# Formula for country proposals

*Monitoring campaign for measles/measles-rubella vaccine*

Presented by
The government of GUINEA-BISSAU

Submission date: 07 September 2017
**Submission limit date: 08 September 2017**

Please send your request using the designated formula.

For all requests for additional information, please send an email to: proposals@gavi.org or to the representatives of a partner institution of Gavi. Partners of Gavi, its collaborators and the public may be informed of these documents. The proposals and attached documents must be submitted in French.

Note: make sure that the Secretariat of Gavi has received the query, at the latest by the submission closing date.

The Secretariat of Gavi will not be able to return to countries documents and attachments previously submitted to it. Unless otherwise indicated, partners of Gavi and the public may be informed of these documents.

## CLAUSES AND CONDITIONS OF GAVI FUNDING

***FINANCING USED ONLY FOR APPROVED PROGRAMMES***

The country presenting the request ("the country") confirms that all funds released by Gavi under this request will be allocated and used for the sole purpose of implementing the programme(s) described in the country's aid request. Any substantial amendments to the approved programme(s) must be reviewed and approved by Gavi beforehand. All financing decisions inherent in this request are the domain of the Gavi Board of Directors and subject to the procedures of the CEI and to the funds' availability.

***AMENDMENT TO THIS PROPOSAL***

The country will inform Gavi through its annual status report if it wishes to propose changes to the description of the programme(s) in this aid request. The Alliance will document all amendments that it approves and the country's proposal will be modified.

***REIMBURSEMENT OF FUNDS***

The country agrees to reimburse Gavi for all funds not used for the programme(s) described in this request. The reimbursement will be done in United States dollars, unless Gavi has decided otherwise, within sixty (60) days after receipt by the country of the Gavi reimbursement request. The funds reimbursed will be paid to the account(s) named by Gavi.

***SUSPENSION / TERMINATION***

Gavi may suspend all or part of the funding to the country if it has reason to suspect the funds are being used for a purpose other than for the programmes described in this request or in any amendment of this request approved by Gavi. Gavi reserves the right to end its aid to the country for the programmes described in this request if embezzlement of funds is confirmed.

***ANTI-CORRUPTION EFFORT***

The country confirms that the funds allocated by Gavi will not under any circumstances be offered by it to a third party, and that it will not directly or indirectly attempt to derive benefits with regard to this request, which could be considered an illegal practice or breach of trust.

***CONTROL OF ACCOUNTS AND FILES***

The country will carry out the annual account verifications and pass them on to Gavi, as required. Gavi reserves the right to carry out, by itself or through an agent, account audits or assessments of the financial management to fulfil the obligation of recording the funds paid to the country. The country will keep accurate accounting books justifying the use of Gavi funds. The country will keep the accounting files pursuant to the accounting practices approved by its government for at least three years after the date of the last payment of Gavi funds. In the event of lawsuit involving the possible embezzlement of funds, the country will keep these files until the audit results are definitive. The country agrees not to claim its document-related privileges against Gavi with regard to any account audit.

***CONFIMATION OF LEGAL VALIDITY***

The country and the government signatories confirm that this aid request and its annual status report are accurate and correct and that they represent a restrictive legal commitment for the country, under its laws, to implement the programmes described in this request, if applicable, in the annual status report.

***CONFIRMATION OF RESPECT FOR GAVI POLICY CONCERNING TRANSPARENCY AND RESPONSIBILITY***

The country confirms that it is aware of Gavi's policy regarding transparency and responsibility and that it will respect the obligations therein.

***USE OF COMMERCIAL BANK ACCOUNTS***

The government of the eligible country is responsible for checking, with all required diligence, the suitability of the commercial banks used to manage the cash aid from Gavi. The country confirms that it will assume full responsibility for replacing the cash aid from Gavi that could be lost due to bank failure, fraud or any other unforeseen event.

***ARBITRATION***

All lawsuits arising between the country and Gavi due to this request or in relation hereto which are not settled amicably within a reasonable period will be submitted for arbitration upon request by Gavi or the country. The arbitration will be conducted pursuant to the Arbitration Regulations of the United Nations Commission on International Trade Law (UNCITRAL) in effect. The Parties accept being bound by the arbitration decision as final settlement of this dispute. The place of arbitration will be Geneva (Switzerland). The language of the arbitration will be English or French.

For all lawsuits for an amount under or equal to 100,000 US$, an arbitrator will be appointed by Gavi. For all lawsuits for an amount above 100,000 US$, three arbitrators will be appointed, as follows: Gavi and the country will each appoint an arbitrator and the two arbitrators appointed this way will jointly appoint a third arbitrator who will preside.

Gavi cannot be held responsible vis-à-vis the country for any claim or loss with regard to the programmes described in this request, and including, without limitation, all financial losses, conflict of responsibilities, all material damages, bodily injury or death. The country is the sole party responsible for all aspects of the management and implementation of the programmes described in this request.

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# 1. Specifications of the proposal

Please verify [X] the vaccine to be used: [1]
[ X ] Measles, 10 doses/bottle, freeze-dried
[ ] Measles-rubella, 10 doses/bottle, freeze-dried

**Q1.** Please specify the date (week/month and year) of the launch of the monitoring campaign:
***1st week/November/2018***

# 2. Summary

Overall, mortality due to measles has dropped significantly, but the efforts against measles and rubella have faced some challenges. Though routine coverage of the first dose of the measles valence vaccine (MVV1) increased overall from 73% in 2000 to 83% in 2009, this coverage has stagnated and has stayed at 77-78% since 2010 in the 73 countries that receive aid from Gavi. The other challenges include financial and programming viability for the countries involved, determining the target age group and guaranteeing the quality of the campaigns. Concerns likewise exist regarding costly campaigns which damage the resources of routine vaccination activities and could create wrongful monetary incentives. Activities against measles are likewise planned independently of the other vaccination interventions with unsuitable processes for planning, budgeting and implementation.
Indeed, Guinea-Bissau signed the Global Measles Eradication Initiative in 2020 and, under this, it has carried out mass vaccination campaigns against measles. The last national campaign for measles vaccination and vitamin A and Mebendazole distribution took place from 04 to 09 December 2015. During the campaign, the measles vaccine was administered to children from 9 to 59 months of age, vitamin A to children from 6 to 59 months of age and Mebendazole to children from 12 to 59 months of age.
A global approach is essential to allow a lasting reduction in morbidity and mortality due to measles and rubella. A routine vaccination executed in a timely manner, for all ages, with a high and uniform coverage rate in each country, is the essential condition for obtaining high and lasting levels of immunity in populations.

In this regard, in December 2015, the Gavi Board of Directors approved the new Gavi strategy against measles and rubella to ensure the coherence of the associated measles-rubella vaccination programme, mainly aimed at improving coverage through routine vaccination and, in particular, emphasising the fight against measles and rubella. The routine vaccination will be completed, as applicable, through the highest quality, best planned, best targeted and most independently controlled campaigns.

Gavi's objective is to maintain a more global approach to the fight against measles and rubella, over a longer duration. Instead of offering aid to campaigns and routine vaccinations as planned activities separately budgeted and implemented, Gavi encourages the countries to plan and implement an ensemble of integrated activities for the fight

[1] For more information on vaccines:
http://www.who.int/immunization_standards/vaccine_quality/PQ_vaccine_list_en/en/

**Note: The CEI may examine prior requests for Gavi.**

against measles and rubella. The countries will henceforth have to finance, themselves, the first measles vaccine dose in their national vaccination programme, and to have a long-term budget plan for activities linked to measles and rubella, in order to ensure financial and programming feasibility.

Preventative vaccine campaigns and those for introduction of new vaccines, such as the measles-rubella vaccine, may be used as strategic opportunities to improve routine vaccinations, for example in support of micro-planning to identify thinly-served populations. These opportunities must be aligned with the needs and priorities for systematic vaccinations expressed by the countries concerned to see that they fill the gaps or treat recognised problems. It is thus recommended that, as the countries develop their applications in support of the fight against measles and rubella, they coordinate and standardise these demands with their requests for HSS aid. Joint evaluations and reviews of the aid should be used to ensure such links. This will enable standardisation of the inputs for measles, rubella and HSS, avoid possible redundancies and maximise the effect of activities for the fight against measles and rubella for overall reinforcement of the entire vaccination programme.

