Global Alliance for Vaccines and Immunisation (GAVI)

APPLICATION FORM FOR COUNTRY PROPOSALS

For Support of:
PNEUMOCOCCAL VACCINE

REPUBLIC OF THE CONGO

April 22, 2008

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

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

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Executive Summary

After the sociopolitical unrest at the end of the 1990s and in order to recommence immunisation activities, the 2004 -2008 multi-year strategic plan for EPI was developed. The implementation of this plan is based on the Reach Every District (RED) approach and the support of GAVI and other partners involved in immunisation which have allowed programme performance to improve over the years. In 2007, this plan was revised as a comprehensive Multi-Year Plan (cMYP) 2008-2011 including a financial and cost analysis.

DTP3 vaccine coverage has significantly increased since 2005. It increased from 65.4% in 2005 to 80.2% in 2007. The Reach Every District strategy was implemented and has been extended to all the health districts in the country since 2005. The internal audit of data quality is being gradually implemented and will improve data quality.

Currently, yellow fever vaccine, tetravalent HepB vaccine (DTPHepB), and vitamin A have been introduced into the routine EPI on a national level. The country was approved for support for pentavalent Hib vaccine and expects to introduce it in October 2008. In terms of vaccine security, auto-disable (AD) syringes were adopted as the only syringes used in routine EPI and are used at a level of 100% in the healthcare setting. The political commitment to introduce these new and under-used vaccines into the routine EPI in the Congo continues. This strong political commitment is evidenced by the statement on the introduction of new vaccines in the actions of the interventions of the head of state and the Minister of Health.

Considering the number of pneumococcal infections in the Congo, as well as the epidemiology of this disease in the sub-region, the opportunities offered by GAVI and its planning concerning this disease in the 2008-2011 comprehensive multi-year plan, starting in January 2010, the Congo, through its Extended Immunisation Programme plans to introduce pneumococcal vaccine. There are several choices: 1st choice 10-valent monodose pneumococcal vaccine, if it is available; 2nd choice; PCV-7 monodose vaccine, which will be available at the end of 2009. In any case, if this form remains unavailable, the country proposes to use the currently available liquid form of 7-valent pneumococcal conjugate vaccine with pre-filled syringes. In this plan all the estimates were made on the basis of PCV-7 monodose vaccine.

Portion of supplies financed by the country and by GAVI (including cost estimates, $US)

		COUNTRY		GAVI	
		2010	2011	2010	2011
Number of vaccine doses	#	17,562	24,228	575,032	588,930
Number de auto-disable syringes	#	0	0	0	0
Number of syringes for reconstitution	#	0	0	0	0
Total number of safety boxes	#	195	269	6 383	6 537
Total value of country co-financing	**$**	$ 88,889	$ 122,632	$ 2,910,511	$2,980,856

Although adopting this form will require an increase in storage volume, the current capacity of the cold chain will be available. In addition, the implementation of the plan for the upgrade and expansion of the cold chain by 2012 by the government and its partners will allow the country to increase its vaccine storage volume. If the option for the monodose form is not available in 2010 and the form with prefilled syringes is available (an option requiring a greater storage volume) is chosen, the additional cold chain capacity related to the introduction of this vaccine will be 5612 litres in 2010[1]. In addition, starting in 2009, a change in the cold chain capacity by 41,057 litres of

[1] Outil_Prevision_Log_Introduction_Pneumo

positive temperature storage and 10,972 litres of negative temperature storage. The cold chain capacities at both the central and intermediate level, related to dividing the shipments will be sufficient for the introduction of the new vaccine regardless of its presentation.

In terms of co-financing, the country commits to pay its share connected with the introduction of this new vaccine. A budget line item is dedicated to this purpose. The efforts of the Government in the co-financing of vaccines with GAVI are real, in fact in March 2008 the country transferred to UNICEF its share of the co-financing for the vaccine pentavalent (DTP- Hep B/Hib)

The organisation of the national MLM course including the AEFI in June and July 2008 will overcome the weaknesses in AEFI surveillance and will contribute to the enhancement of the capacities of newly recruited personnel.

Signatures of the Government and National Coordinating Bodies

Government and Inter-Agency Coordinating Committee for Immunisation

The Government **of the Republic of the Congo** wishes to strengthen the existing partnership with the GAVI Alliance to improve the national programme for the routine immunisation of infants, and specifically requests the support of GAVI for the introduction of the pneumococcal vaccine in the liquid monodose form

The Government **of the Republic of the Congo** commits to develop national immunisation services based on durable strategies, in accordance with the global multi-year plan attached to this document. The Government requests financial and technical assistance from the GAVI Alliance and its partners to support the immunisation of children as presented in this proposal.

Table 6.4 of this proposal lists financial commitment of the Government for the purchase of this new vaccine (only for national immunisation services [NIS]).

Minister of Health, Social Affairs and the Family:

Signature: ……

Name: **Emilienne RAOUL**

Date:

Minister of the Economy, Finance and the Budget:

Signature: ……

Name: **Pacifique ISSOIBEKA**

Date:

National coordinating body: Inter-Agency Coordinating Committee for Immunisation:

We the undersigned members of the Inter-Agency Coordinating Committee for Immunisation (ICC), met on April 30, 2008, to review this proposal. At that meeting, we endorsed this proposal on the basis of the supporting documentation which is attached. (Plan for the introduction of pneumococcal vaccine; revised comprehensive 2008 -2011Multi-Year Plan for immunisation)

- The endorsed minutes of this meeting is attached as DOCUMENT NUMBER **1**:

Name/Title	Institution/Organisation	Signature
Mme Emilienne RAOUL Minister	**Ministry of Health, Social Affairs and the Family**	
Dr Mamadou BALL WHO Representative	**World Health Organisation (WHO)**	
Dr Koenraad VANORMELINGEN UNICEF Representative	**United Nations Children's' Fund (UNICEF)**	
Dr OKO OSSHO	**Congolese Red Cross**	

