GAVI
THE GLOBAL ALLIANCE FOR VACCINES & IMMUNIZATION
Partnering with The Vaccine Fund

Progress Report

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

by the Government of

COUNTRY: Mozambique

Date of submission: 28/05/2004
Reporting period: 2003 *(Information provided in this report MUST refer to the previous calendar year)*

(Tick only one) :

Inception report	ρ
First annual progress report	ρ
Second annual progress report	ρ
Third annual progress report	√
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 the GAVI partners and collaborators*

Progress Report Form: Table of Contents

1. Report on progress made during the previous calendar year

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.*

The National Health Directorate is the overall management institution for the ISS Funds within the Ministry of Health. A bank account named GAVI Fund has been opened. Once the funds are transferred by GAVI Secretariat and become available in this bank account, the information is passed on to the EPI manager, who with his team prepares and proposes the funding allocation for the different components of EPI. This proposal is then discussed with the Deputy National Director for Community Health, before its submission to the ICC for its approval. At last, the approved proposal is submitted to the National Director of Health, who authorizes its implementation. Once the implementation starts, it is the Deputy National Director for Community Health who controls the funding usage.

A financial report was presented to the ICC members in the first quarter of 2004. A total of USD 131,154 was spent in 2003. The areas of expenditures are discriminated as shown bellow:

Material, equipments and transport (400 bikes)	*US $ 48,406.84*
Stationary, Supplies & maintenance	*US $ 3,687.26*
Supervision + EPI meetings	*US $ 45,265.83*
National Health Information System meeting	*US $ 10,260.00*
Salaries for recruited staff + Staff Overtime payment	*US $ 19,120.00*
Other Expenditures	*US $ 4,414.06*

TOTAL *US $ 131,154*

Distribution of Expenditure by level

Level	Expenditures	(%)
Central	U $ 35,028	27%
Provincial + District leves*	U $ 96,126	73%
Total	**U $ 131,154**	**100%**

** Please note that most of this money (U $96,126) was not directly spent by Provinces/districts themselves. For instance, the 400 bikes procured by central have been distributed to 4 provinces, namely Cabo-Delgado, Niassa, Nampula and Zambézia. The objective is to allow the most peripheral health staff to conduct outreach services and visit the district level on a regular basis (say monthly) to provide the reports on their activities. The provinces also benefited form training in two regional EPI seminars (75 people trained all together) and all ten provinces and Maputo city were each represented by 5 persons in the national seminar on health information system.*

However, this year (2004) all provinces were requested to provide us with a provincial plan of supervision to districts and district plan of supervision to health unites that conduct vaccination activities, with their respective budgets, so we can provide them with the money they need to carry out these activities. Therefore, this year (2004) most of the ISS fund will be allocated directly to provinces and districts according to the plans submitted.

In general, no problems were encountered in the use of these funding.

1.1.2 Use of Immunization Services Support

In the <u>past year</u>, the following major areas of activities have been funded with the GAVI/Vaccine Fund contribution.

Please, see table above – Management of ISS funds.

Funds received during the reporting year _ No money was received in 2003. The expenditures above described were essentially done using the money received in late 2002.

Remaining funds (carry over) from the previous year.

The US $ 230,985 planned to be received in 2003 were received in February 2004, due to change of the Ministry's of Health bank account.

Table 1: Use of funds during reported calendar year 2003

Please, note that the information in the table below does not include all recurrent expenditures by EPI in 2003. One of the reasons is that the current system of health information does not allow us to discriminate the expenditures by area. For instance, when we look after the fuel item (budget line), there's no discrimination by program. Most of the time, all means engaged in the system are shared among different programs. When, for example, injection safety supplies, vaccines or fridges are distributed to provinces, districts and health unities, they go together with other supplies such as drugs, hospital equipments, etc. Therefore, it becomes very difficult to ascertain what is the real cost of transporting AD syringes and safety boxes or vaccines only. Different programs also share human resources, storage place, offices, etc.

We recall that when we submitted our FSP the estimative of EPI cost was based on the EPI sharing in the total volume of activities in health units, excluding, of course, the activities taking place in provincial and central hospitals and training institutions. The problem now is that most provinces have not yet submitted their 2003 annual financial report to central level, which usually they do early in the second semester after their annual board meetings. Given this situation, we do not have yet data to estimate the EPI contribution using the same methodology used in the development of theFSP. As soon as these data become available we will send updated information.

