

*GAVI Alliance*

**Application Form for Country Proposals**

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

Submitted by

The Government of

***Nigeria***

Date of submission: **30.05.2011 16:45:58**

**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](https://appsportal.gavialliance.org/PDExtranet).

Enquiries to: [proposals@gavialliance.org](mailto: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.

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| **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 COMMERCIAL BANK ACCOUNTS**  The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.  **ARBITRATION**  Any dispute between the Country and the GAVI 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. |

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| **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, 10 doses/vial, Liquid | 2012 | 2015 | DTP-HepB-Hib, 1 dose/vial, Liquid |  |
| New Vaccines Support | Pneumococcal (PCV10), 2 doses/vial, Liquid | 2013 | 2015 | Pneumococcal (PCV13), 1 doses/vial, Liquid |  |

**[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.

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# **Executive Summary**

Nigeria is an emerging economy with a GDP per capita of US$ 1,452 and a total population of about 164 million projected from the 2006 census. The country is made up of 36 States plus the Federal Capital Territory, divided into 774 LGAs and further sub-divided into 9555 political wards. It operates a three-tier system of government comprising the Federal, States and Local Governments Areas (LGAs). The national healthcare delivery system is also organized as a three-tier system of primary, secondary and tertiary care with the Federal Government providing tertiary health care services through its teaching hospitals and federal medical centers; State governments providing secondary health care; and Local Governments delivering primary health care through an estimated 25,000 public health care facilities. In 2008, under-5 mortality rate (U5MR) was 157 per 1000 live births indicative of insufficient progress towards achieving the Millennium Development Goal (MDG) 4 to reduce U5MR to 75 per 1000 live births in 2015.  
  
There have been significant variations in Expanded Programme on Immunization (EPI) performance with peaks and drops in DPT3 coverage in the 80s and 90s. Consequently, the National Programme on Immunization (NPI) established in 1996 to foster national ownership of the EPI, merged with the National Primary Health Care Development Agency (NPHCDA) in 2007 where its functions are now being discharged by the Department of Disease Control & Immunization. The DPT3 coverage by survey, administrative reporting and WHO/UNICEF estimates show progressive increase from 24% in 2002 (WHO/UNICEF coverage estimate 2002-2009) to 68% (NICS 2010) in 2010. There is an inter-agency coordinating committee (ICC)on immunization with the mandate to co-ordinate Development Partners (WHO, UNICEF, Rotary International, USAID, DFID, EU, JICA and others) supporting various aspects of the EPI programme in the country. All vaccines for the country are purchased through UNICEF.   
  
In Nigeria in 2000, Haemophilus influenzae type B (Hib) caused an estimated 392,000 cases of illness in children under-five, over 95% were pneumonia and 4% were meningitis. The Hib organism caused about 34,000 deaths, of which an estimated 78% and 22% were due to pneumonia, and meningitis respectively. Also in 2000, there were almost 757,000 cases of pneumococcal disease in children less than five years in 2000; almost 697,000 cases presented as pneumonia and 10,000 cases as meningitis. Pneumococcal disease caused an estimated 86,000 deaths; 10.8% and 78.1% in children with pneumonia and meningitis, respectively. Penta-valent and pneumococcal vaccines have the potential to jointly avert more than 150,000 deaths by 2015, with significant impact on the under-5 mortality rate. From 2016, Hib and pneumococcal vaccines could be averting over 70,000 deaths annually.   
  
The Nigerian EPI schedule which stipulates that BCG, OPV, DPT, MV, Yellow Fever and Hepatitis B vaccines should be administered to every child in their first year of life in five routine contacts with primary health care services has been expanded to include penta-valent and pneumococcal vaccines. This application for GAVI support is for the phased introduction of the 10-dose vial penta-valent (DPT-HepB-Hib) vaccine and 2-dose vial pneumococcal (PCV 10) vaccine into the routine EPI program starting in April 2012 and April 2013 respectively. The decision to phase new vaccines introduction was taken to optimize existing capacity for vaccine uptake and therefore minimize wastage. Phasing also reduces the burden on the country’s financial resources.  
  
Positive and negative cold storage capacity is adequate at the national level to accommodate the planned introduction of new vaccines (penta-valent, MenAfriVac, pneumococcal) and traditional vaccines for routine and supplemental activities until the end of the cMYP in 2015. The 2010 Effective Vaccine Management Assessment (EVMA) identified good infrastructure and cold chain equipment; satisfactory knowledge of vaccine management and temperature monitoring at most national and state storage facilities as strengths of the cold chain system. It however revealed inadequacies in transport facilities; temperature monitoring systems; and operational and management issues in the cold chain system especially at the LGA and health facility levels. Based on the EVMA findings, an improvement plan was developed and is being implemented to mitigate the challenges. The plan emphasizes supportive supervision of personnel at lower level stores and provision of transport and cold chain equipment where required.  
  
The EPI injection safety policy stipulates 100 percent bundling of all vaccines with auto disable syringes and safety boxes. Waste management for EPI is a subset of a country-wide health care waste management policy at early stages of implementation which promotes the use of waste disposal units at LGAs.  
  
The cMYP feeds into the National Strategic Health Development Plan (NSHDP) 2010 – 2015 which presents interventions to improve health outcomes in line with national and global targets. It articulates key strategies to achieve EPI goals and objectives and includes capacity building as critical to strengthening immunization service delivery. Training for immunization personnel will occur at all levels with due emphasis on improving capacity at LGAs and health facilities. Other activities for the new vaccines introduction, also described in the cMYP and in the introduction plans, include disease surveillance; pharmaco-vigilance; training; monitoring and evaluation; and social mobilization.   
  
The cMYP is estimated to cost US$2.4 billion over the 5-year period of which 25% of the cost is contributed by vaccines and injection supplies and one-third of the cost is due to SIAs. The funding gap based on secure funds averages 63% over the 5-year period while that based on secure and probable funds, including potential GAVI support, averages 21% over the same periods. Using secured funds only, there is an almost 10-fold increase with significant variations in the cost components of the funding gap between 2011 and 2015. In 2011, less than 10% of the funding gap is contributed by vaccines and injection supplies while an estimated 70% is due to SIAs. The situation is reversed by 2015 with about 50% of the funding gap being contributed by vaccines and supplies while SIAs contribute less than 25%. Mechanisms for mobilizing resources from government, development partners, extra-budgetary sources, the private sector, etc, to bridge the funding gap are described in the plan.   
  
Government co-financing for penta-valent vaccine will commence at US$0.45 per dose in 2012 and that for pneumococcal vaccine will commence at US$0.52 per dose in 2013 increasing by 15% annually. The higher co-financing level is chosen to further demonstrate political commitment and financial investment of the Federal Government of Nigeria to this project. The opportunity to add-on GAVI support to funding from the Nigerian government and its EPI partners significantly increases the possibility of successfully implementing the country’s plans for new vaccines introduction.

# **Signatures**

# **Signatures of the Government and National Coordinating Bodies**

# **Government and the Inter-Agency Coordinating Committee for Immunisation**

The Government of Nigeria 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 10 doses/vial Liquid , Pneumococcal (PCV10) 2 doses/vial Liquid introduction.

The Government of Nigeria 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 March.

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** | Prof Onyebuchi Christian CHUKWU | **Name** | Olusegun AGANGA |
| **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 Avuwa Joseph OTERI | Deputy Director Routine Immunization/GAVI Focal point | +2348026724545 | josephoteri@yahoo.co.uk |  |

# **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: 4.

**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** |
| --- | --- | --- | --- |
| Prof Onyebuchi C CHUKWU Hon Minister of Health | Federal Ministry of Health |  |  |
| Alh Suleiman BELLO Hon Minister of State | Federal Ministry of Health |  |  |
| Linus AWUTE Permanent Secretary | Federal Ministry of Health |  |  |
| Dr David OKELLO WR WHO | World Health Organization |  |  |
| Dr Suomi SAKAI Country Rep UNICEF | UNICEF |  |  |
| Dr Mansur KABIR Director Public Health | Federal Ministry of Health |  |  |
| Dr Anthony AYEKE | EC Delegation |  |  |
| Rot. Busuyi ONABOLU | Rotary International |  |  |
| Abdu GARBA | USAID |  |  |
| Dr Emmanuel ODU Ag ED NPHCDA | NPHCDA |  |  |

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

Enter the family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Dr Muhammad Ali PATE | **Title** | Executive Director/CEO |
| **Tel no** | +2347034156999 |
| **Fax no** |  | **Address** | National Primary Health Care Development Agency Plot 681/682 Port Harcourt Crescent Area 11 Garki Abuja |
| **Email** | muhammad.pate@gmail.com |

# **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 Coordinating Committee for Immunization in Nigeria |
| **Year of constitution of the current committee** | 2000 |
| **Organisational structure (e.g., sub-committee, stand-alone)** | Stands alone with a finance subcommittee, supported by the CORE Group with 5 working groups |
| **Frequency of meetings** | Initially monthly now quarterly plus additional meetings if necessary |

**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** | Honourable Minister of Health Fed Ministry of Health | Prof Onyebuchi O CHUKWU |
| **Secretary** | Executive Director National Primary Health Care Development Agency | Dr Muhammad ALI PATE |
| **Members** | Hon Minister of State for Health Federal Ministry of Health | Alhaji Suleiman BELLO | **Action** |
|  | Permanent Secretary Federal Ministry of Health | Linus AWUTE |  |
|  | Executive Director NPHCDA | Dr Muhammad ALI PATE |  |
|  | WHO Representative WHO | Dr David OKELLO |  |
|  | Country Representative UNICEF | Dr Suomi SAKAI |  |
|  | Director of Public Health Federal Ministry of Health | Dr Mansur KABIR |  |
|  | Director Health Planning Research and Statistics FMOH | Dr Tolu FAKEYE |  |
|  | Charge D' Affairs of delegation of EC in Nigeria | Dr Anthony AYEKE |  |
|  | Health Adviser DFID | Dr Jane MILLER |  |
|  | Mission Director USAID | Dr Ray KIRKLAND |  |
|  | Chairman Rortary Polio Plus in Nigeria | Rot Busuyi ONABOLU |  |
|  | Country director World Bank | Mr Onno RUHL |  |
|  | Ambassador of Japan | Amb. Toshitsugu UESAWA |  |
|  | Secretary Christian Health Association of Nigeria | Patrick KWAKFUT |  |
|  | Senior Special Adviser to the President on MDG | Amina ALZUBAIR |  |
|  | Director General NAFDAC | Dr Paul ORHI |  |
|  | Country Manager MSF | William HENNEQUIN |  |

Major functions and responsibilities of the committee

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| --- |
| **It provides forum for regular information sharing and networking amongst the major stakeholders so as to ensure synergy and complementarity of programme implementation.  Mobilization of resources for supplemental and Routine Immunization  Review and endorsement of action plans: 5 Year comprehensive Multi Year plan (cMYP) and Annual plans  Coordination of Partners efforts in support of Govt. activities  Review of progress reports on Immunization in the Country** |

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

|  |  |
| --- | --- |
| **1.** | **Improved partnership coordination and information sharing** |
| **2.** | **Joint budgeting and resource mobilization** |
| **3.** | **High level advocacy to the Ministry of Health to ensure regularity of meetings** |

# **National Immunization Technical Advisory Group for Immunisation**

(If it has been established in the country)

We the members of the NITAG met on the 08.03.2011 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: 5.