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

Name: **Dr Damase BODZONGO**
Title/address: **Director General for Health, Ministry of Health, Social Affairs and the Family**
Tel. **(242) 536 42 77** ; Fax: **(242) 81 04 81**
email: **bodzongo@ yahoo.fr**
Alternate address:

Tel **(242) 551 12 82 or (242) 651 12 82**
***Disease Control Directorate,* Ministry of Health, Social Affairs and the Family**

The Inter-Agency Coordinating Committee for Immunisation

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

Profile of the ICC/HSCC

Name of the ICC/HSCC: Inter-Agency Coordinating Committee

Date of constitution of the current ICC/HSCC: September 9, 2002

Organisational structure (e.g., sub-committee, stand-alone): independent organisation

Frequency of meetings: Quarterly

Composition

Function	Title / Organisation	Name
President	**Minister of Health, Social Affairs and the Family**	**Mme Emilienne RAOUL Minister**
Vice president	**Director-General of Health, Social Affairs and the Family**	**Dr Damase BODZONGO**
Secretary	**Medical Director, Expanded Programme for Immunisation**	**Dr Edouard NDINGA**
Members**	**WHO Representative** **UNICEF Representative** **European Union Representative** **Red Cross Representative** **National Anti-Measles Campaign (NAMC)Representative** **Ministry of Planning**	**Dr Mamadou D. BALL** **Dr Koenraad VANORMELINGEN** **Mr Miguel AMADO.** **Dr OKO OSSHO** **Beatrice BARUMBANZE** **Gilles MIERRE**

** other members (see document Number 2)

Major functions and responsibilities of the ICC/HSCC

- Approve the EPI annual plans, including projects for organising national immunisation days and enhancement of epidemiological surveillance
- Coordinate the interventions among social and health development partners and the Ministry of Health
- Mobilise the necessary resources for the implementation of programme activities.

Ensure transparent management of the EPI funds and evaluate the implementation of action plans.

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

1. Enhance the role of the ICC in the implementation, follow-up and evaluation of the multi-year EPI strategic plan activities
2. Mobilisation of EPI resources
3. Coordination of additional immunisation activities

3. Immunisation programme data

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

- Please refer to the Comprehensive Multi-Year Plan for Immunisation (or equivalent plan) , and attach a complete copy (with an executive summary) as DOCUMENT NUMBÉR 3
- Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms on Vaccine Preventable Diseases and attach them as DOCUMENTS NUMBÉR 4
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate. DOCUMENT NUMBÉR 5 NPHD

Table 3.1: Basic facts for the year 2006 (the most recent; specify dates of data provided)

	Number	Date	Source
Total population	**4,166,075**	**2007**	**JRF 2007**
Infant mortality rate (per 1000)	**80 p.1000**	**2005**	**NPHD 2007- 2011**
Surviving Infants*	**166,643****	**2007**	**JRF 2006**
GNI per capita (US$)			
Percentage of GDP allocated to Health	**29%**	**2007**	**PPAC**
Percentage of Government expenditure on Health	4 %	2007	PPAC

* Surviving infants = Infants surviving the first 12 months of life
**the number of surviving infants decreased in 2007due to the overestimation of infants in 2006 in the Lékoumou department.

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

Please indicate the name and date of the relevant planning document for health:
National Plan for Health Development (NPHD) 2007-2011
Is the cMYP (or updated Multi-Year Plan) aligned with this document (timing, content etc)? Yes
Please indicate the national planning budgeting cycle for health: **2007-2011**

Please indicate the national planning cycle for immunisation:
The national planning cycle is from **2008-2011, and this period is included in the health planning cycle, which is from 2007-2011**

Table 3.2: Current Vaccination Schedule: Traditional, New Vaccines and Vitamin A Supplement *(page 20 of cMYP)*

Vaccine *(do not use trade name)*	**Ages of administration** *(by routine immunisation services)*	**Indicate by an "x" if given in:**		**Indicate by an "x" if given in:**
		Entire country	**Entire country**	
BCG/OPV 0	At birth	X		
DTP-HepB 1 /OPV 1	8 weeks	X		pentavalent vaccine (DTP HepB Hib) will be introduced in October 2008, whereas pneumococcal vaccine will be introduced in 2010 and all will follow the cycle for the current tetravalent vaccine
DTP-HepB2/OPV2	12 weeks	X		
DTP-HepB3/OPV3	16 weeks	X		
MCV	36 weeks	X		
YFV	36 weeks	X		
TT	Pregnant women TTT1 at 1st visit; TT2 after 1 month; TT3 after 6 month; TT4 after 1 year, TT5 after 1 to 3 years.	X		
Vitamin A	36 weeks	X		

Table 3.3: Trends of immunisation coverage and disease burden
(as per last two annual WHO/UNICEF Joint Reporting Form on Vaccine Preventable Diseases)

Trends of immunisation coverage (in percentage)						**Vaccine preventable disease burden**		
Vaccine		**Reported**		**Vaccine**		**Reported**	**Vaccine**	
		2006	**2007**	**2005**	**2006**		**2006**	**2007**
BCG		83	85,53	SO	SO	Tuberculosis*	1604	ND
DTP	SO			SO	Diphtheria		0	
	SO			SO	Pertussis		108	
Polio 3		77,77	80,2	SO	SO	Polio	0	0
Measles (first dose)		64	66,9	SO	SO	Measles	126	84
TT2+ (Pregnant women)		73,6	77,7	SO	SO	NN Tetanus	2	3
Hib3		SO		SO	SO	Hib **	ND	ND
Yellow Fever		63,94	66,8	SO	SO	Yellow fever	0	0
HepB3		SO	66,3	SO	SO	hepB sero-prevalence*	ND	ND
Vit A supplement	Mothers (<6 weeks post-delivery)	63,6	95,2	SO	SO			
	Infants (>6 months)			SO	SO			

