Gavi NVS Application Form

Submitted by

The Government of

Cameroon

Date of submission: **27 September 2016**

Deadline for submission:

i. **09 September 2016**
ii. 1 May 2015
iii. 9 September 2015

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

Start Year	2015	End year	2019

Form revised in 2016

(To be used with guidelines dated November 2015)

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

Gavi ALLIANCE GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by Gavi 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 Gavi. All funding decisions for the application are made at the discretion of the Gavi Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application. Gavi 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 Gavi 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 Gavi, within sixty (60) days after the Country receives Gavi 's request for a reimbursement and be paid to the account or accounts as directed by Gavi.

SUSPENSION/ TERMINATION

Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purposes other than for the programmes described in this application, or any Gavi-approved amendment to this application. Gavi reserves the right to terminate its support to the Country for the programme(s) described in this proposal if Gavi receives confirmation of misuse of the funds granted by Gavi.

ANTI-CORRUPTION

The Country confirms that funds provided by Gavi 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 Gavi, as requested. Gavi 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 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 Gavi 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 Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with Gavi 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 Gavi arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either Gavi 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 Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: Gavi, the Vaccine 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.

Gavi will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

1. Type of support requested

Please specify the type of Gavi support you would like to apply for.

Type of Support	Vaccine	Start Year	End year	Preferred second presentation[1]
Routine New Vaccines Support	Measles-Rubella, 10 dose(s) per vial, LYOPHILISED, second dose	2017	2019	

[1] If, for a variety of reasons, the country's first product preference might only be available in limited quantities or be 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 postpone introduction until the first preference is available. It should be noted that this may delay the introduction in the country.

2. Contents

3. Executive Summary

Please provide a summary of your country's proposal, including the following the information:

- For each specific request, NVS routine support or NVS campaign:
  - Duration of support
  - The total amount of funds requested
  - Characteristics of vaccine(s), if necessary, and the reason for presentation choice
  - Month and year planned for vaccine introduction (including campaigns and routine immunisations)

- Relevant baseline data, including:
  - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Target population determined based on the evaluation of yellow fever and meningitis A risk
  - Birth cohort, targets and immunisation coverage by vaccines

- Country preparedness
  - Summary of planned activities to prepare vaccine launch, including EVM assessments, progress with regard to EVM improvement plans, communication plans, etc.
  - Summary of the EVM assessment report and progress report on the implementation of improvement plan

- The nature of stakeholders' participation in developing this proposal
  - Interagency Coordination Committee (ICC)
  - i Partners, including CSO involvement

Measles and rubella are serious, contagious diseases with dramatic consequences. However these diseases can be eradicated by immunisation. Every year, nearly three million lives are saved worldwide by immunisation, and more than 750,000 children escape disabling effects of infectious diseases. In order to reduce morbidity and mortality attributed to these diseases, Cameroon proposes introducing the second dose of the combined measles and rubella (MR) vaccine into its national immunisation programme in 2017.

The second dose of the related measles-rubella (MR) vaccine will be introduced into the systematic immunisation calendar in July 2017 for children 15 months of age, as determined by the epidemiology of the country. The introduction of the second dose of MR is based on lessons learned from supplemental immunisation activities related to measles immunisation and the prior introduction of new vaccines. The country is able to fund the cost of the rubella component of the MR vaccine. Cameroon has always honoured its obligations regarding co-funding with Gavi, in spite of delays that generally are due to the process of releasing funds.

This second dose, in addition to the introduction of the combined vaccine for children 9 months of age in the vaccine calendar in November 2015, will allow the country to: (i) improve mothers' and children's health; (ii) attain and maintain the goal of elimination of measles; (iii) limit the incidence of congenital deformities due to rubella; and (iv) accelerate progress toward controlling these two potentially fatal diseases

Cameroon has had extensive experience with the introduction of new vaccines since 2004. Plans for rehabilitation of cold chain equipment and improving gaps in EVM were prepared in 2014 and the implementation of activities is in progress, with partner support. In addition, Gavi has awarded supplemental funding of USD 900,000 to enhance storage capacity at the national level and to replace certain outdated equipment in four regions. In the context of Health System Strengthening (HSS) and the supply chain optimisation platform, the gradual replacement of non-standard refrigerators starting in the second half of 2017.

The Minister approved the decision to introduce MR 2 and ordered the implementation of preparatory activities with a schedule shared with partners. A multi-disciplinary group will be put in place upon approval of the grant application to carry out all planned preparatory activities, including: review of EPI vehicles and the

production of training and communication support modules, cascade training of providers and communication focal points, social mobilisation and the availability of vaccine at health care facilities before launch.

The only risk/challenge determined for this introduction is parents' refusal of an additional injection outside of the EPI targeted diseases. The training of health providers and communication focal points regarding the importance of this additional dose, as well as the awareness of communities will allow this challenge to be overcome.

4. 3. Signatures

4.1. Signatures of the Government and National Coordinating Body

4.1.1 The Government and the Inter-Agency Coordinating Committee (ICC) for immunisation

The Government of Cameroon wishes to consolidate the existing partnership with Gavi to strengthen its national routine infant immunisation programme and is specifically requesting Gavi support for:

Measles-Rubella, 10 dose(s) per vial, lyophilised, second dose systematic introduction

The Government of Cameroon agrees to develop national immunisation services on a sustainable basis in accordance with the 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.

Table(s) 6.2.4 in the NVS Routine section of this application show(s) the amount of support in either supply or cash that is required from Gavi. Table(s) 6.2.3 of this application show(s) the Government financial commitment for the procurement of this new vaccine (NVS support only).

Following the regulations of the internal budgeting and financing cycles the Government will release its portion of the co-financing funds in the month of **December**.

The payment of the first year of co-financed support will be due around **September 2017** for Measles-Rubella, 10 doses per vial, LYOPHILISED, second dose.

It should be noted that any request not signed by the Ministers of Health and Finance, or by their authorised representatives, will not be examined or recommended for approval by the Independent Review Committee (IRC). These signatures appear in Documents Nos.: 2 and 1 in Section 10. Attachments

Minister of Health (or authorised representative)		**Minister of Finance (or authorised representative)**	
Name	Mr. André MAMA FOUDA	**Name**	Mr. Alamine OUSMANE MEY
Date:		**Date:**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted by the Gavi Secretariat if additional information related to this proposal is required):

Full name	Position	Telephone	Email
Dr. Marie KOBELA	Permanent Secretary of the EPI	237/22 23 09 42 - 99 56 74 25	gtc_pev@yahoo.fr - mariekobela2006@yahoo.fr
Dr. NIMPA Marcellin	FP/Surveillance-WHO	237/77 87 73 87 - 22 21 02 58	nimpam@who.int
Dr. NNOMO Awondo ONAMBANY Elise Clarisse	Immunisation Officer - EPI/Unicef	237/698678703 - 690 44 32 60	ennomoawondo@unicef.org
Dr. NSANGOU Charles	Assistant Permanent Secretary of the EPI, at	237/677 47 60 20	charlesnsangou@yahoo.fr
Dr SUME Gerald Etapelong	FP/Routine EPI-WHO	237/698 81 51 24 - 22 21 02 58	sumeetapelongg@who.int

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

Agencies and partners (including development partners and civil society organisations) supporting immunisation services are coordinated 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 ISS and NVS routine support and/or campaign support. Please provide information about the ICC, HSCC, or equivalent committee in your country in the table below.

Profile of the ICC, HSCC, or equivalent committee

Name of the committee	Inter-agency Coordinating Committee for immunisation (ICC)
Year of establishment of the current committee	2002
Organisational structure (e.g., sub-committee, stand-alone)	Independent committee
Frequency of meetings	4 statutory meetings per year

The Terms of Reference or Standard Operating Principles for the ICC, including details on the ICC membership, quorum, dispute resolution process and meeting schedules are presented in the attached document (Document No.: 4) .

Major functions and responsibilities of the ICC/HSCC:

The mission of the ICC is to define major directions and general objectives of the Expanded Programme on Immunisation

In this regard, the ICC shall in particular be responsible for:

- Preparing and implementing the national Expanded Program on Immunisation policy
- Coordinating, harmonizing and overseeing the consistency of all the actions of the various partners
- Adopting the Expanded Program on Immunisation's annual action plans and the associated budgets
- Mobilizing the resources necessary for the Expanded Program on Immunisation's activities
- Coordinating and tracking the implementation of the activities from the various Expanded Program on Immunisation's components
- Tracking the performance of the action plans
- Evaluating the implementation of the Expanded Programme on Immunisation

Please describe the type of support offered by the different partners in the preparation of this request:

This proposal was prepared by the Technical Advisory Group of the Expanded Programme on Immunisation (CTG-EPI), in collaboration with the partners (WHO, Unicef, CHAI, CDC and AMP) and proposed to the ICC which includes all the related ministries, multi- and bi-lateral partners, Civil Society Organisations for validation. The plan for introduction prepared in 2014 was updated by the EPI and proposed to the partners for validation. Then, the form was filled out online and the data generated were validated during a working meeting of EPI personnel and partners.

4.1.3 4.1.3. Signature Table for the Coordinating Committee for Immunisation

We, the undersigned members of the ICC, HSCC or equivalent committee *[1]* met on **Sept. 2, 2016** to review this proposal. At that meeting, we approved this proposal on the basis of the attached supporting documentation. The minutes of this meeting are attached as document number 5. The signatures confirm the request presented in document 6 (please use the list of signatures in the section below).

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

Position	Title/Organisation	Name	Please sign below to indicate your attendance at the meeting during which the proposal was discussed.	Please sign below to indicate your endorsement of the minutes of the meeting during which the proposal was discussed.
Chair	Ministry of Public Health	Mr. André MAMA FOUDA		
Secretary	Permanent Secretary of the CTG-EPI	Dr. Marie KOBELA		

Members	ICC Director of Family Health	Fr. Robinson MBU		
	WHO-Cameroon Representative / Vice-President	Dr. ROUNGOU Jean Baptiste		
	Unicef-Cameroon representative	Mrs. Félicité TCHIBINDAT		
	Health Advisor/French Embassy	Mrs. Caroline COMITI		
	CHAI Country Director	Mr. Divine NZUOBONTANE		
	CDC	Dr. Omer PASI		
	Cameroon Red Cross	William ETEKI MBOUMOUA		
	Pasteur Centre in Cameroon	Dr. GUY VERNET, Director		
	National Polio Experts Committee	Pr. TETANYE EKOE		
	Catholic Organisation for Health in Cameroon	Dr. Marius Macaire BILOA		
	Association Culturelle Islamique du Cameroun	Mr. ISSA DANAMOU		
	Platform of the civil society organisation for the Promotion of Immunisation and Health System Strengthening	Mr. Bertrand KAMPOER		

By submitting the proposal, we confirm that a quorum was present. **Yes**

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

4.2. National Immunisation Technical Advisory Group NITAG

Has a NITAG been established in your country? **No**

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

5. 5 Data on the immunisation program

5.1 Reference material

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.

- Please refer to the Comprehensive Multi-Year Plan (cMYP) for Immunisation (or equivalent plan), and attach a complete copy with an executive summary (DOCUMENT NUMBER 9). Please also attach the cMYP costing tool (DOCUMENT NUMBER 10).
- Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NUMBER : 12
- Please refer to the two most recent joint WHO/UNICEF reports on immunisation 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.

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

	Figure	Year	Source
Total population	21,917,602	2015	General Survey of Housing and Population (GSHP 2005)
Birth cohort	986,292	2015	GSHP 2005
Infant Mortality Rate	103	2013	National Institute of Statistics, Ministries of Finance, BUCREP
Surviving infants*[1]*	832,869	2015	GSHP 2005
GNI per capita (US$)	1,182	2013	National Institute of Statistics, Ministries of Finance, BUCREP
Total Health Expenditure (THE)	728,108	2012	National Health Accounts - 2012 (CNS)
General government expenditure on health (GGHE) as % of general government expenditure	5	2012	National Health Accounts - 2012 (CNS)

[3] Surviving children = children who survived the first 12 months of life

5.1.1 Lessons learned

Support for new routine vaccines

If new or underused vaccines have already been introduced in your country, please complete in detail the lessons learned from previous introduction(s), specifically for: storage capacity, protection against accidental freezing, personnel training, cold chain, logistics, coverage and decrease in rates, wastage rates, etc. and propose areas of action or indicate the measures taken to address them. Please refer to the previous post-introduction evaluation (PIE) report, if necessary. If they are included in the introduction plan, please cite the section only. If this information is already included in the NVIP/AP, please refer to the document and the section/page where this information can be found.

Lessons learned	Actions
The recent introduction of new vaccines (PCV-13 in 2011, Rotarix and HPV in 2014 and IPV in 2015) into the routine expanded programme on immunisation in Cameroon has allowed us to learn the following lessons: - the need to assess storage capacity; - the need for strengthening of storage capacity; - the need to strengthen skills of stakeholders at all levels in the EPI in general, and in particular supply chain management for vaccines and supplies; - the need to strengthen communication activities; - the need to integrate other Ministries, Civil Society and the private sector; - the need to monitor dropout rates and wastage rates; - the need to assess implementation of the introduction;	- To ensure the implementation of Effective Vaccine Management (EVM) recommendations; - Gradual enhancement of storage capacity at all levels; - Conducting an inventory of cold chain equipment; - Training agents in vaccine supply chain and EPI management; - Oversee immunisation actors at all levels; - Conduct communication activities directed at officials, opinion leaders and the population. - Monitor drop out and wastage rates at all levels; - Conduct a post-introduction survey.

5.1.2- Planning and budgeting of health services

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

Planning in Cameroon is framed in the 2015-2027 Sectoral Health Strategy (SSS) and the 2015-2020 National Health Development Plan (NHDP) which define the major strategic directions with regard to health. Considering the NHDP, each technical directorate or priority programme prepares multi-year and annual plans. The budget preparation process is yearly. Several stages follow before being adopted by parliament.

Please indicate the name and date of the relevant planning document for health

2015-2027 Sectoral Health Strategy

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

The national planning and budgeting cycle for health action plans is five years (NHDP) and annual (Annual Work Plan of the Min. of Health).

Please indicate the national planning cycle for immunisation

The national planning cycle for immunisation is five years and yearly, and it is prepared based on the EPI Comprehensive Multi-year Plan; yearly plans are prepared.

5.1.3 Gender and equity

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).

The bottlenecks, which are directly related to geographical and socio-economic inequalities in accessibility to immunisation services, vary in nature and intensity depending on the health system.

At the operational level, we can observe weak implementation of the "Reach each District" approach (2013 EPI external review report). The direct consequence of this is an irregular immunisation service offer with unsatisfactory quality. Indeed, less than 50% of the health facilities carry out immunisation on a daily basis and offer outreach immunisation services. Supervision of the health personnel at the operational level (health districts and areas) and the meetings for coordination and/or review of immunisation data were not sufficiently implemented, throughout the country. There are five separate special population groups, that are difficult to access and marginalised in Cameroon, characterised by their lifestyles, cultures or even the fact that they are in particularly isolated areas. These populations often are not officially included (Assessment report for the poliomyelitis epidemic response in Cameroon, 2014). The health indicators in these zones reflect difficult access to health services in general and to immunisation in particular, with a percentage of children having received the 3rd dose of DTP at around 45%, compared to a national average of 65%[1].

1. The Mbororos community is made up of nomadic livestock herders spread out over the country, with strong concentrations in the northern and southern parts of Cameroon. They are estimated at more than 60,000 persons. They live in certain parts of the Adamawa, East, Northwest, West and Far North regions, and along the borders with Nigeria, Chad, and the Central African Republic. They generally live in the bush, far from sedentary peoples, making their access to basic health services difficult.
2. The Pygmy communities are divided into three distinct groups: the Bakas, the Bagyelis and the

Bedzan. They are distinguished by their lifestyles marked by the conservation of their ancestral traditions and their attachment to the forest, from which they obtain all their food and their pharmacopoeia.[2] The distances that separate their camps from the health facilities represent an obstacle to their access to health services.

- Les Bakas are the most numerous group, with nearly 40,000 people in the East and South of the Country. In the South region, they can be found in the Dja-et-Lobo Department and in the Djoum, Mintom and Oveng arrondissements. In the East province, they can be found in the Boumba-et-Ngoko, Haut-Nyong and Kadey Departments. Some of the Baka cross national borders, as they live in the Sangha Trinational area, more specifically between the Boumba-et-Ngoko, Dja-et-Lobo and Haut-Nyong Departments in Cameroon.
- The Bagyelis, whose population is estimated at around 3700, are spread out over the Bipindi, Lolodorf, Akom II, Kribi and Campo arrondissements.
- The Bedzang, numbering about a thousand, are located in the Ngambé-Tikar arrondissement.

4. The "Kirdi" communities are mountain peoples.. They live in the Mandara Mountains, in the Far North region, specifically in the Tokombéré, Mora and Kolofata arrondissements. Their exact number is not known.

5. The insular communities of the islands at the mouth of the Wouri River: Djéballé (1000 inhabitants), Manoka (20,000 inhabitants) and Cap Cameroon (3000 inhabitants), and the peninsulas of Bakassi, Erong and Akwabana in the Southwest region at the border between Cameroon and Nigeria.

The "refugee" populations: Due to conflicts in the neighbouring countries, there has been a massive influx of refugees estimated at about 290,000 people in 2015, in the northern regions and in the East. The number of refugees could increase significantly along with the sub-regional terrorist threat of Boko Haram.

6. The populations in zones of insecurity: Three Departments of the Far North region are concerned (Logone and Chari, Mayo Sava and Mayo Tsanaga); 11 health districts (Kousseri, Goulfey, Mada, Makary, Mora, Kolofata, Koza, Mokolo, Mogodé and Bourha). In the East region, the health districts bordering the CAR are the most concerned (Garoua Boulaï, Kette, Ndelele, Batouri, Yokadouma, Moloundou).

[1] National Institute of Statistics (NIS) and ICF. International. 2012. Demographic and Health Surveys and Multiple Indicator Survey of Cameroon 2011. Calverton, Maryland, USA : INS and ICF International.

[2] The Rights of Indigenous Peoples in Cameroon, Supplementary Report submitted following the third periodic report of Cameroon, 54th ordinary session, October 2013, Banjul, Gambia

Please examine whether questions of equity (socio-economic, geographic and gender-specific factors) have been taken into consideration in the process of preparing social mobilisation strategies, among other things, to improve immunisation coverage. Specify whether these issues are addressed in the vaccine introduction plan(s).

Questions of equity have been taken into consideration in the process of preparing social mobilisation strategies, among other things, to improve immunisation coverage via: (i) using community health liaisons to facilitate searching for dropouts; (ii) promotion of immunisation and other disease prevention interventions in children, in partnership with community health liaisons and Civil Society Organisations; (iii) advocacy initiated by the EPI directed at government, traditional, religious leaders and certain elected officials to serve as spokespersons appointed to guide decision-making and actions in order to improve their respective municipalities, community participation and local funding of primary health care, including immunisation.

Please indicate if sex disaggregated data is collected and used in routine immunisation reporting systems.

Immunisation data have been collected and disaggregated by sex since 2015. However no significant difference is noted between the sexes with regard to immunisation.

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 immunisation or campaigns and financing of these activities.

The country is currently in a fragile state (lack of security at borders with Central African Republic and Nigeria, refugees and/or displaced persons due to violence by the Boko Haram sect in the North and conflict in the Central African Republic). This fragile state affects the immunisation programme, planning for the introduction

of systematic immunisation and campaigns. The populations in unsecure zones (eleven health districts in the far North: Kousseri, Goulfey, Mada, Makary, Mora, Kolofata, Koza, Mokolo, Mogodé and Bourha; health districts bordering the Central African Republic in the Eastern region: Garoua Boulaï, Kette, Ndelele, Batouri, Yokadouma, Moloundou) are the most worrisome. Access to these zones is difficult and most of the basic health infrastructure has been destroyed or lack trained personnel.

If possible, please provide additional information and documents on the data relative to sub- national coverage, for example comparisons between urban and rural districts, or between districts with the highest and lowest coverage etc.

In 2015, 67% (i.e. 126/189) of operational health districts had vaccine coverage for Penta 3 > 80%, and 03 health districts (Abo, Ndom in the coastal region and Bali in the Northwest) reported vaccine coverage rates below 50%. Immunisation equity among health districts is low and has even declined vis-à-vis 2014, when a single Health District had coverage below 50%. Cameroon never had more than 80% of its health districts with coverage for Penta 3 > 80% as recommended by the GVAP. Nearly 40% of children that are non- or not fully immunised were surveyed in health districts of major urban centres (Douala and Yaoundé).

5.1.4 Data quality

Please attach a Data Quality Assessment (DQA) filled out during the past 48 months using the most recent national survey, including immunisation coverage indicators (DOCUMENT NUMBER: 27) and an immunisation data quality improvement plan (DOCUMENT NUMBER 11). Subject to availability, a report relative to the progress in implementation of the enhancement plan must also be submitted (DOCUMENT NUMBER: 28, DOCUMENT NUMBER: 11).

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.

An immunisation data quality improvement plan was prepared in early 2015 and it is currently being implemented.

Assessments of the health sector at all levels were planned, with an emphasis on the immunisation system. This will involve conducting community, subnational or national surveys on mother & child health, reviews of the health system or one of the pillars of the health system, integrated monitoring, and independent evaluations of the various Gavi grants. These evaluations will help provide information needed for i) analysis of the situation of the next EPI planning cycles; ii) assess the progress made in reaching immunisation results; iii) assess the effectiveness and efficiency of the different financial allocations and technical assistance intended to reinforce the health system in general and the immunisation sub-system particular.

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.

The recent Multiple Indicator Cluster Survey (MICS) was conducted in Cameroon in 2014 by the National Institute of Statistics (INS), in collaboration with the Ministry of Public Health, in the context of the global MICS programme. For the next five years, the country anticipates conducting the following surveys:

- vaccine coverage survey (ECV) in 2018 and 2020;

- surveys of Knowledge, Attitudes and Practices (CAP) of the population with regard to immunisation in 2018 and 2020.

- Multiple Indicator Demographic Health Survey (EDS-MICS) in 2017;

5.1.5 Measles vaccine coverage

Proof of self-funding MCV1

If the country is not fully funding the monovalent measles vaccine component of the first systematic measles dose (MCV1) with domestic funds,provide proof that the country will be able to respect this requirement as of 2018, by a decision recorded in the minutes of the ICC AND a memo signed by the Minister of Health and the Minister of Finance (attach available documents AS DOCUMENT NUMBER 31 in Section 10. Attachments).

Please provide information on measles vaccine coverage.

Coverage	2013		2014		2015	
	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*	Administrative*(1)*	WUENIC*(2)*
Measles 1*st* dose (%)	83	83	80	80	79	79
Measles 2*nd* dose (%)	0	0	0	0	0	0

Coverage	2013		2014		2015	
	Administrative*(1)*	Coverage Survey	Administrative*(1)*	Coverage Survey	Administrative*(1)*	Coverage Survey
Supplementary Immunisation Activities (SIA) (%)	0	0	0	0	97.77	89.2

Note:

(1) National administrative coverage reported

(2) Estimated national immunisation coverage according to WHO/UNICEF

Do the most recent supplementary immunisation activities (SIAs) relate to administrative coverage or an acceptable survey method?**Administrative coverage**

5.2. 5.2 Baseline data and annual objectives (NVS routine immunisation)

Please refer to cMYP pages to assist in filling in this section.

Number	Base Year	Baseline and Targets		
	2015	2017	2018	2019
Total number of births	986,292	1,036,223	1,062,129	1,088,682
Total number of infant deaths	153,423	161,184	165,214	169,345
Total surviving infants	832,869	875,039	896,915	919,337
Total number of pregnant women	1,095,880	1,150,208	1,178,963	1,208,437
Target population that received the OPV3 vaccine*[1]*	690,881	787,535	816,193	845,790
OPV3 coverage*[2]*	83 %	90 %	91 %	92 %
Target population that received the OPV3 vaccine*[1]*	763,957	848,788	870,008	900,950
Target population that received the DTP3 vaccine*[1]*	702,407	787,535	816,193	845,790
DTP3 coverage*[2]*	84 %	90 %	91 %	92 %
Wastage rate*[3]* during the reference year and planned thereafter (%) for the DTP vaccine	5	6	6	6
	1.05	1.06	1.06	1.06
Target population that received the RCV3 vaccine*[1]*	.0	437,520.0	735470.0	781436.0
RCV2 coverage*[2]*	0 %	50 %	82 %	85 %
First Presentation: Measles-Rubella, 10 dose(s) per vial, LYOPHILISED, second dose				
Wastage rate*[3]* in base-year and planned thereafter (%)	0	10	10	10
Wastage factor*[3]* in base-year and planned thereafter (%)	1.00	1.11	1.11	1.11
Maximum wastage rate for the MR vaccine, 10 dose(s) per vial, LYOPHILISED second dose	40 %	40 %	40 %	40 %
Target population that received the 1st dose(s) of the RCV vaccine	655,901	787,535	816,193	845,790
RCV coverage*[2]*	79 %	90 %	91 %	92 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	8 %	7 %	6 %	6 %

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

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

[3]The formula to calculate vaccine wastage rate (in percentage): [(A - B) / A] x 100, where A = balance in stock at the end of the supply period; and B = the number of vaccines administered with the same vaccine during the same period.

5.3. Target for the preventive campaign(s)

No NVS Prevention Campaign Support this year

5.4. Targets for the single catch-up mini-campaigns

No unique catch-up mini-campaign this year

6. 6 New and underused vaccines (routine NVS)

6.1. Calculation of the disease burden for corresponding diseases (if available)

If it is already included in detail in the Introduction Plan or Action Plan, please simply cite the section.

Disease	Title of the assessment	Date:	Results
Measles	EPI Activity Report	2015	649 confirmed cases
Rubella vaccine	EPI Activity Report	2015	277 confirmed cases
Yellow fever	CTG-EPI Annual Report	2015	2614 suspected cases, 70 IgM+ and 60 +ve SN
Rotavirus vaccine	FCB/CME Basis	2015	278 suspected cases, 48 + ELISA
Hib	CTG-EPI Annual Report	2015	1408 suspected MBP (02 +ve Hib)
Pneumococcal	CTG-EPI Annual Report	2015	1408 suspect MBP (10 +ve S. pn)

6.2. Requested vaccine (MR, 10 dose(s) per vial, LYOPHILISED, second dose)

As indicated in the cMYP, the country plans to introduce the Measles vaccine using MR, 10 dose(s) per vial, lyophilised..

When does the country intend to introduce this vaccine? **July 2017**

It should be noted that because of various factors, the launch date may vary compared to the date stipulated in the application. Gavi will work in close collaboration with the countries and its partners to correct this problem.

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain equipment and other logistics requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. The independent review committee must have assurances that the cold chain is ready or will be ready for the new routine vaccine introduction; convincing data/plans must be provided. All the proposals that include Gavi funding for the cold chain intended for storing vaccines must provide equipment that is WHO-prequalified for its performance, quality and programme safety (PQS). The purchase of non-PQS equipment will only be taken into account in special cases, with documentation and prior approval from Gavi.

Cold chain capacity is presented as described below according to the 2016 inventory. The central warehouse currently has 9 cold rooms: 06 are positive and 03 are negative, with a gross, total positive capacity of 170 m3 and negative capacity of 60 m3. Of the nine cold rooms, three are approved and comply with standards (two positive and one negative). Two positive cold rooms are not approved and four are outdated (ages > 25 years, 2 positive and 2 negative). The current positive capacity of the central warehouse is insufficient for receiving all the vaccines with a gap of 120 m3. i.e. 5 cold rooms of 40 m3. Net positive capacities required will be on the order of 320 m3 in 2021. The country proposes constructing a modern warehouse with a capacity of approximately 400 m3 that will be able to meet the introduction of new vaccines and the growth of the target population.
At the intermediate level, according to inventory data, 08/10 regions have sufficient storage capacity to meet the progressive introduction of new vaccines through 2021. Regions in the Centre and far North each need of a cold room to hold all vaccines through 2021.
Updating of Cold Chain equipment inventory data shows that 68% (2499/3675) of the available refrigerators in the country are operational. Nearly 42% of health care facilities do not have operational cold chain equipment. They are supplied on the day of immunisation from a nearby facility and generally organise one immunisation session per month. This is also a major factor in failing to attain the vaccine coverage and equity objectives.
The inventory also showed that the equipment embedded base includes several brands of equipment, 33% of which are household refrigerators.
This situation makes supply chain management difficult (e.g. ordering replacement parts, maintaining equipment, monitoring the cold chain, etc. More than 92% of all refrigerators are not approved and expose the vaccines to heat and/or freezing temperatures. A temperature monitoring study conducted in 2015 and 2016 in X Health Districts in Cameroon showed that 44% of SIBIR [refrigerators] expose vaccines to freezing and 68% of household refrigerators expose the vaccines to heat. Therefore it is important to replace this equipment and enhance the temperature monitoring system.
During the EVM assessment conducted in 2013, the E5 criteria scores (Maintenance: 57% at the level of regions, 54% at the level of Health Districts and 54% at the level of Health Care Facilities) were low, compared to an expected minimum of 80%.
This is a sign of the absence or poor organization of the maintenance system. The inventory also noted that the lack of spare parts (20%) and the absence of a technician (19%) were reasons that refrigerators were not operational. The absence of funding was only cited in 2% of cases of non-operational equipment. The multiple manufacturers of refrigerators used at health care facilities explains the absence of spare parts and technicians who have the skills suited to those brands. In order to alleviate this issue, the country emphasized cold chain maintenance by creating a unit responsible for maintenance within the CTG-EPI, maintenance pools in the regions, and the formalisation of the group responsible for logistics (see Ref. Terms and Conditions in the maintenance plan).

6.2.1 Co-financing information

If you want to co-finance a larger amount, please indicate it on your co-financing line.

Country group	Preparatory Transition Phase		
	2017	**2018**	**2019**

Minimum co-financing	0.30	0.35	0.40
Your co-financing (please change if higher)	0.30	0.35	0.40

6.2.2 Specifications of vaccinations with new vaccine

	Data from		2017	2018	2019
Immunisation Coverage	Table 5.2	%	50%	82%	85%
Number of children to be vaccinated with the first dose	Table 5.2	#	787,535	816,193	845,790
Number of children to be vaccinated with the second dose	Table 5.2	#	437,520	735,470	781,436
Country co-financing per dose	Table 6.4.1	$	0.3	0.35	0.4

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

		2017	2018	2019
Number of vaccine doses	**#**	760,915	947,804	1,091,971
Number of AD syringes	**#**	777,638	953,006	1,093,344
Number of reconstitution syringes	**#**	84,462	105,207	121,210
Number of safety boxes	**#**	9,570	11,747	13,482
Total amount of co-financing by the country *[1]*	**$**	509,942	634,552	730,883

[1] The amount of co-financing for intermediate countries and graduating countries indicates the cost of vaccines, related injection safety equipment and delivery costs. The total co-financing amount does not include supply agency costs and fees, such as handling costs. Information on these additional costs and fees will be provided by the provisioning agency involved, as part of the cost estimates required by the country.

6.2.4 Portion of supply to be procured by Gavi (and cost estimate, US$)

		2017	2018	2019
Number of vaccine doses	**#**	938,885	865,196	735,229
Number of AD syringes	**#**	959,521	869,944	736,153
Number of reconstitution syringes	**#**	104,216	96,037	81,610
Number of safety boxes	**#**	11,807	10,722	9,077
Total value to be co-financed by Gavi	**$**	629,209	579,243	492,102

6.2.5 New and Under-Used Vaccine Introduction Grant

Calculation of the vaccine introduction grant for MR, 10 dose(s) per vial, LYOPHILISED second dose

Year of New Vaccine Introduction	Births (from Table 5.2)	Share per Birth in US$	Total in US$
2017	1,036,223	0.80	828,978

This is a single net subsidy of 0.80 USD/child in a single birth cohort, or a lump sum of $100,000 (whichever of these 2 amounts is greater). It is helpful to note that for grant requests for introduction submitted as of January 2017 and for all Gavi vaccine introductions, planned for implementation starting in 2018, this grant will be adjusted in function of the country's transition phase. The amount of $ 0.70 per target person in a single birth cohort will be provided to countries in preparatory transition phase (Phase 1) and $ 0.60 per target person in a single birth cohort will be provided to countries that have entered an accelerated transition phase (Phase 2). For low-income countries, the amount will be kept at $ 0.80 per target person.

Please explain how the introduction grant provided by Gavi will be used to facilitate the timely and effective implementation of the activities before and during the introduction of the new vaccine (refer to the cMYP and to the vaccine introduction plan).

After approval of the MR2 introduction plan by the ICC, the funds will be allocated to the various levels of the health care system for implementation of preparatory activities, in particular by:
- enhancing logistical capacity of the EPI;
- review of the EPI management media;
- strengthening communication in support of the introduction of the 2nd dose of the MV;
- AEFI surveillance;
- strengthening of the partnership;
- Monitoring, assessment and surveillance.

Please complete the 'Detailed budget for VIG / Operational costs' template provided by Gavi and attach as a mandatory document in the Attachment section.

Detailed budget attached as Document No. 22.

If the Gavi support does not cover all of the requirements, please describe the other sources of funding and the amounts projected, if available, to cover your requirements

With regard to the GAP, it will be fulfilled by the contribution from the Government and local technical partners (WHO, Unicef, CHAI, CDC, etc.)

6.2.6. Technical assistance

Please describe any specific domain for which the Ministry will need technical assistance in order to support the Measles-Rubella vaccine introduction.

The country will request technical assistance to support the implementation of surveillance activities for Congenital Rubella Syndrome (CRS).

7. 7. NVS Preventive Campaigns

No NVS Prevention Campaign Support this year

8. 8 Procurement and management

8.1 Procurement and management of routine immunisation with new or underused vaccines

Note: The PCV vaccine must be procured through UNICEF to be able to access the price awarded by the Advance Market Commitment (AMC).

a) Please show how the support will operate and be managed including purchase of vaccines (Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund):

The funds for this proposal will be managed through the government standard expenditure procedures channel. The funds (Gavi share) for procurement of vaccines and other immunisation supplies will be sent directly to Unicef. The country procures the vaccines and other immunisation supplies through Unicef.

b) If an alternative mechanism for procurement and delivery of vaccine (funded by the country or Gavi) is requested, please document

- A description of the mechanism and the vaccines or commodities to be procured by the country;
- Assurance that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. For the purchase of locally-produced vaccines directly from a supplier which may not have been pre-qualified by WHO, assurance should also be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance with standards is assured by a National Regulatory Authority (NRA) with jurisdiction, as assessed by WHO in the countries of production and purchase.

NA

c) If receiving direct financial support from Gavi (such as operational support for campaigns or VIG activities), please indicate how the funds should be transferred by Gavi.

The funds will be paid into the Gavi EPI account opened with the Independent Payment Fund:

- Name: Independent Payment Fund EXPANDED PROGRAMME ON IMMUNISATION (EPI)-Gavi
- Bank code: 10004
- Branch code: 00200
- Bank account No.: 08021755974
- Control key: 54
- Swift Code: SCBLCMCX
- In Euros:
- STANDARD CHARTERED BANK FRANFURT
- SWIFT CODE: SCBLDEFX
- In USD
- STANDARD CHARTERED BANK FRANFURT
- SWIFT CODE: SCBLUS33

The signatories are:

- Amounts < five million: The Director of Family Health and the EPI Permanent Secretary are cosignatories, with the approval of the Minister of Public Health
- Amounts ≥ five million: the Minister of Public Health is the sole signatory.

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

Co-financing funds are drawn by the Government via CAA from the central procurement account in Copenhagen or via Unicef.

e) Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including procurement.

The funds for this proposal will be managed through the government standard expenditure procedures

channel. The Central Technical Group of the EPI (CTG-EPI) includes five technical sections, including an Administrative and Financial Section (SAF) directed by a qualified accountant. An internal controller was appointed by the Minister of Public Health, to work in collaboration with the Permanent Secretary of the CTG-EPI to monitor financial management. In addition, an annual audit of Gavi funds was conducted and the report should be shared with Gavi and other Partners, 6 months after the end of the fiscal year covered by the audit.

There is a Comprehensive Multi-Year Plan (cMYP) for the period 2015-2019, prepared with all the partners, covering all the activities to be carried out during the period. This cMYP aligns with the National Health Development Plan (NHDP) 2016-2020, which itself issued from the 2015-2017 Sectoral Health Strategy (SHS). From the 2015-2019 cMYP, an Annual Work Plan is prepared at the start of each year, and the quarterly work plans at the start of each quarter. The Annual Work Plan and the quarterly work plan are validated by the ICC.

To conduct these activities, technical sheets are prepared by the technical sections in collaboration with the SAF and the Internal Controller, which verify that: (i) activities are planned in the Annual Work Plan; (ii) the budget conforms to the budget set forth in the Annual Work Plan; (iii) the unit costs are the same. The technical sheets are then validated by the SAF, the Internal Controller and the Permanent Secretary and they are forwarded to the Minister of Health to be signed. At the central level the EPI has an accounting and financial management software package (TOMPRO) that will be replaced by software by TOM 2 PRO. In addition, the EPI has just been provided with an accounting, financial and administrative management procedures manual that describes the internal control system and operational procedures for financial management.

f) Please describe how coverage of the introduced vaccine will be monitored, reported and evaluated (refer to cMYP and Introduction Plan).

Vaccine coverage will be monitored via monthly reports of the number of children receiving the second dose of the measles-rubella vaccine. Data on these vaccines will be included in routine immunisation reports. Surveillance activities on overall immunisation coverage will be conducted every three years. The primary indicator of vaccine coverage for the measles vaccine, 2nd dose, will be the number of children that received this vaccine out of the total number of children aged 12 to 23 months.

g) For a request for support relating to the measles vaccine second dose, does the country wish to receive donations in kind or in cash? **N/A**

8.2 Procurement and management for NVS preventive campaigns

No NVS Prevention Campaign Support this year

8.3. Product licensure

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.

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.

The combined measles-rubella vaccine is approved in Cameroon.

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

The combined measles-rubella vaccine is approved in Cameroon.

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.

Procedures to clear the vaccine from customs and transport it from the airport to the central storage location

will be performed by the government or the UNICEF country office, depending on the vaccine type.

Unicef has a local (in Cameroon), long-term agreement with a transit company/transporter that will pick up the vaccines and immunisation materials upon arrival at the airport or the port. Vaccines follow the direct pickup procedure immediately upon arrival. Once they have been picked up, the products are transported to the central EPI office which initiates the batch release procedure.

In terms of clearing the vaccines and injection supplies for routine immunisation through customs, each year the EPI requests and obtains exemption from customs fees from the Ministry of Finance and Budget. However payment of the information technology tax, approved customs transporter fees and freight are the responsibility of the EPI. The latter ensures pickup and transport of the vaccines and injection materials from the point of entry (port or airport) to the CTG-EPI.

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.

The country has an operational National Regulatory Authority (NRA) that fulfils three out of the six recommended functions, i.e.:

- approval of products and granting market authorisations;
- releasing batches;
- post-sale surveillance, including monitoring of Adverse Events Following Immunisation (AEFIs).

8.4 Vaccine Management (EVSM/EVM/VMA)

It is mandatory for a country to conduct an assessment of effective vaccine management (EVM) before requesting support for the introduction of a new vaccine. This EVM should have been carried out during the **5 preceding years.**

When was the EVM conducted? **October 2013**

Please attach the progress report for the EVM improvement plan (DOCUMENT NUMBER: 21), and if it was not previously submitted, attach the most recent EVM assessment report (DOCUMENT NUMBER: 20,19,21) and the corresponding EVM improvement plan (DOCUMENT NUMBER: 19). The improvement plan should include a timeline, budget of committed resources for these activities and funding gaps, if any, as well as M&E indicators to monitor progress of implementation.

When is the next Effective Vaccine Management (EVM) Assessment planned? **by Jun 2017**

8.5 Waste management

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), of equipment enabling the safe handling of immunisation materials, storage capacity, transportation and disposal of immunisation waste. Please describe the country's waste management plan for immunisation activities (including campaigns).

For the routine EPI, waste from immunisation activities is collected and destroyed at the health care facility and health district level, by incineration or burying.

During campaigns that generate significant waste, waste collection is organised by the national level and taken to foundries to be destroyed.

9. Comments and recommendations from the national coordinating body (ICC/HSCC)

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

After ICC discussions on September 2, 2016, the following recommendations and resolutions were made:

- to implement the equipment maintenance plan to ensure effective management of equipment to be procured (CTG-EPI);

- to implement the redeployment plan for operational cold chain equipment not yet in use (CTG-EPI);

- to come together with Gavi to clarify the choice of refrigerator brand (Partners);

- To follow samples taken in probable Yellow Fever cases sent to Dakar to avoid under-estimating confirmed cases in reports (CTG-EPI);

10. List of documents attached to this proposal

10.1. List of documents attached to this proposal

Table 1: Checklist for required attachments

Document Number	Attachment	Section	File
Approvals			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	Page Signatures Ministres-Soumission 2e dose RR.pdf **File desc:** Signature Page of the Minister of Public Health **Date/time** 09/09/2016 02:43:35 **Size:** 545 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	Page Signatures Ministres-Soumission 2e dose RR.pdf **File desc:** Signature Page of the Minister of Finance **Date/time** 09/09/2016 02:44:46 **Size:** 545 KB
4	ICC Terms of Reference	4.1.2	ORGANIGRAMME PEV SIGNE DU 08-03-2011.pdf **File desc:** ICC Reference terms and conditions: Article 4 of the EPI Organisational Chart signed on March 8, 2011 **Date/time** 09/09/2016 03:24:52 **Size:** 2 MB
5	Minutes of ICC/HSCC meeting endorsing Proposal	4.1.3	Rapport CCIA du 02 Sept 2016.pdf **File desc:** ICC meeting report **Date/time** 09/09/2016 02:47:35 **Size:** 4 MB
6	Signatures of ICC or HSCC or equivalent in Proposal	4.1.3	Pages Signatures Membres CCIA-Soumissions Plateforme et 2e dose RR.pdf **File desc:** Signatures of ICC members **Date/time** 09/09/2016 02:48:30 **Size:** 1 MB
7	Minutes of the three most recent ICC/HSCC meetings	4.1.3	RAPPORTS DES 3 DERNIERS CCIA 2016.rar **File desc:** Reports from the last 3 ICC meetings **Date/time** 09/09/2016 06:26:11 **Size:** 61 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	Décision Nomination Membres Comité Scientifique.pdf **File desc:** Scientific committee for immunisation **Date/time** 09/09/2016 09:30:16 **Size:** 2 MB
Planning, financing and vaccine management			

9	comprehensive Multi Year Plan - cMYP	5.1	PPAC 2015-2019 Ok.rar **File desc:** comprehensive Multi Year Plan - cMYP **Date/time** 09/09/2016 01:31:08 **Size:** 3 MB
10	cMYP Costing tool for financial analysis	5.1	cmyp_costing_tool_3 version du 31-12-2014 Final.rar **File desc:** cMYP Costing tool for financial analysis **Date/time** 09/09/2016 10:52:33 **Size:** 2 MB
11	M&E and monitoring plan in the country existing monitoring plan	5.1.4	Draft0 PNDS 2016-2020.docx **File desc:** Draft0 NHDP 2016-2020 comprising S&E **Date/time** 09/09/2016 11:44:19 **Size:** 477 KB
13	Introduction plan for the combined measles-rubella / EJ / MenA / YF vaccine into the national program.	7.x.4	CMR_Plan d'introduction RR2.docx **File desc:** Plan for introduction of the combined Measles-Rubella vaccine, 2nd dose. **Date/time** 27/09/2016 07:18:35 **Size:** 338 KB
14	Annual EPI plan with a vision for fighting measles and rubella		PTA 2016_version_Revisée 31-05-2016 Final.docx **File desc:** EPI Annual Work Plan 2016 **Date/time** 09/09/2016 10:46:57 **Size:** 999 KB
17	Evidence of commitment to fund purchase of RCV for use in the routine system in place of the first dose of MCV	7.x.3	Page Signatures Ministres-Soumission 2e dose RR.pdf **File desc:** Proof of financial commitment for procuring the RCV. **Date/time** 27/09/2016 07:21:38 **Size:** 545 KB
18	Campaign target population documentation	7.x.1, 6.x.1	Explications-campagnes de prévention RR2.docx **File desc:** Campaign target population documentation **Date/time** 27/09/2016 07:32:40 **Size:** 12 KB
22	Detailed model budget for the grant for the introduction of a vaccine / operating costs	6.x,7.x.2, 6.x.2	CMR_Budget-soumission RR2.xlsx **File desc:** Detailed model budget for the grant for the introduction of a vaccine / operating costs **Date/time** 09/09/2016 10:44:39 **Size:** 166 KB
27	Data quality assessment (DQA) report	5.1.4	Rapport_DQS_Revue_PEV_ Cameroun_2013.rar **File desc:** Data quality assessment (DQA) report **Date/time** 09/09/2016 12:07:46 **Size:** 1 MB
28	DQA improvement plan	5.1.4	plan_amelioration_QD.rar **File desc:** DQA improvement plan **Date/time** 09/09/2016 12:33:16 **Size:** 32 KB

29	Campaign action plan	7.1, 7.x.4	Explications-campagnes de prévention RR2.docx **File desc:** Campaign action plan **Date/time** 27/09/2016 07:33:39 **Size:** 12 KB

Table 2: List of optional attachments

Document Number	Attachment	Section	File
3	MoH Signature (or delegated authority) of Proposal for HPV support	4.1.1	No file uploaded
12	Vaccine introduction plan	5.1	CMR_Plan d'introduction RR2.docx **File desc:** Vaccine introduction plan **Date/time** 09/09/2016 10:48:08 **Size:** 338 KB
15	HPV vaccine roadmap or strategy	6.1.1	No file uploaded
16	Summary of the HPV vaccine assessment methodology	5.1.6	No file uploaded
19	EVM report	8.3	No file uploaded
20	Improvement plan based on EVM	8.3	No file uploaded
21	EVM improvement plan progress report	8.3	No file uploaded
23	Assessment of risks and report from the MeNA consensus meeting. If DPT was used in place, please specify.	7.1	No file uploaded
24	National measles (and rubella) eradication plan, if available		No file uploaded

25	A description of partner participation in preparing the application	4.1.3	No file uploaded
26	Minutes of the NITAG meeting with specific recommendations on NVS introduction or the campaign	4.2	No file uploaded
30	Other documents		No file uploaded
31	Proof of self-funding MCV1	5.1.5	No file uploaded

11. Appendices

Annex 1 - NVS Routine Support

Annex 1.1 - Systematic support for New or Under-utilised Vaccines (VNS) (MR, 10 dose(s) per vial, LYOPHILISED second dose)

Table Annex 1.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in US$

		2017	2018	2019
Number of vaccine doses	**#**	761,000	947,900	1,092,000
Number of AD syringes	**#**	777,700	953,100	1,093,400
Number of reconstitution syringes	**#**	84,500	105,300	121,300
Number of safety boxes	**#**	9,575	11,750	13,500
Total amount of co-financing by the country ***[1]***	**$**	510,000	635,000	731,000

Table Annex 1.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$

		2017	2018	2019
Number of vaccine doses	**#**	938,900	865,200	735,300
Number of AD syringes	**#**	959,600	870,000	736,200
Number of reconstitution syringes	**#**	104,300	96,100	81,700
Number of safety boxes	**#**	11,825	10,725	9,100
Total value to be co-financed by Gavi	**$**	629,500	579,500	492,500

Table Annex 1.1 C: Summary table for the MR vaccine, 10 dose(s) per vial, LYOPHILISED second dose

DI		Data from		2017	2018	2019
	Number of surviving infants	Table 5.2	#	875,039	896,915	919,337
	Immunisation Coverage	Table 5.2	%	50%	82%	85%
	Number of children to be vaccinated with the first dose	Table 5.2	#	787,535	816,193	845,790
	Number of children to be vaccinated with the second dose	Table 5.2	#	437,520	735,470	781,436
	Number of doses per child	Parameter	#	1	1	1
	Estimated vaccine wastage factor	Table 5.2	#	1.11	1.11	1.11
	Number of doses per vial	Parameter	#	10	10	10
	AD syringes required	Parameter	#	Yes	Yes	Yes
	Reconstitution syringes required	Parameter	#	Yes	Yes	Yes
	Safety boxes required	Parameter	#	Yes	Yes	Yes
cc	**Country co-financing per dose**	Table 6.4.1	$	0.3	0.35	0.4
ca	**AD syringe price per unit**	Table Annexes 4A	$	0.041	0.041	0.041
cr	**Reconstitution syringe price per unit**	Table Annexes 4A	$	0.004	0.004	0.004
cs	**Safety box price per unit**	Table Annexes 4A	$	0.005	0.005	0.005
fv	**Freight cost as% of vaccines value**	Table Annexes 4B	%	2.95%	2.95%	2.95%
fd	**Freight cost as% of devices value**	Parameter	%	0	0	0

Table Annex 1.1 D: Estimated numbers for the MR vaccine, 10 dose(s) per vial, LYOPHILISED, second dose, related injection safety equipment and corresponding co-financing budget (page 1)

		Formula	2017		
			Total	Government	GAVI
Y	Country co-financing	*V*	44.76 %		
E	Number of children to be vaccinated with the first dose	*Table 5.2*	787,535	352,540	434,995
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	437,520		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	1,225,055	548,395	676,660
E	Estimated vaccine wastage factor	*Table 5.2*	1.11		
F	Number of doses needed including wastage	*D X E*	1,359,812	608,719	751,093
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	339,953	152,180	187,773
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	1,699,800	760,915	938,885
J	Number of doses per vial	*immunisation parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	1,737,159	777,638	959,521
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	188,678	84,462	104,216
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 × 1.11*	21,377	9,570	11,807
N	Cost of vaccines needed	*I x * vaccine price per dose (g)*	1,036,878	464,158	572,720
Y	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	70,793	31,691	39,102
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	784	351	433
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	99	45	54
R	Freight cost for vaccines needed	*N x freight cost as of% of vaccines value (fv)*	30,597	13,697	16,900
S	Freight cost for devices needed	*(O+P+Q) x freight cost as% of devices value (fd)*	0	0	0
Q2	Total funding needed	*(N+O+P+Q+R+S)*	1,139,151	509,942	629,209
U	Total country co-financing	*I * country co-financing per dose (cc)*	509,940		
V	Country co-financing % of Gavi supported proportion	*U / T*	44.76 %		

Table Annex 1.1 D: Estimated numbers for the MR vaccine, 10 dose(s) per vial, LYOPHILISED, second dose, related injection safety equipment and corresponding co-financing budget (page 2)

		Formula	2018		
			Total	Government	GAVI
Y	Country co-financing	*V*	52.28 %		
E	Number of children to be vaccinated with the first dose	*Table 5.2*	816,193	426,691	389,502
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	735,470		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	1,551,663	811,182	740,481
E	Estimated vaccine wastage factor	*Table 5.2*	1.11		
F	Number of doses needed including wastage	*D X E*	1,722,346	900,412	821,934
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	90,634	47,382	43,252
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	1,813,000	947,804	865,196
J	Number of doses per vial	*immunisation parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	1,822,950	953,006	869,944
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	201,244	105,207	96,037
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 × 1.11*	22,469	11,747	10,722
N	Cost of vaccines needed	*I x * vaccine price per dose (g)*	1,105,930	578,161	527,769
Y	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	74,289	38,837	35,452
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	837	438	399
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	104	55	49
R	Freight cost for vaccines needed	*N x freight cost as of% of vaccines value (fv)*	32,635	17,061	15,574
S	Freight cost for devices needed	*(O+P+Q) x freight cost as% of devices value (fd)*	0	0	0
Q2	Total funding needed	*(N+O+P+Q+R+S)*	1,213,795	634,552	579,243
U	Total country co-financing	*I * country co-financing per dose (cc)*	634,550		
V	Country co-financing % of Gavi supported proportion	*U / T*	52.28 %		

Table Annex 1.1 D: Estimated numbers for the MR vaccine, 10 dose(s) per vial, LYOPHILISED, second dose, related injection safety equipment and corresponding co-financing budget (page 3)

		Formula	2019		
			Total	Government	GAVI
Y	Country co-financing	*V*	59.76 %		
E	Number of children to be vaccinated with the first dose	*Table 5.2*	845,790	505,461	340,329
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	781,436		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*(B + B1) x C*	1,627,226	972,463	654,763
E	Estimated vaccine wastage factor	*Table 5.2*	1.11		
F	Number of doses needed including wastage	*D X E*	1,806,221	1,079,434	726,787
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	20,969	12,532	8,437
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	1,827,200	1,091,971	735,229
J	Number of doses per vial	*immunisation parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	1,829,497	1,093,344	736,153
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	202,820	121,210	81,610
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 × 1.11*	22,559	13,482	9,077
N	Cost of vaccines needed	*I x * vaccine price per dose (g)*	1,114,592	666,103	448,489
Y	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	74,556	44,557	29,999
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	843	504	339
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	104	63	41
R	Freight cost for vaccines needed	*N x freight cost as of% of vaccines value (fv)*	32,890	19,656	13,234
S	Freight cost for devices needed	*(O+P+Q) x freight cost as% of devices value (fd)*	0	0	0
Q2	Total funding needed	*(N+O+P+Q+R+S)*	1,222,985	730,883	492,102
U	Total country co-financing	*I * country co-financing per dose (cc)*	730,880		
V	Country co-financing % of Gavi supported proportion	*U / T*	59.76 %		

