GAVI
THE GLOBAL ALLIANCE FOR VACCINES & IMMUNIZATION

Partnering with The Vaccine Fund

January 2005

Progress Report

to the
Global Alliance for Vaccines and Immunization (GAVI)
and The Vaccine Fund

By the Government of

COUNTRY: UGANDA

Date of submission: May 15, 2005

Reporting period: 2004 *(Information provided in this report **MUST** refer to 2004 activities)*

(Tick only one) :

Inception report	ρ
First annual progress report	ρ
Second annual progress report	ρ
Third annual progress report	ρ
Fourth annual progress report	ρ √
Fifth annual progress report	ρ

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided.
Unless otherwise specified, documents may be shared with GAVI partners and collaborators

Progress Report Form: Table of Contents

1. Report on progress made during 2004

To be filled in by the country for each type of support received from GAVI/The Vaccine Fund.

1.1 Immunization Services Support (ISS)

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC).
Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

Mechanism for management of ISS funds

The UNEPI annual work plan and budget for 2004 were developed. The plan of action outlined the various potential sources of funding for activities including the Ministry of Health (MOH) and partners such as WHO, UNICEF and GAVI. The plan was presented, discussed and approved by the ICC. The ICC, chaired by the Honourable Minister of State for Health (PHC), plays a critical role in reviewing and approving proposed program expenditure including guiding the program on the optimal use of funds.

UNEPI requests the Permanent Secretary of the MOH to authorise release of government and GAVI funds for specific activities as the need arises. The requests are reviewed by the MOH and government (internal and external) auditing system. A cheque is prepared for release of funds according to government regulations. A separate account from the MOH/ UNEPI account is maintained for GAVI funds. The signatories to this separate account are the Permanent Secretary – MOH, Principal Accountant – MOH and the UNEPI Programme Manager. Approved funds for the districts are sent by bank drafts to the district health accounts through the district accounting officers (CAOs). Funds released at district level are subjected to similar auditing procedures prior to the releases. At the national and district levels, the government auditors certify expenditure and accountability after completion of the activity. The MOH is responsible for the overall accountability of funds.

Problems encountered involving use of ISS funds

1. Sustainability of activities supported by ISS funds.
2. ISS funds seen as available; this has affected allocation of government funds to the operations of the programme.

1.1.2 Use of Immunization Services Support

In 2004, the following major areas of activities have been funded with the GAVI/Vaccine Fund ***Immunization Services Support*** *contribution.*

Funds received during 2004 USD 2,180,500 (1st half of GAVI reward)
Remaining funds (carry over) from 2003 USD 1,192,607
Total funds available 2004 USD 3,373,107

Table 1: Use of funds during 2004

Area of Immunization Services Support	Total amount in US $	AMOUNT BUDGETED FOR			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/ Province	District	
Vaccines (clearing and handling costs)	33,627.44	33,627.44			
Injection supplies					
Personnel					
Transportation	133,333.33	133,333.33			
Maintenance and overheads	8,162.79	8.162.79			
Training	90,227.40	6,956.98		74,498.52	8,771.90
IEC / social mobilization	204,785.24	25,363.24		179,422.00	
District operations including monitoring of outreaches	510,406.27			510,406.27	
Supervision	55,576.86			55,576.86	
Monitoring and evaluation					
Epidemiological surveillance	33,231.75	15,687.89		17,543.86	
Vehicles	136,052.86	136,052.86			
Cold chain equipment	71,670.09			71,670.09	
Other: Bank charges	2,267.85	2,267.85			
Collaboration with CBOs	15,087.30				15,087.30
Sub -Total:	**1,294,429.18**	**361,452.38**	**0**	**909,117.60**	**23,859.20**
Funds already committed for disbursement in early 2005					
Vaccines stabilization fund	500,000	500,000			

Vehicles	500,000			500,000	
Construction of Central vaccine stores and offices	1,000,000	1,000,000			
Maintenance and overheads	32,143	32,143			
Sub-Total	**2,032,143**	**1,532,143**	**0**	**500,000**	**0**
Total Expenditure $ Obligated	**3,326,572.18**	**1,893,595.38**	**0**	**1,409,117.60**	**23,859.20**
Remaining funds for 2005:	**46,534.82**				

**If no information is available because of block grants, please indicate under 'other'.*
Please attach the minutes of the ICC meeting(s) when the allocation of funds was discussed.

Dates of ICC meetings: 16th September 2004 **(Document 1)**

Please report on major activities conducted to strengthen immunization, as well as, problems encountered in relation to your multi-year plan.