* If available.
** Note: the attached declaration form requests 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:NA

Table 3.4: Baseline and annual targets *(page 45.of cMYP)*

Number		Base Year	2010	2011
Births		2006	200 553	207 517
Infants' deaths		2006	10727	11100
Surviving infants		2006	186 561	193 035
Pregnant women		2006	200 553	207 517
Target population vaccinated with BCG		2006	187424	198011
BCG coverage*		2006	95%	97%
Target population vaccinated with OPV3		2006	177560	193928
OPV3 coverage**		2006	90%	95%
Target population vaccinated with DTP3***		2006	177560	193928
DTP3 coverage**		2006	90%	95%
Target population vaccinated with DTP1***		2006	187424	193928
Wastage[2] rate in base-year and planned thereafter		2006	5%	5%
Target population vaccinated with **3rd dose** of pneumococcal vaccine……..		2006	177560	193928
Pneumococcal vaccine Coverage**		2006	90%	95%
Target population vaccinated with **1st dose** of pneumococcal vaccine ……..		2006	187424	193928
Wastage[1] rate in base-year and planned thereafter		2006	10%	10%
Target population vaccinated with **1st dose** of Measles		2006	167905	183383
Target population vaccinated with **2nd dose** of Measles		2006	SO	SO
Measles coverage**		2006	90%	95%
Pregnant women vaccinated with TT+		2006	181506	193928
TT+ coverage****		2006	92%	95%
Vit A supplementation	2006	ND	ND	
	2006	167905	183383	
Annual DTP Dropout rate [(DTP1-DTP3)/DTP1] x100		2006	10%	10%
Annual Measles Dropout rate (for countries applying for YF)		2006	SO	SO

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

[2] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check **table α** after Table 7.1.

Table 3.5: Summary of current and future immunisation budget (*page 54 of cMYP)*

	Estimated costs per annum in US$ (,000)				
	2006 (previous funding)	**2008**	**2009**	**2010**	**2011**
Routine Recurrent Cost	**US$**	**US$**	**US$**	**US$**	**US$**
Vaccines (routine vaccines only)	167 440	171 386	186 381	191 902	208 050
Traditional vaccines	107 767	2 565 700	2 183 487	5 272 511	5 758 549
New and underused vaccines	214 884	270 114	324 461	341 412	360 051
Injection supplies	27 360	33 048	39 202	42 024	42 864
Personnel	169 776	180 809	192 216	204 007	208 087
Salaries of full-time NIP health workers (immunisation specific)	73 560	82 130	90 015	94 108	95 990
Per-diems for outreach vaccinators / mobile teams					
Transportation	147 358	116 971	130 725	142 836	144 512
Maintenance and overheads	2 989	44 833	47 681	51 672	51 901
Training					
Social mobilisation and IEC	79 970	87 296	100 793	109 094	69 343
Disease surveillance	1 250	2 015	2 211	2 467	1 164
Program management	79 500	81 090	82 712	84 366	86 053
Other	10 000	10 710	11 470	12 285	13 157
Subtotal Recurrent Costs	15 000	16 065	17 206	18 427	19 736
Routine Recurrent Cost	122 500	131 223	140 453	150 305	161 015
Vaccines (routine vaccines only)	40 500	43 376	46 455	49 753	53 286
Traditional vaccines	5 000	5 355	5 735	6 142	6 579
New and underused vaccines	**1 264 854**	**3 842 121**	**3 601 203**	**6 773 313**	**7 280 335**
Routine Capital Costs					
Vehicles	-	9 180	26 010	26 583	
Cold chain equipment	7 070	29 849	61 357	42 932	71 312
Other capital equipment	1 200	14 790	3 121	4 245	
Subtotal Capital Costs	**8 270**	**53 819**	**90 488**	**73 760**	**71 312**
Campaigns					
Polio					
Measles	274 696				
Yellow Fever	502 150				
MNT campaigns					
Other campaigns				243 731	
Subtotal Campaign Costs				184 393	
Campaigns					
Polio	112 969				
Measles	335 559				
Yellow Fever					
MNT campaigns	51 901				
Other campaigns	-				
Subtotal Campaign Costs	**1 277 274**			**428 124**	
Shared Costs					
Shared costs for personnel	482 478	526 436	582 547	622 354	634 801
Shared cost for transportation	3 890	3 967	4 047	4 128	4 210
Subtotal for Shared Costs	**486 368**	**530 404**	**586 594**	**626 482**	**639 011**
GRAND TOTAL	**3 036 766**	**4 426 344**	**4 278 285**	**7 901 679**	**7 990 658**
Routine Services	**1 759 492**	**4 426 344**	**4 278 285**	**7 473 555**	**7 990 658**
Immunisation Campaigns	**1 277 274**			**428 124**	

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

Table 3.6: Summary of current and future financing and sources of funds *(page 56 of cMYP)*

		Estimated financing per annum in US$ (,000)				
Cost category	**Funding source**	**Base year 2006**	**Year 1 2008**	**Year 2009**	**Year 2010**	**Year 2011**
Recurrent Costs	GVT	293,838	665,148	837,118	848,523	711,303
	GAVI	389, 024	2570,480	2,053,541	4,881,362	4,792,759
	UNICEF	206,461	106,065	206,000	40,000	35,000
	WHO	295,146	125,000	**164,000**	110,000	107,000
Capital Costs	GVT	162,358	9,180	10,000	184,000	0
	GAVI	20,141	15,000	0	0	0
	UNICEF	149,063	35,000	35,000	35,000	35,000
	WHO	52,693	0	0	10,000	0
Campaigns	GVT	41,429	0	0	92,000	0
	GAVI	0	0	0	0	0
	UNICEF	1,011,275	0	0	273 731	0
	WHO	331,900	0	0	63,000	0
Shared Costs	GVT	139,234	0	0	0	0
	GAVI	0	0	0	0	0
	UNICEF	0	0	0	0	0
	WHO	0	0	0	0	0

