# Application Form for Gavi NVS support

Submitted by

## The Government of

## *Eritrea*

Date of submission: **8 September 2017**

**Deadline for submission:**

i. 8 September 2017

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

| Start Year | 2017 | End Year | 2021 |
|---|---|---|---|

**Form revised in 2016**

**(To be used with Guidelines of December 2016)**

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

**Gavi**
**GRANT TERMS AND CONDITIONS**

**FUNDING USED SOLELY FOR APPROVED PROGRAMMES**

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

**AMENDMENT TO THE APPLICATION**

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

**RETURN OF FUNDS**

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

**SUSPENSION/ TERMINATION**

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

**ANTICORRUPTION**

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

**AUDITS AND RECORDS**

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

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

**CONFIRMATION OF LEGAL VALIDITY**

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

**CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY**

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

**USE OF COMMERCIAL BANK ACCOUNTS**

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

**ARBITRATION**

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

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

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

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

## 1. Type of Support requested

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

| Type of Support | Vaccine | Start Year | End Year | Preferred second presentation[1] |
|---|---|---|---|---|
| Preventive Campaign Support | Meningococcal A, 10 dose(s) per vial, LYOPHILISED | 2019 | 2019 | Not applicable |
| Routine New Vaccines Support | Meningococcal A, 10 dose(s) per vial, LYOPHILISED | 2019 | 2021 | |

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

## 2. Table of Contents

## 3. Executive Summary

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

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

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

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

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

**Executive Summary**

Eritrea is located in the meningitis belt and a number of seasonal outbreaks of Meningitis have been reported in the previous years. The outbreak have been occurred in specific areas of the country. The disease is still feared by everyone in the country and the underlying risk factors are still present:- such as evidence of Neisseria Meningitis A circulation and environmental factors that could aggravate the disease including dry season with high temperature, dry dusty winds, and limited rain fall levels in the areas located in the belt. Given the cyclical occurrence of the disease, yet highly unpredictable nature of the meningococcal disease outbreaks can occur as the current trends in climate change, population cross boarder movements in particular to Sudan and Ethiopia. In Eritrea outbreaks can occur again in the future at any for the above mentioned reasons. Moreover, African countries in the meningitis belt have made tremendous regional public health efforts and achievements to control the disease. Eritrea should also make its contribution to lower the epidemic risk of the disease for the future by further building geographic herd protection in the region.

To have a base line information for the status of the disease, Eritrea has carried out a risk assessment using District Prioritization Tool (DPT) in 2016 with technical support from external experts. The aim this assessment was to determine the risk areas and the level in order to develop a work plan of a long term protection for these areas and entire population. Based on the Meningitis Risk Mapping, the identified high risk zones concur with historical patterns in particular at the country border line with Ethiopia and Sudan. Other medium-to-high-risk zones that have not traditionally epidemic-prone have also been identified. This raises some questions as to whether the level of risk in these areas is to be of concern or is related to the insufficiencies of recent year's data. The local expert assessment team has confirmed that no major outbreaks occurred in recent years, but considering the highlighted observation on incompleteness of epidemiological/laboratory data, underreporting and less documented of "sporadic cases" or even "small clusters" particular in areas bordering to Ethiopia in the past five years and the location o the country in the belt they have decided that the country is at risk of the disease and there is a need to carryout wide age range of Men A preventive vaccination campaign.

To this regard, the experts proposed that consequently, a three-fold strategic control approach was proposed namely: First, a nationwide preventive immunization campaign targeting 1-29-years-old people; Second, introduction of the vaccine into routine immunization programme with a single dose administration in places

located in the risk areas, Third, strengthening of meningitis surveillance and laboratory testing activities to have justified documented results.

For implementation of the campaign, projected population size of the country for 2019 was taken as 4,012,708 (NSO, 2015). People aged 1 to 29 years old (70%) is estimated to be 2,808,896 and will be the target for the campaign. The campaign will be carried out in two phases with one month difference: phase one targeting 3 Zobas: Anseba, Debub and Gash-Barka; (total population 2,678,549) with a target population of 1,874,984. Phase two targeting the remaining 3 Zones: Maekel, Northern Red Sea and Southern Red Sea; (total population 1,334,159) with a target population of 933,911. The implementation date for the preventive campaign will April and June 2019. The introduction of Men A into RI will be after 6 months of the second phase of the preventive campaign. Based on the guide line, GAVI will support US$ 0.65/person for operational costs and will be estimated to be **US$1,825,782**. According the target population and expected coverage achievement (95%) for the campaign, the vaccine cost is estimated to be **US$168,379**. The cost for AD syringe **(US$US170, 781),** reconstitution syringe **(US$17, 025)** and safety boxes **(US$39, 137).** Total cost for injection safety is estimated **US$226,943.**

In conclusion, to conduct the meningococcal A preventive vaccination campaign, the country is requesting support of **US$2,221,104** from GAVI for vaccines, syringes, reconstitution syringes, safety boxes and operational cost. The Men A vaccination campaign is planned for 15-25 April first phase and dthe second phase will be 15-25 June 2019

# 4. Signatures

## 4.1. Signatures of the Government and National Coordinating Bodies

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

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

Meningococcal A, 10 dose(s) per vial, LYOPHILISED routine introduction

Meningococcal A, 10 dose(s) per vial, LYOPHILISED preventive campaign

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

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

Table(s) **7.2.3** in the Preventive Campaign Support of this application shows the amount of support in either supply or cash that is required from the Gavi.

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 **January**.

The payment for the first year of co-financed support will be around **January 2019** for Meningococcal A, 10 dose(s) per vial, LYOPHILISED.

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

| Minister of Health (or delegated authority) | | Minister of Finance (or delegated authority) | |
|---|---|---|---|
| **Name** | HE Minister Amina Nurhussein | **Name** | HE Minister Berhane Habtemariam |
| **Date** | | **Date** | |
| **Signature** | | **Signature** | |

*By signing this application form, we confirm 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).*

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

| Full name | Position | Telephone | Email |
|---|---|---|---|
| Mr. Tedros Yehdego | EPI Manager | 291-1-7184525 | tedrosmy@gmail.com |

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

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

**Profile of the Coordination Forum**

| | |
|---|---|
| **Name of the Forum** | Inter-agency Cordination Committee (ICC) |
| **Organisational structure (e.g., sub-committee, stand-alone)** | Stand alone |

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

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

To have a base line information, Eritrea has carried out a risk assessment using District Prioritization Tool (DPT) in 2016 using technical support from external experts and with participation of local experts on communicable diseases in the Ministry and WHO and UNICEF CO staffs working as EPI focal persons, data managers and surveillance officers. This supported to determine the risk areas and their level in order to develop a work plan of long term protection for the risk areas and the entire population. Based on the Meningitis Risk Mapping activities risk areas have identified and historical patterns of the disease particular at the country border line with Ethiopia and Sudan were determined to come up with decision.

To prepare the Mn A proposal and its implementation plan, the EPI program has jointly worked with the local partners especially WHO and UNICEF country offices staffs to develop the draft proposal. The final draft of the proposal was shared to the technical person who are members of the ICC and technical persons working in UNICEF and WHO to have their input before the ICC meeting for endorsement.

