APPLICATION FORM FOR COUNTRY PROPOSALS

to obtain support for:

Conjugated meningococcal A vaccine

Submitted by the Government of

BENIN

Reviewed in February 2011

For the 2011 application submission session

Please send this electronic application along with its attachments (including the signature page) to the following address: proposals@gavialliance.org

Information from: proposals@gavialliance.org or from the representatives of a GAVI partner agency. The proposal and annexes must be presented in English or French.

Please be sure the GAVI Secretariat receives the application before or at the latest on the deadline date.

The GAVI Secretariat is unable to return documents and items which may have been sent to it to individual countries. Unless otherwise specified, documents may be shared with the GAVI partners or the public.

Acronyms

ADIP	Accelerated Development and Introduction Plans
NRA	Autorité Nationale de Réglementation [National Regulatory Authority]
BCG	Calmette-Guérin Bacillus
ICC	Interagency Coordination Committee
HSCC	Health Sector Coordination Committee
IEC	Independent Exam Committee
DQA	Data Quality Audit for Vaccination Data
3rd	Diphtheria-Tetanus-Pertussis, Third Dose
JRF	WHO/UNICEF Joint Report Form on Disease Prevention on vaccination-preventable diseases
ICG	International Coordination Group
Hep B	Hepatitis B vaccine
Hib	*Haemophilus influenzae* type b
MF	Ministry of Finance
MH	Ministry of Health
MDG	Millennium Development Goals
WHO	World Health Organization
UN	United Nations
CSO	Civil Society Organization
EPI	Expanded Program on Immunization
Phase 1	Phase 1 of GAVI Alliance support (2000-2005)
Phase 2	Phase 2 of GAVI Alliance support (2006-2010)
GDP	Gross Domestic Product
LDC	UN list of Least Developed Countries
cMYP	Complete Multiyear Plan for Vaccination
GNR	Gross National Revenue
APR	Annual Progress Report
ALS	Auto-disable (AD) syringes
SAGE	Strategic Advisory Group of Experts from WHO
NVS	New and Underused Vaccine Support
ISS	Injection Safety Support
VSS	Vaccination Services Support
SWAp	Sector Wide Approach Strategy
TT	Tetanus toxoid
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

Table of Contents

1. Executive Summary

Benin is part of the African meningitis belt. Therefore, it is often subject to meningitis epidemics, in particular in the northern part of the country. Serogroup A meningitis is the most common strain found in these epidemic flare-ups.

As stated in the revised cMYP for 2009-2013, the government of Benin plans to organize a mass vaccination campaign to prevent these devastating meningococcal meningitis A epidemics. This will occur during the fourth quarter of 2012 in the five departments in Benin that are part of the meningitis belt (Atacora, Donga, Borgou, Alibori, Collines). To this end, Benin is submitting this request to the GAVI Secretariat. The Ministry of Health coordinated its preparation by a national Technical committee with support from various partners (WHO and UNICEF). It was approved by the Inter-Agency Coordinating Committee on April 28, 2011.

This vaccination campaign is aimed at eliminating serogroup A meningitis epidemics in Benin. It is part of the WHO's recommended strategies in the African region, specifically case-based surveillance, the inclusion of the vaccine in the routine EPI, catch-up vaccination campaigns and tracking and management of cases caused by other germs.

Benin has benefited from the GAVI fund's support to improve injection safety since 2002, and to include new vaccines into the routine EPI: The Viral Hepatitis B vaccine in 2002, Hib infection vaccination in 2005 in pentavalent form (DTP HepB Hib) and improvement of vaccination services since 2009.

In the context of vaccine management at the central level, Benin has four (4) cold rooms including three positive cold rooms with a net total capacity of 15,000 liters and one negative cold room with a net capacity of 5,000 liters. Each of these rooms has two refrigerant groups and four freezers and refrigerators (3 TCW 1152 and 1 TFW 800) with a net total capacity of 752 liters. These are used particularly for freezing the ice packs.

Two emergency electric generators, with automatic starting systems, will ensure the operation of the cold chain in the case of a power outage. The cold rooms have continuous temperature loggers and a reliable alarm system in the event of a power

outage. This capacity is sufficient for storage of routine vaccines and those that will be purchased in the context of the meningitis prevention campaign.

In the context of waste management, the safety boxes filled with used syringes will be collected and supervisors will take them to the closest health facilities that have incinerators. There are two types of incinerators available : De Monfort incinerators and incinerators manufactured by the DHAB (Direction de l'Hygiène et de l'Assainissement de Base). All sharps boxes will be destroyed by incineration at health centers that have incinerators.

Benin has acquired extensive experience through prior vaccination campaigns, and has learned a great deal about the introduction of new vaccines. Benin plans to implement many strategies in order to achieve success. Specifically:

- Improved coordination at all levels (National, departmental, municipal and local);
- An improved micro-planning process at the decentralized level in order to better define roles and responsibilities and to provide improved assessment of resources;
- Improved communication/social mobilization, especially in terms of locally-based communications with the involvement of local leaders;
- Improved employee skills at all levels, through training related to the various components of the vaccination campaigns;
- Effective tracking of vaccines and input items during the entire campaign;
- Reliable management of vaccine stocks and monitoring of their use
- Strict application of injection safety and waste management
- Improved pharmaco-vigilance, specifically in terms of post-vaccination adverse events (PVAEs) and how to properly manage them;
- Improved supervision, tracking and evaluation;
- Improved case-by-case monitoring, taking experiences with measles, yellow fever and polio into account and using knowledge gained from the first countries to introduce MenAfriVac. In order to achieve this, guides and tools for case-by-case monitoring will be revised. Health and laboratory agents will benefit from trickle-down training. Reagents and laboratory equipment will be

purchased. A state-of-the art system for transporting samples from health centers to laboratories will be implemented.

The projected target population is 2,640,459 people between 1 and 29 years of age. The total required quantity of vaccines is 3,115,741 doses. The campaign will consist of one phase in November, 2012.

The plan's overall total cost is US $4,047,779, or US $1.30 per person vaccinated and the operational cost (including investment) is US $2,004,201, or US $0.64 per person vaccinated (the unit cost of the vaccine plus injection materials is estimated at US $0.67).

2. Signatures of the Government and National Coordinating Bodies

Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of Benin would like to expand the existing partnership with the GAVI Alliance for the improvement of the infants' routine immunisation programme of the country, and specifically hereby requests for GAVI support for the conjugate meningococcus A vaccine.

The government of Benin is committed to developing national vaccination services on a sustainable basis, in accordance with the cMYP submitted together with the introduction plan for the meningitis A vaccine. The government requests that GAVI Alliance and its partners provide financial and technical assistance to support the vaccination program as described in this proposal.

Table N° xx of page xx of this application shows the amount of support in either supply or cash that is requested from the GAVI Alliance. Table no. ….. on page ….. of this proposal presents the government's financial commitment to operational costs for vaccination campaigns.

Please note that this application will not be examined or approved by the Independent Review Committee without the signatures of the Minister of Health and the Minister of Finances or their delegated authority.

Directrice de Cabinet du Ministère de la Santé :

Signature : .....

Nom : Dorothée YEVIDE

Date : 11/05/2011

Directrice de Cabinet du Ministère des Finances :

Signature : .....