Major activities conducted to strengthen immunisation:

Planning

- Developed an annual work plan for 2004 based on a review of 2003 performance and emerging issues.
- Developed vaccine management plan.
- Developed financial sustainability implementation plan for 2004
- Developed wild polio virus importation preparedness plan
- Conducted microplanning for accelerated routine immunisation activities with district leaders from 8 conflict-affected districts in north and north eastern Uganda: Apac, lira, Gulu, Sorot, Katakwi, Kaberamaido, Pader and Kitgum.

Capacity building and service delivery

- 209 Health Sub District (HSD/ health zone) EPI Focal Persons were trained in EPI service delivery and management including RED approach.
- 30 EPI central supervisors were trained to strengthen support supervision for routine immunisation and were supported to conduct supervision.
- Sensitised private practitioners in 11 districts on EPI service delivery including HMIS and reporting mechanisms.
- 20 district cold chain assistants were trained to improve cold chain and vaccine management.
- 1,730 operational level health workers in 4 districts were trained in injection safety and waste management in collaboration with JSI/ USAID.
- 352 district and operational health workers trained in vaccine management in 16 districts.
- 112 incinerator operators trained at HSD level on use of de montfort incinerators.

- Financial support provided to 9 districts for implementation of integrated outreaches in hard to reach areas.
- 16 poor performing districts given focussed support through implementation of RED approach and focussed supervision.
- Developed and disseminated guidelines for delivery of outreach services to all districts.

Transport:

- Procured 2 new vehicles (double cabins) and a vaccine truck.
- Placed orders for 500 motorcycles for health centres, 14 vehicles for districts for support supervision, distribution of vaccines and cold chain maintenance, and 4 film vans to boost social mobilisation and obtained quotation for a minibus staff shuttle.

Advocacy and social mobilisation

- Conducted district visits with top management of MOH (including Honourable Minister of State for Health (PHC) and partners) to meet district, religious and local leaders for advocacy in poor performing districts: Kiboga, Masindi, Moroto, Nakapiripirit and Kotido.
- Developed MNTE communication strategy and messages that were used during SIAs in 6 high-risk districts.
- Reviewed the social mobilisation communication strategy for routine immunisation
- Developed IEC materials and radio messages for routine immunisation
- Developed a guide for strengthening interpersonal communication between health workers, parish mobilisers and caretakers for orientation in selected pilot districts: Kayunga and Iganga. The pilot is ongoing.
- Supported 10,336 parish mobilisers to conduct house-house mobilisation for immunisation.

Cold chain and vaccine management

- Conducted forecasting and monthly distribution of vaccines to all districts. No vaccine stock outs were experienced at national level and no stock outs reported at district level.
- Supported districts to conduct cold chain maintenance.
- 26 new static units were established and equipped with refrigerators and immunisation equipment, and 47 refrigerators were distributed for replacement of old/ non functional equipment.
- Established 80 sentinel sites for vaccine utilisation monitoring.

Accelerated disease control

- 30 central trainers and 138 district trainers were trained in maternal and neonatal tetanus elimination (MNTE) for supplemental activities, surveillance and routine immunisation in 6 high-risk districts.
- Conducted 2 rounds of TT campaigns for women of childbearing age in 6 high-risk districts during September and October 2004. Achieved (105%) in round 1 and (91%) in round 2.

Disease Surveillance

- Established a 4th regional EPI/ disease surveillance site: Arua
- Scaled up case based measles surveillance nationwide.
- Supported the 3 Paediatric Bacterial Meningitis (PBM) sites and strengthened pneumococcal disease surveillance with an additional site.

Problems encountered:

- Limited district ownership and leadership of the EPI programme.
- Transport constraints to conduct regular support supervision, cold chain maintenance and distribution of supplies especially at lower levels.
- Understaffing and high attrition rates at service delivery level. This has disrupted functioning of outreaches at some health units.
- High vaccine wastage particularly measles and BCG vaccines
- Procurement delays at MOH.
- Inadequate dry and cold storage space at the central vaccine store.
- Due to competing priorities for the budgetary allocation to the Ministry of Health, majority of the funds allocated for EPI were used to procure the traditional vaccines, leaving the programme with minimal funds for operational activities. The operational activities were mainly supported with the GAVI ISS funds.

1.1.3 Immunization Data Quality Audit (DQA) *(If it has been implemented in your country)*

Has a plan of action to improve the reporting system based on the recommendations from the DQA been prepared?
If yes, please attach the plan.

YES [v] NO [ ]

If yes, please report on the degree of its implementation.

Refer to **Document 2** for the planned activities and progress on implementation of DQA recommendations

Please attach the minutes of the ICC meeting where the plan of action for the DQA was discussed and endorsed by the ICC.

