

# APPLICATION FORM FOR GAVI NVS SUPPORT

Submitted by  
**The Government of Congo,  
Democratic Republic of the**  
for  
Measles follow-up campaign

# 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

10 October 2014

##### Country tier in Gavi's Partnership Engagement Framework

1

##### Date of Programme Capacity Assessment

No Response

#### 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?

5196673094

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

393715484

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

116180456

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

218856236

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

209648492

### 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 2016

To 2020

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

2015-2019

**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

2015

To

2019

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

Revision of the cMYP was initially planned for October 2018 but has now been postponed to November due to the fact that the country deemed it necessary to take into account several strategic requirements, including validation of the new health plan (2019-2023 PNDS) on which the cMYP must be based and anchored, publication of the EPI external review report, lessons learned from the start of implementation of the Marshall plan and data from the MICS survey at the end of October 2018.

All of these components will be used as a basis for the development of a more realistic cMYP that results from a more comprehensive diagnosis. If the 2019 blocks were covered by the current cMYP, the 2020 blocks would also be covered by the revised cMYP.

#### 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.**

Vaccines, vaccine consumables and cold chain equipment will be acquired via the Unicef supply chain and Unicef will deliver them to the national warehouse in Kinshasa, which will distribute them, with partner support, at all levels, while providing follow-up through the logistics committee.

The needs for measles vaccine, auto-destruct syringes, dilution syringes, sharps containers, cold chain equipment (in particular ice chests and vaccine carriers, and other supplies for the EPI will be ordered through UNICEF. Vaccines and immunisation materials must be available at the national level at least 4 months before the campaign launch. The vaccines will first be stored at the national EPI storage facility at temperatures between 2 and 8°C and away from light. Injection materials and other supplies will be stored in dry stores.

As with routine vaccines, distribution of vaccines around the country will be mainly done by air. In the provinces, since the EPI has trucks to transport vaccines and dry supplies at the national level and in the Provinces, these vehicles will be used to transport vaccines to the Provinces and health zones. River transport may be used for certain provinces and health zones. At the local level, depending on the specificities of the terrain, local means of transportation will be used, in particular vehicles, motorcycles, canoes and porters).

A plan for distributing supplies will be developed at the national level and shared at each level to ensure that operations proceed correctly. Remaining vaccines and even supplies from one block may be used for the following block in the same year.

### 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.**

The Pharmacy and Medications Directorate (DPM) plays the role of National Regulatory Authority (NRA).

As VAR is already a WHO-prequalified vaccine that has been used in the country's health system for several years, there is no need for additional formalities beyond those that are carried out routinely.

## 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\$)	3,513,500	3,619,434	3,692,530	3,766,533	3,841,342

#### PCV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)	1,600,512	2,309,392	2,343,510	2,390,389	2,437,761
Gavi support (US\$)	25,108,000	37,707,500	33,610,726	34,283,065	34,962,472

#### Pentavalent Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)	1,337,052	2,349,624	2,837,039	2,789,200	2,844,474
Gavi support (US\$)	3,930,000	6,101,500	7,189,824	7,068,586	7,208,665

#### Rota Routine



	2018	2019	2020	2021	2022
Country Co-financing (US\$)	572,325	596,712	885,612	1,444,192	1,462,648
Gavi support (US\$)	5,372,622	5,601,549	8,313,558	13,557,153	13,730,404

#### Yellow fever preventive mass vaccination campaign

	2018
Country Co-financing (US\$)	
Gavi support (US\$)	121,944,000

#### YF Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)	571,853	812,734	826,552	843,086	859,794
Gavi support (US\$)	2,738,000	3,894,000	3,926,266	4,004,805	4,084,170

#### Measles follow-up campaign

	2019
Country Co-financing (US\$)	209,000
Gavi support (US\$)	7,850,500

#### Summary of active Vaccine Programmes

	2018	2019	2020	2021	2022
Total country co-financing (US\$)	4,081,742	6,277,462	6,892,713	7,466,867	7,604,677
Total Gavi support (US\$)	162,606,122	64,774,483	56,732,904	62,680,142	63,827,053
Total value (US\$) (Gavi + Country co-financing)	166,687,864	71,051,945	63,625,617	70,147,009	71,431,730

## 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:

- o Health work force: availability and distribution;
- o Supply chain readiness;
- o Gender-related barriers: any specific issues related to access by women to the health system;
- o Data quality and availability;
- o Demand generation / demand for immunisation services, immunisation schedules, etc;
- o 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;
- o 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;
- o 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).

#### I. ANALYSIS OF COVERAGE AND BALANCE

According to the 2013-2014 DHS report, the complete vaccination coverage is 45%, and does not vary according to the sex of the child. On the other hand, vaccination coverage varies

according to the environment (53% of children in urban areas are fully vaccinated against only 42% of those in rural areas, mother's education level (42% of children vaccinated when the mother has no education, compared to 54% among children whose mothers have a secondary level). In addition, inequalities related to economic status show a gap of 20% between quintile 1 and 5.

Appropriate child recovery strategies initiated by OSC/SANRU in the 144 HZs of 10 GAVI priority DPS provide hope for improving VC in these HZs; 101 089/120 052 i.e. 84% of children were recovered in Penta 3 by means of the RECO from July 2016 to October 2017.

The revitalisation of community participation bodies with the set-up of the *Comités d'Assise Communautaires* (CAC) in each village will allow to reach each child/woman EPI target. For the five DPS in the former provinces of Kasai Central and Kasai Oriental, it will be necessary to mobilise additional resources urgently, in order to put an approach in place allowing to recoup unvaccinated children in these HZs. For Équateur, Haut-Lomami and Haut Katanga, close monitoring and technical support of the central level in the implementation of the outpost approach is essential to improve the VCs in the HZs concerned in the prospects for the implementation of the Marshall Plan. This implies an adequate and regular disbursement of the RSS 2 funds in favour of not only these 3 DPS, but also of all 10 DPS beneficiaries with a performance contract signed with stakeholders. For the Province of Central Kongo, the HZs could benefit from additional resource mobilisation for the full implementation of the ACZ.

The reinforcement of the ACZ approach will have to be carried out in all the health zones of the country with a focus on vaccination upon any contact with a reliable cold chain within the health structures.

The low performance factors and balance identified in the joint evaluation are as follows:

#### Health personnel

The problem of availability, motivation and the distribution of personnel. There is a high concentration of health personnel in urban areas to the detriment of rural areas. In addition, there is instability of personnel at all levels but especially at operational level due to low motivation of agents and untimely transfers. Moreover, the last EPI management training (MLM) took place 5 years ago and more than 5 years ago for the operational level.

#### Supply Chain

The EVM Improvement Plan called for an increase in the cold chain capacity at health facility level, an improvement in means of transport, as well as the reinforcement of human resources. The number of sanitary structures with a refrigerator within the EPI standards (solar refrigerators without batteries) is clearly increasing. The implementation of RSS2 with the contribution of 2522 solar fridges, 132 solar freezers installation end November 2016 including 57 temperature monitoring systems in the 45 cold rooms of the 26 DPS in the whole country markedly increased coverage in cold chain, which was 36% before RSS2, to 51.7% at present. With the CCEOP1, the cold chain coverage of the health areas will increase to 74.5% and with the CCEOP2 (GAVI finance at \$ 9 Million + 20% of BM), this coverage will reach nearly 80% (in the health areas by the end of 2019). Given that we have 8830 health areas that organise vaccination, and that in any health area there must be at least one working and energy-efficient refrigerator according to the standards for good performance, the challenge still remains huge for the country because of the refrigerator gap, in order to reach the standard of one refrigerator per health area.