Gavi will support **periodic national or subnational monitoring campaigns for the fight against measles** for countries eligible for Gavi aid that have still not implemented a measles and rubella vaccination programme, with emphasis on children no more than 5 years of age. It is worth noting that the calendar, the target age bracket, and the geographic scope must be grounded in epidemiological data and a model whenever this is possible.

For countries admissible for Gavi aid that have introduced a measles-rubella vaccine, aid is available for **periodic monitoring campaigns for measles-rubella vaccination**. It is worth noting again that the calendar, the target age bracket, and the geographic scope must be grounded in epidemiological data and a model if available. Bearing in mind all these considerations, Guinea-Bissau organised its first mass measles campaign from 15 to 29 May 2006, targeting children from 6 months to 14 years of age, with a coverage rate of 93%**.**The country held the mass monitoring campaign every three years thereafter in 2009, 2012 and 2015, targeting children from 9 – 59 months with administrative vaccination coverage of 110% in 2009, 89% in 2012 and 86% in 2015. Following the analysis of certain results judged to be poor in 2015, several regions such as Bolama and the SAB, which alone represented a third of the Guinea-Bissau population, deemed that their target was rated too highly. For reasons of analysis, the Technical Committee likewise calculated the vaccination coverage using the official population revised by the National Public Health Institute ("INASA") and the National Institute of Statistics ("INE"), which was 1,530,653 inhabitants in 2015. This population was obtained by extrapolation from the general population census conducted in 2009 using the natural growth rate. The target population inferred (15%) by this INASA and INE population is estimated at 240,039 children aged 9 to 59 months (children for the 2018 monitoring campaign). Therefore, arbitration of the Ministry of Health is required for the country to have one sole population for all its activities.

**Q2**. Please submit a summary specifying the age bracket concerned, the geographic expanse or progression and the calendar of the planned campaign. Moreover, it is advisable to justify these plans based on precise estimates of the vaccination programme's current state of progress (systematic coverage, prior SVAs, plans for introduction of the second dose of the measles vaccine under the systematic vaccination) and the epidemiological monitoring of measles in the country. The summary must likewise highlight the activities implemented in preparation of the SVAs and intended to reinforce the systematic vaccination programme, as indicated in the aid request guidelines.

In the implementation of the strategies for accelerating the fight against measles in Guinea-Bissau, a catch-up measles vaccination campaign was conducted nationally from 15 to 29 May 2006. This campaign had targeted all children from 6 months to 14 years of age and its goal was to lower the incidence and mortality associated with measles by significantly reducing the population of subjects vulnerable to this disease. The number of targeted children was 694,297 and vaccinated children 588,533, with the cost per child vaccinated $1.01, despite the operating cost per vaccinated child being $0.66. The evaluation of the quality and coverage of this campaign was carried out and the results have shown that 93% of targeted children were vaccinated.

In 2009, the first monitoring campaign was conducted nationally from 03 to 07 July, targeting all children from 9 to 59 months of age. The administrative vaccination coverage was 101%.

In 2012, the 3rd monitoring campaign was conducted nationally from 02 to 06 December, targeting all children from 9 to 59 months of age. The national administrative coverage reached was 101%. The coverage survey was conducted by an INASA team, and vaccination coverage was 98%.

In 2015, the country organised another national monitoring campaign against measles, conducted nationally in one phase (for all 11 regions of the country and 114 health areas), targeting all children from 9 to 59 months of age, with a vaccination coverage of 86%. However, the same year, the joint WHO-UNICEF 2015 report stated
54 cases of measles notified in the country, in which 26 were already vaccinated, or 48% of the cases.

It is in this context – also marked by a measles vaccination coverage rate in the systematic EPI of 92% in 2016 and 95% in 2017 – which, pursuant to Decision AFR/RC61/WP/1 of the 61st Regional Committee of the WHO on the elimination of measles in 2020, Guinea-Bissau planned in 2018, the organisation of a national monitoring campaign against measles for the entire country, with the age bracket concerned being 9 to 59 months.

This campaign will be leveraged to recover children who are not vaccinated or insufficiently vaccinated in the systematic EPI. Thus, upon the campaign's implementation, the message diffused to the community took into account the vaccination calendar's booster in order to allow parents and guardians of children to continue with the routine vaccination.
In any case, it is worth highlighting that the different campaigns organised in Guinea-Bissau always raise the question of the target population size, which is why it is urgent to move to arbitration on the population to be used at all levels in order to have one sole national population. The EPI partners should accompany the Ministry of Health in this exercise.

# 3. Signatures of the members of the government and of national coordinating bodies

## 3.1 *The government*

The government of Guinea-Bissau wishes to reinforce the partnership existing with GAVI to reduce mortality imputable to measles and to improve the national systematic vaccination program for newborns. It thus requests aid from GAVI for the measles/measles-rubella vaccine (10 doses per bottle, freeze-dried) for the purpose of running the supplementary vaccination activities.

The Guinea-Bissau government is committed to permanently reinforcing the national vaccination services, pursuant to the complete multi-year plan and the action plan attached to this document. The government requests that GAVI and its partners provide financial and technical aid in order to support the vaccination programme, as stated in this request.

The government of Guinea-Bissau recognises and accepts the clauses and conditions for GAVI aid included in this aid request form for measles/measles-rubella vaccine monitoring campaigns.

Please note that this proposal will not be examined or approved by Gavi's Independent Review Committee ("CEI") if it does not have the signature of the Minister of Health and the Minister of Finance, or of their authorised representatives.

| **Ministry of Health (or authorised representative)** | | | **representing** |
|---|---|---|---|
| **Name** | Mr Carlito Barai | **Name** | Dr João Aladje M. Fadia |
| **Date** | | **Date** | |
| **Signature** | | **Signature** | |

*This proposal was drafted by (these person may be contacted if the Secretariat of Gavi has questions concerning this proposal):*

| **Full name** | **Role** | **Telephone** | **Email** |
|---|---|---|---|
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| 8. Julio Sa Nogueira | **WHO National Consultant** | **00245966681632** | jcsnogueira@hotmail.com |
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| 15. Papa Malick Sylla | **WHO Consultant** | **00245955760109** | pmsylla72@hotmail.com |

### 3.2 *National coordinating body / Inter-agency Coordination Committee for Vaccines*

We, the members of the Inter-agency Coordination Committee for Vaccines ("CCIA"), the Coordination Committee for the Health Sector ("CCSS") or an equivalent committee[2], came together on this date, **04 September 2017** to examine this proposal. At the meeting, we approved this proposal based on the justifying documents attached to the request.

The minutes of the meeting during which the proposal was endorsed appear as an annex hereto as document number **9.8**

| Name/Title | Agency/Organisation | Signature |
|---|---|---|
| **Mr Carlito Barai** | **Ministry of Health** | |
| **Dr Ayigan Kossi Akla** | **WHO** | |
| **Dr Joao Aladje M. Fadia** | **Ministry of Finance** | |
| **Dr Christine Jaulmes** | **UNICEF** | |
| **Dr Sadna na Bita** | **AGUBEF** | |
| **Dr Isabel Garcia Almeida** | **Rotary Club** | |
| **Dr Agostinho M'barco N'dumba** | **DGPPS** | |
| **Dr Van Hanegem Menezes Moreira** | **DGASS** | |

[2] Inter-agency Coordination Committee, Health Sector Coordination Committee or equivalent committee competent to endorse this proposal in the country in question.

| | | |
|---|---|---|
| **Ms Nhima Cisse** | **Institut des Femmes et des Enfants** | |
| **Dr Alassane Drabo** | **Guinea-Bissau International Plan** | |
| **Mr Sola Inquilin Na Bitchita** | **Ministry of Territorial Administration** | |
| **Mr Braima Camara** | **Industry and Services Chamber of Commerce ("CCIAS")** | |
| | **World Bank** | |
| | **European Union** | |

# 4. Information related to the vaccination programme

## 4.1 *Gender and equity*

**Q4.1** Please describe potential obstacles to accessing, using and supplying vaccination services for districts (or equivalent); obstacles linked to geolocalisation, socioeconomic factors, and/or gender equity. Please describe the actions taken to attenuate these obstacles and express where these issues are dealt with in the action plan.
Explain how the issues concerning equity (geographic, socioeconomic, and/or gender-related) are taken into account in the process of preparing social-mobilisation strategies, among others, for the purpose of improving vaccination coverage.
Please describe which recurrent national surveys are in place in the country to measure the obstacles linked to gender and equity.
Please indicate if the data broken down by sex has been collected then used in the report systems concerning systematic vaccination and/or campaigns.
If this is available, please provide additional information and documents concerning the subnational coverage data, for example: comparison of urban/rural districts, or districts with a low/high coverage rate etc. Please show where these issues are dealt with in the action plan.
Is the country currently in a fragile situation (for example: insecurity, conflict, post-conflict, refugees and/or displaced persons, or recent, current or potential environmental catastrophes such as floods, earthquakes or droughts)? If so, please indicate the extent to which these problems could have an impact on your vaccination programme, the vaccination campaigns and the financing of activities for such purpose, and how the country expects to overcome this situation to attain a high coverage rate.