Nom : Adidjatou MATHYS

Date : 12/05/2011

National Coordinating Body: Inter-Agency Coordinating Committee for Vaccination

We undersigned, members of the ICC/HSCC, met April 28, 2011 to examine this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

- The endorsed minutes of this meeting are attached as Document Number: 3

Nom/Titre	Institution/Organisme	Signature	Date
BOLI I JOSE	OMS		28/04/11
HOUETO DAVID	AMP		28/04/11
Joséphine ABALO	Fondation PEV		28/04/11
AKAKPO Emmanuel	MPDEPP-CAG		27/04/11
MIRCHANDANI ASHOK	CPPN - ROTARY INTL		03/05/2011
MILTON AMAYUN	USAID		5/09/2011
Dr ACLO Soulaymane Representant	UNICEF		10/05/2011

In case the GAVI Secretariat has queries on this submission, please contact:

Name: Laurent Assogba Title: National Director of Public health (NDPH)

Tel No.: (00229) 21336679/95454966 Address: 01 BP 882 Cotonou

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Inter-Agency Coordinating Committee for Vaccination

Agencies and partners (including development partners and CSOs) supporting immunization services are coordinated and organized through an inter-agency coordinating mechanism (ICC/HSCC). The ICC/HSCC are responsible for coordinating and guiding the use of the GAVI ISS and NVS support. Please provide information about the ICC/HSCC in your country in the spaces below.

Profile of the ICC/HSCC

Name of the ICC/HSCC: ..... Inter-Agency Coordinating Committee for the EPI (ICC-EPI)

Date of constitution of the current ICC/HSCC:..... 2005

Structure (for example subcommittee, autonomous body): Stand-alone body

Frequency of meetings: Quarterly

Composition:

Post	Title / Organization	Name
Chair	Minister of Health	Issifou Takpara
Secretary	NDEPI/PHC	Marie Rose Nago
Members	• President, Polio Plus Commission, Rotary International • USAID Representative • European Union Representative • Representative, Belgian Development Agency • Representative, Swiss Development Agency • APM Representative • President, Benin EPI Foundation • EPI Focal Point for the Ministry of Finance and Economy • EPI Focal Point for the Ministry of Planning • Director for Planning and Outlook of the Ministry of Health • Director of Financial Resources and Supplies of the Ministry of Health • Representative of the WHO • Representative of UNICEF	• Ashock Mirchandani • Simplice Takoubo • Thierry Soyez • • • Aristide Aplogan • Joséphine Aballo • Isaïe Zekpa • Françoise Allodjogbe • Pascal Kora Bata • Béatrice Radji • Raphaël Akpa Gbary • Souleymane Diallo

Major functions and responsibilities of the ICC/HSCC:

The ICC-EPI is responsible for:

-Helping to set the policy direction of the EPI;

- Supporting the preparation of EPI strategic and annual plans

-Mobilising the national and international resources required to implement the programmes developed

-Monitoring programme implementation;

-Making periodic inspections of programme activity

-Ensuring that maximum use is made of the resources mobilised

-Supporting the NDEPI/PHC in organizing periodic programme reviews

Three major strategies to enhance the ICC/HSCC's role and functions in the next 12 months:

1. Drafting a work plan for all the structures of the ICC-EPI (meeting timeline).
2. More assertive support and involvement from partners in managing the EPI (in accordance with the recommendations from the most recent internal review of the 2008 EPI and the conclusions of the IACC meetings).
3. Advocating for donor (including GAVI) resources to be allocated to the EPI.

3. Data Regarding the Vaccination Program

Please complete the tables below, using data from available sources. Please identify the source of the data, and the date. Where possible use the most recent data, and attach the source document.

- Please refer to the cMYP and the meningitis A vaccine introduction plan. Please attach a complete copy (with an executive summary) as document number……
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.

Table 3.1: Basic facts for the year 2009... (the most recent; specify dates of data provided)

	Number	Date	Source
Total population	8 778 648	2010	Projections based on the 2002 General Population and Housing Census (GPHC) and 3.2% annual growth rate
Infant mortality rate (per 1000 live births)	67	2006	INSAE, DHS III 2006
Surviving Infants*	351 192	2010	INSAE, DHS III 2006
GNI per capita (US$)	350	2004	INSAE, DHS III 2006
Percentage of GDP allocated to Health	4,6	2005	Health statistics 2006, DPP 2006
Percentage of Government expenditure on Health	10,13	2009	Health statistics 2009, DPP 2009

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

Please provide some additional information on the planning and budgeting context in your country:

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

This document is the National Health Plan for 2009-2018. It was prepared using the "Ministry of Health integrated planning procedure" which was completed in December 2006.

Is the cMYP consistent with this document (schedule, content, etc.)? If not, please attach a MenAfrivac introduction plan for the next upcoming mass campaigns.
YES

Please indicate the national planning budgeting cycle for health

the national planning cycle is 10 years

The budget cycle is three years long with an annual action plan

Please indicate the national planning cycle for vaccination

The national planning cycle for immunisation is 3 years then annual National planning for vaccination is completed in a “bottom to top” manner, beginning with the health zones and ending with the central level.

- Regardless of the level involved, situational analysis is the first step in this process.
- The multi-year vaccination plan is prepared in accordance with the WHO’s tools and strategies (GIVS (Global Immunization Vision and Strategy), cMYP)
- The annual action plan is drawn from the multi-year plan.
- Quarterly activity planning is completed using the annual action plan.
- The plan specifies tracking and evaluation activities (monthly monitoring, quarterly session for evaluating activities related to the EPI and surveillance, coverage studies, EPI performance review).

Vaccination stakeholders are involved in the planning and implementation processes at all levels of the health pyramid.

The ICC members approve the EPI plan documents and the results of their implementation.

Please indicate whether data broken down by sex are reported in conjunction with routine vaccination reporting. No

Please indicate whether gender related aspects have been incorporated in this vaccine's introduction plan:

No. All subjects from 1-29 years of age will receive vaccinations regardless of their gender.

Table 3.2 Current vaccination schedule : Traditional, New Vaccines and Vitamin A Supplement (pages ……. of the cMYP)

Vaccine *(do not use trade name)*	**Ages of administration** *(by routine immunisation services)*	**Indicate by an "x" if given in:**		**Comment**
		entire country	**Only part of the country**	
BCG	Birth	X		
Oral Polio Vaccine	At birth, and at 6 weeks, 10 weeks and 14 weeks of life	X		
DTPHepB+Hib	At birth, and at 6 weeks, 10 weeks and 14 weeks of life	X		Pneumo 13 will be introduced in the EPI starting July 1er, 2001 and will follow the same schedule as DTP-Hep P + HIB.
Measles vaccine	9 months	X		
Yellow fever vaccine	9 months	X		
Tetanus vaccine	1st contact, 4 weeks, 6 months, 1 year, 1 year [sic]	X		For the EPI: Pregnant women (women of childbearing age {15-49 years} during immunisation campaigns)

Table 3.3: Trends of vaccination coverage and disease burden
(as described in the last two annual WHO/UNICEF Joint Reporting Forms on Vaccine Preventable Diseases)