As regards the strengthening of the supply chain, the functionality of the modern warehouse for storing vaccines and other EPI inputs at the central level is effective at the Kinshasa level and the two other decentralised warehouses of Kisangani and Lubumbashi are under construction. The current storage capacity of 10,000 m<sup>3</sup> for the dry warehouse and 2000 m<sup>3</sup> for the cold rooms will enable the secure storage of all campaign and routine inputs. The construction of the Kinshasa hub with a capacity of 10000 m<sup>3</sup> for dry warehouse and 2000 m<sup>3</sup> for cold rooms is

coming to an end. As for the Hubs of Lubumbashi and Kisangani, contracts with companies have been signed and work has started for both sites. The delay in the construction of these two depots requires the extension of the MSP/Gavi/UNICEF tripartite contract. Regarding vehicle acquisitions, 14 trucks (7 refrigerated trucks, 7 regular trucks) and a refrigerated pickup from Kananga planned for these hubs and Kananga. 10 trucks (5 refrigerated trucks and 5 regular trucks) have already arrived in Kinshasa and will be officially handed over to the Ministry in the next few days during the inauguration of the Kinshasa HUB; out of these, 6 are intended for the Kinshasa hub, and 4 are for the Kisangani hub. The remaining 4 trucks will be delivered directly to Lubumbashi before the end of December 2017.

Despite the allocation of vehicles (40 pick-up vehicles within the outposts and health zones) motorcycles (160 motorcycles including 110 for health areas) motorised canoes (75 canoes for riverside health zones and areas) and hulls with outboard engine scheduled for the outposts and health zones, 100HZ/144 in the outpost approach and 1000 health areas remain devoid of means of transport (vehicles, motorcycles or canoes) that can be used for the distribution of vaccines and other health products and for mobile and advanced vaccination activities.

Supply of CS by the HZ is usually done during monthly monitoring meetings of Health Zone activities. Also, support for HZs by provincial teams, monthly monitoring in AS and 144 HZ central offices with OSC/SANRU support and 113 HZs with UNICEF support have contributed enormously to the availability of vaccines and other inputs in these HZs. This implies very good leadership on the part of the HZ Management Team to organise these meetings and to also make them an opportunity for the transportation of vaccines and other inputs. In addition to these meetings, the monthly supervision assignments of the ECZ to the CS offer opportunities for the transportation of vaccines and inputs. The vaccine supply system of the health centres must be optimised by the central offices by redefining the circuit and regulating the rate of distribution at this level on the basis of the experience of Village Reach in Équateur in the 3 HZs supported, which must be extended to other provinces. Among the results achieved in these 3 HZs, we will mention among others: (i) the direct distribution of vaccine to these HZs, (ii) the systemic supervision of support for these HZs at all peripheral levels, (iii) the improvement of promptness and completeness of health information in the MANKANZA & BOLOMBA HZ, (iv) improvement of vaccine coverage in the three zones, and (v) clear improvement in vaccine wastage rates in these 3 HZs.

The solarisation process for cold rooms operating with generators as the main source of energy is being finalised. By the end of September, all 23 cold rooms will be powered by solar energy according to the chronogram of current installations thanks to Gavi funding through WHO/Country. Once established, this situation will allow for the quality of vaccines and other inputs.

With regard to inventory management

There are structures that do not yet have an informatics unit comprising a computer, a printer, a stabiliser/regulator with battery, an external hard drive for data backup. In addition, the untimely cuts in the internet connection due to failure to pay for the subscription do not make it possible to ensure the transmission of the data in direct time at the required time from the HZs to the DPS. The recommendations of the GEV 2014 on stock management include making computer kits and a permanent internet connection in all 518 Health Zones via VSAT available, as well as networking with logistics tools for real-time visualisation of vaccine stocks at all levels. Having computer kits and the internet connection will enable an improvement of the computerised management of vaccines with the networking of logistical tools- particularly the SMT, the cold chain equipment inventory tool and the interconnection of DHIS2/DVD-MT via VSAT with long-term connectivity, whose DAO is ready and will be launched with funding approval from all PTF adhering to data quality funding. Currently, the manual management of stocks and the non-networking of the HZs do not allow for intermediate and central level monitoring in real time of

pre-stock-out problems and the vaccine order requirements between the HZs and the EPI outposts.

#### Generating vaccination request

There are still some pockets comprising groups resistant to vaccination in some provinces (Haut-Lomami, Maniema, Tshuapa, Tanganyika, Équateur, Kasai area etc.). Besides this problem, the fact that, in rural areas, mothers of children under 12 months of age are often doing rural work; children at this age are often looked after by girls of school age who sometimes are unaware of the vaccination schedule, or the vaccination appointment day. The lack of an awareness programme at this level is a cause of the reduction in the demand because a community sensitisation session on the eve of each meeting is required to alert mothers and remind them of the necessity of go to the specified place, on the day and at the time of the vaccination to guarantee that all the expected targets are vaccinated. To date, this programme is only limited in 144 (in these HZs, at least 25% were not reached or vaccinated before the implementation of the outpost approach because there are health areas which are difficult to access, such as in the former Équateur Province and/or with populations resistant to vaccination, such as in Tanganyika) of 518 HZs via CSO/SANRU and other local partners. Reinforcement of interpersonal communication by the RECOs during home visits; based on pre-established lists by the IT in collaboration with CAC; reminders of appointments every Sunday in the churches mobilise all members of the community more and more towards vaccine activity.

#### Barriers related to gender inequality

The MICS and EDS surveys (2011, 2013-14) show that, in the DRC, there are no differences between the vaccination of girls and boys.

#### Geographical barriers

The DRC has a high number of children from 0 to 11 months, who live in very inaccessible locations (islands, camps, rivers, forests, etc.). Some of these locations are periodic depending on the productive seasons. The inaccessible locations are distributed throughout all the provinces with a strong predominance in the Provinces of the central basin (Équateur, Tshuapa, Mongala, Maindombe, Sankuru and Maniema) where the hydrography and the forests make it difficult. Moreover, in addition to Équateur and Lomami, we note the persistence of provinces with more than 15% of HZs that have not reached an average of 80% VC in DTCHebBHib3.

#### Leadership, management and co-ordination

The leadership of the central EPI is sufficient to ensure very good co-ordination of immunisation activities (supervision, data validation, reviews, etc.) at the central level. At this level, 14 EPI executives have been trained in the Strategic Executive Training Programme” (STEP) to develop core competencies in leadership, supply chain management, human resources management, planning, relationship building, performance improvement and personal development. On the other hand, at the intermediate level, only 10/26 so-called priority DPS funded by RSS 2 currently have secure resources to ensure proper co-ordination of vaccine activities. However, late disbursement of funds, weak co-ordination of activities in the DPS/HZs and the functional deficiency of the provincial health clusters (CCIA) must be corrected. The co-ordination problem in the 16 other SDAs arises because this will require harmonisation with all the other partners who support these provinces, in order to ensure that vaccine activities are taken into account during HZ support missions, quarterly reviews of the provinces, evaluations of the HZs, etc. This will require strong leadership at this level to ensure that activities in these provinces are conducted in the same way as in the 10 with the support of RSS 2. However, at this level, this cannot be guaranteed. Other sources of funding will be needed to support these 16 other provinces as regards co-ordination, with a focus on vaccine activities, in this case supporting the HZ, the quarterly reviews and the sessions of self-evaluation of the quality of the data at HZ level.