ICC meeting: The plan of action for DQA was discussed in detail during the UNEPI technical planning meeting that developed the annual work plan 2004. The annual work plan that included the DQA was presented to the ICC meeting of January 28, 2004. **(Document 3)**

Please report on studies conducted regarding EPI issues during 2004 (for example, coverage surveys).

EPI studies, 2004:

- Mass measles campaign verification survey (January 2004). The crude coverage for measles among children sampled between 6 months and 14 years was 98%, while the valid coverage was 67%.
- District specific routine immunisation coverage surveys in 11 districts (January 2004).
- MNTE campaign evaluation in the 5 Busoga region districts (March 2004)
- Effective Vaccine Stores Management assessment (EVSM), March 2004. The assessment was conducted at the central vaccine store and highlighted presence of efficient vaccine storage equipment but lack of adequate storage space.
- Vaccine management assessment (March 2004). 80 health facilities in 8 districts were systematically sampled. The main areas of weakness noted were vaccine wastage monitoring and stock recording.
- Training needs assessment (April 2004). Identified gaps in pre- and in-service training. Recommendations from the assessment have been addressed in the EPI comprehensive plan for 2005-2009.Assessment of system wide barriers to provision of immunisation services (May 2004). The main barriers identified are transport, human and financial resources.
- Ware house efficiency assessment (May 2004). The assessment provided UNEPI with preliminary information on space required for office and storage, and future transport needs.
- Assessment of the risk and epidemiology of Yellow Fever in Uganda (October 2004).
- Gas re-supply study (December 2004). Assessed the distribution of gas, the potential options for decentralisation of gas re-supply from central to the district level and development of a gas cylinder tracking system.

On-going studies

- Drop-out tracking study.
- Hib vaccine effectiveness study.
- Hepatitis B serosurvey among adults aged 15-59 years in Uganda.
- Cost-effectiveness of hepatitis B and Hib vaccines.

1.2 GAVI/Vaccine Fund New & Under-used Vaccines Support

1.2.1 Receipt of new and under-used vaccines during 2004

Start of vaccinations with the new and under-used vaccine: MONTH: June YEAR: 2002

Please report on receipt of vaccines provided by GAVI/VF, including problems encountered.

DPT-HepB+Hib vaccines were received in 2004 as follows:

1. January 7, 2004:	758,200 doses
2. April 21, 2004:	702,400 doses
3. June 23, 2004:	450,200 doses
4. June 30, 2004:	450,200 doses
5. August 25, 2004:	975,000 doses
6. October 10, 2004:	900,000 doses
7. December 9, 2004:	899,800 doses
Total received:	**5,135,800 doses**

Problems encountered: Late delivery of the vaccines for the 4th quarter of 2003 i.e. in December 2003, affected the planning for shipment of vaccines in 2004 due to the constraint of storage space. This was further aggravated by the bulk vaccine stocks required for supplemental immunization activities.

1.2.2 Major activities

Please outline major activities that have been or will be undertaken, in relation to, introduction, phasing-in, service strengthening, etc. and report on problems encountered.

Activities undertaken in relation to service strengthening:
Refer to activities as outlined on pages 5-6

Activities to be undertaken in relation to service strengthening (2005):

- Strengthening of support supervision for routine immunisation including expansion of regional surveillance sites.
- Consolidation of RED approach in all districts.
- Review of programme performance and development of multi year plan.
- Strengthen advocacy for EPI through involvement of political, religious and cultural leaders at all levels, the private sector, women and youth councils.
- Initiation of hepatitis B surveillance and strengthening of Yellow Fever surveillance.
- Continue with operational research.

1.2.3 Use of GAVI/ The Vaccine Fund financial support (US$100,000) for the introduction of the new vaccine

Please report on the proportion of 100,000 US$ used, activities undertaken, and problems encountered such as delay in availability of funds for programme use.

A report on introduction of the new vaccine was given in the 1st and 2nd annual progress report.

1.3 Injection Safety

1.3.1 Receipt of injection safety support

Please report on receipt of injection safety support provided by GAVI/VF, including problems encountered

The following injection safety materials were received with support from GAVI in 2004:

0.05 ml ADs:	1,851,200
0.5 ml ADs:	13,817,200
2 ml syringes:	3,661,800
5 ml syringes:	191,000
Safety boxes:	227,250

1.3.2 Progress of transition plan for safe injections and safe management of sharps waste.

The Government of Uganda has already provided the necessary funds for procurement of all injection safety materials through UNICEF for BCG, TT and measles vaccine for the routine programme for 2005.

Please report problems encountered during the implementation of the transitional plan for safe injection and sharp waste

Problems encountered during implementation of the transitional plan:

Transition of safe injection support from GAVI to Government of Uganda was smooth.

Please report on the progress based on the indicators chosen by your country in the proposal for GAVI/VF support.