4. Immunisation Services Support (ISS)

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

Table 4.1: Estimate of fund expected from ISS

	Base year	Year 1 20…	Year 2 20…	Year 3 20…	Year 4 20…	Year 5 20…
DTP3 Coverage rate						
Number of infants reported / planned to be vaccinated with DTP3 (as in Table 3.4)						
Number of *additional* infants that annually are reported / planned to be vaccinated with DTP3						
Funds expected ($20 per additional infant)						

* Projected figures
** As per duration of the cMYP

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

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

Major Lessons Learned from Phase 1	**Implications for Phase 2**

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

a) when you would like the support to begin:
:

b) when you would like the first DQA to occur:

c) how you propose to channel the funds from GAVI into the country:

d) how you propose to manage the funds in-country:

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

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

5. Injection Safety Support

- Please attach the National Policy on Injection Safety including safe medical waste disposal (or reference the appropriate section of the Comprehensive Multi-Year Plan for Immunisation), and confirm the status of the document: DOCUMENT NUMBER……

- Please attach a copy of any action plans for improving injection safety and safe management of sharps waste in the immunisation system (and reference the Comprehensive Multi-Year Plan for Immunisation). DOCUMENT NUMBER…….

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

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

	Annual requirements		***Cost per item (US$)***		***Total Cost (US$)***
Year	***Syringes***	***Safety Boxes***	***Syringes***	***Safety Boxes***	
2006…					

Table 5.2: Estimated supply for safety of vaccination with …….. vaccine
(Please use one table for each vaccine BCG (1 dose), DTP (3 doses), TT (2 doses) [1], Measles (1 dose) and Yellow Fever (1 dose), and number them from 5.1 to 5.5)

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

[1] GAVI supports the procurement of AD syringes to deliver two doses of TT to pregnant women. If the immunisation policy of the country includes all Women in Child Bearing Age (WCBA), GAVI/The Vaccine Fund will contribute to a maximum of two doses for Pregnant Women (estimated as total births)
[2] To insert the number of infants that will complete vaccinations with all scheduled doses of a specific vaccine.
[3] Estimates of 100% of target number of children is adjusted if a phased-out of GAVI/VF support is intended.
[4] A standard wastage factor of 2.0 for BCG and of 1.6 for DTP, Measles, TT, and YF vaccines is used for calculation of INS support
[5] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero under other years. In case of a phased introduction with the buffer stock spread over several years, the formula should read: [F – number of doses (incl. wastage) received in previous year] * 0.25.
[6] It applies only for lyophilized vaccines; write zero for other vaccines..

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

6. New and Under-Used Vaccines (NVS)

➢

Please give a summary of the cMYP sections that refer to the introduction of new and under-used vaccines. Outline the key points that informed the decision-making process (data considered etc):
The Congo, like other countries in the African la region, has been faced with problems caused by pneumococcal infections. At the global level, the burden of this disease results in approximately 700,000 to 1,000,000 deaths annually in children under 5 years of age. In the Congo, pneumococcus is the leading cause of pneumonia in children under the age of 5, with pneumonia being the number 3 cause of mortality after malaria and diarrheal illness in this age group. These are common and serious illnesses with elevated mortality, particularly among infants under 2 years of age.

Given the opportunities provided by GAVI, the Government of the Congo sent a letter of intention to GAVI for the introduction of pneumococcal vaccine in the routine EPI. Following the meeting of the Central African EPI managers held March 19-21, 2008, in Douala (Cameroun) the Congo confirmed its commitment to present it proposal to GAVI in May 2008.

The form of choice for the integration of pneumococcal vaccine into the EPI of the Republic of the Congo is the monodose pneumococcal vaccine in the liquid form in 2010. This choice is characterised by: 1st choice 10-valent monodose pneumococcal vaccine, if it is available; 2nd choice: PCV-7 monodose vaccine, which will be made available at the end of 2009. In any case, if this form remains unavailable, the country proposes to use the currently available liquid form of 7-valent pneumococcal conjugate vaccine with pre-filled syringes. In this plan all the estimates were made on the basis of PCV- 7 monodose vaccine. This choice is justified for the following reasons:

- Rapid achievement of increased vaccine coverage (because the vaccine will rapidly follow the current trend for the tetravalent vaccine);
- Simplification of programme and management operations, thus reducing the operational costs related to vaccine that requires syringes for reconstitution and simplification of preparation techniques (pre-filled syringe with needle).
- Minimises vaccine wastage
- Traditional administration method (IM)
- Improved adaptability to environmental conditions and performance of the Congo EPI.

Please summarise the cold chain capacity and readiness to accommodate new vaccines, stating how the cold chain expansion (if required) will be financed, and when it will be in place. Please use attached Excel annex 2a (Tab 6) on the Cold Chain. Please indicate the additional cost, if capacity is not available and the source of funding to close the gap

The Congo currently has available at all levels of the health pyramid (central, intermediate, and peripheral) cold chains in accordance with the required standard for better vaccine storage that will be able to handle the volume of the new vaccine. The primary energy source for power used by these cold chains (cold room) differs among departments, with petroleum predominating.

At the central level, the cold chain is powered by electricity and has a storage capacity of 20.815 litres at positive temperatures and 10,792 litres at negative temperatures. There is a base relay station at Pointe Noire which is also powered by electricity and has a storage capacity of 540 litres at positive temperatures and 1,080 litres at negative temperatures.