Trends of vaccination coverage (in percentage)						**Vaccine preventable disease burden**		
Vaccine		**Reported**		**Survey**		**Disease**	**Number of reported cases**	
		2008	**2009**	**2001**	**2008**		**2008**	**2009**
BCG		114%	110%	93%	97%	Tuberculosis	Not available	3987
DTP	3rd	105%	106%	91%	94%	Diphtheria	Not available	Not available
	3rd	93%	98%	78%	82%	Whooping cough	Not available	48
Polio 3		94%	98%	78%	82%	Polio	6	20
Measles (first dose)		89%	95%	70%	70%	Measles	928	718
TT2+ (Pregnant women)		64%	68%	84%	86%	Neonatal tetanus (NT)	7	3
3rd		93%	98%			Hib **	Not available	6
Yellow Fever		89%	95%		70%	Yellow Fever	0	0
HepB3		93%	98%		82%	hepB sero-prevalence*	Not available	Not available
Vit A supplement	Mothers (<6 weeks from delivery)							
	Infants (>6 months)							

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Table 3.4: Vaccination Coverage Trends during Recent Broad Vaccination Campaigns (pages…. of the cMYP)

Number		Baseline and targets					
		Baseline year: 2009	**Year 1 2010**	**Year 2 2011**	**Year 3 2012**	**Year 4 2013**	**Year 5 2014**
Polio	Targets	2 807 512	3 006 224				
	Children immunized	2 915 670 (104%)	2 958 151 (98%)				
Measles	Targets						
	Children immunized						
TT2+ (pregnant women)	Targets						
	Children immunized						
Yellow Fever	Targets	6. 331. 572					
	Children immunized	6.316.808 (99%)					

If survey data is included in the table above, please indicate the years the surveys were conducted, the full title and if available, the age groups the data refers to:

Survey data is not included in the table above. However, in 2009 a yellow fever campaign was organized and six polio vaccination campaigns were completed (National Vaccination Days in February, March, June and July 2009); National Vaccination Day in October (35 municipalities out of 77) and in December (6 municipalities out of 77). In 2010, Benin organized four National Polio Vaccination Days in March, April, November and December.

A measles vaccination campaign is planned for 2011.

Table 3.5: Estimate of Fund and Annual Objectives (pages… of the cMYP)

Please refer to the cMYP and the meningitis A vaccine introduction plan which contain a summary of the estimates of funds and annual objectives in order to complete the mandatory calculation sheet (Annex 1).

Table 3.6 Summary of the Current and Future Vaccination Budget

	Estimated costs per annum in US$ (thousands)

Budget Line Item	Baseline year 2008	Year 1 2009	Year 2 2010	Year 3 2011	Year 4 2012	Year 5 2013
Recurring Cost for routine vaccination						
Vaccines (routine vaccines only)	4 280,242	4 955, 763	5 385, 975	10 251,063	17 483,244	16 595,535
a) Traditional vaccines	637,242	541,515	611,172	625,548	690,249	738,405
b) New vaccines or	3 643,000	4 414,248	4 774,803	4 305,099	3 805,763	3 489,628
c) Under-used vaccines				5 320,415	12 987,232	12 367,502
Injection supplies	292,307	234,839	266,025	371,126	374,628	406,203
Personnel	511,593	537,653	564,535	592,762	673,243	706,905
a) Salaries of full-time NIP health workers (vaccination specific)	76,846	80,688	84,722	88,959	120,078	126,082
b) Per-diems for outreach vaccinators / mobile teams	293,856	308,549	323,976	340,175	357,184	375,043
Transportation	108,970	159,656	191,487	215,648	244,846	149,487
Maintenance and overhead	392,238	502,570	614,138	791,851	855,268	867,523
Training	268,849	164,404	176,077	188,578	201,839	215,967
Social mobilization and IEC	75,255	67,974	73,735	160,011	79,563	83,848
Epidemiological monitoring	446,289	304,256	345,189	346,834	157,205	167,531
Program management	309,768	203,983	194,231	263,498	183,512	413,802
other	19,178	25,525	29,185	19,924	16,600	17,759
Subtotal Recurring Costs	**6 704,689**	**7 156,623**	**7 840,577**	**13 201,295**	**20 269,948**	**19 624,559**
Routine Vaccination Equipment Costs						
Vehicles	64,380	518,006	356,855	349,880	588,975	266,553
Cold chain equipment	222,150	979,933	301,726	751,890	108,982	72,684
Miscellaneous equipment			198,825	169,165	138,568	145,496
Subtotal Equipment Costs	**286,530**	**1 497,939**	**857,406**	**1 270,935**	**836,525**	**484,733**
Campaigns						
Polio	2 566,001	2 724,620	5 736,690	3 345,930	5 175,491	5 599,616
Measles	1 575,524			1 514,378		
Yellow Fever		8 004,120				
MNT campaigns						
Other campaigns						
Subtotal Campaign Costs	**4 141,525**	**10 728,741**	**5 736,690**	**4 860,309**	**12 907,808**	**5 599,616**
GRAND TOTAL	**12 493,338**	**20 775,562**	**15 891,744**	**20 857,567**	**35 660,129**	**27 431,954**

Please list in the tables below the funding sources for each type of cost category (if known). Please try and indicate which vaccination program costs are covered by the Government budget, and which costs are covered by development partners (or the GAVI Alliance), and name the partners.

Table 3.6: Summary of current and future financing and sources of funds (pages…. of the cMYP)

		Estimated financing per annum in US$ (,000)					
Budget Line Item	**Funding source**	**Baseline year 2008**	**Year 1 2009**	**Year 2 2010**	**Year 3 2011**	**Year 4 2012**	**Year 5 2013**
Recurring costs							
1.	1. Government	995,141	1037,242	1214,004	1078,547	1243,094	1325,123
2.	2. GAVI	3788,150	4569,233	4792,200	9236,898	16202,678	15283,088
3.	3. WHO	517,564	375,099	464,589	348,380	243,831	295,058
4.	4. UNICEF	73,462	30,851	83,080	57,624	82,011	191,415
5.	5. European Union	18,000					
6.	6. Swiss Development Agency	25,000					
7.	7. Community Funding	367,808	393,973	426,904	1094,557	843,139	711,225
8.	8. Highly indebted poor countries fund	784,399	750,225	859,800	1385,291	1665,194	1718,650
9.	9. Belgian Development Agency	50,000					
10.	10. UNIDEA	10,000					
11.	11. World Bank	20,000					
12.	12. USAID	55,165					
13.	13. Rotary International	0					
14.	14.						
Equipment Costs							
1.	1. Government		642,166	272,213	284,058		88,851
2.	2. GAVI		38,558	22,501			
3.	3. WHO			38,572			
4.	4. UNICEF		817,415	325,295	485,438	108,982	165,917
5.	5. Japanese Development Agency			198,825	501,439	727,543	189,487
	6. UNIDEA						145,496
Campaigns							

1.	1. Government	1201,710	1161,010	89,376	579,526	676,212	88,444
2.	2. WHO	1067,900	2814,397	3664,416	2703,736	3571,192	3626,196
3.	3. UNICEF	1871,915	1239,420	1982,898	1577,047	1912,597	1884,976
4.	4. GAVI		5513,913			6747,807	
5.	5.						
GRAND TOTAL		**12493,338**	**20775,562**	**15891,744**	**20857,567**	**35660,129**	**27431,954**

4. Request for Meningococcal A conjugate vaccine

Please summarize the cMYP and/or the Meningitis A vaccine introduction plan. Emphasize important points that have information on the decision-making process (data taken into consideration).