Indicators	Targets	Achievements	Constraints	Updated targets
1. % of health units using ADs for routine immunisation	100% of health units using ADs for routine immunisation	100% of health units are using ADs for routine immunisation	-Inadequate waste management of sharps waste. The current number of incinerators is insufficient given that there are 214 HSDs. -Delayed construction of 3 incinerators in 3 districts of northern Uganda due to insecurity (completed in January 2005). -Sub-optimal utilisation of some de Montfort incinerators at HSD level. There is need for an appropriate (language and	1. The MOH is introducing use of ADS for clinical and curative services. 2. The MOH plan is to have an incinerator at every health sub-district. Other programmes will contribute to these two MOH objectives. Therefore these are not specific UNEPI targets.
2. % of districts with at least one incinerator constructed	100% of districts with at least 1 incinerator	53 (95%) of districts had at least 1 incinerator by the end of 2004, constructed at health sub-district (HSD) level.		

			literacy level) manual/ guide for operation of the incinerators.	

1.3.3 Statement on use of GAVI/The Vaccine Fund injection safety support (if received in the form of a cash contribution)

The following major areas of activities have been funded (specify the amount) with the GAVI/The Vaccine Fund injection safety support in the past year:

There was no cash contribution towards injection safety support activities.

2. Financial sustainability

Inception Report: Outline timetable and process for the development of a financial sustainability plan. Describe assistance that may be needed for developing a financial sustainability plan.

First Annual Progress Report: Submit completed financial sustainability plan by given deadline. Describe major strategies for improving financial sustainability.

Subsequent Progress Reports: According to current GAVI rules, support for new and under-used vaccines is covering the total quantity required to meet country targets (assumed to be equal to DTP3 targets) over a five year period (100% x 5 years = 500%). If the requested amount of new vaccines does not target the full country in a given year (for example, a phasing in of 25%), the country is allowed to request the remaining (in that same example: 75%) in a later year. In an attempt to help countries find sources of funding in order to attain financial sustainability by slowly phasing out GAVI/VF support, they are encouraged to begin contributing a portion of the vaccine quantity required. Therefore, GAVI/VF support can be spread out over a maximum of ten years after the initial approval, but will not exceed the 500% limit (see figure 4 in the GAVI Handbook for further clarification). In table 2.1, specify the annual proportion of five year GAVI/VF support for new vaccines that is planned to be spread-out over a maximum of ten years and co-funded with other

sources. **Please add the three rows (Proportion funded by GAVI/VF (%), Proportion funded by the Government and other sources (%), Total funding for DPT-HepB+Hib *(new vaccine)*.**

Table 2.1: Sources (planned) of financing of new vaccine *(specify)* Government of Uganda

Proportion of vaccines supported by *	Annual proportion of vaccines									
	2002	2003	2004	2005	2006	2007	2008	2009	20.	20.
A: Proportion funded by GAVI/VF (%)***	58[1]	53[2]	100	95.8[3]	94.8[4]	75[5]	23.4	-		
B: Proportion funded by the Government and other sources (%)	0	0	0	4.2	5.2	25[6]	26	28		
C: Total funding for DPT-HepB+Hib *(new vaccine)*	58	53	100	100	100	100	49.4	28		

* *Percentage of DTP3 coverage (or measles coverage in case of Yellow Fever) that is target for vaccination with a new and under-used vaccine.*
** *The first year should be the year of GAVI/VF new vaccine introduction*
*** Row A *should total 500% at the end of GAVI/VF support*

1. DPT-HepB-Hib vaccine was introduced in June 2002 and the stock of vaccines received was just enough for the seven months i.e. June-December 2002. Therefore for the calendar year 2002, vaccine was catered for by GAVI for seven of twelve months, or 58.3%.
2. In 2003, due to a global stock-out of vaccine, there was a national stock-out of DPT-HepB-Hib vaccine from September to December, or 4 months. In addition the entire buffer stock was consumed due to vaccine procurement calculation issues previously raised (buffer stock of 25% is the equivalent of approximately 3 months stock). Therefore, of the requested allocation equivalent to 15 months vaccine stock (see 2nd annual GAVI report), an amount sufficient for 8 months was available to the country (or 53%). The gap in supply of pentavalent vaccine of 47% will be requested from GAVI in 2007.
3. The funding proportions given for 2005 are based on a commitment by the Government of Uganda yet to be fulfilled.
4. Government of Uganda has committed to contribute **USD 777,024** corresponding to the cost of the DPT component of the pentavalent vaccine (**5.2%** of total vaccine costs for 2006).
5. According to the guidelines, GAVI will provide support for the equivalent of 5 entire birth cohorts. With a programme beginning in June 2002, and taking into account the stock-out experienced in 2003, there should still be 98.4% of the allocation for a birth cohort available to Uganda. If by 2007, in line with the FSP, Uganda takes on the cost equivalent of hepatitis B vaccine (or approximately 25% of the cost of DPT-HepB-Hib), 23.4% of the GAVI contribution can be phased into 2008.
6. From 2007 onwards, the estimated government contribution is as stated in the Uganda FSP submitted to GAVI in 2003. There may be need to revise future funding proportions from the government according to the proportion of the health budget allocated to EPI. There is a gap in funding from 2008 after the GAVI support ends.