## Public Financial Management

the poor performances of public finances are recorded in 2016 and 2017, for illustrative purposes: out of \$ 203,645,829 (2015), \$ 289,049,042 (2016) and \$ 161,253,796 up to the end of August 2017 of state budget for health, only the following amounts have been put into effect by the MOH for vaccination activities in the DRC, namely: 7 937 187\$, 575 000\$ and 294 451\$. This clearly demonstrates the negative influence of the poor performance of public finances on vaccination activities, which may impact the quality of services.. The delay in the reimbursement of irregular and ineligible expenses resulted in 5 months of cash deficit with a consequent delay in the implementation of Q3 2017 activities. In addition, inadequacies in public finances at the level of the decentralised provinces mean that certain co-ordination activities (reviews, steering committee meetings, etc.) needing to be financed by the latter have not been financed. This has a consequence on decision making and follow-up on the implementation of the activities in spite of the correct mechanism or CAGF - AGFIN/GIZ assembly, which makes it easy to attain the financial resources put at their disposal in the DPS and HZs.

## II. Lessons drawn from prior campaigns

The following lessons were learned during the implementation of the 2016/2017 campaign:

- Establishment of Command Posts (CP) and the publication of Sitrep and bulletins allow the coordination of provisional supervisory teams and Health Zones to be maintained, in spite of multiple postponements;
- The prospective supervision and use of the tool to assess campaign preparations allow the level of preparation to be evaluated;
- The late disbursement of funds for the campaign negatively affects the organisation of the measles campaign;
- The increase in cold chain coverage allows campaign quality to be improved;
- Coordination of waste management during campaigns

Measures necessary for the next campaign:

- Apply the acceptability framework at all levels of campaign implementation;
- Give actors at all levels a sense of responsibility with clear terms of reference for ownership/accountability
- Use of corrective measures to improve the levels of preparation;
- Make funds available at all levels on-time in order to allow the implementation of activities according to the planning cycle;
- Scheduling of cold chain equipment procurement six months before the start of the immunisation campaign;
- Extend monitoring of vial tracking during the implementation of the campaign;
- Develop a public-private partnership framework in order to use private structures and those validated by the logistics commission for the final destruction of waste.

The key results are as follows, according to post-immunisation coverage surveys: estimated immunisation coverage for the campaign in the population of children was 89.0%, according to cards and history, with no variation between genders. Only six branch offices and four provinces reached the objective of 95%. Reasons for not immunising were mostly related to the motivation and information of parents or of persons responsible for the child. The key recommendations from these surveys were:

- 1) intensify strategy-based communication actions and channels to targets;
- 2) develop specific strategies to reach targets living in crisis zones;
- 3) Enhance immunisation stakeholders' expertise and intervention quality for routine, and especially for immunisation campaigns;
- 4) Ensure the different management plans for inputs, AEFI and waste and the endorsed microplan for the campaign are disseminated and implemented;
- 5) provide the EPI Directorate with an updated, consolidated plan for strengthening the cold

chain in Health Centres, Health Zones, and branch offices, with the option of a solar system;  
6) Evaluate contracts to transfer funds executed by partner banks and  
7) strengthen involvement of supervisors in training vaccinators and monitoring the preparatory phase.

The country will make the most of the 2017 post-campaign survey recommendations, to be implemented during preparations, implementation and assessments for the 2019-2020 follow-up campaign. These recommendations, some of which have been implemented, will be monitored using a timeline to position them according to the appropriate time period (before, during and after the campaign). The other transverse components will also be monitored through appropriate mechanisms.

In addition to the main recommendations and lessons learned from previous AVS

### III. ADDITIONAL MEASURES TO IMPROVE THIS CAMPAIGN

To successfully implement this follow-up campaign, some special aspects to increase coverage and improve quality will be taken. This mainly concerns reaching zero-dose and incompletely vaccinated children, strengthening communication by targeting specific groups, strengthening logistics and applying performance-based payment.

#### 3.1. REACHING “ZERO DOSE” CHILDREN

In order to reach “zero dose” children, with the help of a specific tool called zero children identification, some information will be collected including:

- Village/community of residence
- The address/contact details of the parents
- Date of birth
- Antigens received since birth if applicable
- Reasons for non-vaccination
- Distance between the household and the usual vaccination point

In order to identify and vaccinate all zero-dose and incompletely vaccinated children, specific strategies will be put in place to facilitate identification, vaccination and evaluation of their recovery. This will mainly focus on updating and disseminating guidelines for the vaccination of children aged 12-23 months, as well as the identification, vaccination and monitoring of the recovery of zero-dose and incompletely-vaccinated children after enumeration up to 4 months after the vaccination campaign. To this will be added an incentive to pay the coverage bonus for those who have few zero doses before the campaign and those who recoup zero doses within 3 months after the campaign. The details of the directive are provided in the implementation plan.

#### 3.2. STRENGTHENING COMMUNICATION BEFORE AND DURING THE CAMPAIGN

According to the household survey of unvaccinated children (page 44 of the survey report), refusal on religious grounds is not the cause of non-vaccination (1.4% of total unvaccinated children only). The vaccination coverage survey post-AVS revealed 2 major reasons for non-vaccination:

- 35% of parents of unvaccinated children were travelling/absent
- 23% of parents of unvaccinated children were not informed about the campaign

These two reasons, intimately linked to communication, lowered vaccination coverage by 6 percentage points. If resolved, they could achieve the 95% coverage target for the measles campaign.

In order to address these issues, the programme proposes:

- to avoid multiple postponements of the implementation date of the campaign
- to insist on campaign dates when community volunteers visit, specifically asking parents if they plan to travel/be absent on campaign days. If this is the case, the community volunteers will try to convince them to:

- a. change the trip/hours of activities pending the visit of vaccination teams to their locations,
- b. Plan the vaccination of the child with another family member if the child does not accompany the parent;

- c. Vaccinate the child in the place of travel/activity of the mother/guardian,
- d. Identify the households in which the children were missed due to travel and plan the vaccination of the child upon the return of the child from the trip
- e. If a sweeping operation is necessary, this should be done with a schedule changed to evenings when families return from their occupations
  - to strengthen communication around community volunteers/criers, who remain the main source of information for parents.
  - Increase the number of community volunteers before the campaign to ensure that parents are informed of the campaign;
  - improve information on the visit of the teams to the points of transport - markets, stations and the information on the change of time of the vaccination to be more practical along with the schedule of the families,
  - Develop instructions on vaccination in camps/fields, churches
  - Negotiate peace days with groups in conflict.
  - Create WhatsApp groups to track, inform change teams, new messages etc.

This innovation will, however, face certain risks in particular the absence of immunisation cards in a large number households, and community workers risk misidentifying children who are not fully immunised. To address this challenge, during the briefing on household population counts, we are going to place emphasis on the immunisation schedule during training and advise that in case of doubt, treat the child as not fully immunised and health centre staff will check in the register. In addition, the payment of a bonus per number of children recovered raises concerns about over-notification that may include children for whom there is no contradiction with their immunisation schedule; validation by the incumbent nurse at the health centre of the list of children to recover will enable the risk to be mitigated.

These elements will be integrated into the various communication plans (at national, provincial and health zone level) and parents' information before the campaign will be monitored independently a few days before the launch of the campaign..

### 3.3. STRENGTHENING INJECTION SAFETY AND PREVENTION OF AEFI

To avoid AEFIs, vaccinators will be trained and monitored to ensure that the correct techniques are used as part of AVS training.