Data in the table bellow are taken from MoH, WHO, UNICEF and HOPE central offices. These expenditures were covered by funds requested by provinces and districts to either of the central level offices. However, it is worth mentioning that there are other expenditures covered by Government and Provincial Common Fund for Recurrent Expenditures funds, which are under direct control of provincial level. These funds cover different items labelled ***(i)*** *in the table, including personnel wages of recruited staff for limited time. In addition, there are also some provincial/district based NGO´s who provide funds to cover some of the local activities. All this information can only be available by the time when provincial financial reports are submitted to central level. However, we'd like to stress that for EPI activities, these local funds represent a small percentage of total expenditures, given that most of the activities are covered by funds sent centrally, trough MoH, UNICEF and WHO.*

In previous progress report (2002) we planned to introduce forms to request districts and provinces to collect expenditures data per area of immunization. Unfortunately, this action was not successfully implemented, because of the different steps that we need to follow. The Department of Health Information System, brought to our attention on the fact that this form has to be approved first, tested and its introduction carefully planned.

Area of Immunization Services Support	Total amount in US $	Amount of funds			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines	**6,190,910**	**2,732,400** (common fund) [(a)]			**3,458,510** (GAVI)*
Injection supplies	**844,538**	**641,227** (common fund) [(a)]			**203,311** (GAVI)*
Personnel	**1,483,347**	**1,190,148** (Government fund. It covers all levels)			**37,750** (UNICEF) + **19,120** (GAVI) + (Hope) + **54,671** **181,658** (WHO) [(b)]
Transportation	**45,509**	**15,312** (Common Fund) + **2,797** (Govern. Fund)	**(i)**	**(i)**	(HOPE) **25,716 +(**UNICEF**)** **1,684**
Maintenance and overheads	**5,156**	**2,702**	**(i)**	**(i)**	(Hope) **2,454**
Equipment (computers and furniture)	**24,368**		**(i)**	**(i)**	(UNICEF) **24,368**
In Service Training	**104,748**		**(i)**	**(i)**	**59,132** (UNICEF) **+ 10,379** (UNICEF) **+** (Hope) **35,237**
IEC / social mobilization	**48,311**	**25,000**	**(i)**	**(i)**	**33,674** (UNICEF) + **9,455** (HOPE) **5,182**
Outreach	**55,184**		**(i)**	**(i)**	(UNICEF**)** **55,184**
Supervision	**5,488**		**(i)**	**(i)**	(UNICEF) **5,488**
Monitoring and evaluation	**7,504**		**(i)**	**(i)**	**7,504** (UNICEF**)**
Epidemiological surveillance	**131,416**		**(i)**	**(i)**	(WHO) **131,416**

Vehicles	**797,222**	**278,500** (cars) Common Fund) + **198,593** (Motorbikes)			**(GAVI** motorbikes **144,803** + bicycles **32,000)** **+** (WHO) **73,569** + (UNICEF, motorbikes) **69,757**
Cold chain equipment	**26,913**		**(i)**	**(i)**	(UNICEF) **26,913**
International Meetings	**3,017**				(UNICEF) **3,017**
Other *(specify)*- Banking expenses DIVERS	**11,733**		**(i)**	**(i)**	(GAVI) **2,974** + **(**UNICEF) **8,759**
Distribution of EPI related material			**(i)**	**(i)**	
Technical assistance	**35,750**				UNICEF **35,750**
Total:	**9,846,114**	**5,086,679**			**4,759,435**
Remaining funds for next year:					

** Cost includes an additional 30% of insurance and fret.*

****If no information is available because of block grants, please indicate under 'other'.***

(i) Under Common Fund mechanism, Government and partners put the money in the same basket. Therefore, it is not easy to say how much of the Government funds have been allocated to EPI, trough common fund. However, it is known that the Total amount of this funding for 2003 was US $ 30,184,800.00. From this amount, the Government contribution was US $ 8,293,000.00 representing 27%. From the total amount, US $ 2,732,400.00 was spent on vaccines.

(b) These are basically wages of NGOs people.

(c) These are basically Government salaries for all levels.

Please attach the minutes of the ICC meeting(s) when the allocation of funds was discussed.

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

The major activities conducted to strengthen immunization in 2003 were as follow:

- ✓ Health worker training on EPI management during seminars
- ✓ Provincial and district level Supervision and in job training
- ✓ Cold chain upgrade and expansion from 76 % in 2002 to 87 % in 2003 (of health facilities with fixed cold chain)
- ✓ Distribution of motorcycle to increase out reach activities (through monthly health days strategy).