In table 2.2 below, describe progress made against major financial sustainability strategies and corresponding indicators.

Table 2.2: **Progress against major financial sustainability strategies and corresponding indicators**

Financial Sustainability Strategy	Specific Actions Taken Towards Achieving Strategy	Progress Achieved	Problems Encountered	Baseline Value of Progress Indicator	Current Value of Progress Indicator	Proposed Changes To Financial Sustainability Strategy
1. Mobilisation of additional resources	1. Follow up of budget process in MOH to ensure expected resources are budgeted for.	Some effort made by UNEPI and WHO for 2004/05 budget	Expected resources are not guaranteed	MoH allocation caters for BCG, OPV, TT and measles vaccines, gas supply and some operational costs	MoH allocation caters for BCG, OPV, TT and measles vaccine, gas supply and injection materials Contribution towards DPT-HepB-Hib vaccine expected in 2005	Review of government contribution in FSP in view of narrow resource envelope
	2. Identification of potential new donors	Potential donors identified e.g. World Bank	No commitments made; slow progress of implementation	0	1	
	3. Develop required brief(s) highlighting key messages for respective audiences	Policy brief prepared for advocacy				
	4. Distribution and discussion of key FSP messages with respective audiences	Presentations and discussions held with HPAC, JRM, ICC				
	5. Identify and advocate with private corporations	Not yet done	Competing priorities; slow progress of implementation			
	6. Monitoring and follow up of progress	Quarterly ICC meetings held		Quarterly ICC meetings	4 meetings held	
2. Increase reliability of resources	1. Discussions with the MOH planning and budgeting divisions to ensure protection of funds for new vaccine in programme 9.	Discussions held including visits by the GAVI Executive Secretary	Constrained resource enveloped	--	--	

Financial Sustainability Strategy	Specific Actions Taken Towards Achieving Strategy	Progress Achieved	Problems Encountered	Baseline Value of Progress Indicator	Current Value of Progress Indicator	Proposed Changes To Financial Sustainability Strategy
		Participation in health sector working group (HSWG) Disbursement of funds form Government for bulk purchase of vaccines has improved for timely procurement	Representation in HSWG does not specifically include EPI team			
	2. Explore feasibility of a revolving fund for vaccines using GAVI reward money.	Vaccine stabilisation fund (US$500,000) provided to UNICEF		No revolving fund	Revolving funds initiated with GAVI reward funds.	
	3. Stretching out of present GAVI funding beyond 5 years	4.2% of DPT-HepB+Hib cost committed by GOU for 2005	Commitment not yet fulfilled at the time of this report	GAVI fund to end after 5 years: 2006 --	GAVI funding to stretch to 2007	
	4. Establish dialogue with the Vaccine Fund to secure funds not spent due to changes in vaccine availability	Assurance from GAVI that support is for 5 full birth cohorts and no funds will be lost			Funds not spent in 2002 due to late start and 2003 due to stock-out will be requested from GAVI in 2007	
3. Improve efficiency of resources	1. Revise UNEPI 5 year plan to improve programme efficiency	EPI review planned for June 2005		UNEPI plan for 2000-2005 in place	2006-2010 multi year plan to be developed in 2005	
	2.Train personnel at HSD level on managing vaccine programme efficiency,	209 HSD EPI focal persons identified and	Need for follow up; lack of transport for	0	209	

Financial Sustainability Strategy	Specific Actions Taken Towards Achieving Strategy	Progress Achieved	Problems Encountered	Baseline Value of Progress Indicator	Current Value of Progress Indicator	Proposed Changes To Financial Sustainability Strategy
	microplanning	trained	supervision			
	2. Implement recommendations from DQA	Refer to annex 1 for progress	Inadequate staff at all levels for data management; data storage at district level not harmonised			
	3. Utilise most cost-effective power sources where possible, switching from gas to electric fridges	Assessment planned		Districts utilising gas and solar energy as power sources	Districts utilising gas and solar energy as power sources	
	4. Integrate outreaches and identify local low-cost strategies for social mobilisation and training for logistics management	Guidelines for integrated outreaches developed and disseminated; 9 districts supported in implementation of integrated outreaches in hard to reach areas	Transport constraints; inadequate number of health workers to deliver integrated package			
	5. Strengthen supervision and revisit the guidelines for districts.	Focussed supervision to poor performing districts done; integrated supervision by area teams on-going	Transport constraints at district level			

3. Request for new and under-used vaccines for year 2006

*Section 3 is related to the request for new and under used vaccines and injection safety for **2006**.*

3.1. Up-dated immunization targets

Confirm/update basic data approved with country application: figures are expected to be consistent with those reported in the WHO/UNICEF Joint Reporting Forms. Any changes and/or discrepancies **MUST** be justified in the space provided (page 12). Targets for future years **MUST** be provided.