Training will be cascaded from the central level to the health area level. One of the key factors to take into account is the recruitment of vaccinators necessarily from usual vaccination sites in the health area with the requirement that they be qualified nurses with at least two years' experience on VAR injection.

At the central level, after the identification of good practice to be employed to avoid AEFI, a slot will be dedicated to it and will focus on good practice concerning injections in general and the injection of the VAR, in particular based on the EPI data sheets in force in the Democratic Republic of Congo. This training will have two components: theoretical and practical in the form of a role-play with the use of dolls as teaching material. The same logic will be followed at outpost and health zone level (training of the axis supervisors and nurses).

For these two levels, the supervision sheets will be reviewed by including a component of vaccination practice observation at the site, which takes into account all necessary aspects including the safety of injections, hygiene at the injection site, the site of the injection and the key messages given to the Mother or guardian of children.

On the other hand, at health area level, where vaccinator teams will be trained, another approach will be preferred because of the training in small groups and focusing only on the task to be accomplished during the implementation of the campaign; for vaccinators, hands-on training for this specific area will focus on:

- a reminder on the safety of injections;
- VAR vaccination instructions;
- Instructions on hygiene at the injection site;



- Best and worst practices compared to VAR injection;
- Elements of observation of a VAR vaccination action

To this can be added some special features for the health zones that will be able to combine VAR vaccination with VAA.

As for the theoretical part, this will be preceded by a demonstration by the facilitator on the practice of VAR injection followed by all vaccinators in turn before receiving feedback and correction of shortcomings observed in the field.

Injection quality monitoring will be a priority in the day-to-day report by each outreach supervisor, and the flaws observed will be noted and shared with all supervisors, in order to correct these if this is the case.

We will also include in the campaign briefing package a topic on monitoring of AEFI within the context of vaccination safety. This will focus on:

1. Basic concept on AEFI with a focus on the 5 causes of AEFI
2. Principles on vaccine safety (including VAR)
3. Collection and notification of VAR-related AEs (Cause 1 AEFI)
4. Investigation of serious AEFIs and clusters
5. Signal Monitoring
6. Support for AEFIs through the delivery of care kits in care facilities identified for this purpose,
7. CRISIS communication in case of serious AEFIs

### 3.4. SETTING UP A PERFORMANCE FRAMEWORK

Before the campaign, the Minister of Public Health will communicate with the EPI, the Provincial Health Divisions and the IPS concerning the option exercised to use the PBF to pay all the benefits related to the VAR campaign (preparations, implementation, monitoring and evaluation).

This instruction will put in place a performance-based payment for 20% of the amount allocated to vaccinators and workers per level (meal/day). For the vaccinators, their performance will be evaluated on the achievement of vaccination coverage greater than 95% within their outpost after independent monitoring.

For the organisers of the campaign and the supervisors, the payment system will be realised in 3 stages at each level:

- 40% of the PBF pool depending on the quality of the preparations
- 40% depending on the quality of the implementation
- 20% depending on the vaccination coverage results

To ensure that the payment reaches the final beneficiaries, a proposal is made

- To use the mobile phone according to the network available in the region: Orange Money, Mpesa or Airtel money; for this new approach, the health zones of the provinces of Kinshasa, Kongo Central, Kasai Oriental and Haut Katanga will be targeted for an initial run.
- Bank accounts of health zones and health areas
- Direct payment through the Fiduciary Agency in the absence of telephone networks in the Health Zone

This approach will also encounter challenges such as non-compliance with the disbursement plans of the various tranches and demotivation of campaign stakeholders for fear of recording a below-average performance and not receiving all of the benefits at the end of the campaign. To address this, financing requests will be implemented in due course and the performance contract will be explained to the various campaign stakeholders to improve understanding.

The performance framework elements developed in the implementation plan are detailed in the appendix.






## 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

- |   |  |  |
|---|--|--|
|    | <b>Country strategic multi-year plan</b><br><br>Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan | <a href="#">PPAC_RDC 2015-2019_VF CCIA Stratégique 20-01-18_23.17.12.docx</a>            |
|  | <b>Country strategic multi-year plan / cMYP costing tool</b>   | <a href="#">Costing tool DRC 27 06 2015 au 04-02-17 22-01-18_13.21.01.xls</a>            |
|  | <b>Effective Vaccine Management (EVM) assessment</b>   | <a href="#">RDC Rapport GEV 2014 Rapport Final_18-02-18_15.08.48.pdf</a>                 |
|  | <b>Effective Vaccine Management (EVM): most recent improvement plan progress report</b>  | <a href="#">RDCRapport MEO Plan Amélioration GEVDécembre 2017_13-05-18_14.41.01.pdf</a>  |
|  | <b>Data quality and survey documents: Final report from</b>  | <a href="#">RDC_Rapport preliminaire EDS-RDC II version finale_22-01-18_14.12.48.pdf</a> |

**most recent survey containing  
immunisation coverage  
indicators**



**Data quality and survey  
documents: Immunisation data  
quality improvement plan**

[RDC Plan Stratégique de la Qualité des  
données de vaccination 22 janv 2018 GV  
FJ 22-01-18\\_14.23.04.docx](#)



**Data quality and survey  
documents: Report from most  
recent desk review of  
immunisation data quality**

[QD La revue des données du PEV de 2007 à  
2016 Original 22-01-18 14.32.48.docx](#)



**Data quality and survey  
documents: Report from most  
recent in-depth data quality  
evaluation including  
immunisation**

[QD Résultat Evaluation de terrain  
\(DQS\) PM 2017-2011 22-01-  
18 14.44.49.docx](#)



**Human Resources pay scale**

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

[20160831 Reglement commun GIBS actualise  
jan 2016 1 01-06-18 17.30.32.pdf](#)

### **Coordination and advisory groups documents**



**National Coordination Forum  
Terms of Reference**

ICC, HSCC or equivalent

[CCIA TDR ORIENTATIONS 22-01-  
18 18.32.08.ppt](#)



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

[Ordre du Jour CNC du 13 Janv. 017 22-01-  
18 18.54.32.doc](#)

## months

[COMPTE RENDU DE LA REUNION DE  
COORDINATION PEV ET PARTENAIRES  
DU MARDI 19 septembre 2017 AVRIL  
2017\\_01-06-18\\_17.43.06.docx](#)

[COMPTE RENDU DE LA REUNION DE  
COORDINATION PEV ET PARTENAIRES  
DU MARDI 26 septembre 2017 AVRIL  
2017\\_01-06-18\\_17.51.14.docx](#)

[Compte rendu de la réunion de CCIA  
technique du 08 mars 2018 01-06-  
18\\_17.45.05.docx](#)

[Compte rendu de la réunion de CCIA  
technique du 23 VF février 2017 01-06-  
18\\_17.42.00.docx](#)

[Compte rendu de la réunion de CCIA  
technique du 23 février 2017 01-06-  
18\\_17.39.53.docx](#)

[Compte rendu de la réunion de CCIA  
technique du 30 mars 2017 01-06-  
18\\_17.34.33.docx](#)

[Compte rendu de la réunion de CCIA  
stratégique du 19 janvier 2017\\_01-06-  
18\\_17.36.40.docx](#)

[Compte de la réunion de CCIA technique du  
14 septembre 2017\\_01-06-18\\_17.43.32.docx](#)

[Compte rendu de la réunion de coordination  
PEV et partenaires du 25avril 2017\\_01-06-  
18\\_17.42.32.docx](#)

## Other documents



### Other documents (optional)

Please also provide other country documents to support the review of the

[Page des signatures 13-05-18\\_14.45.46.docx](#)

[Prevision budgetaireVAR13062018Plan B\\_10-  
09-18\\_00.32.04.xlsx](#)

applications, for example Health Facility Assessment Reports, Knowledge-Attitude-Practice surveys or other demand-related surveys, if available.