Difficulties encountered		**Activities undertaken to address these issues**
Humana resources	Inadequate (shortage) staffing at central level	In 2003 were recruited two logisticians (one supported by UNICEF and the other by HOPE), to support logistic component of EPI. Additionally, an EPI data manager and an EPI technical adviser (This also supported by HOPE) were also recruited.
	Weak management capacity in logistic system	There were two regional trainings in vaccine management and logistics for provincial level. The provinces in their turn, conducted trainings at district level for front line staff. There has also been supervision of staff at district level.
	Poor competencies at provincial and district levels (some staff with inadequate training in EPI activities, some elder staff needing replacement)	Supervision and more recruitment of younger staff trained in EPI
	Overloaded staff (Usually one person is in charge of many health activities at district level)	This situation is being gradually solved through specific training in different areas, such as preventive medicine (this include EPI matters), maternal and child health care, midwifery, nursing, etc. and their recruitment and allocation to provincial/district levels.

Institutional	Poor planning and weak management of mobile brigades (outreach activities)	A plan of a action to conduct a survey on mobile brigades functioning was developed and implemented in early 2004, financed by Hope-USAID. Now pending results for future action.
	Limited implementation of out reach activities (mobile brigades)	More motorbikes allocated to provinces/districts to improve access to immunization through outreach teams (implementing monthly health days). In addition funds for out reach services expenditures were also made available to districts. However, this improvement is still insufficient compared to the needs.
	It was not possible to conduct the injection safety survey due to staff overload at central level	This survey has been postponed to 2004. Study already conducted. Final report expected end of May. Technical working group already identified for future actions.
Cold chain	Cold chain break-down	Technicians were trained in cold-chain maintenance. Users were trained in proper basic maintenance of the cold- chain. Repairing of broken cold-chain was also conducted.

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 ☐ *NO* ☐

We have just undertaken some important measures to address the issues raised in the DQA (see bellow).

→ *If yes, please attach the plan and report on the degree of its implementation.*

The DQA was conducted in September/October 2002. Preliminary results were made available in February/March 2003 and shared with the ICC members. Following this, two regional seminars (northern and southern) with all provincial and some district EPI managers were organized in April and June to discuss, amongst others, the issue of quality of data produced in the EPI program, in the light of the findings and recommendations of DQA. In addition, in 89 out of 144 districts that benefited of training in EPI in late 2002 and early 2003, the issue of quality of data was discussed including the proper data storing and reporting, data analysis at local level for decision making and setting of targets for each health facility. Charts/tables to monitor immunization performance are now displayed in each of these health facilities. Guidelines for provincial and district EPI managers/supervisors were distributed. These guidelines include aspects of proper data management. However, no system to monitor adverse effects from immunization is in place yet.

One of the reasons presented by provincial and district managers for the weak management capacity of different aspects of the program was the lack of transportation means and funds for supervision and in job training of most peripheral health staff, most of which are not preventative medicine technicians. Reports were usually very late, up to three months in some instances, and even in the cases where managers could detect any inconsistencies, they did not have how to get to the place for corrective measures. In addition, many times the report reached the district health directorate through someone from community such as a taxi man, merchandiser, etc, making it difficult to revise this report with the person who prepared it.

Using funds from different sources, including GAVI funds, we've bought cars, bikes and bicycles to be distributed to provinces and districts, and money also will be sent to these places to guarantee that supervision and more communication with peripheral staff takes place more frequently as needed. Files to keep tally sheets were also bought, and tally sheets reproduced in enough quantities, both items distributed to health facilities. Due to shortage of personnel, most of the health unit staff will be trained in job.

Further, we have planned to train regional data managers to take care of a number of districts (maximum 4), to be selected among the existing health staff under given criteria. These regional data managers would be provided with computers and motorbikes to look at the quality of data (not only for EPI, but for

all health data collected in the district) in the districts under their responsibility, at the same time they will help building local capacity. If nothing interferes with the plan, everything should be in place by end January 2004 and the implementation should start by 1st March, the latest.

A technical support to assist EPI to convert these ideas in a concrete operational plan has been requested to WHO office, and is expected to take place in July 2004.

At central level, procedures to monitor timely reporting from provincial/district levels were set. EPI Manual is being revised and will be reproduced. Norms and procedures will be incorporated taking into account the DQA recommendations.

A national seminar on Health Information System took place in late July 2003, where indicators of many programs were revised and aspects of quality of data were deeply discussed. There was a revision of the health information system for health community department (EPI is a subsection of this department). This seminar has been prepared and conducted with the assistance of an adviser hired for the purpose of working in the improvement of the Health Information System.

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

→ *Please list studies conducted regarding EPI issues during the last year (for example, coverage surveys, cold chain assessment, EPI review).*

- In 2003 was conducted a study on vaccine management with technical assistance from WHO/AFRO and financial support from UNICEF. Some recommendations still need to be implemented.