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

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **06/09/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 7 (please use the list for signatures in the section below).

| Function | Title / Organisation | Name | Please sign below to indicate the attendance at the meeting where the proposal was endorsed | Please sign below to indicate the endorsement of the minutes where the proposal was discussed |
|---|---|---|---|---|
| **Chair** | DIRECTOR GENERAL OF PUBLIC HEALTH | Dr. ANDEBRHAN TESFAZION | | |
| **Secretary** | EPI MANAGER | Mr. TEDROS YEHDEGO | | |
| **Members** | DIRECTOR OF HAM ANDD COMMUNITY HEALTH | Dr. BERHANA HAILE | | |

| | | | | |
|---|---|---|---|---|
| | DIRECTOR OF PMU | Dr. EYOB TEKEL | | |
| | ASMERA COLLEAGE OF HEALTH SCIENCE | Mr. OKBAMICHEAL TEKLE | | |
| | LECTURER | Pro. TEWELDEMEDHIN YOHANNESM | | |
| | NATIONAL REFERAL HOSPITAL | Pro. TZEGEREDA G/MICHEAL | | |
| | HSS PROJECT OFFICER | ROBEL ZEKIRSTOS | | |
| | DIRECTOR OF NATIONAL HEALTH LABORATORY | SALIH MEHAMED SAID GEMAM | | |
| | NUEW | Sr. YEHDEGA ANDEMICHEL | | |
| | WHO EPI FOCAL ON | TZEGAI KIDANEMARIAM | | |

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

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

### 4.2. National Immunization Technical Advisory Group (NITAG)

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

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

## 5. Immunisation Programme Data

### 5.1 Background information

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

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

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

| | Figure | Year | Source |
|---|---|---|---|
| Total population | 3,798,702 | 2017 | NSO, 2015 |
| Birth cohort | 113,961 | 2017 | NSO, 2015 |
| Infant mortality rate (per 1000) | 36 | 2016 | CHERG 2016 |
| Surviving infants*[1]* | 106,364 | 2017 | NSO, 2015 |
| GNI per capita (US$) | 480 | 2011 | 2011 WORLD BANK |
| Total Health Expenditure (THE) as a percentage of GDP | 3 | 2017 | WHO 2014 |
| General government expenditure on health | 3.6 | 2012 | WHO 2014 |

| | | | |
|---|---|---|---|
| (GGHE) as % of General government expenditure | | | |

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

### 5.1.1 Lessons learned

**Routine New Vaccines Support**

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

| Lessons Learned | Action Points |
|---|---|

**Preventive campaign support**

If campaigns with Meningococcal A, 10 dose(s) per vial, LYOPHILISED vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. If they are included in the Introduction Plan or Plan of Action, please cite the section only. If this information is already included in NVIP/POA, please reference the document and in which section/page this information can be found.

| Lessons Learned | Action Points |
|---|---|
| During campaign, addressing and reaching nomadic population groups and people residing in less accessible areas in the Western and Eastern Low lands of the country. | Vising the place and providing vaccination services one week before the national vaccination dates, mapping the seasonal movement of the nomadic population groups in the areas and determine where they are before the campaign dates. |
| Community involvement in the campaign in reaching the hard to reach areas and mapping of the areas during the district micro planning | Conducting campaign micro planning at district level by involving community leaders, village health workers and local administrators to map the hard to reach areas and to get support of the community to reach these areas. |
| Determine the availability of functioning cold chain equipment with adequate storage capacity at service level before the campaign dates. | Conduct pre-campaign monitoring activities and preventive maintenance of the cold chain equipment and verify that there are adequate storage capacity at service level. |

### 5.1.2 Health planning and budgeting

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

The planning and budgeting cycle of Eritrea is from January 1st to December 31st of each year. Proposal of annual work of each ministry is prepared. The budget is reviewed and cleaned at national level and feedback is provided to make amendments before submitting to the MoF. Annual budget of all the ministry and other sectors is submit to Ministry of Finance. Budget reading and hearing is done at governmental level chaired by the Ministry of Finance for more verification defending. Finally the consolidated annual budget is present to the Ministerial Meeting for approval and endorsement in order to implement it at various levels and sectors of the government.

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

Health Sector Strategic Development Plan (HSSDP). A new HSSDP 2017-2021 is developed and endorsed in Dec. 2016

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

Yes, the cMYP (2017-2021)  is aligned with HSSDP, 2017-2021

Please indicate the national planning budgeting cycle for health

The planning and budgeting cycle for health is similar to the country planning cycle which is from January 01

to December 31. In order to set objectives, a situational analysis of the services providing at lower level is conducted. After the existed problems have determined prioritization of the identified problems is made at district and zobas level.

At regional level annual work plan is developed to address the problems. The annual work plan is accompanied with specific objectives, strategies and activity lines. Each activity line is budgeted and compiled at zoba level and submit to the Ministry at the national level. At national level the budget proposals are reviewed evaluated and feedback is provided to zobas to make some amendments based on the recommendations.

After compiling it the annual budget of the Ministry is shared to Ministry of Finance and budget hearing and defending is arranged at governmental level for more verification and consolidation. At the end a budget summary is prepared and present to the ministerial meeting for its approval and endorsement at governmental level. After that the budget is disburse to sub nationals for their implementation and every quarter liquidation of the utilized budget is done and report is submitted to national level. Mid-year review meeting is also done to monitor and evaluate the status of the budget utilization and to observe the progress made in achieving the specific targets and objectives.

Please indicate the national planning cycle for immunisation

The national planning cycle for immunisation is the same as the national planning and budgeting cycle for health, January 1 to December 31.Situational analysis, of available services of the EPI program is done at lower level and problems are identified and prioritized. Based on them objectives, strategies and activity lines are developed and cost. Proposal for their implementation is developed. The annual work plan is sent to the national level and follows the same procedure as of the national planning and budgeting of health sectors and sent to ministry of finance for its approval and endorsement.

### 5.1.3 Coverage and equity

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

In Eritrea Southern Red Sea (SRS), Gash Barka (G/Barka), Northern Red Sea (NRS) and Debub have challenging areas with consistently limited access to EPI services as well as limited access to other priority health services. Valid immunization coverage is below the target of 90% in SRS, G/Barka and NRS for all antigens, while the remaining three regions had coverage of 90% and above. Generally, up to 40% of the population does not have a health facility within 10 kms radius of their residences.

As per the joint assessment report 2016, the life style of the nomadic population at the coastal districts, there is high dropout rate between BCG Measles, limited community empowerment, inequitable access to health services is just a glimpse of inequity of access to EPI/VPD and other priority health services. However, it is worth noting that there is no gender related inequity in the country especially as related to EPI services.

Lowest access to EPI/VPD and other priority services is found in the lowest and second lowest socioeconomic quintiles, putting at risk children of mothers and or families in remote/rural and Hard To Reach (HTR) areas, HTR (mostly nomadic) populations as well as children in households with young mothers below 24 years and aged mothers 35 years and above. The region with some inequities and that deserve remedial approaches are: Zoba SRS, NRS, Debub and G/Barka.

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

for the implementation of Catch campaign, the country will be able to develop detailed micro plans to reach every child in less accessable areas which will be an opportunity for increasing immunization coverage. The country has recieved support from GAVI HSS grant for outreach immunization servs and this will assist to

solve the problem in less accessible areas by strengthening outreach services, and human resource for health at facility and community level. The proposed CCEOP application and aoval will improve the cold chain challenges at all levels to maintain continous avaialblity of vaccine even in less accessible areas and hence improve coverage and equity more.

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

The EPI coverage survey is conducted every five years to assess any gender and equity related barriers. In 2017 EPI coverage survey has been conducted and draft report is being compiled. The health management information system generates routine data every month. The national EPI program analyse the data and conduct further assessment in districts that report low immunization coverage. This year equity assessment is planned to understand the barriers to access and utilization of EPI services. This application has also included Assessments during and after the campaign to assess gender and equity related barriers.

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

No the health management information system does not collect sex disaggregated data however the EPI coverage survey reveals that there is no difference of immunization coverage by gender.

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

The country is not in a situation of fragility.