Table 3 : Update of immunization achievements and annual targets

Number of	Achievements and targets								
	2004	2005	2006	2007	2008	2009	2010	2011	2012
DENOMINATORS									
Births (4.85% of total population)	1,275,662	1,319,569	1,362,572	1,407,332	1,453,937	1,502,483	1,553,069	1,605,804	1,660,799
Infants' deaths	144,663	149,642	154,519	159,595	164,879	170,385	176,121	182,102	188,338
Surviving infants (4.3% of total population)	1,130,999	1,169,927	1,208,053	1,247,737	1,289,058	1,332,098	1,376,948	1,423,702	1,472,461
Infants vaccinated in 2004 (JRF) / to be vaccinated in 2005 and beyond with 1st **dose** of DTP (DTP1)* (1)	-	-	-	-	-	-	-	-	-
Infants vaccinated 2004 (JRF) / to be vaccinated in 2005 and beyond with 3rd **dose** of DTP (DTP3)* (2)	-	-	-	-	-	-	-	-	-
NEW VACCINES **									
Infants vaccinated 2004 (JRF) / to be vaccinated in 2005 and beyond with 1st **dose** of DTP (DTP1)* DTP-HepB-Hib *(new vaccine)*	1,146,716	1,200,808	1,253,566	1,308,819	1,366,701	1,427,359	1,490,946	1,557,630	1,627,583
Infants vaccinated 2004 (JRF) / to be vaccinated in 2005 and beyond with 3rd **dose** of DTP-HepB-Hib *(new vaccine)*	987,520 (87%)	1,029,536 (88%)	1,075,167 (89%)	1,122,963 (90%)	1,173,043 (91%)	1,225,530 (92%)	1,280,562 (93%)	1,338,280 (94%)	1,398,838 (95%)

Wastage rate in 2004 and plan for 2005 beyond*** *DPT-HepB-Hib (new vaccine)*	11%	10%	10%	10%	10%	10%	10%	10%	10%
INJECTION SAFETY**									
Pregnant women vaccinated in 2004 (JRF) / to be vaccinated in 2005 and beyond with TT2	699,561 (53%)	1,032,800 (73%)	1,081,067 (74%)	1,131,669 (75%)	1,184,734 (76%)	1,256,509 (78%)	1,315,466 (79%)	1,377,350 (80%)	1,442,327 (81%)
Infants vaccinated in 2004 (JRF) / to be vaccinated in 2005 and beyond with BCG *	1,280,066 (100%)	1,319,565 (100%)	1,362,572 (100%)	1,407,332 (100%)	1,453,937 (100%)	1,502,483 (100%)	1,553,069 (100%)	1,605,804 (100%)	1,660,799 (100%)
Infants vaccinated in 2004 (JRF) / to be vaccinated in 2005 and beyond with Measles *	1,023,758 (91%)	1,076,333 (92%)	1,123,489 (93%)	1,178,873 (94%)	1,224,605 (95%)	1,278,814 (96%)	1,335,640 (97%)	1,395,228 (98%)	1,457,736 (99%)

* Indicate actual number of children vaccinated in 2004 and updated targets (with either DTP alone or combined)

** Use 3 rows (as indicated under the heading **NEW VACCINES**) for every new vaccine introduced

*** Indicate actual wastage rate obtained in past years

**** Insert any row as necessary

Note:

- The source of the population figures is the Uganda Bureau of Statistics (UBOS) based on provisional results of the 2002 census. Official national estimates from UBOS have been provided up to 2005; projections beyond 2005 are MoH figures awaiting final projections from UBOS.
- The number of children to be vaccinated with DPT-HepB-Hib 1 is calculated as a proportion of the projected birth cohort for vaccine procurement purposes, in line with the requirements for Table 4. The proportions used range from 90% in 2004 (actual doses administered compared to birth cohort) to 98% in 2012 (estimated proportion) in 1% annual increments. This should not be confused with DPT1 coverage which by convention is calculated using the number of surviving infants as a denominator (101% for 2004).
- The coverage targets for 2005 onwards have been revised for all antigens except TT2+ for pregnant women and will be finalised in the multi year plan to be developed in June 2005. Coverage for DPT-HepB-Hib 3 and measles is calculated as a proportion of surviving infants, according to convention. Coverage for BCG is calculated as a proportion of the birth cohort, according to convention.
- This table assumes maintenance of DPT-HepB-Hib vaccine beyond 2007, according to information received of Uganda eligibility for a bridging plan for pentavalent vaccine.
- The DPT-HepB-Hib wastage rate indicated for 2004 is from the national data for doses administered compared to doses distributed (11.2%). Sentinel site for vaccine utilisation monitoring reports wastage of 12.4% in selected sentinel sites.