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

1.2.1 Receipt of new and under-used vaccines during the previous calendar year

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

In 2003, no problems were encountered with vaccines provided by GAVI. They were received in expected quantities. In some cases there has been some delays, but these were previously communicated to EPI central store, and did not result in any stock outs.

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.

In relation to Introduction

- Mozambique is still conducting an assessment to determine the prevalence of Haemophilus Influenzae type B.

In relation to Service Strengthening

- It was conducted supervision and training of health workers.
- Procurement of informatics means for central and provincial level to improve data storage and processing.
- A national EPI inventory is under finalization. Following this exercise, a national cold chain rehabilitation plan will be developed.

In relation to phasing in

- More funds were allocated to EPI program, either at provincial/district or at central levels. This increase has been in recurrent expenditures. Unfortunately, it has not been taken care of in terms of phasing in for DPT/Hep. B vaccine purchase. A proposal of phasing in plan will be developed and presented to GT-SWAP in the second semester of 2004.

Activities to be undertaken

Review of the EPI program and develop another plan of action for the period 2004 – 2008.

Injection safety assessment.

Provincial and district training and supervision

Implementation of vaccine management recommendations, (staff training)

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.

This fund has not been used yet. The reason for this was that the central level was still revising training materials, guide lines and check lists for supervision at different levels, so as to make sure that all supervisions and training sessions conducted will look at all important aspects of the program. Once these documents are ready, the ISS funds will be distributed to provinces and districts along with these documents for training and supervision activities.

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

Table of Syringes and safety boxes reception. *Syringes and safety boxes were received timely and no problems were encountered regarding their distribution and availability at the health facility level.*

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

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

Indicator 1 ***(Adequacy of syringe and needle at the health facility level)***	**Verification means**	**Target for 2003**	**Achievements**	**Constraints**	**Updated targets**
Proportion of Health facilities providing EPI services supplied with AD syringes	Plan of distribution/ local feed-back Supervision Reports - feed-back on the AD syringes availability in health facilities	100%	100%	None	No change made
Adequate delivery of syringes to each facility	Supervision Reports - feed-back on the AD syringes delivery (timeliness and in adequate quantities)	100%	100%	None	No change made
Quality and sterility of syringes	Supervision Reports - feed-back on the expiry date, certified brand	100% of syringes up-to-date with standard quality	100%	None	No changes made
Indicator 2 ***(Disposal of used injection equipment)***					

Proportion of Health facilities providing EPI services supplied with AD safety boxes	Plan of distribution/ local feed-back Supervision Reports - feed-back on the AD safety boxes availability in health facilities	100%	100%	None	No changes made
Availability of an accessible incinerator	Supervision Reports - feed-back on the availability of accessible incinerators for health facilities	10%	Functional Incinerators are not available in most of the health facilities. Burning and burial is the main waste destruction method in almost all health facilities with immunization activities. (*)	None	No changes made
*Presence of used syringes and needles in garbage, dumping area or vicinity of the health facility**	Supervision Reports - feed-back on the presence of used syringes and needles in garbage, dumping area or vicinity of health facilities	10%	See Injection Safety Survey	None	No changes made
Indicator 3 **(a)** ***(Number of abscesses following)*** injection reported (AEFI)	Provincial reports - number of reported abscesses following injection	5%	It will be difficult to monitor adequately this indicator.	Lack of adequate monitoring system .	

(*) However, a plan of building incinerators to be placed in health facilities strategically situated to serve also a number of other health facilities is in course. As for the health facilities with difficult access to the locals with an incinerator, the burning and burial method will continue to be used, until it becomes possible to build an incinerator in these places. As a first investment, almost 300 incinerators are planned to be built.

(a) This indicator is difficult to collect. It s collection needs a community survey but we feel that asking questions to the community on this aspect, which is not a concern may have a side effect of diverting from EPI activities.

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:*

Not applicable

2. Financial sustainability

Inception Report:	Outline timetable and major steps taken towards improving financial sustainability and the development of a financial sustainability plan.
First Annual Report:	Report progress on steps taken and update timetable for improving financial sustainability Submit completed financial sustainability plan by given deadline and describe assistance that will be needed for financial sustainability planning.
Second Annual Progress Report:	Append financial sustainability action plan and describe any progress to date. Describe indicators selected for monitoring financial sustainability plans and include baseline and current values for each indicator.
Subsequent reports:	Summarize progress made against the FSP strategic plan. Describe successes, difficulties and how challenges encountered were addressed. Include future planned action steps, their timing and persons responsible. Report current values for indicators selected to monitor progress towards financial sustainability. Describe the reasons for the evolution of these indicators in relation to the baseline and previous year values. Update the estimates on program costs and financing with a focus on the last year, the current year and the next 3 years. For the last year and current year, update the estimates of expected funding provided in the FSP tables with actual funds received since. For the next 3 years, update any changes in the costing and financing projections. The updates should be reported using the same standardized tables and tools used for the development of the FSP (latest versions available on http://www.gaviftf.org under FSP guidelines and annexes). Highlight assistance needed from partners at local, regional and/or global level

Mozambique is now submitting its third annual progress report.