[ANALYSE DES PERFORMANCES DE VACCINATION ET REVUE DOCUMENTAIRE DES DONNEES\\_15-10-18\\_14.33.45.docx](#)

## 3 Measles follow-up campaign

### 3.1 Vaccine and programmatic data

#### Choice of presentation and dates

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

*Note 3*

Measles follow-up campaign

Preferred presentation	M, 10 doses/vial, lyo
Is the presentation licensed or registered?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
2nd preferred presentation	
Is the presentation licensed or registered?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Required date for vaccine and supplies to arrive	12 May 2019
Planned launch date	5 September 2019
Support requested until	2019

#### 3.1.2 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.**

The license is not the subject of this application given that the vaccine is approved by the country.

### 3.1.3 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 Target Information

### 3.2.1 Targets for campaign vaccination

Please describe the target age cohort for the measles follow-up campaign:

*Note 4*

From

6

weeks ☐

months ☒

years ☐

To

59

weeks ☐

months ☒

years ☐

	2019
Population in target age cohort (#)	18,824,141
Target population to be vaccinated (first dose) (#)	18,824,141
Estimated wastage rates for preferred presentation (%)	10

### 3.2.2 Targets for measles routine first dose (M1)

To be eligible for measles and rubella vaccine support, **countries must be fully financing with domestic resources the measles mono-valent vaccine component of MCV1** which is already in their national immunisation schedule, or have firm written commitments to do so. Please provide information on the targets and total number of doses procured for measles first dose.

	2019
Population in the target age cohort (#)	4,047,926
Target population to be vaccinated (first dose) (#)	4,047,926
Number of doses procured	4,452,800

## 3.3 Co-financing information

### 3.3.1 Vaccine and commodities prices

Price per dose (US\$) - Measles follow-up campaign

	2019
10 doses/vial, lyo	0.32

Commodities Price (US\$) - Measles follow-up campaign (applies only to preferred presentation)

	2019
AD syringes	0.04
Reconstitution syringes	0.04
Safety boxes	0.47
Freight cost as a % of device value	0.02

### 3.3.2 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 5*

	2019
Country co-financing share per	2

dose (%)	
Minimum Country co-financing per dose (US\$)	0.01
Country co-financing per dose (enter an amount equal or above minimum)(US\$)	0.01

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

Measles follow-up campaign

	2019
Vaccine doses financed by Gavi (#)	20,370,900
Vaccine doses co-financed by Country (#)	523,900
AD syringes financed by Gavi (#)	20,187,500
AD syringes co-financed by Country (#)	519,200
Reconstitution syringes financed by Gavi (#)	2,240,900
Reconstitution syringes co-financed by Country (#)	57,700
Safety boxes financed by Gavi (#)	246,750
Safety boxes co-financed by Country (#)	6,350
Freight charges financed by Gavi (\$)	710,530



Freight charges co-financed by Country (\$)	18,273
---	--------

	2019
Total value to be co-financed (US\$) Country	209,000
Total value to be financed (US\$) Gavi	8,125,500
Total value to be financed (US\$)	8,334,500

### 3.3.4 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 6*

	2019
Minimum number of doses financed from domestic resources	4,452,800
Country domestic funding (minimum)	1,362,557

### 3.3.5 Co-financing payment

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

The Government has agreed through the Ministry of Finance to pay expenses related to co-funding. And a disbursement plan was shared with Gavi. The two first tranches paid are estimated to be US\$ 3,400,000. Procedures are in place for the payment of the remaining US\$ 1,300,000.

**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:

August

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

Month

March

Year

2019

### 3.4 Financial support from Gavi

#### 3.4.1 Campaign operational costs support grant(s)

Measles follow-up campaign

#### Population in the target age cohort (#)

*Note 7*

18,824,141

#### Gavi contribution per person in the target age cohort (US\$)

0.65

#### Total in (US\$)

12,235,691.65

Funding needed in country by

9 March 2019

### 3.4.2 Operational budget

Please complete the Gavi budgeting and planning template to document how the Campaign Operational Costs support grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the campaign. 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\$)**

1,742,205

#### **Total amount - Other donors (US\$)**

2,398,875

#### **Total amount - Gavi support (US\$)**

12,642,612

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

0.091

#### **Amount per target person - Other donors (US\$)**

0.13

#### **Amount per target person - Gavi support (US\$)**

0.65

### 3.4.3 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.

Refer to the budget file

#### 3.4.4 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 financial management procedures will be implemented in accordance with the Management Practices Manual for Health Sector Financing (PGFSS).

#### 3.4.5 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.**

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

The financial management procedures will be implemented in accordance with the Management Practices Manual for Health Sector Financing (PGFSS). All funds go through the Management support cell for Financial Management of the Ministry of Public Health which is also the Fiduciary/GIZ Agency:

- preparation and transmission of the application to the financial management support cell (FMSC)
  - preparation of the payment order by the FMSC to the financial agency (GIZ) for disbursement, the transfer of funds to beneficiary structures and support in management according to the procedures of the Ministry and the donors
  - Upon completion of the activity, each beneficiary must provide all GIZ supporting documents within the term specified by the health sector procedures manual. The country will adhere to current procedures in force on public procurement. All procurement of services will be carried out by the CAGF and the support unit for public procurement management of the Ministry of Health, which is managed by the Ministry of Public Health and supervised by the Directorate General of Public Procurement Control of the Ministry of Budget and the Public Procurement Regulation Authority from the Prime Minister's office. To this end, for each contract or collective purchase, the relevant procedures will be abided by through a bid to third parties.
- The financial management procedures for the campaign will be the same as for the other donor funds.

#### 3.4.6 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 8*

In addition to the technical assistance present in the country as part of the various partners' PEF/TCA (WHO, UNICEF, CDC and other partners), who will be mobilised for preparations, including the micro-planning, the implementation and the evaluation of this campaign, that we will need just as we did for the follow-up campaigns organised from 2013-2017, the country still needs both national and international consultants to support the organisation and implementation of the follow-up campaign in 2019-2020. A total of 12 national consultants and 4 international consultants will be recruited and deployed in the problem outposts and health zones. The duty station of these consultants will vary from one block of provinces to another. Scheduling of the campaign and assessment of preparation status (WHO/HQ, UNICEF/HQ and WCAR);

Position one epidemiologist and one data manager (both international) at the Directorate of Public Health (national), Follow-up and supervision (WHO, CDC);

Position one epidemiologist and one logistician at the national level (both international) and at the level of the Provincial Health Directorates (national) Monitoring and supervision (Unicef);

Position one specialist in C4D at the national level (International) and the Provincial Health Directorates (National) / strengthen communication and advocacy (Unicef);

Position one epidemiologist, one logistician and one data manager (all international) at the level of the Provincial Health Directorates Monitoring and Supervision./Strengthening routine immunisation (JSI).

The country considers that the need expressed is consistent with the complexity of the campaign with the yellow fever integration aspect, the country has in addition to the technical aspects needs the international consultants to cover other aspects related to logistics, communication and data management.

