Global Alliance for Vaccines and Immunisation (GAVI)

APPLICATION FORM FOR COUNTRY PROPOSALS

For Support to:

Immunisation Services, Injection Safety
and New and Under-Used Vaccines

Revised 15 July 2007

Please return a signed copy of the document to:
GAVI Alliance Secretariat; c/o UNICEF, Palais des Nations, 1211 Geneva 10, Switzerland.

Enquiries to: Dr Ivone Rizzo, irizzo@gavialliance.org or representatives of a GAVI partner agency. All documents and attachments must be in English or French, preferably in electronic form.

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Executive Summary

To achieve the MDGs, the country subscribed to the GIVS objectives. To this end, the introduction of the new vaccines and the implementation of the technologies in its immunisation program were selected as one of the priority strategic focuses.

The Democratic Republic of the Congo received GAVI support for immunisation services from 2002 to 2007, injection safety support from 2003 to 2005, and support for the introduction of the yellow fever vaccine in 2003 and the viral hepatitis B vaccine in 2007. The application for introducing the *Haemophilus influenzae b* vaccine and support for immunisation services in 2008-2009 was also approved in 2007.

These different types of support contributed to improving EPI performance. DTP3 vaccine coverage rose from 49% in 2002 to 87% in 2007.

In its 2008-2012 multiyear plan, the country proposes to introduce the pneumococcal vaccine in January 2010 to further protect children from these diseases. Pneumococcal infection diseases are one of the leading causes of morbidity and mortality in children under five years old in the DRC.

The logistical analyses took into account current cold chain capacity and cold chain accommodation capacity with the introduction of this new vaccine. With this information, and with its experience in introducing new vaccines, the DRC chose the liquid conjugated pneumo vaccine in a single-dose vial. As for the choice of blood types, preference will be given to the vaccine with the highest number of blood types that will be available when the first order is placed. Introduction is scheduled beginning in January 2010.

However, if it turns out that this form is still not available in 2010, the ICC will assess the situation, make the right decision, and inform GAVI. To this end, permanent contact will be maintained with GAVI to learn about changes in the availability of one or the other form of the vaccine in the market.

The costs of acquiring supplementary cold chain equipment will be co-financed using the grant from GAVI, UNICEF and the other partners.

As for financial sustainability, the government already has a cost category entitled “purchases of drugs, medical and surgical equipment and vaccines.” The country agrees to make its co-financing amount available to purchase the vaccines through UNICEF. Moreover, advocacy is in progress to create a specific cost category entitled “Purchases of vaccines and immunisation supplies” in the country’s budgetary classification system.

The recommended strategies for successfully introducing the pneumococcal vaccine are as follows:

- Advocacy and strengthening links with the community;
- Strengthening personnel capacities;
- Improving the management of vaccines and immunisation supplies;
- Strengthening cold chain capacity;
- Strengthening injection safety;
- Strengthening program management;
- Improving the supply and use of services;
- Strengthening epidemiological and AEFI surveillance;
- Revitalizing operations research;
- Financial sustainability.

Consequently, the government of the DRC is submitting this application to GAVI. The application was validated at the April 2008 ICC meeting to request GAVI support for introducing the single-dose pneumococcal vaccine into its immunisation program.

The total budget for introducing this vaccine amounts to US$ 135,852,847, US$ 134,865,000 of which is for the pneumococcal vaccine and immunisation supplies, and US$ 987,847 is for other standard activities.

The quantities required of vaccines, the estimated cost and the co-financing amounts are summarized in the table below.

Table I: Quantity of vaccines, costs and co-financing by the country and GAVI for the pneumo vaccine

Years/Category	2010	2011	2012	Total
Quantities of total vaccines required	9,697,700	8,153,200	8,377,000	**26,227,900**
Number of AD syringes	10,354,500	8,623,300	8,858,900	**27,836,700**
Number of safety boxes	107,650	90,525	93,000	**291,175**
Total funds necessary	$49,871,000	$41,922,000	$43,072,000	**$134,865,000**
Maximum country co-financing	$1,455,000	$1,631,000	$1,675,500	**$4,761,500**
Maximum GAVI co-financing	$48,416,000	$40,291,000	$41,396,500	**$130,103,500**

2. Signatures of the Government and National Coordinating Bodies

Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of the Democratic Republic of the Congo would like to expand the existing partnership with the GAVI Alliance for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests for GAVI support for the pneumococcal infections vaccine.

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

Table N° 6.5 of page 26 of this application shows the amount of support in either supply or cash that is required from the GAVI Alliance. **Table N° 6.4 of page 26** of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

According to the regulation of budgeting and internal financing cycles, the government will be its share of the financing on a yearly basis **in September of the previous year.** Purchases made during the first year of co-financed support will be paid for somewhere around **September 2009.** *(indicate month and year)*.

Minister of Health:		**Minister of Finance:**	
Signature: ……		Signature: ……	
Name:	Dr. Victor Makwenge Kaput	Name:	Mr. Athanase Matenda Kyelu
Date:	__ April 2008	Date:	__ April 2008

National Coordinating Body - Inter-Agency Coordinating Committee for Immunisation:

We the members of the ICC/HSCC[1] met on the 30th day of April 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: 3.

Name/Title	Agency/Organisation	Signature
Dr. Jean Baptiste Roungou Representative	**WHO**	
Mr. Anthony Bloomberg Representative	**UNICEF**	
Mr. Ambroise Tshimbalanga Chair, National Polio Plus Committee	**Rotary**	
Mr. Stephen M. Haykin	**USAID**	

[1] Inter-agency coordinating committee or Health sector coordinating committee, whichever is applicable.

Director		

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

Name:	Dr. Micheline Mabiala Eleyi	Title:	Director-Physician of the DRC EPI
Tel No.:	00243 997 029 865	Address:	N°28 Av de la justice, C/ Gombe, Kinshasa, DRC
Fax No.:	not available		……
Email:	maeleyi@yahoo.fr directionpevrdc@gmail.com		……

The GAVI Secretariat is unable to return documents and attachments to individual countries. Unless otherwise specified, documents may be shared with the GAVI partners and collaborators.

The Inter-Agency Coordinating Committee for Immunisation

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

Profile of the ICC/HSCC

Name of the ICC/HSCC: ***Inter-agency Coordinating Committee for Immunisation in the DRC (ICC)***

Date of constitution of the current ICC/HSCC: 13 July 1995

Organisational structure (e.g., sub-committee, stand-alone): ***there is a strategic level and a technical level. The technical level is comprised of four commissions (technical, logistics, social mobilization and financial)***

Frequency of meetings: ***Quarterly for the Strategic ICC and monthly for the commissions***.

Composition:

Function	Title / Organization	Name
Chair	Minister of Health	Dr. Victor Makwenge Kaput
Secretary	Director-Physician of the EPI	Dr. Micheline Mabiala Eleyi
Members	• WHO representative • UNICEF representative • President of Rotary • Director of USAID	• Dr. Jean Baptiste Roungou • Mr. Anthony Bloomberg • Mr. Ambroise Tshimbalanga • Mr. Stephen M. Haykin

Major functions and responsibilities of the ICC/HSCC:
- Coordinating partner programs
- Mobilizing resources
- Monitoring and evaluation of EPI activities, oversight of EPI funds management

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

1. Expand the ICC to the level of the other partners

2. Strengthen the ICC at the provincial level

3. Establish systems for monitoring recommendations from the different ICC meetings

3. 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 (or equivalent plan), and attach a complete copy (with an executive summary) as DOCUMENT NUMBER **1a**.
- Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms on Vaccine Preventable Diseases and attach them as DOCUMENT NUMBERS **2a and 2b.**
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.

Table 3.1: Basic facts for the year 2007 (the most recent; specify dates of data provided)

	Figure	Date	Source
Total population	67,272,544	2007	Populations provided by the provinces of the DRC following the census/ organized by the health zones in 2007. This population is lower than the 2005 and 2006 figures which were estimates.
Infant mortality rate (per 1000)	92	2007	EDS-DRC (Demographic and Health Survey, 2007, DRC)
Surviving Infants*	2,347,812	2007	3.49% of the total population in 2007
GNI per capita (US$)	6.1	2007	Ministry of Planning
Percentage of GDP allocated to Health	1%	2007	Ministry of the Budget
Percentage of Government expenditure on Health	3.6%	2007	Ministry of the Budget

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

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

Please indicate the name and date of the relevant planning document for health
2007-2011 Strategies Paper for Strengthening the Health System 2000-2009 Health Development Master Plan

Is the cMYP (or updated Multi-Year Plan) aligned with this document (timing, content etc)
Yes. The cMYP covers the period from 2008 to 2012

Please indicate the national planning budgeting cycle for health
The health sector budget is prepared based on different programs and directions from the ministry in August. It is defended before the Ministry of the Budget for validation in September. Once it is validated, the budget is discussed in the Council of Ministers and then it is defended before the Parliament during the October budgetary session. This budget covers an annual period from January to December.

Please indicate the national planning cycle for immunisation
The EPI multiyear plan (cMYP) covers the period from 2008 to 2012.
The annual EPI action plan is based on the cMYP and the health zone (health district) microplans.
The cMYP is prepared with the involvement of all the EPI partners. This plan contains the immunisation budget, which is included in the total health budget.

Table 3.2: Current Vaccination Schedule: Traditional, New Vaccines and Vitamin A Supplement *(refer to cMYP pages)*

Vaccine *(do not use trade name)*	**Ages of administration** *(by routine immunisation services)*	**Indicate by an "x" if given in:**		**Comments**
		Entire country	**Only part of the country**	
BCG	Birth	x		
OPV	Birth, 6,10 and 14 weeks	x		
DTP_HepB	6,10 and 14 weeks	x		Hib will be introduced in the EPI in January 2009 and pneumo in January 2010. The same schedule will be used as for DTP_HepB.
Measles	9 months	x		
Yellow Fever	9 months	x		
TT	Pregnant women (1st dose at the first contact, 2nd dose 4 weeks after the 1st)	x		
Vitamin A	1st dose at 6 months and then every 6 months for the following doses until age 59 months.	x		The routine administration of Vitamin A will begin in July 2008
ITN	One ITN will be given to all children that complete their vaccine program and to all pregnant women who receive the 2nd dose of TT	x		Integration will begin in January 2009

Table 3.3: 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 (in percentage)						Vaccine preventable disease burden		
Vaccine		Reported		Survey		Disease	Number of reported cases	
		2006	2007	2006	2007		2006	2007
BCG		86.9%	94.2%	ND	ND	Tuberculosis*	62,573	80,474
DTP		87.2%	95%	ND	ND		ND	ND
		77.2%	87.0%	ND	ND		3,558	3,799
Polio 3		77.9%	87.5%	ND	ND	Polio	13	41
Measles (first dose)		73.0%	79.3%	ND	ND	Measles	80,123	55,577
TT2+ (PregNDnt women)		73.3%	80.3%	ND	ND	NN Tetanus	717	379
Hib3		NA	NA	NA	NA	Hib **	NA	NA
Yellow Fever		73.7%	82.0%	ND	ND	Yellow fever	81	204
HepB3		ND	ND	ND	ND	hepB sero-prevalence*	ND	ND
Vit A supplement	Mothers (<6 weeks post-delivery)	ND	ND	ND	ND			
	Infants (>6 months)	ND	ND	ND	ND			

ND = not available
NA = not applicable

* If available
** 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:

Table 3.4: Baseline and annual targets *(refer to cMYP pages **49 and 50**)*

Number		Baseline and targets					
		Reference Year 2007[2]	Year 2 2008	Year 3 2009	Year 4 2010	Year 5 2011	Year 6 2012
Births		2,690,902	2,771,629	2,854,778	2,940,421	3,028,634	3,119,493
Infants' deaths		343,090	353,383	363,984	374,904	386,151	397,735
Surviving infants		2,347,812	2,418,246	2,490,794	2,565,517	2,642,483	2,721,757
Pregnant women		2,690,902	2,771,629	2,854,778	2,940,421	3,028,634	3,119,493
Target population vaccinated with BCG		2,536,170	2,633,047	2,740,587	2,822,804	2,937,775	3,057,103
BCG coverage*		94	95	96	96	97	98
Target population vaccinated with OPV3		2,053,257	2,176,422	2,291,530	2,385,931	2,457,509	2,558,452
OPV3 coverage**		87	90	92	93	93	94
Target population vaccinated with DTP3***		2,042,176	2,176,422	2,291,530	2,385,931	2,457,509	2,558,452
DTP3 coverage**		87	90	92	93	93	94
Target population vaccinated with DTP1***		2,230,336	2,297,334	2,391,162	2,462,897	2,563,208	2,640,105
Wastage[3] rate in base-year and planned thereafter		17	5	5	5	5	5
Target population vaccinated with **3rd dose** of pneumo		NA NA	NA NA	NA NA	2,385,931	2,457,509	2,558,452
Pneumo Coverage**		NA	NA	NA	93	93	94
Target population vaccinated with **1st dose** of Pneumo		NA	NA	NA	2,462,897	2,563,208	2,640,105
Wastage[1] rate in base-year and planned thereafter		NA	NA	NA	5	5	5
Target population vaccinated with **1st dose** of Measles		1,878,249	2,055,509	2,166,990	2,308,966	2,378,235	2,504,017
Target population vaccinated with **2nd dose** of Measles		NA	NA	NA	NA	NA	NA
Measles coverage**		79,3	85	87	90	90	92
Pregnant women vaccinated with TT+		2,152,721	2,355,884	2,483,657	2,646,379	2,725,770	2,869,933
TT+ coverage****		80.3	85	87	90	90	92
Vit A supplement	Mothers (<6 weeks from delivery)	NA	NA	NA	NA	NA	NA
	Infants (>6 months)	NA	NA	NA	NA	NA	NA
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100		8.4%	5.3%	4.2%	3.1%	4.1%	3.1%
Annual Measles Drop out rate (for countries applying for YF)		NA	NA	NA	NA	NA	NA

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants

[2] We preferred to use 2007 as the reference year instead of 2006 for Table 3.4 and 4.1 because the 2007 immunisation results are already available and they provide a better understanding of coverage projections.
[3] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby: A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check **table α** after Table 7.1.

*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women

Table 3.5: Summary of current and future immunisation budget *(or refer to cMYP pages)*

	Estimated costs per annum in US$ (,000)					
Cost category	**Base year 2006**	**2008**	**2009**	**2010**	**2011**	**2012**
	US$	**US$**	**US$**	**US$**	**US$**	**US$**
Routine Recurrent Cost						
Vaccines (routine vaccines only)						
Traditional vaccines	3,105	2,790	2,766	2,862	2,923	3,038
New and under-used vaccines	2,350	8,951	36,090	76,271	67,953	68,153
Injection supplies	2,692	3,087	3,541	4,262	4,393	4,531
Personnel						
Salaries of full-time NIP health workers (immunisation specific)	1,746	1,891	1,979	2,018	2,059	2,100
Per-diems for outreach vaccinators / mobile teams	2,225	2,269	2,315	2,361	2,408	2,456
Per-diems for supervision	2,911	2,995	3,068	3,129	3,192	3,255
Transportation	4,651	4,890	5,204	5,573	4,565	4,927
Maintenance and overheads	4,659	7,665	9,601	10,883	11,802	12,962
Training	1,088	1,261	1,301	1,353	1,408	1,465
Social mobilisation and IEC	319	1,089	1,087	571	582	594
Disease surveillance	5,913	4,977	6,041	6,069	6,315	6,570
Program management	2,882	3,611	3,744	3,109	3,235	3,365
Other	267	2,827	2,889	527	549	571
Subtotal Recurrent Costs	**34,807**	**48,303**	**79,626**	**118,990**	**111,383**	**113,986**
Routine Capital Costs						
Vehicles	1,008	468	743	771	749	764
Cold chain equipment	2,205	5,824	4,369	4,115	2,895	2,911
Other capital equipment	42	516	1,201	482	491	501
Subtotal Capital Costs	**3,255**	**6,808**	**6,313**	**5,368**	**4,136**	**4,176**
Campaigns						
Polio	17,266	27,917	14,199	0	0	0
Measles	10,801	3,357	3,514	0	0	0
Neonatal Tetanus	1,682	14,871	2,455	0	0	0
Vitamin A	152	1,347	673	0	0	0
Subtotal Campaign Costs	**30,058**	**47,492**	**20,842**	**0**	**0**	**0**

Shared costs							
Shared personnel costs		2,342	2,389	2,436	2,485	2,535	2,586
Shared transportation costs		1,436	1,465	1,494	1,524	1,555	1,586
Buildings		50	765	780	0	812	0
Subtotal of shared costs		**3,828**	**4,619**	**4,711**	**4,009**	**4,901**	**4,171**
GRAND TOTAL		**71,948**	**107,221**	**111,492**	**128,367**	**120,420**	**122,333**

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.

Table 3.6: Summary of current and future financing and sources of funds *(pages 70 and 71 of the cMYP)*

		Estimated financing per annum in US$ (,000)					
Cost category	**Funding source**	**Base year**	**Year 1 20…**	**Year 2 20…**	**Year 3 20…**	**Year 4 20…**	**Year 5 20…**
Routine Recurrent Cost							
1.	1. Government	1,441	6,105	7,527	7,980	8,884	9,029
2.	2. GAVI (ISS)	3,437	2,453	2,786	1,786	1,354	1,910
3.	3. GAVI (NV)	3,086	8,427	35,996	75,809	66,331	66,588
4.	4. WHO	5,738	5,082	5,071	5,192	5,165	5,192
5.	5. UNICEF	8,904	6,836	6,918	7,165	7,366	7,415
6.	6. USAID	1,843	1,500	1,500	3,700	3,700	3,700
7.	7. ROTARY	216	261	261	310	310	310
8.	8. CTB	-	419	1,104	303	303	303
9.	9. OTHER PARTNERS	1,632	460	463	1,278	1,277	1,278
10.	10. GAVI CSO	-	2,641	2,330	-	-	-
11.	11.						
12.	12.						
13.	13.						
14.	14.						
Routine Capital Costs							
1.	1. Government	5	283	283	246	246	246
2.	2. GAVI (ISS)	675	140	159	102	77	109
3.	3. GAVI (NV)	-	588	-	700	-	-
4.	4. WHO	82	294	305	191	191	191
5.	5. UNICEF	1,615	1,300	1,300	1 ,65	1,365	1,365

6.	6. USAID	192	-	-	-	-	-
7.	7. ROTARY	100	244	244	122	122	122
8.	8. CTB	-	671	671	1,000	1,000	1,000
9.	9. OTHER PARTNERS	40	164	164	188	188	188
10.	10. GAVI CSO	-	348	348	-	-	-
Campaigns							
1.	1. Government	-	-	-	-	-	-
2.	2. GAVI (ISS)	372	-	-	-	-	-
3.	3.. WHO	11,804	16,307	9,377	-	-	-
4.	4. UNICEF	17,846	28,985	11,465	-	-	-
5.	5. USAID	-	2,200	-	-	-	-
	6. ROTARY	-	-	-	-	-	-
GRAND TOTAL		**59,025**	**85,708**	**88,273**	**107,437**	**97,879**	**98,945**

4. Immunisation Services Support (ISS)

Please indicate below the total amount of funds you expect to receive through ISS:

Table 4.1: Estimate of fund expected from ISS

	Base Year 2009	Year 3 2010	Year 4 2011	Year 52012
DTP3 Coverage rate	92	93	93	94
Number of infants reported / planned to be vaccinated with DTP3 (as in Table 3.4)	2,291,530	2,385,931	2,457,509	2,558,452
Number of *additional* infants that annually are reported / planned to be vaccinated with DTP3	115,109	94,401	71,578	100,943
Funds expected ($20 per additional infant)	2,302,160	1,888,020	1,431,560	2,018,860

* Projected figures
** As per duration of the cMYP

If you have received ISS support from GAVI in the past, please describe below any major lessons learned, and how these will affect the use of ISS funds in future.

Please state what the funds were used for, at what level, and if this was the best use of the flexible funds; mention the management and monitoring arrangements; who had responsibility for authorising payments and approving plans for expenditure; and if you will continue this in future.

Major Lessons Learned from Phase 1	Implications for Phase 2
1. The flexibility and steady flow of GAVI funds made it possible to promptly meet essential program needs.	It is advisable for these funds to continue to be flexible and easily disbursed

2. In a context of insufficient resources for health, GAVI funds made a considerable contribution to improving program performance.	Continued GAVI support is necessary to maintain program balance
3. GAVI funds have not been integrated into the national accounting system.	The EPI accounting system is in the process of being made consistent with the Congolese accounting plan. To this end, a consulting firm is now implementing the appropriate management tools and training the personnel in charge of EPI financial management in their use. An account will be opened for the EPI in the government's name so that GAVI funds are listed in the government budget
4. The weakness of the effective internal audit [sic] made it impossible to identify the management weaknesses in time to correct them.	An internal auditing system has been implemented and will work on the basis of a plan and procedure validated by the ICC.
5. The failure to allocate 65% of GAVI funds set aside for the operational level had a negative impact on the implementation of certain activities in the health zones that are not receiving support	Monitoring systems are in place to ensure that these funds actually reach the health zones.
6.	

If you have not received ISS support before, please indicate:

a) when you would like the support to begin: **NOT APPLICABLE**

b) when you would like the first DQA to occur: **NOT APPLICABLE**

c) how you propose to channel the funds from GAVI into the country: **NOT APPLICABLE**

d) how you propose to manage the funds in-country: **NOT APPLICABLE**

e) who will be responsible for authorising and approving expenditures:

NOT APPLICABLE

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

5. Injection Safety Support

NOT APPLICABLE

- Please attach the National Policy on Injection Safety including safe medical waste disposal (or reference the appropriate section of the Comprehensive Multi-Year Plan for Immunisation), and confirm the status of the document: DOCUMENT NUMBER……
- Please attach a copy of any action plans for improving injection safety and safe management of sharps waste in the immunisation system (and reference the Comprehensive Multi-Year Plan for Immunisation). DOCUMENT NUMBER……

Table 5.1: Current cost of injection safety supplies for routine immunisation

NOT APPLICABLE

Please indicate the current cost of the injection safety supplies for routine immunisation.

	Annual requirements		*Cost per item (US$)*		*Total Cost (US$)*
Year	*Syringes*	*Safety Boxes*	*Syringes*	*Safety Boxes*	
20…					

Table 5.2: Estimated supply for safety of vaccination with …….. vaccine

NOT APPLICABLE

(Please use one table for each vaccine BCG(1 dose), DTP(3 doses), TT(2 doses) [1], Measles(1 dose) and Yellow Fever(1 dose), and number them from 5.1 to 5.5)

		Formula	Year 1 20…	Year 2 20…	Year 3 20…	Year 4 20…	Year 5 20…
A	Number of children to be vaccinated [2]	#					
B	Percentage of vaccines requested from GAVI [3]	%					
C	Number of doses per child	#					
D	Number of doses	*A x B/100 x C*					
E	Standard vaccine wastage factor [4]	*Either 2.0 or 1.6*					
F	Number of doses (including wastage)	*A x B/100 x C x E*					
G	Vaccines buffer stock [5]	*F x 0.25*					
H	Number of doses per vial	#					
I	Total vaccine doses	*F + G*					
J	Number of AD syringes (+ 10% wastage) requested	*(D + G) x 1.11*					
K	Reconstitution syringes (+ 10% wastage) requested [6]	*I / H x 1.11*					
L	Total of safety boxes (+ 10% of extra need) requested	*(J + K) / 100 x 1.11*					

[1] GAVI supports the procurement of AD syringes to deliver two doses of TT to pregnant women. If the immunisation policy of the country includes all Women in Child Bearing Age (WCBA), GAVI/The Vaccine Fund will contribute to a maximum of two doses for Pregnant Women (estimated as total births)
[2] To insert the number of infants that will complete vaccinations with all scheduled doses of a specific vaccine.
[3] Estimates of 100% of target number of children is adjusted if a phased-out of GAVI/VF support is intended.
[4] A standard wastage factor of 2.0 for BCG and of 1.6 for DTP, Measles, TT, and YF vaccines is used for calculation of INS support

[5] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero under other years. In case of a phased introduction with the buffer stock spread over several years, the formula should read: [F – number of doses (incl. wastage) received in previous year] * 0.25.
[6] It applies only for lyophilized vaccines; write zero for other vaccines.

- If you do not intend to procure your supplies through UNICEF, please provide evidence that the alternative supplier complies with WHO requirements by attaching supporting documents as available.

6. New and Under-Used Vaccines (NVS)

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):

The introduction of a pneumococcal vaccine is the result of advocacy in favour of the countries by the PneumoADIP Initiative during the forum of decision-makers from French-speaking countries that are eligible for GAVI. This forum was held in January 2007 in Brazzaville. Other than this awareness session, the Alliance Secretariat sent a circular letter to the health ministers of the eligible countries, reminding them of the burden of pneumococcal infections worldwide, and informing them that the heptavalent vaccine is available and that GAVI support is available for introducing this new vaccine. After this correspondence, and based on the WHO recommendation on the introduction of the pneumococcal vaccine in countries with high infant mortality rates, the DRC opted to commit to the process of introducing this new vaccine. To this end, the EPI Multiyear Plan was revised and plans were included to introduce this new vaccine in 2010.

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 use attached excel annex 2a (Tab 6) on the Cold Chain. Please indicate the additional cost, if capacity is not available and the source of funding to close the gap

Central level

The evaluation of the cold chain capacity at the central level did not show any additional needs for storing all vaccines, including the pneumococcal vaccine. As of today, the central store has a net available positive volume of 117,000 litres, while requirements in volume compared to the pace of shipments for the coming years are estimated at 36,157 litres in 2008, 81,834 litres in 2009, 105,195 litres in 2010, 108,804 litres in 2011, and 112,409 litres in 2012. This shows that the national level has sufficient capacity for storing all the vaccines to be included in the projection period, including the pentavalent vaccine in 2009 and pneumo in 2010. Furthermore, the program is preparing to install two new cold chambers with a gross volume of 30 cm3 each. The chambers came from UNICEF and they will increase cold chain capacity considerably at the national level.

Intermediate level

However, at the intermediate level, the logistical analysis showed additional cold chain equipment requirements that will be covered as follows:

- Quarterly shipments will be continued for all the intermediate facilities except the facilities in Kinshasa where, since they are close to the national store, there will be deliveries every two months.
- 6 cold chambers, 20 m3 gross, will be acquired.

- 7 cold chambers, 10 m3 gross, will be acquired
- 15 cold chambers, 5 m3 gross, will be acquired
- 87 refrigerators, 100 litres net, will be acquired
- 6 freezers, 100 litres net, will be acquired

It should be noted that the estimate of additional equipment necessary for this level was based on needs for 2012. This is the year when needs are the highest. This was done to obtain an idea of the maximum volume requirement for the entire projection period. The total cost is US$ 748,757.

Operational level

As for the operational level, of the 515 health zones, just 63 zones will require strengthening of their cold chains. This strengthening will involve providing a net 100-litre refrigerator to each health zone at a unit cost of US$ 1,081, which will bring the total cost of the operational level to US$ 68,101 for strengthening the cold chain at the operational level.

Gap financing

To date, the program already has secured financing in the amount of US$ 588,000 to strengthen the cold chain. The program just obtained this funding from the GAVI grant for introducing the pentavalent vaccine.

In addition, under the GAVI grant for pneumo introduction, the EPI budgeted US$ 700,126 to strengthen the cold chain out of the US$ 882,126 expected. This shows that the country has sufficient resources not just for meeting the cold chain requirement for pneumo, but to anticipate probable requirements for the rotavirus vaccine as well.

The other partners, including UNICEF, USAID, and Rotary, are also continuing to strengthen the cold chain at the national level (UNICEF) and the operational level (UNICEF, Rotary, USAID, etc.).

Table 6.1: Capacity and cost (for positive storage) (*Refer to Tab 6 of Annex 2a or Annex 2b)*
National level

		Formula	Year 1 2008	Year 2 2009	Year 3 2010	Year 4 2011	Year 5 2012
A	Annual ***positive*** volume requirement, including new vaccine (specify:_____) (litres or m3)[4]	*Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine*	72,314 litres	163,667 litres	315,585 litres	326,411 litres	337,226 litres
B	Annual ***positive*** capacity, including new vaccine (specify:_____) (litres or m3)	#	117,000 litres	117,000 litres	117,000 litres	117,000 litres	117,000 litres
C	Estimated minimum number of shipments per year required for the actual cold chain capacity	*A / B*	0.62	1.40	2.70	2.79	2.88

[4] Use results from table 5.2. Make the sum-product of the total vaccine doses row (I) by the unit packed volume for each vaccine in the national immunisation schedule. All vaccines are stored at positive temperatures (+5°C) except OPV which is stored at negative temperatures (-20°C).

D	Number of consignments / shipments per year	*Based on national vaccine shipment plan*	2	2	3	3	3
E	Gap (if any)	*((A / D) - B)*	**- 80,843 litres**	**- 35,166 litres**	**- 11,805 litres**	**- 8,196 litres**	**- 4,591 litres**
F	Estimated cost for expansion	*US $*	$0	$0	$0	$0	$0

Combined intermediate level

		Formula	**Year 1 2008**	**Year 2 2009**	**Year 3 2010**	**Year 4 2011**	**Year 5 2012**
A	Annual ***positive*** volume requirement, including new vaccine (specify:_____) (litres or m3)[5]	*Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine*	130,142	267,306	495,288	511,582	528,938
B	Annual ***positive*** capacity, including new vaccine (specify:_____) (litres or m3)	#	54,327	54,327	54,327	54,327	54,327
C	Estimated minimum number of shipments per year required for the actual cold chain capacity	*A / B*	2.40	4.92	9.12	9.42	9.74
D	Number of consignments / shipments per year	*Based on national vaccine shipment plan*	4	4	4	4	4
E	Gap (if any)	*((A / D) - B)*	- 21,792	12,500	69,495	73,569	77,908
F	Estimated cost for expansion	*US $*	$0	$378,395	$701,123	$724,188	$748,757

Detailed analysis of the cold chain at the intermediate level for 2012

National /Provincial /District	Total Population 2012	Current cold chain capacity in litres		Deliveries per year		GAP (litres)		Additional cold chain, adjusted by the country			
				vaccine &	injection			equipment, units/types			Equip-ment costs
		positive	negative	diluents	equipment	Positive	negative	positive		negative	($US)
National store	77,987,316	117,000	37,000	21	1	- 4,591 litres	- 25,073 litres	no equipment		no equipment	$0
BANDUNDU	1,549,940	4,247	4,384	4	4	- 2,465 litres	- 4,307 litres	no equipment		no equipment	$0
INONGO	494,490	274	108	4	4	295 litres	- 83 litres	3 Refrig.-100 litres		no equipment	$3,411
KAHEMBA	613,555	291	-	4	4	418 litres	31 litres	4 Refrig.-100 litres		0 Freezer-100 litres	$4,994
KENGE	1,534,491	288	192	4	4	1,480 litres	- 115 litres	1 Cold Ch.-5m3		no equipment	$19,081
KIKWIT	5,784,349	402	324	4	4	6,234 litres	- 36 litres	1 Cold Ch.-20m3		no equipment	$29,530
BOMA	1,111,802	553	372	4	4	724 litres	- 316 litres	7 Refrig.-100 litres		no equipment	$8,388
MATADI	3,382,806	329	372	4	4	3,551 litres	- 204 litres	1 Cold Ch.-10m3		no equipment	$25,381
MBANZA NGUNGU	1,438,654	243	372	4	4	1,408 litres	- 300 litres	1 Cold Ch.-5m3		no equipment	$19,081
BOENDE	1,415,248	240	768	4	4	1,389 litres	- 697 litres	1 Cold Ch.-5m3		no equipment	$19,081
BUMBA	800,101	418	-	4	4	506 litres	40 litres	5 Refrig.-100 litres		0 Freezer-100 litres	$6,067
GBADOLITE	5,429,530	221	344	4	4	6,006 litres	- 74 litres	1 Cold Ch.-20m3		no equipment	$29,530
GEMENA	2,390,254	410	-	4	4	2,333 litres	119 litres	1 Cold Ch.-10m3		1 Freezer-100 litres	$25,381

[5] Use results from table 5.2. Make the sum-product of the total vaccine doses row (I) by the unit packed volume for each vaccine in the national immunisation schedule. All vaccines are stored at positive temperatures (+5°C) except OPV which is stored at negative temperatures (-20°C).

National /Provincial /District	Total Population 2012	Current cold chain capacity in litres		Deliveries per year		GAP (litres)		Additional cold chain, adjusted by the country			
								equipment, units/types			Equip-ment costs
		positive	negative	vaccine & diluents	injection equipment	Positive	negative	positive		negative	($US)
LISALA	1,096,424	160	344	4	4	1,107 litres	- 289 litres	11 Refrig.-100 litres		no equipment	$12,816
MBANDAKA	3,326,089	-	-	4	4	3,817 litres	166 litres	1 Cold Ch.-20m3		2 Freezer-100 litres	$32,018
KANANGA	5,528,197	3,567	5,328	4	4	2,768 litres	- 5,053 litres	1 Cold Ch.-10m3		no equipment	$25,381
LUIZA	1,087,746	312	336	4	4	942 litres	- 282 litres	9 Refrig.-100 litres		no equipment	$10,914
MWEKA	1,473,297	273	720	4	4	1,423 litres	- 647 litres	1 Cold Ch.-5m3		no equipment	$19,081
TSHIKAPA	1,793,207	246	780	4	4	1,812 litres	- 691 litres	1 Cold Ch.-5m3	2 Refrig 100 litres	no equipment	$21,569
KABINDA	1,914,665	165	336	4	4	1,952 litres	- 684 litres	1 Cold Ch.-5m3	2 Refrig 100 litres	no equipment	$21,569
LODJA	1,545,385	592	1,600	4	4	1,189 litres	- 1,523 litres	1 Cold Ch.-5m3		no equipment	$19,081
MBUJI MAYI	7,724,593	3,364	5,920	4	4	5,492 litres	- 5,535 litres	1 Cold Ch.-20m3		no equipment	$29,530
MUENE DITU	1,840,691	165	576	4	4	1,947 litres	- 484 litres	1 Cold Ch.-5m3		no equipment	$19,081
KABONDO DIANDA	1,757,729	247	316	4	4	1,770 litres	- 228 litres	1 Cold Ch.-5m3	1 Refrig 100 litres	no equipment	$20,325
KALEMIE	2,295,999	317	980	4	4	2,322 litres	- 866 litres	1 Cold Ch.-10m3		no equipment	$25,381
KAMINA	1,454,556	220	632	4	4	1,454 litres	- 560 litres	1 Cold Ch.-5m3		no equipment	$19,081
KISENGE	933,478	226	608	4	4	847 litres	- 561 litres	8 Refrig.-100 litres		no equipment	$9,815
KOLWEZI	794,569	110	388	4	4	802 litres	- 348 litres	8 Refrig.-100 litres		no equipment	$9,284
LIKASI	979,101	346	1,056	4	4	781 litres	- 1,007 litres	8 Refrig.-100 litres		no equipment	$9,048
LUBUMBASHI	8,867,680	3,181	3,752	4	4	6,980 litres	- 3,310 litres	1 Cold Ch.-20m3		no equipment	$29,530
KIN CENTRE	7,196,106	3,127	3,672	6	6	2,375 litres	- 3,433 litres	1 Cold Ch.-10m3		no equipment	$25,381
KIN EST	2,098,875	182	-	6	6	1,427 litres	70 litres	1 Cold Ch.-5m3		1 Freezer-100 litres	$19,437
KIN OUEST	2,480,355	137	-	6	6	1,764 litres	83 litres	1 Cold Ch.-5m3	2 Refrig 100 litres	1 Freezer-100 litres	$23,234
KASONGO	1,221,023	109	-	4	4	1,298 litres	61 litres	1 Cold Ch.-5m3		1 Freezer-100 litres	$19,392
KINDU	2,038,471	3,304	144	4	4	- 966 litres	- 42 litres	no equipment		no equipment	$0
BUTEMBO	3,535,554	220	804	4	4	3,832 litres	- 628 litres	1 Cold Ch.-10m3		no equipment	$25,381
GOMA	6,447,290	10,989	7,016	4	4	- 3,593 litres	- 6,695 litres	no equipment		no equipment	$0
ARU	1,937,755	165	720	4	4	2,064 litres	- 623 litres	1 Cold Ch.-10m3		no equipment	$25,381
BUNIA	4,477,057	791	1,948	4	4	4,344 litres	- 1,725 litres	1 Cold Ch.-20m3		no equipment	$29,530
BUTA	872,915	305	1,336	4	4	705 litres	- 1,292 litres	7 Refrig.-100 litres		no equipment	$8,160
LOKUTU	729,696	381	690	4	4	467 litres	- 653 litres	5 Refrig.-100 litres		no equipment	$5,405
KISANGANI	5,148,349	7,580	7,992	4	4	- 1,674 litres	- 7,735 litres	no equipment		no equipment	$0
ISIRO	1,675,557	394	1,064	4	4	1,537 litres	- 981 litres	1 Cold Ch.-5m3		no equipment	$19,081
BUKAVU	4,957,778	5,183	8,376	4	4	507 litres	- 8,129 litres	5 Refrig.-100 litres		no equipment	$5,873
UVIRA	1,267,220	55	708	4	4	1,402 litres	- 645 litres	1 Cold Ch.-5m3		no equipment	$19,081

Summary of the level of intermediate-level storage capacity

	Category	Year 4 2009	Year 4 2010	Year 5 2011	Year 2012
A	Total number of intermediate facilities	44	44	44	44

B	Number of facilities with adequate storage capacity	7	5	4	4
C	Number of facilities with insufficient storage capacity	37	39	40	40

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):
To ensure financial sustainability for the EPI, the DRC plans to use the following strategies: -Mobilize adequate resources; -Facilitate access to funding and -Manage resources rationally. A. Strategy to mobilize adequate resources This strategy applies to the government, the community, and the partners. Government: A series of measures are already being taken, especially as part of the reform of the government and improvements in the macroeconomic environment. The principles of good governance and transparent management that have been adopted will probably enable the government to increase its co-financing amount for immunisation. Starting in 2008, the Government agreed to gradually increase its share by paying for the cost of purchasing traditional vaccines and injection supplies, except for the cost paid for by GAVI as part of introducing the pentavalent Hib vaccine (DTP-HepB-Hib). As for new and under-used vaccines, the government will contribute with minimal funding of US$ 0.15 per dose of pneumo starting in 2010. The following programs are being considered to make the program viable: - Raise the health sector's co-financing amount in the government budget through advocacy with the government and other institutions such as the National Assembly, Senate, and the Office of the President of the Republic, to gradually increase the percentage of the government budget allocated to the health sector and in the context of the HIPC Initiative. To this end, an advocacy session was organized by the DRC's Minister of Health for members of Parliament and members of the central government on the status of the WPV in the DRC and funding for the EPI. During this session, the central government representative reaffirmed his commitment to immunisation. - Advocacy is in progress to create a specific cost category entitled "purchase of vaccines and immunisation supplies" in the country's budget classification system. - The Ministry of Health's objective is to raise the health budget to 15% of the total government budget before 2010. This increase will have a major impact on funding for immunisation, which is one of the Ministry of Health's four priority programs. - Create the Health Promotion Fund (Fonds de Promotion pour la santé - FPS). These funds will come from various nuisance taxes, and contributions from both public and private health care establishments, etc. They will be used to revitalize the health facilities in implementing the minimum package of activities, including immunisation.

- The implementation of the HSS, supported by GAVI, will contribute to funding costs for the activities package planned in the cMYP, in particular the costs for strengthening personnel capacities and motivating personnel, strengthening integrated supervision, improving the working environment both at the level of the Provincial Health Inspection Offices and the general reference hospitals and health centres, and introducing adequate knowledge of vaccine-preventable diseases beginning with basic training for nurses, and during on-the-job training.

- The provincial governments and assemblies will be enlisted to mobilize resources at the decentralized level to increase financing for the health sector in general and for immunisation in particular. This mobilization will target, among other things, the community, local businesses, and all other organizations. To this end, the Kinshasa Declaration of 2 March 2007, which attests to the commitment of the provincial authorities to immunisation, was signed by all governors of all the provinces in the DRC.

Partners

- Continue to have the ICC mobilize resources from donors to maintain or even increase their support.

- Organize roundtables to identify new partners that can intervene in funding for immunisation.

- Strengthen the coordination of the partners that intervene directly in the health zones in favour of the EPI through the ICC.

B . Strategy to facilitate access to financing

- Develop the capacities of the managers in the Ministry of Health, including the EPI, to accelerate the process of obtaining financing (harness government contracting and spending procedures);
- Put in place systems to decentralize financial decisions to benefit the health sector's intermediate facilities;

C. Strategy for rational and efficient resource management

- Implement efficient and consensual management procedures, in particular those related to procurement, regular audits, etc.

- Lower vaccine wastage rates by: regularly supplying oil and replacement parts for the cold chain, using the open-vial policy, observing VVM, putting in place a suitable vaccine distribution system, and strengthening the cold chain in all the HCs; do all of the above and include employee training and formative supervision at all levels.

- Strengthen coordination at all levels through the ICCs and National and Provincial Steering Committees.

- Organize harmonization meetings with the different partners to balance their financing in order to avoid over-financing of certain categories and under-financing in others;

- Sign a memorandum of understanding, at the national as well as provincial level, on the EPI, including performance indicators, as is done at the central level.

Table 6.2: Assessment of burden of relevant diseases *(if available)*:

Comment [SRS1]: Add the information provided by the WHO on the meningitis and pneumococcal pneumonia burden in the letter to the government of the DRC dated September 2007

Disease	Title of the assessment	Date	Results
purulent meningitis	Bacteriological analysis of CSF samples in the City of Kinshasa, Epicentre, INRB	2001	This was a study of a bacteriological analysis of 212 CSF samples collected, 77 of which were positive and showed that pneumococcus was responsible for 28.5% of cases of purulent meningitis, and it was in first place, followed by meningococcus (20.8%) and Haemophilus influenzae type b (16.9%).
	Etiological and evolving aspects of purulent meningitis in children in Kinshasa, Omanga et al. Medicine of Black Africa.	1980	While pointing out the preponderant role pneumococcus plays in the etiology of purulent meningitis (33%), the Omanga study in 1980[6] revealed that children with sickle cell syndrome paid a high price in terms of pneumococcal infection (80%). According to the estimates of the National Sickle Cell Program, the prevalence of this genetic defect is estimated at 25%.
	Study of the prevalence of bacterial meningitis in Kinshasa. Mukadi	2001	Of 374 samples of CSF received from several hospitals in the City of Kinshasa from all ages combined, 11% of the CSF tested positive, 15% due to pneumococcus, and 10% due to *Haemophilus influenzae de type b.*

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

Lessons Learned	Solutions / Action Points
i. Introduction of the yellow fever vaccine 1. The selective approach to the introduction of the YF vaccine in the major cities in the country was difficult to implement in the urban health zones adjacent to the rural health zones.	• Introduce the new vaccine at the same time throughout the country
ii. Introduction of Hep B: 1. Failure to comply with the schedule for preparatory activities, which caused a delay in introducing the vaccine in some health zones.	• Comply with the schedule for preparatory activities
1. The sequential delivery by the supplier of the required quantities of DTP-HepB made introduction impossible at first in all the health zones and delayed the use	• Ensure that the vaccines are actually available at the central level three months prior to introduction.

[6] OMANGA, medicine of Black Africa

of the new DTP-Hep B vaccine; 2. Poor management of the DTP vaccine during the transitional period resulted in the destruction of a large inventory of this vaccine (over two millions doses). .	• Put in place an effective inventory management system during the transitional period.

Please list the vaccines to be introduced with support from the GAVI Alliance (and presentation):

The DRC selected the liquid single-dose pneumo conjugate vaccine in vials. As for blood types, preference will be given to the vaccine with the highest number of blood types that is available at the time the first order is placed. Introduction is scheduled beginning in January 2010.
However, if it turns out that this type is still not available in 2010, the ICC will evaluate the situation, make the right decision, and inform GAVI. To this end, permanent contact will be maintained with GAVI to learn of changes in the availability of either form of the vaccine in the market.

First Preference Vaccine

As reported in the cMYP, the country plans to introduce the pneumococcal infections vaccine (*antigen)* vaccinations, using the PCV vaccine, in *a single-dose vial (n° of doses per vial) liquid (lyophilized or liquid)* form.

Please refer to the Excel spreadsheet Annex 2a or Annex 2b (for Rotavirus and Pneumo vaccines) and proceed as follows:

- Please complete the "Country Specifications" Table in Tab 1 of Annex 2a or Annex 2b, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose[7].
- Please summarise the list of specifications of the vaccines and the related vaccination programme in Table 6.3 below, using the population data (from Table 3.4 of this application) and the price list and co-financing levels (in Tables B, C, and D of Annex 2a or Annex 2b).
- Then please copy the data from Annex 2a or 2b (Tab "Support Requested") into Tables 6.4 and 6.5 (below) to summarize the support requested, and co-financed by GAVI and by the country.
- Please submit the electronic version of the excel spreadsheets Annex 2a or 2b together with the application

[7] *Table D1 should be used for the first vaccine, with tables D2 and D3 for the second and third vaccine co-financed by the country*

Table 6.3: Specifications of vaccinations with new vaccine

Vaccine: single PCV	*Use data in:*		**Year 1 2010**	**Year 2 2011**	**Year 3 2012**
Number of children to be vaccinated with the third dose	*Table 3.4*	#	2,385,931	2,457,509	2,558,452
Target immunisation coverage with the third dose	*Table 3.4*	#	93	93	94
Number of children to be vaccinated with the first dose	*Table 3.4*	#	2,462,897	2,563,208	2,640,105
Estimated vaccine wastage factor	*Annex 2a or 2b Table E - tab 5*	#	1.05	1.05	1.05
Country co-financing per dose *	*Annex 2a or 2b Table D - tab 4*	$	0.105	0.15	0.15

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 6.4: Portion of supply to be co-financed by the country (and cost estimate, US$)

		Year 1 2010	**Year 2 2011**	**Year 3 2012**
Number of vaccine doses	#	457,100	512,500	526,600
Number of AD syringes	#	488,100	542,100	556,900
Number of re-constitution syringes	#	5,075	5,700	5,850
Number of safety boxes	#	$1,455,000	$1,631,000	$1,675,500
Total value to be co-financed by country	**$**	$1,455,000	$1,631 000	$1,675 500

Table 6.5: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		Year 1 2010	**Year 2 2011**	**Year 3 2012**
Number of vaccine doses	#	9,240 600	7,640,700	7,850,400
Number of AD syringes	#	9,866,400	8,081,200	8,302,000
Number of re-constitution syringes	#	102,575	84,825	87,150
Number of safety boxes	#	$29,408,500	$24,311,000	$24,978,000
Total value to be co-financed by GAVI	**$**	$48,416,000	$40,291,000	$41,396,500

- Please refer to http://www.unicef.org/supply/index_gavi.html for the most recent GAVI Alliance Vaccine Product Selection Menu, and review the GAVI Alliance NVS Support Country Guidelines to identify the appropriate country category, and the minimum country co-financing level for each category.

Second Preference Vaccine

If the first preference of vaccine is in limited supply or currently not available, please indicate below the alternative vaccine presentation

Liquid PCV, two-dose vials

- Please complete tables 6.3 – 6.4 for the new vaccine presentation
- Please complete the excel spreadsheets Annex 2a or Annex 2b for the new vaccine presentation and submit them alongside the application.

Procurement and Management of New and Under-Used Vaccines

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):

The country decided that its vaccine purchases would go through UNICEF. The government regularly deposits funds into the UNICEF/DR Congo bank account for GAVI. There has already been an experiment of this type, in 2004, when the country participated in purchasing traditional vaccines (OPV).

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 description of the mechanisms 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.*

Not applicable

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

The pneumococcal vaccine will be introduced beginning in January 2010 throughout the entire country.
To do so, the following preparatory activities are planned:

- Advocate with the political-administrative leaders and authorities
- Strengthen cold chain capacity at different levels
- Revise the program management tools
- Strengthen personnel capacity
- Raise the awareness of health care workers, clinicians and the community
- Set up a surveillance system based on the sentinel sites
- Monitor and evaluate the introduction process

There will be no catch-up dose for children over 12 months old, nor will there be immunisation at birth or for adults.

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

There is already an operational funds transfer system between GAVI and the country that entails a transfer to the program's bank account. This is the same system that will be used for the funds for introducing the pneumococcal vaccine.

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

The co-financing amounts from the country will be deposited with UNICEF DR Congo to purchase vaccines and immunisation supplies provided for under co-financing by the Ministry of Finance at the request of the Minister of Health. This will already have been included in the government budget.

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

The data on pneumococcal immunisation will be monitored in accordance with the reporting system in effect with the program.
The tools will be revised beforehand so that the aspects related to this new vaccine can be incorporated.

The data will be validated beforehand by local health authorities before it is sent to the higher level.

Special emphasis will be placed on holding monthly monitoring meetings at the operational level and quarterly reviews at the intermediate level to measure progress in reaching the objectives as set in the cMYP.

At the national level, the immunisation data will be regularly updated by the ICC before it is shared with the international level.

The DQS, now being implemented more broadly, will be one of the pillars that will guarantee data quality.

New and Under-Used Vaccine Introduction Grant

Table 6.5: calculation of lump-sum

Year of New Vaccine introduction	N° of births (from table 3.4)	Share per birth in US$	Total in US$
2010	**2,940,421**	**$ 0.30**	**882,126**

Please indicate in the tables below how the one-time Introduction Grant[8] will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP).

[8] 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

Table 6.6: Cost (and finance) to introduce the first preference vaccine (US$)

Cost Category	Full needs for new vaccine introduction	Funded with new vaccine introduction grant
	US$	US$
Training	145,390	100,000
Social Mobilization, IEC and Advocacy	55,900	46,000
Cold Chain Equipment & Maintenance	748,757	700,126
Vehicles and Transportation		
Programme Management	21,400	20,000
Surveillance and Monitoring	16,400	16,000
Human Resources		
Waste Management		
Technical assistance		
Total	987 847	882 126

Comment [SRS2]: Since the grant will not cover all the requirements, how do you plan to bridge the gap?

Note: The financing gap observed between the requirements and the resources of the GAVI grant will be made up in the regular routine EPI budget by the government and the partners, including the WHO, UNICEF, USAID and Rotary.

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

Please complete a table similar to the one above for the second choice vaccine (if relevant) and title it **Table 6.7: Cost (and finance) to introduce the second preference vaccine (US$)**

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

The ICC meeting was held on … April 2008 to adopt the plan to introduce the pneumococcal vaccine, to adopt the revised cMYP, and to review the proposal to be submitted to GAVI.
At the conclusion of this meeting, the following essential points were adopted:

1. *Pneumo infections are indeed one of the country's priority health problems, hence the necessity of protecting children by immunisation;*
2. *The liquid single-dose form of PCV was approved as the first choice of the form to be introduced because of its logistical and program advantages;*
3. *The country opted to begin introducing the pneumococcal vaccine in January 2010;*
4. *At first the vaccine will be introduced in all the health zones and it will be administered to target children using the same schedule as the DTP-HepB-Hib;*
5. *The ICC encouraged the start-up of activities for preparing to introduce the new vaccine by placing special emphasis on the coordination system at all levels;*
6. *The ICC deemed that the strategies proposed in the plan to introduce the pneumococcal vaccine into the routine EPI were appropriate;*
7. *The ICC members agreed to allocate 79% of the GAVI grant funds to support the process of introducing the new vaccine and to expand the cold chain for a total amount of US$ 700,126.*
8. *The ICC was satisfied with the strengthening and expansion of the partnership and agreed to continue efforts in this direction.*

8. Documents required for each type of support

Type of Support	Document	DOCUMENT NUMBER	Duration *
ALL	WHO / UNICEF Joint Reporting Form (last two)	02	2006, 2007
ALL	Comprehensive Multi-Year Plan (cMYP)	01	2008-2012
ALL	Endorsed minutes of the National Coordinating Body meeting where the GAVI proposal was endorsed	03	April 2008
ALL	Endorsed minutes of the ICC/HSCC meeting where the GAVI proposal was discussed	04	April 2008
ALL	Minutes of the three most recent ICC/HSCC meetings	05	January - March 2008
ALL	ICC/HSCC workplan for the forthcoming 12 months	06	April 2008 – March 2009
Injection Safety	National Policy on Injection Safety including safe medical waste disposal (if separate from cMYP)		
Injection Safety	Action plans for improving injection safety and safe management of sharps waste (if separate from cMYP)		
Injection Safety	Evidence that alternative supplier complies with WHO requirements (if not procuring supplies from UNICEF)		
New and Under-used Vaccines	Plan for introduction of the new vaccine (if not already included in the cMYP)		

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

ANNEX 1

Banking Form

SECTION 1 ***(To be completed by payee)***

In accordance with the decision on financial support made by the GAVI Alliance dated . . . . . , the Government of . . . . . .
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.:**	
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**	
For credit to: ***Bank account's title***			
Bank account No.:			
At: ***Bank's name***			

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

By whom is the account audited? .....

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

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

SECTION 2 ***(To be completed by the Bank)***

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.:		
Bank Contact Name and Phone Number:		

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 …… *(number of signatories)* of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name:	**Signature:**
Title:	**Date:**
2 Name:	**Seal:**
Title:	
3 Name:	
Title:	
4 Name:	
Title:	

COVERING LETTER

(To be completed by UNICEF representative on letter-headed paper)

TO: GAVI Alliance – Secretariat
Att. Dr Julian Lob-Levyt
Executive Secretary
C/o UNICEF
Palais des Nations
CH 1211 Geneva 10
Switzerland

On the …… I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official	.....	.....
Bank's authorizing official	.....	.....

Signature of UNICEF Representative:

Name .....

Signature .....

Date .....

CLARIFICATIONS PROVIDED AFTER THE REVIEW:

En ce qui concerne l'introduction du Pneumo, l'acquisition de la chaine de froid ainsi que son déploiement sur terrain:

6 mois de la commande à la livraison

3 mois l'installation du matériels sur terrain dans l'ensemble du pays où le besoin se pose.