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

Enter the family name in capital letters.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | Dr Emmanuel ABANIDA | **Title** | Director Disease Control and Immunization |
| **Tel no** | +2347082886490 |
| **Fax no** |  | **Address** | NPHCDA Plot 681/682 Port Harcourt Crescent Area 11 Garki Abuja |
| **Email** | drabanida@gmail.com |

# **The NITAG Group for Immunisation**

**Profile of the NITAG**

|  |  |
| --- | --- |
| **Name of the NITAG** | There is no NITAG but the Expert Review Committee (ERC) is filling in that role |
| **Year of constitution of the current NITAG** | 2004 |
| **Organisational structure (e.g., sub-committee, stand-alone)** | Advisory body initially for Polio but now includes Routine immunization and other Accelerated Disease Control Initiative |
| **Frequency of meetings** | Initially quarterly and now bi annual |

**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** | Redeemers University Ogun State | Prof. Oyewole TOMORI |
| **Secretary** | ED NPHCDA | Dr Muhammad Ali PATE |
| **Members** | CDC | Olive KEV | **Action** |
|  | WHO HQ | Chris MAHER |  |
|  | University of Calabar | Itam Hogan ITAM |  |
|  | WHO HQ | Bruce AYLWARD |  |
|  | University Maiduguri | Umaru SHEHU |  |
|  | State Ministry of Health Katsina | Salisu BANYE |  |
|  | UNICEF | Brigette TOURE |  |
|  | CDC | Stephen COCHI |  |
|  | University of Nigeria | Prof Okafor |  |
|  | UNICEF HQ | M Costales |  |
|  | WHO AFRO | Sam Okiror |  |
|  | Polio laboratory Ibadan | Festus Adu |  |
|  | University of Ibadan | Prof O.O Kale |  |

Major functions and responsibilities of the NITAG

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| --- |
| **1. Advisory body to the Honourable Minister of Health. 2. Critically assess the situation of poliomyelitis eradication, Routine Immunization and Accelerated Disease Control in Nigeria including progress made in addressing the recommendations of the previous ERC. 3. Make recommendations on the progress in the implementation of the four strategies of polio eradication. 4. Coordinate the integration of routine immunization and accelerated disease control with Polio eradication activities in Nigeria (technical aspects of the programmes). 5. Submit a report following each meeting of the ERC to the Honourable Minister of Health** |

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

|  |  |
| --- | --- |
| **1.** | **Expand membership of the ERC to include additional experts in routine immunization and new vaccine introduction.** |
| **2.** | **Review of the terms of reference of the ERC to strengthen synergies between polio eradication, routine immunization and accelerated disease control.** |
| **3.** | **Institute mechanisms to ensure the ICC implements ERC recommendations.** |

# **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 11
* 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.

# **Basic facts**

For the year 2010 (most recent; specify dates of data provided)

|  | **Figure** | | **Year** | **Source** |
| --- | --- | --- | --- | --- |
| Total population | 158,811,827 |  | 2010 | Projection from 2006 National census |
| Infant mortality rate (per 1000) | 75 |  | 2007 | 2008 Nigeria Demographic & Health survey(NDHS) |
| Surviving Infants**[1]** | 5,558,414 |  | 2010 | Projection from 2006 National census |
| GNI per capita (US$) | 1,190 |  | 2009 | World Bank(Atlas method) |
| Total Health Expenditure (THE) as a percentage of GDP | 8.56 | % | 2005 | National Health Acount (NHA) 2003 - 2005 |
| General government expenditure on health (GGHE) as % of General government expenditure | 6.40 | % | 2009 | Projection from National Health Account 1995 - 2009 |

**[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

|  |
| --- |
| **National Strategic Health Development Plan (NSHDP)(2010-2015) is a five year strategic plan from which annual operational plans are derived. National planning and budgeting is done annually (January - December)** |

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

|  |
| --- |
| **Yes it is aligned. The 2009 - 2014 cMYP has been updated to 2011 - 2015 to align with the National Strategic Health Development Plan (NSHDP) (2010-2015). The content of the immunization section is aligned with the National Strategic Health Development Plan (NSHDP) (2010-2015)** |

Please indicate the national planning budgeting cycle for health

|  |
| --- |
| **The National planning budgeting is annual (Jan - December)** |

Please indicate the national planning cycle for immunisation

|  |
| --- |
| **Annual planning (January - December )** |

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

|  |
| --- |
| **It is not used routinely but the National Immunization Coverage Surveys disaggregates by Sex** |

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

|  |
| --- |
| **No because gender is not an issue in Immunization in the country** |

# **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 |  |  |
| DTP | At 6, 10 and 14 weeks | Yes |  |  |
| Polio | At Birth, 6, 10, and 14 weeks | Yes |  |  |
| Measles | At 9 months | Yes |  |  |
| Yellow Fewer | At 9 months | Yes |  |  |
| HepB | At Birth, 10 and 14 weeks | Yes | With planned introduction of HiB It will be aligned with DPT but birth dose will be retained |  |
| TT | Pregnancy and WCBA | Yes |  |  |
| **Vitamin A** | Infants, 6 months and 12 months | Yes |  |

# **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 | 2006 | 2010 |  | **2009** | **2010** |
| **BCG** | | 75 | 76 | 41 | 76 | **Tuberculosis** | 46,889 | 78,032 |
| **DTP** | **DTP1** | 91 | 95 | 72 | 73 | **Diphtheria** |  |  |
| **DTP3** | 79 | 85 | 36 | 68 | **Pertussis** | 11,281 |  |
| **Polio 3** | | 70 | 79 | 37 | 74 | **Polio** | 388 | 21 |
| **Measles (first dose)** | | 90 | 97 | 33 | 64 | **Measles** | 1,272 | 2,563 |
| **TT2+ (Pregnant women)** | | 47 | 45 | 5 | 65 | **NN Tetanus** | 90 | 176 |
| **Hib3** | |  |  |  |  | **Hib[2]** |  |  |
| **Yellow Fever** | | 69 | 89 | 27 | 60 | **Yellow fever** | 0 | 0 |
| **HepB3** | | 62 | 75 | 30 | 64 | **HepBsero-prevalence[1]** | 9,953 |  |
| **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

|  |
| --- |
| **National Immunization Coverage Survey(NICS) 2006 and 2010. Children aged 12 - 23 months were surveyed to determine infant immunization status and mothers of children aged 0-11 months were surveyed to determine mothers TT immunization status.** |

# **Baseline and Annual Targets**

(refer to cMYP pages)

**Table 1:** baseline figures

| **Number** | **Base Year** | **Baseline and Targets** | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **2008** | **2012** | **2013** | **2014** | **2015** |  |  |
| **Total births** | 5,982,529 | 6,785,840 | 7,002,987 | 7,227,082 | 7,458,349 |  |  |
| **Total infants' deaths** | 448,690 | 441,080 | 420,179 | 361,354 | 261,042 |  |  |
| **Total surviving infants** | 5,533,839 | 6,344,760 | 6,582,808 | 6,865,728 | 7,197,307 |  |  |
| **Total pregnant women** | 7,478,161 | 8,482,300 | 8,753,733 | 9,033,853 | 9,322,936 |  |  |
| **Number of infants vaccinated (to be vaccinated) with BCG** | 4,486,896 | 5,089,379 | 5,462,329 | 5,926,207 | 6,488,763 |  |  |
| **BCG coverage (%)[1]** | 75% | 75% | 78% | 82% | 87% |  |  |
| **Number of infants vaccinated (to be vaccinated) with OPV3** | 4,150,380 | 4,758,570 | 5,134,590 | 5,629,897 | 6,261,657 |  |  |
| **OPV3 coverage (%)[2]** | 75% | 75% | 78% | 82% | 87% |  |  |
| **Number of infants vaccinated (or to be vaccinated) with DTP1[3]** | 4,814,440 | 5,519,941 | 5,924,526 | 6,385,127 | 6,693,495 |  |  |
| **Number of infants vaccinated (to be vaccinated) with DTP3[3]** | 4,150,380 | 4,758,570 | 5,134,590 | 5,629,897 | 6,261,657 |  |  |
| **DTP3 coverage (%)[2]** | 75% | 75% | 78% | 82% | 87% |  |  |
| **Wastage[1] rate in base-year and planned thereafter for DTP (%)** | 25% | 25% | 25% | 25% | 25% |  |  |
| **Wastage[1] factor in base-year and planned thereafter for DTP** | 1.33 | 1.33 | 1.33 | 1.33 | 1.33 |  |  |
| **Infants vaccinated (to be vaccinated) with 1st dose of HepB and/or Hib** | 4,150,380 | 1,913,585 | 3,873,729 | 6,385,127 | 6,693,495 |  |  |
| **Infants vaccinated (to be vaccinated) with 3rd dose of HepB and/or Hib** | 4,150,380 | 1,649,642 | 3,357,232 | 5,629,897 | 6,261,657 |  |  |
| **HepB and/or Hib 3rd dose coverage (%)[2]** | 75% | 26% | 51% | 82% | 87% |  |  |
| **Target population vaccinated with 1st dose of Pneumococcal** | 0 | 0 | 2,050,797 | 4,126,971 | 6,693,495 |  |  |
| **Target population vaccinated with 3rd dose of Pneumococcal** | 0 | 0 | 1,777,358 | 3,638,835 | 6,261,657 |  |  |
| **Pneumococcal coverage (%)[2]** | 0% | 0% | 27% | 53% | 87% |  |  |
| **Infants vaccinated (to be vaccinated) with 1st dose of Measles** | 4,150,380 | 4,758,570 | 5,134,590 | 5,629,897 | 6,261,657 |  |  |
| **Measles coverage (%)[2]** | 75% | 75% | 78% | 82% | 87% |  |  |
| **Pregnant women vaccinated with TT+** | 5,608,621 | 6,361,724 | 6,827,912 | 7,407,759 | 8,110,954 |  |  |
| **TT+ coverage (%)[4]** | 75% | 75% | 78% | 82% | 87% |  |  |
| **Vit A supplement to mothers within 6 weeks from delivery** |  |  |  |  |  |  |  |
| **Vit A supplement to infants after 6 months** |  |  |  |  |  |  |  |
| **Annual DTP Drop-out rate[ ( DTP1 - DTP3 ) / DTP1 ] x 100[5]** | 14% | 14% | 13% | 12% | 6% |  |  |