### 5.1.4 Data quality

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

### 5.1.5 Meningococcal A Immunisation coverage

Please provide information concerning immunisation coverage related to Meningococcal A vaccine (MenA)

**Table 5.1.5: MenA Immunisation coverage**

| Coverage | 2012 | | 2013 | | 2014 | |
|---|---|---|---|---|---|---|
| | Administrative*(1)* | WUENIC*(2)* | Administrative*(1)* | WUENIC*(2)* | Administrative*(1)* | WUENIC*(2)* |
| **Meningococcal A 1*st* dose (%)** | | | | | | |

| Coverage | 2015 | | 2016 | |
|---|---|---|---|---|
| | Administrative*(1)* | WUENIC*(2)* | Administrative*(1)* | WUENIC*(2)* |
| **Meningococcal A 1*st* dose (%)** | | | | |

| Coverage | 2012 | | 2013 | | 2014 | |
|---|---|---|---|---|---|---|
| | Administrative*(1)* | Coverage survey | Administrative*(1)* | Coverage survey | Administrative*(1)* | Coverage survey |
| **Supplementary** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Immunisation Activities (SIA) (%)** | | | | | | |

| **Coverage** | **2015** | | **2016** | |
|---|---|---|---|---|
| | Administrative*(1)* | Coverage survey | Administrative*(1)* | Coverage survey |
| **Supplementary Immunisation Activities (SIA) (%)** | | | | |

**Note:**

*(1)* National reported Administrative Coverage

*(2)* WHO/UNICEF estimates of national immunization coverage

Was the last Meningococcal A Supplementary Immunization Activities (SIA) administrative coverage or results of a survey of acceptable methodology **Not selected**

## 5.2. Baseline and Annual Targets for Routine Vaccines

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

**Table 5.2**: Baseline NVS routine figures

| Number | Base Year | Baseline and Targets | | |
|---|---|---|---|---|
| | | 2019 | 2020 | 2021 |
| **Total births** | | | | |
| **Total infants' deaths** | | | | |
| **Total surviving infants** | 0 | 0 | 0 | 0 |
| **Total pregnant women** | | | | |
| | | | | |
| **Target population (routine cohort) vaccinated with OPV3*[1]*** | | | | |
| **OPV3 coverage*[2]*** | 0 % | 0 % | 0 % | 0 % |
| | | | | |
| **Target population (routine cohort) vaccinated with DTP1*[1]*** | | | | |
| **Target population (routine cohort) vaccinated with DTP3*[1]*** | | | | |
| **DTP3 coverage*[2]*** | 0 % | 0 % | 0 % | 0 % |
| **Wastage*[3]* rate in base-year and planned thereafter (%) for DTP** | | | | |
| **Wastage*[3]* factor in base-year and planned thereafter for DTP** | 1.00 | 1.00 | 1.00 | 1.00 |
| **Target population (routine cohort) vaccinated with Meningococcal*[1]*** | | | | |
| **Meningococcal A coverage*[2]*** | 0 % | 0 % | 0 % | 0 % |
| **First Presentation: Meningococcal A, 10 dose(s) per vial, LYOPHILISED** | | | | |
| **Wastage*[3]* rate in base-year and planned thereafter (%)** | | | | |
| **Wastage*[3]* factor in base-year and planned thereafter (%)** | 1.00 | 1.00 | 1.00 | 1.00 |
| **Maximum wastage rate value for Meningococcal A, 10 dose(s) per vial, LYOPHILISED** | 50 % | 50 % | 50 % | 50 % |
| | | | | |
| **Target population (routine cohort) vaccinated with 1st dose of MCV** | | | | |
| **MCV coverage*[2]*** | 0 % | 0 % | 0 % | 0 % |
| | | | | |
| **Annual DTP Drop out rate [ ( DTP1 – DTP3 ) / DTP1 ] x 100** | 0 % | 0 % | 0 % | 0 % |

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

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

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

## 5.3. Targets for Preventive Campaign(s)

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

### 5.3.1 Targets (Meningococcal A campaign)

Mini catch-up campaigns will be introduced at the same time as routine EPI. Gavi will support one-time mini catch-up campaigns with Meningococcal A conjugate vaccine targeting cohorts born between the initial mass campaign and introduction of routine infant vaccination in all 26 endemic countries in the African meningitis belt. The exact age range will depend on the specific country epidemiology and situation, although the target number to be reached should be included in table 5.3.1)

Cohort for Meningococcal A via mass preventative campaigns is population 1-29 years old

**Table 5.3.1 Baseline NVS campaign figures for Meningococcal A**

| Number | Targets: preventative mass campaigns |
|---|---|
| | 2019 |
| **Total target population** | 2,808,896 |
| **Wastage rate (%) for Meningococcal A (campaign)** | 10 |
| **Maximum wastage rate value for Meningococcal A (campaign)** | 10 % |

| Number | Targets: mini catch-up campaigns |
|---|---|
| | 2019 |
| **Total target population** | 521,652 |
| **Wastage rate (%) for Meningococcal A (campaign)** | 10 |
| **Maximum wastage rate value for Meningococcal A (campaign)** | 10 % |

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

No One time mini-catchup campaign this year

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

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

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

| Disease | Title of the assessment | Date | Results |
|---|---|---|---|
| Assessment not done | | | |

### 6.2. Requested vaccine (Meningococcal A, 10 dose(s) per vial, LYOPHILISED)

As reported in the cMYP, the country plans to introduce Meningococcal A, using Meningococcal A, 10 dose(s) per vial, LYOPHILISED.

When is the country planning to introduce this vaccine? **November 2019**

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

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

#### 6.2.1. Vaccine Prices

| Vaccine | Presentation | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|
| **Meningococcal A, 10 dose(s) per vial, LYOPHILISED** | 10 | 0.565 | 0.565 | 0.565 | 0.565 | 0.565 |

#### 6.2.2. Co-financing information

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

| **Country group** | Initial self-financing phase |
|---|---|

| | 2019 | 2020 |
|---|---|---|
| **minimum co-financing per dose** | 0.20 | 0.20 |
| **your co-financing per dose (please change if higher)** | 0.20 | 0.20 |

| | 2021 |
|---|---|
| **minimum co-financing per dose** | 0.20 |
| **your co-financing per dose (please change if higher)** | 0.20 |

#### 6.2.2.1.Specifications of vaccinations with new vaccine for routine cohort

| | Source | | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| **Number of children in routine cohort to be vaccinated with the first dose** | Table 5.2 | # | 0 | 0 | 0 |
| **Immunization coverage** | Table 5.2 | % | 0 | 0 | 0 |
| **Country co-financing per dose** | Table 6.2.2 | $ | 0.2 | 0.2 | 0.2 |

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

| | | 2019 | 2020 |
|---|---|---|---|
| **Number of vaccine doses** | # | | |
| **Number of AD syringes** | # | | |
| **Number of re-constitution syringes** | # | 0 | 0 |
| **Number of safety boxes** | # | | |
| **Total value to be co-financed by the Country *[1]*** | $ | 0 | 0 |

*[1]* The co-financing amount for initial self-financing countries indicates costs for the vaccines and any freight charges. The total co-financing amount does not contain the costs and fees of the relevant Procurement Agency, such as contingency buffer and handling fees. Information on these extra costs and fees will be provided by the relevant Procurement Agency as part of the cost estimate to be requested by the Country.

| | | 2021 |
|---|---|---|
| **Number of vaccine doses** | # | |
| **Number of AD syringes** | # | |
| **Number of re-constitution syringes** | # | 0 |
| **Number of safety boxes** | # | |
| **Total value to be co-financed by the Country *[1]*** | $ | 0 |

*[1]* The co-financing amount for initial self-financing countries indicates costs for the vaccines and any freight charges. The total co-financing amount does not contain the costs and fees of the relevant Procurement Agency, such as contingency buffer and handling fees. Information on these extra costs and fees will be provided by the relevant Procurement Agency as part of the cost estimate to be requested by the Country.

