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| **Application Form for Country Proposals** |

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| *Preventive Campaign Support* |

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| ***Democratic Republic of Congo (Kinshasa)*** |

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| Date of submission: **26 January 2015** |

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| **Deadline for submission: 25 January 2015** |

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

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| **Form revised in 2015** |

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| **(To be used with Guidelines of October 2014)** |

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| **Please submit the Proposal using the online platform** |
| [https://AppsPortal.gavialliance.org/PDExtranet](https://appsportal.gavialliance.org/PDExtranet) |

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| Enquiries to: proposals@gavi.org or representatives of a GAVI partner agency.Unless otherwise specified, the documents can be shared with GAVI partners, collaborators and the 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 GAVI on or before day of the deadline. |
| GAVI is unable to return submitted documents and attachments to countries. |

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| **GAVI ALLIANCE GRANT TERMS AND CONDITIONS** |
| **FINANCING 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 Allie 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. GAVI Alliance will provide the necessary documents for the approved change, and the country's request will be duly 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 this application, or any GAVI Alliance-approved amendment to this application. GAVI Alliance reserves the right to terminate its support to the Country for the programs described in this proposal if GAVI Alliance receives confirmation of abusive use of the funds granted by GAVI Alliance. |
| **ANTI-CORRUPTION** |
| 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 are 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 languages of the arbitration will be English or French. |
| 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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| **1. 1. Application Specification** |
| Please specify for which type of GAVI support you would like to apply: |

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| **Type of Support** | **Vaccine** | **Start Year** | **End year** | **Preferred second presentation[1]** |
| Preventive Campaign Support | Meningococcal A vaccine, 10 dose(s) per vial, LYOPHILISED | 2015 | 2015 |  |

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| ***If, for various reasons, the first preference vaccine is only available in limited quantities or unavailable in the short term, GAVI will contact the country and its partners to explore alternative options.*** A country will not be obliged to accept its second or third preference, however, GAVI will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine. If a country does not indicate a second or third preference, it will be assumed that the country prefers to delay introduction until the first preference is available. It should be noted that this may delay the introduction in the country.  |

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| **3. Executive Summary** |

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| [Veuillez fournir un résumé de la proposition de votre pays, contenant notamment les informations suivantes:](#ApplicationSpecification) |
|  |  |  |  |
|  | [Pour chaque demande spécifique, soutien systématique aux nouveaux vaccins ou campagne SNV :](#ApplicationSpecification)  |
|  |  | The duration of support |
|  |  | The total amount of funds requested |
|  |  | Details of the vaccine(s), if applicable, and reason for the choice of presentation  |
|  |  | Projected month and year of introduction of the vaccine  |
|  |
|  | Relevant baseline data, including: |
|  |  | DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form) |
|  |  | Birth cohort, targets and immunisation coverage by vaccines |
|  |
|  | Country preparedness |
|  |  | Summary of EVM assessment and progress on EVM improvement plan |
|  |
|  | The nature of stakeholders' participation in developing this proposal |
|  |  |  Inter-Agency Coordinating Committee (ICC) |
|  |  | Partners, including CSO involvement |
|  |
| * Duration of support 6 months
* Total amount of funds requested in USD: 12,682,837 (vaccines and injection supplies) + 11,645,067 (operational cost) = 24,327,904 USD
* The vaccine requested is MenAfriVac. It comes in liquid form packaged in 10-dose vials.
* The vaccine will be introduced during a campaign from September 21-30, 2015 in the 6 provincial health divisions (DPS): 4 in Orientale province (Tshopo, Haut Uélé, Bas Uélé, and Ituri), plus 1 South Kivu DPS and 1 North Kivu DPS.
* The immunization coverage data reported by DRC in 2013 (JRF) was 90% for DTP-Hep B-Hib 3 and 88% for measles.
* Population data for 2015:
	+ Total population in the 3 provinces covered by the campaign: 25,225,990 inhabitants
	+ Live births: 1,009,040 newborns
	+ Campaign target population: 17,915,493 people between the ages of 1 and 29
	+ The goal is to vaccinate at least 95% of the target population, or 17,019,718 people between the ages of 1 and 29 in the three provinces.
* **Country preparedness:**
* The partners involved in developing this proposal were: WHO, UNICEF, BMGF, and the SABINE VACCINE INSTITUTE
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| **4. Signatures** |

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| **4.1 Signatures of the Government and National Coordinating Bodies** |

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| **4.1.1 The Government and the Inter-Agency Coordinating Committee (ICC) for Immunisation** |

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| The Government of the Democratic Republic of Congo (Kinshasa) would like to expand the existing partnership with Gavi for the improvement of the infants routine immunisation programme of the country, and specifically hereby request Gavi support for:  |

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| Meningococcal A vaccine, 10 dose(s) per vial, LYOPHILISED, preventive campaigns |

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

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| Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as documents 1 and 2 in Section 10. Attachments.  |

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| **Minister of Health (or delegated authority)** | **Minister of Finance (or delegated authority)** |
| **Name** | **Dr. Félix KABANGE NUMBI MUKWAMPA** | **Name** | **Mr. YAV MULANG** |
| **Date** |  | **Date** |  |
| **Signature** |  | **Signature** |  |

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| *This report has been compiled by (these persons may be contacted in case Gavi has queries on this document):*  |

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| --- | --- | --- | --- |
| **Full name** | **Function** | **Telephone** | **Email** |
| Dr. Audry MULUMBA WA KAMBA | EPI Director | +243 816179384 | audrywakamba@gmail.com |

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| **4.1.2. National Coordinating Body - Inter-Agency Coordinating Committee (ICC) for Immunisation** |

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

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| **Profile of the ICC, HSCC, or equivalent committee** |

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| **Name of the committee** | ICC |
| **Year of constitution of the current committee** | 1998 |
| **Organisational structure (e.g., sub-committee, stand-alone)** | Technical ICC |
| **Frequency of meetings** | Once a month |

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| The Terms of Reference or Standard Operating Principles of the ICC, including details on the membership, quorum, dispute resolution process and meeting schedules is attached as document no. 4. 4) . |

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| Major functions and responsibilities of the ICC/HSCC: |

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| The ICC has four committees:  **Technical Committee** -Develops and implements the EPI action plan-Analyzes immunization data monthly, including vaccine and supplies management data and health zone surveillance data - Conducts surveillance in health zones-Identifies problems and constraints related to the EPI-Shares information with all partners -Provides feedback to the provinces -Communicates with stakeholders**Logistics committee**-Analyzes vaccine management data from health zones and identifies vaccine needs-Takes inventory of cold chain supplies in health zones and in the EPI structure-Identifies problems related to inventory management (vaccines, diluents, petroleum, spare parts, management tools, etc.)-Provides feedback to the health zones**Social mobilization committee**-Analyzes and identifies social mobilization problems and their causes-Makes suggestions/recommendations for improvement-Defines effective EPI communication strategies-Identifies partners at the community level-Trains and involves Community Relays in managing rumors and following up with persons lost to follow-up-Develops strategies to increase links between health facilities and local communities for the EPI**Resource mobilization committee**-Reinforces EPI advocacy efforts-Identifies unsupported zones-Determines what areas lack support-Identifies potential donors and follows up (Recovery)-Prepares advocacy meetings -Prepares reports of the ICC meetingsThe ICC strategic committee (comprised of agency heads) will approve and follow up on the recommendations of the various ICC committees. |

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| Please describe how partners have provided support in preparation of the proposal:  |

