GAVI Alliance

Application Form for Country Proposals

For Support to New and Under-Used Vaccines (NVS)

Submitted by

The Government of

Haiti

Date of submission: **30.05.2011 19:37:19**

Deadline for submission: 1 Jun 2011

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

Start Year 2011 End Year 2015

Revised in January 2011

(To be used with Guidelines of December 2010)

Please submit the Proposal using the online platform https://AppsPortal.gavialliance.org/PDExtranet.

Enquiries to: proposals@gavialliance.org or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public. The Proposal and attachments must be submitted in English, French, Spanish, or Russian.

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

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES
The applicant country ("Country") confirms that all funding provided by the GAVI Alliance 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 Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

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

RETURN OF FUNDS
The Country agrees to reimburse to the GAVI Alliance 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 Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION
The GAVI Alliance 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 Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION
The Country confirms that funds provided by the GAVI Alliance 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 Alliance, as requested. The GAVI Alliance 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 Alliance 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 Alliance 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 Alliance 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 ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY
The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMR.CIAL BANK ACCOUNTS
The Country is responsible for undertaking the necessary due diligence on all comMr.cial 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 Alliance 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 Alliance 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 language of the arbitration will be English.
For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. 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 Alliance 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 Alliance 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. Application Specification

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

Important note: To enable proper functioning of the form, please first select the cMYP years on the previous page.

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]	Action
New Vaccines Support	DTP-HepB-Hib, 1 dose/vial, Liquid	2012	2015		
New Vaccines Support	Pneumococcal (PCV13), 1 doses/vial, Liquid	2013	2015		
New Vaccines Support	Rotavirus 2-dose schedule	2013	2015		

[1] This "***Preferred second presentation***" will be used in case there is no supply available for the preferred presentation of the selected vaccine ("**Vaccine**" column). If left blank, it will be assumed that the country will prefer waiting until the selected vaccine becomes available.

2. Table of Contents

Sections

3. Executive Summary

1. Background

the Republic of Haiti occupies the western third of the Quisqueya Island it shares with the Dominican Republic. It has an area of 27,750 square kilometers. The last general Population and Housing Census (PHC), conducted by the Haitian Institute of Statistics and Informatics (IHSI) in 2003, counted a population of 8,938,655. This is estimated to be 10,363,566 in 2011 considering a growth rate of 2.76%. This is a very young population with 12% under the age of 5 years, more than 50% under the age of 21 years. Distribution by sex shows that there are slightly more women (52%) than men (48%).

The population density of 373 inhabitants per km2 is very high. About 60% of the population lives in rural areas (2003). Two-thirds of this rural population lives in isolated villages in mountainous areas. This situation, added to the dispersion of rural housing makes the delivery of basic health services extremely difficult, in view of the advanced immunization strategy.

Since the late '60s, the country has experienced a large movement of its rural population towards the capital Port-au-Prince and larger cities. This rural exodus aggravated from the 90s, has resulted in a steep decline in agricultural production, the impoverishment of the peasantry and the growing formation of poverty belts around the main cities of the country.

The Republic of Haiti is divided into 10 departments, 140 municipalities and 553 communal sections. The distribution of as many health institutions across the territory as of human resources reflects the acuteness of social inequalities in health. Indeed the country has 2.5 doctors, 1 nurse and 2.5 auxiliary nurses per 10,000 inhabitants, being 6 human resources against 25/ 10,000 by PAHO/ WHO standards. On the other hand, a little over 50% of the population lives more than 1 hours walking distance of a health institution. About 74% of women deliver at home (EMMUS IV)

The Haitian health system is divided into ten health departments whose 140 municipalities are grouped into 58 municipal health units (MHU) which form the organizational basis of health decentralization advocated by the national health policy. The hybrid system consists of public health institutions, private philanthropy, mixed and private for profit institutions, added to the over-reliance of its funding from the international community, does not facilitate the coordination of multiple stakeholders through a Department whose management capabilities need to be strengthened.

Finally health decentralization is supposed to realization through three levels of care: a primary level, where first line Health Services will be networked with and around a Reference Community Hospital, a secondary level represented by a County hospital and a tertiary level by university hospitals and specialized hospitals. The decentralization process initiated in the 80s has not evolved much. To date, the county health departments have very little power and few resources to perform the duties assigned to them. On the other hand, the MOPHP, have not yet taken concrete measures to make the of UCS the health decentralization approach par excellence, it follows that despite the plans developed for this purpose and the resources invested, very few Communal Health units are functional. Routine vaccine coverage for 0-11 months is insufficient (DTP 3: 70% and RR 45% in 2010) lead to the accumulation of unvaccinated people. Routine covers estimated for 2010 by the Health Information System (administrative covers) must be interpreted keeping in mind:

- Firstly, the completeness of national institutions monthly reporting is 56%;
- On the other hand, the Measles Rubella (MR) was generally only administered after the first year, the MOPHP's CEO's circular requiring the administration of the MR at 9 months has not been followed in many service delivery sites.
- Finally, the catch up made during the infancy week was not taken into account.

The EPI Multi-Year Plan, covering the period 2011-15 which underlies the present application, provides not only the introduction of new vaccines and the development of measures to control and reduce vaccine

wastage, but also the implementation of strategies aimed at improving immunization coverage. This Plan, developed as the National Health Sector Plan expired (2010), should be revised as the new National Health Sector Plan will be made available and validated by the new government.

2. Nature of the proposal.-

The Department of Public Health and Population (MOPHP) in Haiti seeks support from the GAVI Alliance to introduce 3 new vaccines into the national schedule: the pentavalent vaccine, DTP-HepB-Hib, the anti-pneumococcal vaccine and the anti rotavirus vaccine. The MOPHP has planned a national introduction of these vaccines, from the beginning of 2012 for the pentavalent and 2013 for the two others, capitalizing on the experience of introducing the pentavalent. The support requested from GAVI is for a period of 5 years from the year of introduction of the vaccine in question.

3. Justification of the proposal

a) Pentavalent vaccine (DTP-HepB-Hib).-

Acute respiratory infections are the most common causes of mortality in underdeveloped countries. Pneumonia kills more children less than 5 years old than other diseases. In 2008, the WHO and UNICEF reported that globally pneumonia was responsible for 14% of all deaths of children less than 5 years old (being 1.6 million deaths) and in the Americas, it was 10%. The introduction of the pentavalent vaccine in the immunization schedule in countries like Gambia and Kenya in Africa has resulted in a substantial reduction in infant and child mortality due to pneumonia. Similar results were obtained in South American countries like Colombia, Chile, Brazil and Uruguay. On the other hand the introduction of the pentavalent vaccine in the Dominican Republic was followed by a drastic reduction in the incidence of childhood meningitis.

In Haiti, it is estimated that pneumonia is responsible for approximately 20% of deaths in this age group. This rate is 2 times that of other Latin American and Caribbean countries, with the exception of the Dominican Republic where it is 18%. As we know, the type B Haemophilus influenza is placed as the second leading cause of pneumonia and is the leading cause of death in infants and children in underdeveloped countries, primarily affecting the group of 6 to 18 months.Haiti is currently the only country in Latin America and the Caribbean that has not yet introduced the conjugates type B Haemophilus influenza and anti-hepatitis B into its program.

The MOPHP taking into account the importance of ARI in infant/ child mortality and the contribution of the type B haemophilus influenza in the etiology of the latter, has decided to benefit Haitian children with the pentavalent vaccine that in addition, prevents cases of hepatitis B in which seroprevalence in blood donors shows a high rate of 4 to 6%. (Ref PNST -2009). The MOPHP gives higher priority to the pentavalent vaccine considering the fact that it avoids the deaths of children at minimal cost.

b) Pneumococcal and rotavirus vaccines

Regionally, in Latin America and the Caribbean, it was estimated that pneumococcal infections annually caused 1.3 million of low profile otitis, 327,000 cases of pneumonia, 1229 cases of pneumococcal septicemia and 3918 cases of pneumococcal meningitis. Immunization with the anti-pneumococcal conjugate vaccine would probably have prevented many of these cases being, 0.9 lives saved per 1000 children vaccinated, and 1 case of pneumococcal disease prevented for every 80 children vaccinated. On the other hand, it is estimated that in Latin America and the Caribbean the rotavirus causes about 111 million cases of gastroenteritis requiring home care, 25 million doctor visits, 2 million hospitalizations and between 352,000 and 592,000 deaths in children under 5 years of age.

In Haiti, the most recent estimate of the rate of infant and child mortality rates (ICMR) goes back to the EMMUS-IV (2005-2006). It was 86 per 1000 live births. It is a very high ICMR: it means that the 282,386 expected births in 2010 will be followed by the death of 2428 children aged 0-5 years and that a Haitian child has a 1 in 12 child risk of death before their fifth birthday.

The causes of infant deaths as well as those of child deaths are dominated by the so-called poverty diseases, namely: infectious diseases and malnutrition that respectively hold 1st and 2nd place and total more than half (56%) of deaths under one year and three quarters (81%) thereafter. Among the common

fatal infections under 1 year, 31% are ARI, 26% are diarrhea and 13% meningitis. Whilst from 1 year to 4 years, among the common fatal infections, 37% are diarrhea diseases, 21% acute respiratory infections and 9% are meningitis. There is evidence that the pneumococcus, like type B Haemophilus influenza, is a predominant etiology of serious ARI and potentially fatal in those under 5 years of age. It is the same for meningitis in this age group. It is also established that the rotavirus is a predominant etiology of deaths from diarrhea in children less than 5 years of age.

The Department of Public Health and Population (MOPHP) taking into account the importance of ARI and diarrhea diseases in infant/ child mortality and estimates of the respective contribution of the pneumococcus and rotavirus in the etiology of these has decided to give Haitian children anti-pneumococcal and anti-rotavirus vaccines.

4. Selected formulations

Haiti has chosen to introduce the following forms of new vaccines:

• The vial of 1 dose of Pentavalent vaccine DTP-HepB-Hib (liquid form) to be given to children under one year following the same schedule as the DTC vaccine being three doses of primary vaccination at 6, 10 and 14 weeks. This form provides three advantages: it requires no dilution or reconstitution syringes, reduces the risks associated with handling by unskilled workers and significantly reduces the risk of losses. For the booster set in the national calendar, because of the limited impact of Haemophilus influenza observed between 12 and 24 months and the high cost of the DTP-HepB-Hib vaccine, one dose of DPT is administered 1 year after the third dose of the pentavalent vaccine.

• The Vial of 1 dose of anti-pneumococcal vaccine liquid. This vaccine will be administered as 3 doses on the same schedule as DTP-Hep B-Hib, being 6, 10 and 14 weeks.

• The vial of a liquid dose of anti-rotavirus vaccine for 2 scheduled doses. This vaccine will be administered as 2 doses at 6 and 10 weeks.

5. Cold chain

An external evaluation of the cold chain and vaccine management has just been carried out by an international consultant. This allowed the estimation of existing storage capacity on the three operational levels. This data was compared with the storage capacities that are necessary in view of the introduction of the new vaccines.
The assessment has identified gaps in the storage volume at operational level and allowed for the proposal of adequate measures to meet the needs of additional storage space. Accompanying measures in the short term and budget projections are also proposed for improving the cold chain management, as well as the distribution of vaccines and inputs at all levels.

At a central level, the necessary capacity in preparation for the introduction of 3 new vaccines is estimated at 40 M3, against a current capacity of 17 M3 in positive temperature. It is intended to complete the storage capacity in 2011, by installing two additional cold rooms of 20 m3 capacity each.

At departmental level, the overall storage capacity necessary for the introduction of 3 new vaccines is estimated at almost 10 M3. The total consolidated existing capacity is 3.8 m3. These gaps in storage capacity will be filled within the 21 departmental and sub departmental depots in 2011/12. These depot's equipment parks will be reconfigured to gradually replace the existing small gas refrigerators by the use of larger electrical refrigerators. Priority use of solar energy is also planned to continually satisfy the energy needs of this new cold chain intermediary. Subsequently, the substitution of certain departmental depot's refrigerator pools with cold rooms will be considered amongst the support opportunities and feasibility studies results.

At institutional level, providers whose storage capacity is usually sufficient, reinforcements will be made according to needs identified by detailed physical inventories. Preference will be given to solar units while ensuring retention of the panels. The recommendations of the external vaccine management and cold chain evaluation will be implemented from 2011 and assessed at the end of 2012, to control and reduce losses.