The indicators chosen by Mozambique to monitor FSP are as follow:

National operating expenditures: National expenditure on the immunization program-specific operating costs as a share of GDP after adjustment for debt service in a specific year. [Expenditure on program-specific operating costs/(GDP-debt service)]

Health expenditure as a proportion of GDP

Year	2000	2001	2002
Evolution	3.4	3.8	4.0

Even though this data is not specific to EPI program, it can be understood that the increase in the health expenditures as a % of GDP was reflected, to a certain extent, in an increase in the expenditures in the EPI as it is a priority area for the Ministry of Health.

National capital expenditures: National expenditure on immunization program-specific capital costs as a share of GDP after adjustment for debt service over a five-year period. [Expenditure on program-specific capital costs/(GDP-debt service)]

Donor expenditures and pledges: Donor actual expenditure in the past year expressed as a percentage of the gap between total costs estimated for the multi-year strategic plan (MYP) and expected national expenditures.

Regarding these last two indicators we can explain that Mozambique is now undergoing reforms in health care system, which, since 2001 are based on Swaps. The emphasis now is on strengthening the system. There is a change in the financing strategy form vertical to integrated, with donors contributing to finance health initiatives according to a previously approved health sector strategic plan. This financing is done through common fund. Given that EPI is one of the key components of this plan, the needs of the program were satisfied within the limitation of available resources. Nevertheless, as stated before, the sharing of resources makes it difficult to specify how much has been devoted to EPI in terms of recurrent expenditures.

Taking into account what has been mentioned in the precedent paragraph, the utility of these indictors for monitoring proposes is limited. Therefore, we believe that other indicators should be considered or, otherwise, find a methodology that might make the usage of these indictors possible in our conditions. Following our attendance to the regional FSP meeting in Gaborone, Botswana, in middle March 2004, a task force compounded by EPI, National Directorate of Plan and Cooperation, Ministry of Plan and Finance, WHO and UNICEF persons, who attended the meeting, was proposed. The objective of this group is to carefully assess how we can best monitor the implementation of the FSP and draft a proposal of phasing in for purchase of DPT7Hep. B to be presented to the GT-Swap by September 2004.

3. Request for new and under-used vaccines for year …….. *(Indicate forthcoming year)*

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

3.1. Up-dated immunization targets

→ Confirm/update basic data (= surviving infants, DTP3 targets, New vaccination targets) approved with country application: revised Table 4 of approved application form.

DTP3 reported 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 10). Targets for future years **MUST** be provided.

Table 2 : Baseline and annual targets

Number of	Baseline and targets					
	2000	2001	2002	2003	2004	2005
DENOMINATORS	17,242,240	17,656,153	18,082,523	18,521,246	18,972,396	19,436,452
Births	775,901	794,527	813,714	833,456	853,758	874,640
Infants' deaths	86,211	88,281	90,413	92,606	94,862	97,182
Surviving infants	689,690	706,246	723,301	740,850	758,896	777,458
Infants vaccinated with DTP3 *	574,420					

Infants vaccinated with DTP3: administrative figure reported in the WHO/UNICEF Joint Reporting Form						
NEW VACCINES						
Infants vaccinated with ____ * (use one row per new vaccine) DPT/Hep B			604,174	662,917		
Wastage rate of ** …….. *(new vaccine)*						
INJECTION SAFETY						
Pregnant women vaccinated with TT [(c)]	466,687	503,224	251,079	528,132		
Infants vaccinated with BCG	730,383	672,062	769,836	815,461		
Infants vaccinated with Measles [(d)]	619,173	649,755	644,842	699,998		

* Indicate actual number of children vaccinated in past years and updated targets

** Indicate actual wastage rate obtained in past years

→ *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.*

3.2 Confirmed/Revised request for new vaccine *(to be shared with UNICEF Supply Division)* **for the year** ..... *(Indicate forthcoming year)*

→ *Please indicate that UNICEF Supply Division has assured the availability of the new quantity of supply according to new changes.*

Confirmed new vaccines for the years 2002-2004 for Mozambique according to UNICEF				
		2002	**2003**	**2004**
New and under-used vaccines:	DTP-HepB (10 ds vial)	2074000 doses	2,660,400 ds	2703566 ds
	AD-Syringes	1,756,000 pcs	2,220,400 pcs	2,400,767 pcs
	Safety Boxes	19,500 pieces	24,650 pcs	26,649 pcs
		Total		