At the department level, (not including the base relay station at Pointe Noire), 187 cold chain units are operational, of which 37 are power by electricity and 150 by petroleum with a storage capacity of 2,700 litres at negative temperatures and 8,982 litres at positive temperatures.

With the introduction of the monodose form of the pneumococcal vaccine, the current capacity will be adequate until 2011. In the case that the form with a pre-filled syringe (PCV-7) is still the only

form available in 2010, the storage volume will need to be increased. Additional cold chain capacities associated with the introduction of this vaccine will be 5,612 litres in 2010[3]. Thus it is planned that, starting in 2009, an increase in cold chain capacity of 41,057 litres at positive temperatures and 10,972 litres at negative temperatures will be required. Central and intermediate level cold chain capacities, associated with divided shipments will be adequate for the introduction of the new vaccine.

In fact, construction of a cold room of 20,000 litres at positive temperatures and 10,000 litres at negative temperatures is planned for the central level in Brazzaville. In addition, there are plans for the construction of a cold room of 10,000 litres at positive temperatures at the base relay station in Pointe Noire as well as the renovation of refrigerators and freezers and the appropriation for 199 refrigerators and 30 freezers. This forecast is included in the cMYP as well as the plan for upgrading the cold chain

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

		Formula	2008	2009	2010	2011
A	Annual ***positive*** volume requirement, including new vaccine (specify: **litres**)[4]	*Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine*	10,400	10,957	47,124	21,750
B	Annual ***positive*** capacity, including new vaccine (specify: **litres**)	#	6,527	6,527	6,527	6,527
C	Estimated minimum number of shipments per year required for the actual cold chain capacity	*A / B*	1.59	1.68	7.22	3.33
D	Number of consignments / shipments per year	*Based on national vaccine shipment plan*	2	2	4	4
E	Gap (if any)	*((A / D) - B)*	**- 1,327**	**- 1,049**	**5,254**	**- 1,090**
F	Estimated cost for expansion	*US $*	$29,530			

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

The cMYP was developed on the basis of an improved macroeconomic environment. In fact the overall GDF is constantly improving. As a consequence, the increase in GDP per resident went from $950 in 2005 to $1100 in 2006. These indicators should consolidate in the future in terms of a good outlook for growth.

Several years ago the Congo signed with WB and the IMF a Facility for the Reduction of Poverty and Growth (FRPG). To this end, a Strategic Document for the Reduction of Poverty was developed. This document outlines a framework programmed for development over the next few

[3] Outil_Prevision_Log_Introduction_Pneumo

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

years. In this document, the country commits to reduce poverty by among other actions, increasing expenditures the management of social sectors, including health.
Following the improvement of macroeconomic performance, a reduction in debt was granted to the Congo from the level of the Paris Club de Paris for its adherence to the decision point within the framework of the HIPC Debt Initiative. The adherence to the completion point will also result in a greater debt reduction. Just as for the decision point, the resources provided must be used particularly to assist in the fight against poverty.

Therefore, greater mobilisation of Government resources is necessary with regard to the need for significant financing. In addition, this forecast allows the progressive decrease in resources contributed by the donors to cMYP. It is essential to advocate to the Government for the continuation of these EPI activities.

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

The burden of morbidity due to pneumococcus has not yet been systematically evaluated. Nevertheless, in the Congo, pneumococcal infections are the leading cause of pneumonia among children under the age of 5 years with increased lethality particularly among infants under the age of 2 years. DOCUMENT 5

Disease	Title of the assessment	Date	Results

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

Since January 2004, the EPI has introduced yellow fever vaccine with the support of GAVI. In 2007 hepatitis B vaccine was also introduced into the routine EPI. The proposal for the introduction of HIV vaccine was approved by GAVI and will be implemented starting in October 2008.

Lessons Learned	Solutions / Action Points
The strategy for the introduction of vaccine throughout the entire country allows rapid coverage to be achieved	Maintain this strategy
The cold chain inventory prior to the introduction of new vaccines will allow the storage capacity to be handled	Use logistics data to maintain the capacities
An overstock of trivalent vaccine (DTP) was reported due to the emergency order made to compensate for the delay in delivery of the tetravalent vaccine (DTP/HepB)	Adhere to delivery deadlines for the pentavalent vaccine Develop a temporary management plan for the tetravalent vaccine before the actual introduction of the pentavalent vaccine

Please list the vaccines to be introduced with support from the GAVI Alliance (and presentation): The Congo proposes to introduce monodose pneumococcal vaccine in the liquid form with the support of the GAVI Alliance.

First Preference Vaccine

As reported in the cMYP, the Congo, through its Expanded Programme on Immunisation, starting in January 2010, has proposes the introduction of pneumococcal vaccine in the following form: 1st choice: 10-valent monodose pneumococcal vaccine, if it is available; 2nd choice: PCV-7 monodose vaccine, which will be made available at the end of 2009. In any case, if this form remains unavailable, the country proposes to use the currently available liquid form of 7-valent pneumococcal conjugate vaccine with pre-filled syringes. In this plan all the estimates were made on the basis of PCV 7 monodose vaccine.

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

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

Table 6.3: Specifications of vaccinations with new vaccine

Vaccine: ……	*Use data in:*		**2008**	**2009**	**2010**	**2011**
Number of children to be vaccinated with the third dose	*Table 3.4*	#			167,905	183, 383
Target immunisation coverage with the third dose	*Table 3.4*	#			90	95
Number of children to be vaccinated with the first dose	*Table 3.4*	#			186,561	193,035
Estimated vaccine wastage factor	*Annex 2a or 2b Table E - tab 5*	#			1.05	1.05
Country co-financing per dose *	*Annex 2a or 2b Table D - tab 4*	$			0.10	0.15

* Total price per dose included vaccine cost, plus freight, supplies, insurance, fees, etc.