6. Plan for the introduction of new vaccines

The introduction of pentavalent as concomitant of the anti pneumococcal and anti Rotavirus vaccine will be preceded by preparatory measures to: a) supplement the storage capacity and improve cold chain and vaccine management to control and reduce losses, set up the target disease monitoring devices and suspected Adverse Events Following Immunization (AEFI), capacity of health personnel and inform and educate the public as well as professional bodies, the media and authorities/ leaders

7. Expected Results

The objectives of vaccination coverage of 281,192 survivors at one year in 2012 (which will be 305,124 in 2015) are: for the third dose of Pentavalent: 75% in 2012, 80% in 2013, 85% in 2014, and 90% in 2015. For the anti pneumococcal vaccines, they are for the third dose, 80% in 2013, 85% in 2014, 90% in 2015; for the anti rotavirus vaccine, the objectives are for the second dose of 80% in 2013 85% in 2014 and 90% in 2015. Meanwhile, the rate of loss of all these vaccines should not exceed the minimum loss rate of 5%.

8. The Partners:

The national vaccination program is approved by several partners who are all part of the Interagency Coordinating Committee/ EPI (ICC/ EPI). They are:

• the traditional partners: PAHO/ WHO (technical and financial support), UNICEF (financial, technical and logistic support)

• the other partners: ACDI (financial support), the Japanese Cooperation (logistics), The Center for Disease Control (CDC/ USA) (technical and financial), Brazil and Cuba through the tripartite project (financial and technical)

9. Financing

The amount of support requested from GAVI for the acquisition of pentavalent and related inputs is estimated by the country application form at: USD 7,299,000.00 for co-financing expected from the country of USD 694,000.00. For pneumococcus, the co-financing amounts are respectively USD 9,774,000.00 and USD 552,000.00. For rotavirus, they amounted to USD 7,783,000.00 and USD 368,500.00. The operational costs of the introduction, which will be financed through the "One Time New Vaccine Introduction Grant from GAVI Alliance" is US$ 300,000.00 (being 100,000.00 per new vaccine.) On the other hand, the cold chain adjustment costs by level will be supported by the tripartite project (Haiti-Brazil-Cuba) as well as by JICA probably.

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 Haiti 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 DTP-HepB-Hib 1 dose/vial Liquid , Pneumococcal (PCV13) 1 doses/vial Liquid , Rotavirus 2-dose schedule introduction.

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

Tables 6.(n).5. (where (n) depends on the vaccine) in the NVS section of this application shows the amount of support in either supply or cash that is required from the GAVI Alliance. Tables 6.(n).4. of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

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 October.

Please note that this application will not be reviewed or approved by the Independent Review Committee (IRC) without the signatures of both the Minister of Health & Minister of Finance or their delegated authority.

Enter the family name in capital letters.

Minister of Health (or delegated authority)		**Minister of Finance (or delegated authority)**	
Name	Dr Alex LARSEN	**Name**	Mr. Ronald BAUDIN
Date		**Date**	
Signature		**Signature**	

This report has been compiled by

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.
Enter the family name in capital letters.

Full name	Position	Telephone	Email	Action
Dr Jean Ronald Cadet	National Director EPI	(509) 34595601 / (509)36615091	janwonal@yahoo.fr	

4.1.2. National Coordinating Body - Inter-Agency Coordinating Committee for Immunisation

We the members of the ICC, HSCC, or equivalent committee[1] met on the 10.05.2011 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

[1] Inter-agency Coordinating Committee or Health Sector Coordinating Committee, or equivalent committee which has the authority to endorse this application in the country in question.

The endorsed minutes of this meeting are attached as DOCUMENT NUMBER: 1.

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.
Enter the family name in capital letters.

Name/Title	Agency/Organisation	Signature	Action
Dr Alex LARSEN / Minister	Ministry of Public Health and Population		
Dr Gabriel THIMOTHE/ Director General	Ministry of Public Health and Population		
Mme Gabrielle MATHIEU/ First Secretary, Development	Canadian Embassy		
Dr Peter GRAAFF / Representative in Haiti	Representative of PAHO/WHO		
Ms. Francoise GRULOOS-ACKERMANS / Representative in Haiti	UNICEF		
Mr. Koïchiro ISHIYAMA / Attaché	Japan Embassy		
Mr. Carlos FELIPE ALMEIDA / Coordinator	Tripatrite project Haiti/ Brazill/ Cuba		
Mr. Jorge VELASCO / Director	Health /Nutrition Project USAID		
Sr Estivez GONZALO / Coordinator	Cuban Medical Brigade		
Dr Elsie OVILE POTHEL	Haitian Pediatric Society (HPS)		

In case the GAVI Secretariat has queries on this submission, please contact
Enter the family name in capital letters.

Name	Dr Jean Ronald CADET	**Title**	National EPI Director
Tel no	(509) 34595601 / (509)36615091		
Fax no		**Address**	EPI Office Ministère de la Sante Publique et de la Population Ancien local de l'hôpital Militaire Rue St Honore # 111 Port-au-Prince , Haiti
Email	janwonal@yahoo.fr		

4.1.3. The Inter-Agency Coordinating Committee for Immunisation

Agencies and partners (including development partners and NGOs) supporting immunisation services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC, HSCC, or equivalent committee). The ICC, HSCC, or equivalent committee is responsible for coordinating and guiding the use of the GAVI NVS support. Please provide information about the ICC, HSCC, or equivalent committee in your country in the table below.

Profile of the ICC, HSCC, or equivalent committee

Name of the committee	Inter-agency Coordination Committee EPI (ICC/EPI)
Year of constitution of the current committee	1987
Organisational structure (e.g., sub-committee, stand-alone)	The ICC is not part of the committee. It is an ad hoc Committee formed by the MOPHP for ensuring the development of EPI
Frequency of meetings	Quarterly

Composition

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.
Enter the family name in capital letters.

Function	Title / Organisation	Name	
Chair	Minister/MOPHP or Director General MOPHP	Dr Alex LARSEN or Dr Gabriel THIMOTHE	
Secretary	National Director EPI	Dr Jean Ronald CADET	
Members	Representative/ PAHO/WHO	Mr.Peter GRAAFF	**Action**
	First Secretary, Development// Canadian Embassy	Mrs. Gabrielle MATHIEU	
	Representative/ UNICEF	Mrs.Françoise GRULOOS	
	Attaché to the Japanese Embassy	Mr. Koïchiro ISHYAMA	
	Coordinator / Tripatrite Project Haiti /Brazil / Cuba	Mr. Carlos FELIPE ALMEIDA	
	–Director/ Health/Nutrition Project USAID	Mr. Jorge VELASCO	
	Coordinator/ Cuban Medical Brigade	Mr. Estivez GONZALO	
	Dr Elsie OVILE POTHEL	Haitian Pediatric Society (HPS)	

Major functions and responsibilities of the committee

The ICC/ EPI are the consultative bodies between the MOPHP and its partners. This consultation covers the program guidelines, within the following interventions:

- **development of the EPI Strategic Multi-Year Plan (EPI-SMYP).**
- **Reconciliation of the needs and resources available or mobilizable at local or international level.**
- **monitoring and evaluation of the implementation of EPI-SMYP.**

The functionality of the ICC-EPI can be assessed on the level of adequacy according to the following five criteria:

1. **Official existence and formal regulatory framework.**
2. **Integration of all institutions amenable to be members, namely the major international and national agencies involved in supporting the EPI**
3. **Regular Meeting**
4. **It is systematically taken from the strategic guidelines and key events (and adoption of strategic plans, action plan, negotiations with any new partner, and milestones for monitoring/ evaluation and validation of the implementation report of the**

annual action plan 5. Its deliberations are supported by the preliminary work of the CT and are promulgated officially.

Three major strategies to enhance the committee's role and functions in the next 12 months

1.	**Evaluate, in light of these roles and functions, the actions conducted by the ICC/ EPI in the past 2 years.**
2.	**On the basis of the assessment results, develop an Action Plan jointly with the Committee addressing the issues or weaknesses that have been identified**
3.	**Strengthen the management of ICC/ EPI with emphasis on the following:** **a) Formalizing the Committee's operation structure and method in a document** **b) Developing a schedule of meetings covering the whole year** **c) Organizing the ICC/ EPI archives**

4.2. National Immunization Technical Advisory Group for Immunisation

(If it has been established in the country)

We the members of the NITAG met on the 05.05.2011 to review 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: 2.

In case the GAVI Secretariat has queries on this submission, please contact
Enter the family name in capital letters.

Name	Dr Jean Ronald CADET	**Title**	Director EPI
Tel no	(509) 34595601 / (509) 36615091		
Fax no		**Address**	Ministère de la Sante Publique et de la Population - Bureau de la DPEV--Ancien local de l'hôpital Militaire , Rue .....
Email	janwonal@yahoo.fr		

4.2.1. The NITAG Group for Immunisation

Profile of the NITAG

Name of the NITAG	EPI Technical Committee
Year of constitution of the current NITAG	1987
Organisational structure (e.g., sub-committee, stand-alone)	Subcommittees are formed only when there are works to be done. In such cases, work groups are formed.
Frequency of meetings	Monthly

Composition

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.
Enter the family name in capital letters.

Function	Title / Organisation	Name
Chair	Director or Assistant Director / National Directorate EPI	Dr Jean Ronald CADET or Dr François JEANNOT
Secretary	Head of Operations / EPI Directorate	Mme Marie Nicole NOEL

Function	Title / Organisation	Name	
Members	Senior Officer for Health / USAID	Dr Zolberg DESINOR	**Action**
	Director General / Association of Private Health Care services.	Dr Philippe HIRSH	
	Expert on Health / United Support for Canadian Projects (USCP)	Dr André Paul VENOR	
	Head of EPI /UNICEF	Dr Clement DJUMO	
	Consultant EPI/PAHO/WHO	Dr François LACAPERE	
	Director of Project / SDSH	Dr Florence GUILLAUME	
	Director DSF / MOPHP	Dr Guylaine RAYMOND	
	Director UPE/ MOPHP	Dr Antoine ALCEUS	

Major functions and responsibilities of the NITAG

It is a body that brings the country's technical expertise together, including other branches of the MOPHP regarding public health and vaccination, in the view of:

1. Bringing technical assistance to the DPEV in the development of policy decisions and the steering of the program.
2. Assist the DPEV in developing the supporting arguments and documents for the decisions it is submitting to the ICC-EPI for deliberation.

Three major strategies to enhance the NITAG's role and functions in the next 12 months

1.	**Evaluate the actions conducted by the CTPEV over the past 2 years regarding their consistency with the functions assigned to this structure.**
2.	**Based on evaluation results, correct Committee functions or possibly enhance them**
3.	**Strengthen the management of CTC/ EPI by:** **a) Formalizing the Committee's operation method in a document** **b) Developing a schedule of meetings covering the whole year** **c) Organizing the ICC/ EPI archives**

5. Immunisation Programme Data

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 Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan) and attach a complete copy (with an Executive Summary) as DOCUMENT NUMBER 3
- Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases.
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.

5.1. Basic facts

For the year (most recent; specify dates of data provided)

	Figure		Year	Source
Total population	10,363,566		2011	IHSI
Infant mortality rate (per 1000)	57		2005	EMMUS IV
Surviving Infants[1]	266,290		2011	Calculated from data from EMMUS IV and IHSI
GNI per capita (US$)	450		2006	Internal Monetary Agency
Total Health Expenditure (THE) as a percentage of GDP	2.70	%	2006	PAHO/WHO
General government expenditure on health (GGHE) as % of General government expenditure	5.00	%	2010	MOPHP/UPE

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

Please provide some additional information on the planning and budgeting context in your country; also indicate the name and date of the relevant planning document for health

Planning and budgeting .- refers to the 1987 Constitution which for example upholds the rights to health for all citizens for example:

- to the General Government Policy in place that offers specific intervention.
.-to the sector's National Policy.
and Strategic Plan of the area.
In the health sector, until 2010, the reference document was the National Strategic Plan for the Reform of the Health Sector 2006-2010.
For the five year plan that started in 2011, the Plan will be developed by the new government that will take office in May 2011.

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

The CMYP is in accordance with the guidelines of the National Strategic Health Plan which has just ended in 2010. The absence of the New Strategic Health Plan 2011-201...is not a serious problem as the new authorities will make contact with the sectors to learn about the different dossiers. The new government will also make contact with the international cooperation of which the members of the ICC/ EPI are a part. Therefore, given the support of the EPI, there is no risk that the new authorities do not continue to provide the same support to the EPI and disagree with the decisions taken by the previous government.

Please indicate the national planning budgeting cycle for health

The fiscal year begins October 1st and ends September 30th.

With regard to Planning, from the month of May each year, the Ministry of Planning requires public institutions and departments to prepare their operational plans for the coming year so that they are ready to be submitted before the start of the next fiscal year.
The Ministry of Health carries out this exercise first with the health municipalities that develop the Integrated Community Plans (CIP) from which the integrated departmental plans are prepared (IDP). Finally the synthesis of the IDPs provides the national integrated operational plan or POI.
The budgeting process follows that of the planning that goes through the following steps:
a) The prime minister issues a budget circular or framework letter requesting sectors to initiate the budgeting process focusing on priority government areas.
b) On this basis, the Minister of Finance prepares a budget outline that is sent to public institutions and ministers.
c) The public institutions and ministers each propose a draft budget on the basis of their developed operational plans and send it to the Minister of Finance) The Minister of Finance carries out a first arbitration and prepares a preliminary draft budget that is submitted to the Cabinet.
e) The Council of Ministers after discussion adopt the draft or suggest changes, f) Once adopted, the preliminary draft is sent to the National Assembly for adoption.
g) Then sent to the President for budget law promulgation for the year ahead.
It is at the result of this process that the MOPHP will know the amount that is granted and the necessary changes to its budget.
Of this transaction, the MOPHP fills the program Operation Form and the program Projects Operational Identification Sheet (POIS) that is submitted to the Planning Minister to request the disbursement of funds for the first quarter.
The POIS also contains a chapter devoted to the evaluation of activities financed with public funds and with external funds.
The disbursement of the next portion of the allocated budget is conditioned by the submission of the results of this evaluation...

Please indicate the national planning cycle for immunisation

The National Expanded Program on Immunization develops its plan within the framework of the MOPHP's planning cycle. However, whether its municipality health schemes, or health departments, they all refer to the CMYP to develop their operational plans.

Please indicate if sex disaggregated data (SDD) is used in immunisation routine reporting systems

The vaccination statistics are not disaggregated by sex. Disaggregating by sex would complicate the collection of data too much, which is already is by age, by antigen and by dose.
This already presents data reliability problems when it concerns the level of service personnel.
Therefore, data monitoring by gender is performed only by surveys which show no negative discrimination against females (Ref: EMMUS I-IV)

Please indicate if gender aspects relating to introduction of a new vaccine have been addressed in the introduction plan

There is no reason to believe that the introduction of these new vaccines is likely to lead to gender discrimination.

5.2. Current vaccination schedule

Traditional, New Vaccines and Vitamin A supplement (refer to cMYP pages)

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.

Vaccine (do not use trade name)	**Ages of administration** (by routine immunisation services)	**Given in entire country**	**Comments**	**Action**
BCG	At Birth	Yes		

Vaccine (do not use trade name)	Ages of administration (by routine immunisation services)	Given in entire country	Comments	Action
Polimylite	At birth 6 weeks - 10 weks	Yes	1 dose de renforcement 1 an après la 3ème dose	
DTC	1 dose for strenthening 1 year ager the 3rd dose.	Yes	A partir de 2012	
RR	9 mois	Yes	1 dose a 15 mois (Sera remplace par ROR en 2012)	
Pentavalent	6 weeks-10 weeks-14 weeks	Yes		
Antirotavirus	6,10 weeks	Yes		
Anti pneumococcus	6,10 , 14 sweeks	Yes		
Td	5 does of vaccinnes 2 doses at FE and 5 doses at FEAP	Yes	1 dose at 15 years after 4th; 3rd after 6 months	
			4th dose after 1 yrear; 5th doese after 1 year	
Vitamin A	each six months (100,000 ui before one year and 200,000 ui after)	Yes	From 6 months to 6 eyars 11 months	

5.3. Trends of immunisation coverage and disease burden

(as per last two annual WHO/UNICEF Joint Reporting Form on Vaccine Preventable Diseases)

Trends of immunisation coverage (percentage)						Vaccine preventable disease burden		
Vaccine		Reported		Survey		Disease	Number of reported cases	
		2009	2010	2009			2009	2010
BCG		61	64	88		Tuberculosis	10,155	
DTP	DTP1	59	75	92		Diphtheria	17	
	DTP3	53	79	75		Pertussis		
Polio 3		52	62	73		Polio	0	0
Measles (first dose)			45	45		Measles	0	0
TT2+ (Pregnant women)						NN Tetanus		
Hib3						Hib[2]		
Yellow Fever						Yellow fever		
HepB3						HepBsero-prevalence[1]		
Vitamin A supplement Mothers (< 6 weeks post-delivery)								
Vitamin A supplement Infants (>6 months)								

[1] If available

[2] **Note**: JRF asks for Hib meningitis

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

This is a survey that was conducted with technical assistance from CDC in 2009 The survey was conducted in each of the 10 departments of Haiti. . - The objectives were to evaluate immunization coverage against measles and rubella among children aged 1-19 years during the last campaign.
. - to evaluate the routine immunization coverage among children 12 to 23 months.

5.4. Baseline and Annual Targets

(refer to cMYP pages)

Table 1: baseline figures

Number	Base Year	Baseline and Targets					
	2010	2012	2013	2014	2015		
Total births	282,386	298,189	306,419	314,876	323,567		
Total infants' deaths	16,096	16,997	17,466	17,948	18,443		
Total surviving infants	266,290	281,192	288,953	296,928	305,124		
Total pregnant women	282,386	298,189	306,419	314,876	323,567		
Number of infants vaccinated (to be vaccinated) with BCG	184,680	193,823	214,493	236,157	258,854		
BCG coverage (%)[1]	65%	65%	70%	75%	80%		
Number of infants vaccinated (to be vaccinated) with OPV3	176,284	196,834	216,715	237,542	274,611		
OPV3 coverage (%)[2]	66%	70%	75%	80%	90%		
Number of infants vaccinated (or to be vaccinated) with DTP1[3]	214,896	224,954	245,610	267,235	289,867		
Number of infants vaccinated (to be vaccinated) with DTP3[3]	193,859	210,894	231,162	252,389	274,611		
DTP3 coverage (%)[2]	73%	75%	80%	85%	90%		
Wastage[1] rate in base-year and planned thereafter for DTP (%)	30%	25%	20%	15%	10%		
Wastage[1] factor in base-year and planned thereafter for DTP	1.43	1.33	1.25	1.18	1.11		
Infants vaccinated (to be vaccinated) with 1st dose of HepB and/or Hib	214,896	224,954	245,610	267,235	289,867		
Infants vaccinated (to be vaccinated) with 3rd dose of HepB and/or Hib	193,859	210,894	231,162	252,389	274,611		
HepB and/or Hib 3rd dose coverage (%)[2]	73%	75%	80%	85%	90%		
Target population vaccinated with 1st dose of Pneumococcal			245,610	267,235	289,867		
Target population vaccinated with 3rd dose of Pneumococcal			231,162	252,389	274,611		
Pneumococcal coverage (%)[2]	0%	0%	80%	85%	90%		
Target population vaccinated with 1st dose of Rotavirus			245,610	267,235	289,867		

Number	Base Year	Baseline and Targets					
	2010	2012	2013	2014	2015		
Target population vaccinated with last dose of Rotavirus			231,162	252,389	274,611		
Rotavirus coverage (%)[2]	0%	0%	80%	85%	90%		
Infants vaccinated (to be vaccinated) with 1st dose of Measles	119,158	168,715	202,267	237,542	274,611		
Measles coverage (%)[2]	45%	60%	70%	80%	90%		
Pregnant women vaccinated with TT+	159,599	178,913	199,172	220,413	258,853		
TT+ coverage (%)[4]	57%	60%	65%	70%	80%		
Vit A supplement to mothers within 6 weeks from delivery							
Vit A supplement to infants after 6 months	844,734	934,822	1,029,239	1,128,156	1,231,749		
Annual DTP Drop-out rate[(DTP1 - DTP3) / DTP1] x 100[5]	10%	6%	6%	6%	5%		

[1] Number of infants vaccinated out of total births

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

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

[4] Number of pregnant women vaccinated with TT+ out of total pregnant women

[5] 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.

5.5. Summary of current and future immunisation budget

(or refer to cMYP pages)

Cost category	Estimated costs per annum in US$ (in thousand US$)								
	Base Year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
	2006	2012	2013	2014	2015				
Routine Recurrent Cost									
Vaccines (routine vaccines only)	**534,100**	**4,268,867**	**12,597,116**	**11,927,594**	**12,917,881**				
Traditional vaccines	534,100	360,284	369,556	378,718	411,006				
New and underused vaccines		3,908,583	12,227,560	11,548,876	12,506,875				
Injection supplies	82,591	176,644	266,576	279,842	310,864				
Personnel	**2,361,285**	**2,488,985**	**2,538,765**	**2,589,540**	**2,641,332**				
Salaries of full-time NIP health workers (immunisation specific)	201,285	241,721	246,556	251,487	256,517				
Per-diems for outreach vaccinators / mobile teams	2,160,000	2,247,264	2,292,209	2,338,053	2,384,815				
Transportation	349,341	363,551	399,670	408,879	713,693				
Maintenance and overheads	410,848	968,501	1,056,034	1,154,155	1,262,262				
Training	103,280	894,744	912,639	930,892	949,509				
Social mobilisation and IEC	847	104,040	159,181	162,365	165,612				
Disease surveillance	926,250	1,440,902	1,469,720	1,499,114	1,529,097				
Program management	5,987	1,252,642	1,277,694	1,303,248	1,329,313				
Other		10,404	10,612	10,824	11,041				

Cost category	Estimated costs per annum in US$ (in thousand US$)								
	Base Year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
	2006	2012	2013	2014	2015				
Subtotal Recurrent Costs	***4,774,529***	***11,969,280***	***20,688,007***	***20,266,453***	***21,830,604***				
Routine Capital Costs									
Vehicle	192,000	27,467	28,016		241,794				
Cold chain equipment		369,997	231,874	236,511	241,242				
Other capital equipment		305,878	301,383	307,411	313,559				
Subtotal Capital Costs	***192,000***	***703,342***	***561,273***	***543,922***	***796,595***				
Campaigns									
Polio				1,163,409					
Measles				2,426,390					
Yellow Fever									
MNT campaigns		706,117	732,544	1,948,379	3,749,463				
Other campaigns			6,878,599						
Subtotal Campaign Costs	***0***	***706,117***	***7,611,143***	***5,538,178***	***3,749,463***				
GRAND TOTAL	**4,966,529**	**13,378,739**	**28,860,423**	**26,348,553**	**26,376,662**				

5.6. Summary of current and future financing and sources of funds

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

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.

Cost category	Funding source	Estimated costs per annum in US$ (in thousand US$)								
		Base Year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8

		2006	2012	2013	2014	2015				
Routine Recurrent Cost										
Traditional Vaccines	UNICEF/ JICA ;Bresil(Tripartite)	534,100	360,284	369,556	378,778	411,006				
Under Used and New Vaccines	MOPHP, GAVI, CDC		39,085,583	12,227,560	11,548,876	12,506,875				
Mtrls Injection	JICA, UNICEF	82,591	176,664	266,576	279,842	310,864				
Salaries and per idem	MOPHP, ACDI, WHO	2,361,285	2,488,985	2,538,765	2,589,540	2,641,331				
Surveillance/Monitoring (inc per diem)	WHO, ACDI, GAVI	926,250	1,440,902	1,469,720	1,499,114	1,529,097				
Transport	PAHO/WHO/ACDI	349,341	363,551	399,670	408,879	713,693				
Maintenance	MOPHP, UNICEF/ACDI	410,848	968,501	1,056,034	1,154,155	1,262,262				
Formation	CDC, GAVI, WHO/PAHO/ACDI	103,280	894,744	912,639	930,892	949,509				
Social Mobilization/IEC	WHO/PAHO/ACDI, B.Mondiale	847	104,040	159,181	162,365	165,612				
Program Management	WHO/PAHO/ACDI,	5,987	1,252,642	1,277,694	1,303,248	1,329,313				
Others	To be finalized		10,404	10,612	10,824	11,041				
Routine Capital Costs										
Vehicles, CDF and others	MOPHP, UNICEF/JICA;Bresil(Tripartite)	192,000	703,342	561,273	543,922	796,594				
Campaigns										
All Campaigns	UNICEF et WHO (50 /50)		706,117	7,611,142	6,298,211	4,538,096				
GRAND TOTAL		**4,966,529**	**48,555,759**	**28,860,422**	**27,108,646**	**27,165,293**				

6. New and Under-Used Vaccines (NVS)

Please summarise the cold chain capacity and readiness to accommodate new vaccines, stating how the cold chain expansion (if required) will be financed, and when it will be in place. Please indicate the additional cost, if capacity is not available and the source of funding to close the gap.

At a central level, the necessary capacity with regard to the introduction of 3 new vaccines is estimated at 40 M3, against a current capacity of 17 M3 in positive temperature. It is intended to complete the storage capacity in 2011, by installing two additional cold rooms of 20 m3 capacity.... each. These cold rooms are already purchased by UNICEF with JICA funds and are ready to be installed.