According to the WHO-UNICEF (WUENIC), the analysis of the coverage data showed a continuous growth of national coverage in Penta 3 from 45% in 1999 to 80% in 2009; however since these years, there has been stagnation.
The DTC1-DTC3 drop-out rate went from 35% in 1999 to 13% in 2009. The vaccination coverages in MCV have been stagnating at 69% since 2009.
According to the EDS/MICS of 2014, the national coverage in DTC3 is estimated at 82.9%.
For the vaccination equity plan, measured through penta3 coverage, there is a great difference between the country's health-care regions. It ranges from 72.8% in Gabú to 98.2% in Cacheu.
In addition, there are disparities between the quintiles of socioeconomic well-being (15.9%), mothers' education levels (15.5%), and children's place of residence (7.4%). However, there is no disparity according to gender.
Figure 1 below shows the 2016 vaccination coverage data according to region.

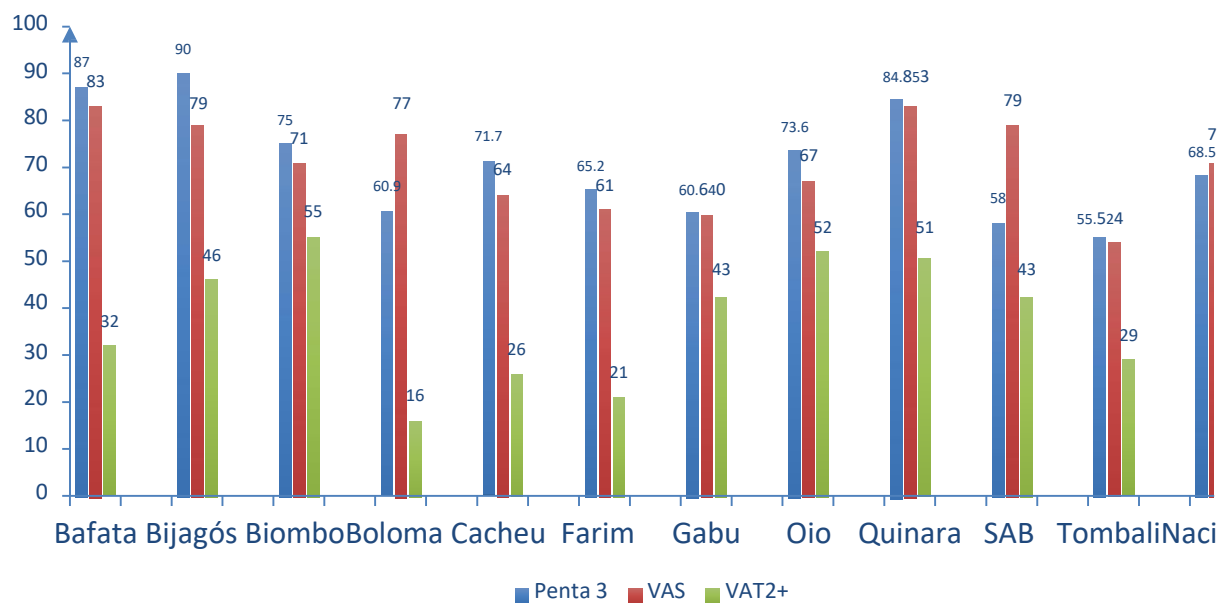


*Figure 1: 2016 administrative vaccination coverages by region in Guinea-Bissau*

The national penta 3 coverage is estimated at 68.5%. One in 11 regions attained 90% of coverage in penta3. The regions of Cacheu, Bolama, Farim, Gabu, Tombali an SAB are below 80% CV.
Concerning the MCV, the administrative coverage nationally was 71%. One sole region attained a vaccination coverage of 80% (Quinara).
The VAT2+ vaccination coverage was 39% nationally. Eight out of 11 regions for such purpose had at least 50% of VAT2+ vaccination coverage.

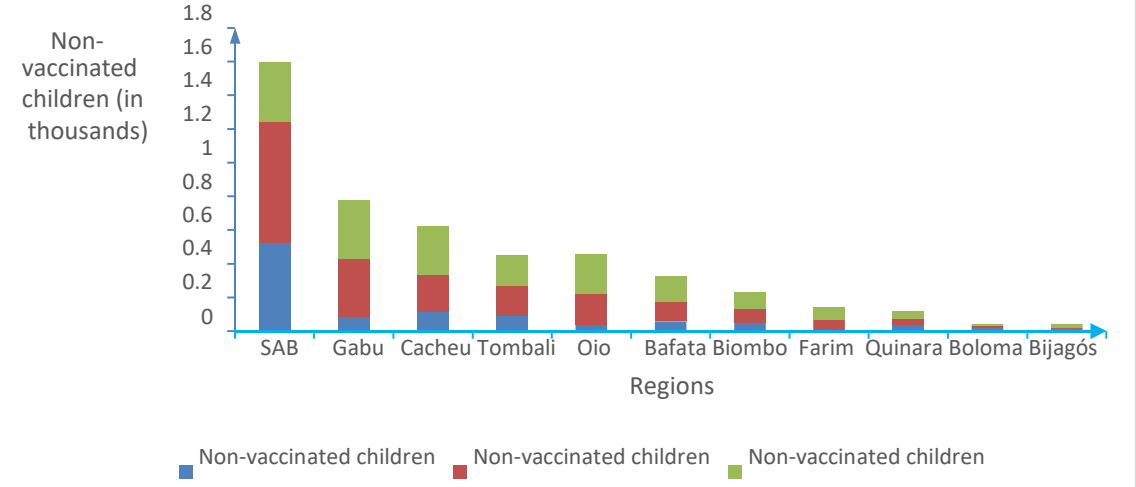


*Figure 2: Distribution of non-vaccinated children according to region in 2016 (administrative data).*

The number of non-vaccinated children for penta1 and Penta3 was 10,062 and 19,936 respectively. The number for the MCV is 18,050 children. Nationally, 1/5 of children are not reached by vaccination services. This disparity is more pronounced for the Bissau sector and the regions of Bolama, Cacheu, Tombali and Gabu.
In these regions and in Farim, two in five children have not finished their penta series. The same proportions are found for the measles vaccine.
The priority regions identified for year 2017 arise from this analysis; they are SAB, Gabu, Tombali and Cacheu.

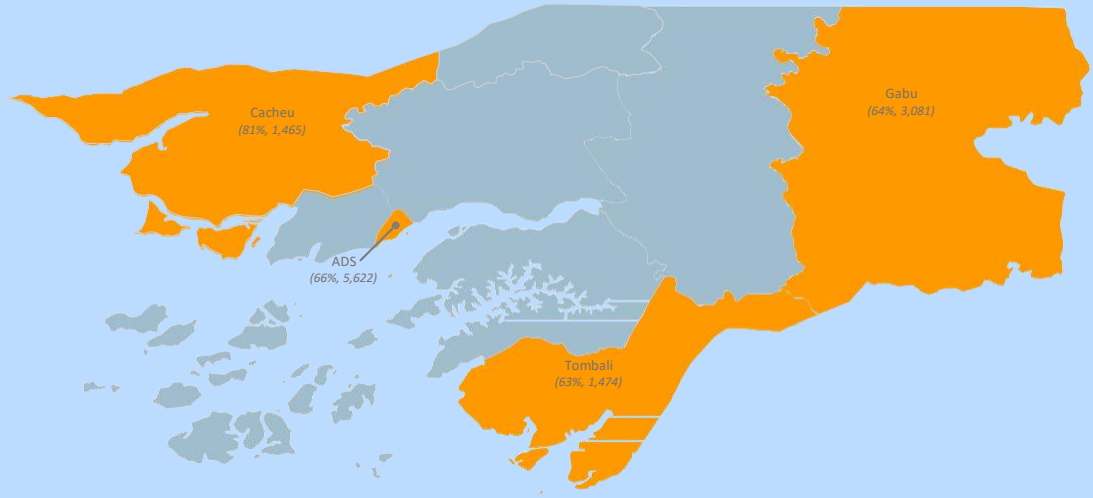


*Figure 3: Map of prioritisation of regions according to equity in immunisation*

The bottlenecks in these four regions are the following:

## Tombali region

Three community groups which are difficult to access were identified in the Tombali region, and they represent around 13% of the region's total population. Migrants represent 10.2% of disadvantaged/difficult-to-access communities, nomads (4%) and dispersed/remote populations (85.8%). The latter are located in around 27 villages in the region and comprise ethnic groups in the subregions. The most frequent professional occupations are fishing and farming.