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

		2010	**2011**
Number of vaccine doses	#	17,562	24,228
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	195	269
Total value to be co-financed by country	**$**	$ 88,889	$ 122,632

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

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

As the liquid monodose form of the vaccine will be administered with an auto-disable syringe, it is necessary to estimate the funding required from SAB [Synergies Africaines en Belgique].

		2010	2011
Number of vaccine doses	#	575 032	588 930
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	6 383	6 537
Total value to be co-financed by the country	**$**	$ 2 910 511	$2 980 856

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

Second Preference Vaccine

If the first preference of vaccine is in limited supply or currently not available, please indicate below the alternative vaccine presentation:
2nd choice: 7-valent monodose PCV, which will be available at the end of 2009. In any case, if this form remains unavailable, the country proposes to use the currently available liquid form of 7-valent pneumococcal conjugate vaccine with pre-filled syringes. In this plan all the estimates were made on the basis of PCV-7 monodose vaccine.

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

Procurement and Management of New and Under-Used Vaccines

a) Please show how the support will operate and be managed including procurement of vaccines (GAVI expects that most countries will procure vaccine and injection supplies through UNICEF):
For the purchase of vaccines and other intrants, the Ministry of Health will disburse funds from the UNICEF account which will support the order

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

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

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

The country proposes to introduce pneumococcal vaccine. Implementation of activities associated with this introduction will include particularly those involving the training of agents, raising the awareness of clinicians by targeting large cities with radio and television PSAs, and social mobilisation via community networks. This introduction will occur commence on January 1, 2010.

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

Funds allocated by GAVI will be transferred to the EPI bank account located at La Congolaise de Banques (LCB) in Brazzaville

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

The co-financing amounts will be provided by the Ministry of Finance which will transfer the funds to the Ministry of Health which will in turn transfer these funds to the UNICEF account.

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

Coverage for pneumococcal vaccine will be evaluated with currently used programme methods (monitoring, supervision, internal and external audit of data quality). The data will be collected from established vaccination centres and will be transferred to the district level for analysis and compilation. The department will develop summaries by health district and will transmit the data to the central level. In parallel, internal audits will be conducted to monitor data quality.

New and Under-Used Vaccine Introduction Grant

Table 6.5: calculation of lump-sum

Year of New Vaccine introduction	N° of births (from table 3.4)	Share per birth in US$	Total in US$
2010	197,289	$ 0.20	394,578

Please indicate in the tables below how the one-time Introduction Grant[6] will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP).

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

Cost Category	Full needs for new vaccine introduction	Funded with new vaccine introduction grant
	US$	US$
Training	10,710	710
Social Mobilization, IEC and Advocacy	10,000	0
Cold Chain Equipment & Maintenance	29,849	29,849
Vehicles and Transportation	44,833	19,833
Programme Management	43,376	18,316
Surveillance and Monitoring	31,223	1,223
Human Resources	0	
Waste Management	0	
Technical assistance	0	
Supervision	82,130	23,519
Fixed outreach strategy and delivery of vaccines	16,971	6,550
Total	269 092	100,000

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

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

[6] 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

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

The political commitment is expressed at the highest level of the government for the financing of the current health system, and additional opportunities for health system financing exist with cooperating agencies and partners within the framework of the SWAP (World Bank) which will have a significant impact on vaccine financing.

8. Documents required for each type of support

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

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

ANNEX 1

Banking Form

SECTION 1 *(To be completed by payee)*

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

Name of Institution: *(Account Holder)*	**MINISTERE DE LA SANTE DES AFFAIRES SOCIALES ET DE LA FAMILLE**		
Address:	**B.P 2889**		
City – Country:	**BRAZZAVILLE-CONGO**		
Telephone No.:	**+ 242 81 09 78**	**Fax :**	**+ 242 81 09 77**
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**	FCFA
For credit to: *Bank account's title*	*COMPTE ORDINAIRE*		
Bank account No.:	108626 – 1001/07		
At: *Bank's name*	**LA CONGOLAISE DES BANQUES**		

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

By whom is the account audited? **Minister of Health**

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

Name:	**Emilienne RAOUL**	**Seal:**
Title:	**Minister of Health, Social Affairs and the Family**	
Signature:		
Date:		
Address and Phone number		
Fax number		
Email address:		

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

FINANCIAL INSTITUTION		CORRESPONDENT BANK (*In the United States*)
Bank Name:	LA CONGOLAISE DES BANQUES	
Branch Name:		
Address:	BP : 2889 AVENUE AMILCAR CABRAL	
	BRAZZAVILLE	
City – Country:	CONGO	
Swift code:	CRAGCGCG	
Sort code:		
ABA No.:		
Telephone No.:	(242) 81 09 55/56/78	
Fax No.:	(242) 81 09 77	
Bank Contact Name and Phone Number:		

I certify that the account No. . . .108626- 1001/07. . . . . is held by *(Institution name)* . . . . Extended Immunisation Programme. . . . at this banking institution.

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name: Dr Edouard NDINGA **Title:** EPI Medical Director	**Signature:** **Date:**
2 Name: Dr Charlotte GOKABA OKEMBA **Title:** Director of Disease Control	**Seal:**
3 Name: Dr Damase BODZONGO **Title:** Director-General for Health	
4 Name: **Title:**	

COVERING LETTER

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

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

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

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

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

Signature of UNICEF Representative:

Name .....

Signature .....

Date .....

MINISTRY OF HEALTH, SOCIAL AFFAIRS AND THE FAMILY
-=-=-=-
INTER-AGENCY COORDINATING COMMITTEE FOR THE EXPANDED PROGRAM ON IMMUNIZATION
-=-=-=-

REPUBLIC OF THE CONGO
Unity * Labor * Progress
-=-=-

ANSWERS FROM THE GOVERNMENT OF THE CONGO ON THE CONDITIONS TO BE MET FOR GAVI ALLIANCE APPROVAL OF SUPPORT FOR NEW AND UNDERUSED VACCINES (SNV)

Introduction

In May 2008, the government of the Congo applied to the GAVI Alliance for support for new and underused vaccines (SNV) to introduce the 7-valent pneumococcal vaccine into the systematic immunization program for 2010 to 2011.