### 6.2.4 New and Under-Used Vaccine Introduction Grant

**Calculation of Vaccine Introduction Grant for the Meningococcal A, 10 dose(s) per vial, LYOPHILISED**

| Year of New Vaccine Introduction | Births (from Table 5.2) | Share per Birth in US$ | Total in US$ |
|---|---|---|---|
| | | | |

This is a one-time cash grant of US$0.80/child in a single birth cohort or a lump sum of $100,000 (whichever is higher). It should be noted that for introduction applications submitted from January 2017 onwards and for all Gavi vaccine introductions planned for implementation in 2018 onwards, this grant will be adjusted according to transition stage of the country. Countries in preparatory transition phase (Phase 1) will be provided with $0.70 per targeted person in a single birth cohort, and countries which have entered accelerated transition phase (Phase 2) $0.60 per targeted person in a single birth cohort. For low income countries, the amount will remain at $0.80 per targeted person.

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

The GAVI VIG will be used for providing technical assistance and training of the health workers, conduct supervisory activities, logistic delivery before and during the introduction plan.

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

Detailed budget attached as Document No. 22.

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

According our expreience the GAVI support for VIG is enough

### 6.2.5.Technical assistance

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

The Men A vaccine introduction into RI service will be done in selected districts and can be managed locally. No need to have technical support

# 7. NVS Preventive Campaigns

## 7.1. Assessment of burden of relevant diseases related to campaigns (if available)

| Disease | Title of the assessment | Date | Results |
|---|---|---|---|
| Meningococcal A diseases | Mn A risk assessment | July 2016 | The local expert assessment team has confirmed that no major outbreaks occurred in recent years, but considering the highlighted observation on incompleteness of epidemiological/laboratory data, underreporting and less documented of “sporadic cases” or even “small clusters” particular in Zoba Debud areas bordering to Ethiopia in the past five years they have decided that the country is at risk of the disease and there is a need to carryout wide age range Mn A preventive vaccination campaign. |

Please attach the Plan of Action for each campaign as Document No. 34 in Section 10.

### 7.1.1 Epidemiology and disease burden for Meningococcal A

Please select at least one of the following information sources to justify Meningococcal A disease burden results:

Epidemiological information on burden of disease:

☑ 1 - Risk assessments

☐ 2 - Other

## 7.2.Request for Meningococcal A, 10 dose(s) per vial, LYOPHILISED campaign support

### 7.2.1. Summary for Meningococcal A campaign support

When is the country planning to conduct the Meningococcal A catchup campaign? **April 2019**

When is the country planning to conduct this campaign? **April 2019**

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

Please give a summary of the cMYP and/or the Meningococcal A, 10 dose(s) per vial, LYOPHILISED introduction plan sections that refer to the introduction of Meningococcal A, 10 dose(s) per vial, LYOPHILISED. Outline the key points that informed the decision-making process (data considered etc) and describe the plans for social mobilisation and microplanning, including strategies for insecure or hard-to-reach areas. If they are included in the introduction plan or plan of action, please cite the sections only.

For the successful implementation of the campaign and achieve high immunization coverage of MeN A, the following activities will be implemented:

1. Developing social mobilization materials with key health messages and leaflets containing key information about Men A disease and importance of the catch-up campaign.
2. Training of the EPI focal persons, vaccinators and community health workers on vaccine administration, cold chain management, handling and disposal of injection safety materials during the campaign.
3. Mn A catch-up campaign tools such as: guidelines, tally sheets, summary sheet, and supervision checklist will be prepared at national level and will be distributed to districts based on the target population for the campaign.
4. Pre campaign assessment will made on CCE by zoba solar and electrical technicians to monitor their status and conduct preventive maintenance for the CCE.
5. Storage capacity for vaccines of the solar and electrical refrigerators at service level will be checked by the zonal cold chain focal persons and EPI technicians at sub national level in all health facilities before the campaign dates.
6. Micro planning at national, sub national and district level will be done in a cascade form by involving local administrators, community health agent and local civil society organizations to have contribution in social mobilization activities and supporting the vaccination teams to reach the hard to reach areas with required information and EPI logistics.
7. Mapping of the hard to reach areas by involving the community members of the setting during district microplanning

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain **equipment** and other **logistical** requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. Please describe how the surge capacity for campaigns will be managed. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled. The Independent Review Committee requires assurance that the cold chain is ready or will be ready for the campaign, and evidence/plans need to be provided (if they are included in detail in the plan of action, please cite the section here). **All proposals** that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure equipment pre-qualified by WHO under their Performance Quality and Safety (PQS) program. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi. Please note that all Gavi-financed cold chain equipment needs to be WHO pre-qualified. The purchase of non-PQS equipment will only be considered on exceptional basis, with justification and advance agreement from Gavi.

The country has installed additional one cold room at central vaccine store and zoba Maekel to have additional storage capacity and use it also as a back-up. Currently, there is a net storage capacity of 26,000Lts positive storage at national level and 25,240 capacity at zonal levels. Hence, the country has a total of 51,240Lts net which is estimated to be enough storage capacity to store all vaccine of the routine and including the campaign doses. In accordance with five year plan, the EPI program has renewed efforts to reduce wastage of EPI vaccines since the cost of new vaccines and quantity of the vaccines in the routine program are increasing. The wastage rates among new and traditional vaccines have been developed and will be monitored wastage rates according to the WHO recommended estimates. EPI monitoring tools are also in place. Consumption and wastage of the vaccine will be calculated after the introduction of the new vaccine in a regular base.

The Men A catch-up campaign will carry out in two phases to have adeqaute logistic support for thee campaign and manage the plan appropriately and distribution of the vaccine to sub national level will be in two in order to monitor wastage.

Please describe how the campaign activities will contribute to strengthening routine immunisation services. Please refer to specific activities to be undertaken during planning and implementation, to evaluate the implementation of the routine strengthening activities completed during the campaign, and to assess, via an independent survey, the quality and coverage achieved through the campaign.

In planning and implementation of the campaign will focus on pre, intra and post campaign activities. Using this opportunity the program will focus also to strengthen routine immunization infrastructures and logistics. From previous experiences of EPI programs activities and campaigns lessons learned to synergize immunization through campaign resources will be applied in this campaign. The Men A campaign will be such an opportunity and the following activities:

- In addition to Micro-planning for Men A with Zobas and stake holders awareness and update on routine immunization, the following will be included:
- Immunization performances
- Bottle necks to routine immunization
- Resource mobilization for routine immunization
- Gathering views for best practices
- The training for Men A at central and Zonal level will include RED/REC planning tools orientation and use for action,
- The Men A campaign communication plan will include activities that strengthen routine immunization strategy, Social mobilization and community involvement at all levels
- Use the childimmunization cards and historyto asses child immunization status
- Identifying pockets of children missing out on routine immunization,
- Identifying the characteristics of such children and reasons for missing immunization,
- Identifying the socio-economic characteristics of the un/under immunized
- Identifying and mapping high-risk communities in each district,
- The opportunity of Men A campaign will be used to bridge some gaps identified during the comprehensive EPI and surveillance review 2015/16,
- The campaign will give opportunity for repair and maintenance of the cold chain equipment at health facility level and to identify existing gaps during the pre-campaign assessment & monitoring activities.
- Post Men A campaign evaluation will give opportunity to:
    - Study lessons learnt and implement the actions through routine immunization and other campaigns,
    - Sustain the gains of the campaign lessons

Please submit relevant documentation to support the estimates of the size of the campaign target population (as DOCUMENT NUMBER : 18).