At departmental level, the overall storage capacity necessary for the introduction of 3 new vaccines is estimated at almost 10 M3. The total consolidated existing capacity is 3.8 m3. These gaps in storage capacity will be filled within the 21 departmental and sub departmental depots in 2011/12. These depots equipment parks will be reconfigured to gradually replace the existing small gas refrigerators by the use of larger electrical refrigerators. Priority use of solar energy is also planned to continually satisfy the energy needs of this new cold chain intermediary. Subsequently, the substitution of certain departmental depot's refrigerator pools with cold rooms will be considered amongst the support opportunities and feasibility studies results Departmental level solar units will be purchased with the Brazil/ Cuba/ Haiti project funds.

At institutional level, providers whose storage capacity is usually sufficient, reinforcements will be made according to needs identified by detailed physical inventories. Preference will be given to solar units while ensuring retention of the panels. The recommendations of the external vaccine management and cold chain evaluation will be implemented from 2011 and assessed at the end of 2012, to control and reduce losses.

Please give a summary of the cMYP sections that refer to the introduction of new and under-used vaccines. Outline the key points that informed the decision-making process (data considered etc)

From 2012, the program will introduce the pentavalent vaccine, liquid form (DTP-HepB-Hib1) downstream of 10 doses which will be administered as 3 doses according to the DTC implementation schedule (6, 10.14 weeks). In 2013 two new vaccines will be introduced namely:

. -- anti-pneumococcal (PCV13) downstream of 1 liquid dose still to be administered at 6, 10 and 14 weeks.
. -- oral anti-rotavirus downstream of 1 liquid dose to be administered in 2 doses at 6 and 14 weeks.

The introduction of these new vaccines is carried out simultaneously throughout the 10 health departments.
In preparation for the introduction of these new vaccines, a cold chain capacity and functionality evaluation is achieved. The results will allow for the adaptation of existing capacity to the need for additional storage that will require new vaccines.On the other hand, this introduction requires a readiness on the one hand of staff training to ensure the administration of these new services, on the other, beneficiary's information and awareness (public or community).To this end, an introduction plan is developed for the introduction of pentavalent in early 2012 and of this plan are expected the following results:

. -- A staff training and information program is developed.
-- Didactic training materials are designed, reproduced and distributed.
-- A Communication Plan for the introduction of the pentavalent vaccine is developed and executed.
. -- The personnel at central, departmental and operational levels are informed of the characteristics of the new vaccine and are trained in the standards of its administration.
-- The health departments develop their operational plan for the introduction of the new vaccine.
-- A promotional campaign for the introduction of the new vaccine is launched (the general public and institutions are informed of the benefits of the new vaccine - and its inclusion in the national schedule.
. -- The introduction of the new vaccine is officially launched by the national authorities and partners.
. -- The new vaccine is administered in all health departments.
. -- The monitoring component of ARI and meningitis due to Haemophilus influenza is added to the number of diseases controlled by vaccination under epidemiology surveillance.
.-- The monitoring component of the seroprevalence of hepatitis B is added to the number of immune diseases

controlled under surveillance epidemiology

It is important to note that the preparation of materials and documents necessary for the execution of said plan will begin in the month of June 2011.Regarding the two other new vaccines, namely: the anti pneumococcal and the anti rotavirus, to be introduced in 2013, their introduction plan will be a replication of that of the pentavalent vaccine. As for the pentavalent, the preparation of materials and documents necessary to execute the Introduction plan begins in June 2012. The decision process goes through the following stages namely:

. - Filling the application form addressed to GAVI.
- The development of the Financial Sustainability Plan.
- The presentation of the proposal to the ICC.
- The validation of the proposal by the ICC. - The sending of the proposal to GAVI.

6.1. Capacity and cost (for positive storage)

		Formula	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
			2012	2013	2014	2015				
A	Annual positive volume requirement, including new vaccine (litres or m^3) Liters	Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine	16,467	34,860	35,290	38,097				
B	Existing net positive cold chain capacity (litres or m^3) Liters	#	17,000							
C	Estimated minimum number of shipments per year required for the actual cold chain capacity	A / B	1							
D	Number of consignments / shipments per year	Based on national vaccine shipment plan	3	3	3	3				
E	Gap (if any)	((A / D) - B)	-11,511							
F	Estimated additional cost of cold chain	US$	270,000	20,250	20,250	20,250				

Please briefly describe how your country plans to move towards attaining financial sustainability for the new vaccines you intend to introduce, how the country will meet the co-financing payments, and any other issues regarding financial sustainability you have considered (refer to the cMYP)

The resource mobilization/ securing strategies will revolve around three axes:

1) The mobilization of additional resources at national and international levels:

- Strategy 1:

Strengthening the participation of the Haitian state in the financing:
The government has so far only funded the salaries of workers in the program.

- The commitment of the state to take over the propane gas refrigerator that has been made by the successive MOPHPs is a great step forward. It is essential that this commitment is kept, with regard to the fact that there is no cold chain without propane and that external agencies refuse to fund this section.
- To qualify for support from GAVI for the financing of new vaccines, the Haitian state should provide a financial contribution of $ 0.20 per dose. Even if it is a relatively symbolic contribution compared to the actual price it will represent a substantial fiscal effort (US$ 1.6 million).

Table 18: Financial viability

• Strategy 2:

Establishment of contracts with NGOs to support staff salaries ensuring the availability of community services (outreach) and institution's supply costs.

• Strategy 3:

Mobilizing international resources available at GAVI level, through:

- Preparation and submission of an application for funding from Health system reinforcement (GAVI-HSR)
- Preparation and submission of an application for funding for the introduction of new vaccines (GAVI-INV)]
- Implementation of recommendations from the Data Quality Audit (DQA) to reach a score at the next DQA rendering Haiti litigant of financial support from GAVI for immunization services support (GAVI-ISS).

• Strategy 4:

Renegotiate some funding categories with certain partners. This is a corollary with Strategy point 1, knowing that the two financial gap tables clearly identify that there are some budget categories that are under- and over-funded. The Haiti state and partners should agree to better cover the unfunded needs.

2) Improving the reliability of resources:

• Strategy 5:

Program performance improvement in terms of vaccine coverage, vaccine wastage reduction and cost control. This is in fact essential in order for the program to strengthen credibility without which it will have no long term donor commitment; Strategy 6: revitalization of the Inter Agency Coordination Committee to resume links and restore confidence equally indispensable between the program and the donors.

3) Improved resource efficiency:

Two strategies are to be implemented to improve the efficiency and effectiveness of the program:

• Strategy 6:

Improved management of financial resources, by 1) the use of budgeting programming tools that have been introduced since 2010, and 2) the development and introduction of transparent and effective management and accounting tools.

• Strategy 7:

Reducing vaccine wastage by improving the cold chain and vaccine management at all levels by implementing the recommendations of the external vaccine management and cold chain evaluation

6.2. Assessment of burden of relevant diseases (if available)

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.

Disease	Title of the assessment	Date	Results	

If new or under-used vaccines have already been introduced in your country, please give details of the lessons learned from storage capacity, protection from accidental freezing, staff training, cold chain, logistics, drop-out rate, wastage rate etc., and suggest action points to address them

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.

Lessons Learned	Action Points	
The only experience of introducing a new vaccine has been that of the measles/ rubella (MR), introduced into the routine in 2009 after	The program took the opportunity to update the vaccination standards and procedures.	

Lessons Learned	Action Points	
its use in the 2007-2008 national vaccination campaign. This introduction was preceded by a cold chain evaluation which highlighted a need for increased storage capacity at central level only. Action was given to this recommendation.	This is followed by a circular from MOPHP senior management addressed to all health staff officially announcing the introduction of the new vaccine, a change in the immunization schedule. Indeed, the age of administration of MR has been a change compared to that of the measles vaccine. It was agreed for the age of 9 months for the primary vaccination with a booster at 12 months.	

Please list the vaccines to be introduced with support from the GAVI Alliance (and presentation)
The following vaccines will be introduced respectively in 2012 and 2013:
1). - The DTP-HepB-Hib liquid vaccine in 1 dose vials.
2). - The anti pneumococcal (PCV 13) liquid vaccine, in 1 dose vials.
3). - The oral anti rotavirus vaccine, liquid form in 1 dose vials.

6.3.1. Requested vaccine (DTP-HepB-Hib, 1 dose/vial, Liquid)

As reported in the cMYP, the country plans to introduce DTP-HepB-Hib, 1 dose/vial, Liquid vaccine.

6.3.2. Co-financing information

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

Note: Selection of this field has direct impact on automatic calculations of support you are requesting and should not be left empty.

Country group	Low

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
	2012	2013	2014	2015				
Minimum co-financing	0.20	0.20	0.20	0.20				
Your co-financing (please change if higher)	0.20	0.20	0.20	0.20				

6.3.3. Wastage factor

Please indicate wastage rate:

Countries are expected to plan for a maximal wastage rate of:

- 50% - for a lyophilised vaccine in 10 or 20-dose vial,
- 25% - for a liquid vaccine in 10 or 20-dose vial or a lyophilised vaccine in 5-dose vial,
- 10% - for a lyophilised/liquid vaccine in 2-dose vial, and
- 5% - for a liquid vaccine in 1-dose vial

Note: Selection of this field has direct impact on automatic calculations of support you are requesting and should not be left empty.

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	**Year 8**
	2012	2013	2014	2015				
Vaccine wastage rate in %	5%	5%	5%	5%				
Equivalent wastage factor	1.05	1.05	1.05	1.05				

6.3.4. Specifications of vaccinations with new vaccine

	Data from		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
			2012	2013	2014	2015				
Number of children to be vaccinated with the first dose	Table 1	#	224,954	245,610	267,235	289,867				
Number of children to be vaccinated with the third dose[1]	Table 1	#	210,894	231,162	252,389	274,611				
Immunisation coverage with the third dose	Table 1	#	75.00%	80.00%	85.00%	90.00%				
Estimated vaccine wastage factor	Table 6.(n).3[3]	#	1.05	1.05	1.05	1.05				
Country co-financing per dose[2]	Table 6.(n).2[3]	$	0.20	0.20	0.20	0.20				

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Total price per-dose includes vaccine cost, plus freight, supplies, insurance, visa costs etc.
[3] Where (n) depends on the vaccine

6.3.5. Portion of supply to be procured by the country (and cost estimate, US$)

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
		2012	2013	2014	2015				
Number of vaccine doses	#	67,500	64,000	79,200	93,900				
Number of AD syringes	#	72,100	67,700	83,800	99,300				
Number of re-constitution syringes	#								
Number of safety boxes	#	800	775	950	1,125				
Total value to be co-financed by country	$	**177,500**	**158,000**	**172,000**	**186,500**				

6.3.6. Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
		2012	2013	2014	2015				
Number of vaccine doses	#	818,400	726,100	779,800	837,100				
Number of AD syringes	#	873,800	768,300	825,100	885,800				
Number of re-constitution syringes	#								
Number of safety boxes	#	9,700	8,550	9,175	9,850				
Total value to be co-financed by GAVI	$	**2,150,000**	**1,794,500**	**1,693,000**	**1,661,500**				

6.3.7. New and Under-Used Vaccine Introduction Grant

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).

Calculation of lump-sum for the DTP-HepB-Hib, 1 dose/vial, Liquid

If the total is lower than US$100,000, it is automatically rounded up to US$100,000

Year of New Vaccine Introduction	Births (from Table 1)	Share per Birth in US$	Total in US$
2012	298,189	0.30	100,000

[1] The Grant will be based on a maximum award of $0.30 per infant in the birth cohort with a minimum starting grant award of $100,000

Cost (and finance) to introduce the DTP-HepB-Hib, 1 dose/vial, Liquid (US$)

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.

Cost Category	Full needs for new vaccine introduction in US$	Funded with new vaccine introduction grant in US$
Training	79,000	50,000
Social Mobilization, IEC and Advocacy	65,000	50,000
Cold Chain Equipment & Maintenance	330,750	
Vehicles and Transportation	560,750	
Programme Management		
Surveillance and Monitoring		
Human Resources		
Waste Management		
Technical assistance		
Totals	1,035,500	100,000

6.4.1. Requested vaccine (Pneumococcal (PCV13), 1 doses/vial, Liquid)

As reported in the cMYP, the country plans to introduce Pneumococcal (PCV13), 1 doses/vial, Liquid vaccine.

6.4.2. Co-financing information

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

Note: Selection of this field has direct impact on automatic calculations of support you are requesting and should not be left empty.

Country group	Low

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
	2013	2014	2015					
Minimum co-financing	0.20	0.20	0.20					
Your co-financing (please change if higher)	0.20	0.20	0.20					

6.4.3. Wastage factor

Please indicate wastage rate:

Countries are expected to plan for a maximal wastage rate of:

- 50% - for a lyophilised vaccine in 10 or 20-dose vial,
- 25% - for a liquid vaccine in 10 or 20-dose vial or a lyophilised vaccine in 5-dose vial,
- 10% - for a lyophilised/liquid vaccine in 2-dose vial, and
- 5% - for a liquid vaccine in 1-dose vial

Note: Selection of this field has direct impact on automatic calculations of support you are requesting and should not be left empty.