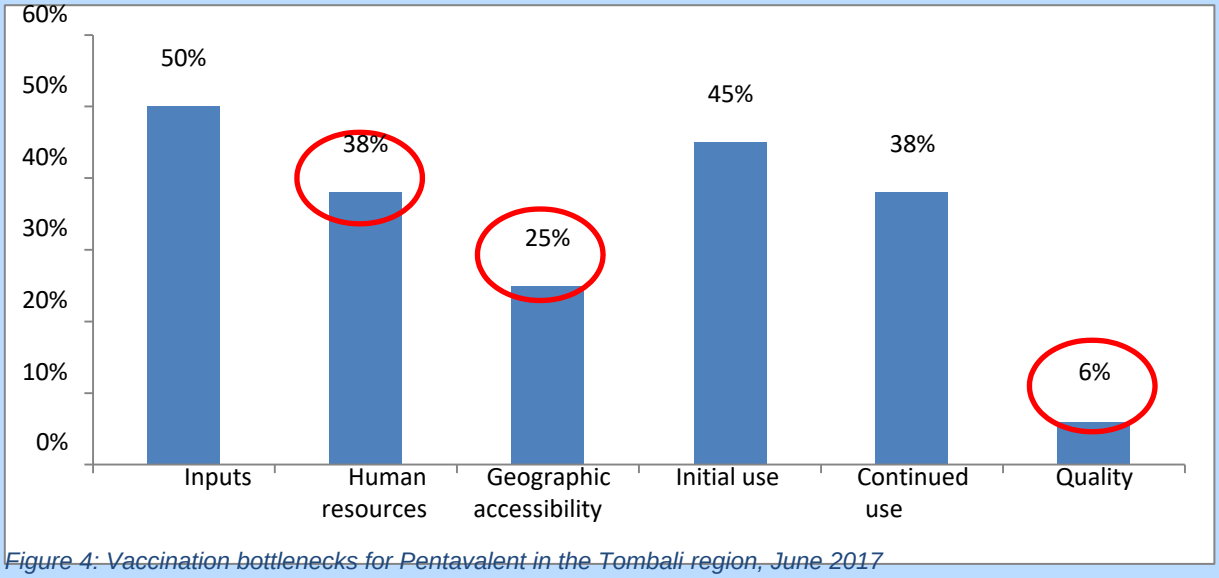


*Figure 4: Vaccination bottlenecks for Pentavalent in the Tombali region, June 2017*

The bottlenecks identified for the vaccination or newborns are related to human resources, challenging geographic accessibility and insufficiencies in the quality of the vaccination services. Added to this is the bottleneck of unsatisfactory continued use related to antenatal consultations and tetanus vaccinations.

. Geographic accessibility is 25%. The proportion of vaccination sessions in

advanced strategy is 53% for the vaccination of newborns and 35% for antenatal consultations; this indicates the insufficiency in all services related to advanced strategies. The mobile-strategy missions are almost non-existent regionally. In addition, the quality of the services is below or equal to 10% for all vaccination services and antenatal care. Activities for planning, monitoring and community meetings are non-existent for the district as well as for health-care areas. Seven health-care areas out of eight have seen ruptures in BCG, Penta and/or MCV.

## Cacheu region

Six disadvantaged/difficult-to-access communities were identified in the Cacheu region, representing 7,603 or 3.84% of the total population. Poor people in urban and peri-urban zones, ethnic groups and dispersed populations constitute most of the disadvantaged/difficult-to-access communities. Over 68% of the region's population is found within a radius of more than 5 kilometers of one health-care structure. The cashew nut harvest periods spanning from March to June lead to massive displacements of the population between the different regions of the country and often lead to poor attendance at health-care services.

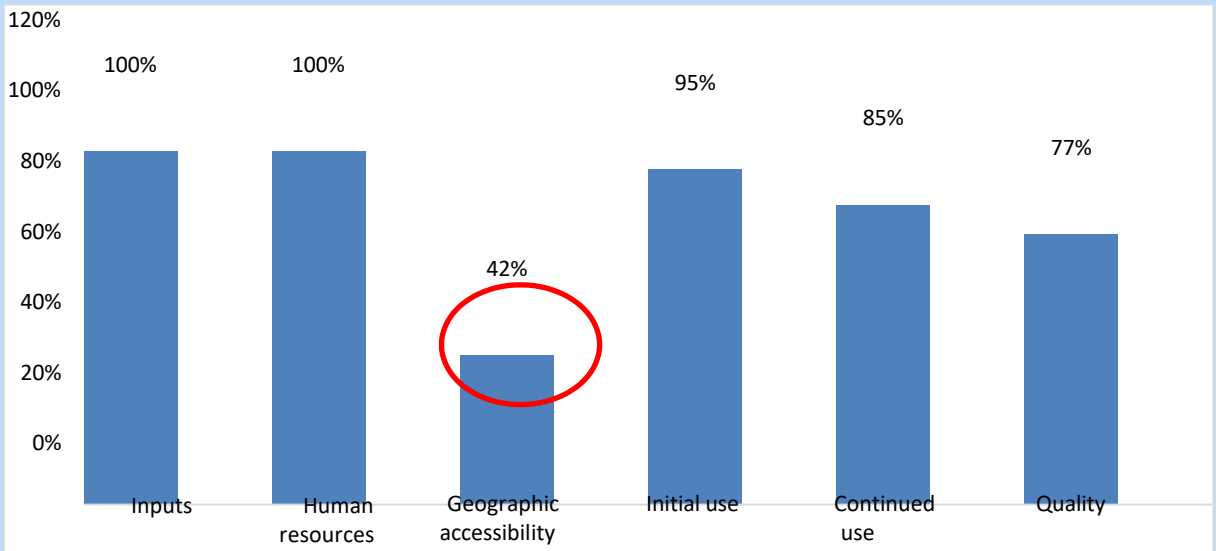


*Figure 5: Vaccination bottlenecks for Pentavalent in the Cacheu region, June 2017*

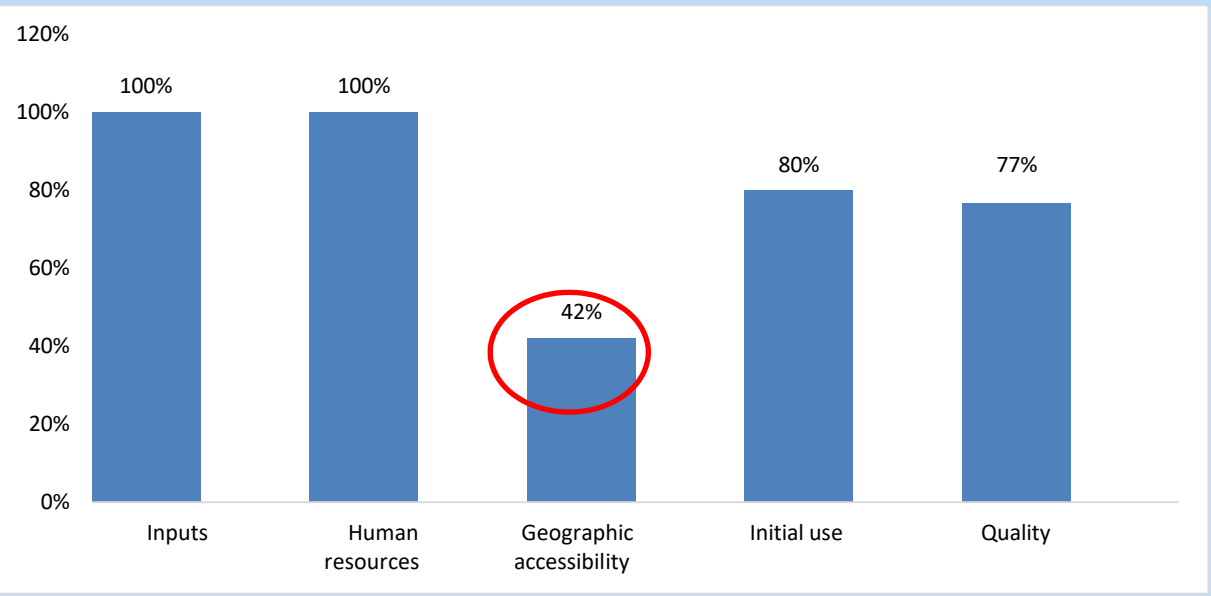


*Figure 6: Vaccination bottlenecks for the MCV vaccine in the Cacheu region, June 2017*