### 7.2.2. Grant Support for Operational Costs of the Meningococcal A Campaign

**Table 7.2.2:** calculation of grant to support the operational costs of the campaigns (mini catch up campaigns and mass campaigns)

| Year of Meningococcal A support | Total target population (from Table 5.5) | Gavi contribution per target person in US$ | Total in US$ |
|---|---|---|---|
| 2019 | 2,808,896 | 0.65 | 1,825,782 |

*[1]* The Grant will be based on a maximum award of $0.65$ per target person- (synergies between mass campaigns, mini catch up campaigns and routine immunisation need to be highlighted. There will be common activities such as training across the new introductions).

Please describe how the grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population (refer to the cMYP and the Vaccine Introduction Plan).

The grant will be used to facilitate the effective implementation of the catch-up campaign by preparing detailed micro plans at national and sub national levels to identify and reach all target population. The grant will be used to provide training to health workers, monitor cold chain status, and conduct assessment before the start of the campaign. The fund will also be used to mobilize the community to participate and utilize the services and to identify hard to reach areas and nomadic population. The grant will also be used to strengthen

surveillance and AEFI, safe disposal of injection safety materials. Please refer to the introduction plan attached**.**

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

The transport cost of the campaign is expensive hence the Government will made fuel subsidy and transport support to cover especially the hard to reach and less accessible geographical areas. Community members and local CSO will give support on transport of camels to carry EPI logistics to less accessible area.

Please complete the 'Detailed budget for VIG / Operational costs' template provided by Gavi and attach as a mandatory document in the Attachment section. VIG/operational costs template should detail or highlight activities for mini catch and comment on synergies across the VIGs).

Detailed budget attached as Document No. 22.

### 7.2.3 Meningococcal A Vaccine introduction Grant

Has a Meningococcal A vaccine already been introduced nationally on a routine basis? **No**

**Calculation of Vaccine Introduction Grant for the Meningococcal A, 10 dose(s) per vial, LYOPHILISED**

Please indicate in the tables below how the one-time Introduction Grant***[1]*** will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP). Gavi's support may not be enough to cover the full needs so please indicate in the table below how much and who will be complementing the funds needed.

| Year of New Vaccine Introduction | Birth cohort (from Table 5.1) | Gavi contribution per target person in US$ | Total in US$ |
|---|---|---|---|
| 2019 | 0 | 0.80 | 0 |

***[1]*** The Grant will be based on a maximum award of $0.80 per person in the birth cohort with a minimum starting grant award of $100,000

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

VIG is not applicable for this preventive campaign.

## 8. NVS Follow-up Campaigns

No NVS Follow-up Campaign Support this year

# 9. Procurement and Management

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

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

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

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

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

c) If receiving direct financial support from Gavi (such as operational support for campaigns or VIG activities), please indicate how the funds should be transferred by Gavi.

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

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

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

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

## 9.2 Procurement and Management for NVS Preventive Campaign(s)

### 9.2.1 Procurement and Management for Meningococcal A, 10 dose(s) per vial, LYOPHILISED campaign

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

In Eritrea, any new vaccine is registered prior to its introduction by the National Food and Drug Administration (NFDA) division of Ministry of Health. Manufacturer registration or national vaccine licensure is not needed as the country procures of vaccine procurement is through UNICEF from WHO prequalified vaccine manufacturers. Hence the country will accepted the expedited procedure for national registration of WHO prequalified vaccines if needed. The Meningococcal A conjugated vaccines is registered and accepted by NFDA of MoH for its introduction and use it in the preventive catch-up campaign. The Men A vaccine of 10 dose lyophilized vaccine will be used for the campaign. The vaccine will be procured through UNICEF Supply Division. Any imported by UNICEF is tax free and custom clearance is facilitated by the Government. There is no means that may cause potential delay in receiving and clearing the vaccine upon its arrival in the country. Moreover, all EPI logistics procured through UNICEF are all tariff free.

b) Please describe the financial management procedures that will be applied for the management of the

preventive campaign cash support, including any procurement to be incurred.

The financial support for campaign on Men A should be transferred to Ministry of health, Project Management Unit (PMU) in the National bank. The banking information is stated in the annex. Budget break down will be prepared by the program manager and will be endorsed by Minister before transferring it to the zobas to implement it according the activity line prepared at national level. Some of the budget will remain at national level for mircoplan and providing ToT for zonal management team. At sub national further budget break down will made based on the activity line hu

c) Please indicate if the campaign is going to be phased, and if so, how this will be done.

The Men A wide age range vaccination campaign will be carried out nationwide targeting 70% of the total population of the country. Based on the projected population size of the country for 2019 from the National Statistics Office (NSO, 2015) is 4,012,708 and people aged 1 to 29 years old will be estimated to be 2,808,896. Based on the geographical distribution of the people and topographical condition of the country, the campaign is planned to carry out in two phases with a two months difference in between.

The two phased plan are: Phase 1 of the campaign will be targeting 3 Zobas: Anseba, Debub and Gash-Barka; (a total population 2,678,549) with a target population of 1,874,984. Phase 2 is targeting the remaining 3 Zones: Maekel, Northern Red Sea and Southern Red Sea; (total population 1,334,159) with a target population of 933,911. GAVI contribution per target person for operational activities is US$ 0.65 and will be estimated to be US$ 1,825,782 for operational and the vaccine cost US$ 1,131,985 and AD syringe and safety boxes (US$ 229,754 + US$ 48,567). Total cost for the campaign will be US$ 3,236, 088 (1,825,782 for operational and 1,410,306 for vaccine and injection safety materials). To conduct the meningococcal vaccination campaign, the country is requesting support from GAVI for vaccines, syringes, safety boxes and operational cost of US$ 3,236,088 for nationwide campaign, targeting all people aged 1 to 29 years old. The campaign will be done in two phases a two months apart, to ensure quality campaign with careful management of logistics and programmatic issues, as well as sound full communication and advocacy activities by conducting monitoring and evaluation of the current status of the activities. The two-phase campaign is proposed to be conducted in the first Quarter of 2019- till the second Quarter of 2019.

d) Please outline how coverage of the campaign including mini catch up campaigns will be monitored, reported and evaluated (refer to the cMYP and/or the Meningococcal A, 10 dose(s) per vial, LYOPHILISED campaign introduction plan)

A detailed bottom-up planning process will be conducted at local level and will be aggregated at national level. The micro planning will determine the human, material and financial resource required to reach all target age group as well as the appropriate strategies will be employed to reach population residing in the hard to reach areas. Furthermore, the sites in these areas will be mapped and a detailed sub-zoba work plan will developed and will be elaborated during the micro-planning process. Best practice and lessons learnt from the micro-planning and operational activities of MR catch-up campaign will be utilized and incorporated for the meningitis campaign. Such lessons include conducting the micro-planning processes will in advance at least 8 weeks prior to the date of vaccination, allocating adequate resources according to the micro-plans rather than on an ad hoc basis to impress upon the importance of the micro-planning. Best strategies will be identified to support the campaign process and implementation plan at least 3 months prior to the campaign dates.

At national level planning will be coordinated through the ICC members, the campaigns will be used to consolidate the planning process that include the following key activities to be addressed:

- Review and update the training, reporting and mentoring tools for the campaign,
- Participation of other line ministries and Civil Society Organizations (CSOs) who are stake holders i.e. Ministry of Education, National Union of Eritrean Youth and Students andYouth (NUEYS)and Women Association(NUEW) to participate in planning process and implementation of the operational activities of the campaign,
- Include all health facilities in the planning process,
- Conduct mapping of vaccination sites and choosing appropriate strategiesin regard to geographical settings and barriers,
- Plan for outreach sites and less accessible areas,
- Compile the micro plans of zoba and sub zobas into a comprehensive budget plan at national level.

Micro planning is being used, especially with respect to the target populations, logistics, and strategies for

social mobilization activities plan. Micro planning, training, orientation and implementation of social mobilization activities will be mainly the responsibility of the zones with technical guidance and logistical support from the national level. The zonal medical officers will set-up multi-sectorial committees for planning and implementing activities at zonal and sub zonal levels. The sub zonal education officers and school inspectors/head masters, other heads of institutions will be involved and will be participate in every committee of the sub-zone to address the target population for the campaign.

## 9.3 Product Licensure

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

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

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

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

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

## 9.4 Waste management

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

## 9.5 Procurement and Management for Follow up Campaign(s)

No NVS Follow-up Campaign Support this year

## 10. List of documents attached to this proposal

**Table 1**: Checklist of mandatory attachments

| Document Number | Document | Section | File |
|---|---|---|---|
| **Endorsements** | | | |
| 1 | MoH Signature (or delegated authority) of Proposal | 4.1.1 | Signatrue of Minister of Health Men A App.pdf<br>**File desc:**<br>**Date/time :** 07/09/2017 05:17:54<br>**Size:** 395 KB |
| 2 | MoF Signature (or delegated authority) of Proposal | 4.1.1 | 001.jpg<br>**File desc:**<br>**Date/time :** 08/09/2017 03:09:20<br>**Size:** 927 KB |
| 4 | Terms of Reference for the Coordination Forum (ICC/HSCC or equivalent) including all sections outlined in Section 5.2 of the General Application Guidelines (Note: countries applying before May 2017 can submit their existing Terms of Reference) | 4.1.2 | ERI ICC ToR_Final.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 04:41:17<br>**Size:** 173 KB |
| 5 | Minutes of Coordination Forum meeting endorsing Proposal | 4.1.3 | ICC meeting minutes endorsing Men A proposal.pdf<br>**File desc:**<br>**Date/time :** 07/09/2017 05:19:16<br>**Size:** 218 KB |
| 6 | Signatures of Coordination Forum members in Proposal | 4.1.3 | 001.jpg<br>**File desc:**<br>**Date/time :** 07/09/2017 05:26:36<br>**Size:** 688 KB |
| 7 | Minutes of the Coordination Forum meetings from the past 12 months before the proposal | 4.1.3 | ICC_Meeting of Previous 2.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 06:01:30<br>**Size:** 729 KB |
| 8 | Role and functioning of the advisory group, description of plans to establish a NITAG | 4.2.1 | ERI NITAG ToR Final.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 04:48:59<br>**Size:** 186 KB |
| 26 | List of areas/districts/regions and targets to be supported for meningitis A mini catch up campaigns | | Mini-Catch-up Campaign.docx<br>**File desc:**<br>**Date/time :** 07/09/2017 06:06:44<br>**Size:** 10 KB |
| 31 | Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign | 4.2 | National Immunization Technical Advisory Group H.docx<br>**File desc:**<br>**Date/time :** 07/09/2017 05:30:20<br>**Size:** 10 KB |
| **Planning, financing and vaccine management** | | | |

| | | | |
|---|---|---|---|
| 9 | Comprehensive Multi Year Plan - cMYP | 5.1 | ERI cMYP 2017-2021.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 04:46:54<br>**Size:** 1 MB |
| 10 | cMYP Costing tool for financial analysis | 5.1 | Eritrea Nov 23 cMYP_Costing_Tool_V3.9.3.xlsx<br>**File desc:**<br>**Date/time :** 05/09/2017 04:52:14<br>**Size:** 3 MB |
| 11 | M&E and surveillance plan within the country's existing monitoring plan | 5.1.4 | M & E plan 2017-2021.pdf<br>**File desc:**<br>**Date/time :** 13/10/2017 01:59:14<br>**Size:** 1 MB |
| 12 | New vaccine introduction plan (NVIP), New Vaccine Introduction Checklist and Activity List & Timeline for routine vaccines or Plan of Action (PoA) for campaign vaccines | 5.1,7.2.3 | Eritrea Men A Catch up Campain Proposal & WP Aug. 2017.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 05:39:13<br>**Size:** 1 MB |
| 18 | Campaign target population documentation | 8.x.1, 6.x.1 | Eritrea -Population Size_Projection 2000-2022.xlsx<br>**File desc:**<br>**Date/time :** 05/09/2017 05:05:36<br>**Size:** 314 KB |
| 19 | EVM report | 9.3 | ERI National Vaccine Store_EVMA March 2017.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 04:55:03<br>**Size:** 1 MB |
| 20 | Improvement plan based on EVM | 9.3 | EVMA Improvement Plan 2012.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 05:35:13<br>**Size:** 185 KB |
| 21 | EVM improvement plan progress report | 9.3 | EVMA 2012 Recommondations Implementation Status Proogress March 2017.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 05:13:46<br>**Size:** 132 KB |
| 22 | Detailed budget template for VIG / Operational Costs | 6.x,7.x.2,6.x.2,8.2.3 | ERI_ Budgeting & Planning Template Men A Preventive Campaign.xlsm<br>**File desc:**<br>**Date/time :** 13/10/2017 01:52:08<br>**Size:** 1 MB |
| 32 | Data quality assessment (DQA) report | 5.1.4 | EPI Data Qulaity assessment & Desk Review August 2017.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 08:23:47<br>**Size:** 946 KB |
| 34 | Plan of Action for campaigns | 8.1, 8.x.4 | Eritrea Men A Catch up Campain Plan of Action.doc<br>**File desc:**<br>**Date/time :** 05/09/2017 08:32:52<br>**Size:** 178 KB |

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|---|---|---|---|
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**Table 2**: Checklist of optional attachments

| Document Number | Document | Section | File |
|---|---|---|---|
| 3 | MoE signature (or delegated authority) of HPV Proposal | 4.1.1 | No file loaded |
| 14 | Annual EPI Plan with 4 year forward view for measles and rubella | | EPI 5 Years Work_Plan Updated.pdf<br>**File desc:**<br>**Date/time :** 07/09/2017 05:59:41<br>**Size:** 384 KB |
| 15 | HPV Region/ Province profile | 6.1.1 | No file loaded |
| 16 | HPV Key Stakeholder Roles and Responsibilities | 6.1.1,6.1.2 | No file loaded |
| 17 | Evidence of commitment to fund purchase of RCV (in place of the first dose of MCV) / for use in the routine system | 5.1.6, 6.1.7 | Gov. Commitment.docx<br>**File desc:**<br>**Date/time :** 07/09/2017 03:28:33<br>**Size:** 144 KB |
| 24 | Risk assessment and consensus meeting report for Yellow Fever, including information required Section 5.3.2 in the General Guidelines on YF Risk Assessment process | 5.1 | No file loaded |
| 25 | Post Introduction Evaluation report from any recent NVS introduction | 5.1 | Eritreia EPI Review Report July 2016 v3.pdf<br>**File desc:**<br>**Date/time :** 07/09/2017 06:23:16<br>**Size:** 1 MB |
| 27 | National Measles (& Rubella) elimination plan if available | | No file loaded |
| 28 | A description of partner participation in preparing the application | 4.1.3 | No file loaded |
| 30 | For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, ICC minutes committing to finance from 2018 onwards. | | No file loaded |

| | | | |
|---|---|---|---|
| 33 | DQA improvement plan | 5.1.4 | EPI Data Qulaity Assessment & Improvemen Plan.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 08:37:09<br>**Size:** 946 KB |
| 35 | Other | | M & E plan 2017-2021.pdf<br>**File desc:**<br>**Date/time :** 13/10/2017 09:26:54<br>**Size:** 1 MB<br><br>Eritrea_ Meningitis Risk Assessment REPORT 2016_draft_v2_16Aug.pdf<br>**File desc:**<br>**Date/time :** 13/10/2017 09:33:00<br>**Size:** 1 MB |
| 36 | Strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control | | No file loaded |
| 37 | Evidence of self-financing MCV1 | 5.1.5 | Gov. Commitment.docx<br>**File desc:**<br>**Date/time :** 07/09/2017 03:30:36<br>**Size:** 144 KB |
| 38 | For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, a signed letter from the Minister of Health and the Minister of Finance committing to finance from 2018 onwards. | | No file loaded |
| 39 | Epidemiological analysis/evidence | 8.3.1 | Eritreia EPI Review Report July 2016 v3.pdf<br>**File desc:**<br>**Date/time :** 05/09/2017 12:05:17<br>**Size:** 1 MB |
| 40 | Post Campaign Coverage Survey report for MR catch-up applications | 5.1.x | No file loaded |
| 41 | cMYP addendum on measles and rubella | | No file loaded |
| 42 | Offline cofinancing calculator for this campaign | 5.5, 8.2.3 | No file loaded |