Meningitis is responsible for approximately 170,000 deaths each year. Approximately 10-20% of people who contract the disease become disabled. This situation results in a heavy socio-economic burden on families. The disease's mortality rate is often very high; without proper treatment, it can reach 50%. Despite the measures that health care facilities take for their patients, the mortality rate exceeds 10%. There are 12 meningitis serotypes. The most common are A, B, C W 135 and X. These are the most frequent causes of epidemics. Serogroup A accounts for 80-85% of all cases in the meningitis belt, and it causes the epidemics that occur every 7-14 years.

During the 2009 epidemic season, there were serogroup A epidemics in 14 African countries including Benin. This resulted in 88,199 cases including 5,352 deaths, a number unprecedented since 1996.

In Benin and other countries in the meningitis belt, meningitis cases are recorded each year. These cause not only deaths, but harmful after-effects. The table below shows the progression of cases, deaths and mortality in Benin from 2006 to 2010.

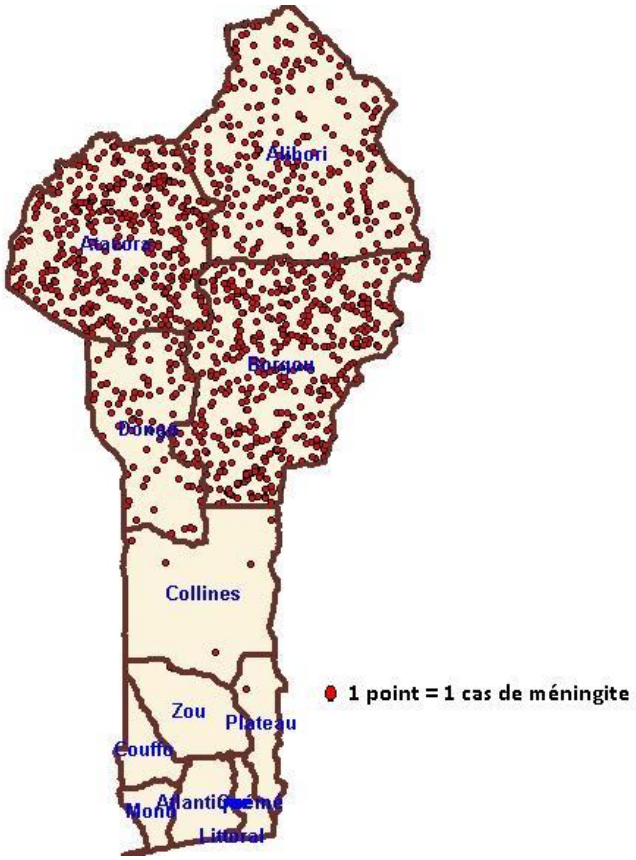
Table 1: Progression of cases, deaths and mortality caused by meningitis in Benin from 2006 to 2010.

Year	Cases	Incidence per 100,000 residents	Deaths	Mortality
2001	9561	Not available	436	5%
2002	762	Not available	91	11,9%
2003	488	Not available	91	19%
2004	413	Not available	101	24,5%
2005	305	Not available	75	24,6%
2006	385	4,91	97	25%
2007	504	6,21	107	21%
2008	461	5,61	63	14%
2009	416	4,9	64	15%
2010	318	3,62	52	16%
2011 (W13)	113	1,28	25	22,1%

The most recent epidemic in Benin was in 2001, resulting in 9,561 cases and **436** deaths.

An analysis of case-by-case data on meningitis in Benin from 2006 to 2009 (for a total of 1,203 meningitis cases) shows that the most severe epidemic conditions are in the northern half of the country. (See figure below)

Figure 1: Geographic breakdown of cases:



1) Breakdown by age and sex

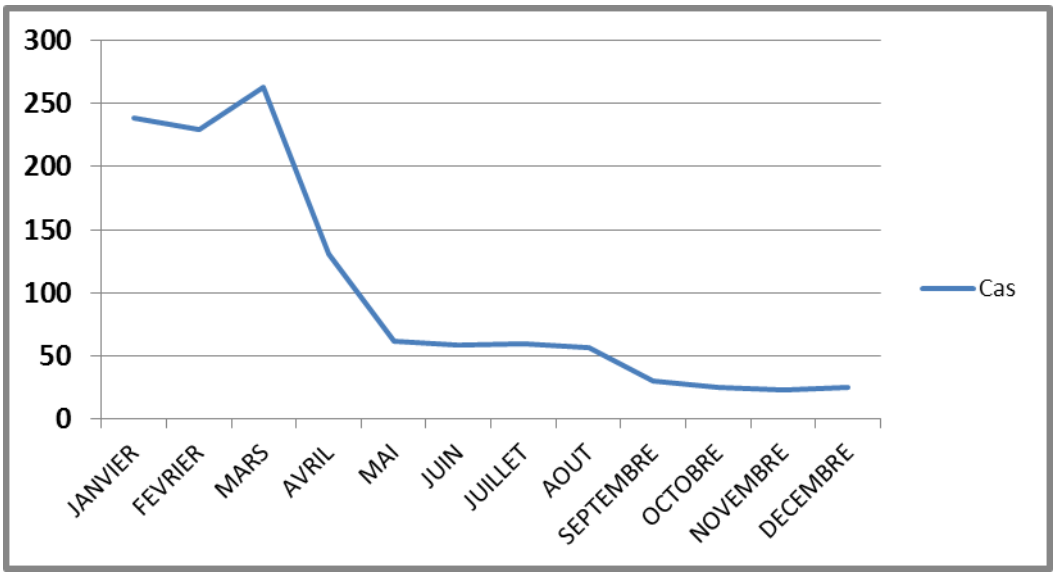
   The breakdown by sex shows 538 women and 665 men, and the breakdown by age shows that the under-30 age group represents 90% of cases, for a total of 1,086 cases. The additional 10% of the population represents 117 cases.

   Children under 5 represent 35% of cases, for a total of 416 cases out of 1,203.

2) Breakdown by epidemiologic week and by month

   The chart below clearly shows that the majority of cases occur between the 1st and 22nd epidemiologic weeks with a spike in the 14th or 15th week.

Figure 2 : Monthly change in meningitis cases in 2006 in Benin



3) Primary causative germs:

In 2004, a study in the Tanguiéta health zone showed that out of 102 cases, three primary germs were the cause: N. Meningitidis (50%) ; S. pneumoniae (37, 2%) and H. influenzae (6,9%).

The African meningitis belt runs through Benin's northern departments and through a portion of the country's center (the Collines department). Because the country's central and southern regions have almost never experienced meningococcus A epidemics, the ICC decided at its April 28, 2011 meeting to conduct the MenAfriVac campaign in the high-risk departments in the north (Alibori, Atacora, Borgou and Donga) and in the Collines department. This decision was also made because of the vaccine's characteristics: it gives herd immunity and it will be included in the routine EPI after 2013.