Please provide justification on changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the WHO/UNICEF Joint Reporting Form in the space provided below.

A national census was conducted in 2002. According to the latest update of the 2002 population census figures, the proportions of pregnant women, surviving infants and birth cohort have been revised to 5.0%, 4.3% and 4.85% respectively. The denominators for 2004 and subsequent years have therefore been revised from the previously approved plan. Due to achievement of vaccination coverage figures above the set targets, coverage targets have also been revised to reflect current and future expected performance.

5. Availability of revised request for new vaccine *(to be shared with UNICEF Supply Division)* **for 2006**

In case you are changing the presentation of the vaccine, or increasing your request; please indicate below if UNICEF Supply Division has assured the availability of the new quantity/presentation of supply.

Not applicable.

Table 4: Estimated number of doses of DPT-HepB+Hib vaccine *(specify for one presentation only):*

		Formula	For 2006
A	Infants vaccinated/to be vaccinated with 1st dose of DPT-HepB-Hib*		1,253,566
B	Percentage of vaccines requested from The Vaccine Fund taking into consideration the Financial Sustainability Plan	%	94.8%
C	Number of doses per child		3
D	Number of doses	*A x Bx C*	3,565,142
E	Estimated wastage factor	*(see list in table 3)*	1.11
F	Number of doses (incl. Wastage)	*A x C x E x B/100*	3,957,307
G	Vaccines buffer stock	*F x 0.25*	989,327
H	Anticipated vaccines in stock at start of year 2006 (including balance of buffer stock)		2,732,000
I	Total vaccine doses requested	*F + G - H*	2,214,634
J	Number of doses per vial		2
K	Number of AD syringes (+10% wastage)	*(D + G – H) x 1.11*	2,022,940
L	Reconstitution syringes(+10% wastage)	*I / J x 1.11*	1,229,122
M	Total safety boxes (+10% of extra need)	*(K + L) / 100 x 1.11*	36,098

**Please report the same figure as in table 3.*

NB. Line B. Government proportion different from FSP due to unavailability of anticipated resources.

Table 5: Wastage rates and factors

Vaccine wastage rate	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%
Equivalent wastage factor	1.05	1.11	1.18	1.25	1.33	1.43	1.54	1.67	1.82	2.00	2.22	2.50

Remarks

- **Phasing:** Please adjust estimates of target number of children to receive new vaccines, if a phased introduction is intended. If targets for hep B3 and Hib3 differ from DTP3, explanation of the difference should be provided
- **Wastage of vaccines:** Countries are expected to plan for a maximum of: 50% wastage rate for a lyophilized vaccine in 10 or 20-dose vial; 25% for a liquid vaccine in a10 or 20-dose vial; 10% for any vaccine (either liquid or lyophilized) in 1 or 2-dose vial.
- **Buffer stock:** The buffer stock is recalculated every year as 25% the current vaccine requirement
- **Anticipated vaccines in stock at start of year 2006:** It is calculated by counting the current balance of vaccines in stock, including the balance of buffer stock. Write zero if all vaccines supplied for the current year (including the buffer stock) are expected to be consumed before the start of next year. Countries with very low or no vaccines in stock must provide an explanation of the use of the vaccines.
- **AD syringes:** A wastage factor of 1.11 is applied to the total number of vaccine doses requested from the Fund, excluding the wastage of vaccines.
- **Reconstitution syringes:** it applies only for lyophilized vaccines. Write zero for other vaccines.
- **Safety boxes:** A multiplying factor of 1.11 is applied to safety boxes to cater for areas where one box will be used for less than 100 syringes

6. Confirmed/revised request for injection safety support for the years 2006 –2007

Table 6: Estimated supplies for safety of vaccination for the next two years with ..... *(Use one table for each vaccine BCG, DTP, measles and TT, and number them from 4 to 8)*

		Formula	For 2006	For 2007
A	Target if children for ….. Vaccination (for TT: target of pregnant women) *1*	#		
B	Number of doses per child (for TT: target of pregnant women)	#		
C	Number of ….doses	A x B		
D	AD syringes (+10% wastage)	C x 1.11		
E	AD syringes buffer stock *2*	D x 0.25		
F	Total AD syringes	D + E		
G	Number of doses per vial	#		
H	Vaccine wastage factor *4*	Either 2 or 1.6		
I	Number of reconstitution syringes (+10% wastage) *3*	C x H X 1.11/G		
J	Number of safety boxes (+10% of extra need)	(F + I) x 1.11/100		

1 Contribute to a maximum of 2 doses for Pregnant Women (estimated as total births)

2 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 for other years.