# 11. Annexes

## Annex 1 - NVS Routine Support

## Annex 1.1 Meningococcal A, 10 dose(s) per vial, LYOPHILISED

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

| | | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Number of vaccine doses** | # | | | |
| **Number of AD syringes** | # | | | |
| **Number of re-constitution syringes** | # | 0 | 0 | 0 |
| **Number of safety boxes** | # | | | |
| **Total value to be co-financed by the Country *[1]*** | $ | 0 | 0 | 0 |

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

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

| | | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Number of vaccine doses** | # | 0 | 0 | 0 |
| **Number of AD syringes** | # | 0 | 0 | 0 |
| **Number of re-constitution syringes** | # | 0 | 0 | 0 |
| **Number of safety boxes** | # | 0 | 0 | 0 |
| **Total value to be co-financed by Gavi** | $ | 0 | 0 | 0 |

## Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 1)

| | | Formula | 2019 | | |
|---|---|---|---|---|---|
| | | | Total | Government | Gavi |
| A | Country co-finance | *V* | 0.00 % | | |
| B | Number of children to be vaccinated with the first dose | *Table 5.2* | 0 | 0 | 0 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 1 | | |
| D | Number of doses needed | *B x C* | 0 | 0 | 0 |
| E | Estimated vaccine wastage factor | *Table 5.2* | 1 | | |
| F | Number of doses needed including wastage | *D x E* | 0 | 0 | 0 |
| G | Vaccines buffer stock | *Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]* | 0 | 0 | 0 |
| I | Total vaccine doses needed | *Round up((F + G) / Vaccine package size) * Vaccine package size* | 0 | 0 | 0 |
| J | Number of doses per vial | *Vaccine parameter* | 10 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G) x 1.10* | 0 | 0 | 0 |
| L | Reconstitution syringes (+ 10% wastage) needed | *(I / J) x 1.10* | 0 | 0 | 0 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) / 100 x 1.10* | 0 | 0 | 0 |
| N | Cost of vaccines needed | *I x vaccine price per dose (g)* | 0 | 0 | 0 |
| O | Cost of AD syringes needed | *K x AD syringe price per unit (ca)* | 0 | 0 | 0 |
| P | Cost of reconstitution syringes needed | *L x reconstitution price per unit (cr)* | 0 | 0 | 0 |
| Q | Cost of safety boxes needed | *M x safety box price per unit (cs)* | 0 | 0 | 0 |
| R | Freight cost for vaccines needed | *N x freight cost as of % of vaccines value (fv)* | 0 | 0 | 0 |
| S | Freight cost for devices needed | *(O+P+Q) x freight cost as % of devices value (fd)* | 0 | 0 | 0 |
| T | Total fund needed | *(N+O+P+Q+R+S)* | 0 | 0 | 0 |
| U | Total country co-financing | *I x country co-financing per dose (cc)* | 0 | | |
| V | Country co-financing % of Gavi supported proportion | *U / (N + R)* | 0.00 % | | |

## Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 2)

| | | Formula | 2020 | | |
|---|---|---|---|---|---|
| | | | Total | Government | Gavi |
| A | Country co-finance | *V* | 0.00 % | | |
| B | Number of children to be vaccinated with the first dose | *Table 5.2* | 0 | 0 | 0 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 1 | | |
| D | Number of doses needed | *B x C* | 0 | 0 | 0 |
| E | Estimated vaccine wastage factor | *Table 5.2* | 1 | | |
| F | Number of doses needed including wastage | *D x E* | 0 | 0 | 0 |
| G | Vaccines buffer stock | *Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]* | 0 | 0 | 0 |
| I | Total vaccine doses needed | *Round up((F + G) / Vaccine package size) * Vaccine package size* | 0 | 0 | 0 |
| J | Number of doses per vial | *Vaccine parameter* | 10 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G) x 1.10* | 0 | 0 | 0 |
| L | Reconstitution syringes (+ 10% wastage) needed | *(I / J) x 1.10* | 0 | 0 | 0 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) / 100 x 1.10* | 0 | 0 | 0 |
| N | Cost of vaccines needed | *I x vaccine price per dose (g)* | 0 | 0 | 0 |
| O | Cost of AD syringes needed | *K x AD syringe price per unit (ca)* | 0 | 0 | 0 |
| P | Cost of reconstitution syringes needed | *L x reconstitution price per unit (cr)* | 0 | 0 | 0 |
| Q | Cost of safety boxes needed | *M x safety box price per unit (cs)* | 0 | 0 | 0 |
| R | Freight cost for vaccines needed | *N x freight cost as of % of vaccines value (fv)* | 0 | 0 | 0 |
| S | Freight cost for devices needed | *(O+P+Q) x freight cost as % of devices value (fd)* | 0 | 0 | 0 |
| T | Total fund needed | *(N+O+P+Q+R+S)* | 0 | 0 | 0 |
| U | Total country co-financing | *I x country co-financing per dose (cc)* | 0 | | |
| V | Country co-financing % of Gavi supported proportion | *U / (N + R)* | 0.00 % | | |

## Table Annex 1.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 3)

| | | Formula | 2021 | | |
|---|---|---|---|---|---|
| | | | Total | Government | Gavi |
| A | Country co-finance | *V* | 0.00 % | | |
| B | Number of children to be vaccinated with the first dose | *Table 5.2* | 0 | 0 | 0 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 1 | | |
| D | Number of doses needed | *B x C* | 0 | 0 | 0 |
| E | Estimated vaccine wastage factor | *Table 5.2* | 1 | | |
| F | Number of doses needed including wastage | *D x E* | 0 | 0 | 0 |
| G | Vaccines buffer stock | *Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]* | 0 | 0 | 0 |
| I | Total vaccine doses needed | *Round up((F + G) / Vaccine package size) * Vaccine package size* | 0 | 0 | 0 |
| J | Number of doses per vial | *Vaccine parameter* | 10 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G) x 1.10* | 0 | 0 | 0 |
| L | Reconstitution syringes (+ 10% wastage) needed | *(I / J) x 1.10* | 0 | 0 | 0 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) / 100 x 1.10* | 0 | 0 | 0 |
| N | Cost of vaccines needed | *I x vaccine price per dose (g)* | 0 | 0 | 0 |
| O | Cost of AD syringes needed | *K x AD syringe price per unit (ca)* | 0 | 0 | 0 |
| P | Cost of reconstitution syringes needed | *L x reconstitution price per unit (cr)* | 0 | 0 | 0 |
| Q | Cost of safety boxes needed | *M x safety box price per unit (cs)* | 0 | 0 | 0 |
| R | Freight cost for vaccines needed | *N x freight cost as of % of vaccines value (fv)* | 0 | 0 | 0 |
| S | Freight cost for devices needed | *(O+P+Q) x freight cost as % of devices value (fd)* | 0 | 0 | 0 |
| T | Total fund needed | *(N+O+P+Q+R+S)* | 0 | 0 | 0 |
| U | Total country co-financing | *I x country co-financing per dose (cc)* | 0 | | |
| V | Country co-financing % of Gavi supported proportion | *U / (N + R)* | 0.00 % | | |