Despite steps that have been taken to ensure that medications are available in health facilities, the fact that treatment is given free of charge and there have been periodic vaccinations with polio vaccine, there is still a high mortality rate. This exceeds the expected rate of 10% and can be up to 25%. This situation affects not only the country's socio-economic and health sectors, but it also impedes the government of Benin's efforts to reach its internal goals for improving the health of the general population and that of children in particular. This affects its ability to reach the MDGs

and primarily MDG No. 4. In addition Benin, like most countries, has implemented the GIVS and is committed to implementing the strategies suggested by it. Within this framework, the country has committed since the year 2000 to introduce new vaccines and new immunisation technologies and the cMYP strategies have been aligned with those of the GIVS.

Hepatitis B (Hep B) vaccine and yellow fever vaccine (YFV) were introduced in an effective manner into the routine EPI starting in August 2002 with the assistance of the Global Alliance for Vaccines and Immunisation (GAVI). Based on this experience, after an evaluation of the morbidity burden related to infections with Haemophilus influenza, the country decided to introduce Hib vaccine. This was successfully done in June 2005 throughout the entire country of the Republic of Benin. At present, vaccination coverage paints a favorable picture of the country's efforts to improve vaccination coverage for this antigen. In less than two years, it has reached the same level of coverage that the DTP3 has. In addition, Benin has decided to submit an application to GAVI for the introduction of the pneumococcus vaccine which will occur this year.

There are many vaccines to prevent meningitis. However, some of them have limited effectiveness. Specifically, the existing polio vaccines that are currently used against meningitis A cannot be given to children under two years of age. These vaccines are effective for only 2-3 years, they do not decrease carrying of the bacteria and they do not give herd immunity. The development and market availability of the new MenAfriVac conjugate vaccine have sparked renewed interest in the countries that are affected by this disease. The vaccine has been successfully introduced into some countries in the sub-region: Burkina Faso, Mali and Niger.

Consequently, the government of Benin hopes to obtain GAVI's support for the introduction of the new conjugate meningitis A vaccine, MenAfriVac. The government of Benin considers this application to be of the utmost importance.

As stated in the revised cMYP for 2009-2013, the government of Benin plans to organize a mass vaccination campaign to prevent these devastating meningococcal meningitis A epidemics. This will occur during the fourth quarter of 2012 in the five departments in Benin that are part of the meningitis belt (Atacora, Donga, Borgou, Alibori, Collines).

From the programmatic point of view, the introduction of this vaccine is appealing because the country has the ability to effectively store and distribute it, and to ensure vaccination that meets the required safety standards.

Benin has gained a great deal of experience in (i) implementing integrated surveillance of diseases and response (since 1998), as well as in specific aspects of case-based surveillance (AFP, measles, yellow fever), (ii) implementing additional polio vaccination campaigns, (iii) implementing measles vaccination campaigns (catch-up and booster) in the context of the accelerated measles control program, (iv) organizing response campaigns against numerous meningitis epidemics with polysaccharide vaccines, with administration coverage of more than 95% in the vaccinated areas.

In the context this application, an initial MenAfriVac catch-up campaign plan has been prepared. This plan deals with Benin's specific context, goals to be reached, primary strategies and activities including evaluation, and some critical implementation steps as well as the required budget.

In accordance with the Yaoundé declaration of September, 2008, Benin has committed to transforming this document into a national strategic plan for reducing meningitis-related morbidity and mortality. Other strategic initiatives will be

developed in an integrated manner along with the response activities that the country normally conducts.

Based on the experience of previous campaigns conducted in Benin and the lessons that have been learned about the introduction of new vaccines, the following primary strategies have been selected. These will support the success of this inaugural introduction campaign for the conjugate meningitis A vaccine:

- Improved coordination at all levels (National, departmental, municipal and local);
- An improved micro-planning process at the decentralized level in order to better define roles and responsibilities and to provide improved assessment of resources;
- Improved communication/social mobilization, especially in terms of locally-based communications with the involvement of local leaders;
- Improved employee skills at all levels, through training related to the various components of the vaccination campaigns;
- Effective tracking of vaccines and input items during the entire campaign;
- Reliable management of vaccine stocks and monitoring of their use
- Strict application of injection safety and waste management
- Improved pharmaco-vigilance, specifically in terms of post-vaccination adverse events (PVAEs) and how to properly manage them;
- Improved supervision, tracking and evaluation;
- Improved case-by-case monitoring, taking experiences with measles, yellow fever and polio into account and using knowledge gained from the first countries to introduce MenAfriVac. In order to achieve this, guides and tools for case-by-case monitoring will be revised. Health and laboratory agents will benefit from trickle-down training. Reagents and laboratory equipment will be purchased. A state-of-the art system for transporting samples from health centers to laboratories will be implemented.

The projected target population is 2,640,459 people between 1 and 29 years of age. The total quantity of vaccines required is 3,115,741 doses (with a 15% wastage rate, for a wastage factor of 1.18). The campaign will consist of one phase in November

2012.

In light of the workloads facing the NDEPI and the NDPH, the introduction of this new vaccine and the efficient implementation of this campaign will require considerable technical support, consisting of the hiring of an international consultant to support coordination at the national level.

The plan's overall total cost (with investment included) is US $2,004,201, or US $0.64 per person vaccinated (the unit cost of the vaccine plus injection materials is estimated at US $0.67). The country's financial contribution is 150 million CFA francs.

This campaign requires substantial funding and will require advocacy with respect to international partners working in Benin (WHO, UNICEF, the European Union, The French Development Agency, the Belgian Development Agency, the Danish Development Agency, the Swiss Development Agency, the Japanese Development Agency, USAID, Rotary, the Red Cross, etc.) and economic players (mobile phone providers), para-governmental and private enterprises.

The government of Benin has committed to contribution to operational costs in the amount of 150 million CFA francs from its own funds.

In the context of the integrated epidemiologic surveillance program, the country has had standard operational procedure documents and revised and approved directives on meningitis since 2008. In addition, the laboratory network has been improved with trainings in 2009 and 2010, additional equipment and additional supervision tools.

A case-by-case monitoring system will be implemented in order to measure this campaign's impact. Using data from the first countries that have already introduced MenAfriVac, the guide and the case-by-case surveillance tools will be revised. The health and laboratory agents will undergo trickle-down training, equipment and reagents will be purchased and deployed to laboratories, and the method for sending samples to laboratories will be improved. We will use information technology (Internet and SMS) to transmit data.

Briefly describe (1) the vaccine wastage management plan, and (2) the cold chain capacity and

indicate whether it is sufficient to store the new vaccines. Please indicate whether the acquisition of vaccines for this campaign will have consequences on the delivery and storage capacity for traditional vaccines and indicate how this situation will be managed.

1) Waste management:

The safety boxes filled with used syringes will be collected and supervisors will take them to the closest health facilities that have incinerators. There are two types of incinerators available : De Monfort incinerators and incinerators manufactured by the DHAB (Direction de l'Hygiène et de l'Assainissement de Base). All sharps boxes and other waste (boxes, empty vials and packaging) will be destroyed by incineration at health centers that have incinerators.