Geographic accessibility is the main bottleneck found for the vaccination of newborns. However, 11 health-care areas out of 19 reported vaccination coverages for penta 1 and penta 3 that were abnormally high, contrasting with a geographic accessibility below 30% for over 7 health-care areas; it seems that this is partly due to the poor quality of the data. In addition to this situation, the request for services is disrupted during the cashew nut harvest periods.

As regards antenatal consultations, the bottlenecks identified are difficult geographic accessibility, insufficiencies in continued use and the quality of services.

Based on this situation, we would be tempted to conclude that the use of vaccination services is disrupted by these different limiting factors. This is why the solutions should take into account insufficiency in the use of the services in addition to difficult geographic accessibility. Thus, the solutions identified and adopted according to prioritisation are the systematisation of the inclusive micro-planning, implementation of advanced and mobile vaccination strategies, communication and promotion of the EPI and establishment of quality-monitoring in the region.

## Gabú region

Populations that are disadvantaged and difficult to access in Gabú were estimated at 87,895 or 34% of the region's total population. These populations were found in over 90 localities. Dispersed and remote populations represent over 67% of difficult-to-access communities due to a highly developed hydrographic network in the foothills of Fouta-Djallon, making most localities difficult to access all year round, or even inaccessible over the winter season (May to October).

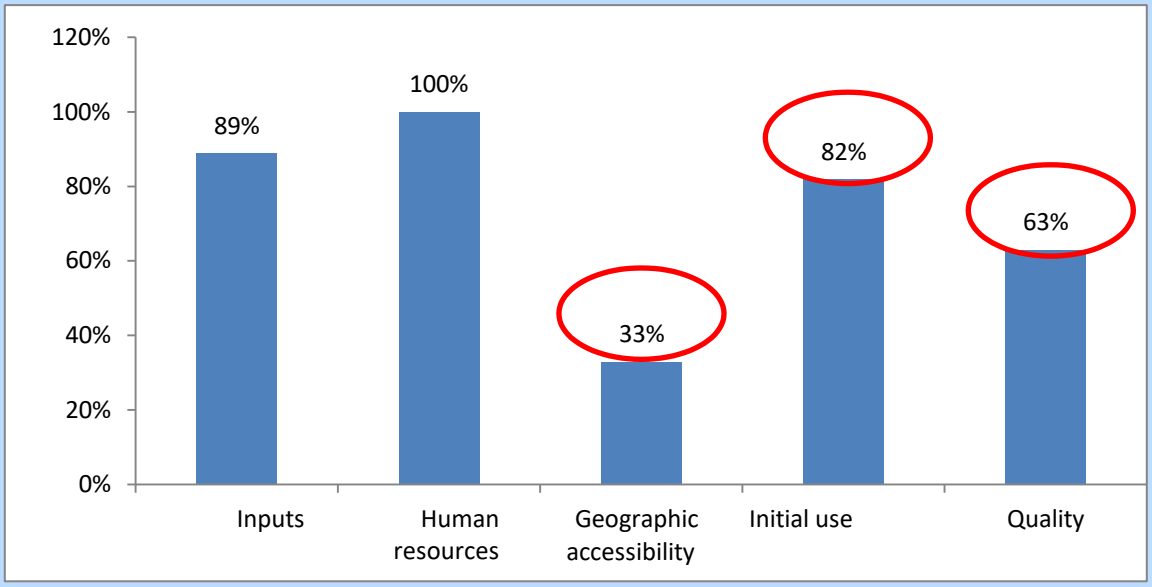


*Figure 7: Vaccination bottlenecks for Penta in the Gabú region, June 2017*

The bottlenecks identified in the region of Gabú are difficult geographic accessibility, insufficiencies in continued use and the quality of vaccination services and antenatal health care. The geographic steepness of certain zones and the hydrographic network are the major difficulties in this region. This has repercussions on transportation, but also on personnel in terms of distances they have to cover. The roads are blocked by waterways during the rainy season in several health-care zones. The poor planning and implementation of the advanced activities and the non-existence of the mobile vaccination teams lead to a limited service. In addition, the community's involvement in logistic domains (e.g. making available a canoe for crossing rivers, motivation of the community personnel) is either insufficient or non-existent.
The solutions identified and adopted according to prioritisation are the systematisation of the inclusive micro-planning, implementation of advanced and mobile vaccination strategies, communication and promotion of the EPI and establishment of quality-monitoring in the region.

## SAB region

Populations that are disadvantaged and difficult to access in SAB are numbered at 158,857 or 32% of the region's total population. These populations were found in 35 districts and cities.
In this region, the main bottlenecks are inputs and human resources.
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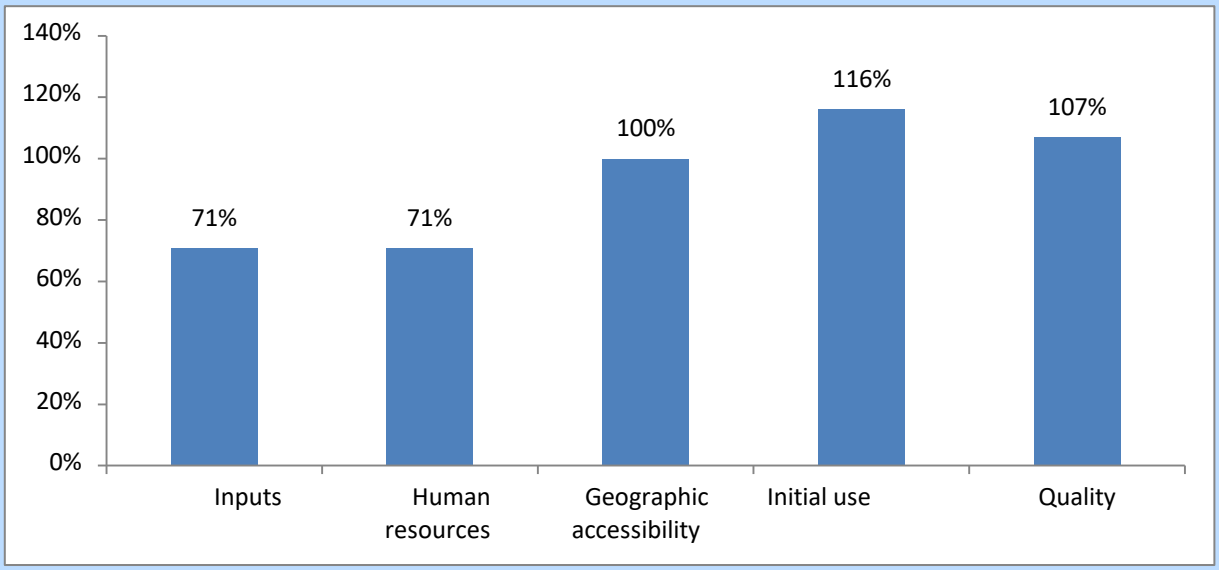


*Figure 8: Vaccination bottlenecks for the MCV vaccine in the SAB region, March 2017*

Overall, the recommended corrective measures at all levels are as follows:

- Centrally:
  - Broaden the equity approach in the seven other regions of the country, ensuring the quality of the data of health-care areas and regions.
  - Standardise the demographic data (INASA, SIVE, ASC) centrally
  - Establish a pool of experts to analyse the equity in immunisation, plus
  - Reinforce leadership in the management of vaccination programmes at all levels
  - Train chief doctors and EPI managers regarding DVD-MT and SMT
  - Direct managers of health-care areas regarding monitoring and EPI micro-planning
  - Allocate refrigerators to regions with mobile logistics and secondary health structures
  - Prepare and disseminate monthly bulletins of EPI retro-information
  - Implement a performance incentive mechanism at all levels.
- Regionally
  - Reinforce leadership in the management of health-care programmes
  - Prepare the planning documents (AWP including CEA, supervision and monitoring, DQS etc.)
  - Plan and implement the mobile strategy activities
  - Reinforce the training supervision of service providers regarding vaccination
  - Reinforce the monitoring of field visits in advanced strategies

- Adopt successful strategies for the integration of activities for child survival
- Promote the exercise of analysis on regional equity

- Health-care area level
  - Systematise the micro-planning of activities
  - Implement the activities planned in cooperation with the community
  - Vaccinate every day at health centres and visit at least once a month the children of disadvantaged populations
  - Integrate activities for child survival (vaccination campaign, advanced strategies, acceleration day)
  - Ensure the continuity of services even during vaccination campaigns
  - Create community monitoring mechanisms for target children of the EPI and pregnant women.
  - Systematise meetings with the community for better participation in activities for child survival
  - Issue the results of the vaccination coverage to the members of the community during monthly coordination meetings.
- Community-wide
  - Take over child survival programmes by committed and responsible community health-care agents
  - In the households under monitoring, identify children missing in the ASC, community leaders and women's and youth associations
  - Push health-care areas for access to local travel means (availability of traditional canoes etc.)
  - Push for the organisation of coordination meetings in health-care areas
- Partners
  - Press for financing of micro-plans, equity in regions and the EPI management plan
  - Push for analysis of equity in the remaining regions
  - Push for reinforcement of the competences of those involved in the EPI
  - Reinforce mobile logistics and fuel in regions for the implementation of advanced and mobile vaccination strategies

### 4.2 *Vaccination coverage*

Please provide in the table below the data on annual national coverage for the first and second dose of the measles valence vaccine (VVR1 and VVR2) that have been transmitted in the three last joint WHO/UNICEF statement forms.

**Table 4.1**. National coverage by the VVR

| **Joint WHO/UNICEF report** | | | | | | |
|---|---|---|---|---|---|---|
| | **National VVR1 vaccination coverage trend reported** | | | **National VVR2 vaccination coverage trend reported (where applicable)** | | |
| Year | **2014** | **2015** | **2016** | N/A | N/A | N/A |
| Total population of the target cohort | 60,180 | 61,696 | 63,252 | N/A | N/A | N/A |
| Number of vaccinated children | 44,605 | 46,291 | 45,202 | N/A | N/A | N/A |
| VVR coverage (%) | 74 % | 75 % | 71 % | N/A | N/A | N/A |

**Q4.2** If a survey on national VVR1 coverage was carried out over the last three years, please answer the following questions (repeating the following questions for each survey). If any survey was not carried out, tick this box: [x]

Please provide in the table below the national (or subnational, as applicable) coverage estimates for the three most recent measles or measles-rubella campaigns. Please likewise provide the estimates based on post-campaign coverage surveys, if available.

**Table 4.2**. Measles/measles-rubella campaign coverage

| | **Reported** | | |
|---|---|---|---|
| **Vaccine (measles or measles-rubella)** | | | |
| Year | **03 - 07 July 2009** | **02 - 06 December 2012** | **04 - 09 December 2015** |
| Target cohort | 231,435 | 247,786 | 261,487 |
| Total population of the target cohort | 1,542,902 | 1,651,904 | 1,732,882 |
| Geographic scope (nationally and subnationally) | national | national | national |
| Number of vaccinated children | 208,608 | 220,826 | 218,651 |

| | | | |
|---|---|---|---|
| Coverage of the campaign (%) | 101% | 89% | 86% |
| Loss rate (%) measles/measles-rubella campaign | - | 2% | - |

**Q4.3**If a survey on national coverage was carried out after each of the last three measles/measles-rubella campaigns, please answer the following questions (repeating the following questions for each survey). If any survey was not carried out for the three last campaigns, tick this box: ☐

**Date of the survey**: 2016
**Methodology (ESS/MICS, PEC 30-cluster sampling, LQAS, other)**: 50 clusters
**Sample size:** 500 children **Number of clusters:** 50 clusters **Number of children** 500:
**Coverage** 89 %

## 5. Goals and planning of measles/measles-rubella campaigns, and increase of coverage by the systematic measles vaccine

**Table 5.1**. Numerical targets for measles/measles-rubella campaigns (make sure that the targets are pursuant to the projections provided in Section 7 and to the action plan stated in Section 9) COMPLETE THE SECOND AND THIRD COLUMNS ONLY FOR TIERED CAMPAIGNS.

| | **Objective**<br><br>**1st week/November/2018** | **Objective (where applicable, for tiered campaigns*)** | **Objective (where applicable, for tiered campaigns*)** |
|---|---|---|---|
| Target cohort | 9-59 months | N/A | N/A |
| Total population of the target cohort (nationally) | 240,039 | N/A | N/A |
| % of the population intended for the | 15% | N/A | N/A |
| Number of persons to vaccinate in the measles campaigns | 240,039 (the campaign's objective = at least 228,037 target children vaccinated, meaning at least 95% of the target population) | N/A | N/A |

*Tiered: if just one part of the country will be covered (for example, 1/3 of the country every year for three years)

**Table 5.2**. Coverage objectives for systematic measles vaccination for the duration of the entire multi-year vaccination plan ("PPAC") (making sure the objectives are pursuant to the PPAC)

| | Objective | Objective | Objective | Objective |
|---|---|---|---|---|
| | **2014** | **2015** | **2016** | **2017** |
| Systematic VVR1 coverage | 85% | 90% | 92% | 95% |
| Systematic VVR2 coverage (where applicable) | N/A | N/A | N/A | N/A |

# 6. Financial aid

## 6.1 *Government financial aid for previous measles/measles-rubella campaigns*

The country must provide information on the total amount and the amount per targeted person of the financing allocated by the government to cover the vaccine costs and operational costs of at least the most recent measles/measles-rubella campaigns. This information should specify the real expenses; in the absence of this, it should indicate the end budget. Please also provide information concerning the financing allocated by the partners.

**Table 6.1.** Proportional allocations for the financing of recent measles/measles-rubella campaigns

| Section | Category | Financing from government (US$) | Financing from partners (US$) |
|---|---|---|---|
| Vaccines and injection material | Total amount | - | 96,900 |
| | Amount ($US) per target person | - | 0.36 |
| Operational costs | Total ($US) amount | - | 283,416 |
| | Amount per target person | - | 1.08 |

Campaign year: **2015**

Estimated target population: **261,487 children 9-59 months**

Are these amounts based on the end budget or the real expenses? ***These amounts are based on the real expenses.***

### 6.2 *Government aid for recent systematic measles/measles-rubella vaccination activities*

To benefit from the aid for measles and rubella vaccinations, the countries must finance, entirely with national resources, the measles VVR1 monovalent part, which must already be included in their national vaccination calendar. If this is not the case, they must announce to us in writing their firm commitments to finance this. If the country has still not begun financing the VVR1 with state funds, the country will have until 2018 to do so. As of this date, the country will have to self-finance the VVR1 to be able to continue to receive Gavi aid for measles and rubella prevention. The proof of the country's commitment to fully finance the VVR1 doses by 2018 may be demonstrated in the CCIA minutes and in a letter signed by the Ministry of Health and the Ministry of Finance.

Please provide the information on total financing, and the amount per child vaccinated, allocated by the government to **systematic** measles/measles-rubella vaccination activities implemented over the last three years. Please also provide information concerning the financing allocated by the partners.
**Table 6.2**. Proportional allocations for the financing of systematic measles/measles-rubella vaccination

| Year | Category | Financing from government (US$) | Financing from partners (US$) |
|---|---|---|---|
| 2014 | Total amount | - | 28,736 |
| | Amount per child vaccinated | - | 0.64 |
| 2015 | Total amount | - | 73,330 |
| | Amount per child vaccinated | - | 1.5 |
| 2016 | Total amount | - | 0* |
| | Amount per child vaccinated | - | - |

*In 2016, there were no orders for measles vaccines because there were still large stocks from the December 2015 campaign!