## Annex 2 - NVS Routine – Preferred Second Presentation

No NVS Routine – Preferred Second Presentation requested this year

## Annex 3 - NVS Preventive campaign(s)

## Annex 3.1 - NVS Preventive campaign(s) (Meningococcal A, 10 dose(s) per vial, LYOPHILISED)

### Table Annex 3.1 C: Summary table for CAMPAIGN Meningococcal A, 10 dose(s) per vial, LYOPHILISED

| | Source | | 2019 |
|---|---|---|---|
| **Total target population** | Table 5.2 | # | 2,808,896 |
| **Number of doses per persons** | Parameter | # | 1 |
| **Estimated vaccine wastage factor** | Table 5.2 | # | 1.11 |
| **Wastage Rate** | Table 6.2.2 | # | 10 |
| **Number of doses per vial** | Parameter | # | 10 |
| **AD syringes required** | Parameter | # | Yes |
| **Reconstitution syringes required** | Parameter | # | Yes |

| | | | |
|---|---|---|---|
| **Safety boxes required** | Parameter | # | No |
| **AD syringe price per unit** | Table Annexes 4A | $ | 0.036 |
| **Reconstitution syringe price per unit** | Table Annexes 4A | $ | 0.031 |
| **Safety box price per unit** | Table Annexes 4A | $ | 0.461 |
| **Freight cost as % of vaccines value** | Table Annexes 4B | % | 3.36% |
| **Freight cost as % of devices value** | Parameter | % | 10.00% |

## Table Annex 3.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 1)

| | | Formula | 2019 | | |
|---|---|---|---|---|---|
| | | | Total | Government | Gavi |
| B | Total target population | *Table 5.3.1* | 2,808,896 | 0 | 2,808,896 |
| C | Number of doses per persons | *Vaccine parameter (schedule)* | 1 | | |
| D | Number of doses needed | *B x C* | 2,808,896 | 0 | 2,808,896 |
| E | Estimated vaccine wastage factor | *100 / (100 - Vaccine wastage rate)* | 1.11 | | |
| F | Number of doses needed including wastage | *D x E* | 3,117,875 | 0 | 3,117,875 |
| G | Vaccines buffer stock | *0* | 0 | 0 | 0 |
| I | Total vaccine doses needed | *Round up((F + G) / Vaccine package size) * Vaccine package size* | 3,118,000 | 0 | 3,118,000 |
| J | Number of doses per vial | *Vaccine parameter* | 10 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G) x 1.10* | 3,089,786 | 0 | 3,089,786 |
| L | Reconstitution syringes (+ 10% wastage) needed | *(I / J) x 1.10* | 342,980 | 0 | 342,980 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) / 100 x 1.10* | 0 | 0 | 0 |
| N | Cost of vaccines needed | *I x vaccine price per dose (g)* | 1,761,670 | 0 | 1,761,670 |
| O | Cost of AD syringes needed | *K x AD syringe price per unit (ca)* | 111,233 | 0 | 111,233 |
| P | Cost of reconstitution syringes needed | *L x reconstitution price per unit (cr)* | 10,519 | 0 | 10,519 |
| Q | Cost of safety boxes needed | *M x safety box price per unit (cs)* | 0 | 0 | 0 |
| R | Freight cost for vaccines needed | *N x freight cost as of % of vaccines value (fv)* | 59,243 | 0 | 59,243 |
| S | Freight cost for devices needed | *(O+P+Q) x freight cost as % of devices value (fd)* | 12,176 | 0 | 12,176 |
| T | Total fund needed | *(N+O+P+Q+R+S)* | 1,954,841 | 0 | 1,954,841 |

**Note:** There is no co-financing for NVS preventive campaigns

## Annex 4

### Table Annex 4A:Commodities costs

Estimated prices of supply are not disclosed

| Vaccine | Presentation | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| **Meningococcal A, 10 dose(s) per vial, LYOPHILISED** | 10 | 0.565 | 0.565 | 0.565 | 0.565 |

| Supply | Form | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| **RECONSTIT-SYRINGE-YF** | SYRINGE | 0.031 | 0.031 | 0.031 | 0.031 |

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

### Table Annex 4B: Freight cost as percentage of value

| Vaccine Antigen | Vaccine Type | 2019 | 2020 |
|---|---|---|---|
| Meningococcal A, 10 dose(s) per vial, LYOPHILISED | MENINACONJUGATE | 3.36 % | 3.36 % |

| Vaccine Antigen | Vaccine Type | 2021 |
|---|---|---|
| Meningococcal A, 10 dose(s) per vial, LYOPHILISED | MENINACONJUGATE | 3.36 % |

### Table Annex 4C: Initial self-financing phase - Minimum country co-payment per dose of co-financed vaccine

| Vaccine | 2019 | 2020 |
|---|---|---|
| **Meningococcal A, 10 dose(s) per vial, LYOPHILISED** | 0.2 | 0.2 |

| Vaccine | 2021 |
|---|---|
| **Meningococcal A, 10 dose(s) per vial, LYOPHILISED** | 0.2 |

## 12. Banking Form

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

| | |
|---|---|
| **Name of Institution (Account Holder):** | Project Management Unit (PMU) |
| **Address:** | Denden Street # 174 Asmara, Eritrea |
| **City Country:** | Asmara, Eritrea |
| **Telephone no.:** | 291-1-199 |
| **Fax no.:** | 291-1-124357 |
| **Currency of the bank account:** | USD |
| **For credit to:** | |
| **Bank account's title:** | PMU/MoH GAVI HSS (c) |
| **Bank account no.:** | 1201220162 |
| **Bank's name:** | Bank of Eritrea |

Is the bank account exclusively to be used by this program? Yes

By who is the account audited? General audit of Eritrea

Signature of Government's authorizing official

| | | Seal |
|---|---|---|
| **Name:** | Amina Nurhussien | |
| **Title:** | Minister of Health | |
| **Signature:** | | |
| **Date:** | 9/5/2017 | |

| FINANCIAL INSTITUTION | | CORRESPONDENT BANK (In the United States) |
|---|---|---|
| **Bank Name:** | Bank of Eritrea | GAZPROM BANK (OPEN JOINT STOCK COMPANY |
| **Branch Name:** | ---- | -- |
| **Address:** | ____ | --- |
| **City Country:** | Asmara, Eritrea | MOSCOW, RUSSIA |
| **Swift Code:** | S.W.I.F.T. BoERERAI | GAZPRUMMXXX |
| **Sort Code:** | ---- | --- |
| **ABA No.:** | --- | ---- |
| **Telephone No.:** | 00291 1 127948 | ---- |
| **FAX No.:** | 00291 122091/98 | ---- |

I certify that the account No 1201220162 is held by Bank of Eritrea at this banking institution

The account is to be signed jointly by at least 3 (number of signatories) of the following authorized signatories:

| | | |
|---|---|---|
| **1** | | |
| | **Name:** | Mr. Yemane Teadel |
| | **Title:** | Director General of Finance and Administration |
| **2** | | |
| | **Name:** | Mr. Tsehaye Tesgay |
| | **Title:** | Administration and Finance Head |
| **3** | | |
| | **Name:** | Dr. Eyob Tekle |
| | **Title:** | Project director |

| | |
|---|---|
| **Name of bank's authorizing official** | |
| Zere Seyoum | |
| **Signature:** | |
| | |
| **Date:** | 9/5/2017 |
| **Seal:** | |
| | |