2. Cold Chain

The vaccine storage capacity available centrally and regionally makes it possible to accommodate routine vaccines and vaccines for the meningitis A campaign. Therefore in 2012 there will be no storage capacity gap, for the following reasons:

- The routine EPI vaccines (including the pneumococcus vaccine) are delivered 4 times per year from the central level to the departments;
- In addition, there will be three National Vaccination Days for polio vaccine and one day for the MenAfriVac vaccination (with a corresponding target of 28% of the total population): Population from 1-29 years of age in the departments of Atacora/Donga, Borgou/Alibori and Collines.

Nevertheless, there are two constraints still to be managed:

- The EPI uses a refrigerated truck to distribute vaccines; it was purchased in 2003 and it now breaks down frequently. A new refrigerated truck is very much needed in order to avoid delays in distributing vaccines to intermediate storage areas.
- A new warehouse needs to be constructed in order to eliminate the 1,485 m3 deficit in ambient storage area for consumables and equipment.

During the campaign, the vaccine will be distributed to the various departments using the refrigerated truck. Coolers will be used to transport the vaccines from the departmental locations to the municipalities. The regions will make use of these boxes and coolers available locally for transporting the vaccine to the health centers.

Considering the availability in the field, it can be said that all the teams will each have a vaccine carrier for implementing the campaign. However, the mobile teams will need an additional vaccine carrier to store the vaccines and ice packs.

Table 4.1: Capacity and Cost (for Positive Storage)

		Formula	Year 1 2009	Year 2 2010	Year 3 2011	Year 4 2012	Year 5 2013
A	Yearly positive volume needs, including the new vaccine(s) (specify: _____) (liters or m3)	*Product of total vaccine doses times unit packed volume of the vaccine*	23,554 liters	23,703 liters	40,432 liters	48,869 liters	51,007 liters
B	Annual positive capacity, including new vaccine (specify:_____ _____) (liters or m3)	#	15,000 liters	15,000 liters	15,000 liters	15,000 liters	15,000 liters
C	Estimate of minimum number of annual shipments required for actual cold chain capacity	*A / B*	1.57	1.58	2.70	3.26	3.40
D	Number of consignments/shipments per year	*Based on national vaccine shipment plan*	4	4	4	4	4
E	Difference (where applicable)	*((A / D) - B)*	- 9,111 liters	- 9,074 liters	- 4,892 liters	- 2,783 liters	- 2,248 liters
O	Estimated cost for expansion	*US$*	$0	$0	$0	$0	$0

MenAfriVac studies are ongoing, and an indication for use in children under one year of age is expected to be issued in January, 2014. Briefly describe when your country plans to introduce the conjugate Meningococcus A vaccine into the systematic vaccination schedule, how your country plans to fulfil its co-financing options for systematically introducing the Meningococcus A vaccine and other issues related to the systematic introduction that you are considering (refer to the cMYP).

The country plans to include the vaccine in the routine EPI as soon as it is available, using the same co-financing principles as the other new vaccines (pneumococcus in 2011).

Table 4.2: Evaluation of the Meningococcus Disease Burden (if available):

Disease	Title of the assessment	Date	Outcomes

Meningitis	Epidemiology of bacterial meningitis in the Tanguieta health zone in Benin, 2004, Public Health Brief, D. Toboe	2004	- 102 cases of meningitis were reported - The three primary causative germs were: N. Meningitidis (50%) ; S. pneumoniae (37.2%) and H. influenzae (6.9%).
Meningitis	Meningitis surveillance data	2009	Cases: 416 Deaths: 64 Mortality: 15,4% Bacterio : N Meningitidis W135, H. influenzae and S. Pneumonia
Meningitis	Meningitis surveillance data	2010	Cases: 318 Deaths: 52 Mortality: 16% Bacterio : S. Pneumonia
Meningitis	Meningitis surveillance data	2011 (weeks 1 to 13)	Cases: 113 Deaths: 25 Mortality: 22,1% Bacterio :H. influenzae and S. Pneumonia

If new or under-used vaccines have already been introduced in your country or if you have already conducted vaccination campaigns, please give details of the lessons learned from the experience related to storage capacity, protection from accidental freezing, staff training, cold chain logistics, drop out rate, wastage rate, etc. and suggest improvements on these points:

Lessons Learned	**Solutions / Action Points**
Micro-planning is an essential component of the success of vaccination campaigns	Particular emphasis should be placed on fundamental micro-planning with community involvement and with support from central and departmental teams.
Involvement of politicians at the highest level makes it possible to mobilize the resources that are required in the context of co-financing, and it also enables community mobilization.	Improved advocacy and social mobilization for effective involvement of higher authorities and other sectors, and the country's health development.
The need to join mass communication with increased continuous nearby communication and improved communication in order to manage risks and rumors.	Provide local communication in order for the populations to have more accurate knowledge of the new vaccines. Prepare for managing risks/rumors.
Selection and training of campaign stakeholders.	There will be particular emphasis placed on training of local staff (vaccinators, health and safety technicians, supervisors)
The need for local tracking of providers after	Provide close monitoring of the providers' skills

training	after training
A dynamic organizational committee (national, department and local) is crucial to the success and quality of a campaign to introduce a new vaccine.	Prepare a work plan including regular meetings to ensure the involvement of all EPI partners. Reports from these meetings will be sent to the ICC members and they will follow up on them.
The importance of implementing a PVAE management system	Timely implementation of PVAE management committees at all levels (central, departmental and remote). These committees must be trained and must have substantial tools.
The need to have a detailed logistics and waste management plan (as far as the municipal level)	- Improve stakeholder logistics capacity; - Inspect incinerators and carry out any necessary repairs
The need for monitoring during the campaign	Independent monitoring needs to be done early (beginning with the second day)

5. Procurement and Management of New and Under-Used Vaccines

a) Please show how the support will be implemented and managed, including the purchase of vaccines (GAVI expects that the countries will buy their vaccines and injection supplies through UNICEF):

This arrangement is part of the current procurement mechanism for traditional vaccines and supplies through UNICEF in compliance with the terms of the memorandum of agreement for the provision of procurement services reached between UNICEF and Benin's Ministry of Health. Payment of Benin's share will be made during the second half of each year by bank wire transfer to UNICEF.

b) Please indicate when you intend to plan the conduct of the campaign (month and date) and how the campaign will be deployed, e.g. different phases or one single time)

Fourth quarter of 2012, one phase, in the five departments in the meningitis belt. These are: Collines, Borgou, Alibori, Atacora and Donga.

f) Please describe how the new vaccine's coverage will be monitored and declared (refer to the cMYP and the Meningitis A vaccine introduction plan)

Monitoring will be ensured through daily compilation and tracking of vaccination coverage data; daily meetings will be held between vaccinators and team supervisors in health units, and between supervisors at the municipal and departmental level. Quick studies will be conducted in the high-risk areas beginning with the third day after the campaign is implemented, and based on a protocol prepared at the central level. In addition, a vaccination coverage study will be conducted at the end of the campaign.