### 6.3 *Aid proposed in the next campaigns for measles/measles-rubella*

The country must provide information on the amount (total and per targeted person) of the financing allocated by the government to cover the costs of the vaccines and the injection material, as well as the operational costs of measles/measles-rubella campaigns for which the GAVI aid is requested. If you plan to implement tiered campaigns financed through diverse contributions, the table below may be copied for each phase. If Gavi's support is not enough to cover all the needs, please indicate in the table below the shortfall amount and the other sources of financing planned to supplement the state funds (and record this in the action plan and/or PPAC). Gavi support is not a substitute for financing from state funds. Each country must cover a share of the costs inherent in measles vaccination; the government's prior contributions to measles/measles-rubella campaigns serve as a reference.

**Table 6.3a.** Proposal for financing upcoming measles/measles-rubella campaigns for which Gavi aid is requested.

| Section | Category | Financing from government (US$) | Aid from other donors (US$) | Gavi aid requested (US$) |
|---|---|---|---|---|
| Vaccine and injection material* | Total amount | - | - | 91,765 |
| | Amount per target person | - | - | 0.38 |
| Operational costs** | Total amount | 125,925 | | 156,025 |
| | Amount per target person | 0.52 | | 0.65 |

Estimated target population: **240,039 children 9-59 months old**

* To reinforce handover of control to the countries, cost-sharing conditions must be introduced for the periodic monitoring campaigns for RR and measles vaccines planned for implementation as of 2018, as set out in the revised Gavi co-financing policy. Cost-sharing will not take effect for monitoring campaigns for which implementation is planned for 2017. If the campaign is implemented as of 2018, countries with low income must co-finance 2% and countries in transition (Phase 1 and Phase 2) must co-finance 5% of the cost of the vaccines used in these campaigns.

** This subsidy is currently 0.65 USD per target person and will not change for campaigns with implementation planned for 2017. For campaign aid requests submitted as of January 2017 and for campaigns with ***implementation planned as of 2018***, this subsidy will be adjusted according to the country's state of transition. The countries will receive 0.55 USD per target person in the preparatory transition phase (Phase 1) and 0.45 USD per target person for the accelerated transition phase (Phase 2). The sum will likewise be 0.65 USD per target person, for countries with low income.

Please provide a precise estimate of operational costs in the table below.

**Table 6.3b.** Amount (and financing) of operational costs inherent in upcoming measles/measles-rubella campaigns

| Budgetary item | Total cost anticipated (US$) | Financing from government (US$) | Financing from partners (US$) | Operational aid from Gavi (US$) |
|---|---|---|---|---|
| Training | 59,831 | - | - | |
| Social mobilisation, CEI and advocacy | 48,411 | - | | 48,411 |
| Cold-chain equipment and maintenance | 27,836 | - | | 27,836 |
| Vehicles and transport | 40,018 | - | | 40,018 |
| Programme management | | | | |
| Surveillance and monitoring | | | | |
| Human resources | 70,293 | | | 67,326 |

| | | | | |
|---|---|---|---|---|
| Waste management | | | | |
| Technical assistance | | | | |
| Planning | | | | |
| Premiums and bonuses for volunteer workers | | | | |
| Supplies and material | | | | |
| Post-campaign vaccine coverage survey | 29,574 | | | - |
| Reinforcement of systematic vaccination services | | | | |
| Other (please specify)<br>➢ Telephone cards<br>➢ Collection and incineration of waste | <br>1,196<br>4,791 | | | <br><br>270 |
| **Total** | **281,950** | **125,925*** | | **156,025** |

*Gap to be filled by the country

**To obtain this aid, in the request, countries must define the activities they plan to implement, the preliminary budget specifying all the non-vaccination costs (pursuant to the national plan for the introduction of vaccines and/or the action plan using corresponding models) and the activities for which the subsidy will be used.** A budget model is available online. For activities not covered by the subsidy, the countries will indicate a budget and another source of financing.

All revisions made to the budget after approval must be reported to the Gavi Secretary's Office (in the country in question). For the campaigns, the budget revised according to the micro-planning must be submitted. The revised budgets will form the basis of the preparation of financial reports and must be accompanied by a document describing and justifying all significant changes (>20 %) in all expense items.

The budgets may be prepared using standard parameters and the target population, supplemented by the budgetary decisions grounded in the experience acquired from previous campaigns.
The countries must likewise justify the use of the aids in their annual status reports sent to Gavi. All cash aid will be subject to fiduciary control, as set out in Gavi's policy of transparency and financial responsibility.

It should be noted that the subsidy or aid for operational costs cannot be used to finance co-financing obligations or the purchase of vaccines. If a country's target population size is modified, the subsidy amount will not be recalculated.

## 7. Supply

The measles/measles-rubella vaccines and associated supplies supported by Gavi will be provided through UNICEF, unless otherwise specified by the country.

Depending on the estimated size of the target population, please indicate in the table below your needs with regard to vaccines and injection materials for measles/measles-rubella campaigns. In the case of tiered campaigns, please copy the table below and indicate your needs for each of the planned Phases. Make sure all these estimates match the estimates presented in Tables 5.1 and 6.3a.

**Table 7.** Information related to supplies by source of financing

| | | Proportion of funds from the government | Proportion of funds from partners | Proportion of funds from Gavi |
|---|---|---|---|---|
| **Date of delivery requested (vaccines and injection** | 4th week /September /2018 | | | |
| **Campaign date** | 1st week/November/2018 | | | |
| **Target population size** | 240,039 | | | |
| **Loss rate*** | 10% | | | |
| **Total amount of vaccine doses** | 253,122 | 0% | 0% | 100% |
| **Number of syringes** | 253,122 | 0% | 0% | 100% |
| **Number of reconstitution syringes** | 25,312 | 0% | 0% | 100% |
| **Number of safes** | 2,784 | 0% | 0% | 100% |

*It should be noted that the maximum loss rate of vaccines authorised for the Gavi aid will be 10%. This rate is calculated according to the target population size. Please likewise note that the campaigns do not need regulating stocks to be constituted.

## 8. Provisions specific to the fiduciary management

**Q8.** Please indicate if the funds intended for operational aid, as specified in Section 6, may be transferred to the government or to the WHO and/or UNICEF. Likewise specify the date on which the country will need these funds. Please attach a bank transfer request form if the funds need to be transferred to the government. It should be noted that the WHO and/or UNICEF may demand a contribution to the administrative costs of around 7%, which will be debited from the funds allocated to the operational aid.

Guinea-Bissau opts for the transfer of the funds through:

- The UNICEF account for the social mobilisation constituent
- The WHO account for the other constituents of the operating costs

Receipt date of funds: 1st week/June/2018

Please provide all the information requested in the table below. This information may be sent in a separate file if you wish.

| **Information to be provided by the organisation / beneficiary country** | |
|---|---|
| **1. Name and telephone number of contact person of the beneficiary organisation(s)** | ***EP Management of Guinea-Bissau***<br>***Tel: 00245 966050001***<br>***e-mail:*** **mariogomes61@yahoo.com.br** |
| **2. Experience of beneficiary organisation of financing with Gavi, the World Bank, the WHO, UNICEF, the Global Fund and in operations financed by other donors (financial aid granted, for example)** | **YES or NO?**<br><br>**If YES,** please specify the title of the financing, the years and the amount:<br>• ***WHO: several years of experience of support to the EPI and SVAs***<br>• ***UNICEF: several years of experience of support to the EPI and SVAs***<br>• ***GAVI: several years of experience of support to the EPI and SVAs***<br>• ***INTERNATIONAL PLAN: several years of experience of support to the EPI and SVAs***<br>• ***ROTARY in the field of support to activities for polio eradication***<br><br>and indicate the following:<br><br>**for financing completed:**<br>➢ What were the main conclusions concerning the use of the funds?<br>***According to the last Programme Capacity Evaluation (PCE) conducted by GAVI in March 2017 on the EPI, there is essentially an absence of external auditing of GAVI funds and a lack of competition between suppliers for the purchasing of goods and services.***<br><br>**for the financing in progress:**<br>➢ What is the most recent evaluation of the performance of financial management and procurement mechanisms for programmes managed or in progress? ***The GAVI evaluation. This was done in March 2017, covering the financial years 2013, 2014, 2015 and 2016***<br><br>➢ Were financial management and procurement mechanisms for programmes managed or in progress problematic or difficult to find upon implementation?<br>***Up to now, the problems encountered by the EPI in the implementation of mechanisms for financial management and procurement are linked to the manual compatibility in effect in the service (slowness of procedures, absence of bank*** |