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
	2013	2014	2015					
Vaccine wastage rate in %	5%	5%	5%					
Equivalent wastage factor	1.05	1.05	1.05					

6.4.4. Specifications of vaccinations with new vaccine

	Data from		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
			2013	2014	2015					
Number of children to be vaccinated with the first dose	Table 1	#	245,610	267,235	289,867					
Number of children to be vaccinated with the third dose[1]	Table 1	#	231,162	252,389	274,611					
Immunisation coverage with the third dose	Table 1	#	80.00%	85.00%	90.00%					
Estimated vaccine wastage factor	Table 6.(n).3[3]	#	1.05	1.05	1.05					
Country co-financing per dose[2]	Table 6.(n).2[3]	$	0.20	0.20	0.20					

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Total price per-dose includes vaccine cost, plus freight, supplies, insurance, visa costs etc.
[3] Where (n) depends on the vaccine

6.4.5. Portion of supply to be procured by the country (and cost estimate, US$)

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
		2013	2014	2015					
Number of vaccine doses	#	51,700	45,900	49,800					
Number of AD syringes	#	55,200	48,600	52,700					
Number of re-constitution syringes	#								
Number of safety boxes	#	625	550	600					
Total value to be co-financed by country	$	**193,500**	**172,000**	**186,500**					

6.4.6. Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
		2013	2014	2015					
Number of vaccine doses	#	915,500	813,000	881,200					
Number of AD syringes	#	977,500	860,300	932,500					
Number of re-constitution syringes	#								
Number of safety boxes	#	10,850	9,550	10,350					
Total value to be co-financed by GAVI	$	**3,429,000**	**3,044,500**	**3,300,500**					

6.4.7. New and Under-Used Vaccine Introduction Grant

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).

Calculation of lump-sum for the Pneumococcal (PCV13), 1 doses/vial, Liquid

If the total is lower than US$100,000, it is automatically rounded up to US$100,000

Year of New Vaccine Introduction	Births (from Table 1)	Share per Birth in US$	Total in US$
2013	306,419	0.30	100,000

[1] The Grant will be based on a maximum award of $0.30 per infant in the birth cohort with a minimum starting grant award of $100,000

Cost (and finance) to introduce the Pneumococcal (PCV13), 1 doses/vial, Liquid (US$)

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.

Cost Category	Full needs for new vaccine introduction in US$	Funded with new vaccine introduction grant in US$
Training	50,000	50,000
Social Mobilization, IEC and Advocacy	50,000	50,000
Cold Chain Equipment & Maintenance		
Vehicles and Transportation		
Programme Management		
Surveillance and Monitoring		
Human Resources		
Waste Management		
Technical assistance		
Totals	100,000	100,000

6.5.1. Requested vaccine (Rotavirus 2-dose schedule)

As reported in the cMYP, the country plans to introduce Rotavirus 2-dose schedule vaccine.

6.5.2. Co-financing information

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

Note: Selection of this field has direct impact on automatic calculations of support you are requesting and should not be left empty.

Country group	Low

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
	2013	2014	2015					
Minimum co-financing	0.20	0.20	0.20					
Your co-financing (please change if higher)	0.20	0.20	0.20					

6.5.3. Wastage factor

Please indicate wastage rate:

Countries are expected to plan for a maximal wastage rate of:

- 50% - for a lyophilised vaccine in 10 or 20-dose vial,
- 25% - for a liquid vaccine in 10 or 20-dose vial or a lyophilised vaccine in 5-dose vial,
- 10% - for a lyophilised/liquid vaccine in 2-dose vial, and
- 5% - for a liquid vaccine in 1-dose vial

Note: Selection of this field has direct impact on automatic calculations of support you are requesting and should not be left empty.

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
	2013	2014	2015					
Vaccine wastage rate in %	5%	5%	5%					
Equivalent wastage factor	1.05	1.05	1.05					

6.5.4. Specifications of vaccinations with new vaccine

	Data from		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
			2013	2014	2015					
Number of children to be vaccinated with the first dose	Table 1	#	245,610	267,235	289,867					
Number of children to be vaccinated with the third dose[1]	Table 1	#	231,162	252,389	274,611					
Immunisation coverage with the third dose	Table 1	#	80.00%	85.00%	90.00%					
Estimated vaccine wastage factor	Table 6.(n).3[3]	#	1.05	1.05	1.05					
Country co-financing per dose[2]	Table 6.(n).2[3]	$	0.20	0.20	0.20					

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Total price per-dose includes vaccine cost, plus freight, supplies, insurance, visa costs etc.
[3] Where (n) depends on the vaccine

6.5.5. Portion of supply to be procured by the country (and cost estimate, US$)

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
		2013	2014	2015					
Number of vaccine doses	#	24,600	27,300	32,800					
Number of AD syringes	#								
Number of re-constitution syringes	#								
Number of safety boxes	#	275	325	375					
Total value to be co-financed by country	$	**129,000**	**115,000**	**124,500**					

6.5.6. Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8
		2013	2014	2015					
Number of vaccine doses	#	620,300	545,400	587,900					
Number of AD syringes	#								
Number of re-constitution syringes	#								
Number of safety boxes	#	6,900	6,075	6,525					
Total value to be co-financed by GAVI	$	**3,261,000**	**2,295,000**	**2,227,000**					

6.5.7. New and Under-Used Vaccine Introduction Grant

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).

Calculation of lump-sum for the Rotavirus 2-dose schedule

If the total is lower than US$100,000, it is automatically rounded up to US$100,000

Year of New Vaccine Introduction	Births (from Table 1)	Share per Birth in US$	Total in US$
2013	306,419	0.30	100,000

[1] The Grant will be based on a maximum award of $0.30 per infant in the birth cohort with a minimum starting grant award of $100,000

Cost (and finance) to introduce the Rotavirus 2-dose schedule (US$)

Note: To add new lines click on the ***New item*** icon in the ***Action*** column. Use the ***Delete item*** icon to delete a line.

Cost Category	Full needs for new vaccine introduction in US$	Funded with new vaccine introduction grant in US$
Training	50,000	50,000
Social Mobilization, IEC and Advocacy	50,000	50,000
Cold Chain Equipment & Maintenance		
Vehicles and Transportation		
Programme Management		
Surveillance and Monitoring		
Human Resources		
Waste Management		
Technical assistance		
Totals	100,000	100,000

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

Note: The PCV vaccine must be procured through UNICEF

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)

Funds intended to finance activities relating to the introduction of new vaccines will be donated to the Minister for Public Health and Population, which will manage it. The CCIAG will support the program in the monitoring of budget execution and expenditure control.
While the amount corresponding to the GAVI contribution for the purchase of vaccines and vaccination equipment will be paid to the PAHO/ WHO Revolving Fund.

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

- Other vaccines or immunisation commodities procured by the country and descriptions of the mechanism used.
- The functions of the National Regulatory Authority (as evaluated by WHO) to show they comply with WHO requirements for procurement of vaccines and supply of assured quality.

Non applicable

c) Please describe the introduction of the vaccines (refer to cMYP)

The introduction of new vaccines:

- Substitution of bivalent vaccine against Measles-Rubella (MR), with the trivalent measles-mumps-rubella (MMR)
- Substitution of Diphtheria Tetanus Pertussis (DTP) vaccine with Pentavalent (DTP + anti Haemophilus influenza B + anti Hepatitis B)
- o Introduction of new vaccines: pneumococcal vaccine, and anti rotavirus vaccine. Table 10: Comparisons of vaccine prices The chronology of substitutions and introductions will affect funding needs throughout the 2011-2015 fiscal year.

The proposed time line is as follows:

- ? The substitution of the DT Per with the Pentavalent DTP-Hib-HepB is predicted for 2012 throughout the territory
- ? The substitution of the RR with the ROR is equally predicted for 2012 throughout the territory
- ? The substitution of the anti pneumococcal vaccine and anti rotavirus vaccine is predicted for 2013 throughout the territory
- ? The choice of pentavalent formulation: the liquid 1 dose form will be chosen, to minimize the risks involved in low-skilled workers handling the reconstitution, the choice between 10 doses and 1 dose(s) is made according the financial impact given the level of expected loss, unit price and volume storage needs of each option.

Interventions preparatory to the introduction will target adequacy of storage space with additional biological volumes, cold chain and vaccine management strengthening, strengthening epidemiological surveillance and information system strengthening In addition, an information campaign will be planned and carried out in which the targets will be health personnel and the general public Finally with the effect of introducing these new vaccines, medical personnel will be trained in their identification, preparation and administration.

These staff will also prepare to inform parents and caregivers about the new immunization schedule, the possible side effects and especially on the benefits of the new vaccines.

d) Please indicate how funds should be transferred by the GAVI Alliance (if applicable)

On the MOPHP's request, the funds for the introduction of new vaccines will be transferred to an MOPHP account which will be opened for this purpose.

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

In the case where the Haitian government is to pay the assessments, it will be paid on documents application from the Minister of Public Health and Population to the Minister of Economy and Finance who will make a transfer to the account of FOND ROTATOIRE DE PAHO.

f) Please outline how coverage of the new vaccine will be monitored and reported (refer to cMYP)

a) At fixed service point level, officials use graphical monitoring of vaccination coverage, collect service statistics, prepare monthly reports and retro inform the community.

b) .- At municipal level, the focal point, ensuring that the delivery institutions are able to provide services to pregnant women and women of childbearing age, that target children receive the vaccine doses needed to protect them in the conditions and within the proposed strategies, according to the required standards, enforces these and relates to the need at departmental level.

c) .- The Departmental Management is responsible for the coordination and monitoring of the provision of immunization services, communication on the subject, the supply of institutions, epidemiological monitoring of EPI diseases, collection of immunization data processing and analysis and DPEV communications, with respect to its jurisdiction.

d) .- The DPEV, at national level is responsible for monitoring the implementation of this plan in all its components, is accountable to the Senior Management according to the mechanisms established at MOPHP level.

All supervisory or technical supervisory activities are reported and recommended and the quarterly reports indicate corrections to problems, constraints and potential threats to remove for the smooth running of the program, in this respect the EPI Technical Committee and ICC/ EPI can be particularly useful.

e) .- Two evaluations are planned in the framework of the implementation of this plan: a formative evaluation will be conducted at the end of the first stage which is at the end of 2012, to identify possible bottlenecks and to realign the plan in accordance with the guidelines of new strategic health sector plan.

A summary evaluation planned in the second quarter of the fifth year is to prepare for the next multi-year plan for Haiti's EPI.

7.1. Vaccine Management (EVSM/EVM/VMA)

When was the last Effective Vaccine Store Management (EVSM) conducted? -

When was the last Effective Vaccine Management (EVM) or Vaccine Management Assessment (VMA) conducted? April - 2011

If your country conducted either EVSM, EVM, or VMA in the past three years, please attach relevant reports. (Document N°4)

A VMA report must be attached from those countries which have introduced a New and Underused Vaccine with GAVI support before 2008.

Please note that EVSM and VMA tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

For countries which conducted EVSM, VMA or EVM in the past, please report on activities carried out as part of either action plan or improvement plan prepared after the EVSM/VMA/EVM.

Activities that will be conducted within the framework of the cold chain and vaccine management improvement plan:

a). - Increase storage capacity at the central level by 33 cubic meters.
b). - At the same time, the energy source power should be increased according to the increase in cold chain units.
c). - The new rooms will be installed at PROMESS (Depot managed by PAHO), pending the construction of the Minister of Public Health and Population Depots.

Maintenance.
a). - Provide for new cold chain units, the same maintenance regime as the old units at PROMESS.
b). - The maintenance budget will also be increased perhaps annually by 10% of the cost of new equipment

Waste Management

a). - Installation of an incinerator in each of the 29 peripheral depots. The incinerator choice criterion:
(They must not generate any situation that may constitute a danger to the environment)

Training / -

a). - Revision, harmonization, testing and adoption of management tools for cold chain and vaccines in use.
b). - Review and adoption of computerized stock management system.
c) .- Training of EPI staff at all levels to use the stock management system)
d). - Implementation of an incentives system to encourage the conscious adoption and use of the parley personnel stock management system.

When is the next Effective Vaccine Management (EVM) Assessment planned? May - 2012

Under new guidelines, it will be mandatory for the countries to conduct an EVM prior to an application for introduction of new vaccine.

8. Additional Comments and Recommendations

Comments and Recommendations from the National Coordinating Body (ICC/HSCC)

The minutes of the CCIAG meeting held on 10 May annexed to the proposal includes the recommendations made by the partners.