6. Grants for the Operational Cost for Vaccination Campaigns

Table 6.5: calculation of lump-sum

Year of New Vaccine introduction	Objective 1-29 years-old (see table 3.4)	Amount per dose in US $	Total in US$
2012	2 640 459	$ 0,30	934 722

In the following tables, please indicate how this amount will be used for financing the vaccination campaign introduction cost and also other essential activities. GAVI support will not be sufficient to cover all the needs, consequently please indicate in the following table how the remaining needs will be met and by whom (refer to the cMYP and/or to the Meningitis A conjugate vaccine introduction plan).

Table 6.6: Campaign Cost (and Financing; US$. Rate:) 1US$= 475 F CFA)

No.	Budget Line Item	Total needs		GAVI Support US$	Other source: US$
		CFA	US$		
1	*Functioning of the national organization and coordination committee (management of members and various activities) and ICC members*	5 000 000	10 526		10 526
2	*Functioning of the organizational committee, decentralized level (department and municipality)*	4 550 000	9 579		9 579
3	*Preparation meeting for the mass vaccination plan, and tailoring of the case-by-case monitoring guide*	10 000 000	21 053	21 053	
4	*Preparation meetings for the communication plan, including communication tools*	10 000 000	21 053	21 053	
5	*Municipal micro-planning meetings*	5 000 000	10 526	10 526	
6	*Departmental micro-plan summary meeting*	11 000 000	23 158	23 158	
7	*National micro-plan summary*	5 000 000	10 526	10 526	
8	*Department planning meeting*	11 000 000	23 158		23 158
9	*National planning meeting*	5 000 000	10 526		10 526
10	*Copying of the case by monitoring plan and guide*	2 000 000	4 211	4 211	
11	*Data collection*	1 000 000	2 105	2 105	
12	*Copying of documents and other central office supplies*	5 000 000	10 526		10 526
13	Technical input	PM	0	0	0
	Sub-total 1: Coordination-planning and tracking	**74 550 000**	**156 947**	**50 526**	**106 421**
14	Training of departmental trainers	11 000 000	23 158		23 158
15	Trickle-down training sessions for health agents, volunteers and team supervisors	46 519 600	97 936		97 936
	Sub-total 2: Training	**57 519 600**	**121 094**		**121 094**
16	Transportation of vaccination teams	39 690 000	83 558		83 558
17	Transportation of team supervisors	6 240 000	13 137		13 137
18	Transportation of municipal supervisors	6 600 000	13 895		13 895
19	Transportation of departmental supervisors	4 500 000	9 474		9 474
20	Transportation of national consultants	1 500 000	3 158		3 158
21	Transportation for resupplying municipalities with vaccines	2 009 478	4 230		4 230
22	C/SRFM transportation of DDS	800 000	1 684		1 684
23	Fuel for supervision and training for the campaign at the central level	8 000 000	16 842		16 842
24	Fuel for trips to collect supporting documents (financial, central level)	800 000	1 684		1 684
25	Rental of 2 vehicles	7 200 000	15 158	15 158	

26	Rental of motorcycles and car/motorcyle maintenance	6 050 000	12 737	12 737	
27	Vaccine supply (central and departmental levels)	2 000 000	4 211		4 211
	Sub-total 3: Transportation	**85 389 478**	**179 767**	**27 895**	**151 872**
28	Implementation of communication activities at the central level using media. Copying of media materials and official launch	20 000 000	42 105		42 105
29	Social mobilization, town criers (local communications)	12 445 000	26 200		26 200
30	Municipal social mobilization	3 300 000	6 947		6 947
31	Departmental social mobilization	1 000 000	2 105		2 105
	Sub-total 4: Communication and social mobilisation	**36 745 000**	**77 358**		**77 358**
32	Volunteer management	123 680 000	260 379	260 379	
33	Health agent (vaccinators) management	262 820 000	553 305	553 305	
34	Management of team supervisors	26 520 000	55 832		55 832
35	Management of municipal supervisors	6 600 000	13 895		13 895
36	Management of municipal drivers	3 300 000	6 947		6 947
37	Management of departmental supervisors	13 500 000	28 421		28 421
38	Management of departmental drivers	4 500 000	9 474		9 474
39	Management of national consultants	3 000 000	6 316		6 316
40	Management of national consultant drivers	2 000 000	4 211		4 211
41	Management C/SRFM and collaborator	900 000	1 895		1 895
42	Management of C/SRFM drivers	300 000	632		632
43	Management of municipal accountant	1 402 500	2 953		2 953
44	Management of data managers	1 200 000	2 526		2 526
45	Managements of national supervisors	12 000 000	25 263		25 263
46	Management of national supervisors' drivers	12 000 000	25 263		25 263
47	Management of members of the finance subcommittee	600 000	1 263		1 263
48	Management of drivers for the members of the finance subcommittee	300 000	632		632
	Sub-total 5: Personnel management	**474 622 500**	**999 205**	**813 684**	**185 521**
49	Waste management (management of operators, supervision or tracking, incineration oversight) in the 5 departments	6 000 000	12 632		12 632
50	Implementation of case by case monitoring activities and support for laboratories	17 000 000	35 789		35 789
51	Monitoring/investigation and management of PVAEs	50 000 000	105 263		105 263
52	Purchase of cotton rolls	2 640 459	5 559		5 559
	Sub-total 6: Epidemiologic and injection safety monitoring	**75 640 459**	**159 243**		**159 243**
53	Purchase of a refrigerated truck	40 000 000	84 211		84 211
54	Construction of a dry warehouse at the central level	40 000 000	84 211		84 211
	Sub-total 7: Investment	**80 000 000**	**168 421**		**168 421**
55	Vaccination card order	47 528 262	100 059		100 059
56	Conducting monitoring and evaluation for the	20 000 000	42 105	42 105	

	campaign				
	Sub-total 8: Monitoring and evaluation	**67 528 262**	**142 165**	**42 105**	**100 060**
	Total operational costs	**871 995 299**	**1 835 780**	**934 210**	**901 570**
	Total investment costs	**80 000 000**	**168 421**		**168 421**
	GRAND TOTAL	**951 995 299**	**2 004 201**	**934 210**	**1 069 991**

- Please complete the banking form (annex 1) if necessary

Please briefly describe who will finance the operational costs not financed by GAVI. If the government is the source of financing, please confirm that this is in fact entered in the health budget. If you are looking for other sources of financing, please indicate and confirm their commitments.

This campaign requires substantial funding and will require advocacy with respect to international partners working in Benin (WHO, UNICEF, the European Union, the French Development Agency, the Belgian Development Agency, the Danish Development Agency, the Swiss Development Agency, the Japanese Development Agency, USAID, Rotary, the Red Cross, etc.) and economic players (mobile phone providers), para-governmental and private enterprises.

The government of Benin has committed to contribution to operational costs in the amount of 150 million CFA francs from its own funds.

7. Additional comments and recommendations from the National Coordinating Body (ICC/HSCC)

Recommendations

- Conduct a meningococcal meningitis A vaccination campaign (MenAfriVac) in 5 of the country's departments located in the meningitis belt (Atacora, Donga, Collines, Borgou, Alibori);
- Set up a national MenAfriVac organization committee;
- Prepare a ministerial decree creating the National PVAE Monitoring Committee;
- Immediately begin the process of registering the vaccine in Benin by the ANR;
- Advocate with other economic partners and operators in order to support the State's contribution (MenAfriVac Organization Committee)
- Ensure that the Minister of Health and the Minister of Finance sign during the week of May 3-6.
- Emphasis on micro-planning and the efficient implementation of activities;

8. Documents required for each type of support

Document	DOCUMENT NUMBER	Duration *
Complete Multiyear Plan (CMYP) MenAfriVac introduction plan (if not already included in the cMYP)	1 2	2009-2013 2012
endorsed minutes of the National Coordinating Body meeting where the GAVI proposal was endorsed	Not available	
endorsed minutes of the ICC/HSCC meeting where the GAVI proposal was discussed	3	28 April 2011
Minutes of the three most recent ICC/HSCC meetings	4 5 6	
ICC/HSCC workplan for the next 12 months	Not available	
The calculation sheet required for the vaccine	7	

** Please indicate the duration of the plan / assessment / document where appropriate*

Annex 1 - Banking Form

Banking form

SECTION 1 (To be completed by payee)

Again we indicate that without the complete and accurate bank information (IBAN, SWIFT code, bank contact information and the corresponding bank in the USA, the bank transfer will prove to be impossible and that can cost needless delays.

Banking Form	
SECTION 1 (To be completed by payee)	
Name of Institution: *(Account holder)*	National Agency for Vaccination and primary health care
Address:	01 BP 882 Cotonou
City/Country:	Cotonou, Benin
Telephone no.:	(229) 21 33 75 90 **Fax no.:**
Currency of the bank account:	CFA
To be credited to: ***Account name***	*DIR.RECH.DVPT.SANTE.PEV.SSP.*
Bank account No.:	BJ062 01001 231102050801 52
At: ***Bank name***	ECOBANK BENIN

Is the bank account exclusively to be used by this program? **YES (X) NO ( )**

Who audits the account? IGM (General Ministry Inspectorate) .....

Signature of the authorised government representative:
By signing below, the authorizing official confirms that the bank account mentioned above is known to the Ministry of Finance and is under the oversight of the Auditor General.

Name	.....	**Stamp:**
Title	.....	
Signature	.....	
Date:	.....	
Address and Phone number	.....	
Fax number	.....	
Email address:		

SECTION 2 (To be completed by the Bank)

FINANCIAL ESTABLISHMENT		CORRESPONDING BANK *(In the United States)*
Bank Name:	**ECOBANK**	**CITYBANK-NEW YORK**
Branch Name:	**Main Branch**	
Address:	**01 BP 1280 COTONOU BENIN**	**111 WALL STREET 19 THFLOOR ZONE 1 NEW YORK-10043 USA**
City/Country:	**COTONOU BENIN**	**New York**
Swift code :	**ECOCBJBJ**	**CITUS 33**
Sort Code:		
ABA No.:		
Telephone no.:	**00229 21313069**	**1212657 55 18**
Fax No.:		
Bank Contact Name and Phone Number:		**1212 657 115**

I certify that account no. BJ062 01001 231102050801 52. . . . . is registered in the name of (name of institution) DIR.RECH.DVPT.SANTE.PEV.SSP . . . . . at this banking institution.

The account is to be signed jointly by at least ..... (number of signatories) of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name: Marie Rose Nago	**Signature**
Title: NDEPI/PHC	**Date:**
2 Name: Evariste Tokplonou	**Stamp:**
Title: C/SVAC	
3 Name:	
Title:	
4 Name:	
Title:	

Annex 2: GAVI Alliance general terms

FINANCING USED SOLELY FOR APPROVED PROGRAMMES

The candidate country ("Country") confirms that any financing granted by the GAVI Alliance in conjunction with this application will be used and allocated solely for the purpose of conducting the program(s) described in this application. Any significant change to the approved program(s) must be examined and approved by the GAVI Alliance in advance. Any financing decision on this proposal is made at the discretion of the GAVI Alliance council and depends on the IEC process and funds availability.

AMENDMENT OF THIS PROPOSAL

The Country shall inform the GAVI Alliance through its Annual Status Report of its desire to propose a modification of any kind to the description of the program(s) in this proposal. The Country shall produce documents supporting any modification approved by the GAVI Alliance and this proposal will be amended as a consequence.

RESTITUTION OF THE FUNDS

The Country agrees to return to the GAVI Alliance any financing amount which is not used on behalf of the program(s) described in this proposal. Unless the GAVI Alliance decides otherwise, reimbursement must be made by the Country in US dollars within sixty (60) days following receipt by the Country of the request from the GAVI Alliance and will be deposited in the account(s) indicated by the GAVI Alliance.

SUSPENSION/TERMINATION

GAVI Alliance may suspend all or part of its financing to a Country if it has reason to suspect that the funds have been used for any purpose other than for the programs described in this proposal or an amendment to this proposal approved by GAVI. GAVI Alliance reserves the right to terminate its support to the Country for the programs described in this proposal if GAVI Alliance receives confirmation of abusive use of the funds granted by GAVI Alliance.

ANTICORRUPTION

The Country confirms that the funds provided by the GAVI Alliance will not be offered to a third party by the Country and the country will not seek on the basis this proposal a gift, payment or other direct or indirect advantage which could be interpreted as an illegal practice or an act of corruption.

AUDITS AND RECORDS

The Country will conduct a financial audit annually and share the results with the GAVI Alliance on the first request. The GAVI Alliance reserves the right for itself or through an agent to conduct audits or any other form of evaluation of the financial management in order to assure itself of the financial accountability for the funds deposited on behalf of the Country.

The Country shall retain precise accounting records which documents the manner in which the GAVI Alliance funds were used. The Country will keep up to date accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. In case of recourse for abusive use of the funds, the Country will retain these records until the final conclusion of the audit. The Country agrees not to raise privilege with the GAVI Alliance over the documents in conjunction with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the government confirm that this proposal is accurate and correct and constitutes an irrevocable legal obligation on the Country, under the terms of the Country's laws, to conduct the programs described in this proposal.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE ACCOUNTING TRANSPARENCY AND RESPONSIBILITY POLICY

The Country confirms that it is been informed of the GAVI Alliance accounting transparency and responsibility (ATR) policy and will comply with its requirements.

ARBITRATION

Any dispute between the Country and the GAVI I Alliance which arises from this proposal or refers to this proposal and cannot be amicably resolved in a reasonable interval will upon the request of either the GAVI Alliance or the country be subject to arbitration. The arbitration will be conducted according to the UNCITRAL Arbitration Rules in force at that time. The parties agree that they shall be bound by the arbitration sentence as a definitive settlement of the dispute. The forum shall be Geneva, Switzerland. The language of the arbitration shall be English.

For any dispute involving a contested amount which is less than or equal to US$100,000, the single arbitrator shall be designated by the GAVI Alliance. For any dispute whose contested amount is over US$100,000, three arbitrators shall be designated as follows: The GAVI Alliance and the Country shall each designate one arbitrator and these two arbitrators shall by mutual agreement designate a third arbitrator who will preside over the panel.

The GAVI I Alliance shall not be responsible to the Country for any recourse or loss relative to the programs described in this proposal, including (list not exhaustive) financial losses, appeal on suspicion, property damage, physical lesions to people or death. The Country is solely responsible for all aspects of managing and implementing the programs described in this proposal.