| | |
|---|---|
| | ***reconciliations, etc.). Other difficulties were encountered in the collection of receipts and justifying*** |
| **3. Amount of financing proposed (US$)** | ***See tables 6.2; 6.3a & 6.3b*** |
| ***4. Information on the mechanisms for the financial management of measles/measles-rubella campaigns:*** | |
| ➢ Will the resources be managed via the usual procedure for state expenses management? | ***The Programme Capacity Evaluation (PCE) conducted in March 2017 noted the absence of an accounting and financial management system for monitoring GAVI financing. However, for the 2018 measles vaccination campaign, the management of funds will be based on the foundations of state expense accounting, always with reference to management mechanisms that govern GAVI funds.*** |
| ➢ Does the beneficiary organisation have a financial management manual or operating manual describing the internal control system and financial management operating procedures? | ***As noted in the PCE of March 2017, there is no administrative and financial procedure manual for the EPI; however, the manual is used by the General Management of the Health System Administration ("DGASS"). This is a manual of accounting procedures of the Ministry of Health in which guidelines are given for all levels of the Health Care System.*** |
| ➢ What is the procedure followed for budgetary preparation and execution? | ***Before the execution phase, the budget is first submitted for approval by the CCIA. There is no specific bank account for receipt of GAVI funds and the funds are paid out by GAVI to the WHO for operational costs and to UNICEF for social mobilisation. The WHO and UNICEF pay the funds to structures of the Ministry of Health through the General Management of the Health Care System (DGASS). Once the funds are paid into the DGASS account, the payouts are made to the EPI; payouts intended for the implementation of activities are done based on two signatures.*** |
| ➢ What is the accounting system used and is this a computerised or manual system? | ***For the EPI Management, the system is manual.*** |
| ➢ In the organisation, how are human resources organised for the management of accounting, auditing and financial reporting (workforce, qualifications, experience)? | ***The procedures for the management of accounting are provided by the EPI's administrative and financial manager. He hold a degree in business management and a master's degree in public administration. As noted in the March 2017 PCE, the absence of internal auditing in the EPI's accounts constitutes a system weakness.*** |
| ➢ What are the bank arrangements? Please provide the details of the bank account open with the central bank or commercial bank, as well as the list of authorised signers, with their posts | ***DGASS account: MINSAP-GAVI 120854.01.01.87,***<br>***Bank: BAO,***<br>***Address: Bissau (Guinea-Bissau)***<br><br>***Three signatories:***<br>- ***Van Hanegem Menezes Moreira (DGASS)***<br>- ***Samba Baldé (DAF-MINSAP)***<br>- ***Agostinho B. N'Dumba (DGPPS)*** |
| ➢ What is the cash-flow diagram | ***Once the request is approved by the Minister of Health*** |

| | |
|---|---|
| for the placement of funds, or which will be used to ensure payouts of funds, without delay, to entities in the implementation of the programme or to | ***the implementation of an activity, the signing of checks intended for payout, is done by the EPI Director and co-signed by the Health Director, who if absent, is replaced by EPI's administrative and financial manager.*** |
| ➢ Does the implementing entity keep sufficiently up-to-date with the recording of financial transactions (accounting books/ledgers), including funds received and spent, and cash and bank balances as well as detailed records of goods and assets acquired? | ***The EPI Administrative and Financing Management keeps records. The accounting is completely manual.*** |
| ➢ How frequently does the implementing entity issue interim financial reports? | ***Interim financial reports are created at the end of every large activity. Reports on activities and financial reports are submitted to DGASS, who then transfers this to its partners, the WHO and UNICEF.*** |
| ➢ Are the annual financial accounts audited by an external auditing firm or external public supervisory institution (for example, the State Audit/Inspection Courts, etc.)? | ***State funds are likely to be audited by the Court of Audit, through State Inspection or through internal audit. However, the absence of internal auditing was identified as a weakness by the EPI of March 2017. GAVI funds and those of other partners are audited by an external firm.*** |
| ***5. Information on provisions for the management of procurement for vaccines and supplies and other associated material and services related to measles/measles-rubella campaigns proposed:*** | |
| ➢ What is the procurement system used or to be used for the campaign (national procurement procedures or specific ones)? | ***The procurement procedure in effect with the Ministry of Health will be used by the EPI Management during the campaign, bearing in mind GAVI's requirements regarding the management of financial resources allocated and the recommendations of the March 2017 PCE.*** |
| ➢ Does the beneficiary organisation have a procurement plan for the programme or will one be established for the campaign? | ***YES; for the campaign, there will be financial management procedures of the Ministry of Health recommended at all levels of the Health-Care System in addition to GAVI fund management mechanisms.*** |
| ➢ Does the organisation have a complaint management mechanism? | ***The EPI does not have an general, formal complaint management mechanism; however, being in mind numerous material, human and financial resources to be managed nationally during the vaccination campaigns, such a structure will be implemented in the EPI Administrative and Financial Management during the 2018 measles SVAs.*** |
| ➢ Howa are human | ***The transfer of funds will be done through:*** |

| | |
|---|---|
| resources organised for the management of procurements? In its workforce, does the implementing entity have a specialist with experience in procurement (certifications, experience)? | ➢ ***The UNICEF account for social mobilisation constituent***<br>➢ ***The WHO account for the other constituents of the operating costs***<br>***The EPI entrusted with the implementation has an administrative and financial service headed by a specialist qualified in business, who holds a master's degree in public administration, and seconded to the EPI Management by the Ministry of Health*** |
| ➢ Does it have procedures for the quality and quantity control of assets, works and services delivered? | ***The quality and quantity control procedures for goods are respected during procurements. In addition to the administrative and financial service of the EPI entrusted with this work, the WHO or UNICEF may be requested in certain circumstances (quality and quantity of inputs ordered under the systematic EPI and SVAs)*** |

## 9. List of mandatory documents to be attached to this proposal

9.1 Completed request formula, signed by the CCIA or the equivalent body, and signed by the Minister of Health and Minister of Finance, or their appointed representative(s). The submission of a signed aid request represents a commitment by the country regarding its preparation and its financial capacity for the activities aimed at reinforcing the prevention of measles and for the implementation of high-quality campaigns.

9.2 Report of the meeting of the CCIA or an equivalent body, endorsing the proposal

9.3 Current multi-year plan and cost calculation tool of the multi-year plan for financial analysis

9.4 Detailed action plan and budget for measles/measles-rubella campaigns and activities for the enforcement of routine vaccination for the first dose of the VVR1 measles valence vaccine, relying, for example, on the measles SVA practical planning and implementation guide published by the WHO covering a certain number of specific activities:

- for the implementation of campaigns;
- which will be organisations in the planning and implementation of the measles/measles-rubella campaigns intended to reinforce the capacities of the systematic vaccination system and to improve the provision of the services;
- to evaluate, in a reliable and independent survey, the coverage level attained thanks to the campaigns;
- to take stock of the activities for the reinforcement of the systematic vaccination implemented in the campaigns;

- if it is planned to only cover one part of the country each year (progressively), the action plan must encompass the period required to vaccinate the entire national cohort.

9.5 EPI annual plan and summary of the main indicative measles and rubella activities, including introductions and VVR2 and measles-rubella campaigns planned over the five years to come.

9.6 An Effective Vaccine Management (EVM) report and Improvement Plan based on the EVM as well as a status report on the Improvement Plan

9.7 A national plan for the elimination of measles (and rubella), as applicable

9.8 Document specifying the size of the target population, or validation by the CCIA of the target population size

9.9 The country's commitment to fully finance the requested VVR1 doses by 2018 may be demonstrated through a recorded decision in the CCIA minutes and in a letter signed by the Minister of Health and the Minister of Finance

9.10 A bank transfer request form, as applicable