The Independent Review Committee (IRC) recommended that the GAVI Alliance approve it with conditions.

The conditions to be met were as follows:

- The government's contribution to the EPI (assured and probable funding) decreases from 2010 to 2011 while program requirements increase – Table 3.6 of the support application and worksheet on the discrepancies and indicators of the software for calculating the costs of the cMYP. The government is asked to revise the data that were submitted and to justify this trend.

Answers to the conditions

The government of the Republic of the Congo is satisfied with the conditional approval and is pleased to submit the appropriate replies in the next few lines. Taking the relevant IRC observations into account, the data that were submitted were revised as detailed below.

1. Worksheet on the discrepancies and indicators of the software for calculating the costs of the cMYP

- The following errors were detected and corrected:
    - Funding for the traditional vaccines was assured in 2010 (1) but was reported as probable (2) in 2011; this was corrected so that in 2011 funding for the vaccines will be assured (1)
    - The government's contribution to cofinancing for introducing new and underused vaccines was incorrectly estimated for the 2009-2011 period

- In 2008, the government's contribution to cofinancing the pentavalent vaccine, calculated on the basis of the group of countries to which the Congo belongs (group of fragile countries), and on the vaccine type (1st new vaccine), was transferred to UNICEF in April 2008 in the amount of USD 36,500
- Beginning in 2009, government contributions to cofinancing the new and underused vaccines (yellow fever, pentavalent and pneumococcus), and injection materials, will be entered in the government budget, and thus are considered assured financing.
- Since the country is eligible for GAVI, the financing for new and underused vaccines and for injection materials that GAVI approves are also considered assured financing.
- The government share of financing for new vaccines has been readjusted (USD 180,000 in 2011 versus USD 139,232).

  - In 2011 the costs of the compensation for the advanced strategy (USD 80,000) and the supervision compensation (USD 40,000), which nonetheless are listed in 2010 and which are routine activities, were not included; this has been corrected.

  - Building costs (USD 85,000) and short-term training costs (USD 6,500) were not included in 2011. This omission has been corrected.

  The discrepancies between resource requirements and assured financing have improved significantly.

It should be noted that the operational costs for supplementary measles immunization activities that were planned in 2010 have increased the costs for this year.

These corrections that have been made changed the financial discrepancies and indicators in the multi-year plan, the summaries of which are on the following pages.

Financial Discrepancies and Indicators – MultiYear Plan
Republic of the Congo

Indicator for the reference year	2006
Total spending for immunization	$2,550,399
Immunization campaign	$1,277,274
Routine immunization	$1,273,124
per inhabitant	$0.3
per child for DTP3	$10.1
% vaccine and injection materials	38.5%
% national financing	23.1%
% of total spending on health	1.1%
% of total government spending on health	80.5%
% of GDP	0.03%
Total shared costs	$486,368
% of shared costs in the total	16%
TOTAL	$3,036,766

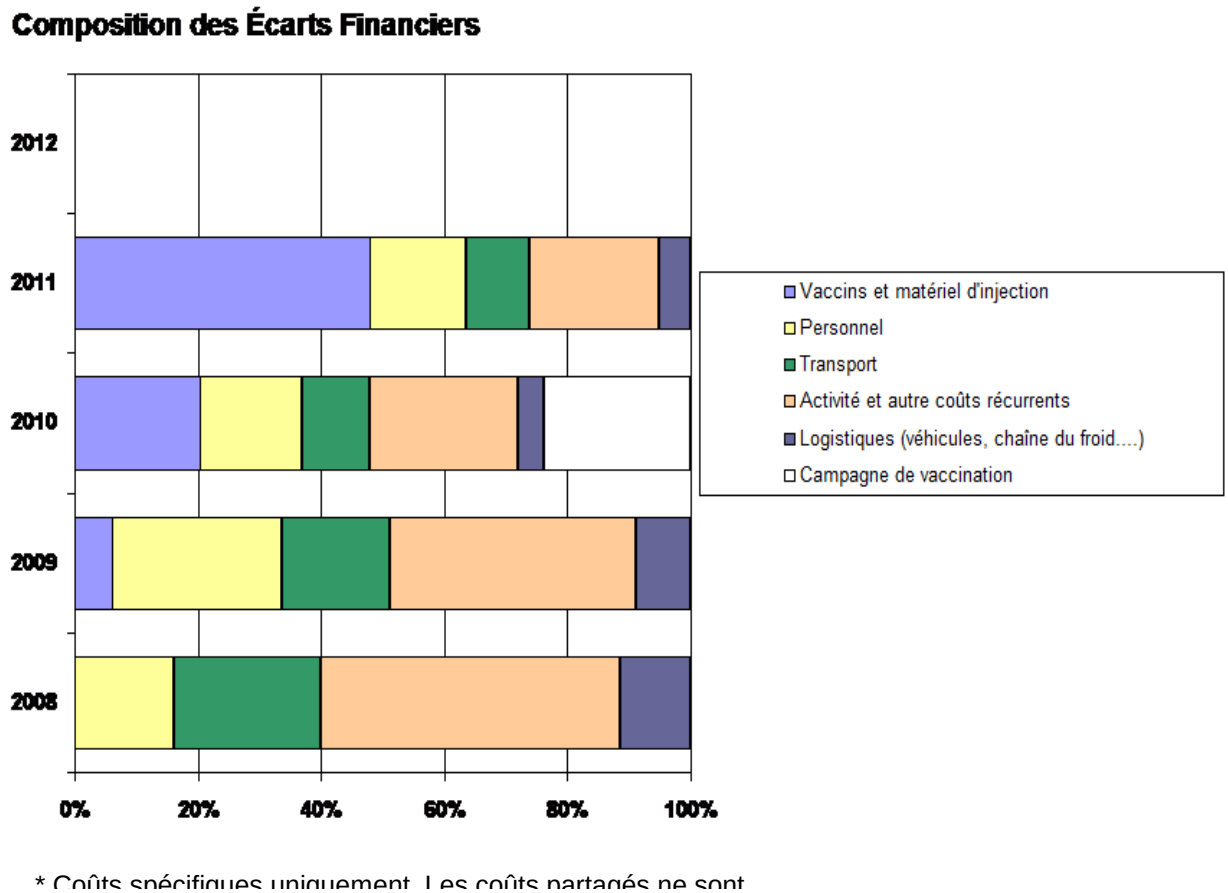
Future Trends	2008	2009	2010	2011
Resource requirements	**$3,895,941**	**$3,691,691**	**$7,275,198**	**$7,382,069**
Annual growth rate	35%	-6%	49%	1%
Resource requirements (routine immunization)	**$3,895,941**	**$3,691,691**	**$6,847,073**	**$7,382,069**
per inhabitant	$0.9	$0.8	$1.5	$1.5
per child DTP3	$28.2	$24.3	$41.1	$40.6
% of vaccine and injection materials	77%	73%	85%	86%
Total of assured financing	**$3,503,715**	**$2,671,639**	**$5,484,357**	**$5,439,916**
National government	$467,411	$336,202	$627,546	$670,914
GAVI – Vaccine Fund	$2,805,239	$2,335,437	$4,856,811	$4,769,002
UNICEF	$106,065			
WHO	$125,000			
Financing discrepancy (assured financing)	**$392,226**	**$1,020,052**	**$1,790,841**	**$1,942,153**
% of resource requirements	10%	28%	25%	26%
Total probable financing (not assured)	**$35,000**	**$742,321**	**$867,520**	**$498,975**
National government		$362,065	$309,655	$291,500
GAVI – Vaccine Fund		$45,256	$24,551	$23,757
UNICEF	$35,000	$171,000	$360,314	$50,000
WHO		$164,000	$173,000	$133,718
Financing discrepancy (assured and probable financing)	**$357,226**	**$277,731**	**$923,321**	**$1,443,178**
% of resource requirements	9%	8%	13%	20%