Table 3: Estimated number of doses of …… vaccine *(specify for one presentation only)* : *(Please repeat this table for any other vaccine presentation requested from GAVI/The Vaccine Fund*

		Formula	For year ……
A	**Number of children to receive new vaccine**		*
B	**Percentage of vaccines requested from The Vaccine Fund taking into consideration the Financial Sustainability Plan**	*%*	
C	**Number of doses per child**		
D	**Number of doses**	*A x B/100 x C*	
E	**Estimated wastage factor**	*(see list in table 3)*	
F	**Number of doses (incl. wastage)**	*A x C x E x B/100*	
G	**Vaccines buffer stock**	*F x 0.25*	
H	**Anticipated vaccines in stock at start of year ….**		
I	**Total vaccine doses requested**	*F + G - H*	
J	**Number of doses per vial**		
K	**Number of AD syringes (+ 10% wastage)**	*(D + G – H) x 1.11*	
L	**Reconstitution syringes (+ 10% wastage)**	*I / J x 1.11*	

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:** The country would aim for a maximum wastage rate of 25% for the first year with a plan to gradually reduce it to 15% by the third year. No maximum limits have been set for yellow fever vaccine in multi-dose vials.
- **Buffer stock:** 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.
- **Anticipated vaccines in stock at start of year… ….:** It is calculated by deducting the buffer stock received in previous years from the current balance of vaccines in stock.
- **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

M	**Total of safety boxes (+ 10% of extra need)**	*(K + L) / 100 x 1.11*	

areas where one box will be used for less than 100 syringes

Table 3 : 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

**Please report the same figure as in table 1.*

Table 4 Estimated number of doses of DPT/Hepatitis B (baseline data - Quibb)

		Formula	2002	2003	2004	2005
Y	Total Population		18082523	18521246	18972396	19436452
A	Number of children to receive new vaccine	Y*4%*exp. coverage	477379	563046	652650	707487
B	Number of doses per child	#	3	3	3	3
C	Estimated wastage rate in percent	%	25%	25%	25%	20%
D	Equivalent wastage factor	See table	1.33	1.33	1.33	1.25
E	Number of doses	A*B*D	1904741	2246553	2604075	2653076
F	Number of vaccines buffer stock	E*0.25	476185	0	0	0
G	Total of vaccine doses needed	E+F	2380926	2246553	2604075	2653076
H	Percentage of doses requested from the Vaccine Fund	%	100%	100%	100%	100%
I	Number of doses requested from the Vaccine Fund	G*H/100	2380926	2246553	2604075	2653076
J	Number of doses per vial	#	10	10	10	10
K	Number of AD syringes (+ 10% wastage)	[(A*B)+F]*1.11*H/100	2118236	1874943	2173326	2355931
L	Number of AD syringes buffer stock	K*0.25	529559	468736	543331	588983

M	Total of AD syringes	K+L	2647795	2343678	2716657	2944914
N	Number of reconstitution syringes (+ 10% wastage)		0	0	0	0
O	Number of safety boxes (+ 10% of extra need)	M*1.11/100	29391	26015	30155	32689

Table 4 (a) Estimated number of doses of DPT/Hepatitis B vaccine (baseline data-official coverage rate)

		Formula	2002	2003	2004	2005
Y	Total Population		18082523	18521246	18972396	19436452
A	Number of children to receive new vaccine	Y*4%*exp. coverage	614806	666765	720951	754134
B	Number of doses per child	#	3	3	3	3
C	Estimated wastage rate in percent	%	25%	25%	25%	20%
D	Equivalent wastage factor	See table	1.33	1.33	1.33	1.25
E	Number of doses	A*B*D	2453075	2660392	2876595	2828004
F	Number of vaccines buffer stock	E*0.25	613269	0	0	0
G	Total of vaccine doses needed	E+F	3066344	2660392	2876595	2828004
H	Percentage of doses requested from the Vaccine Fund	%	100%	100%	100%	100%
I	Number of doses requested from the Vaccine Fund	G*H/100	3066344	2660392	2876595	2828004
J	Number of doses per vial	#	10	10	10	10
K	Number of AD syringes (+ 10% wastage)	[(A*B)+F]*1.11*H/100	2728032	2220327	2400767	2511267
L	Number of AD syringes buffer stock	K*0.25	682008	555082	600192	627817

M	Total of AD syringes	K+L	3410039	2775409	3000959	3139084
N	Number of reconstitution syringes (+ 10% wastage)	I*1.11/J	0	0	0	0
O	Number of safety boxes (+ 10% of extra need)	M*1.11/100	37851	30807	33311	34844