### **3.5 Strategic considerations**

#### **3.5.1 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 Campaign Plan of Action, please cite the sections only.**

The planned follow-up campaign is closely aligned with the implementation of the strategic measles elimination plan 2012-2020, which anticipates the coordination of supplementary immunisation activities every 3 years; the last campaigns were held in 2016/2017. Also, the status of measles in the Democratic Republic of Congo was worrisome in 2017 with 45,165 suspected cases reported, including 535 deaths, i.e. a lethality ratio of 1.2% and 61 health

zones had epidemics Of the 3,268 cases investigated, 639 were IgM+. For 2018, the number of health zones with measles epidemics was 19 as of late April.

The country had just reviewed its strategic measles elimination plan, after which a roadmap spread out over two years was developed, with specific activities on strengthening routine immunisation, surveillance, the introduction of the second dose of MCV, and organising MR catch-up SIAs. The cMYP will be revised and aligned with NHDP 2016-2020 and will include these activities. Activities related to measles will be included in developing cMYP 2021-2025. Despite organising 2016-2017 follow-up immunisation campaigns, some HZ were in the midst of a measles epidemic and localised responses in some HZ does not exclude these in organising national follow-up campaigns. The other information is summarised in the plan of action for the campaign in the “Summary and Justification of the Campaign”

According to the data from the risk analysis carried out in February 2018 and updated in August 2018 (in the appendix), based on the criteria of the immunity of the population, the performance of the system of the epidemiological monitoring, the programme’s performance, the existence of vulnerable groups, insecurity, the incidence of measles and case-by-case monitoring data, out of the country's 519 health zones, one single health zone is at higher risk, 41 health zones are at high risk, 186 health zones are medium risk and 291 health zones are at low risk.

Since these higher-risk, high-risk, and medium-risk health zones are spread across several provinces, we have used one criterion for the provinces, and that is to have a proportion of health zones at risk (higher, high and medium) in order to be considered as priorities for the first two blocks.

Provinces with a proportion of zones at risk are categorised as follows:

- Provinces with a proportion of health zones at risk greater than 60%: 7 provinces (Haut Uélé, Équateur, Bas Uélé, Lualaba, Mai Ndombe, Tanganyika and Tshuapa)
- Provinces with a proportion of health zones at risk between 40 and 59%: 7 provinces (Upper Katanga, Ituri, Kinshasa, Kwango, Mongala, North Kivu and South Kivu)
- Provinces with a proportion of health zones at risk of less than 40%: 12 provinces (the other provinces)

Another criterion used is the coverage estimated by the vaccination coverage survey of the follow-up AVS 2016/2017 which grouped the provinces into 3 categories:

- Vaccination coverage greater than or equal to 95% (Haut Uele, South Kivu, Mai Ndombe and Lomami);
- Vaccination coverage between 80% and 95% (the rest of the 19 provinces)
- Vaccination coverage below 80% (Maniema, Sankuru and Lualaba)

Based on these two major criteria, with a prioritisation of the less performing provinces according to the results of the post-campaign survey of 2017 and the risk analysis of 2018, which takes into account the situation of the last 3 years (2015, 2016 and 2017), we propose the following group of provinces in terms of blocks:

- Block 1: 9 provinces (Maniema, Sankuru, Lualaba, Haut Uele, Equator, Bas Uele, Mai Ndombe, Tanganyika and Tshuapa)
- Block 2: 7 provinces (Upper Katanga, Ituri, Kinshasa, Kwango, Mongala, North Kivu and South Kivu)
- Block 3: 10 provinces (Upper Lomami, Kasai, Central Kasai, Eastern Kasai, Central Kongo, Kwilu, Lomami, North Ubangi, South Ubangi and Tshopo).

This prioritisation will be reviewed at the beginning of 2019 with the release of the MICS results and vaccination coverage by means of administrative reports for 2018.

In order to reduce costs, a comparative analysis has been done to identify a possible linkage with yellow fever campaigns and it appears that some provinces in Block 1 VAR can be linked with some provinces with Blocks 2 and 3 of the yellow fever prevention campaign (June and October 2019).

The linkage facilitates the saving of resources but seems to be difficult to apply following the

chronogram of yellow fever prevention campaigns, which is spread over 5 years, while this VAR follow-up campaign is planned to be implemented during the same year, in order to be aligned with the 2012-2020 strategic plan for measles elimination. The country proposes to carry out linkage case-by-case according to the coincidence of implementation dates in the same province (compare Budget), but favours separate planning based on the individual risk analysis for each disease (yellow fever and measles).

The option raised by the country in the spirit of this proposal is that, in all cases, priority should be given to health zones with low coverage, according to the results of the 2017 vaccination coverage survey, and in the high-risk and medium-risk health zones, according to the August 2018 risk analysis presented in the implementation plan.

Pending the implementation of the campaign, some routine actions to strengthen monitoring will be implemented including:

- Training for monitoring of the DPS and HZs with follow-up of the restitution in the CS to include the collection and analysis by the SMIR

- Provision of sampling kits, reagents to INRB

- Establishment of linear lists by the SMIR already displaying an increase in the number of suspect cases

- Training of the DPS for the investigation and funds to achieve this

- Analysis of linear lists, reports of investigations

The risk analysis and the occurrence of measles outbreaks in 2018 prompted the country to submit a request to MRI, in order to pre-position additional funds in time to respond to outbreaks. Given the delay in the transmission of this request and the changing situation in terms of health zones with outbreaks, the health zones initially targeted are also taken into account for this proposal. Since, in 2019, campaigns will be organised in the last quarter of 2019, the MRI request will help the country to have funds available to respond to emergencies during the first 9 months of the year.

### 3.5.2 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.**

The implementation of this campaign is in accordance with the cMYP and with the strategy for measles elimination in the DRC.

The current cMYP covers the period of 2015-2019. It is planned for October of this year, to revise and extend it until 2020 to align it with the PNDS 2016-2020.

### 3.5.3 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 primary functions and responsibilities of the ICC/HSCC can be summarised as follows:

- Coordinating the interventions by the technical and financial partners in order to best support the EPI
- Sharing technical, financial and logistical information in relation to immunisation services
- Coordinating and guiding the use of Gavi and partner funds for immunisation
- Providing technical and financial support for the Immunisation Programme in order to attain the Programme goals and objectives
- Conducting advocacy among donors to mobilise resources and support the Programme
- Conduct follow-up of Programme performance.

The ICC is comprised of 4 committees, including:

Technical Committee:

- Preparing the EPI plan of action and its implementation
- Analysing monthly immunisation data including those from management of vaccines and other supplies and surveillance by health zone
- Identifying the EPI constraints and problems
- Sharing information with all the partners
- Providing feedback to the provinces
- Communicating with stakeholders

Logistics Committee:

- Analysing management data for vaccines and other supplies by health zone and identification of vaccine requirements
- Conducting the inventory of Cold Chain equipment by Health Zone and within the EPI structure
- Identifying problems related to inventory management (vaccines, diluting agents, oil, spare parts, management tools, etc.)
- Providing feedback to the provinces and Health Zones.

Social Mobilisation Committee

- Analysing and identifying communication issues and their causes
- Making suggestions/recommendations for improvement
- Defining effective EPI communications strategies
- Identifying partners at the community level
- Involving and training community health workers in follow-up of dropouts and in rumour management
- Developing strategies likely to increase ties between healthcare facilities and the community for the EPI.

Mobilisation of resources

- Strengthening advocacy in support of the EPI
- Identifying unsupported Zones
- Determining domains without support
- Identifying potential donors and conducting follow-up (Recovery)
- Prepare advocacy meetings
- Prepare the Report during the ICC meetings

The strategic ICC (comprised of agency heads) will approve and follow the recommendations of the various ICC commissions.

The NITAG has been established since last February but has not yet held its first meeting due



to the conflict of agenda between the members.