3 Only for lyophilized vaccines. Write zero for other vaccines.

4 Standard wastage factor will be used for calculation of reconstitution syringes. It will be 2 for BCG, 1.6 for measles and YF

If quantity of current request differs from the GAVI letter of approval, please present the justification for that difference.

No request from Uganda for 2006 – 2007.

7. Please report on progress since submission of the last Progress Report based on the indicators selected by your country in the proposal for GAVI/VF support

Indicators	Targets	Achievements (2004)	Constraints	Updated targets (2005)
1. DPT3 coverage	80%	87%	▪ Inadequate transport for supervision ▪ Inadequate support supervision at all levels ▪ Shortage of adequate manpower coupled with high turn over of service providers at various levels	88%
2. DPT1-3 dropout rate	14%	14%		10%
3. Completeness of reporting to ESD (% districts reporting to ESD for weekly tracking of epidemic prone diseases).	97%	97%		
4. % of health units using ADS for routine immunisation	100%	100%		

8. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission	v	
Reporting Period (consistent with previous calendar year)	v	
Table 1 filled-in	v	
DQA reported on	v	See Annex 1
Reported on use of 100,000 US$		Not applicable

Injection Safety Reported on	v	
FSP Reported on (progress against country FSP indicators)	v	
Table 2 filled-in	v	
New Vaccine Request completed	v	
Revised request for injection safety completed (where applicable)		Not applicable
ICC minutes attached to the report	v	
Government signatures	v	
ICC endorsed	v	

6. Comments

ICC/RWG comments:

- The Government of Uganda contribution to procurement of vaccines for the EPI program over the years is commendable.
- Financial sustainability of the DPT-HepB-Hib vaccine remains a major challenge. The Government should critically review its commitment to sustaining hepatitis B and Hib vaccines.
- There is need to review the targets for Government contributions towards DPT-HepB-Hib vaccine set up in the FSP, in view of the commitments made so far and the resource constraints.

7. Signatures

For the Government of .....

Signature: .....

Title: .....

Date: .....

We, the undersigned members of the Inter-Agency Co-ordinating Committee endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Financial accountability forms an integral part of GAVI/The Vaccine Fund monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form. The ICC Members confirm that the funds received have been audited and accounted for according to standard government or partner requirements.

Agency/Organisation	Name/Title	Date Signature	Agency/Organisation	Name/Title	Date Signature
Ministry of Health	Hon. Dr. Alex Kamugisha, Minister of State for Health, Primary Health Care, Chair ICC		European Union/ EDF	Mr. Tom Vens, Head of Economics and Social Sectors Desk	
WHO	Dr Oladapo Walker, WHO Representative		DANIDA	Lise Kaalund-Jorgensen, Health Advisor	
UNICEF	Mr Martin Mogwanja, UNICEF Representative		JICA	Mr. Takehiro Susaki JICA Resident Representative	
USAID	Dr. Erik Janowsky, Health Team Leader		Uganda Red Cross Society	Mr Robert Kwesiga, Secretary General	
World Bank	Dr Patrick Okwero, Health Advisor		National Council for Children	Dr. Sam Agatre Okuonzi, Secretary General, NCC	
DFID	Dr. Alastair Robb, Senior Health Advisor		Rotary International Uganda	Hon Nelson Kawalya	

7. Signatures

For the Government of ..... REPUBLIC OF UGANDA

Signature: ..... (DHS - PRD)

Title: ..... FOR PERMANENT SECRETARY

Date: ..... 11th May 2005

We, the undersigned members of the Inter-Agency Co-ordinating Committee endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

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Agency/Organisation	Name/Title	Date	Signature
European Union/ EDF	Mr. Joaris Alain, Head of Economics and Social Sectors Desk		
DANIDA	Lise Kaalund-Jorgensen, Health Advisor	12/5/05	
JICA	Mr. Takehiro Susaki JICA Resident Representative		
Uganda Red Cross Society	Mr Robert Kwesiga, Secretary General		
National Council for Children	Dr. Sam Agatre Okuonzi, Secretary General, NCC		
Rotary International Uganda	Hon Nelson Kawalya		