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| Technical support: * WHO: provided the expertise of an international consultant, WHO country office, IVE team
* UNICEF: sent an immunisation team to the country office
* BMGF: sent an immunisation team to the country
* SABIN VACCINE INSTITUTE: sent a country team
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| **4.1.3. Signature Table for the Coordinating Committee for Immunisation** |

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| We, the members of the ICC, HSCC, or equivalent committee *[1]* met on 01/30/2015 to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 6 (please use the list for signatures in the section below). |

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| Please refer to Annex C of the ‘Gavi HSS and NVS General Guidelines’ for more information on ICCs. |

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| **Function** | **Title / Organisation** | **Name** | **Please sign below to indicate the attendance at the meeting where the proposal was endorsed**  | **Please sign below to indicate the endorsement of the minutes where the proposal was discussed**  |
| **Chair** | Ministry of Public Health  | Dr. Félix KABANGE NUMBI MUKWAMPA |  |  |
| **Secretary** |  |  |  |  |
| EPI Director | Dr. Audry MULUMBA |  |  |
| **Members** | DRC WHO Representative | Dr. Joseph CABORE |  |  |
| DRC UNICEF Representative | Mr. Pascal VILLENEUVE |  |  |
| SABIN Representative | Dr. MAMBU Hélène |  |  |
| BMGF Representative | Dr. Ado BWAKA |  |  |
| Rotary Representative | Dr. Valentin MUTOMBO |  |  |
| CSO Representative | Dr. Assy LALA |  |  |
| CNOS Representative | Mr. Nestor MUKINAYI TUM TUM |  |  |
| USAID Representative | Mrs. LINA PIRI PIRI |  |  |
|  | Dr. Nestor MUKINAYI  |  |  |
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| EPI Director of Administration and Finance | Mrs. Fatuma KAWENDE |  |  |
| Head of Measles EPI | Dr. Augustin MILABYO |  |  |
| Head of EPI Logistics Division | Mr. Serge KABEYA |  |  |
| Head of New Vaccines | Dr. Crispin KAZADI |  |  |
| Head of the Statistics Unit | Mr. Pascal MUKENYI |  |  |
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| Head of New Vaccines, WHO | Dr. Léon KINUANI |  |  |
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| By submitting the proposal we confirm that the quorum has been met. **Yes**  |

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| The minutes from the three most recent ICC meetings are attached as DOCUMENT NUMBER 7.  |

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| **4.2. National Immunization Technical Advisory Group (NITAG)**  |

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| Has a NITAG been established in the country? **Not selected** |

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| In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as (Document Number: XXX)  |

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| **5. 5. Immunisation Programme Data** |

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| **5.1. Background information**  |

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| Please complete the table 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. |

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| ▪  | 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 attach the cMYP costing tool as DOCUMENT NUMBER 12.  |
| ▪  | Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NUMBER: 14. |
| ▪  | Please refer to the two most recent annual WHO/UNICEF joint reports on immunization activities. |
| ▪  | Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc., as appropriate. |
| ▪  | Please refer to the attached risk assessments in the case of meningitis A mass preventive campaigns. |

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| Please use the most recent data available and specify the source and date.  |

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|  | **Figure** | **Year** | **Source** |
| Total population | 86 453 301 |  | 2013 | PAO 2014 |
| Birth cohort | 3 458 132 |  | 2013 | PAO 2014 |
| Infant mortality rate | 58 |  | 2013 | 2013 EDS [National Health and Demographic Survey] |
| Surviving infants*[1]* | 3 020 710 |  | 2013 | PAO 2014 |
| GNI per capita (US$) | 217 | % | 2014 | 2015-2019 cMYP |
| Total Health Expenditure (THE) as a percentage of GDP | 16 | % | 2012 | Report on national health accounts 2010-2012 |
| General government expenditure on health (GGHE) as % of General government expenditure  | 16 | % | 2012 | Report on national health accounts 2010-2012 |

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| *[3]* Surviving infants = Infants surviving the first 12 months of life |

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| **5.1.1 Lessons learned**  |

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| **Routine New Vaccines Support** |

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| **Preventive campaign support** |

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| If campaigns with Meningococcal A vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. If they are included in the Introduction Plan or Plan of Action, please cite the section only. |

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| **Lessons Learned** | **Action Points**  |
| Not applicable |  |

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| **5.1.2 Health planning and budgeting**  |

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| Please provide information on the planning and budgeting cycle in your country  |
| The government planning and budgeting cycle is annual, but there is a quarterly financial commitment plan. |
| Please indicate the name and date of the relevant planning document for health |
| The relevant planning document for health is the 2011-2015 National Health Development Plan (PNDS). |
| Is the cMYP (or updated Multi-Year Plan) aligned with the proposal document (timing, content, etc.)?  |
| The current 2015-2019 cMYP includes a one-year meningitis campaign (page 83 of the 2015-2019 cMYP). However, given the timeframe for the process to introduce this new vaccine, the implementation date was postponed to September 2015. |
| Please indicate the national planning budgeting cycle for health |
| The national planning budgeting cycle for health is 5 years. However, this is accompanied by a one-year annual operational plan. |
| Please indicate the national planning cycle for immunisation |
| The national planning cycle for immunisation is 5 years and is accompanied by an annual operational plan. |

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| **5.1.3 Preparatory activities**  |

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| Please provide an outline of all preparatory activities for vaccine(s) introduction or campaigns. If they are included in detail the Introduction Plan and/or Plan of Action, please cite the sections only. |
| Preparatory activities include:* Developing guides, instructions, and tools for training and activity implementation
* Micro-planning at the grassroots level
* Developing a logistics plan, including a CTC and supply distribution
* Training supervisors at the central and provincial levels
* Deploying supervisors
* Recruiting and training service providers
* Conducting communication, outreach, social mobilization, etc. activities
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| **5.1.4 Gender and equity**  |

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| Please describe any barriers to access, utilisation and delivery of immunisation services at district level (or equivalent) that are related to geographic, socio-economic and/or gender equity. Please describe actions taken to mitigate these barriers and highlight where these issues are addressed in the vaccine introduction plan(s). |
| According to the 2013-2014 DRC EDS 2 (National Health and Demographic Survey):* There is no gender-based difference among vaccinated children.
* There is a major difference among vaccinated children depending on whether they live in urban or rural areas. More children are vaccinated per antigen and with all the antigens in urban areas. Rural areas have more unvaccinated children. The same is true for the lowest income quintile.
* The mother's level of education impacts child immunization.

Based on the foregoing, the following solutions will be implemented in the short and medium term in conflict zones: * Continue providing immunization services through collaboration with local NGOs;
* Pursue negotiations with rebel groups in conflict zones;
* Strengthen the RED (Reach Every District) approach in zones with low demand for immunization.
 |
| Discuss how equity issues (geographic, socio-economic and/or gender) are being taken into account in the design of social mobilisation and other strategies to increase immunisation coverage. Highlight where these issues are addressed in the vaccine introduction plan(s).  |
| The vaccine introduction plan takes into account the various factors that impact immunization services. |
| Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems.  |
| Not applicable |
| Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought or others)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities. |
| Yes, the country is in a situation of fragility because there are zones of insecurity due to the armed conflicts in the eastern provinces. |
| If available, please provide additional information and documents on subnational coverage data, e.g. comparing urban/rural districts or districts with highest/lowest coverage, etc. |
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| **January – December 2014 Data** |
| Province | Field Office | Districts | Periodical Target Population 3.49% (DTP, OPV, measles) | CV DPT-HepB-Hib3 | CV DTP-HepB-Hib3 |
| Nord-Kivu | Butembo | Butembo |  10 682  |  10 525  | 98.5% |
| Nord-Kivu | Goma | Goma |  8 505  |  7 584  | 89.2% |
| Nord-Kivu | Goma | Karisimbi |  20 773  |  16 019  | 77.1% |
| Nord-Kivu | Goma | Pinga |  5 105  |  4 129  | 80.9% |
| Nord-Kivu | Goma | Rwanguba |  8 796  |  8 616  | 98.0% |
| Nord-Kivu | Goma | Walikale |  5 316  |  5 096  | 95.9% |
| Oriental | Kisangani | Kabondo |  5 556  |  5 571  | 100.3% |
| Oriental | Kisangani | Lubunga |  5 052  |  5 101  | 101.0% |
| Oriental | Kisangani | Mangobo |  6 581  |  6 847  | 104.0% |
| Oriental | Bunia | Mambasa |  3 269  |  2 576  | 78.8% |
| Oriental | Bunia | Mongbwalu |  4 549  |  3 883  | 85.4% |
| Oriental | Bunia | Nia-Nia |  2 432  |  1 927  | 79.2% |
| Sud-Kivu | Bukavu | Bagira-Kasha  |  4 300  |  4 911  | 114.2% |
| Sud-Kivu | Bukavu | Ibanda |  13 967  |  12 229  | 87.6% |
| Sud-Kivu | Bukavu | Kadutu |  11 388  |  11 505  | 101.0% |
| Sud-Kivu | Bukavu | Shabunda Centre  |  6 214  |  5 501  | 88.5% |
| Sud-Kivu | Uvira | Kimbi Lulenge |  6 227  |  6 231  | 100.1% |
| Sud-Kivu | Uvira | Lemera |  5 660  |  5 376  | 95.0% |
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| **Key** |  |  |  |  |  |
| In Blue: Urban health zone |  |  |  |  |
| In Red: Rural health zone |  |  |  |  |

CV = Children vaccinated |
| Please describe what national surveys take place routinely in country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers. |
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| **5.1.1 Data quality**  |

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| Please attach a data quality assessment (DQA) report if one has been completed within the previous 48 months (DOCUMENT NUMBER: 13). If available, an improvement plan and progress report on the implementation of the improvement plan should also be submitted (DOCUMENT NUMBER: 16, DOCUMENT NUMBER: 17). |
| If DQA not available, please briefly describe plans to establish mechanisms for data quality assessment. |
| Report already attached. |
| Please indicate what routine mechanisms to independently assess the quality of administrative data are in place, and if so what these mechanisms are and how they enable the country to track changes in data quality over time. |
| The EPI does not have a mechanism to independently assess data quality, but there are internal data-assessment mechanisms at every level: EPI data validation meetings and data quality self-assessments (DQS) at the health zone (HZ) level. |
| Please detail what household surveys have been conducted in recent years to independently assess immunisation coverage and equity, and describe any survey plans for the coming five year period. |
| * Surveys conducted: 2010 MICS, 2012 WHO/UNICEF Immunisation Coverage Survey, 2013-2014 EDS, 2014 SARA
* Surveys planned for the coming months: 2015 MICS, 2016 WHO/UNICEF Immunisation Coverage Survey, 2018 EDS.
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| **5.2 Baseline and Annual Targets (NVS Routine Support)** |

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| NVS routine support is not requested. |

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| **5.3. Targets for Preventive Campaign(s)** |

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| **5.3.1 Targets (Meningococcal A campaign)** |

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| Mini catch-up campaigns will be introduced at the same time as routine EPI. Gavi will support one-time mini catch-up campaigns with Meningococcal A conjugate vaccine targeting cohorts born between the initial mass campaign and introduction of routine infant vaccination in all 26 endemic countries in the African meningitis belt. The exact age range will depend on the specific country epidemiology and situation, although the target number to be reached should be included in table 5.3.1. |

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| Cohort for Meningococcal A via mass preventative campaigns is population 1-29 years old |

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| **Table 5.3.1 Baseline NVS campaign figures for Meningococcal A** |

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| **Number** | **Targets: preventative mass campaigns** |
| **2015** | **2017** | **2018** | **2019** |
| **Total target population** | 17,915,493 |  |  |  |
| **Wastage rate (%) for Meningococcal A (campaign)**  | 10 |  |  |  |

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| **Number** | **Targets: mini catch-up campaigns** |
| **2016** | **2017** | **2018** | **2019** |
| **Total target population** | 0 | 0 | 0 | 0 |
| **Wastage rate (%) for Meningococcal A (campaign)**  | 0 | 0 | 0 | 0 |

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| **6. 6. New and Under-Used Vaccines (NVS Routine)** |

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| NVS routine support is not requested. |

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| **7. 7 NVS Preventive Campaign** |

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| **7.1. Assessment of burden of relevant diseases related to campaigns (if available)** |

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| **Disease** | **Title of the assessment** | **Date** | **Results** |
| Bacterial Meningitis | Meningitis surveillance in DRC and characteristic elements of high-risk zones for introduction of MenAfriVac | September 2012 | “The DRC is one of the 26 countries in the vast meningitis belt that have an increased risk of meningitis A. However, only part of the country is in the belt. The north and northeast zones are considered to be high-risk due to their climate characteristics and geographic proximity with other countries in the meningitis belt. As part of IDSR, 6 years of cumulative data from 2009 to 2014 indicate that the total number of suspected meningitis cases was 47,095 with 4,789 deaths, which is a case fatality rate of 10.2%. The incidence rate based on suspected cases shows that meningitis is prevalent in the following provinces: Equateur, Orientale, Maniema, Kasai-Oriental, and Katanga. However, due to the absence of systematic laboratory confirmation, it is not possible to attribute these higher rates to a specific germ or serogroup. Analysis of sentinel site data since 2009 provides information that concerns only a portion of the country but is nevertheless important. The three sentinel sites, where laboratory confirmation is done systematically, are located in the Kinshasa and Katanga provinces. The data shows that pneumococcus is clearly predominant and that meningococcus is primarily the group C type. Only one source of meningitis A was detected in Katanga in 2012 through rapid diagnostic tests that were not confirmed through culture or the PCR method (see table). Serogroup A is therefore not a major problem in these two provinces. Consequently, they have not been included in the initial campaign strategy. The key factor in determining the priority locations for immunization was a review of investigated and confirmed epidemics where the bacterium was confirmed. Fatal epidemics of serogroup A were documented in Orientale, Nord-Kivu and Sud-Kivu provinces. Orientale province also reported the highest number of epidemic episodes between 1994 and 2011. Based on this factual data, DRC is planning to organize a preventive campaign in these three provinces first. This will establish the southern boundary of the immunological front for the African regional strategy to eliminate meningitis A epidemics. It should be noted that the risk assessment conducted in DRC in 2012 was inconclusive concerning the location of a possible preventive campaign. Based on data collected during this risk assessment and after re-analyzing and updating this data, the EPI notes that the absence of laboratory-confirmed data still poses a challenge for optimal interpretation, but the campaign in the priority zones is justified given the risk and the considerable burden of this disease. WHO approved this approach during a consultation mission in January 2015.Thus, it is essential to increase surveillance, especially in the other non-eligible provinces, to acquire more evidence of the presence of group A meningococcus. The EPI’s 2015-2019 cMYP plans to extend the sentinel sites to Kananga and Kisangani to obtain more representative data from the sites.” |

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| Please attach the Plan of Action for each campaign as Documents No. 30 and 29 in Section 10. |

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| **7.1.1 Epidemiology and disease burden for Meningococcal A** |
| Please select at least one of the following information sources to justify Meningococcal A disease burden results: |
| Epidemiological information on burden of disease: |
|  | 1 - Risk assessments |
|  | 2 - Other |
|  | * Integrated disease surveillance data
* Data from sentinel surveillance of bacterial meningitis in pediatric environments
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| **7.2. Request for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, campaign support** |
| **7.3.1. Summary for Meningococcal A campaign support** |
| When is the country planning to conduct the Meningococcal A catch-up campaign? September 2015 **From September 21-30, 2015** |
| When is the country planning to conduct an immunization campaign? **From September 21-30, 2015** |
| Please give a summary of the cMYP and/or the Meningococcal A conjugate vaccine, 10 dose(s) per vial, LYOPHILISED introduction plan sections that refer to the introduction of Meningococcal type A, 10 dose(s) per vial, LYOPHILISED. Outline the key points that informed the decision-making process (data considered etc.) and describe the plans for social mobilisation and micro-planning, including strategies for insecure or hard-to-reach areas. If they are included in the introduction plan or plan of action, please cite the sections only. |
| DRC plans to conduct a high-quality campaign with the following characteristics:* Campaign preparations will start on time (at least 6 months prior);
* High-quality training provided in advance for personnel at the intermediary and operational levels (develop training modules, hold trainings at every level from the central to the operational level);
* Continuous supply of vaccines and injection supplies;
* Bottom-up micro-planning starting at the health area level, focusing on unvaccinated or under-vaccinated children (village-to-village micro-planning approach);
* Health area microplans consolidated at the health zone level;
* Local microplans validated and timely feedback provided (within at least 3 months) at every level and budget adjusted accurately if possible;
* Detailed logistics and cold chain plan developed and implemented;
* Supervisors with adequate profiles deployed to the health zones in time (at least 7 days before campaign);
* Supervisors will conduct quick surveys on convenience during the campaign;
* A post-campaign survey will be conducted looking at reasons why target population did not get vaccinated;
* Good coordination and leadership at the national, provincial and health zone levels before, during and after the campaign;
* Local political-administrative authorities and community leaders involved in social mobilization activities prior to launching activities.
 |
| Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain and other logistic requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. Please describe how the surge capacity for campaigns will be managed. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled. The Independent Review Committee (IRC) requires a certain level of assurance that the cold chain is ready or will be ready for the campaign, and evidence/plans need to be provided (if they are included in detail in the plan of action, please cite the section here). New Requirement: As approved by Gavi in June 2014 all future proposals (2015 and beyond) that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure pre-qualified equipment by WHO under their Performance Quality and Safety (PQS) programme. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi. Please note that all Gavi-financed cold chain equipment must be pre-qualified by WHO. The purchase of non-PQS equipment will only be considered on exceptional basis, with justification and advance agreement from GAVI. |
| The purchased equipment already available in the country (220 refrigerators) will be deployed to Orientale, Nord Kivu and Sud Kivu provinces starting in March 2015 based on their needs. Current storage capacity at the central level is 143 m3 cold storage and 40 m3 freezer storage.For vaccine distribution, the supply schedule will be based on the current storage capacity at the central level.  |
| Please describe any plans for expanding measles surveillance to include rubella and plans for the introduction of Congenital Rubella Syndrome (CRS) surveillance. |
| Activities to improve routine EPI include:* Micro-planning at the grassroots level, village by village, which will help update immunization targets for each immunization zone
* Advocacy and community outreach activities to promote immunization
* Increasing cold chain capacity at every level
* Building the capacities of healthcare personnel through briefings and various forms of supervision
* Catching up children who were not vaccinated or under-vaccinated as part of routine EPI during mass campaigns
 |
| Please submit relevant documentation to support the estimates of the size of the campaign target population (DOCUMENT NUMBER: 23).  |

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| **7.2.2. Grant Support for Operational Costs of the Meningococcal A Campaign**  |

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| **Table 7.2.2: calculation of grant to support the operational costs of the campaigns (mini catch up campaigns and mass campaigns)** |

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| **Year of Meningococcal A support**  | **Total target population (from Table 5.3)**  | **Gavi contribution per target person in US$**  | **Total in US$** |
| 2015 | 17,915,493 | 0.65 | 11,645,070 |
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| *[1]* The Grant will be based on a maximum award of $0.65$ per target person- (synergies between mass campaigns, mini catch up campaigns and routine immunisation need to be highlighted. There will be common activities such as training across the new introductions). |

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| Please describe how the vaccine introduction grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population in advance of and during introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).  |
| The grant will be used for: * Micro-planning
* Revising training and data management tools
* Improving logistics
* Supply distribution
* Cascade training
* Implementing activities
* Supervision
* Increasing surveillance for better results assessment
* Service-provider incentives
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| Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs. |

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| DRC is not planning to use any other funding source for the mass meningitis immunization campaign.  |

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| Please complete the ‘Detailed budget for VIG / Operational costs’ template provided by Gavi and attach as a mandatory document in the Attachment section. This template must describe or list the activities related to mini catch-up campaigns and describe the potential synergies between the VIGs. |
| Detailed budget attached as Document No. 28. |

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| **7.2.3. Meningococcal A Vaccine Introduction Grant** |

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| Has the country introduced the Meningococcal A vaccine in the routine immunization program? **No** |

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| **Calculation of Vaccine Introduction Grant for the Meningococcal A conjugate vaccine, 10 dose(s) per vial, LYOPHILISED** |

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| Please indicate in the table below how the one-time introduction grant ***[1]*** will be used to cover the inherent cost of vaccine introduction and essential preparatory activities (refer to the cMYP). If Gavi support is not enough to cover the full needs, please indicate the remaining amount needed in the table below and who will provide the additional funds.  |

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| **Year of New Vaccine Introduction**  | **Births (from Table 5.1)** | **Gavi contribution per target person in US$** | **Total in US$**  |
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| ***[1]*** The Grant will be based on a maximum award of $0.80 per infant in the birth cohort with a minimum starting grant award of $100,000 |

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| Please describe how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).  |
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| **8. Procurement and Management** |

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| **8.1 Procurement and Management of New and Under-Used Vaccines (Routine)** |

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| NVS routine support is not requested. |

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| **8.2 Procurement and Management for NVS Preventive Campaign(s)** |

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| **8.2.1 Procurement and Management for Meningococcal A conjugate vaccine, 10 dose(s) per vial, LYOPHILISED campaign**  |
| 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): |
| DRC will procure the vaccines through the UNICEF circuit. |
| b) Please describe the financial management procedures that will be applied for the management of the preventive campaign cash support, including any procurement to be incurred.  |
| The financial management procedures for Gavi funds in DRC are as follows:* All funds for operational costs go to the Health Ministry’s Financial Management Support Unit (Cellule d'Appui à la gestion Financière - CAG)
* The EPI sends funding requests signed by the EPI Director and the Secretary-General for Health to the CAG
* For purchases exceeding US $150, the CAG instructs the fiduciary (KPMG or GIZ) to solicit bids before the product is procured and delivered to the EPI. The bids are reviewed and the contract is awarded to the best offer.
* Funds to cover operational costs of activities are paid directly into the account of the EPI central office (for activities at the central level) or the accounts of the regional coordination offices or EPI field offices (for activities at the province level).
 |
| c) Please indicate if the campaign will take place in phases. If so, specify how to organize these different phases. |
| The campaign will occur in one phase in September in the three designated provinces. |
| d) Please outline how coverage of the campaign including mini catch up campaigns will be monitored, reported and evaluated (refer to the cMYP and/or the Meningococcal A conjugate vaccine, 10 dose(s) per vial, LYOPHILISED campaign introduction plan). |
| * The various coordinating structures (CLC, CPC, and CNC) will set up a system for regular monitoring of immunization data at the central level and in every province and health zone.
* This data will be sent to the CLC daily.
* The CLCs will compile data from each immunization area and send a summary to the CPC every day after analyzing and confirming the data.
* The CPCs will compile data from the health zones every day and will analyze, confirm and send the data to the CNC.
* Supervisors will conduct internal oversight during the campaign.
* A post-introduction evaluation will be conducted one month after the campaign.
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| **8.3. Product Licensure** |

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| For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines. |

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| *Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.* |

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| The vaccine is already prequalified and approved by WHO. In addition, the MenAfriVac vaccine has already been registered with the Department of Pharmacy and Drugs in the DRC. |

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| For each of the vaccine(s) requested, please provide the actual licensure status of the preferred presentation and of any alternative presentations, if required. |

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| These are 10-dose vials, lyophilized. |

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| Please describe local customs regulations, requirements for pre-delivery inspection, special documentation requirements that may potentially cause delays in receiving the vaccine. If such delays are anticipated, explain what steps are planned to handle these. |

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| The vaccines are tax and duty-free. |

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| Please provide information on NRA in the country, including status (e.g. whether it is WHO-certified). Please include points of contact with phone numbers and e-mail addresses. UNICEF will support the process by communicating licensing requirements to the vaccine manufacturers where relevant. |

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| The NRA has been established and has produced its institutional development plan. It is not yet functioning at optimum level. However, the Department of Pharmacy and Medications is working with WHO and UNICEF to obtain the license to market all the products, including the vaccines. |

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| **8.4 Vaccine Management (EVSM/EVM/VMA)** |

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| It is mandatory for countries to conduct an Effective Vaccine Management (EVM) assessment prior to an application for introduction of new vaccine. This EVM should have been conducted within the preceding 36 months. Please note that this assessment is recommended, but not required for requests for operational support for Supplementary Immunization Activities (SIA) or campaigns.  |

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| When was the EVM conducted? **September 2014** |

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|  The improvement plan should include a timeline, a budget of committed resources for these activities and funding gaps, if any, as well as M&E indicators to monitor progress of implementation. |

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| If any of these required documents (EVM Assessment Report, EVM improvement plan, EVM improvement plan progress report) is not available, please explain why and refer to other documents such as the post-introduction evaluation and external EPI reviews. |

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| When is the next Effective Vaccine Management (EVM) Assessment planned? **September 2017** |

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| All the documents are attached. |

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| **8.5. Waste Management**  |

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| Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), and equipment for the safe handling, storage, transportation and disposal of immunisation waste. Please describe the country’s waste management plan for immunisation activities (including campaigns). |
| Lessons learned from previous measles campaigns will serve as a basis for improving waste management during the meningitis campaign. Concrete actions include:* Conducting a site inventory of incinerators at the various reference hospitals;
* Filling in gaps based on needs identified;
* Capitalizing on training opportunities to remind personnel how to use burn and bury methods;
* Setting up waste management committees at every level;
* Increasing public awareness messages.

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| **9. Additional Comments and Recommendations from the National Coordinating Body (ICC/HSCC)** |

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

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|  | **Decisions made** | **Responsible Entity** |
| **1** | Support the Minister of Health in increasing efforts to lobby the Prime Minister and other members of the government with regard to monitoring the government's commitments to sustained funding. | Secretary-General and partners |
| **2** | Monitor and coordinate grants of vehicles and data transmission equipment for Equateur province during CNP-SS meetings in order to resolve the problem with promptness and incomplete data. | Secretary-General |
| **3** | Ask the Gavi Alliance to transfer the funds linked to IPV introduction to the EPI bank account at Rawbank. | Secretary-General |
| **4** | Disaggregate the data reported from the 11 provinces into 26 DPS (provincial health divisions) | Technical Committee |
| **5** | Reflect on how the DPS should assume the responsibilities of the coordinating bodies and EPI field offices under the current reform | Technical Committee |
| **6** | Reflect on how the DPS should assume the responsibilities of the coordinating bodies and EPI field offices under the current reform | Technical Committee |
| **7** | Reflect on how the DPS should assume the responsibilities of the coordinating bodies and EPI field offices under the current reform | Technical Committee |
| **8** | Present the joint assessment report for Gavi-funded programs at the next ICC meeting  | Technical Committee |
| **9** | Highlight the status of emergency vaccine supplies in the presentation  | Logistics Committee |
| **10** | Highlight logistics forecasts for 2015 in the presentation | Logistics Committee |
| **11** | Include data from the active search for cases (reporting sites) in the presentation  | Oversight Committee |
| **12** | Report data on children recovered by Community Relays / organize civil society based on anticipated number of children | Communication Committee |
| **13** | Highlight the co-financing table in the presentation | Financial Committee |

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| **10. List of documents attached to this proposal** |

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| **10.1. List of documents attached to this proposal** |

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| **Document Number** | **Document** | **Section** | **Mandatory** | **File** |
| 1 | MoH Signature (or delegated authority) of Proposal | 4.1.1 | ..\bl.jpg | Page de signatures des Ministres de la Santé et des Finances.docx**File desc:** MoH signatures page**Date/time:** 24/01/2015 09:47:12**Size:** 70 KB |
| 2 | MoF Signature (or delegated authority) of Proposal | 4.1.1 | ..\bl.jpg | Page de signatures des Ministres de la Santé et des Finances.docx**File desc:** MoF signatures page**Date/time:** 24/01/2015 09:48:48**Size:** 70 KB |
| 3 | MoH signature (or delegated authority) of HPV Proposal | 4.1.1 | ..\bl.jpg | No file uploaded    |
| 4 | Terms of Reference for the ICC | 4.1.2 | ..\bl.jpg | Termes de Référence CCIA \_RDC.pptx**File desc:** Terms of Reference for the ICC/DRC**Date/time:** 24/01/2015 04:29:49**Size:** 70 KB |
| 5 | Minutes of ICC/HSCC meeting endorsing Proposal | 4.1.3 | ..\bl.jpg | Compte tenu rendu reunion CCIA avalisant Proposal.docx**File desc:** Minutes of ICC meeting endorsing Proposal **Date/time:** 24/01/2015 10:41:16**Size:** 70 KB |
| 6 | Signatures of ICC or HSCC or equivalent in Proposal | 4.1.3 | ..\bl.jpg | Compte tenu rendu reunion CCIA avalisant Proposal.docx**File desc:** Minutes of ICC meeting endorsing Proposal**Date/time:** 24/01/2015 10:01:38**Size:** 70 KB |
| 7 | Minutes of the last three ICC/HSCC meetings | 4.1.3 | ..\bl.jpg | CR 3 dernieres Reunions CCIA.zip**File desc:** Minutes of last 3 meetings **Date/time:** 24/01/2015 08:10:59**Size:** 70 KB |
| 8 | A description of partner participation in preparing the application | 4.1.3 | ..\bl.jpg | No file uploaded    |
| 9 | Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign | 4.2 | ..\bl.jpg | No file uploaded    |
| 10 | Role and functioning of the advisory group, description of plans to establish a NITAG | 4.2.1 | ..\bl.jpg | Groupe Technique Consultatif pour la vaccination.docx**File desc:** Technical Advisory Group on Immunization**Date/time:** 24/01/2015 09:35:25**Size:** 70 KB |
| 11 | comprehensive Multi Year Plan - cMYP | 5.1 | ..\bl.jpg | PPAC RDC 2015-2019\_Bukavu 28122014\_VA\_GNM.docx**File desc:** 2015-2019 cMYP / DRC**Date/time:** 24/01/2015 02:39:26**Size:** 4 MB |
| 12 | cMYP Costing tool for financial analysis | 5.1 | ..\bl.jpg | **File desc:** DRC 2015-2019 cMYP costing tool**Date/time:** 24/01/2015 03:09:43**Size:** 4 MB |
| 13 | Monitoring and evaluation and surveillance (M&E) plan for the support requested, within the context of the country’s existing monitoring plan for the EPI programme | 5.1.5 | ..\bl.jpg | Plan d'action MenafriVac 24 01 2015.docx**File desc:** **Date/time:** 24/01/2015 10:58:02**Size:** 4 MB |
| 14 | Vaccine introduction plan | 5.1 | ..\bl.jpg | Plan d'action MenafriVac 24 01 2015.docx**File desc:** **Date/time:** 24/01/2015 11:00:00**Size:** 4 MB |
| 15 | Introduction Plan for the introduction of RCV / JE / Men A into the national programme | W14 | ..\bl.jpg | No file uploaded    |
| 16 | Data quality assessment (DQA) report | 5.1.5 | ..\bl.jpg | Rapport atelier sur la qualite des donnees PEV\_20112014 Final.docx**File desc:** Data quality workshop report**Date/time:** 24/01/2015 08:12:34**Size:** 70 KB |
| 17 | DQA improvement plan | 5.1.5 | ..\bl.jpg | Plan Amélioration Qualité des Données\_Nov.2014xls.xls**File desc:** DQA improvement plan**Date/time:** 24/01/2015 08:13:16**Size:** 70 KB |
| 19 | HPV roadmap or strategy | 6.1.1 | ..\bl.jpg | No file uploaded    |
| 20 | Plan for the introduction of RCV into the national programme | W14 | ..\bl.jpg | No file uploaded    |
| 21 | HPV summary of the evaluation methodology | 5.1.6 | ..\bl.jpg | No file uploaded    |
| 22 | Evidence of commitment to fund purchase of RCV for use in the routine system in place of the first dose of MCV | 7.11. | ..\bl.jpg | No file uploaded    |
| 23 | Campaign target population documentation  | II.1. | ..\bl.jpg | **File desc:** Target population MenAfriVac (2nd worksheet in Excel workbook)**Date/time:** 24/01/2015 03:43:33**Size:** 4 MB |
| 24 | Roadmap or strategy for strengthening a comprehensive approach to pneumonia and/or diarrhoea prevention and treatment | Q6. | ..\bl.jpg | No file uploaded    |
| 25 | EVM report | 8.3 | ..\bl.jpg | RDC EGEV 2014 Rapport Final.pdf**File desc:** 2014 EVM Report / DRC**Date/time:** 24/01/2015 02:32:09**Size:** 4 MB |
| 26 | Improvement plan based on EVM | 8.3 | ..\bl.jpg | Plan d'amélioration de la GEV 2014\_DRC\_cEVM-IP\_vs.2.5.xlsx**File desc:** 2014 EVM Improvement Plan / DRC**Date/time:** 24/01/2015 04:52:34**Size:** 70 KB |
| 27 | EVM improvement plan progress report | 8.3 | ..\bl.jpg | Rapport situation plan amélioration GEV.docx**File desc:** EVM improvement plan progress report**Date/time:** 24/01/2015 09:40:04**Size:** 70 KB |
| 28 | Detailed budget template for VIG / Operational Costs | 7.11. | ..\bl.jpg | **File desc:** **Date/time:** 24/01/2015 11:04:08**Size:** 4 MB |
| 29 | Risk assessment and consensus meeting report for Meningitis / Yellow Fever: (for yellow fever please include information required in the NVS guidelines on YF Risk Assessment process) | 7.1 | ..\bl.jpg | Meningite RDC rias assessment RAPPORT Aout2012.pdf**File desc:** Risk assessment**Date/time:** 24/01/2015 05:59:09**Size:** 70 KB |
| 30 | Plan of Action for campaigns | 7.11. | ..\bl.jpg | Plan d'action MenafriVac 24 01 2015.docx**File desc:** **Date/time:** 24/01/2015 11:02:00**Size:** 4 MB |
|  | Other |  | ..\bl.jpg | Chronogramme AVS MenAfriVac.xlsx**File desc:** MenAfriVac SIA timeline**Date/time:** 24/01/2015 11:05:43**Size:** 70 KB |
| MEO CTC RDC olicomments.docx**File desc:** Implementation of CTC**Date/time:** 24/01/2015 11:06:07**Size:** 70 KB |

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| **11. Annexes** |

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| **Annex 1 - NVS Routine Support** |

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| NVS routine support is not requested. |

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| **Annex 2 - NVS Routine – Preferred Second Presentation** |

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| Routine NVS support not requested / preferred second presentation not requested this year.  |

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| **Annex 3 - NVS Preventive campaign(s)** |

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| **Annex 3.1 - NVS Preventive campaign(s) (Meningococcal A conjugate vaccine, 10 dose(s) per vial, LYOPHILISED)** |
| **Table Annex 3.1 C: Summary table for CAMPAIGN Meningococcal A conjugate vaccine, 10 dose(s) per vial, LYOPHILISED** |

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|  | **Data from** |  | **2016** | **2017** | **2018** | **2019** |
| **Total target population** | Table 5.3.1 | # | 18 452 958 | 19 006 546 | 19 576 743 | 20 104 045 |
| **Number of doses per persons** | Parameter | # | 1 | 1 | 1 | 1 |
| **Wastage rate** | Table 5.3.1 | # | 10 | 10 | 10 | 10 |
| **Estimated vaccine wastage factor** |  | # | 1,11 | 1,11 | 1,11 | 1,11 |
| **Number of doses per vial** | Parameter | # | 10 | 10 | 10 | 10 |
| **AD syringes required** | Parameter | # | Yes | Yes | Yes | Yes |
| **Reconstitution syringes required** | Parameter | # | Yes | Yes | Yes | Yes |
| **Safety boxes required** | Parameter | # | No | No | No | No |
| **AD syringe price per unit** | Table Annexes 4A | $ | 0.0448 | 0.0448 | 0.0448 | 0.0448 |
| **Reconstitution syringe price per unit** | Table Annexes 4A | $ | 0.035 | 0.035 | 0.035 | 0.035 |
| **Safety box price per unit** | Table Annexes 4A | $ | 0.0054 | 0.0054 | 0.0054 | 0.0054 |
| **Freight cost as % of vaccines value** | Table Annexes 4B | % | 12.00 % | 11.00 % | 11.00 % | 10.00 % |
| **Freight cost as % of devices value** | Parameter | % | 0 | 0 | 0 | 0 |

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| **Table Annex 3.1 D: Estimated number of Meningococcal A conjugate vaccine, 10 dose(s) per vial, LYOPHILISED associated injection safety material and related co-financing budget (page 1)** |

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|  |  | **Formula** | **Gavi** |
|  |  |  | **2016** | **2017** | **2018** |
| B | **Total target population** | *Table 5.3.1* | 18 452 958 | 19 006 546 | 19 576 743 |
| C | **Number of doses per persons** | *Vaccine parameter (schedule)* | 1 | 1 | 1 |
| D | **Number of doses needed** | *B X C* | 18 452 958 | 19 006 546 | 19 576 743 |
| E | **Estimated vaccine wastage factor** | *100 / (100 - Vaccine wastage rate)* | 1.11 | 1.11 | 1.11 |
| F | **Number of doses needed including wastage** | *D X E* | 20 482 784 | 21 097 267 | 21 730 185 |
| G | **Vaccines buffer stock** | *0* | 0 | 0 | 0 |
| I | **Total vaccine doses needed** | *Round up((F + G) / Vaccine package size) x Vaccine package size* | 20 483 000 | 21 097 500 | 21 730 500 |
| J | **Number of doses per vial** | *Vaccine parameter* | 10 | 10 | 10 |
| K | **Number of AD syringes (+ 10% wastage) needed** | *(D + G) x 1.11* | 20 482 784 | 21 097 267 | 21 730 185 |
| L | **Reconstitution syringes (+ 10% wastage) needed** | *(I / J) x 1.11* | 2 273 613 | 2 341 823 | 2 412 086 |
| N | **Cost of vaccines needed** | *I x vaccine price per dose (g)* | 13 170 569 | 14 040 387 | 14 967 969 |
| O | **Cost of AD syringes needed** | *K x AD syringe price per unit (ca)* | 917 629 | 945 158 | 973 513 |
| P | **Cost of reconstitution syringes needed** | *L x reconstitution price per unit (cr)* | 79 577 | 81 964 | 84 424 |
| Q | **Cost of safety boxes needed** | *M x safety box price per unit (cs)* | 0 | 0 | 0 |
| R | **Freight cost for vaccines needed** | *N x freight cost as of % of vaccines value (fv)* | 1 540 957 | 1 586 564 | 1 631 509 |
| S | **Freight cost for devices needed** | *(O+P+Q) x freight cost as % of devices value (fd)* | 0 | 0 | 0 |
| T | **Total fund needed** | *(N+O+P+Q+R+S)* | 15 708 732 | 16 654 073 | 17 657 415 |

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|  |  | **Formula** | **Gavi** |
|  |  |  | **2019** |
| B | **Total target population** |  | 20 104 045 |
| C | **Number of doses per persons** |  | 1 |
| D | **Number of doses needed** | *B X C* | 20 104 045 |
| E | **Estimated vaccine wastage factor** | *100 / (100 - Vaccine wastage rate)* | 1.11 |
| F | **Number of doses needed including wastage** | *D X E* | 22 315 490 |
| G | **Vaccines buffer stock** | *0* | 0 |
| I | **Total vaccine doses needed** | *Round up((F + G) / Vaccine package size) x Vaccine package size* | 22 315 500 |
| J | **Number of doses per vial** | *Vaccine parameter* | 10 |
| K | **Number of AD syringes (+ 10% wastage) needed** | *(D + G) x 1.11* | 22 315 490 |
| L | **Reconstitution syringes (+ 10% wastage) needed** | *(I / J) x 1.11* | 2 477 021 |
| N | **Cost of vaccines needed** | *I x vaccine price per dose (g)* | 15 908 720 |
| O | **Cost of AD syringes needed** | *K x AD syringe price per unit (ca)* | 999 734 |
| P | **Cost of reconstitution syringes needed** | *L x reconstitution price per unit (cr)* | 86 696 |
| Q | **Cost of safety boxes needed** | *M x safety box price per unit (cs)* | 0 |
| R | **Freight cost for vaccines needed** | *N x freight cost as of % of vaccines value (fv)* | 1 670 416 |
| S | **Freight cost for devices needed** | *(O+P+Q) x freight cost as % of devices value (fd)* | 0 |
| T | **Total fund needed** | *(N+O+P+Q+R+S)* | 18 665 566 |

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| **Note: There is no co-financing for NVS preventive campaigns** |

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| **Annex 4** |

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| **Table Annex 4A: Commodities Cost** |

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| Estimated prices of supply are not disclosed |

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| **Table Annex 4B: Freight cost as percentage of value** |

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| **Vaccine Antigen** | **Vaccine Type** | **2016** | **2017** | **2018** | **2019** |
| Meningococcal A vaccine, 10 dose(s) per vial, LYOPHILISED | MENINACONJUGATE | 11.70 % | 11.30 % | 10.90 % | 10.50 % |

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| **Table Annex 4C: Low revenue - Minimum country's co-payment per dose of co-financed vaccine.** |

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| **Vaccine** |

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| **Table Annex 4D: Wastage rates and factors** |

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| The following table shows the wastage rates for routine and campaign vaccines, set for 2016.  |

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| **Vaccine** | **dose(s) per vial** | **Maximum Vaccine wastage rate\*** | **Benchmark Wastage Rate \*\*** |
| Yellow Fever, 5 dose(s) per vial, LYOPHILISED | 10 | 40 % |  |
| Yellow Fever, 5 dose(s) per vial, LYOPHILISED | 5 | 10 % |  |
| Meningococcal A vaccine, 10 dose(s) per vial, LYOPHILISED | 10 | 10 % |  |
| Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | 2 | 10 % |  |
| Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | 1 | 5 % |  |
| Rotavirus, 3-dose schedule | 1 | 5 % |  |
| Rotavirus, 3-dose schedule | 1 | 5 % |  |
| Measles, second dose, 10 dose(s) per vial, LYOPHILISED | 10 | 40 % |  |
| DTP-HepB-Hib, 10 dose(s) per vial, LIQUID; | 1 | 5 % |  |
| DTP-HepB-Hib, 10 dose(s) per vial, LIQUID; | 10 | 25 % | 15 % |
| DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED | 2 | 10 % |  |
| JE, 5 dose(s) per vial, LYOPHILISED | 5 | 10 % |  |
| HPV bivalent, 2 dose(s) per vial, LIQUID | 2 | 10 % |  |
| HPV quadrivalent, 1 dose(s) per vial, LIQUID | 1 | 5 % |  |
| MR, 10 dose(s) per vial, LYOPHILISED | 10 | 15 % |  |

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| Comments:  |

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| \* Source: WHO indicative wastage rates  |

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| \*\* Source: Country APRs and studies, approved by WHO, UNICEF, and the Gavi Secretariat  |

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| Note: HPV demonstration project wastage rates are the same as for the national introduction of the vaccine |

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| **Table Annex 4E: Vaccine maximum packed volumes** |

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| **Kindly note that this table is for reference purposes only and includes Gavi- and non Gavi-supported vaccines.** |