#### 3.5.4 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?**

Aside from the government commitment, the country will mobilise resources (Government and partners)

Efforts are being made by the Government in the sense of improving the co-financing default and for this fact the following schedule shows the deadlines and amounts discussed with the Gavi team on February 28th:

Timetable for the first tranche of the 2018-2020 payment plan: 1st tranche of 2017 Government co-financing (US \$ 1,000,000) and 2018 Government co-financing (US \$ 4,324,500)

- 1st tranche to be paid by April 30, 2018

- 2nd tranche to pay before June 30, 2018 - 3rd tranche to be paid before August 31, 2018

Total to pay by August 31, 2018 (US\$) 5,324,500

Out of the amount of US\$ 5,324,500, the Government already paid two tranches that represent a total of US\$ 3,500,000.

#### 3.5.5 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.**

The introductory plan takes into account the different factors that influence the different vaccination services. The EPI and its partners, within the context of strengthening community dynamics, will complement and make CACs functional to mobilise households in favour of vaccination.

Advocacy work will be conducted with local authorities for their involvement in mobilising communities with difficult access.

The introductory plan takes into account the different factors that influence the different vaccination services. The EPI and its partners, within the context of strengthening community dynamics, will complement and make CACs functional to mobilise households in favour of vaccination.

Advocacy work will be conducted with local authorities for their involvement in mobilising communities with difficult access.

Plan to overcome the various obstacles:

- Concerning the supply of vaccines, increasing the coverage of cold chain materials, estimated to date at 76%, will facilitate the proper storage of vaccines and diluents;

- Specific strategies are described in the implementation plan for the different areas including access to populations that have often missed vaccination, including the displaced, refugees and especially zero-dose children, improving communication before the vaccination campaign to avoid absences when vaccination teams visit;
- Other aspects related to the preparation, training, strengthening of routine vaccination during AVS, reduction of AEFI and independent evaluation of the campaign are described in the implementation plan.
- The establishment of a performance framework is also under consideration to ensure coverage of more than 95% according to administrative data and surveys, in order to reach these layers of children, who have not been reached by the vaccination system and thus reduce the cycle of measles epidemics in the DRC

### 3.5.6 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.**

As it relates to the equity, 86% of the health zones have a Penta 3 VC over 80%. From the 2013-2014 DHS DRC II, it can be seen that there are no significant differences between immunised children by gender. In contrast, we have noted significant differences between the poorest quintile and the richest quintile depending on the rural or urban environment as well as the level of education of the mother.

(Kinshasa, Sud Ubangi, Mongala, Sud Kivu, Equateur, Tanganyika, Tshopo, Ituri, Kasai Oriental, Kwilu, Tshuapa, etc.), poor immunisation data quality (DTC-HepB-Hib3: 12%, PCV-13(3): 13% and YFV: poor coverage of cold chain equipment, poor rate of meeting vaccine needs in certain Provincial Health Directorates.

Corrective actions:

- In order to resolve the equity problems related to geographic accessibility, the REZ approach will be strengthened by considering special populations to be vaccinated in the microplanning and in the cartography of health areas in the second half of 2016.

The General Secretary for Public Health will organise between now and the first quarter of 2017 a forum between the stakeholders on socio-economic barriers which prevent access to immunisation in order to debate the question of making currency from the immunisation act in private and religious group medical training in major urban concentrations.

The country will use this follow-up campaign to reinforce the achievement of routine immunization coverage and equity through the capacity building activities of actors and communities during training and integrated micro planning with village approach. This micro-planning will identify communities that are not often reached by routine immunization services. In addition CCEOP 1 and 2 will increase the cold-chain equipment coverage to 75% with a positive effect of increasing routine immunisation sessions with good quality vaccines.

The implementation of the aforementioned actions will be evaluated by means of the following indicators:

The various actions that will be implemented will be evaluated according to certain defined indicators. The measurable indicators for evaluating the impact of the proposed campaign on routine vaccination are:

- a. Number of target children vaccinated out of those expected during the period
- b. Number of non-vaccinated or inadequately vaccinated children identified before or during campaign implementation (having received the tokens)

c. Number of zero-dose children vaccinated during the campaign based on coverage and monitoring surveys  
d. Number of inadequately vaccinated children routinely recovered during the campaign based on coverage and monitoring survey  
e. Number of fixed and advanced strategy vaccination sessions held during the vaccination campaign;  
f. Number of health areas that had a shortage of vaccine and other inputs during the vaccination campaign  
g. Number of reported AEFI in children routinely vaccinated during vaccination campaign  
h. Number of children to be monitored to complete the EPI vaccination schedule  
Other aspects related to strengthening routine vaccination are detailed in the implementation plan.

### 3.5.7 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 9*

As the country had planned yellow fever vaccination campaigns in 4 blocks of provinces in 2019 and 2020 for target populations from 1 to 60 years, and the target children of the measles follow-up vaccination campaigns having been included in those of the campaigns against yellow fever, the campaigns against measles will be organised while being integrated with those of yellow fever in certain blocks according to the chronogram drawn up. During implementation, specific vaccination posts will be set up on the vaccination sites to receive only children from 6 to 59 months who must receive the 2 vaccines.

### 3.5.8 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-rubella follow up campaign, etc.).**

In the next 5 years, it is planned to complete the implementation of the first cycle of the GMR phase-out plan covering the period 2018-2020. The outline of this plan emphasises the introduction of the second dose of the VAR or at best the introduction of the RR coupled with the reinforcement of the epidemiological monitoring and the continuation of the implementation of the follow-up AVS every 3 years.

To this will be added the operations for the reinforcement of the routine vaccination by means of the “Reach Every Health Zone” approach, which will be implemented in all the zones of all 26 provinces.

- Organise micro-quality planning performed at the outset: in order to properly implement the quality campaign - micro-planning carried out at operational level proves essential. During this exercise, the emphasis will be on the exhaustive identification of all localities, camps and population groups in the areas targeted by the intervention. The use of innovative methods, such as the use of CACs that will perform enumeration according to the “village approach”, in order to identify the target to be routinely vaccinated (children from 0 to 11 months). A briefing

will be held at central, provincial and operational levels; support will be provided by the central and provincial levels, including the support that will be mobilised as part of this campaign. Taken into account as actors will be the APA from the province to the villages (Governors, territory Administrators, grouping Heads, chieftaincy Chiefs, Heads of villages), leaders of special groups, the OAC, the partners intervening in the insecurity hotbeds and special populations. Pending the enumeration, the target of children to be routinely vaccinated is estimated at 4% of the total population;

- Update of the measles risk analysis using the new version of the tool to identify the location of children who are not or are inadequately vaccinated;
- Organise intensified routine vaccination (PIRI) activities against measles in localities identified as at risk based on the new risk analysis tool;
- Train operational personnel in EPI technical management
- Make routine EPI management tools available in all structures that offer immunisation services in the targeted provinces;
- Assure the regular supply of Health Zones and Health Areas with vaccines and other supplies (implement a vaccine availability tracking system for the outposts in health zones and for zones in the health areas);
- Make transport means available to facilitate resupply with vaccines and other supplies, implementation of various strategies to reach each child and to ensure follow-up activities;
- Increase the number of fixed strategy, advances strategy and mobile strategy immunisation sessions for each Health Area based on the needs of the villages to be reached (one fixed strategy, two or more advanced strategies and one mobile strategy at least per week and per immunising structure);
- Provide one immunisation to every contact in the structures with high frequency, having an operational cold chain, vaccine availability and sufficient personnel;
- Integrate immunisation into the health stations and private structures in order to reduce the cost of the advanced strategy;
- Improve the quality of immunisation sessions (shorten the waiting line, missed times, injection and immunisation safety, etc.);
- Assure the analysis of routine immunisation data in all health areas, village by village (identify and locate target populations not reached by routine immunisation, in particular for MCV);
- Strengthen routine immunisation for MCV in the 518 targeted health zones;
- Provide technical support in terms of formative supervision, immunisation data analysis after each session, management of vaccines and cold chain;
- Provide supplemental technical support (national and international consultants) to support training, supervision, monitoring of activities and data, validation of data at the level of each health zone;
- Implement a mechanism for immunisation in health areas with a lack of safety by making local teams responsible with the help of humanitarian organisations;