Table 5. Estimated number of doses of BCG vaccine (baseline data - Quibb)

		Formula	2002	2003	2004	2005
Y	Total Population		18082523	18521246	18972396	19436452
A	Number of children to receive new vaccine	Y*4%*exp. coverage	593107	644539	698184	754134
B	Number of doses per child	#	1	1	1	1
C	Estimated wastage rate in percent	%	50%	50%	45%	40%
D	Equivalent wastage factor	See table	2	2	1.82	1.67
E	Number of doses	A*B*D	1186214	1289079	1270695	1259404
F	Number of vaccines buffer stock	E*0.25	296553	0	0	0
G	Total of vaccine doses needed	E+F	1482767	1289079	1270695	1259404
H	Percentage of doses requested from the Vaccine Fund	%	100%	100%	100%	100%
I	Number of doses requested from the Vaccine Fund	G*H/100	1482767	1289079	1270695	1259404
J	Number of doses per vial	#	20	20	20	20
K	Number of AD syringes (+ 10% wastage)	[(A*B)+F]*1.11*H/100	987523	715439	774984	837089

L	Number of AD syringes buffer stock	K*0.25	246881	178860	193746	209272
M	Total of AD syringes	K+L	1234403	894298	968731	1046361
N	Number of reconstitution syringes (+ 10% wastage)	I*1.11/J	82294	71544	70524	69897
O	Number of safety boxes (+ 10% of extra need)	(M+N)*1.11/100	14615	10721	11536	12390

Table 5 (a) Estimated number of doses of BCG vaccine (baseline data - official coverage rate)

		Formula	2002	2003	2004	2005
Y	Total Population		18082523	18521246	18972396	19436452
A	Number of children to receive new vaccine	Y*4%*exp. coverage	723301	740850	758896	777458
B	Number of doses per child	#	1	1	1	1
C	Estimated wastage rate in percent	%	50%	50%	45%	40%
D	Equivalent wastage factor	See table	2	2	1.82	1.67
E	Number of doses	A*B*D	1446602	1481700	1381190	1298355
F	Number of vaccines buffer stock	E*0.25	361650	0	0	0
G	Total of vaccine doses needed	E+F	1808252	1481700	1381190	1298355
H	Percentage of doses requested from the Vaccine Fund	%	100%	100%	100%	100%
I	Number of doses requested from the Vaccine Fund	G*H/100	1808252	1481700	1381190	1298355
J	Number of doses per vial	#	20	20	20	20
K	Number of AD syringes (+ 10% wastage)	[(A*B)+F]*1.11*H/100	1204296	822343	842374	862978

L	Number of AD syringes buffer stock	K*0.25	301074	205586	210594	215745
M	Total of AD syringes	K+L	1505370	1027929	1052968	1078723
N	Number of reconstitution syringes (+ 10% wastage)	I*1.11/J	100358	82234	76656	72059
O	Number of safety boxes (+ 10% of extra need)	(M+N)*1.11/100	17824	12323	12539	12774

Table 6. Estimated number of doses of Measles vaccine (baseline data - Quibb)

		Formula	2002*	2003	2004	2005
Y	Total Population		18082523	18521246	18972396	19436452
A	Number of children to receive new vaccine	Y*4%*exp. coverage	520777	570454	622295	676389
B	Number of doses per child	#	1	1	1	1
C	Estimated wastage rate in percent	%	25%	25%	25%	20%
D	Equivalent wastage factor	See table	1.33	1.33	1.33	1.25
E	Number of doses	A*B*D	692633	758704	827652	845486
F	Number of vaccines buffer stock	E*0.25	173158	0	0	0
G	Total of vaccine doses needed	E+F	865791	758704	827652	845486
H	Percentage of doses requested from the Vaccine Fund	%	100%	100%	100%	100%
I	Number of doses requested from the Vaccine Fund	G*H/100	865791	758704	827652	845486
J	Number of doses per vial	#	10	10	10	10
K	Number of AD syringes (+ 10% wastage)	[(A*B)+F]*1.11*H/100	770268	633204	690747	750791

L	Number of AD syringes buffer stock	K*0.25	192567	158301	172687	187698
M	Total of AD syringes	K+L	962835	791505	863434	938489
N	Number of reconstitution syringes (+ 10% wastage)	I*1.11/J	96103	84216	91869	93849
O	Number of safety boxes (+ 10% of extra need)	(M+N)*1.11/100	11754	9721	10604	11459

Table 6 (a) Estimated number of doses of Measles vaccine (baseline data - official coverage rate)