9. Annexes

Annex 1

Annex 1.1 – DTP-HepB-Hib, 1 dose/vial, Liquid

Table 1.1 A - Rounded up portion of supply that is procured by the country and estimate of related cost in US$

Required supply item		2012	2013	2014	2015				
Number of vaccine doses	#	67,500	64,000	79,200	93,900				
Number of AD syringes	#	72,100	67,700	83,800	99,300				
Number of re-constitution syringes	#								
Number of safety boxes	#	800	775	950	1,125				
Total value to be co-financed by the country	*$*	177,500	158,000	172,000	186,500				

Table 1.1 B - Rounded up portion of supply that is procured by GAVI and estimate of related cost in US$.

Required supply item		2012	2013	2014	2015				
Number of vaccine doses	#	818,400	726,100	779,800	837,100				
Number of AD syringes	#	873,800	768,300	825,100	885,800				
Number of re-constitution syringes	#								
Number of safety boxes	#	9,700	8,550	9,175	9,850				
Total value to be co-financed by the country	***$***	**2,150,000**	**1,794,500**	**1,693,000**	**1,661,500**				

Table 1.1 C - Summary table for DTP-HepB-Hib, 1 dose/vial, Liquid

	Data from		2012	2013	2014	2015				
Number of Surviving infants	*Table 1*	#	281,192	288,953	296,928	305,124				
Number of children to be vaccinated with the third dose[1]	*Table 1*	#	210,894	231,162	252,389	274,611				
Immunisation coverage with the last dose	*Table 1*	#	75.00%	80.00%	85.00%	90.00%				
Number of children to be vaccinated with the first dose	*Table 1*	#	224,954	245,610	267,235	289,867				
Number of doses per child		#	3	3	3	3				
Estimated vaccine wastage factor	*Table 6.(n).3*[2]	#	1.05	1.05	1.05	1.05				
Number of doses per vial		#	1	1	1	1				
AD syringes required		#	Yes	Yes	Yes	Yes				
Reconstitution syringes required		#	No	No	No	No				
Safety boxes required		#	Yes	Yes	Yes	Yes				
Vaccine price per dose		$	2.470	2.320	2.030	1.850				
Country co-financing per dose	*Table 6.(n).2*[2]	$	0.20	0.20	0.20	0.20				
AD syringe price per unit		$	0.053	0.053	0.053	0.053				
Reconstitution syringe price per unit		$								
Safety box price per unit		$	0.640	0.640	0.640	0.640				
Freight cost as % of vaccines value		%	3.50	3.50	3.50	3.50				
Freight cost as % of devices value		%	10.00	10.00	10.00	10.00				

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Where (n) depends on the vaccine

Table 1.1 D - Estimated number of doses for DTP-HepB-Hib, 1 dose/vial, Liquid associated injection safety material and related co-financing budget (page 1)

		Formula	2012			2013		
			Total	**Government**	**GAVI**	**Total**	**Government**	**GAVI**
A	**Country Co-finance**		7.61%			8.09%		
B	**Number of children to be vaccinated with the first**	Table 1 (baseline & annual	224,954	17,127	207,827	245,610	19,879	225,731

		Formula	2012			2013		
			Total	Government	GAVI	Total	Government	GAVI
	dose[1]	targets)						
C	**Number of doses per child**	Vaccine parameter	3	3	3	3	3	3
D	**Number of doses needed**	B * C	674,862	51,379	623,483	736,830	59,635	677,195
E	**Estimated vaccine wastage factor**	Table 6.(n).3. in NVS section[2]	1.05	1.05	1.05	1.05	1.05	1.05
F	**Number of doses needed including wastage**	D * E	708,606	53,948	654,658	773,672	62,616	711,056
G	**Vaccines buffer stock**	(F - F of previous year) * 0.25	177,152	13,487	163,665	16,267	1,317	14,950
I	**Total vaccine doses needed**	F + G	885,758	67,434	818,324	789,939	63,933	726,006
J	**Number of doses per vial**	Vaccine parameter	1	1	1	1	1	1
K	**Number of AD syringes (+ 10% wastage) needed**	(D + G) * 1.11	945,736	72,001	873,735	835,938	67,656	768,282
L	**Reconstitution syringes (+ 10% wastage) needed**	I / J * 1.11						
M	**Total of safety boxes (+ 10% of extra need) needed**	(K + L) / 100 x 1.11	10,498	800	9,698	9,279	751	8,528
N	**Cost of vaccines needed**	I * vaccine price per dose	2,187,823	166,562	2,021,261	1,832,659	148,324	1,684,335
O	**Cost of AD syringes needed**	K * AD syringe price per unit	50,125	3,817	46,308	44,305	3,586	40,719
P	**Cost of reconstitution syringes needed**	L * reconstitution price per unit						
Q	**Cost of safety boxes needed**	M * safety box price per unit	6,719	512	6,207	5,939	481	5,458
R	**Freight cost for vaccines needed**	N * freight cost as % of vaccines value	76,574	5,830	70,744	64,144	5,192	58,952
S	**Freight cost for devices needed**	(O + P + Q) * freight cost as % of devices value	5,685	433	5,252	5,025	407	4,618
T	**Total fund needed**	(N + O + P + Q + R + S)	2,326,926	177,152	2,149,774	1,952,072	157,988	1,794,084
U	**Total country co-financing**	I * country co-financing per dose	177,152			157,988		
V	**Country co-financing % of GAVI supported proportion**	U / T	7.61%			8.09%		

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Where (n) depends on the vaccine

Table 1.1 D - Estimated number of doses for DTP-HepB-Hib, 1 dose/vial, Liquid associated injection safety material and related co-financing budget (page 2)

		Formula	2014			2015		
			Total	Government	GAVI	Total	Government	GAVI
A	**Country Co-finance**		9.21%			10.08%		
B	**Number of children to be vaccinated with the first dose**[1]	Table 1 (baseline & annual targets)	267,235	24,619	242,616	289,867	29,210	260,657
C	**Number of doses per child**	Vaccine parameter (schedule)	3	3	3	3	3	3

		Formula	2014			2015		
			Total	**Government**	**GAVI**	**Total**	**Government**	**GAVI**
D	**Number of doses needed**	B * C	801,705	73,856	727,849	869,601	87,630	781,971
E	**Estimated vaccine wastage factor**	Table 6.(n).3. in NVS section[2]	1.05	1.05	1.05	1.05	1.05	1.05
F	**Number of doses needed including wastage**	D * E	841,791	77,549	764,242	913,082	92,012	821,070
G	**Vaccines buffer stock**	(F - F of previous year) * 0.25	17,030	1,569	15,461	17,823	1,797	16,026
I	**Total vaccine doses needed**	F + G	858,821	79,118	779,703	930,905	93,808	837,097
J	**Number of doses per vial**	Vaccine parameter	1	1	1	1	1	1
K	**Number of AD syringes (+ 10% wastage) needed**	(D + G) * 1.11	908,796	83,722	825,074	985,041	99,263	885,778
L	**Reconstitution syringes (+ 10% wastage) needed**	I / J * 1.11						
M	**Total of safety boxes (+ 10% of extra need) needed**	(K + L) / 100 x 1.11	10,088	930	9,158	10,934	1,102	9,832
N	**Cost of vaccines needed**	I * vaccine price per dose	1,743,407	160,609	1,582,798	1,722,175	173,545	1,548,630
O	**Cost of AD syringes needed**	K * AD syringe price per unit	48,167	4,438	43,729	52,208	5,262	46,946
P	**Cost of reconstitution syringes needed**	L * reconstitution price per unit						
Q	**Cost of safety boxes needed**	M * safety box price per unit	6,457	595	5,862	6,998	706	6,292
R	**Freight cost for vaccines needed**	N * freight cost as % of vaccines value	61,020	5,622	55,398	60,277	6,075	54,202
S	**Freight cost for devices needed**	(O + P + Q) * freight cost as % of devices value	5,463	504	4,959	5,921	597	5,324
T	**Total fund needed**	(N + O + P + Q + R + S)	1,864,514	171,765	1,692,749	1,847,579	186,181	1,661,398
U	**Total country co-financing**	I * country co-financing per dose	171,765			186,181		
V	**Country co-financing % of GAVI supported proportion**	U / T	9.21%			10.08%		

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule

[2] Where (n) depends on the vaccine

Annex 1.2 – Pneumococcal (PCV13), 1 doses/vial, Liquid

Table 1.2 A - Rounded up portion of supply that is procured by the country and estimate of related cost in US$

Required supply item		2012	2013	2014	2015				
Number of vaccine doses	#	51,700	51,700	45,900	49,800				
Number of AD syringes	#	55,200	55,200	48,600	52,700				
Number of re-constitution syringes	#								
Number of safety boxes	#	625	625	550	600				
Total value to be co-financed by the country	*$*	193,500	193,500	172,000	186,500				

Table 1.2 B - Rounded up portion of supply that is procured by GAVI and estimate of related cost in US$.

Required supply item		2012	2013	2014	2015				
Number of vaccine doses	#	915,500	915,500	813,000	881,200				
Number of AD syringes	#	977,500	977,500	860,300	932,500				
Number of re-constitution syringes	#								
Number of safety boxes	#	10,850	10,850	9,550	10,350				
Total value to be co-financed by the country	***$***	**3,429,000**	**3,429,000**	**3,044,500**	**3,300,500**				

Table 1.2 C - Summary table for Pneumococcal (PCV13), 1 doses/vial, Liquid

	Data from		2012	2013	2014	2015				
Number of Surviving infants	*Table 1*	#	288,953	288,953	296,928	305,124				
Number of children to be vaccinated with the third dose[1]	*Table 1*	#	231,162	231,162	252,389	274,611				
Immunisation coverage with the last dose	*Table 1*	#	80.00%	80.00%	85.00%	90.00%				
Number of children to be vaccinated with the first dose	*Table 1*	#	245,610	245,610	267,235	289,867				
Number of doses per child		#	3	3	3	3				
Estimated vaccine wastage factor	*Table 6.(n).3*[2]	#	1.05	1.05	1.05	1.05				

	Data from		2012	2013	2014	2015				
Number of doses per vial		#	1	1	1	1				
AD syringes required		#	Oui	Yes	Yes	Yes				
Reconstitution syringes required		#	Non	No	No	No				
Safety boxes required		#	Oui	Yes	Yes	Yes				
Vaccine price per dose		$	3.500	3.500	3.500	3.500				
Country co-financing per dose	*Table 6.(n).2*[2]	$	0.20	0.20	0.20	0.20				
AD syringe price per unit		$	0.053	0.053	0.053	0.053				
Reconstitution syringe price per unit		$								
Safety box price per unit		$	0.640	0.640	0.640	0.640				
Freight cost as % of vaccines value		%	5.00	5.00	5.00	5.00				
Freight cost as % of devices value		%	10.00	10.00	10.00	10.00				

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Where (n) depends on the vaccine

Table 1.2 D - Estimated number of doses for Pneumococcal (PCV13), 1 doses/vial, Liquid associated injection safety material and related co-financing budget (page 1)

		Formula	2013			2014		
			Total	**Government**	**GAVI**	**Total**	**Government**	**GAVI**
A	**Country Co-finance**		5.34%			5.34%		
B	**Number of children to be vaccinated with the first dose**[1]	Table 1 (baseline & annual targets)	245,610	13,115	232,495	267,235	14,272	252,963
C	**Number of doses per child**	Vaccine parameter	3	3	3	3	3	3
D	**Number of doses needed**	B * C	736,830	39,344	697,486	801,705	42,816	758,889
E	**Estimated vaccine wastage factor**	Table 6.(n).3. in NVS section[2]	1.05	1.05	1.05	1.05	1.05	1.05
F	**Number of doses needed including wastage**	D * E	773,672	41,312	732,360	841,791	44,957	796,834
G	**Vaccines buffer stock**	(F - F of previous year) * 0.25	193,418	10,328	183,090	17,030	910	16,120
I	**Total vaccine doses needed**	F + G	967,090	51,639	915,451	858,821	45,866	812,955
J	**Number of doses per vial**	Vaccine parameter	1	1	1	1	1	1
K	**Number of AD syringes (+ 10% wastage) needed**	(D + G) * 1.11	1,032,576	55,136	977,440	908,796	48,535	860,261
L	**Reconstitution syringes (+ 10% wastage) needed**	I / J * 1.11						
M	**Total of safety boxes (+ 10% of extra need) needed**	(K + L) / 100 x 1.11	11,462	613	10,849	10,088	539	9,549
N	**Cost of vaccines needed**	I * vaccine price per dose	3,384,815	180,736	3,204,079	3,005,874	160,530	2,845,344
O	**Cost of AD syringes needed**	K * AD syringe price per unit	54,727	2,923	51,804	48,167	2,573	45,594
P	**Cost of reconstitution syringes needed**	L * reconstitution price per unit						