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| **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 |  |
| Diphtheria-Tetanus | DT | Liquid | IM | 3 | 10 | 3 |  |
| Tetanus-Diphtheria | Td | Liquid | IM | 2 | 10 | 3 |  |
| Tetanus Toxoid | TT | Liquid | IM | 2 | 10 | 3 |  |
| Tetanus Toxoid | TT | Liquid | IM | 2 | 20 | 2.5 |  |
| Tetanus Toxoid UniJect | TT | Liquid | IM | 2 | Uniject | 12 |  |
| Measles | Measles | lyophilized | SC | 1 | 1 | 26.1 | 20 |
| Measles | Measles | lyophilized | SC | 1 | 2 | 13.1 | 13.1 |
| Measles | Measles | lyophilized | SC | 1 | 5 | 5.2 | 7 |
| Measles | Measles | lyophilized | SC | 1 | 10 | 3.5 | 4 |
| 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 |
| Measles-Rubella freeze dried | MR | lyophilized | SC | 1 | 10 | 2.5 | 4 |
| 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 |
| Measles-Mumps-Rubella freeze dried | MMR | lyophilized | SC | 1 | 10 | 3 | 4 |
| Polio | OPV | Liquid | Oral | 4 | 10 | 2 |  |
| Polio | OPV | Liquid | Oral | 4 | 20 | 1 |  |
| Yellow Fever | YF | lyophilized | SC | 1 | 5 | 6.5 | 7 |
| Yellow Fever | YF | lyophilized | SC | 1 | 10 | 2.5 | 3 |
| Yellow Fever | YF | lyophilized | SC | 1 | 20 | 1.5 | 2 |
| Yellow Fever | YF | lyophilized | SC | 1 | 50 | 0.7 | 1 |
| DTP-HepB combined | DTP-HepB | Liquid | IM | 3 | 1 | 9.7 |  |
| DTP-HepB combined | DTP-HepB | Liquid | IM | 3 | 2 | 6 |  |
| DTP-HepB combined | DTP-HepB-Hib | Liquid | IM | 3 | 10 | 3 |  |
| Hepatitis B | HepB | Liquid | IM | 3 | 1 | 18 |  |
| Hepatitis B | HepB | Liquid | IM | 3 | 2 | 13 |  |
| Hepatitis B | HepB | Liquid | IM | 3 | 6 | 4.5 |  |
| Hepatitis B | HepB | Liquid | IM | 3 | 10 | 4 |  |
| Hepatitis B UniJect | HepB | Liquid | IM | 3 |  | 12 |  |
| Hib liquid | Hib\_liq | Liquid | IM | 3 | 1 | 15 |  |
| Hib liquid | Hib\_liq | Liquid | IM | 3 | 10 | 2.5 |  |
| Hib freeze-dried | Hib\_lyo | lyophilized | IM | 3 | 1 | 13 | 35 |
| Hib freeze-dried | Hib\_lyo | lyophilized | IM | 3 | 2 | 6 |  |
| Hib freeze-dried | Hib\_lyo | lyophilized | IM | 3 | 10 | 2.5 | 3 |
| DTP liquid + Hib freeze-dried | DTP+Hib | liquid+lyop. | IM | 3 | 1 | 45 |  |
| DTP-Hib combined liquid | DTP+Hib | liquid+lyop. | IM | 3 | 10 | 12 |  |
| 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 |  |
| DTP-HepB-Hib liquid | DTP-HepB+Hib | liquid+lyop. | IM | 3 | 2 | 11 |  |
| 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 |
| Meningitis A/C | MV\_A/C | lyophilized | SC | 1 | 50 | 1.5 | 3 |
| Meningococcal A/C/W/ | MV\_A/C/W | lyophilized | SC | 1 | 50 | 1.5 | 3 |
| Meningococcal A/C/W/Y | MV\_A/C/W/Y | lyophilized | SC | 1 | 10 | 2.5 | 4 |
| Meningitis W135 | MV\_W135 | lyophilized | SC | 1 | 10 | 2.5 | 4 |
| Meningitis A conjugate | Men\_A | lyophilized | IM | 1 | 10 | 2.6 | 4 |
| Japanese Encephalitis | JE\_lyo | lyophilized | SC | 1 | 5 | 2.5 | 2.9 |
| Rota vaccine | Rota\_liq | Liquid | Oral | 2 | 1 | 17.1 |  |
| Rota vaccine | Rota\_liq | Liquid | Oral | 3 | 1 | 45.9 |  |
| Pneumococcal conjugate vaccine, 10-valent. | PCV-10 | Liquid |  | 3 | 1 | 11.5 |  |
| Pneumococcal conjugate vaccine, 10-valent. | PCV-10 | Liquid | IM | 3 | 2 | 4,8 |  |
| Pneumococcal conjugate vaccine, 13-valent. | PCV13 | Liquid | IM | 3 | 1 | 12 |  |
| Polio inactivated | IPV | Liquid | IM | 3 |  | 107.4 |  |
| Polio inactivated | IPV | Liquid | IM | 3 | 10 | 2.5 |  |
| Polio inactivated | IPV | Liquid | IM | 3 | 1 | 15.7 |  |
| Human Pappilomavirus vaccine | HPV | Liquid | IM | 3 | 1 | 15 |  |
| Human Pappilomavirus vaccine | HPV | Liquid | IM | 3 | 2 | 5.7 |  |
| Monovalent OPV-1 | PVC13 | Liquid | Oral |  | 20 | 1.5 |  |
| Monovalent OPV-3 | Penta/OPV3 | Liquid | Oral |  | 20 | 1.5 |  |

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| **12. Banking Form** |

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| In accordance with the decision on financial support made by the Gavi, the Government of Democratic Republic of Congo (Kinshasa) hereby requests that a payment be made via electronic bank transfer as detailed below: |  |
|  |  |  |  |  |
| **Name of Institution (Account Holder):** | Expanded Program on Immunization |  |
|  |  |  |
|  |  |  |  |  |
| **Address:** | Avenue de la Justice n°32, Commune de la Gombe |  |
| **City Country:** | Kinshasa, Democratic Republic of Congo |  |
| **Telephone no.:** | +243 81 61 79 384 | **Fax no.:** |  |  |
|  | **Currency of the bank account:** | USD |  |
| **For credit to:** |  |  |  |  |
| **Bank account's title:** | GAVI EPI |  |
| **Bank account no.:** | 01009961101-45USD |  |
| **Bank's name:** | RAWBANK |  |
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| Is the bank account exclusively to be used by this program? True |

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| By who is the account audited? CAG |

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| Signature of Government's authorizing official |

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| --- | --- | --- |
|  |  | **Seal** |
| **Name:** | Audry MULUMBA wa KAMBA |  |
|  |  |  |
| **Title:** | EPI Director |  |
|  |  |  |
| **Signature** |  |  |
|  |  |  |
| **Dated:** | 24/01/2015 |  |

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| **FINANCIAL INSTITUTION** |
|  |
| **Bank Name:** | RAWBANK |
| **Branch Name:** | KINSHASA |
| **Address:** | 3487, BLD DU 30 JUIN-KINSHASA/GOMBE |
| **City Country:** | Kinshasa, Democratic Republic of Congo |
| **Swift Code:** | RAWBCDKI |
| **Sort Code:** |  |
| **ABA No.:** |  |
| **Telephone No.:** | +243998015907 |
| **Fax No.:** |  |

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| **CORRESPONDENT BANK** |
| **(In the United States)** |
|  | CITIBANK |
|  | NEW YORK |
|  |  |
|  | SOCIETE GENERALE |
|  | NEW YORK BRANCH |
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| I certify that the account No. 01009961101-45USD is held by The Expanded Program on Immunization 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:** | Audry MULUMBA wa KAMBA |
|  | **Title:** | EPI Director |
|  |  |
| **2** | **Name:** | KAWENDE FATUMA |
|  | **Title:** | EPI Director of Administration and Finance |
|  |  |
| **3** | **Name:** |  |
|  | **Title:** |  |

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| --- |
| **Name of bank's authorizing official** |
|  |
| **Signature:** |
|  |
|  |
| **Date:** | 24/01/2015 00:00:00 |
| **Seal:** |
|  |
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