptance and appropriation of public and private media for the promotion of immunisation. The contribution of community outreach agents will be key to the generation of demand through communication activities for development such as home visits, interpersonal communication, educational talks and in the search for lost targets.
With respect to the use of community health workers (CHW), 1,642 will be used as part of the Programme Support Rationale (PSR) with 2 workers per area of responsibility. However, other partners such as the World Bank (1,091 CHW in 5 regions including 3 selected by the PSR), the Global Fund (1,000 CHW for awareness-raising and 950 for support including 5 regions covered by the PSR) and Expertise France (46 in Ouaddaï and 40 in N'Djamena and the Logone Occidental all covered by the project) finance CHW activities at the regional and district level. These various CHW will complement those to be funded on the PSR to provide a comprehensive package in the area of health promotion under the leadership of the community health working group.
In order to improve demand, the country organised a national immunisation forum that focused on multi-sectorality and the taking ownership of immunisation activities by community leaders and civil society. This will, undoubtedly, increase demand for immunisation services.

The quality, the availability of data:
Immunisation coverage surveys conducted in the country showed low immunisation coverage as opposed to administrative data. Based on the results of the 2017 immunisation coverage survey, the discrepancy between administrative and survey data is 55% for PENTA 3. Stock shortages of management and collection tools as well as the large number of them in health units also contribute to the poor quality of this data.
The external review conducted in 2017 showed the low quality of the programme data. The inadequate practice of data quality self-assessment (DQS), the irregularity of monthly meetings with a view to their harmonisation and approval, is also noted. The DQS carried out in 2018 on 85 healthcare centres show a discrepancy of data between the various media in 71 HC, i.e. 83%. According to 2017 routine EPI data, the completeness and timeliness of immunisation reports are 99% and 73%, respectively. In response, the country developed a strategic plan to improve the quality of data. The implementation of this plan, which will be financed with the support of the partners Global Fund, Coopération Suisse and Gavi, will help to improve the quality of the programme data.

Leadership, management and coordination
The EPI Management's capacity for leadership and management is poor. It is characterised by an excessively large workforce and unsuitable profiles. The ICC and TSC/EPI (coordinating bodies of the immunisation system) are inefficient and not very functional. This is evident in the absence of regular statutory meetings of the ICC and the lack of follow-up of recommendations. Management capacity at the regional level is inadequate (steering committees are not held regularly, human resources are inadequate from both a qualitative and quantitative perspective).
The establishment of the National Immunisation Technical Advisory Group (NITAG) and the Health Sector Coordinating Committee is provided for in the framework of the implementation of the NHP3 and the 2018-2022 cMYP.
In addition, particular emphasis will be placed on strengthening governance, multi-sectorality and accountability at all levels. This aspect is taken into account in the NHP3, the 2018-2022 cMYP and the roadmap of the National Immunisation Forum.
The national immunisation policy, which is currently under review, will also take into account this issue of accountability and governance.

3.2.5.6 Improving coverage and equity of routine immunisation

Explain how the proposed NVS support will be used to improve the coverage and equity of routine immunisation, by detailing the proposed activities and budget will contribute to overcoming key barriers.

The main difficulty is related to the inadequate supply and availability of immunisation services. This stems from i) the weakness of fixed, outreach and mobile strategies (only 38% of healthcare centres achieve at least 80% of planned field visits), ii) the non-systematisation of tailored and sustainable strategies for reaching difficult-to-access populations (nomadic, island, desert populations), iii) poor geographical and physical accessibility (80% of the population lives more than 5 km from healthcare centres), iv) poor quality of service (absent vaccinator, poor reception, unsuitable immunisation time, long wait time, see 2017 immunisation coverage survey report p.34), v) missed opportunities for immunisation (42% in N'Djamena). As part of this submission, formative supervision and outreach and mobile strategies will be strengthened during the preparatory and implementation phases, the implementation of vaccines and inputs will be ensured by the additional budget allocated to the introduction, communication activities will be organised to strengthen immunisation in general and facilitate the introduction of VAR2 in particular.

3.2.5.7 Synergies

Describe potential synergies across planned introductions or campaigns. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines in a year. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions.

Note 17

The country did not anticipate the introduction of several vaccines in the same year because of the many challenges that arise in the field of immunisation. However, in 2020 and 2021, the introduction of the second dose of VAR and the PCV will take place in the same year as the measles SIA.
In the context of the implementation of these activities, the programme intends to merge actions in the implementation of the activities. For example, in 2019, the introduction of the second dose of VAR and the VAR campaign, will be planned and executed concomitantly by the same team. Thus, economies of scale will be made on training, distribution of vaccines, review and reproduction of modules and tools, post-introduction and post-campaign evaluations and communication (advocacy, social mobilisation). This same synergy will be used in 2021 for the introduction of the PCV and the VAR campaign. In addition, the distribution of inputs at the operational level may take into account other antigens or other interventions by the Ministry of Public Health (routine EPI, vitamin A, Mebendazole etc.).
The country has gained considerable experience in the organisation of concurrent activities as part of the process of eradicating polio, controlling measles and combating meningitis with the organisation of several SIA in the same year.

3.2.5.8 Indicative major measles and rubella activities planned for the next 5 years

Summarise in one paragraph the indicative major measles and rubella activities planned for the next five years that are reflected in the annual EPI plan (e.g. measles second dose introduction, measles or measles follow up campaign, etc.).

1. The strengthening of routine immunisation including the introduction of the second dose of VAR;
2. The carrying out of measles immunisation campaigns, including efforts to improve coverage of hard-to-reach populations over the next 5 years, will focus on: i) micro-planning for routine and SIA including taking into account the contexts and specificities of hard-to-reach populations, ii) increase the coverage of

health facilities in cold chain equipment, iii) availability of the VAR at the operational level, iv) strengthening of formative supervision and v) data monitoring;
3. The strengthening of the cold chain in order to improve vaccine storage and conservation conditions, the strengthening of mobile logistics for outreach and mobile strategies and supervision;
4. The strengthening of measles monitoring and laboratory confirmation will focus on i) training/re-training of healthcare workers and community workers in charge of monitoring, ii) availability of reagents and equipment for sampling and iii) monitoring of monitoring data.
5. Development of the epidemic response plan
6. The strengthening of immunisation communication through the implementation of the roadmap of the National Immunisation Forum.

3.2.6 Report on Grant Performance Framework

Grant Performance Framework – Application Instructions

The Grant Performance Framework (GPF) contains all indicators that will be used to monitor programmatic performance for your requested type of support. Targets that were entered for number to be vaccinated in section 3 on the Target Information tab, have been carried over into their respective indicators in the GPF. Based on these numbers, coverage and dropout rate targets were calculated (where applicable). These appear as “calculated targets”. If you wish to revise these target values, please revise in the application form – they are not editable in the performance framework. In addition, as a part of your application, there are several items to be filled directly into the GPF. These are broken into required and optional items, below:

Required
1. In addition to the calculated targets, country targets are required to be submitted for outcome indicators. These targets should align to those in your cMYP or NHSP. If these targets are not in your cMYP or NHSP, or are the same as the calculated targets, please enter “NA” for each target value.
2. Additional indicators that appear in the Performance Framework that are not included in the application form. Please enter targets for these indicators.
3. For many indicators, reporting dates have been pre-populated. For those that have not yet been pre-populated, please add reporting dates.

Optional
1. Adding data sources to existing indicators: If there are data sources for indicators that you would like to include, you may add an additional source by clicking on the pencil icon next to the indicator name.
2. Adding new indicators: Gavi requires all countries to report on core indicators, which are already included in the GPF. If you wish to add supplemental indicators to monitor performance, you may do so by clicking the “Add indicator” button at the respective performance level (Outcome, Intermediate Result, or Process).

Please note that the GPF is filtered by default to only show indicators that are relevant to the specific types of support contained in the application. You may view the entire GPF by using the “Grant Status” filter. Please ensure your pop-up blocker is disabled when launching the GPF.

If you have any questions, please send an email to countryportal@gavi.org.

3.2.7 Upload new application documents

3.2.7.1 Upload new application documents

Below is the list of **application specific documents** that must be provided with your application.

In the case a document cannot be provided, please use the comment box to explain why, or by when it will be available.

4 Review and submit application

4.1 Submission Details

Country vaccine funding summary

Please review the estimated projections for new vaccine programmes included in this application.

Active Vaccine Programmes

Note 18

IPV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)					
Gavi support (US$)	1,169,000	1,300,390	1,341,030	1,381,838	1,422,826

MenA Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	232,552		289,767	239,355	246,778
Gavi support (US$)	421,000		508,221	419,804	432,822

Pentavalent Routine

	2018	2019	2020	2021	2022
Country Co-	385,600	414,737	424,738	437,579	450,477

financing (US$)					
Gavi support (US$)	1,134,000	1,051,055	1,076,402	1,108,942	1,141,629

YF Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	110,367	154,859	159,809	164,783	169,784
Gavi support (US$)	528,000	735,606	759,121	782,749	806,505

Total Active Vaccine Programmes

	2018	2019	2020	2021	2022
Total country co-financing (US$)	728,519	569,596	874,314	841,717	867,039
Total Gavi support (US$)	3,252,000	3,087,051	3,684,774	3,693,333	3,803,782
Total value (US$) (Gavi + Country co-financing)	3,980,519	3,656,647	4,559,088	4,535,050	4,670,821

New Vaccine Programme Support Requested

Measles 1st and 2nd dose routine

	2020	2021	2022
Country Co-financing (US$)	497,000	414,000	429,000
Gavi support (US$)	474,500	390,500	404,500

Total country co-financing (US$)					
Total Gavi support (US$)					
Total value (US$) (Gavi + Country					

co-financing)

Total Portfolio Overview – Existing Programs + New Vaccine Support Requested (US$)

	2018	2019	2020	2021	2022
Total country co-financing (US$)	762,019	735,596	1,576,814	1,468,217	1,307,539
Total Gavi support (US$)	4,502,000	3,252,051	4,355,774	4,287,333	4,631,782
Total value (US$) (Gavi + Country co-financing)	5,264,019	3,987,647	5,932,588	5,755,550	5,939,321

Contacts

Person(s) who should be contacted in case Gavi needs to ask for more information in regard to the application.

Name	Position	Phone Number	Email	Organisation
Youssouf Ahmat Annadif	Sous Directeur de la Vaccination	+235 66 28 06 90	yannadif@yahoo.ca	
Dr Kalilou Souley	Point Focal IVD	+235 60732823	kalilous@who.int	
Dr Etienne Dembele	Chef de Section Immunisation	+235 68000029	edembele@unicef.org	

Comments

Please let us know if you have any comments about this application

No Response

Government signature form

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

Measles follow-up campaign and Measles 1st and 2nd dose routine

The Government of Chad commits itself to developing national immunisation services on a sustainable basis in accordance with the national health and immunisation strategic plans. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

The co-financing commitments in this application include the amount of support in either supplies or cash that is requested from Gavi, and the financial commitment of the Government for the procurement of this new vaccine.

Please note that Gavi will not review this application without the signatures of both the Minister of Health and Minister of Finance (and Minister of Education, if applicable) or their delegated authority.

We, the undersigned, affirm that the objectives and activities in this request are fully aligned with the national health and immunisation strategic plans (or equivalent), and that funds for implementing all activities, including domestic funds and any needed vaccine co-financing will be included in the annual budget of the Ministry of Health.

We, the undersigned, further affirm that the requested funding for salaries, salary top-ups/allowances, per diems and incentives does not duplicate funding from other sources (e.g. from other donors).

We, the undersigned, further affirm that the terms and conditions of the Partnership Framework Agreement between Gavi and the Country remain in full effect and shall apply to any and all Gavi support made pursuant to this application.[1]

Minister of Health (or delegated authority)	**Minister of Finance (or delegated authority)**
Name	Name
Date	Date
Signature	Signature

For countries requesting HPV support, with a school linked strategy, the signature of the Minister of Education (or delegated authority) is also required.

Minister of Education (or delegated authority)

Name

Date

Signature

[1] *In the event the Country has not yet executed a Partnership Framework Agreement, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.*

Appendix

NOTE 1
The new cMYP must be uploaded in the country document section.

NOTE 2
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.

NOTE 3
* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* 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.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the "support requested until" field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

NOTE 4
* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* The wastage rate applies to first and last dose.

NOTE 5

* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/library/gavi-documents/supply-procurement/detailed-product-profiles/ The wastage rate applies to first and last dose.

NOTE 6

Co-financing requirements are specified in the guidelines.

NOTE 7

*The price used to calculate costs is based on UNICEF-single dose per vaccine procurement cost for measles monovalent vaccine.** This value will differ from the total cost if the vaccine selection is MR, as a country is only required to finance the cost of the measles monovalent vaccine.

NOTE 8

Note: The population in the target age cohort used here is the number you entered for year one in the target information section.

NOTE 9

A list of potential technical assistance activities in each programmatic area is available here: http://www.gavi.org/support/pef/targeted-country-assistance/

NOTE 10

E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.

NOTE 11

* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* 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.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request

Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the “support requested until” field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

NOTE 12

* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* The wastage rate applies to first and last dose.

NOTE 13

* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/library/gavi-documents/supply-procurement/detailed-product-profiles/
The wastage rate applies to first and last dose.

NOTE 14

Co-financing requirements are specified in the guidelines.

NOTE 15

*The price used to calculate costs is based on UNICEF-single dose per vaccine procurement cost for measles monovalent vaccine.** This value will differ from the total cost if the vaccine selection is MR, as a country is only required to finance the cost of the measles monovalent vaccine.

NOTE 16

A list of potential technical assistance activities in each programmatic area is available here: http://www.gavi.org/support/pef/targeted-country-assistance/

NOTE 17

E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.

NOTE 18

The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.