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
Q	**Cost of safety boxes needed**	M * safety box price per unit	7,336	392	6,944	6,457	345	6,112
R	**Freight cost for vaccines needed**	N * freight cost as % of vaccines value	169,241	9,037	160,204	150,294	8,027	142,267
S	**Freight cost for devices needed**	(O + P + Q) * freight cost as % of devices value	6,207	332	5,875	5,463	292	5,171
T	**Total fund needed**	(N + O + P + Q + R + S)	3,622,326	193,418	3,428,908	3,216,255	171,765	3,044,490
U	**Total country co-financing**	I * country co-financing per dose	193,418			171,765		
V	**Country co-financing % of GAVI supported proportion**	U / T	5.34%			5.34%		

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Where (n) depends on the vaccine

Table 1.2 D - Estimated number of doses for Pneumococcal (PCV13), 1 doses/vial, Liquid associated injection safety material and related co-financing budget (page 2)

		Formula	2015					
			Total	Government	GAVI	Total	Government	GAVI
A	**Country Co-finance**		5.34%					
B	**Number of children to be vaccinated with the first dose[1]**	Table 1 (baseline & annual targets)	289,867	15,481	274,386			
C	**Number of doses per child**	Vaccine parameter (schedule)	3	3	3	3	3	3
D	**Number of doses needed**	B * C	869,601	46,442	823,159			
E	**Estimated vaccine wastage factor**	Table 6.(n).3. in NVS section[2]	1.05	1.05	1.05			
F	**Number of doses needed including wastage**	D * E	913,082	48,764	864,318			
G	**Vaccines buffer stock**	(F - F of previous year) * 0.25	17,823	952	16,871			
I	**Total vaccine doses needed**	F + G	930,905	49,716	881,189			
J	**Number of doses per vial**	Vaccine parameter	1	1	1	1	1	1
K	**Number of AD syringes (+ 10% wastage) needed**	(D + G) * 1.11	985,041	52,607	932,434			
L	**Reconstitution syringes (+ 10% wastage) needed**	I / J * 1.11						
M	**Total of safety boxes (+ 10% of extra need) needed**	(K + L) / 100 x 1.11	10,934	584	10,350			
N	**Cost of vaccines needed**	I * vaccine price per dose	3,258,168	174,003	3,084,165			
O	**Cost of AD syringes needed**	K * AD syringe price per unit	52,208	2,789	49,419			
P	**Cost of reconstitution syringes needed**	L * reconstitution price per unit						
Q	**Cost of safety boxes needed**	M * safety box price per unit	6,998	374	6,624			
R	**Freight cost for vaccines needed**	N * freight cost as % of vaccines	162,909	8,701	154,208			

		Formula	2015					
			Total	Government	GAVI	Total	Government	GAVI
		value						
S	**Freight cost for devices needed**	(O + P + Q) * freight cost as % of devices value	5,921	317	5,604			
T	**Total fund needed**	(N + O + P + Q + R + S)	3,486,204	186,181	3,300,023			
U	**Total country co-financing**	I * country co-financing per dose	186,181					
V	**Country co-financing % of GAVI supported proportion**	U / T	5.34%					

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Where (n) depends on the vaccine

Annex 1.3 – Rotavirus 2-dose schedule

Table 1.3 A - Rounded up portion of supply that is procured by the country and estimate of related cost in US$

Required supply item		2012	2013	2014	2015				
Number of vaccine doses	#	24,600	24,600	27,300	32,800				
Number of AD syringes	#								
Number of re-constitution syringes	#								
Number of safety boxes	#	275	275	325	375				
Total value to be co-financed by the country	*$*	129,000	129,000	115,000	124,500				

Table 1.3 B - Rounded up portion of supply that is procured by GAVI and estimate of related cost in US$.

Required supply item		2012	2013	2014	2015				
Number of vaccine doses	#	620,300	620,300	545,400	587,900				
Number of AD syringes	#								
Number of re-constitution syringes	#								
Number of safety boxes	#	6,900	6,900	6,075	6,525				
Total value to be co-financed by the country	***$***	**3,261,000**	**3,261,000**	**2,295,000**	**2,227,000**				

Table 1.3 C - Summary table for Rotavirus 2-dose schedule

	Data from		2012	2013	2014	2015				
Number of Surviving infants	*Table 1*	#	288,953	288,953	296,928	305,124				
Number of children to be vaccinated with the third dose[1]	*Table 1*	#	231,162	231,162	252,389	274,611				
Immunisation coverage with the last dose	*Table 1*	#	80.00%	80.00%	85.00%	90.00%				
Number of children to be vaccinated with the first dose	*Table 1*	#	245,610	245,610	267,235	289,867				
Number of doses per child		#	2	2	2	2				
Estimated vaccine wastage factor	*Table 6.(n).3*[2]	#	1.05	1.05	1.05	1.05				
Number of doses per vial		#	1	1	1	1				
AD syringes required		#	Non	No	No	No				
Reconstitution syringes required		#	Non	No	No	No				
Safety boxes required		#	Oui	Yes	Yes	Yes				
Vaccine price per dose		$	5.000	5.000	4.000	3.600				
Country co-financing per dose	*Table 6.(n).2*[2]	$	0.20	0.20	0.20	0.20				
AD syringe price per unit		$	0.053	0.053	0.053	0.053				
Reconstitution syringe price per unit		$								
Safety box price per unit		$	0.640	0.640	0.640	0.640				
Freight cost as % of vaccines value		%	5.00	5.00	5.00	5.00				
Freight cost as % of devices value		%	10.00	10.00	10.00	10.00				

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Where (n) depends on the vaccine

Table 1.3 D - Estimated number of doses for Rotavirus 2-dose schedule associated injection safety material and related co-financing budget (page 1)

		Formula	2013			2014		
			Total	**Government**	**GAVI**	**Total**	**Government**	**GAVI**
A	**Country Co-finance**		3.80%			4.75%		
B	**Number of children to be vaccinated with the first dose[1]**	Table 1 (baseline & annual targets)	245,610	9,343	236,267	267,235	12,702	254,533
C	**Number of doses per child**	Vaccine parameter	2	2	2	2	2	2
D	**Number of doses needed**	B * C	491,220	18,686	472,534	534,470	25,404	509,066
E	**Estimated vaccine wastage factor**	Table 6.(n).3. in NVS section[2]	1.05	1.05	1.05	1.05	1.05	1.05
F	**Number of doses needed including wastage**	D * E	515,781	19,620	496,161	561,194	26,674	534,520
G	**Vaccines buffer stock**	(F - F of previous year) * 0.25	128,946	4,905	124,041	11,354	540	10,814
I	**Total vaccine doses needed**	F + G	644,727	24,525	620,202	572,548	27,214	545,334
J	**Number of doses per vial**	Vaccine parameter	1	1	1	1	1	1
K	**Number of AD syringes (+ 10% wastage) needed**	(D + G) * 1.11						
L	**Reconstitution syringes (+ 10% wastage) needed**	I / J * 1.11						
M	**Total of safety boxes (+ 10% of extra need) needed**	I / 100 x 1.11	7,157	273	6,884	6,356	303	6,053
N	**Cost of vaccines needed**	I * vaccine price per dose	3,223,635	122,624	3,101,011	2,290,192	108,855	2,181,337
O	**Cost of AD syringes needed**	K * AD syringe price per unit						
P	**Cost of reconstitution syringes needed**	L * reconstitution price per unit						
Q	**Cost of safety boxes needed**	M * safety box price per unit	4,581	175	4,406	4,068	194	3,874
R	**Freight cost for vaccines needed**	N * freight cost as % of vaccines value	161,182	6,132	155,050	114,510	5,443	109,067
S	**Freight cost for devices needed**	(O + P + Q) * freight cost as % of devices value	459	18	441	407	20	387
T	**Total fund needed**	(N + O + P + Q + R + S)	3,389,857	128,946	3,260,911	2,409,177	114,510	2,294,667
U	**Total country co-financing**	I * country co-financing per dose	128,946			114,510		
V	**Country co-financing % of GAVI supported proportion**	U / T	3.80%			4.75%		

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule
[2] Where (n) depends on the vaccine

Table 1.3 D - Estimated number of doses for Rotavirus 2-dose schedule associated injection safety material and related co-financing budget (page 2)

		Formula	2015					
			Total	**Government**	**GAVI**	**Total**	**Government**	**GAVI**
A	**Country Co-finance**		5.28%					
B	**Number of children to be vaccinated with the first dose**[1]	Table 1 (baseline & annual targets)	289,867	15,306	274,561			
C	**Number of doses per child**	Vaccine parameter (schedule)	2	2	2	2	2	2
D	**Number of doses needed**	B * C	579,734	30,611	549,123			
E	**Estimated vaccine wastage factor**	Table 6.(n).3. in NVS section[2]	1.05	1.05	1.05			
F	**Number of doses needed including wastage**	D * E	608,721	32,142	576,579			
G	**Vaccines buffer stock**	(F - F of previous year) * 0.25	11,882	628	11,254			
I	**Total vaccine doses needed**	F + G	620,603	32,769	587,834			
J	**Number of doses per vial**	Vaccine parameter	1	1	1	1	1	1
K	**Number of AD syringes (+ 10% wastage) needed**	(D + G) * 1.11						
L	**Reconstitution syringes (+ 10% wastage) needed**	I / J * 1.11						
M	**Total of safety boxes (+ 10% of extra need) needed**	I / 100 x 1.11	6,889	364	6,525			
N	**Cost of vaccines needed**	I * vaccine price per dose	2,234,171	117,967	2,116,204			
O	**Cost of AD syringes needed**	K * AD syringe price per unit						
P	**Cost of reconstitution syringes needed**	L * reconstitution price per unit						
Q	**Cost of safety boxes needed**	M * safety box price per unit	4,409	233	4,176			
R	**Freight cost for vaccines needed**	N * freight cost as % of vaccines value	111,709	5,899	105,810			
S	**Freight cost for devices needed**	(O + P + Q) * freight cost as % of devices value	441	24	417			
T	**Total fund needed**	(N + O + P + Q + R + S)	2,350,730	124,121	2,226,609			
U	**Total country co-financing**	I * country co-financing per dose	124,121					
V	**Country co-financing % of GAVI supported proportion**	U / T	5.28%					

[1] 2nd dose if Measles vaccine or Rotavirus 2-dose schedule

[2] Where (n) depends on the vaccine

Annex 2

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Table A - Commodities Cost

Vaccine	Presentation	2011	2012	2013	2014	2015	2016	2017
AD syringe	0	0.053	0.053	0.053	0.053	0.053	0.053	0.053
DTP-HepB	2	1.600						
DTP-HepB	10	0.620	0.620	0.620	0.620	0.620	0.620	0.620
DTP-HepB-Hib	WAP	2.580	2.470	2.320	2.030	1.850	1.850	1.850
DTP-HepB-Hib	WAP	2.580	2.470	2.320	2.030	1.850	1.850	1.850
DTP-HepB-Hib	WAP	2.580	2.470	2.320	2.030	1.850	1.850	1.850
DTP-Hib	10	3.400	3.400	3.400	3.400	3.400	3.200	3.200
HepB monoval	1							
HepB monoval	2							
Hib monoval	1	3.400						
Measles	10	0.240	0.240	0.240	0.240	0.240	0.240	0.240
Pneumococcal(PCV10)	2	3.500	3.500	3.500	3.500	3.500	3.500	3.500
Pneumococcal(PCV13)	1	3.500	3.500	3.500	3.500	3.500	3.500	3.500
Reconstit syringe for Pentaval (2ml)	0	0.032	0.032	0.032	0.032	0.032	0.032	0.032
Reconstit syringe for YF	0	0.038	0.038	0.038	0.038	0.038	0.038	0.038
Rotavirus 2-dose schedule	1	7.500	6.000	5.000	4.000	3.600	3.600	3.600
Rotavirus 3-dose schedule	1	5.500	4.000	3.333	2.667	2.400	2.400	2.400
Safety box	0	0.640	0.640	0.640	0.640	0.640	0.640	0.640
Yellow Fever	WAP	0.856	0.856	0.856	0.856	0.856	0.856	0.856
Yellow Fever	WAP	0.856	0.856	0.856	0.856	0.856	0.856	0.856

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 B - Commodities Freight Cost

Vaccines	Group	No Threshold	200'000 $		250'000 $		2'000'000 $	
			<=	>	<=	>	<=	>
Yellow Fever	Yellow Fever		20%				10%	5%
DTP+HepB	HepB and or Hib	2%						

Vaccines	Group	No Threshold	200'000 $		250'000 $		2'000'000 $	
			<=	>	<=	>	<=	>
DTP-HepB-Hib	HepB and or Hib				15%	3,50%		
Pneumococcal vaccine (PCV10)	Pneumococcal	5%						
Pneumococcal vaccine (PCV13)	Pneumococcal	5%						
Rotavirus	Rotavirus	5%						
Measles	Measles	10%						

Table C - Low - Minimum country's co-payment per dose of co-financed vaccine.

vaccine	2012	2013	2014	2015			
DTP-HepB-Hib, 1 dose/vial, Liquid	0.20	0.20	0.20	0.20			
Pneumococcal(PCV13), 1 doses/vial, Liquid		0.20	0.20	0.20			
Rotavirus 2-dose schedule		0.20	0.20	0.20			

Table D - Wastage rates and factors

Countries are expected to plan for a maximal wastage rate of:

- 50% - for a lyophilised vaccine in 10 or 20-dose vial,
- 25% - for a liquid vaccine in 10 or 20-dose vial or a lyophilised vaccine in 5-dose vial,
- 10% - for a lyophilised/liquid vaccine in 2-dose vial, and
- 5% - for a liquid vaccine in 1-dose vial

Vaccine wastage rate	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%

Equivalent wastage factor	1.05	1.11	1.18	1.25	1.33	1.43	1.54	1.67	1.82	2	2.22	2.5

WHO International shipping guidelines: maximum packed volumes of vaccines

Table E - Vaccine maximum packed volumes

Vaccine product	Designation	Vaccine formulation	Admin route	No. Of doses in the schedule	Presentation (doses/vial, prefilled)	Packed volume vaccine (cm3/dose)	Packed volume diluents (cm3/dose)
BCG	BCG	lyophilized	ID	1	20	1.2	0.7
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	20	2.5	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	10	3.0	
Diphtheria-Tetanus	DT	liquid	IM	3	10	3.0	
Tetanus-Diphtheria	Td	liquid	IM	2	10	3.0	
Tetanus Toxoid	TT	liquid	IM	2	10	3.0	
Tetanus Toxoid	TT	liquid	IM	2	20	2.5	
Tetanus Toxoid UniJect	TT	liquid	IM	2	Uniject	12.0	
Measles	Measles	lyophilized	SC	1	1	26.1	20.0
Measles	Measles	lyophilized	SC	1	2	13.1	13.1
Measles	Measles	lyophilized	SC	1	5	5.2	7.0
Measles	Measles	lyophilized	SC	1	10	3.5	4.0
Measles-Rubella freeze dried	MR	lyophilized	SC	1	1	26.1	26.1
Measles-Rubella freeze dried	MR	lyophilized	SC	1	2	13.1	13.1
Measles-Rubella freeze dried	MR	lyophilized	SC	1	5	5.2	7.0
Measles-Rubella freeze dried	MR	lyophilized	SC	1	10	2.5	4.0
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	1	26.1	26.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	2	13.1	13.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	5	5.2	7.0
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	10	3.0	4.0
Polio	OPV	liquid	Oral	4	10	2.0	
Polio	OPV	liquid	Oral	4	20	1.0	
Yellow fever	YF	lyophilized	SC	1	5	6.5	7.0
Yellow fever	YF	lyophilized	SC	1	10	2.5	3.0
Yellow fever	YF	lyophilized	SC	1	20	1.5	2.0
Yellow fever	YF	lyophilized	SC	1	50	0.7	1.0

Vaccine product	Designation	Vaccine formulation	Admin route	No. Of doses in the schedule	Presentation (doses/vial, prefilled)	Packed volume vaccine (cm3/dose)	Packed volume diluents (cm3/dose)
DTP-HepB combined	DTP-HepB	liquid	IM	3	1	9.7	
DTP-HepB combined	DTP-HepB	liquid	IM	3	2	6.0	
DTP-HepB combined	DTP-HepB	liquid	IM	3	10	3.0	
Hepatitis B	HepB	liquid	IM	3	1	18.0	
Hepatitis B	HepB	liquid	IM	3	2	13.0	
Hepatitis B	HepB	liquid	IM	3	6	4.5	
Hepatitis B	HepB	liquid	IM	3	10	4.0	
Hepatitis B UniJect	HepB	liquid	IM	3	Uniject	12.0	
Hib liquid	Hib_liq	liquid	IM	3	1	15.0	
Hib liquid	Hib_liq	liquid	IM	3	10	2.5	
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	1	13.0	35.0
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	2	6.0	
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	10	2.5	3.0
DTP liquid + Hib freeze-dried	DTP+Hib	liquid+lyop.	IM	3	1	45.0	
DTP-Hib combined liquid	DTP+Hib	liquid+lyop.	IM	3	10	12.0	
DTP-Hib combined liquid	DTP-Hib	liquid	IM	3	1	32.3	
DTP-HepB liquid + Hib freeze-dried	DTP-Hib	liquid	IM	3	10	2.5	
DTP-HepB liquid + Hib freeze-dried	DTP-HepB+Hib	liquid+lyop.	IM	3	1	22.0	
DTP-HepB-Hib liquid	DTP-HepB+Hib	liquid+lyop.	IM	3	2	11.0	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	10	4.4	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	2	13.1	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	1	19.2	
Meningitis A/C	MV_A/C	lyophilized	SC	1	10	2.5	4.0
Meningitis A/C	MV_A/C	lyophilized	SC	1	50	1.5	3.0
Meningococcal A/C/W/	MV_A/C/W	lyophilized	SC	1	50	1.5	3.0
Meningococcal A/C/W/Y	MV_A/C/W/Y	lyophilized	SC	1	10	2.5	4.0
Meningitis W135	MV_W135	lyophilized	SC	1	10	2.5	4.0
Meningitis A conjugate	Men_A	lyophilized	SC	2	10	2.6	4.0
Japanese Encephalitis	JE_lyo	lyophilized	SC	3	10	15.0	
Japanese Encephalitis	JE_lyo	lyophilized	SC	3	10	8.1	8.1
Japanese Encephalitis	JE_lyo	lyophilized	SC	3	5	2.5	2.9
Japanese Encephalitis	JE_lyo	lyophilized	SC	3	1	12.6	11.5
Japanese Encephalitis	JE_liq	liquid	SC	3	10	3.4	
Rota vaccine	Rota_lyo	lyophilized	Oral	2	1	156.0	

Vaccine product	Designation	Vaccine formulation	Admin route	No. Of doses in the schedule	Presentation (doses/vial, prefilled)	Packed volume vaccine (cm3/dose)	Packed volume diluents (cm3/dose)
Rota vaccine	Rota_liq	liquid	Oral	2	1	17.1	
Rota vaccine	Rota_liq	liquid	Oral	3	1	45.9	
Pneumo. conjugate vaccine 7-valent	PCV-7	liquid	IM	3	PFS	55.9	
Pneumo. conjugate vaccine 7-valent	PCV-7	liquid	IM	3	1	21.0	
Pneumo. conjugate vaccine 10-valent	PCV-10	liquid	IM	3	1	11.5	
Pneumo. conjugate vaccine 10-valent	PCV-10	liquid	IM	3	2	4.8	
Pneumo. conjugate vaccine 13-valent	PCV-13	liquid	IM	3	1	12.0	
Polio inactivated	IPV	liquid	IM	3	PFS	107.4	
Polio inactivated	IPV	liquid	IM	3	10	2.5	
Polio inactivated	IPV	liquid	IM	3	1	15.7	
Human Papilomavirus vaccine	HPV	liquid	IM	3	1	15.0	
Human Papilomavirus vaccine	HPV	liquid	IM	3	2	5.7	
Monovalent OPV-1	mOPV1	liquid	Oral		20	1.5	
Monovalent OPV-3	mOPV3	liquid	Oral		20	1.5	

10. Attachments

10.1. List of Supporting Documents Attached to this Proposal

Document	Section	Document Number	Mandatory[1]
MoH Signature (or delegated authority) of Proposal		**1**	**Yes**
MoF Signature (or delegated authority) of Proposal		**2**	**Yes**
Signatures of ICC or HSCC or equivalent in Proposal		**3**	**Yes**
Minutes of ICC/HSCC meeting endorsing Proposal		**4**	**Yes**
comprehensive Multi Year Plan - cMYP		**5**	**Yes**
cMYP Costing tool for financial analysis		**6**	**Yes**
Minutes of last three ICC/HSCC meetings		**7**	**Yes**
Improvement plan based on EVM		**8**	**Yes**
WHO/UNICEF Joint Reporting Form (JRF)			
ICC/HSCC workplan for forthcoming 12 months			
National policy on injection safety			
Action plans for improving injection safety			
Plan for NVS introduction (if not part of cMYP)		**9**	
Banking details			

[1] Please indicate the duration of the plan / assessment / document where appropriate

10.2. Attachments

List of all the mandatory and optional documents attached to this form

Note: Use the ***Upload file*** arrow icon to upload the document. Use the ***Delete item*** icon to delete a line. To add new lines click on the ***New item*** icon in the ***Action*** column.

ID	File type	File name		New file	Actions
	Description	Date and Time	Size		
1	**File Type:** MoH Signature (or delegated authority) of Proposal * **File Desc:** Page 2 du document (correspondant au Point 4.1.2, de la soumission)	**File name:** doccu150.pdf **Date/Time:** 30.05.2011 18:16:53 **Size:** 7 MB			
2	**File Type:** MoF Signature (or delegated authority) of Proposal * **File Desc:** Page 2 du document (correspondant au point 4.1.2 de la Soumission)	**File name:** doccu150.pdf **Date/Time:** 30.05.2011 18:37:16 **Size:** 7 MB			
3	**File Type:** Signatures of ICC or HSCC or equivalent in Proposal * **File Desc:** Page 1 du document (correspondant au Point 4.1.2.de la soumission)	**File name:** doccu150.pdf **Date/Time:** 30.05.2011 18:40:20 **Size:** 7 MB			
4	**File Type:** Minutes of ICC/HSCC meeting endorsing Proposal *	**File name:** Minutes de reunion CCIA_PEV			

	File Desc: Document de 6 pages avec au bas la liste des participants a la rencontre qui eut lieu le 10 mai . Cette version du rapport est du 15 mai 2011.	vers du 15 mai_vf.doc **Date/Time:** 30.05.2011 18:54:26 **Size:** 50 KB		
5	**File Type:** comprehensive Multi Year Plan - cMYP * **File Desc:** C'est le Plan pluriannuel complet 2011-2015	**File name:** PPAc-PEV-2011-2015 29 Mai.doc **Date/Time:** 30.05.2011 18:59:29 **Size:** 660 KB		
6	**File Type:** cMYP Costing tool for financial analysis * **File Desc:** Document which describes the finanical analysis of the CMYP and which also presents the elements of financial viability of the program for a period of 5 years.	**File name:** HAITI PPAc_Costing_Tool_May 29 MAI.xls **Date/Time:** 30.05.2011 19:02:13 **Size:** 3 MB		
7	**File Type:** Minutes of last three ICC/HSCC meetings * **File Desc:** We have here the minutes of the last two meetings one for 3 March, the other ofr 10 may, 2011 (9 pages).	**File name:** compte rendu des 2 dernieres reunions du CCIAG.doc **Date/Time:** 30.05.2011 19:12:04 **Size:** 56 KB		
8	**File Type:** Improvement plan based on EVM * **File Desc:** This document details the results of a study conducted by an international consultant for evaluating the additional capacity required for different levels to introduce the 3 new vaccines. He also describes the reliefl measures to be taken for	**File name:** Assessment Cold Chain & vaccine management- Haiti 04.11.docx **Date/Time:** 30.05.2011 19:15:27 **Size:** 446 KB		
9	**File Type:** Plan for NVS introduction (if not part of cMYP) **File Desc:** Document de 28 pages décrivant les phases et stratégies prévues dans le cadre de l'introduction des nouveaux vaccins	**File name:** Plan d'introduction Nouveaux vaccins 29 mai.doc **Date/Time:** 30.05.2011 19:17:05 **Size:** 225 KB		

Banking Form

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

Name of Institution (Account Holder):			
Address:			
City Country:			
Telephone no.:		**Fax no.:**	
	Currency of the bank account:		
For credit to:			
Bank account's title:			
Bank account no.:			
Bank's name:			

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

By who is the account audited?

Signature of Government's authorizing official

Name:		**Seal**
Title:		
Signature:		
Date:		

FINANCIAL INSTITUTION		CORRESPONDENT BANK (In the United States)	
Bank Name:			
Branch Name:			
Address:			
City Country:			
Swift Code:			
Sort Code:			
ABA No.:			
Telephone No.:			
FAX No.:			

I certify that the account no is held by (Institution name) at this banking institution.

The account is to be signed jointly by at least 0 (number of signatories) of the following authorized signatories:		
1		
	Name:	
	Title:	
2		
	Name:	
	Title:	
3		
	Name:	
	Title:	
4		
	Name:	
	Title:	

Name of bank's authorizing official
Signature:
Date:
Seal: