Global Alliance for Vaccines and Immunisation (GAVI)

APPLICATION FORM FOR COUNTRY PROPOSALS

For Support to:

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

Revised 15 January 2008

(To be used with Guidelines dated 15 July 2007)

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

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

CONTENTS

Executive Summary

The Government of Socialist Republic of Viet Nam seeks financial assistance with the introduction of Hib vaccine in the form of fully liquid single-dose DTP-HepB-Hib pentavalent vaccine from the GAVI alliance starting from January 1, 2009. Support is requested from GAVI for 5,701,600 doses of vaccine, 6087,700 AD syringes, 53,975 safety boxes with a total value of US $21.263 million. Government will co-finance 498,800 doses of vaccine, 532,600 AD syringes, and 5,925 safety boxes in 2009 valued at US $1.86 million.

WHO has recently estimated that almost 1.9% of total under-5 deaths can be attributed to Hib infection (pneumonia and meningitis) in Viet Nam. Hib is estimated to cause 625 cases of meningitis, 107,565 cases of severe pneumonia and 235 cases of non-pneumonia and non-meningitis cases each year in Viet Nam. Hence introduction of Hib vaccine is likely to make substantial contribution to the achievement of MDG-4 goal in Viet Nam.

The pentavalent vaccine is proposed to replace the current DPT (used in 20-dose vial) and monovalent hepatitis B vaccine (in 2-dose vial) which was earlier expanded nationwide with GAVI support in 2002[1]. Monovalent Hepatitis B will continue to be used for the birth dose. The pentavalent vaccine is proposed to be introduced nationwide starting from January 1, 2009 in a three dose schedule at 2 months, 3 months and 4 months to all the infants in addition to provision of the hepatitis B birth dose within 24 hours of birth. The Government commits itself to co-finance the cost of pentavalent vaccine at the rate of $0.30 per dose as applicable to Viet Nam as per the current GAVI co-financing policy. The cold chain capacity analysis at different levels has shown sufficient capacity to accommodate the new vaccine introduction in single-dose vials. In addition, introduction of single dose vials is likely to greatly reduce the vaccine wastage, which is currently estimated to be 15% for hepatitis B vaccine in two-dose vials and 35% for DPT vaccine in 20-dose vials. It will also further improve the quality of immunization services by reducing the total number of injections required by each child to complete the vaccination schedule as each child will require two less injections with the introduction of pentavalent vaccine, and yet will receive the benefit of an additional antigen.

A detailed vaccine introduction plan has been prepared including training, IEC and surveillance components, as enclosed with this application as document # 8. The Government plans to procure the pentavalent vaccine to be co-financed by country by itself. The Government will procure only the WHO prequalified vaccine once it is also licensed in Viet Nam. The GAVI financed portion (as explained in Table 6.5) will be procured and supplied through UNICEF. The government will start the procurement process for its share (approximately 9% of total needs) as specified in Table 6.4 in early 2009 to enable it to procure the vaccine in mid-2009.

The proposal for Hib vaccine introduction has been reviewed and endorsed by the Inter-agency coordinating committee (ICC) on 2nd Nov. 2007 (and 25th March 2008). Signatures of members of the Interagency Coordinating Committee along with minutes of the meeting are also enclosed. Immunization Program data and summary information from the forecasted immunization budget from 2006-2010 are also enclosed.

[1] GAVI provided 89% of vaccine support each year between 2002 and 2007, while rest of the vaccine needs were supported by government using its domestically produced vaccine

2. Signatures of the Government and National Coordinating Bodies

Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of **Viet Nam** would like to expand the existing partnership with the GAVI Alliance for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests for GAVI support for **introduction of Hib containing pentavalent vaccine (DPT-HepB-Hib).**

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

Table N° **6.5** of page 21 of this application shows the amount of support in either supply or cash that is required from the GAVI Alliance. Table N° **6.4** of page 21 of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

"Following the regulations of the internal budgeting and financing cycles the Government will annually *procure* its portion of vaccine supply to be co-financing by it in the month of July The *procurement* for the first year of co-financed support/vaccine will be around July 2009 (specify month and year)."

Minister of Health:

Signature: .....

Name: Mr. Nguyen Quoc Trieu

Date: .....

Minister of Finance:

Signature: .....

Name: Mr. Vu Van Ninh

Date: .....

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

We the members of the ICC/HSCC[2] met on (25th March 2008) to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

- The endorsed minutes of this meeting are attached as DOCUMENT NUMBER: 4

Name/Title	Agency/Organisation	Signature
Dr. Jean-Marc Olivé, WHO Representative in Viet Nam	WHO	
Mr. Jesper Morch, UNICEF Representative in Viet Nam	UNICEF	
Mrs. Michelle Gardner, PATH Representative in Viet Nam	PATH	
Mr. Yosuke KOBAYASHI, Deputy Resident Representative, JICA Vietnam	JICA	

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

3

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

Name: Dr. Nguyen Van Cuong

Title: Deputy NEPI manager, Vietnam

Tel No.: + 84 4 9725 745

Address: National Institute of Hygiene and Epidemiology, No. 1 Yersin str., Hanoi, Vietnam.

Fax No.: +84 4 8213 782

Email: vancuong@fpt.vn

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

The Inter-Agency Coordinating Committee for Immunisation

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

Profile of the ICC/HSCC

Name of the ICC/HSCC: Inter-agency Co-ordinating Committee for EPI (ICC). In addition, there is a National Steering Committee for EPI (NSC) consisting of national partners (governmental and non-governmental) responsible for direct management of the EPI in Viet Nam.

Date of constitution of the current ICC/HSCC: September 2000

Organisational structure (e.g., sub-committee, stand-alone)
Steering Committees for EPI have been established and are functioning at all levels, including:

- Central level: National Steering Committee for EPI (NSC)
- Provincial level: Provincial Steering Committee for EPI
- District level: District Steering Committee for EPI
- Commune level: Communal Steering Committee for EPI

In addition to the above, from September 2000, the Inter-agency Co-ordinating Committee (ICC) was reconvened with terms of reference and composition as described below.

Frequency of meetings: Quarterly and whenever necessary

Composition:

Function	**Title / Organization**	**Name**
Chair	WHO Representative in Vietnam	Dr. Jean-Marc Olivé
Secretary		
Members	• Dr. Jean-Marc Olivé, WHO Representative in Viet Nam • Mr. Jesper Morch, UNICEF Representative in Viet Nam • Mrs. Michelle Gardner, PATH Representative in Viet Nam	• WHO • UNICEF • PATH

	• Mr. Yosuke KOBAYASHI, Deputy Resident Representative, JICA Vietnam.	• JICA

Major functions and responsibilities of the ICC:

- Review and endorse annual and five-year plans, country proposals and reports and other relevant documents prepared by the National EPI;
- Review progress in achieving milestones/objectives;
- Co-ordinate actions needed to overcome constraints and achieve milestones/objectives;
- Mobilize funding and assist in planning and monitoring in areas of priority as determined by the National Steering Committee for EPI.

Three major strategies to enhance the ICC role and functions in the next 12 months:

1. To hold ICC meeting more regularly at least four times per year.
2. To form a ICC working group on donor communication for EPI funding following the ICC decision taken during its 12th meeting on 3 March 2006.
3. ICC working group (include WHO, UNICEF, PATH and NEPI) to cooperate more closely with the National EPI quarterly review meetings.

3. Immunisation Programme Data

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

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

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

	Figure	Date	Source
Total population	84,155,800	2006	GSO statistical yearbook, 2007
Infant mortality rate (per 1000)	16	2006	Health Statistical year book, 2007
Surviving Infants*	1,594,187	2007	Joint reporting Form, 2008
GNI per capita (US$)	690	2006	World Development Indicators data base as published on September 2007, The World Bank Group
Percentage of GDP allocated to Health	2.54%	2006	Health Statistical year book, 2007
Percentage of Government expenditure on Health	8.39%	2006	Health Statistical year book, 2007

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

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

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

1. Five year plan for protection, care and promotion of people's health for 2006-2010, January 2006

2. Master plan for the development of health sector, June 2006

Among various preventive health programs, 12 priority programs are ranked in the 2006-2010 health 5-year plan as national target health programs, including the expanded program on immunization (EPI), malaria control, TB control, dengue fever control, leprosy control, HIV/AIDS control, nutrition program, mental health and food safety and hygiene, reproductive health, school health and military civilian health collaboration. These programs are established to achieve the objectives of the Government Policy and Strategy for Protection and Care of the People's health in the period of 2001-2010. The specific objectives are to reduce morbidity and mortality due to epidemic diseases, prevent, control and manage non-infectious diseases, enhance equity in access to and use of health care services and to improve quality of care.

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

Yes, cMYP (2006-2010) is aligned with this document in timing (both national health plan and cMYP are for years 2006-2010.)

Please indicate the national planning budgeting cycle for health

Multiyear health sector plans are prepared for five year period. The current plan is from 2006 to 2010. Annual plans with annual budget are prepared every year on the basis of multiyear plan. The budget for the implementation of health sector is approved on annual basis by the government. The financial year of Vietnam starts from January 1st and ends December 31st.

Please indicate the national planning cycle for immunisation

The EPI prepares a multi-year plan to coincide with the national multiyear plan for the health sector. The current multiyear plan is from 2006 to 2010. In addition, EPI program prepares annual work plans based on the multiyear plan for annual budgeting and implementation purposes.

Table 3.2: Current Vaccination Schedule: Traditional, New Vaccines and Vitamin A Supplement. *please refer to **Annex 2** of enclosed **c-MYP***

Vaccine *(do not use trade name)*	**Ages of administration** *(by routine immunisation services)*	**Indicate by an "x" if given in:**		**Comments**
		Entire country	**Only part of the country**	
BCG	As soon as possible after Birth	√		
Hep B	Birth (within 24 hours), 2 months 4 months	√		
DPT	2 months, 3 months, 4 months	√		
Measles	9 months, 6 years	√		Measles 2nd dose Introduced in December 2007 with GAVI support

Japanese encephalitis	Three doses 12 – 24 months, (0, 7 days, 1 year), starting at 12 months		√	Planned to be expanded nationwide in 2010[2]. Domestically produced mouse-brain derived vaccine (liquid 10-dose vial) is being used.
Cholera	Two doses 2-5 years		√	Only high risk areas (covering 30% of eligible population)
Typhoid	Single dose 3-10 years		√	Only high risk areas (covering 30% of eligible population age group)
Vitamin A	6 month to 36 months every 6 months	√	6 month to 36 months every 6 months	

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

Trends of immunisation coverage (in percentage)						**Vaccine preventable disease burden**		
Vaccine		**Reported (JRF)**		**Survey**		**Disease**	**Number of reported cases (JRF)**	
		2006	**2007**	**2002 (VDHS)**	**2006 (MICS)**		**2006**	**2007**
BCG		94.5	94	93.4	95.2	Tuberculosis*		
DTP	DTP1	92.1	92	88.3	94.2	Diphtheria	25	32
	DTP3	92.3	92	72.4	79.4	Pertussis	144	183
Polio 3		93.9	92	75.8	75.6	Polio	0	0
Measles (first dose)		93.5	83	83.2	88.8	Measles	1978	17
TT2+ (Pregnant women)		91.3	91	70.5	80.3	NN Tetanus	27	36
Hib3		NA	NA			Hib **		N/A
Yellow Fever		NA	NA			Yellow fever	N/A	N/A
HepB3		93.2	67		33.9	hepB sero-prevalence*	N/A	N/A
Vit A supplement	Mothers (<6 weeks post-delivery)	65			32.5			
	Infants (>6 months)	87			53.1			

* If available
** Note: JRF asks for Hib meningitis

If survey data is included in the table above, please indicate the years the surveys were conducted, the full title and if available, the age groups the data refers to:
VDHS (2002)—is Viet Nam Demographic and Health Survey conducted from October 2002 to December 2002, and immunization coverage refers to children 12-23 month of age at any time before survey.

MICS (2006) Is the multiple indicator cluster survey conducted by UNICEF from Aug 28,2006 to mid-October 2006 and immunization coverage refers to children 12-23 month of age at any time before survey.
Table 3.4: Baseline and annual targets *(refer to cMYP pages);* ***Please see the attached excel-sheet accompanying the cMYP***

[2] the expansion will take place in phased manner to 2010 using domestic resources.

Number	Baseline and targets					
	Base year (2005)	**Year 1 2006**	**Year 2 2007**	**Year 3 2008**	**Year 4 2009**	**Year 5 2010**
Births						
Infants' deaths						
Surviving infants	1,545,475	1,568,657	1,594,187	1,616,070	1,640,311	1,664,915
Pregnant women	1,545,475	1,568,657	1,594,187	1,616,070	1,640,311	1,664,915
Target population vaccinated with BCG	1,459,908	1,482,738	1,493,823	1,535,266	1,558,295	1,581,670
BCG coverage*	94.8%	94%	93.7%	95%	95%	95%
Target population vaccinated with OPV3	1,459,908	1,473,027	1,466,768	1,535,266	1,558,295	1,581,670
OPV3 coverage**	94.5%	93.9	92%	95%	95%	95%
Target population vaccinated with DTP3***	1,461,520	1,470,290	1,468,089	1,535,266	1,558,295	1,581,670
DTP3 coverage**	94.6%	93.7	92.3%	95%	95%	95%
Target population vaccinated with DTP1***	1,457,302	1,568,657	1,468,539	1,551,427	1,574,699	1,598,318
Wastage[3] rate in base-year and planned thereafter	38%	36%	34%	32%	31%	30%
Target population vaccinated with **3rd dose** of **DPT-Hepb-Hib**	0	0	0	0	1,558,295	1,581,670
DPT-HepB-Hib3 Coverage**	0%	0%	0%	0%	95%	95%
Target population vaccinated with **1st dose** of ……..	0	0	0	0	1,574,699	1,598,318
Wastage[1] rate in base-year and planned thereafter	NA	NA	NA	NA	5%	5%
Target population vaccinated with **1st dose** of Measles	1,471,332	1,466,129	1,320,758	1,535,266	1,558,295	1,581,670
Target population vaccinated with **2nd dose** of Measles	NA	NA	275,343	1,535,266	1,558,295	1,581,670
Measles coverage**	95.2%	93.5%	82.8%	95%	95%	95%
Pregnant women vaccinated with TT+	1,436,015	1,431,658	1,442,097	1,454,463	1,476,280	1,498,424
TT+ coverage****	93%	91.3%	91%	90%	90%	90%
Vit A supplement	1,180,644					
	3,841,128					
Annual DTP Drop out rate [(DTP1- DTP3)/ DTP1] x100	-0.3	-0.002	0.03	1	1	1
Annual Measles Drop out rate (for countries applying for YF)	NA	NA	NA	NA	NA	NA

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

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

Table 3.5: Summary of current and future immunisation budget *(or refer to cMYP pages)*
Please refer to the accompanying excel sheet to c-MYP and Part III in the cMYP on costing and financing.

	Estimated costs per annum in US$ (,000)					
Cost category	**Base year (2005)**	**Year 1 (2006)**	**Year 2 (2007)**	**Year 3 (2008)**	**Year 4 (2009)**	**Year 5 (2010)**
Routine Recurrent Cost						
Vaccines (routine vaccines only)	**$4,650,432**	**$4,762,792**	**$5,292,286**	**$5,470,920**	**$26,177,329**	**$20,168,148**
Traditional vaccines	*$2,232,991*	*$2,258,540*	*$2,239,140*	*$1,685,242*	*$1,674,458*	*$2,227,034*
New and underused vaccines	*$2,417,441*	*$2,504,252*	*$3,053,146*	*$3,224,426*	*$24,502,871*	*$18,502,808*
Injection supplies	$1,899,552	$1,950,759	$2,164,940	$2,241,097	$2,034,214	$2,086,802
Personnel (cost						
Salaries of full-time NIP health workers (immunisation specific)	$830,136	$832,536	$832,536	$830,136	$830,136	$830,136
Per-diems for outreach vaccinators / mobile teams (at local level)	1,400,000	1,470,000	1,543,500	1,620,675	1,701,709	1,786,794
Transportation (vaccine+outreach)	$300,000	$307,500	$315,188	$323,067	$331,144	$339,422
Maintenance and overheads	$200,000	$200,000	$220,000	$220,000	$220,000	$220,000
Training	$40,000	$55,000	$250,000	$300,000	$250,000	$300,000
Social mobilisation and IEC	$265,000	$265,000	$320,000	$330,000	$340,000	$350,000
Disease surveillance	$260,000	$343,000	$280,000	$315,000	$405,000	$410,000
Program management	$35,000	$35,000	$40,000	$80,000	$50,000	$50,000
Subtotal Recurrent Costs	**$9,870,120**	**$10,221,587**	**$11,258,450**	**$11,169,643**	**$32,339,532**	**$27,102,997**
Routine Capital Costs						
Vehicles	$0	$0	$0	$0	$0	$0
Cold chain equipment	$196,000	$278,436	$80,100	$3,621,298	$0	$0
Other capital equipment	$20,000	$20,000	$20,000	$20,000	$20,000	$20,000
Subtotal Capital Costs	$216,000	$298,436	$100,100	$3,641,298	$20,000	$20,000
Campaigns						
Polio	$270,411	$260,241	$0	$0	$0	$0
Measles	$0	$0	$3,638,579	$1,309,539	$0	$0
Japanese encephalitis	$215,228	$248,805	$475,715	$482,681	$492,633	$746,414

Typhoid vaccine	$763,289	$706,039	$504,313	$504,313	$504,313	$504,313
Cholera vaccine	$573,768	$708,486	$193,223	$193,223	$193,223	$193,223
Subtotal Campaign Costs	**$1,822,695**	**$1,923,570**	**$4,811,830**	**$2,489,757**	**$1,190,170**	**$1,443,951**
GRAND TOTAL	**$11,908,815**	**$15,170,455**	**$16,121,342**	**$20,103,227**	**$37,830,452**	**$28,566,947**

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

Table 3.6: Summary of current and future financing and sources of funds *(or refer to cMYP)*
Please refer to the accompanying excel sheet to c-MYP and Part III in the cMYP on costing and financing.

		Estimated financing per annum in US$ (,000)					
Cost category	**Funding source**	**Base year (2005)**	**Year 1 (2006)**	**Year 2 (2007)**	**Year 3 (2008)**	**Year 4 (2009)**	**Year 5 (2010)**
Routine Recurrent Cost							
1.Vaccines (traditional)	1.Govt	$2,232,991	$2,258,540	$1,989,140	$1,996,494	$1,674,458	$1,665,339
	2.JICA	0	0	$250,000	$250,000	0	0
2. vaccine (new and underutilized)	1.Govt	$912,272	$969,104	$1,706,776	$2,761,996	$3,520,987	$3,389,166
	2.GAVI	$1,505,169	$1,535,148	$1,346,369	$462,430	$20,981,885	$15,113,643
3. Injection supplies	1. govt	$631,707	$662,783	$1,823,915	$2,096,861	$1,460,870	$1,504,858
	2. GAVI.	$1,267,845	$1,287,976	$341,025	$144,236	$573,344	$581,944
4. Operational costs	1.Gov	$2,880,136	$2,925,536	$3,372,724	$2,828,203	$2,801,280	$2,814,558
	2.WHO	$260,000	$325,000	$280,000	$270,000	$270,000	$270,000
	3.UNICEF	$100,000	$100,000	$100,000	$200,000	$200,000	$200,000
	4.PATH	$110,000	$155,000	$25,000	$0	$0	$0
	5. Hib Initiative through WHO	$0	$0		$40,000	$135,000	$135,000
	6. GAVI (ISS+new vacc introduction grant	$0	$0	$0	$580,000	$540,000	$600,000
Routine Capital Costs							
1. Cold chain equipment	1. Govt.	**$0**	**$0**	**$80,100**	**$0**	**$0**	**$0**
	2. Luxembourg	**$0**	**$0**	**$0**	$2,874,070	**$0**	**$0**
	3. JICA	**$196,000**	**$278,436**	**$0**	**$0**	**$0**	**$0**
	4. UNICEF/GOJ	**$0**	**$0**	**$0**	$747,229	**$0**	**$0**

Campaigns							
1.	Government	$1,722,695	$1,823,570	$996,954	$1,001,338	$1,007,602	$1,167,333
	GAVI through UN foundation	$0	$0	$3,638,579	$1,309,539	$0	$0
	UNICEF	$100,000	$100,000	$0	$0	$0	$0
GRAND TOTAL		**$11,908,815**	**$15,170,455**	**$16,121,342**	**$20,103,227**	**$37,830,452**	**$28,566,947**

4. Immunisation Services Support (ISS): Not Applicable

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

Table 4.1: Estimate of fund expected from ISS

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

* Projected figures
** As per duration of the cMYP

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

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

Major Lessons Learned from Phase 1	**Implications for Phase 2**
1.	
2.	
3.	
4.	

5.	
6.	

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

a) when you would like the support to begin:

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

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

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

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

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

5. Injection Safety Support: Not Applicable

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

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

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

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

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

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

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

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

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

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

6. New and Under-Used Vaccines (NVS)

Please give a summary of the cMYP sections that refer to the introduction of new and under-used vaccines. Outline the key points that informed the decision-making process (data considered etc):

Section 2.4 of enclosed c-MYP (document #3) and the vaccine introduction plan enclosed as document # 8 refer to the introduction of pentavalent vaccine. In addition, section 2.8 of c-MYP describe the assessment of cold chain capacity on its readiness to introduce pentavalent vaccine. Section 3.1 and 3.2 describe the cost and financing of the pentavalent vaccine including co-financing by the government.

The key points considered in decision making process were estimated disease burden, the programmatic feasibility including readiness of the cold chain and financing capacity of the government as described below.

Pneumonia is an important contributor to under-5 morbidity and mortality in Viet Nam. WHO HQ estimated that Haemophilus influenzae type B (Hib) related mortality may account for almost 1.9% of total under-5 mortality in 2000. The total number of annual cases of severe illness due to Hib among children 1-59 years of age in year 2000 are estimated to be 108,423 (85083-154,093), which includes an estimated 625 (0-1330) meningitis cases and 107,563 (85083-152,262) severe pneumonia cases. The total number of annual deaths attributed to Hib are estimated to be 890 (456-1535) including 181(0-419) deaths from meningitis deaths and 683(456-1056) deaths from pneumonia. Hence the introduction of Hib vaccine is likely to have substantial impact on reducing childhood morbidity and mortality. The schedule of pentavalent vaccine is the same as DPT, and hence it is programmatically convenient to introduce the vaccine replacing DPT and HepB given at the same time. Also the cold chain requirement by the new vaccine is almost same as for DPT and HepB as explained later.

Apart from 2007, when coincidental events with Adverse Events Following Immunization occured after immunization with Hepatitis B vaccine that caused low uptake, NEPI has successfully reached high coverage with DTP and Hep B. With the pentavalent vaccine, the programme is well-equipped to achieve equally or increased coverage.

Hib vaccine will be introduced as the pentavalent DTP-HepB-Hib vaccine (liquid, single dose vials) from January 1, 2009, given a successful GAVI application for funding assistance in May 2008. Introduction of the new vaccine will be supported with a mass media campaign highlighting the new disease that children will be protected against, as well as the reduced number of injections required, as well as emphasizing the importance of early and full vaccination for all children.

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

Please refer to section 2.8 in the attached c-MYP (document # 3) for complete analysis of cold chain capacity. The planned pentavalent vaccine (DPT-HepB-Hib) will replace the DPT (used in 20-dose vials) and monovalent hepatitis B vaccine (used in 2-dose vials). The lower wastage associated with single dose pentavalent vaccine (5%) will compensate the extra space needed with single dose vials. At the current schedule with three doses of DPT and three doses of Hepatitis vaccine, the total cold chain volume required for one child for these two vaccines is [(3.8*3)+(13.9*3)] is 53.10 cm3. With introduction of pentavalent vaccine, the space required will be [(13.5*3)+(13.9*1)] 54.4 cm3, including Hepatitis B birth dose. This is just 2.4% increase in cold chain space requirement with introduction of pentavalent vaccine as compared to

the current EPI schedule. A detailed assessment carried out by JICS in October 2007, concluded that the current cold chain capacity at national, provincial and district level is either sufficient or surplus for the current vaccination schedule (please see attached document 9 for JICS assessment report).

There are 9 walk-in-cold rooms (WIC) at national level (5 at central level and 4 classified in north region but located at the same place as central store) with a total net positive storage capacity of 81000 liters. Generally the imported vaccine on receipt at Hanoi airport is stored in these 9 WIC. Hence, the capacity is more than adequate to introduce the pentavalent vaccine assuming receipt of three vaccine shipments each year and a buffer stock for three months, assuming even 100% coverage (please see section 2.8 in c-MYP). All 8 WICs are carefully temperature monitored.

At provincial and district level, there are TCW 3000 ice-lined refrigerators. In 2007, Government of Luxembourg supplied 990 units for provinces and districts providing either additional capacity or replacing the old equipment. After installation of these refrigerators in all the 64 provinces and 665 districts, there is a surplus of net positive storage capacity even assuming 100% vaccine coverage even after introduction of pentavalent vaccine and expansion of JE vaccine.

While the remote and mountainous commune health centers have a RCW-50EG with a net positive storage capacity of 24 liters, other communes pick up their vaccine just before the monthly immunization day from the district health centers. Three additional vaccine carriers along with thermometers and icepacks are being procured and supplied to all the commune centers with support from Government of Japan through UNICEF in 2008. Through these funds, temperature monitoring devices are also being procured to assure the quality of the pentavelent vaccine.

Hence to conclude, the cold chain capacity is more than adequate at all levels of immunization service delivery at current vaccination schedule and for introduction of single dose pentavalent vaccine.

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

		Formula	Year 1 2006	Year 2 2007	Year 3 2008	Year 4 2009	Year 5 2010
A	Annual ***positive*** volume requirement in liters, including new vaccine	*Sum-product of total vaccine doses multiplied by unit packed volume of the vaccine*	116,002	117,742	119,508	123729	125585
B	Annual ***positive*** capacity, including new vaccine in liters	*#*	81000	81000	81000	81,000	81000
C	Estimated minimum number of shipments per year required for the actual cold chain capacity	*A / B*	2	2	2	2	2
D	Number of consignments / shipments per year	*Based on national vaccine shipment plan*	3	3	3	3	3
E	Gap (if any)	*((A / D) - B)*	none	none	none	none	none
F	Estimated cost for expansion	*US $*	none	none	none	none	none

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

As explained in the c-MYP (please see section 3.1 and 4.0), country will start co-financing for the pentavalent vaccine at the rate of $0.30 cents per dose right from the first year of vaccine introduction in 2009 and in the next year of this multi-year plan. At this co-financing rate, the country will procure approximately 500,000 doses of vaccine constituting about 10% of total vaccine and injection supply needs at a cost of 1.8 million (please see table 6.4) from its own resources in middle of 2009.

A new multi-year plan covering next five years 2011-2015 will be prepared in late 2010, and an annual increase in government co-financing by 10% of the current cost of vaccine will be proposed starting from 2011 to 2015. The proposed co-financing by government will also take into account the revised GAVI policies on co-financing from 2011 to 2015, which we understand will be announced in late 2010. It is hoped that the price of pentavalent vaccine will decline sufficiently by 2015 to allow government of Viet Nam to fully finance the vaccine from its own domestic resources. However, depending upon the economic situation in Viet Nam in 2015 and market price of pentavalent vaccine in 2015, further strategies for financing of pentavalent vaccine will be reviewed in 2015.

The Government of Viet Nam is fully committed to children health as explained in section 1 of c-MYP (page 1-2) and is currently fully financing the cost of all the traditional vaccines and injection supplies (BCG, DPT, TT, measles, OPV). In the next five year plan, the government will also take over the financing of 2nd dose of measles vaccine after the end of 5 years support from GAVI in 2012. In addition, the government is fully committed to finance all the operational costs related to immunization services. The cold chain capacity is sufficient to allow introduction of pentavalent vaccine, and financing for the cold chain is fully secured in this current plan to replace old cold chain equipment at province and district level. In addition, government is financing the nationwide expansion of vaccine against Japanese encephalitis in the current multi-year from its own domestic resources.

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

Disease	Title of the assessment	Date	Results
Hib	WHO estimates for Hib and pneumococcal disease, sent to country in August 2007	2000	Total annual **cases** of severe illness due to Hib among children 1-59 years of age in year 2000=108423 (85083-154093) Meningitis cases=625(0-1330) Severe pneumonia cases: 107563 (85083-152262) Non-meningitis, non-pneumonia cases: 235 (0-501) Total number of annual deaths attributed to Hib: 890 (456-1535)_ Meningitis deaths=181(0-419) Pneumonia deaths=683(456-1056) Non-meningitis, non-pneumonia deaths=26(0-60) The estimates are as on 2000. These deaths amount to 1.9% of all under-5 deaths in 2000.

Formatted: English (United States)

Disease	Title of the assessment	Date	Results
Hib	Rapid assessment of Hib using WHO Hib RAT tools, September 2006	2006	The estimated Hib meningitis incidence in children <5 years age was higher in Ho Chi Minh City (22.5 cases/100,000 [95% CI, 18.4-27.5]) compared with Hanoi (9.8 cases/100,000 [95% CI, 6.5-14.8]). Each year, the Hib RAT suggests there are a total of 883 to 1,915 cases of Hib meningitis and 4,414 to 9,574 cases of Hib pneumonia.
Hib	Anh D, et al, and the Vietnam Invasive Bacterial Disease Surveillance Network. *Haemophilus influenzae* type b meningitis among children in Ha Noi, Viet Nam: epidemiologic patterns and estimates of *H. Influenzae* type b disease burden. *American Journal of Tropical Medicine and Hygiene*, Mar 2006, 74: 509-515	March 2000 to Feb 2002	A more recent study, using the WHO generic protocol for population-based surveillance of Hib in urban Ha Noi between March 2000 and February 2002, estimated the annual incidence of confirmed and probable Hib meningitis based on culture and Hib PCR at 12 per 100 000 under-5 population, with a 4% case fatality rate and a 10% sequelae rate. Confirmed or probable Hib meningitis accounted for 14% of all probable meningitis cases among children under five years of age. However, if probable meningitis cases in the neonatal period are excluded from the denominator, then the proportion of Hib meningitis cases rises to 20.5%, lower than the 35% estimated in the study conducted in Ho Chi Minh City. No cases were detected among children older than two years of age.

Disease	Title of the assessment	Date	Results
Hib, pneumoccocus	Tran TT, *et al*. The etiology of bacterial pneumonia and meningitis in Vietnam. *Pediatric Infectious Disease Journal*, 1998, 17(9 Suppl):S192-194.	May 1995-Nov 1996	Tram and others examined the etiology of bacterial pneumonia and meningitis by recruiting children of one month to 59 months presenting with symptoms and signs of bacterial pneumonia and meningitis between May 1995 and November 1996 in Pediatric Hospital No. 1 in Ho Chi Minh City in South Viet Nam. Based on cerebrospinal fluid (CSF) culture and latex agglutination, among 86 probable bacterial meningitis cases recruited, Hib, pneumococci and other bacterial organisms accounted for 34.9%, 26.7% and 13.6%, respectively. The remaining 21 cases (24%) had pleocytosis and elevated albumin concentrations, but no evidence of bacterial etiology by culture or latex agglutination of CSF. About 90% of Hib meningitis cases occurred in children under one year of age. Among probable bacterial pneumonia cases (n=300), *S. pneumoniae*, Hib and other organisms were identified in 92.5%, 1% and 6.6% of cases, respectively.

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

Lessons Learned	Solutions / Action Points
Sufficient training of health workers and staff at all level is essential for smooth introduction	Comprehensive training plan is included in the pentavalent vaccine introduction plan as enclosed document #8
Strong IEC efforts are essential to increase community demand and to use this opportunity to improve overall coverage with all the vaccines.	Comprehensive IEC plan is included in the pentavalent vaccine introduction plan (please see document # 8)
Involvement of local community leaders is important for uptake of new vaccine.	Involvement of local community leaders is planned. One day workshops for community leaders will be conducted. The role of community leaders and what they can do for introduction of new vaccine will be discuss during the workshops.

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

1. DTP-HepB-HIB single dose vial (fully liquid)

First Preference Vaccine

As reported in the cMYP, the country plans to introduce *Haemphilous influzenza* vaccinations, using **DTP-HepB-HIB** vaccine, in *one dose vial presentation(liquid)* form

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

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

Table 6.3: Specifications of vaccinations with new vaccine

Vaccine: DPT-Hepb-Hib	*Use data in:*		**Year 1 2006**	**Year 2 2007**	**Year 3 2008**	**Year 4 2009**	**Year 5 2010**
Number of children to be vaccinated with the third dose	*Table 3.4*	#	NA	NA	NA	1558295	1581670
Target immunisation coverage with the third dose	*Table 3.4*	#	NA	NA	NA	95%	95%
Number of children to be vaccinated with the first dose	*Table 3.4*	#	NA	NA	NA	1574699	1598318
Estimated vaccine wastage factor	*Annex 2a or 2b Table E - tab 5*	#	NA	NA	NA	1.05	1.05
Country co-financing per dose *	*Annex 2a or 2b Table D - tab 4*	$				$0.30	$0.30

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

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

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

		Year 1 2006	Year 2 2007	Year 3 2008	Year 4 2009	Year 5 2010
Number of vaccine doses	#	NA	NA	NA	498,800	456,100
Number of AD syringes	#	NA	NA	NA	532,600	482,200
Number of re-constitution syringes	#	NA	NA	NA	0	0
Number of safety boxes	#	NA	NA	NA	5,925	5,375
Total value to be co-financed by country	**$**	NA	NA	NA	1,860,500	1,516,000

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

		Year 1 2006	Year 2 2007	Year 3 2008	Year 4 2009	Year 5 2010
Number of vaccine doses	#	NA	NA	NA	5,701,600	4,597,300
Number of AD syringes	#	NA	NA	NA	6,087,700	4,860,900
Number of re-constitution syringes	#	NA	NA	NA	0	0
Number of safety boxes	#	NA	NA	NA	67,575	53,975
Total value to be co-financed by GAVI	**$**	NA	NA	NA	$21,263,000	$15,283,500

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

Second Preference Vaccine

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

DTP-HepB-HIB 2-dose vial (lyophilized)

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

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

		Year 1 2006	Year 2 2007	Year 3 2008	Year 4 2009	Year 5 2010
Number of vaccine doses	#	NA	NA	NA	495,200	452,300
Number of AD syringes	#	NA	NA	NA	528,700	478,200
Number of re-constitution syringes	#	NA	NA	NA	274,800	251,000
Number of safety boxes	#	NA	NA	NA	8,925	8,100
Total value to be co-financed by country	**$**	NA	NA	NA	$1,860,500	$1,516,000

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

		Year 1 2006	Year 2 2007	Year 3 2008	Year 4 2009	Year 5 2010
Number of vaccine doses	#	NA	NA	NA	5,705,300	4,601,100
Number of AD syringes	#	NA	NA	NA	6,091,700	4,864,900
Number of re-constitution syringes	#	NA	NA	NA	3,166,500	2,553,600
Number of safety boxes	#	NA	NA	NA	102,775	82,350
Total value to be co-financed by GAVI	**$**	NA	NA	NA	$21,435,000	$15,423,500

Procurement and Management of New and Under-Used Vaccines

a) Please show how the support will operate and be managed including procurement of vaccines (GAVI expects that most countries will procure vaccine and injection supplies through UNICEF):

Viet Nam will prefer procuring of the pentavalent vaccine which is financed by GAVI through the UNICEF supply system. Two shipments each year will be ordered. However, for its own co-financed part, Viet Nam will procure the vaccine and injection supplies independently, in July of each year, through a WHO prequalified supplier. As per the new regulations in the country, the vaccines imported in Viet Nam have to be licenced in the country, even if the vaccine is procured by UNICEF. Hence, for the supply of any vaccine either by UNICEF or self-procurement, the vaccine has to be both WHO prequalified as well as licensed in Viet Nam. It is very essential that that the pentavalent vaccine to be procured by UNICEF on behalf of GAVI be licensed in Viet Nam as soon as possible in 2008 to enable Viet Nam to introduce this vaccine in January 2009.

In addition, the cash grant ($492,093) for introduction of new vaccine (@$0.30 per child) will be received in a bank account held by NIHE (National Institute of Hygiene and epidemiology), which is part of the MOH as specified in annex 1 on the banking form. NEPI, the national EPI steering group and the ICC will provide oversight over implementation of new vaccine introduction activities and its monitoring and supervision.

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

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

Viet Nam is currently self-procuring BCG, DPT, HepB, JE, cholera, typhoid, measles and OPV vaccines. Among these, BCG, DPT, hepatitis B,JE, cholera, typhoid and OPV are produced within the country and are procured from domestic suppliers. The Country is importing itself the measles vaccine from Sanofi Pasteur. Viet Nam used the UNICEF procurement system only to procure the measles vaccine used in 2007-08 vaccination campaign, as the campaign was financed by UNICEF through the UN foundation. In the case of international importation of vaccines, the country invites an open tender from all suppliers who have a WHO prequalified vaccine and whose vaccine is licensed in Viet Nam. A similar mechanism is proposed to be adopted for the import of pentavalent vaccine.

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

Please refer to document # 8 for detailed introduction plan for pentavalent vaccine.

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

Viet Nam would like to use UNICEF procurement system to purchase the share of pentavalent vaccine along with AD syringes & safety boxes to be financed by GAVI. Hence the funds for vaccine and AD syringes purchase to be financed by GAVI may directly be transferred to UNICEF.

Viet Nam would request GAVI to transfer the new vaccine introduction grant of $492,093 (@$0.30 per birth) to the bank account of NIHE in MOH as indicated in the banking form on Annex 1.

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

Ministry of Health of Viet Nam will be responsible for procurement of the vaccine and injection supply equipment which is to be cofinanced by it. Viet Nam will procure its share of vaccine and injection equipment (about 10% of total estimated requirement) each year in July, starting from 2009.

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

The NEPI regularly monitors the coverage of all routine vaccines by district and province through monthly reports. All the commune health centers are required to send the coverage data in pre-defined reporting forms to districts, which in turn aggregates data for all health centers and sends it upward to provinces. Provinces compile data for all the districts and send to NEPI.

With the introduction of pentavalent vaccine, the reporting forms, immunization registers at the health facility and child immunization cards will be revised to reflect introduction of pentavalent vaccine. The NEPI and ICC will regularly monitor the reported coverage data through regular reviews and analysis. In addition, supportive supervision reports from the routine immunization monitoring system will be used for on-site monitoring. A data quality self-assessment surveys will be organized for selected areas to validate the administratively reported data and the consistency in reporting across different levels of health facilities. NEPI also plans to conduct small scale EPI coverage surveys in selected districts and provinces during the five year plan period as part of EPI review. UNICEF conducts a nationwide Multiple Indicator Cluster Survey (MICS) every five years. The last two MICS surveys were conducted in 2000 and 2006. It is expected that the next survey will be conducted by UNICEF in 2010/2011. These are household surveys that will validate the administrative reported national coverage levels. USAID and Macro International also conduct DHS surveys, and the last two surveys were conducted in 1997 and 2002.

In addition to reporting and monitoring of vaccine coverage data, the sentinel surveillance for meningoencephalitis at the selected hospitals will be established and continued during this plan period. The surveillance data will help to assess the impact of vaccine. Finally, the data on admissions for pneumonia and meningitis in hospitals for children under five years of age as reported through the national health information systems will be regularly monitored.

New and Under-Used Vaccine Introduction Grant

Table 6.5: calculation of lump-sum

Year of New Vaccine introduction	N° of births (from table 3.4)	Share per birth in US$	Total in US$
2009	1,640,311	$ 0.30	492,093

Please indicate in the tables below how the one-time Introduction Grant[5] will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP).

[5] The Grant will be based on a maximum award of $0.30 per infant in the birth cohort with a minimum starting grant award of $100,000

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

Cost Category	Full needs for new vaccine introduction	Funded with new vaccine introduction grant
	US$	**US$**
Training	**700,000**	**180,000**
Social Mobilization, IEC and Advocacy	**286,000**	**173,000**
Cold Chain Equipment & Maintenance	**NA**	**NA**
Vehicles and Transportation	**NA**	**NA**
Programme Management	**100,000**	**82,000**
Surveillance and Monitoring	**457,000**	**57,000**
Total	**1,543,000**	**492,000**

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

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

The 2nd choice vaccine is lyophilized pentavalent vaccine and requirement of funding for this 2nd preference is not likely to be different from liquid vaccine and the same table given above will also be applicable to the 2nd preference vaccine.

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

8. Documents required for each type of support

Type of Support	Document	DOCUMENT NUMBER	Duration *
ALL	WHO / UNICEF Joint Reporting Form (last two)	1, 2	2006, 2007
ALL	Comprehensive Multi-Year Plan (cMYP)	3	2006-2010
ALL	Endorsed minutes of the National Coordinating Body meeting where the GAVI proposal was endorsed		
ALL	Endorsed minutes of the ICC/HSCC meeting where the GAVI proposal was discussed	4	2008
ALL	Minutes of the three most recent ICC/HSCC meetings	5,6,7	2007
ALL	ICC/HSCC workplan for the forthcoming 12 months		
Injection Safety	National Policy on Injection Safety including safe medical waste disposal (if separate from cMYP)		
Injection Safety	Action plans for improving injection safety and safe management of sharps waste (if separate from cMYP)		
Injection Safety	Evidence that alternative supplier complies with WHO requirements (if not procuring supplies from UNICEF)		
New and Under-used Vaccines	Plan for introduction of the new vaccine (if not already included in the cMYP)	8	2008 - 2010
JICS assessment report		9	2007

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

ANNEX 1

Banking Form

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

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

Name of Institution: *(Account Holder)*			
Address:			
City – Country:			
Telephone No.:		**Fax No.:**	
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**	
For credit to: ***Bank account's title***			
Bank account No.:			
At: ***Bank's name***			

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

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

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

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

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

FINANCIAL INSTITUTION		CORRESPONDENT BANK (*In the United States)*
Bank Name:		
Branch Name:		
Address:		
City – Country:		
Swift code:		
Sort code:		
ABA No.:		
Telephone No.:		
Fax No.:		
Bank Contact Name and Phone Number:		

I certify that the account No. . . . . is held by *(Institution name)* . . . . . .at this banking institution.

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name:	**Signature:**
Title:	**Date:**
2 Name:	**Seal:**
Title:	
3 Name:	
Title:	
4 Name:	
Title:	

COVERING LETTER

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

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

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

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

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

Signature of UNICEF Representative:

Name .....

Signature .....

Date .....