### **3.6 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](mailto:countryportal@gavi.org).

## 3.7 Upload new application documents

### 3.7.1 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.

### Application documents



**New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline**

[DRCREPONSES AU CEIapplication  
Rougeole04092018\\_15-10-18 15.05.21.docx](#)

[Prescreening questions RDC table reponses  
VF 15102018\\_15-10-18 15.03.39.docx](#)

If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication.

[RDCRapport MEO Plan Amélioration GEVDécembre 2017\\_13-05-18\\_17.10.16.pdf](#)

[EPILogForecastingToolRDCv2016 20152019Janv 2016 Reconf 2017 12102018\\_15-10-18\\_14.50.38.xlsx](#)

[Prevision budgetaireVARIntégré15102018VF\\_15-10-18\\_14.49.21.xlsx](#)

[4. MMR campaign plan of action DRC15102018\\_15-10-18\\_14.42.17.docx](#)



### **Gavi budgeting and planning template**

[Prevision budgetaireVAR13062018Plan B\\_10-09-18\\_00.40.49.xlsx](#)

[Prevision budgetaireVARIntégré15102018VF\\_15-10-18\\_14.54.51.xlsx](#)



### **Most recent assessment of burden of relevant disease**

If not already included in detail in the Introduction Plan or Plan of Action.

[DRCMeasles Risk Assessment ToolAug 2018\\_10-09-18\\_00.47.51.xlsm](#)

[RobMeasles Risk Assessment Toolv1.7 1\\_10-09-18\\_00.44.51.zip](#)



### **Campaign target population (if applicable)**

[Population cible et chronogramme\\_10-09-18\\_00.52.58.xlsx](#)

**Endorsement by coordination and advisory groups**



**National coordination forum meeting minutes, with endorsement of application, and including signatures**

[RDC Compte rendu CNC Validation soumission VAR 04 mai 2018\\_13-05-18\\_16.30.43.docx](#)

The minutes of the national coordination forum meeting should mention the domestic funding of MCV1



**NITAG meeting minutes**

[Rapport Synthèse GTCVRDC\\_13-05-18\\_16.33.53.docx](#)

with specific recommendations on the NVS introduction or campaign

**Vaccine specific**



**cMYP addendum**

[PPACRDC 20152019VF\\_13-05-18\\_16.25.40.docx](#)

Situation analysis and 5 year plan captured in the cMYP or as an addendum to the cMYP



**Annual EPI plan**

[Plan d'Action Opérationnel PEV 201826012018PTCMKJPM\\_13-05-18\\_17.02.41.docx](#)

Annual EPI plan detailing planning of all measles and rubella-related activities for the current year, including realistic timelines, designated responsible individual(s) and a budget



**MCV1 self-financing commitment letter**

[Page des signatures\\_13-05-18\\_16.59.00.docx](#)

If the country is not yet financing the measles monovalent component of MCV1, a letter signed by the Minister of Health and Minister of Finance committing for the country to self-finance MCV1 from 2018 onwards.



**Measles (and rubella) strategic plan for elimination**

[Plan strategique d'Elimination rougeole en RDC 2012\\_2020Final\\_13-05-18\\_16.54.28.pdf](#)

If available



## Other documents (optional)

[RDCRapport MEO Plan Amélioration  
GEVDécembre 2017\\_13-05-18\\_17.10.16.pdf](#)

## 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 10*

##### IPV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)					
Gavi support (US\$)	3,513,500	3,619,434	3,692,530	3,766,533	3,841,342

##### PCV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)	1,600,512	2,309,392	2,343,510	2,390,389	2,437,761
Gavi support (US\$)	25,108,000	37,707,500	33,610,726	34,283,065	34,962,472

##### Pentavalent Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)	1,337,052	2,349,624	2,837,039	2,789,200	2,844,474
Gavi support	3,930,000	6,101,500	7,189,824	7,068,586	7,208,665



(US\$)

Rota Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)	572,325	596,712	885,612	1,444,192	1,462,648
Gavi support (US\$)	5,372,622	5,601,549	8,313,558	13,557,153	13,730,404

Yellow fever preventive mass vaccination campaign

	2018
Country Co-financing (US\$)	
Gavi support (US\$)	121,944,000

YF Routine

	2018	2019	2020	2021	2022
Country Co-financing (US\$)	571,853	812,734	826,552	843,086	859,794
Gavi support (US\$)	2,738,000	3,894,000	3,926,266	4,004,805	4,084,170

Measles follow-up campaign

	2019
Country Co-financing (US\$)	209,000
Gavi support (US\$)	7,850,500

**Total Active Vaccine Programmes**

	2018	2019	2020	2021	2022
Total country co-financing (US\$)	4,081,742	6,277,462	6,892,713	7,466,867	7,604,677
Total Gavi support (US\$)	162,606,122	64,774,483	56,732,904	62,680,142	63,827,053

Total value (US\$) (Gavi + Country co-financing)	166,687,864	71,051,945	63,625,617	70,147,009	71,431,730
--	-------------	------------	------------	------------	------------

## New Vaccine Programme Support Requested

Measles follow-up campaign

	2019
Country Co-financing (US\$)	209,000
Gavi support (US\$)	8,125,500

	2019
Total country co-financing (US\$)	209,000
Total Gavi support (US\$)	8,125,500
Total value (US\$) (Gavi + Country co-financing)	8,334,500

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

	2018	2019	2020	2021	2022
Total country co-financing (US\$)	4,081,742	6,486,462	6,892,713	7,466,867	7,604,677
Total Gavi support (US\$)	162,606,122	72,899,983	56,732,904	62,680,142	63,827,053
Total value (US\$) (Gavi + Country co-financing)	166,687,864	79,386,445	63,625,617	70,147,009	71,431,730

## Contacts

### 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
Dr Guillaume NGOIE MWAMBA	Medical Director of the EPI	+243817975023	guillaumengoiemwamba@gmail.com	
Dr Elisabeth MUKAMBA MUSENGA	Assistant Medical Director	+243999992735	elisabethmukamba@gmail.com	

### Comments

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

The request was approved by the National Coordination Committee for disease control that met in place of the strategic ICC. The report on this meeting is contained in an appendix to this submission. The signatures page will be provided in a short time period due to emergencies involving certain officials who must sign the document.

## **Government signature form**

The Government of Congo, Democratic Republic of the 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

The Government of Congo, Democratic Republic of the 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.<sup>1</sup>*

**Minister of Health (or delegated authority)**

Name

Date

Signature

**Minister of Finance (or delegated authority)**

Name

Date

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

---

<sup>1</sup> 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**

Co-financing requirements are specified in the guidelines.

#### **NOTE 6**

\*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 7**

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

#### **NOTE 8**

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

#### **NOTE 9**

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

#### **NOTE 10**

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.