		Formula	2002*	2003	2004	2005
Y	Total Population		18082523	18521246	18972396	19436452
A	Number of children to receive new vaccine	Y*4%*exp. coverage	650971	740850	758896	777458
B	Number of doses per child	#	1	1	1	1
C	Estimated wastage rate in percent	%	25%	25%	25%	20%
D	Equivalent wastage factor	See table	1.33	1.33	1.33	1.25
E	Number of doses	A*B*D	865791	985330	1009331	971823
F	Number of vaccines buffer stock	E*0.25	216448	0	0	0
G	Total of vaccine doses needed	E+F	1082239	985330	1009331	971823
H	Percentage of doses requested from the Vaccine Fund	%	100%	100%	100%	100%
I	Number of doses requested from the Vaccine Fund	G*H/100	1082239	985330	1009331	971823
J	Number of doses per vial	#	10	10	10	10
K	Number of AD syringes (+ 10% wastage)	[(A*B)+F]*1.11*H/100	962835	822343	842374	862978

L	Number of AD syringes buffer stock	K*0.25	240709	205586	210594	215745
M	Total of AD syringes	K+L	1203543	1027929	1052968	1078723
N	Number of reconstitution syringes (+ 10% wastage)	I*1.11/J	120129	109372	112036	107872
O	Number of safety boxes (+ 10% of extra need)	(M+N)*1.11/100	14693	12624	12932	13171

Table 7. Estimated number of doses of TT vaccine

	Formula	2002	2003	2004	2005
Total Population		18082523	18521246	18972396	19436452
Number of pregnant women to receive TT vaccine	Y*5%*expected coverage	542476	601940	664034	728867
Number of doses per woman	#	2	2	2	2
Estimated wastage rate in percent	%	25%	25%	25%	20%
Equivalent wastage factor	See table	1.33	1.33	1.33	1.25
Number of doses	A*B*D	1442985	1601162	1766330	1822167
Number of vaccines buffer stock	E*0.25	360746	0	0	0
Total of vaccine doses needed	E+F	1803732	1601162	1766330	1822167
Percentage of doses requested from the Vaccine Fund	%	100%	100%	100%	100%
Number of doses requested from the Vaccine Fund	G*H/100	1803732	1601162	1766330	1822167
Number of doses per vial	#	10	10	10	10
Number of AD syringes (+ 10% wastage)	[(A*B)+F]*1.11*H/100	1604724	1336308	1474155	1618085

Number of AD syringes buffer stock	K*0.25	401181	334077	368539	404521
Total of AD syringes	K+L	2005906	1670385	1842694	2022606
Number of reconstitution syringes (+ 10% wastage)	I*1.11/J	0	0	0	0
Number of safety boxes (+ 10% of extra need)	(M+N)*1.11/100	22266	18541	20454	22451

4. 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	Achievements		Progress	Constraints	Updated targets
	2002	2003			
Coverage rate [(a)] DPT/Hep B 3	**85.7%**	**91.5% [(c)]**	**5.8%**	**Data not reliable**	**No update made**
Drop out rate DPT/Hep B 3	**13.5%**	**11.2%**	**- 2.3%**	**Data not reliable**	**No update made**
Wastage Rate [(b)]	**Not applicable yet**	**(b)**			

(a) Please note that according to **the last Health Demographic Survey** conducted in 2003, the DPT3 coverage was estimated at 71%, representing 11% increase compared to QUIBB Survey held in 2001 (60%). In the mean time, according to our administrative data, our progress in 2003 was 5.8%. However, we recall that our DQA conducted in 2002 fell at 55.4%, which means, according to the final report of this assessment, that our official data reporting is not reliable enough to be trusted. Another DQA assessment is expected to be conducted in the year 2005.

(b) Only 37 districts out of 144 reported their wastage rate, which was 7.3% for DPT/Hep B. Efforts will be done to extend the number of reporting districts (target 100% in 2004). However, it is good news that districts have already started to report the wastage rate.

5. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission	X	
Reporting Period (consistent with previous calendar year)	X	
Table 1 filled-in	X	
DQA reported on	X	
Reported on use of 100,000 US$	X	
Injection Safety Reported on	X	
FSP Reported on (progress against country FSP indicators)	X	
Table 2 filled-in	X	
New Vaccine Request completed	X	
Revised request for injection safety completed (where applicable)		Not Applicable
ICC minutes attached to the report		
Government signatures		
ICC endorsed		

6. Comments

ICC comments:

ICC focal point to provide comments

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.

GAVI/The Vaccine Fund financial accountability forms will be an integral part of Government audit requirements as detailed in the Banking form.

Agency/Organisation	Name/Title	Date	Signature	Agency/Organisation	Name/Title	Date	Signature

~ End ~