**[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.

# **Summary of current and future immunisation budget**

(or refer to cMYP pages)

|  | **Estimated costs per annum in US$ (in thousand US$)** | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Cost category** | **Base Year** | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Year 6** | **Year 7** | **Year 8** | |
| 2008 | 2012 | 2013 | 2014 | 2015 |  |  |  |  | |
| **Routine Recurrent Cost** | | | | | | | | | | |
| **Vaccines (routine vaccines only)** | **22,300** | **38,729** | **89,090** | **151,715** | **221,788** |  |  |  |  | |
| **Traditional vaccines** | 17,000 | 11,864 | 12,641 | 13,694 | 16,827 |  |  |  |  | |
| **New and underused vaccines** | 5,300 | 26,865 | 76,449 | 138,021 | 204,961 |  |  |  |  | |
| **Injection supplies** | 7,014 | 4,424 | 4,584 | 4,768 | 5,136 |  |  |  |  | |
| **Personnel** | **27,198** | **34,073** | **38,180** | **42,693** | **47,843** |  |  |  |  | |
| **Salaries of full-time NIP health workers (immunisation specific)** | 8,764 | 11,065 | 12,441 | 13,968 | 15,704 |  |  |  |  | |
| **Per-diems for outreach vaccinators / mobile teams** | 18,434 | 23,008 | 25,739 | 28,725 | 32,139 |  |  |  |  | |
| **Transportation** | 5,392 | 10,646 | 12,802 | 16,073 | 19,844 |  |  |  |  | |
| **Maintenance and overheads** | 5,086 | 9,631 | 12,100 | 12,704 | 14,124 |  |  |  |  | |
| **Training** | 1,675 | 2,271 | 2,642 | 3,017 | 3,608 |  |  |  |  | |
| **Social mobilisation and IEC** | 4,668 | 5,346 | 5,284 | 5,689 | 6,456 |  |  |  |  | |
| **Disease surveillance** | 1,477 | 19,289 | 23,216 | 26,722 | 31,608 |  |  |  |  | |
| **Program management** | 614 | 13,713 | 16,822 | 20,480 | 24,765 |  |  |  |  | |
| **Other** | 13,623 | 17,291 | 19,546 | 21,938 | 24,793 |  |  |  |  | |
| ***Subtotal Recurrent Costs*** | ***89,047*** | ***155,413*** | ***224,266*** | ***305,799*** | ***399,965*** |  |  |  |  | |
|  | | | | | | | | | | |
| **Routine Capital Costs** | | | | | | | | | | |
| **Vehicle** | 789 | 1,866 | 1,209 | 1,569 | 1,998 |  |  |  |  | |
| **Cold chain equipment** | 1,112 | 4,470 | 4,258 | 4,166 | 4,166 |  |  |  |  | |
| **Other capital equipment** | 11 | 447 | 447 | 447 | 447 |  |  |  |  | |
| ***Subtotal Capital Costs*** | ***1,912*** | ***6,783*** | ***5,914*** | ***6,182*** | ***6,611*** |  |  |  |  | |
|  | | | | | | | | | | |
| **Campaigns** | | | | | | | | | | |
| **Polio** | 102,601 | 139,229 | 151,070 | 100,930 | 106,494 |  |  |  | |  |
| **Measles** | 29,468 |  |  | 33,282 |  |  |  |  | |  |
| **Yellow Fever** |  |  |  |  |  |  |  |  | |  |
| **MNT campaigns** |  | 3,433 |  |  |  |  |  |  | |  |
| **Other campaigns** |  | 28,264 | 25,675 |  |  |  |  |  | |  |
| ***Subtotal Campaign Costs*** | ***132,069*** | ***170,926*** | ***176,745*** | ***134,212*** | ***106,494*** |  |  |  | |  |
| **GRAND TOTAL** | **223,028** | **333,122** | **406,925** | **446,193** | **513,070** |  |  |  | |  |

# **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.

|  | | **Estimated costs per annum in US$ (in thousand US$)** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Cost category** | **Funding source** | **Base Year** | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Year 6** | **Year 7** | **Year 8** |
| **2008** | **2012** | **2013** | **2014** | **2015** |  |  |  |  |
| **Routine Recurrent Cost** | | | | | | | | | | |
| Vaccines (Routine Traditional) | Governemnt | 17,000 | 11,865 | 12,641 | 13,694 | 16,827 |  |  |  |  |  |
| Vaccines (Underused) | Government/GAVI (Co financing) | 5,300 | 26,865 | 44,566 | 72,831 | 83,929 |  |  |  |  |  |
| Vaccines (New) | Government/GAVI Co financing | 0 | 0 | 31,883 | 65,189 | 121,032 |  |  |  |  |  |
| Injection supplies | Government (GAVI INS till 2010) | 7,014 | 4,425 | 4,584 | 4,768 | 5,136 |  |  |  |  |  |
| Personnel | Govt, WHO, UNICEF, EU, GAVI (ISS) | 40,821 | 51,364 | 57,727 | 64,631 | 72,637 |  |  |  |  |  |
| Transport | Govt, UNICEF, GAVI (ISS) | 5,392 | 10,645 | 12,802 | 16,073 | 19,844 |  |  |  |  |  |
| Maintenance and overhead | Govt, UNICEF, USAID, GAVI(ISS) | 5,086 | 9,631 | 12,100 | 12,704 | 14,124 |  |  |  |  |  |
| Short term training | Govt, UNICEF, WHO, GAVI (HSS) | 1,675 | 2,271 | 2,643 | 3,017 | 3,608 |  |  |  |  |  |
| IEC/Social mobilization | Govt, UNICEF, Rotary, GAVI (ISS) B&MGF | 4,668 | 5,346 | 5,284 | 5,689 | 6,456 |  |  |  |  |  |
| Disease surveillance | WHO | 1,477 | 19,289 | 23,216 | 26,722 | 31,608 |  |  |  |  |  |
| Programme management | Govt, WHO, USAID, UNICEF, EU, DFID | 614 | 13,713 | 16,822 | 20,480 | 24,765 |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | | | | | |  |
| **Routine Capital Costs** | | | | | | | | | | |  |
| Vehicle | Govt, WHO, UNICEF | 789 | 1,866 | 1,209 | 1,569 | 1,998 |  |  |  |  |  |
| Cold chain equipment | Govt, UNICEF | 1,112 | 4,470 | 4,258 | 4,166 | 4,166 |  |  |  |  |  |
| Other capital equipment | Govt UNICEF EU | 11 | 447 | 447 | 447 | 447 |  |  |  |  |  |
|  | | | | | | | | | | |  |
| **Campaigns** | | | | | | | | | | |  |
| Polio | Govt, World Bank, B&MGF, WHO, Rotary, KFW, UNICEF | 102,601 | 139,229 | 151,070 | 100,930 | 106,494 |  |  |  |  |  |
| Measles | Govt, Measles Partners, UN Foundation | 29,468 | 0 | 0 | 33,282 | 0 |  |  |  |  |  |
| TT | Govt, UNICEF & WHO | 0 | 3,433 | 0 | 0 | 0 |  |  |  |  |  |
| Meningitis | Govt & GAVI, WHO, MVP, & UNICEF | 0 | 28,264 | 25,675 | 0 | 0 |  |  |  |  |  |
| **GRAND TOTAL** | | **223,028** | **333,123** | **406,927** | **446,192** | **513,071** |  |  |  |  |  |

# **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.

|  |
| --- |
| **1.0 Cold Chain  1.0.1 The Cold Chain System The cold chain system consists of the National Strategic Cold Store (NSCS) in Abuja, six zonal cold stores located in each of the six geo-political zones, 36 States vaccine cold stores plus the Federal Capital territory (FCT) and 774 Local Government Area (LGA) vaccine stores serving about 20,630 health facilities providing immunisation services. The NSCS and the zonal cold stores constitute the national level cold storage capacity which operates as a single entity.  1.0.2 National Strategic Cold Store (NSCS) and Zonal Stores The National Strategic Cold Store is located in Abuja and receives all nationally procured vaccines coming into the country. In addition there are six zonal cold stores for vaccine and dry materials storage located in the six geopolitical zones. Together these stores provide the total nationally available cold storage capacity. Vaccines and dry materials are distributed to the thirty-six States and the Federal Capital Territory from the NSCS and/or zonal stores, coordinated by the NSCS. The routine immunization buffer stock, campaign vaccines and strategic vaccines for emergencies and disease outbreaks are held in national and zonal stores. The distribution of routine vaccines and supplies from the NSCS to state stores occurs quarterly based on state requests determined by current stock levels in state stores.  Table 1: Cold chain capacity of National Strategic Cold Store (Positive and Negative). Cold Chain capacity at the National Strategic Cold Store Cold Store Net storage Litres (+2°C to +8°C) Net storage Litres (-15°C to -25°C) NSCS, Abuja 28,571 9,524 SW Zone, Lagos 29,762 17,857 NC Zone, Minna 14,286 4,762 SS Zone, Warri 14,286 4,762 NE Zone, Bauchi 14,286 4,762 SE Zone, Enugu 14,286 4,762 NW Zone, Kano 0 0 TOTAL 115,477 46,429  Zonal stores in Lagos and Minna are fully functional. Construction of the Kano Zonal store is nearing completion and will be commissioned this year. The zonal stores of Warri, Bauchi and Enugu are not fully functional due to absence of preventive maintenance practices and poor electricity supply, etc. It is envisaged that these zonal stores will be made functional by June 2011  1.0.3 State Cold Stores Each State and the FCT in Nigeria has a functional cold store which is run and maintained by the State Ministry of Health. Cold chain equipment in state cold stores is provided by the State government, NPHCDA and Development Partners. The cumulative total capacity of the cold chain system in all 36 states and FCT is 273,204 and 205,324 litres for positive and negative volumes respectively. (source: Inventory Replacement plan as at April 2011).  1.0.4 LGA Cold Stores The LGAs have adequate cold chain capacity to store one-month’s routine and supplemental vaccines requirements for the LGA. The predominant cold chain equipment in the LGAs are refrigerators and deep freezers. Each LGA has at least 2 solar refrigerators providing additional 40 litres to the cold storage capacity and greatly improving vaccine management at the LGA and Health Facility (HF) levels where frequent power outage is major challenge. There is progress in addressing this challenge where state governments, with support from the Federal Government, provides funds to run back-up electric power generators.   1.0.5 Health Facility Stores Government policy specifies that at least 1 HF in each of the 9,555 political wards nationwide must be fully equipped to provide regular routine immunization services. Ward health facilities usually have cold boxes but plans are underway to equip all HFs with solar refrigerators. Presently, government at all levels with support from development partners provides funding for this expansion: GAVI Health Systems Support (HSS) grant funded the provision of 485 solar refrigerators; the Federal Government procured 644; and UNICEF additional 400 solar refrigerators.  1.0.6 EVM assessment  Recently in December 2010, Nigeria concluded an Effective Vaccine Management Assessment (EVMA) which comprehensively reviewed the country’s vaccine supply chain from vaccine arrival into the country to service delivery points. Seventy-five facilities at National, State, LGA and facility levels were assessed. The main positive findings were good infrastructure including buildings and cold chain equipment; good knowledge of vaccine management; and satisfactory knowledge of temperature monitoring at most national and state storage facilities. However, the LGAs and HFs did not fare so well and the assessment revealed inadequacies in transport facilities; comprehensive temperature monitoring systems; and operational and management issues. As a result, of the EVMA results, an improvement plan which includes supportive supervision to lower level stores to entrench a preventive maintenance culture was developed and is being implemented to mitigate some of these challenges. Where gaps exist in the availability of cold chain equipment, steps have been taken to hasten the delivery of relevant equipment, temperature monitoring devices and refrigerator trucks as part of the cold chain revamping plan.  1.0.7 Storage capacities available compared to needs National positive and negative cold storage capacity is adequate to accommodate the planned introduction of new vaccines (Penta, MenAfriVac, Pneumo) and traditional vaccines for routine and supplemental activities until the end of the revised Country Multi-year Plan (cMYP) 2011-2015. The adequacy in national storage capacity has been achieved through integration of the six zonal stores with the National Strategic Cold Store using a highly responsive, effective mechanism for re-distributing vaccines at this level to optimize capacity utilization. With the construction of the zonal store in Kano, an additional 14,286 litres positive capacity will be available at national level by 2012. Additional expansion in national capacity is also anticipated with installation of fifteen 40m3-cold rooms: 3 at the NSCS and 2 each in the 6 zonal stores. This is an additional 142,857 litres positive storage capacity to the national capacity by 2012. This will also help prepare the country for additional future new vaccines introductions like HPV and Rotavirus.   Nigeria has adequate storage capacity to cater for all traditional RI vaccines and planned Penta vaccine, Pneumo vaccine and MenAfriVac (Table 1 above and 6.1 in application form). The existing capacity in addition to the planned 142, 487 litres expansion in 2012 brings total capacity to 257,964 litres which guarantees accommodation of new vaccines introduction in the future. This robust expansion in capacity is the outcome of a planned one-off investment for revamping cold storage anticipatory to accommodate the initial choice of 2 dose Penta-valent and single dose PCV.   An analysis of capacity to store vaccine requiring positive temperature is presented in the attached introduction plans. The Federal Government and development partners have allocated additional cold rooms to address inadequacies in positive cold storage capacity in six states; Benue, FCT, Niger, Adamawa, Imo, Ondo in the 2011 cold chain revamping plan. All states in the country have adequate capacity for negative temperature storage.   Figure 4 in pentavalent and PCV Introduction plans shows that all the states in Phase 1 introduction of pentavalent vaccines in 2012, and PCV in 2013, except the FCT, have adequate positive capacity. The gap in the FCT will be bridged by the NSCS which is located within the FCT.** |

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)

|  |
| --- |
| **WHO data shows that in Nigeria in 2000, Hib caused 391,724 cases of illness in children under-five, split between cases of pneumonia at 379,408 (96.8%) and meningitis at 16,677 (4.3%). It is also estimated that Hib caused 33,912 deaths. These deaths are second only to India with a record of 72, 000 deaths. Of these deaths, 26,455 (78%) are due to pneumonia, and 7,431 (22%) due to meningitis. Based on this data, the incidence of Hib in 2000 can be calculated to be 1775 per 100, 000 children under five lower than our neighbours.  Similarly there were an estimated 756,796 cases of pneumococcal disease in children less than five years in 2000; 696,861 cases were pneumonia (3157 per 100,000) and 10,062 cases were meningitis (46 per 100,000). There were 85,717 estimated total deaths from pneumococcal disease in these children (including HIV-positive deaths); 10.8% and 78.1% of these were from children who had pneumonia and meningitis, respectively. Comparatively, there were 49,873 cases of non-pneumonia, non-meningitis invasive disease with 2,221 deaths.   The WHO position paper on the use of Hib vaccine in routine childhood vaccination programmes in the Weekly Epidemiological Review in November 24, 2006 states that : "In view of their demonstrated safety and efficacy, Hib conjugate vaccines should be included in all routine infant immunization programmes. Lack of local surveillance data should not delay the introduction of the vaccine, especially in countries where regional evidence indicates a high disease burden." The Task Force on Immunization (TFI) meeting for the WHO Africa Regional Office (AFRO) held in Maputo, Mozambique in December 2006 endorsed the WHO position paper and recommended that Member States should include Hib conjugate vaccines in all routine infant immunization programmes in the African Region. Countries were also strongly encouraged to use existing and innovative mechanisms for funding of Hib vaccines, including GAVI funding. Nigeria is the only one of thirty five countries in the WHO AFRO region yet to introduce penta-valent vaccine in its routine immunization schedule.   A study conducted in Gambia between 1997 to 2002 following the introduction of Hib vaccine demonstrated a high level of impact with the annual incidence rates of Hib meningitis dropping from over 200 in the early nineties prior to vaccine introduction to nil per 100,000 children aged 0-11 months in 2002; and from 60 to nil cases per 100,000 children less than 5 years. The prevalence of Hib disease decreased from 12% to 0.25% (p<0.0001).   Similarly, in Bamako, Mali, where surveillance revealed a high incidence of Hib invasive disease, the impact of Hib vaccine introduction to the EPI was assessed. Annual confirmed Hib hospitalizations for infants aged 0-11 months fell from 175 per 100,000 to 44 per 100,000 (P < 0.001).    The WHO position paper on pneumococcal infection and vaccines, in response to the enormous burden from the disease, recommends pneumococcal vaccines as a priority for national immunization programmes especially in countries where the under-five mortality rate is higher than 50/1000 live births, or where more than 50,000 children die annually.  In Gambia and South Africa, the pneumococcal conjugate vaccine (PCV) demonstrated high levels of safety, immunogenicity and non-interference with other routine EPI vaccinations. The Gambia study showed an overall 15% reduction in hospital admissions from pneumococcal disease from 2000 to 2004. A cost effectiveness study of PCV vaccination in Pakistan showed the average cost of outpatient treatment of childhood pneumonia is US$13.44. For hospitalized care, the average cost rises to US$71 per episode; US$235 for severe pneumonia; and US$2,043 for meningitis.  Expected impact of pentavalent and pneumococcal vaccine introduction  Based on WHO-UNICEF Global Disease Burden estimates and the Kenya and Gambia Hib vaccine efficacy studies, a cumulative estimate of around 80,000 deaths from 2012 to 2015 will be averted from introducing the Hib component of the penta-valent vaccine in a phased manner from 2012. By 2015, Hib vaccine would be averting around 30,000 deaths per year. The same studies on PCV efficacy showed a cumulative estimate of around 75,000 deaths from 2013 to 2015 will be averted from introducing PCV into Nigeria in a phased manner from 2013. Penta-valent and pneumococcal vaccines will jointly avert more than 150,000 deaths by 2015, with significant impact on the under-5 mortality rate (see annex 7.1).  Phasing the introduction of the new vaccines  The introduction of penta-valent and pneumococcal vaccines will be rolled out in three phases at yearly intervals over a 3-year period commencing in April 2012 and April 2013 respectively. Pneumococcal vaccine phasing will begin with those states that will have introduced the Penta-valent vaccine in 2012 (penta phase 1 states). This phased approach to new vaccine introduction will be adopted to minimize the challenges that the immunization system, in its current state, poses to effective NVI. The major criteria for prioritizing state selection are based on routine immunization (RI) system performance as proven by the NICS 2010 and cold chain and logistics adequacy. The aim is to launch the vaccine introduction in states with robust RI systems and that possess better capacity to absorb the new vaccines while concurrently strengthening the system in weaker states to prepare them to absorb the new vaccines in subsequent years. Also considered in the criteria for state selection was the need to ensure geographical spread required to maintain balance, equity and fairness in the country’s socio-political context. In addition, mobilising the resources required for “at once” introduction will be significantly more challenging.   Despite its benefits, this phased approach has the potential to accentuate health inequities. This challenge is being delicately balanced against the risk of potential loss of scarce health resources from high wastage rates that will result from introducing expensive, new vaccines into systems with sub-optimal absorptive capacities.** |

# **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 m3)**  **Litres** | **Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine** | 217,509 | 258,044 | 301,388 | 371,870 |  |  |  |  |
| **B** | **Existing net positive cold chain capacity (litres or m3)**  **Litres** | **#** | 115,477 | 115,477 | 115,477 | 115,477 |  |  |  |  |
| **C** | **Estimated minimum number of shipments per year required for the actual cold chain capacity** | **A / B** | **2** | **3** | **3** | **4** |  |  |  |  |
| **D** | **Number of consignments /**  **shipments per year** | **Based on national vaccine shipment plan** | 4 | 4 | 4 | 4 |  |  |  |  |
| **E** | **Gap (if any)** | **((A / D) - B)** | -61,100 | -50,966 | -40,130 | -22,510 |  |  |  |  |
| **F** | **Estimated additional cost of cold chain** | **US$** | **0** | **0** | **0** | **0** |  |  |  |  |

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)

|  |
| --- |
| **5.1.1 Closing the funding gaps  The program has an average funding gap of 21% for the period 2011-2015, mainly driven by campaigns, vaccines and personnel costs. When only secured funding is considered this increases to 64%. However, a gap of this size is unlikely based on the experience that pledged funds for the immunization program have always been committed by government and partners. In addition, the Office of the Senior Special Assistant to The President on the MDGs is a strong partner to the Immunization Program, in recognition that this intervention will contribute directly to the attainment of MDG4. In 2010, this office has provided significant funds for immunization; e.g. measles control efforts were funded to the tune of 2.2 Billion Naira, polio eradication efforts supported with 2.7 Billion Naira, cold chain expansion supported with 1.035 Billion Naira and other immunization related activities received 3.6 Billion Naira.   In order to address the 21% funding gap, at the federal level, additional funds will be leveraged from the debt relief grant from the MDG office in country.   Another important source of additional funding will be the proposed Primary Health Care (PHC) fund outlined in the National health bill that has been passed by the National Assembly. The PHC fund when created will be financed from the “consolidated fund of the Federation, an amount not less than two per cent of its value”; this translates to about 600 billion naira (4 billion USD) annually. “Fifty percent of the fund shall be used for the provision of basic minimum package of health services to all citizens, in primary health care facilities” while the remaining fifty percent will be channelled through the NPHCDA to provide essential drugs; provision and maintenance of facilities, equipment and transport; and the development of Human Resources for Primary Health Care.  In addition, the country intends to explore extra budgetary mechanisms (e.g supplementary budgetting), mobilization of the private sector through the Public-Private Partnership (PPP) programme, intensified advocacy for Mr President’s assent to the National Health Bill, engaging more partners , and collaborating with the national health insurance scheme in order to leverage capitation funds to finance immmunization in the long run.   In the medium term, it is expected that the government immunization budget line will be reclassified from a capital expenditure item to a recurrent expenditure item, which would further increase the security of funds for immunization activities. At state level, each State has been supported to develop a State Strategic Health Development plans akin to the National SHDP. Functional state task forces on PHC and Immunization exist in all states and the FCT and they have the important mandate to facilitate the release of operational funds for immunization activities as outlined in their respective state plans.   Finally, the 10th European Development Fund has approved 50million Euros for RI strengthening in Nigeria.   5.2 Resource mobilization  To address the funding gaps identified in the financial analysis, a number of resource mobilization activities will commence in 2011. These activities with timelines and milestones are outlined below.  1. Advocacy to the National Assembly to pass the Health Bill and re-categorize vaccine budget line in 2nd Quarter of 2011. 2. Negotiation with NHIS for part of Capitation funds to be used for vaccine procurement in 2nd Quarter of 2011. 3. Advocacy to Governors’ Forum and ALGON for continued and increased funding in 3rd quarter of 2011. 4.Negotiate with the Private-Public Partnership (PPP) for Immunization services package in 2nd quarter of 2011. 5.Immediately pursue the release of the European Development Fund (EDF).** |

# **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** |
| --- | --- | --- | --- |
| Haemophilus Influenza Type B | Wat,JP et al (2009)"burden of disease caused by haemophyillus influenza b in children less than 5 years- The Lancet | September 12, 2009 | There were 391,724 Hib cases in children under-five, split between cases of pneumonia at 379,408 (96.8%) and meningitis at 16,677 (4.3%). It is also estimated that Hib caused 33,912 deaths. These deaths are second only to India with a record of 72, 000 deaths. Of these deaths, 26,455 (78%) are due to pneumonia, and 7,431 (22%) due to meningitis |  |
| Pneumococcal Disease | WHO/UNICEF Global Disease burden estmates | 2000 | There were an estimated 756,796 cases of pneumococcal disease in children less than five years in 2000; 696,861 cases were pneumonia (3157 per 100,000) and 10,062 cases were meningitis (46 per 100,000). There were 85,717 estimated total deaths from pneumococcal disease in these children (including HIV-positive deaths); 10.8% and 78.1% of these were from children who had pneumonia and meningitis, respectively. Comparatively, there were 49,873 cases of non-pneumonia, non-meningitis invasive disease with 2,221 deaths |  |

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** |
| --- | --- |
| When Hepatitis B was introduced into the schedule, there was no adequate information about the introduction nationwide and insufficient social mobilization to generate demand in the target population | Centralized introduction planning coordinated by the ICC |  |
| A proportion of the vaccine was wasted by accidental freezing in some states due to inadequate knowledge of some of the health workers on the storage and handling of the vaccine. | Development of robust training materials by the relevant working group of the ICC to optimize capacity building of health workers and significantly strengthen vaccine management skills |  |
| Weak data management. | Training and supportive supervision to improve data management at the service delivery points. |  |

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

|  |
| --- |
| **Pentavalent (DTP-HepB-Hib) 10 dose vial liquid Pneumococcal (PCV,10) 2 doses/vial, liquid** |

# **6.****3.1. Requested vaccine ( DTP-HepB-Hib, 10 doses/vial, Liquid )**

As reported in the cMYP, the country plans to introduce DTP-HepB-Hib, 10 doses/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** | Intermediate |

|  | **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 | 0.23 | 0.26 | 0.30 |  |  |  |  |
| **Your co-financing (please change if higher)** | 0.45 | 0.52 | 0.60 | 0.68 |  |  |  |  |

# **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 %** | 25% | 25% | 25% | 25% |  |  |  |  |
| **Equivalent wastage factor** | 1.33 | 1.33 | 1.33 | 1.33 |  |  |  |  |

# **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 | # | 1,913,585 | 3,873,729 | 6,385,127 | 6,693,495 |  |  |  |  |
| **Number of children to be vaccinated with the third dose[1]** | Table 1 | # | 1,649,642 | 3,357,232 | 5,629,897 | 6,261,657 |  |  |  |  |
| **Immunisation coverage with the third dose** | Table 1 | # | 26.00% | 51.00% | 82.00% | 87.00% |  |  |  |  |
| **Estimated vaccine wastage factor** | Table 6.(n).3**[3]** | # | 1.33 | 1.33 | 1.33 | 1.33 |  |  |  |  |
| **Country co-financing per dose[2]** | Table 6.(n).2**[3]** | $ | 0.45 | 0.52 | 0.60 | 0.68 |  |  |  |  |

**[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** | # | 1,642,300 | 3,682,900 | 7,780,500 | 9,324,300 |  |  |  |  |
| **Number of AD syringes** | # | 1,461,100 | 3,187,600 | 6,685,300 | 7,811,100 |  |  |  |  |
| **Number of re-constitution syringes** | # |  |  |  |  |  |  |  |  |
| **Number of safety boxes** | # | 16,225 | 35,400 | 74,225 | 86,725 |  |  |  |  |
| **Total value to be co-financed by country** | $ | **4,295,000** | **9,054,000** | **16,789,500** | **18,370,000** |  |  |  |  |

# **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** | # | 7,901,900 | 13,728,600 | 20,201,400 | 17,690,500 |  |  |  |  |
| **Number of AD syringes** | # | 7,030,000 | 11,882,400 | 17,357,900 | 14,819,700 |  |  |  |  |
| **Number of re-constitution syringes** | # |  |  |  |  |  |  |  |  |
| **Number of safety boxes** | # | 78,050 | 131,900 | 192,675 | 164,500 |  |  |  |  |
| **Total value to be co-financed by GAVI** | $ | **20,665,500** | **33,751,000** | **43,592,000** | **34,853,000** |  |  |  |  |

# **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, 10 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$** | **Total in US$** |
| --- | --- | --- | --- |
| 2012 | 6,785,840 | 0.30 | 2,036,000 |

**[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, 10 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** | 1,526,857 | 665,000 |
| **Social Mobilization, IEC and Advocacy** | 202,676 | 150,000 |
| **Cold Chain Equipment & Maintenance** | 2,272,100 | 1,000,000 |
| **Vehicles and Transportation** | 53,841 | 50,000 |
| **Programme Management** | 26,448 | 25,000 |
| **Surveillance and Monitoring** | 68,958 | 60,000 |
| **Human Resources** |  |  |
| **Waste Management** | 57,653 | 50,000 |
| **Technical assistance** | 57,926 | 36,000 |
|  |  |  |  |
| **Totals** | 4,266,459 | 2,036,000 |

# **6.4.1. Requested vaccine ( Pneumococcal (PCV10), 2 doses/vial, Liquid )**

As reported in the cMYP, the country plans to introduce Pneumococcal (PCV10), 2 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** | Intermediate |

|  | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Year 6** | **Year 7** | **Year 8** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2013 | 2014 | 2015 |  |  |  |  |  |
| **Minimum co-financing** | 0.20 | 0.23 | 0.26 |  |  |  |  |  |
| **Your co-financing (please change if higher)** | 0.52 | 0.60 | 0.69 |  |  |  |  |  |

# **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 %** |  |  |  |  |  |  |  |  |
| **Equivalent wastage factor** | 1.11 | 1.11 | 1.11 |  |  |  |  |  |

# **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 | # | 2,050,797 | 4,126,971 | 6,693,495 |  |  |  |  |  |
| **Number of children to be vaccinated with the third dose[1]** | Table 1 | # | 1,777,358 | 3,638,835 | 6,261,657 |  |  |  |  |  |
| **Immunisation coverage with the third dose** | Table 1 | # | 27.00% | 53.00% | 87.00% |  |  |  |  |  |
| **Estimated vaccine wastage factor** | Table 6.(n).3**[3]** | # | 1.11 | 1.11 | 1.11 |  |  |  |  |  |
| **Country co-financing per dose[2]** | Table 6.(n).2**[3]** | $ | 0.52 | 0.60 | 0.69 |  |  |  |  |  |

**[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** | # | 1,186,100 | 2,480,800 | 4,504,300 |  |  |  |  |  |
| **Number of AD syringes** | # | 1,212,200 | 2,511,300 | 4,547,700 |  |  |  |  |  |
| **Number of re-constitution syringes** | # |  |  |  |  |  |  |  |  |
| **Number of safety boxes** | # | 13,475 | 27,875 | 50,500 |  |  |  |  |  |
| **Total value to be co-financed by country** | $ | **4,439,000** | **9,283,000** | **16,854,000** |  |  |  |  |  |

# **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** | # | 7,350,400 | 12,990,500 | 19,921,700 |  |  |  |  |  |
| **Number of AD syringes** | # | 7,512,100 | 13,150,200 | 20,113,400 |  |  |  |  |  |
| **Number of re-constitution syringes** | # |  |  |  |  |  |  |  |  |
| **Number of safety boxes** | # | 83,400 | 145,975 | 223,275 |  |  |  |  |  |
| **Total value to be co-financed by GAVI** | $ | **27,509,500** | **48,609,500** | **74,542,000** |  |  |  |  |  |

# **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 (PCV10), 2 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 | 7,002,987 | 0.30 | 2,101,000 |

**[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 (PCV10), 2 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** | 921,326 | 850,000 |
| **Social Mobilization, IEC and Advocacy** | 120,008 | 120,008 |
| **Cold Chain Equipment & Maintenance** | 1,053,890 | 853,890 |
| **Vehicles and Transportation** | 110,663 | 107,663 |
| **Programme Management** | 15,959 | 15,959 |
| **Surveillance and Monitoring** | 44,602 | 44,602 |
| **Human Resources** |  |  |
| **Waste Management** | 70,258 | 70,258 |
| **Technical assistance** | 37,790 | 37,790 |
|  |  |  |  |
| **Totals** | 2,374,496 | 2,100,170 |

# **Procurement and Management of New and Under-Used Vaccines**

**Note:** The PCV vaccine must be procured through UNICEF

1. 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 Government of Nigeria has has an MOU with UNICEF for the procuring of her routine immunization vaccines and this will be used for the procurement of Hib and PCV vaccines |

1. 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.

|  |
| --- |
|  |

1. Please describe the introduction of the vaccines (refer to cMYP)

|  |
| --- |
| 2011: Assessment of disease burden due to Hib and Pneumococcal infection 2012: Introduction of Pentavalent vaccines (first 13 States) 2013: Introduction of Pentavalent vaccines (second 12 States) and Introduction of pneumococcal conjugate vaccines (first 13 States) 2014: Introduction of Pentavalent vaccines (third 12 States) completion of Pentavalent introduction and Introduction of pneumococcal conjugate vaccines (second 12 States) 2015: Introduction of pneumococcal conjugate vaccines (third 12 States) completion of PCV introduction |

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

|  |
| --- |
| The country is requesting for commodity. The only funds that will be transferred is the introduction grant on approval which will be sent into the attached existing GAVI ISS bank account |

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

|  |
| --- |
| The Federal Government of Nigeria will be responsible for the co-financing of 45 cent and 52 cent at the introduction year of 2012 and 2013 for Hib and PCV respectively.The co-financing amount will be channelled to UNICEF. The National Primary Health Care Development Agency will ensure that the co financing amount is remitted prompmtly. |

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

|  |
| --- |
| The cMYP has outlined program indicators that will be used to monitor coverage of the new vaccines. These indicators will be monitored and feedback provided to policy and programme managers. Data for measuring these indicators are collected routinely and supplemented with periodic reviews and surveys. The plan will also be assessed through collation and analysis of routine reports from the peripheral levels.  Immunization coverage in the cMYP will also be monitored indirectly with data from periodic Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS).In addition,a mid-term evaluation will be organized specifically in 2013 to evaluate progress and performance in the implementation of programmes and plans and the progress towards achieving set targets and objectives.  The following coverage targets were set for the new vaccines from 2012 to 2015: Coverage target for Pentavalent vaccine in states were set at : 2012 –75% , 2013-78% 2014 82% – 2015- 87% and the Coverage target for pneumococcal vaccine in states were set : 2013-78%; 2014-82% 2015- 87% |

# **Vaccine Management (EVSM/EVM/VMA)**

When was the last Effective Vaccine Store Management (EVSM) conducted?December - 2010

When was the last Effective Vaccine Management (EVM) or Vaccine Management Assessment (VMA) conducted?December - 2010

If your country conducted either EVSM, EVM, or VMA in the past three years, please attach relevant reports. (Document N°12)

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.

|  |
| --- |
| Following the EVM assessment a vaccine management improvement plan has been articulated to be actualised by June 2011 and includes the following: 1. Consultative meeting between NLWG, DFA, Director Human Resources, Director Admin & Supplies and Zonal Coordinators on immediate implementation of the approved Concept Note on operationalization of the zonal cold stores. 2. Completion of the construction work on the North West zonal cold store and ongoing expansion work on other zonal stores 3. Regualr supervision and assessment of quality of work 4. Test running of all installed equipments including temperature monitoring devices 5. Revision of SOPs and re-orient staff  6. Expansion of the existing contractual agreements for planned preventive as well as break-down maintenance to all zonal stores and follow up on implementation of the maintenance works 7. Review of the human resources needs for each store against expected workload, identification of gaps and re-deployment or recruitment where necessary 8. Conducting training needs assessment and follow up with appropriate capacity building (supply chain management, maintenance, information management systems etc.) 9. Improving power by allocating special lines to stores, 10. Additional dry storage for national stores will come on board by 2013 to address gaps   The greatest challenge exists in vaccine supply chain management at the LGA-health facility level i.e. between the 774 LGAs and 25,000 public health facilities providing conducting routine immunization. The LGA stores serve as vaccine depots for the health facilities and in most cases, double as storage facility for returned vaccine where the MDVP is applied. The pull system of vaccine distribution/collection is commonly used at this level but some LGAs combine the push and pull systems depending on the proximity of the HFs to the LGA cold store. Key issues at this level include the replacement of passive cold chain equipment (cold boxes and geostyle) that no longer meet WHO Standards. Permanent reliable means of transportation and communication are grossly inadequate/mostly absent with personal phones being widely used as a means to perform official functions. To improve the vaccine distribution between these two levels, the following activities are planned:  1. Provision of standard cold storage equipment as in solar refrigerators. While this will require heavy investment interms of procurement of cold chain equipment, maintenance and training of the users, it will minimize wastage as the MDVP will be applied easily and missed opportunities will be reduced leading to high coverage. 2. Renovation of buildings and provision of transport. In this regard, resources from NPHCDA, GAVI HSS, MDGs and Partners are gradually being invested. The investments are also heavy and require time. 3. Provision of standard generator set with adequate fuel tank capacity. Funding would also be provided for running and maintenance. 4. Stock recording is a prerequisite for adequate vaccine security. Standardised stock recording templates in the form of ledgers, issue/receipt vouchers and bin cards would be introduced for recording stock movements. These will be printed and distributed to all levels.  5. Training of lower level cold chain officers using the MLM training format on the proper management of vaccines, cold chain and stocks management.  6. Provision of computerized for stock management system at the LGA level 7. Standardization of building plans for LGA cold stores and HFs to adopt and advocacy for provision of communication facilities or the means of communication (e.g. stipends for recharge cards) to facilitate communication. |

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

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

# **Additional Comments and Recommendations**

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

|  |
| --- |
| The Inter agency Coordinating Committee (ICC) recognizes that new vaccine introduction will accelerate progress towards achieving MDG 4. Development partners have been involved at every stage of developing this proposal including review/finalization of the Comprehensive Multi Year Plan (cMYP) and other supporting documents; conduct of the Effective Vaccine Management Assessment (EVMA); implementation of the cold chain revamping plan; amongst others. The ICC endorses and supports the plan to introduce the new vaccines into the routine immunization schedule and the application for GAVI support. |

# **Annexes**

# **Annex 1**

# **Annex 1.1 – DTP-HepB-Hib, 10 doses/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** | *#* | 1,642,300 | 3,682,900 | 7,780,500 | 9,324,300 |  |  |  |  |
| **Number of AD syringes** | *#* | 1,461,100 | 3,187,600 | 6,685,300 | 7,811,100 |  |  |  |  |
| **Number of re-constitution syringes** | *#* |  |  |  |  |  |  |  |  |
| **Number of safety boxes** | *#* | 16,225 | 35,400 | 74,225 | 86,725 |  |  |  |  |
| **Total value to be co-financed by the country** | *$* | 4,295,000 | 9,054,000 | 16,789,500 | 18,370,000 |  |  |  |  |

**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** | *#* | 7,901,900 | 13,728,600 | 20,201,400 | 17,690,500 |  |  |  |  |
| **Number of AD syringes** | *#* | 7,030,000 | 11,882,400 | 17,357,900 | 14,819,700 |  |  |  |  |
| **Number of re-constitution syringes** | *#* |  |  |  |  |  |  |  |  |
| **Number of safety boxes** | *#* | 78,050 | 131,900 | 192,675 | 164,500 |  |  |  |  |
| **Total value to be co-financed by the country** | ***$*** | **20,665,500** | **33,751,000** | **43,592,000** | **34,853,000** |  |  |  |  |

**Table 1.1 C** - Summary table for DTP-HepB-Hib, 10 doses/vial, Liquid

|  | **Data from** |  | **2012** | **2013** | **2014** | **2015** |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Number of Surviving infants** | *Table 1* | # | 6,344,760 | 6,582,808 | 6,865,728 | 7,197,307 |  |  |  |  |
| **Number of children to be vaccinated with the third dose[1]** | *Table 1* | # | 1,649,642 | 3,357,232 | 5,629,897 | 6,261,657 |  |  |  |  |
| **Immunisation coverage with the last dose** | *Table 1* | # | 26.00% | 51.00% | 82.00% | 87.00% |  |  |  |  |
| **Number of children to be vaccinated with the first dose** | *Table 1* | # | 1,913,585 | 3,873,729 | 6,385,127 | 6,693,495 |  |  |  |  |
| **Number of doses per child** |  | # | 3 | 3 | 3 | 3 |  |  |  |  |
| **Estimated vaccine wastage factor** | *Table 6.(n).3***[2]** | # | 1.33 | 1.33 | 1.33 | 1.33 |  |  |  |  |
| **Number of doses per vial** |  | # | 10 | 10 | 10 | 10 |  |  |  |  |
| **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]** | $ | 0.45 | 0.52 | 0.60 | 0.68 |  |  |  |  |
| **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, 10 doses/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** |  | 17.21% |  |  | 21.15% |  |  |
| B | **Number of children to be vaccinated with the first dose[1]** | Table 1 (baseline & annual targets) | 1,913,585 | 329,264 | 1,584,321 | 3,873,729 | 819,363 | 3,054,366 |
| C | **Number of doses per child** | Vaccine parameter | 3 | 3 | 3 | 3 | 3 | 3 |
| D | **Number of doses needed** | B \* C | 5,740,755 | 987,791 | 4,752,964 | 11,621,187 | 2,458,087 | 9,163,100 |
| E | **Estimated vaccine wastage factor** | Table 6.(n).3. in NVS section**[2]** | 1.33 | 1.33 | 1.33 | 1.33 | 1.33 | 1.33 |
| F | **Number of doses needed including wastage** | D \* E | 7,635,205 | 1,313,763 | 6,321,442 | 15,456,179 | 3,269,256 | 12,186,923 |
| G | **Vaccines buffer stock** | (F - F of previous year) \* 0.25 | 1,908,802 | 328,441 | 1,580,361 | 1,955,244 | 413,569 | 1,541,675 |
| I | **Total vaccine doses needed** | F + G | 9,544,007 | 1,642,203 | 7,901,804 | 17,411,423 | 3,682,825 | 13,728,598 |
| J | **Number of doses per vial** | Vaccine parameter | 10 | 10 | 10 | 10 | 10 | 10 |
| K | **Number of AD syringes (+ 10% wastage) needed** | (D + G) \* 1.11 | 8,491,009 | 1,461,018 | 7,029,991 | 15,069,839 | 3,187,538 | 11,882,301 |
| 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 | 94,251 | 16,218 | 78,033 | 167,276 | 35,382 | 131,894 |
| N | **Cost of vaccines needed** | I \* vaccine price per dose | 23,573,698 | 4,056,241 | 19,517,457 | 40,394,502 | 8,544,153 | 31,850,349 |
| O | **Cost of AD syringes needed** | K \* AD syringe price per unit | 450,024 | 77,435 | 372,589 | 798,702 | 168,940 | 629,762 |
| P | **Cost of reconstitution syringes needed** | L \* reconstitution price per unit |  |  |  |  |  |  |
| Q | **Cost of safety boxes needed** | M \* safety box price per unit | 60,321 | 10,380 | 49,941 | 107,057 | 22,645 | 84,412 |
| R | **Freight cost for vaccines needed** | N \* freight cost as % of vaccines value | 825,080 | 141,969 | 683,111 | 1,413,808 | 299,046 | 1,114,762 |
| S | **Freight cost for devices needed** | (O + P + Q) \* freight cost as % of devices value | 51,035 | 8,782 | 42,253 | 90,576 | 19,159 | 71,417 |
| T | **Total fund needed** | (N + O + P + Q + R + S) | 24,960,158 | 4,294,804 | 20,665,354 | 42,804,645 | 9,053,940 | 33,750,705 |
| U | **Total country co-financing** | I \* country co-financing per dose | 4,294,804 |  |  | 9,053,940 |  |  |
| V | **Country co-financing % of GAVI supported proportion** | U / T | 17.21% |  |  | 21.15% |  |  |

**[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, 10 doses/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** |  | 27.81% |  |  | 34.52% |  |  |
| B | **Number of children to be vaccinated with the first dose[1]** | Table 1 (baseline & annual targets) | 6,385,127 | 1,775,407 | 4,609,720 | 6,693,495 | 2,310,286 | 4,383,209 |
| C | **Number of doses per child** | Vaccine parameter (schedule) | 3 | 3 | 3 | 3 | 3 | 3 |
| D | **Number of doses needed** | B \* C | 19,155,381 | 5,326,220 | 13,829,161 | 20,080,485 | 6,930,858 | 13,149,627 |
| E | **Estimated vaccine wastage factor** | Table 6.(n).3. in NVS section**[2]** | 1.33 | 1.33 | 1.33 | 1.33 | 1.33 | 1.33 |
| F | **Number of doses needed including wastage** | D \* E | 25,476,657 | 7,083,873 | 18,392,784 | 26,707,046 | 9,218,042 | 17,489,004 |
| G | **Vaccines buffer stock** | (F - F of previous year) \* 0.25 | 2,505,120 | 696,558 | 1,808,562 | 307,598 | 106,169 | 201,429 |
| I | **Total vaccine doses needed** | F + G | 27,981,777 | 7,780,430 | 20,201,347 | 27,014,644 | 9,324,210 | 17,690,434 |
| J | **Number of doses per vial** | Vaccine parameter | 10 | 10 | 10 | 10 | 10 | 10 |
| K | **Number of AD syringes (+ 10% wastage) needed** | (D + G) \* 1.11 | 24,043,157 | 6,685,283 | 17,357,874 | 22,630,773 | 7,811,100 | 14,819,673 |
| 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 | 266,880 | 74,207 | 192,673 | 251,202 | 86,704 | 164,498 |
| N | **Cost of vaccines needed** | I \* vaccine price per dose | 56,803,008 | 15,794,273 | 41,008,735 | 49,977,092 | 17,249,789 | 32,727,303 |
| O | **Cost of AD syringes needed** | K \* AD syringe price per unit | 1,274,288 | 354,321 | 919,967 | 1,199,431 | 413,989 | 785,442 |
| P | **Cost of reconstitution syringes needed** | L \* reconstitution price per unit |  |  |  |  |  |  |
| Q | **Cost of safety boxes needed** | M \* safety box price per unit | 170,804 | 47,493 | 123,311 | 160,770 | 55,491 | 105,279 |
| R | **Freight cost for vaccines needed** | N \* freight cost as % of vaccines value | 1,988,106 | 552,800 | 1,435,306 | 1,749,199 | 603,743 | 1,145,456 |
| S | **Freight cost for devices needed** | (O + P + Q) \* freight cost as % of devices value | 144,510 | 40,182 | 104,328 | 136,021 | 46,949 | 89,072 |
| T | **Total fund needed** | (N + O + P + Q + R + S) | 60,380,716 | 16,789,067 | 43,591,649 | 53,222,513 | 18,369,958 | 34,852,555 |
| U | **Total country co-financing** | I \* country co-financing per dose | 16,789,067 |  |  | 18,369,958 |  |  |
| V | **Country co-financing % of GAVI supported proportion** | U / T | 27.81% |  |  | 34.52% |  |  |

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

**[2]** Where (n) depends on the vaccine

# **Annex 1.2 – Pneumococcal (PCV10), 2 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** | *#* |  | 1,186,100 | 2,480,800 | 4,504,300 |  |  |  |  |
| **Number of AD syringes** | *#* |  | 1,212,200 | 2,511,300 | 4,547,700 |  |  |  |  |
| **Number of re-constitution syringes** | *#* |  |  |  |  |  |  |  |  |
| **Number of safety boxes** | *#* |  | 13,475 | 27,875 | 50,500 |  |  |  |  |
| **Total value to be co-financed by the country** | *$* |  | 4,439,000 | 9,283,000 | 16,854,000 |  |  |  |  |

**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** | *#* |  | 7,350,400 | 12,990,500 | 19,921,700 |  |  |  |  |
| **Number of AD syringes** | *#* |  | 7,512,100 | 13,150,200 | 20,113,400 |  |  |  |  |
| **Number of re-constitution syringes** | *#* |  |  |  |  |  |  |  |  |
| **Number of safety boxes** | *#* |  | 83,400 | 145,975 | 223,275 |  |  |  |  |
| **Total value to be co-financed by the country** | ***$*** |  | **27,509,500** | **48,609,500** | **74,542,000** |  |  |  |  |

**Table 1.2 C** - Summary table for Pneumococcal (PCV10), 2 doses/vial, Liquid

|  | **Data from** |  | **2012** | **2013** | **2014** | **2015** |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Number of Surviving infants** | *Table 1* | # |  | 6,582,808 | 6,865,728 | 7,197,307 |  |  |  |  |
| **Number of children to be vaccinated with the third dose[1]** | *Table 1* | # |  | 1,777,358 | 3,638,835 | 6,261,657 |  |  |  |  |
| **Immunisation coverage with the last dose** | *Table 1* | # |  | 27.00% | 53.00% | 87.00% |  |  |  |  |
| **Number of children to be vaccinated with the first dose** | *Table 1* | # |  | 2,050,797 | 4,126,971 | 6,693,495 |  |  |  |  |
| **Number of doses per child** |  | # |  | 3 | 3 | 3 |  |  |  |  |
| **Estimated vaccine wastage factor** | *Table 6.(n).3***[2]** | # |  | 1.11 | 1.11 | 1.11 |  |  |  |  |
| **Number of doses per vial** |  | # |  | 2 | 2 | 2 |  |  |  |  |
| **AD syringes required** |  | # |  | Yes | Yes | Yes |  |  |  |  |
| **Reconstitution syringes required** |  | # |  | No | No | No |  |  |  |  |
| **Safety boxes required** |  | # |  | Yes | Yes | Yes |  |  |  |  |
| **Vaccine price per dose** |  | $ |  | 3.500 | 3.500 | 3.500 |  |  |  |  |
| **Country co-financing per dose** | *Table 6.(n).2***[2]** | $ |  | 0.52 | 0.60 | 0.69 |  |  |  |  |
| **AD syringe price per unit** |  | $ |  | 0.053 | 0.053 | 0.053 |  |  |  |  |
| **Reconstitution syringe price per unit** |  | $ |  |  |  |  |  |  |  |  |
| **Safety box price per unit** |  | $ |  | 0.640 | 0.640 | 0.640 |  |  |  |  |
| **Freight cost as % of vaccines value** |  | % |  | 5.00 | 5.00 | 5.00 |  |  |  |  |
| **Freight cost as % of devices value** |  | % |  | 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 (PCV10), 2 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** |  | 13.89% |  |  | 16.03% |  |  |
| B | **Number of children to be vaccinated with the first dose[1]** | Table 1 (baseline & annual targets) | 2,050,797 | 284,942 | 1,765,855 | 4,126,971 | 661,740 | 3,465,231 |
| C | **Number of doses per child** | Vaccine parameter | 3 | 3 | 3 | 3 | 3 | 3 |
| D | **Number of doses needed** | B \* C | 6,152,391 | 854,826 | 5,297,565 | 12,380,913 | 1,985,220 | 10,395,693 |
| E | **Estimated vaccine wastage factor** | Table 6.(n).3. in NVS section**[2]** | 1.11 | 1.11 | 1.11 | 1.11 | 1.11 | 1.11 |
| F | **Number of doses needed including wastage** | D \* E | 6,829,155 | 948,857 | 5,880,298 | 13,742,814 | 2,203,595 | 11,539,219 |
| G | **Vaccines buffer stock** | (F - F of previous year) \* 0.25 | 1,707,289 | 237,215 | 1,470,074 | 1,728,415 | 277,144 | 1,451,271 |
| I | **Total vaccine doses needed** | F + G | 8,536,444 | 1,186,071 | 7,350,373 | 15,471,229 | 2,480,738 | 12,990,491 |
| J | **Number of doses per vial** | Vaccine parameter | 2 | 2 | 2 | 2 | 2 | 2 |
| K | **Number of AD syringes (+ 10% wastage) needed** | (D + G) \* 1.11 | 8,724,245 | 1,212,164 | 7,512,081 | 15,661,355 | 2,511,224 | 13,150,131 |
| 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 | 96,840 | 13,456 | 83,384 | 173,842 | 27,875 | 145,967 |
| N | **Cost of vaccines needed** | I \* vaccine price per dose | 29,877,554 | 4,151,247 | 25,726,307 | 54,149,302 | 8,682,581 | 45,466,721 |
| O | **Cost of AD syringes needed** | K \* AD syringe price per unit | 462,385 | 64,245 | 398,140 | 830,052 | 133,095 | 696,957 |
| P | **Cost of reconstitution syringes needed** | L \* reconstitution price per unit |  |  |  |  |  |  |
| Q | **Cost of safety boxes needed** | M \* safety box price per unit | 61,978 | 8,612 | 53,366 | 111,259 | 17,840 | 93,419 |
| R | **Freight cost for vaccines needed** | N \* freight cost as % of vaccines value | 1,493,878 | 207,563 | 1,286,315 | 2,707,466 | 434,130 | 2,273,336 |
| S | **Freight cost for devices needed** | (O + P + Q) \* freight cost as % of devices value | 52,437 | 7,286 | 45,151 | 94,132 | 15,094 | 79,038 |
| T | **Total fund needed** | (N + O + P + Q + R + S) | 31,948,232 | 4,438,951 | 27,509,281 | 57,892,211 | 9,282,738 | 48,609,473 |
| U | **Total country co-financing** | I \* country co-financing per dose | 4,438,951 |  |  | 9,282,738 |  |  |
| V | **Country co-financing % of GAVI supported proportion** | U / T | 13.89% |  |  | 16.03% |  |  |

**[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 (PCV10), 2 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** |  | 18.44% |  |  |  |  |  |
| B | **Number of children to be vaccinated with the first dose[1]** | Table 1 (baseline & annual targets) | 6,693,495 | 1,234,319 | 5,459,176 |  |  |  |
| C | **Number of doses per child** | Vaccine parameter (schedule) | 3 | 3 | 3 | 3 | 3 | 3 |
| D | **Number of doses needed** | B \* C | 20,080,485 | 3,702,956 | 16,377,529 |  |  |  |
| E | **Estimated vaccine wastage factor** | Table 6.(n).3. in NVS section**[2]** | 1.11 | 1.11 | 1.11 |  |  |  |
| F | **Number of doses needed including wastage** | D \* E | 22,289,339 | 4,110,281 | 18,179,058 |  |  |  |
| G | **Vaccines buffer stock** | (F - F of previous year) \* 0.25 | 2,136,632 | 394,008 | 1,742,624 |  |  |  |
| I | **Total vaccine doses needed** | F + G | 24,425,971 | 4,504,288 | 19,921,683 |  |  |  |
| J | **Number of doses per vial** | Vaccine parameter | 2 | 2 | 2 | 2 | 2 | 2 |
| K | **Number of AD syringes (+ 10% wastage) needed** | (D + G) \* 1.11 | 24,661,000 | 4,547,628 | 20,113,372 |  |  |  |
| 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 | 273,738 | 50,479 | 223,259 |  |  |  |
| N | **Cost of vaccines needed** | I \* vaccine price per dose | 85,490,899 | 15,765,006 | 69,725,893 |  |  |  |
| O | **Cost of AD syringes needed** | K \* AD syringe price per unit | 1,307,033 | 241,025 | 1,066,008 |  |  |  |
| P | **Cost of reconstitution syringes needed** | L \* reconstitution price per unit |  |  |  |  |  |  |
| Q | **Cost of safety boxes needed** | M \* safety box price per unit | 175,193 | 32,307 | 142,886 |  |  |  |
| R | **Freight cost for vaccines needed** | N \* freight cost as % of vaccines value | 4,274,545 | 788,251 | 3,486,294 |  |  |  |
| S | **Freight cost for devices needed** | (O + P + Q) \* freight cost as % of devices value | 148,223 | 27,334 | 120,889 |  |  |  |
| T | **Total fund needed** | (N + O + P + Q + R + S) | 91,395,893 | 16,853,920 | 74,541,973 |  |  |  |
| U | **Total country co-financing** | I \* country co-financing per dose | 16,853,920 |  |  |  |  |  |
| V | **Country co-financing % of GAVI supported proportion** | U / T | 18.44% |  |  |  |  |  |

**[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% |  |  |  |  |  |  |
| 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 -** **Intermediate** - Minimum country's co-payment per dose of co-financed vaccine.

| **vaccine** | **2012** | **2013** | **2014** | **2015** |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DTP-HepB-Hib, 10 doses/vial, Liquid** | 0.20 | 0.23 | 0.26 | 0.30 |  |  |  |
| **Pneumococcal(PCV10), 2 doses/vial, Liquid** |  | 0.20 | 0.23 | 0.26 |  |  |  |

**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 |
| 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 |  |
| 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 |  |

# **Attachments**

# **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** |  | **11** | **Yes** |
| **cMYP Costing tool for financial analysis** |  | **10** | **Yes** |
| **Minutes of last three ICC/HSCC meetings** |  | **7, 8, 9** | **Yes** |
| **Improvement plan based on EVM** |  | **12** | **Yes** |
| **WHO/UNICEF Joint Reporting Form (JRF)** |  | **6** |  |
| **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)** |  | **13, 14** |  |
| **Banking details** |  | **15** |  |

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

# **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.

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| **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:** | **File name:**  [Ministers.jpg](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b0%5d.FileData)  **Date/Time:**  08.06.2011 08:51:39  **Size:**  1 MB | |  |  |
| 2 | **File Type:**  MoF Signature (or delegated authority) of Proposal \*  **File Desc:** | **File name:**  [Ministers.jpg](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b1%5d.FileData)  **Date/Time:**  08.06.2011 08:52:06  **Size:**  1 MB | |  |  |
| 3 | **File Type:**  Signatures of ICC or HSCC or equivalent in Proposal \*  **File Desc:** | **File name:**  [ICC.jpg](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b2%5d.FileData)  **Date/Time:**  08.06.2011 08:52:44  **Size:**  1 MB | |  |  |
| 4 | **File Type:**  Minutes of ICC/HSCC meeting endorsing Proposal \*  **File Desc:** | **File name:**  [Minutes May 10th 2011 ICC meeting.zip](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b3%5d.FileData)  **Date/Time:**  27.05.2011 14:21:10  **Size:**  3 MB | |  |  |
| 5 | **File Type:**  other  **File Desc:** | **File name:**  [21st Meeting of the Expert Review Committee full report with cover page.docx](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b4%5d.FileData)  **Date/Time:**  25.05.2011 14:17:57  **Size:**  260 KB | |  |  |
| 6 | **File Type:**  WHO/UNICEF Joint Reporting Form (JRF)  **File Desc:** | **File name:**  [NIGERIA JRF\_DATA\_FOR\_2010\_FINAL.xls](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b5%5d.FileData)  **Date/Time:**  24.05.2011 06:16:37  **Size:**  463 KB | |  |  |
| 7 | **File Type:**  Minutes of last three ICC/HSCC meetings \*  **File Desc:**  June 2010 Minute | **File name:**  [June 2010 ICC meeting.zip](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b6%5d.FileData)  **Date/Time:**  28.05.2011 05:15:07  **Size:**  4 MB | |  |  |
| 8 | **File Type:**  Minutes of last three ICC/HSCC meetings \*  **File Desc:**  Feb 2011 Minute | **File name:**  [February 2011 ICC meeting.zip](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b7%5d.FileData)  **Date/Time:**  28.05.2011 05:22:01  **Size:**  3 MB | |  |  |
| 9 | **File Type:**  Minutes of last three ICC/HSCC meetings \*  **File Desc:**  May 2011 Minute | **File name:**  [May 2011 ICC Meeting.zip](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b8%5d.FileData)  **Date/Time:**  28.05.2011 05:28:31  **Size:**  3 MB | |  |  |
| 10 | **File Type:**  cMYP Costing tool for financial analysis \*  **File Desc:** | **File name:**  [Nigeria cMYP 2011\_ 2015 Costing\_Tool country final.xlsm](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b9%5d.FileData)  **Date/Time:**  30.05.2011 14:03:52  **Size:**  1 MB | |  |  |
| 11 | **File Type:**  comprehensive Multi Year Plan - cMYP \*  **File Desc:** | **File name:**  [cMYP 2011-2015 country final.pdf](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b10%5d.FileData)  **Date/Time:**  30.05.2011 14:06:58  **Size:**  5 MB | |  |  |
| 12 | **File Type:**  Improvement plan based on EVM \*  **File Desc:** | **File name:**  [EVM Report and Improvement Plan.zip](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b11%5d.FileData)  **Date/Time:**  30.05.2011 14:14:27  **Size:**  2 MB | |  |  |
| 13 | **File Type:**  Plan for NVS introduction (if not part of cMYP)  **File Desc:**  Introductory Plan PCV with work plan | **File name:**  [PCV Introplan and Work plan.zip](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b12%5d.FileData)  **Date/Time:**  30.05.2011 14:37:34  **Size:**  2 MB | |  |  |
| 14 | **File Type:**  Plan for NVS introduction (if not part of cMYP)  **File Desc:**  Introductory Plan Pentavalent with workplan | **File name:**  [Intro plan Pentavalent..zip](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b13%5d.FileData)  **Date/Time:**  30.05.2011 14:30:50  **Size:**  2 MB | |  |  |
| 15 | **File Type:**  Banking details  **File Desc:** | **File name:**  [Banking Details.zip](/PDExtranet/ObjectEditor/OpenFileItem?editedObjectId=6070315&propertyName=FormAttachments%5b14%5d.FileData)  **Date/Time:**  30.05.2011 15:53:10  **Size:**  2 MB | |  |  |

Banking Form

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In accordance with the decision on financial support made by the GAVI Alliance, the Government of Nigeria hereby requests that a payment be made via electronic bank transfer as detailed below: | | | | |  |
|  |  | | |  | |
| **Name of Institution (Account Holder):** | National Primary Health Care Development Agency | | |  | |
|  |  | | |  | |
| **Address:** | Plot 681/682 Portharcourt Crescent,off Gimbya Street Area Eleven Garki Abuja | | |  | |
| **City Country:** | Nigeria | | |  | |
| **Telephone no.:** | +23496701778 | **Fax no.:** |  |  | |
| **Currency of the bank account:** | | | USD |  | |
| **For credit to:** | | | | |  |
| **Bank account's title:** | NPHCDA GAVI ISS ACCOUNT | | |  | |
| **Bank account no.:** | 3791550000846 | | |  | |
| **Bank's name:** | UNION BANK PLC AREA THREE ABUJA | | |  | |
|  | | | | |  |

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

By who is the account audited? Internal Audit of the Agency and external auditors

Signature of Government’s authorizing official

|  |  |  |
| --- | --- | --- |
| **Name:** | DR MUHAMMAD ALI PATE | **Seal** |
|  |
| **Title:** | EXECUTIVE DIRECTOR/CEO |
| **Signature:** |  |
| **Date:** | 27.05.2011 |

| **FINANCIAL INSTITUTION** | | **CORRESPONDENT BANK**  **(In the United States)** | |
| --- | --- | --- | --- |
| **Bank Name:** | UNION BANK OF NIGERIA PLC |  | DEUTSCHES BANK TRUST |
| **Branch Name:** | ABUJA MAIN BRANCH |  | COMPANY AMERICAS |
| **Address:** | AREA 3 GARKI ABUJA |  | NEW YORK 60, WALL STREET NEW YORK |
| **City Country:** | ABUJA - NIGERIA |  | NY 1005 |
| **Swift Code:** | UBNINGLA |  | BKTRUS 33 |
| **Sort Code:** | 235797 |  |  |
| **ABA No.:** |  |  | -021001033 |
| **Telephone No.:** | 09-2342784 |  |  |
| **FAX No.:** | 09-2347578 |  |  |
|  | |  | |

I certify that the account no 3791550000846 is held by (Institution name) NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY (NPHCDA) at this banking institution.

|  |  |  |
| --- | --- | --- |
| The account is to be signed jointly by at least 2 (number of signatories) of the following authorized signatories: | | |
| **1** |  | |
| **Name:** | DR MUHAMMAD ALI PATE |
| **Title:** | EXECUTIVE DIRECTOR/CEO |
| **2** |  | |
| **Name:** | PAG BUSUYI ONABOLU |
| **Title:** | CHAIRMAN ROTARY POLIO PLUS |
| **3** |  | |
| **Name:** |  |
| **Title:** |  |
| **4** |  | |
| **Name:** |  |
| **Title:** |  |

|  |
| --- |
| **Name of bank’s authorizing official** |
| MR CHRIS C. UZUH |
| **Signature:** |
|  |
| **Date:** |
|  |
| **Seal:** |
|  |