Components of Nonfinancial Costs and Composition of Financing Discrepancies – (Specific Costs Only)

Composition of financing discrepancies	2008	2009	2010	2011
Vaccines and injection materials	$0	$61,892	$363,493	$929,598
Personnel	$63,204	$282,232	$298,114	$304,077
Transport	$93,674	$178,406	$194,508	$199,774
Activity and other recurring costs	$190,709	$407,035	$432,841	$410,332
Logistics (vehicles, cold chain, etc.)	$44,639	$90,488	$73,760	$98,373
Immunization campaign			$428,124	
Financing discrepancy*	**$392,226**	**$1,020,052**	**$1,790,841**	**$1,942,153**

* Specific costs only. Shared costs are not included.

[Translator's note: The description below was not Word-accessible; the translation is the same as the table above.]



* Coûts spécifiques uniquement. Les coûts partagés ne sont

Revised Table 3.6

With regard to current financing for the EPI and the source of funds, and taking the corrections into account, Table 3.6 was revised and updated as the table below indicates.

Summary of current and future financing and sources of funds

		Estimate of annual financing in US$				
Budget line item	**Source of funds**	**2006 Reference Year**	**Year 2008**	**Year 2009**	**Year 2010**	**Year 2011**
Recurring costs	GVT	293,838	458,231	688,267	845,808	962,414
	GAVI	389,024	2,805,239	2,420,693	4,881,362	4,792,759
	UNICEF	206,461	106,065	158,211	40,000	30,000
	WHO	295,146	125,000	159,000	110,000	106,657
Capital costs	GVT	0	9,180	10,000	0	0
	GAVI	0	14,790	0	0	0
	UNICEF	149,063	20,000	35,000	46,583	20,000
	WHO	52,693	0	0	0	27,061
Campaigns	GVT	41,429	0	0	91,393	0
	GAVI	0	0	0	0	0
	UNICEF	1,011,275	0	0	273,731	0
	WHO	331,900	0	0	63,000	0
Shared Costs	GVT	139,234	0	0	0	0
	GAVI	0	0	0	0	0
	UNICEF	0	0	0	0	0
	WHO	0	0	0	0	0

Conclusion

These revisions, as made, show that the government's contribution to the EPI will increase from 2010 to 2011 in proportion to program requirements:

- The share of funding provided by the government is up from USD 627,546 in 2010 to USD 670,914 in 2011 (versus USD 42,000 as indicated previously)
- Government financing (probable and assured) for the recurring costs rises to USD 962,414 in 2011 (instead of USD 711,303) versus USD 845,808 in 2010.

These changes led to a partial revision of the cMYP,[7] a copy of which is attached.
In addition to the revisions of the financial part, the observations of the IRC on the plan to introduce the pneumococcal vaccine were taken into account.

[7] Revised cMYP in the annex

The ICC[8] inspected and validated this document on September 23, 2008.

The government of the Congo will spare no effort to honor its commitments as it is already doing for cofinancing and to ensure the financial sustainability of the activities that were planned.

For the ICC members

Name/Title	**Institution/Organization**	**Signature**
Dr. Damase BODZONGO Director General of Health	Ministry of Health, Social Affairs and the Family	
Dr. Mamadou D BALL, WHO Representative	WHO	
Dr. Koenraad VANORMELINGEN UNICEF Representative	UNICEF	
Dr. OKO OSSHO	Congolese Red Cross	

[8] The minutes of the ICC meeting are in the annex.