Annex 2 – NVS Routine Support – Preferred Second Presentation

No NVS – routine immunisation – second preferred presentation requested this year

Annex 3 – NVS Preventive campaign(s)

No NVS Prevention Campaign Support this year

Annex 4

Table Annex 4A: Commodities Cost

Estimated prices of supplies are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Type of Vaccine	2017	2018	2019
Measles-Rubella, 10 dose(s) per vial, LYOPHILISED, second dose	MR2	2.73 %	2.73 %	2.73 %

Table Annex 4C: Preparatory transition phase - Minimum country co-payment per dose of co-financed vaccine.

Vaccine	2017	2018	2019
Measles-Rubella, 10 dose(s) per vial, LYOPHILISED, second dose	0.3	0.35	0.4

Table Annex 4D: Wastage rates and factors

The table below presents the wastage rates for the different vaccines (routine immunisation and campaigns) for 2017.

Vaccine	dose(s) per vial	Maximum Wastage rate*		Benchmark Wastage Rate ***
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	40 %	0 %	
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	10 %	0 %	
Meningococcal, 10 dose(s) per vial, LYOPHILISED	10	50 %	10 %	
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	10 %	0 %	
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	5 %	0 %	
Rotavirus, 2-doses schedule	1	5 %	0 %	
Rotavirus, 3-doses schedule	1	5 %	0 %	
Measles, 10 dose(s) per vial, LYOPHILISED, second dose	10	40 %	0 %	
JE, 5 dose(s) per vial, LYOPHILISED	5	10 %	10 %	
HPV bivalent, 2 dose(s) per vial, LIQUID	2	10 %	0 %	
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5 %	0 %	
Measles-Rubella, 10 dose(s) per vial, LYOPHILISED, second dose	10	40 %	15 %	

Observations:

Sources WHO recommended wastage rates

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

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

Table Annex 4E: Vaccine maximum packed volumes

Please note that this table is used solely for reference and includes both the vaccines supported by Gavi as well as vaccines not supported.

Vaccine product	Description	Vaccine formulation	Admin route	No. Of doses in the schedule	Presentation (doses/vial, prefilled)	Packed volume vaccine (cm3/dose)	Packed volume diluents (cm3/dose)
IC	IC	lyophilised	DI	1	20	1.2	0.7
Diphtheria-Tetanus	DT:	liquid	IM	3	10	3	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	20	2.5	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	10	3	
DTP liquid + Hib freeze-dried	DTP-Hib	liquid+lyop.	IM	3	1	45	
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	liquid	IM	3	10	3	
DTP-HepB liquid + Hib lyophilised	DTP+Hib	liquid	IM	3	10	2.5	
DTP-HepB liquid + Hib lyophilised	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	
DTP-Hib combined liquid	DTP-Hib	liquid+lyop.	IM	3	10	12	
DTP-Hib combined liquid	DTP+Hib	liquid	IM	3	1	32.3	
Hepatitis B	HIPC	liquid	IM	3	1	18	
Hepatitis B	HIPC	liquid	IM	3	2	13	
Hepatitis B	HIPC	liquid	IM	3	6	4.5	
Hepatitis B	HIPC	liquid	IM	3	10	4	
Hepatitis B Uniject	HIPC	liquid	IM	3	Uniject	12	
Hib lyophilised	Hib_lyo	lyophilised	IM	3	1	13	35
Hib lyophilised	Hib_lyo	lyophilised	IM	3	2	6	
Hib lyophilised	Hib_lyo	lyophilised	IM	3	10	2.5	3
Hib liquid	Hib_liq	liquid	IM	3	1	15	
Hib liquid	Hib_liq	liquid	IM	3	10	2.5	
Human Papillomavirus vaccine	Anti HPV	liquid	IM	3	1	15	
Human Papillomavirus vaccine	Anti HPV	liquid	IM	3	2	5.7	
Japanese Encephalitis	JE_lyo	lyophilised	SC	1	5	2.5	2.9
Measles	Measles	lyophilised	SC	1	1	26.1	20
Measles	Measles	lyophilised	SC	1	2	13.1	13.1
Measles	Measles	lyophilised	SC	1	5	5.2	7
Measles	Measles	lyophilised	SC	1	10	3.5	4
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	1	26.1	26.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	2	13.1	13.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	5	5.2	7
Measles-Mumps-Rubella freeze dried	MMR	lyophilised	SC	1	10	3	4
Measles-Rubella freeze dried	RR	lyophilised	SC	1	1	26.1	26.1
Measles-Rubella freeze dried	RR	lyophilised	SC	1	2	13.1	13.1
Measles-Rubella freeze dried	RR	lyophilised	SC	1	5	5.2	7
Measles-Rubella freeze dried	RR	lyophilised	SC	1	10	2.5	4
Meningitis A conjugate	Men_A	lyophilised	IM	1	10	2.6	4
Meningitis A/C	MV_A/C	lyophilised	SC	1	10	2.5	4
Meningitis A/C	MV_A/C	lyophilised	SC	1	50	1.5	3
Meningitis W135	MV_W135	lyophilised	SC	1	10	2.5	4

Meningococcal A/C/W/	MV_A/C/W/	lyophilised	SC	1	50	1.5	3
Meningococcal A/C/W/Y	MV_A/C/W/Y	lyophilised	SC	1	10	2.5	4
Monovalent OPV-1	mOPV1	liquid	Oral		20	1.5	
Monovalent OPV-3	mOPV3	liquid	Oral		20	1.5	
Pneumo. conjugate vaccine 10-valent	PCV -10	liquid	IM	3	1	11.5	
Pneumo. conjugate vaccine 10-valent	PCV -10	liquid	IM	3	2	4.8	
Pneumo. conjugate vaccine 13-valent	PCV -13	liquid	IM	3	1	12	
Polio	OPV	liquid	Oral	4	10	2	
Polio	OPV	liquid	Oral	4	20	1	
Polio inactivated	VPI	liquid	IM	3	PFS	107.4	
Polio inactivated	VPI	liquid	IM	3	10	2.5	
Polio inactivated	VPI	liquid	IM	3	1	15.7	
Rota vaccine	Rota_liq	liquid	Oral	2	1	17.1	
Rota vaccine	Rota_liq	liquid	Oral	3	1	45.9	
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	
Tetanus-Diphtheria	Td	liquid	IM	2	10	3	
Yellow Fever	YF	lyophilised	SC	1	5	6.5	7
Yellow Fever	YF	lyophilised	SC	1	10	2.5	3
Yellow Fever	YF	lyophilised	SC	1	20	1.5	2
Yellow Fever	YF	lyophilised	SC	1	50	0.7	1

12. Banking form

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

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

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

By whom is the account audited?

Signature of Government's authorising official

Name:		**Seal**
Title:		
Signature		
Dated:		

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

I certify that the account No. is held by at this banking institution

The account must be signed jointly by at least 2 (number of signatories) of the following authorised signatories:

1		
	Name:	
	Title:	
2		
	Name:	
	Title:	
3		
	Name:	
	Title:	

Name of bank's authorising official
Signature
Dated:
Seal: