# APPLICATION FORM FOR GAVI NVS SUPPORT

Submitted by
**The Government of Viet Nam**
**for**
Rotavirus routine

Gavi
The Vaccine Alliance

Reach Every Child
www.gavi.org

# 1 Gavi Grant terms and conditions

## 1.2 Gavi terms and conditions

### 1.2.1 Gavi terms and conditions

The terms and conditions of the Partnership Framework Agreement (PFA) between Gavi and the Country, including those provisions regarding anti-corruption and anti-terrorism and money laundering, remain in full effect and shall apply to any and all Gavi support made pursuant to this application. The terms and conditions below do not create additional obligations or supersede those of the PFA. In the event the Country has not yet executed a PFA, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

#### GAVI GRANT APPLICATION TERMS AND CONDITIONS

**FUNDING USED SOLELY FOR APPROVED PROGRAMMES**
The applicant country ("Country") confirms that all funding provided by Gavi will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by Gavi. All funding decisions for the application are made at the discretion of Gavi and are subject to IRC processes and the availability of funds.

**AMENDMENT TO THE APPLICATION**
The Country will notify Gavi in its Joint Appraisal, or in any other agreed annual reporting mechanism, if it wishes to propose any change to the programme(s) description in its application. Gavi will document any change approved by Gavi according with its guidelines, and the Country's application will be amended.

**RETURN OF FUNDS**
The Country agrees to reimburse to Gavi all funding amounts that Gavi determines not to have been used for the programme(s) described in its application. The Country's reimbursement must be in US dollars and be provided, unless otherwise decided by Gavi, within sixty (60) days after the Country receives Gavi's request for a reimbursement and be paid to the account or accounts as directed by Gavi.

**SUSPENSION/ TERMINATION**
Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programme(s) described in the Country’s application, or any Gavi-approved amendment to the application. Gavi retains the right to terminate its support to the Country for the programme(s) described in its application if a misuse of Gavi funds is confirmed.

**NO LIABILITY**
The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programme(s) in the Country; and (ii) the use or distribution of vaccines

and related supplies after title to such supplies has passed to the Country.
Neither party shall be responsible for any defect in vaccines and related supplies, which remain the responsibility of the relevant manufacturer. Gavi shall not be responsible for providing any additional funding to replace any vaccines and related supplies that are, or became, defective or disqualified for whatever reason.

**INSURANCE**
Unless otherwise agreed with Gavi, the Country shall maintain, where available at a reasonable cost, all risk property insurance on the Programme assets (including vaccines and vaccine related supplies) and comprehensive general liability insurance with financially sound and reputable insurance companies. The insurance coverage will be consistent with that held by similar entities engaged in comparable activities.

**ANTI-CORRUPTION**
The Country confirms that funds provided by Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

**ANTI-TERRORISM AND MONEY LAUNDERING**
The Country confirms that funds provided by Gavi shall not be used to support or promote violence, war or the suppression of the general populace of any country, aid terrorists or their activities, conduct money laundering or fund organisations or individuals associated with terrorism or that are involved in money-laundering activities; or to pay or import goods, if such payment or import, to the Country’s knowledge or belief, is prohibited by the United Nations Security Council.

**AUDITS AND RECORDS**
The Country will conduct annual financial audits, and share these with Gavi, as requested. Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against Gavi in connection with any audit.

**CONFIRMATION OF LEGAL VALIDITY**
The Country and the signatories for the Country confirm that its application, or any other agreed annual reporting mechanism, is accurate and correct and forms legally binding obligations on the Country, under the Country's law, to perform the programme(s) described in its application, as amended, if applicable.

**COMPLIANCE WITH GAVI POLICIES**
The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant

to the programme(s), including without limitation the Transparency and Accountability Policy (TAP) and complies with the requirements therein. All programme related policies, guidelines and processes are available on Gavi's official website and/or sent to the Country.

**USE OF COMMERCIAL BANK ACCOUNTS**

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

**ARBITRATION**

Any dispute between the Country and Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either Gavi or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: Gavi and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

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

## 1.3 Gavi Guidelines and other helpful downloads

### Guidelines and documents for download

Please refer to the relevant guidelines concerning your request for support.

Please ensure to consult and download all documents. It is important to note that some documents must be completed offline, and will need to be uploaded in the final steps of your application.

This application form is designed to collect information needed by Gavi to process requests for support, plan procurement of vaccines, plan technical assistance, track data for future reporting, and more.

A key component of the application is a solid operational plan (New Vaccine Introduction Plan for routine support, or Plan of Action for campaign support), explaining how the country will

introduce the vaccine or conduct the envisaged campaign, with a corresponding budget. The New Vaccine Introduction Plan or Plan of Action must be submitted together with this application form and will be considered as the foundation of the support request.

For more information on the documents to submit with your application and what they should contain, please refer to the appropriate guidelines: http://www.gavi.org/support/process/apply/

# 2 Review and update country information

## 2.1 Country profile

### 2.1.1 Country profile

**Eligibility for Gavi support**

Eligible

**Co-financing group**

Accelerated transition

**Date of Partnership Framework Agreement with Gavi**

9 October 2013

**Country tier in Gavi's Partnership Engagement Framework**

3

**Date of Programme Capacity Assessment**

No Response

### 2.1.2 Country health and immunisation data

Please ensure your Country health and immunisation data is up to date. If not, please go to the Overall expenditures and financing for immunisation section of the portal to submit this information.

### 2.1.3 National health planning and budgeting cycle, and national planning cycle for immunisation:

**The government planning cycle starts on the**

1 January

The current National Health Sector Plan (NHSP) is

| | |
|---|---|
| From | 2016 |
| To | 2020 |

**Your current Comprehensive Multi-Year Plan (cMYP) period is**

2016-2020

**Is the cMYP we have in our record still current?**

| | |
|---|---|
| Yes☐ | No☒ |

If you selected “No”, please specify the new cMYP period, and upload the new cMYP in country documents section.

*Note 1*

| | |
|---|---|
| From | 2021 |
| To | 2025 |

**If any of the above information is not correct, please provide additional/corrected information or other comments here:**

The new cMYP is being drafted and will be shared with Gavi upon completion. This document will therefore be in place in advance of the introduction

### 2.1.4 National customs regulations

**Please describe local customs regulations, requirements for pre-delivery inspection, and special documentation requirements that are instrumental for the delivery of the vaccine.**

As Vietnam will use local produced rota virus vaccine (Rotavin), so no import related regulations, requirements are required

### 2.1.5 National Regulatory Agency

**Please provide information on the National Regulatory Agency in the country, including status (e.g. whether it is WHO-certified). Please mention a point of contact with phone number and e-mail address. UNICEF will support the process and may need to communicate licensing requirements to the vaccine manufacturers where relevant.**

Vietnam NRA is WHO-certified since 22 June 2015. Re-benchmarking of National Regulatory Authority in Vietnam was conducted in November 2018. WHO Benchmarking team has recommended to develop some IDPs (Institutional Development Plans) and all units of NRA have implemented these IDPs now. WHO NRA benchmarking evaluation is on-going, and the result will be shared with DAV/NRA before end of October 2019.

## 2.2 National Immunisation Programmes

### 2.2.2 Financial Overview of Active Vaccine Programmes

IPV Routine

*Note 2*

| | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|
| Country Co-financing (US$) | | | | |
| Gavi support (US$) | 1,940,253 | 1,931,577 | 1,920,261 | 1,904,839 |

Pentavalent Routine

| | 2019 |
|---|---|
| Country Co-financing (US$) | 5,873,083 |
| Gavi support (US$) | 922,500 |

**Summary of active Vaccine Programmes**

| | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|
| Total country co-financing (US$) | 5,873,083 | | | |
| Total Gavi support (US$) | 2,862,753 | 1,931,577 | 1,920,261 | 1,904,839 |
| Total value (US$) (Gavi + | 8,735,836 | 1,931,577 | 1,920,261 | 1,904,839 |

| | |
|---|---|
| Country co-financing) | |

## 2.3 Coverage and Equity

### 2.3.1 Coverage and equity situation analysis

Note: If a recent analysis of the coverage and equity analysis is already available, for example as part of a Joint Appraisal report, you may simply reference the report and section where this information can be found.

Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement. In particular, identify the areas and groups of low coverage or high inequity linked to geographic, socioeconomic, cultural or female literacy considerations, as well as systematically marginalized communities. Specify both the areas and/or populations with low coverage (%) and those with the largest absolute numbers of un-/under-vaccinated children. Among data sources, consider administrative data, coverage surveys, DHS/MCS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles.

Describe the challenges underlying the performance of the immunisation system, such as:

- Health work force: availability and distribution;
- Supply chain readiness;
- Gender-related barriers: any specific issues related to access by women to the health system;
- Data quality and availability;
- Demand generation / demand for immunisation services, immunisation schedules, etc;
- Leadership, management and coordination: such as key bottlenecks associated with the management of the immunisation programme, the performance of the national/ regional EPI teams, management and supervision of immunisation services, or broader sectoral governance issues;
- Financing issues related to the immunisation programme that impact the ability to increase coverage, including bottlenecks related to planning, budgeting, disbursement and execution of resources;
- Other critical aspects: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports.

Describe lessons learned and best practices on the effectiveness of implemented activities to improve coverage and equity; recommendations on changes or new interventions that might be required to ac
celerate progress (include data to support any findings or recommendations).

Coverage and equity situation analysis
Vietnam is a high coverage country. A recent analysis of the coverage and equity is referred to item 3.1 - Joint Appraisal submitted to GAVI in December 2018.

Challenges
o Health work force
- Changing the organizational structure of preventive medicine systems at provincial and district levels: At provincial level, CDCs were established by merging Preventive Medicine Centres, Communication centres and others. At districts level, Health Centres and District hospitals are merged. This change caused a high turnover and replacement of EPI staff at all levels. They need to be trained or re-trained on immunization.
- Vaccine hesitancy among health service providers: Health care workers at commune health centers are concerned about switch of pentavalent vaccines, introduction of new vaccines and vaccine safety. This, in turn, has led to low Penta coverage in 2018 and first months of 2019. Commune health workers hesitate to indicate vaccination to children with chronic or underlying diseases, or congenital defects.
- AEFI investigations: Although the AEFI surveillance system has been established at all levels, some healthcare workers are still not confident to deal with AEFI situations.
- New staff at the provincial and district levels, including the preventive medicine system and hospital, are not trained on VPDs case definition and surveillance procedure, case investigation and taking sample.

o Supply chain readiness
- Current supply chain: Regarding vaccine management, in general good vaccine management practices were widely observed by international surveyors in the last EPI review. Systems were in place to collect and report the information required for monitoring vaccine wastage rates and factors on a monthly basis. Some practice gaps were observed in the area of vaccine forecasting. In the areas with unpredictable or increasing migrant populations, insufficient vaccine supply was reported sometime due to insufficient vaccine forecasting. In the framework of GAVI Post-transition in 2020, EPI will train HCWs on effective vaccine forecast.
- Cold chain system:
Cold chain capacity of EPI has been recently upgraded. It will be capable to accommodate new vaccine at present. EPI plans to introduce locally produced Rota vaccine presented as 3 doses per vial. This presentation would save cold chain volume. Historically about 60%-70% commune health centers (CHCs) had refrigerators for storing EPI vaccines, with priority given to the CHCs serving geographically challenging areas (e.g. remote mountainous areas). In recent years, encouragingly the number of CHCs with refrigerators has been increasing, with the funds contributed by either provincial or district governments.
However, in future, when more vaccines will be introduced, the cold chain capacity in the country may need to be upgraded especially for bulky vaccines.
Given the above background, to facilitate decision-making and preparedness for introduction, EPI is working on CCEOP1, CCEOP2 applications supported by GAVI, WB on refrigerator supply for all 63 provincial stores and selected district stores from 2020-2021.

It is found that the cold-chain capacity is enough to accommodate the RV introduction (either current Rotavin-M1 or new liquid formulation Rotavin to be licensed in 2021) and other new vaccines in the future. Detailed cold chain capacity by district and provinces with areas of RV vaccine introduction is provided in the “Estimation of cold chain capacity for routine immunization plus RV vaccine introduction”. Given above cold chain improvement plans, the cold chain capacity meets need of routine immunization and RV vaccine introduction in every

district and province during the period 2022-2025.

o Gender-related barriers: The last coverage survey in 2015 indicated that gender is not a significant factor effecting immunization services utilization. There were no differences between boys and girls in terms of receiving vaccines and vaccine coverages.

o Data quality and availability
A comprehensive immunization information is available at all levels, with overall completeness and timeliness of this information. Immunization registries were available at National Immunization Information System accessed by over 13,000 immunization facilities nationwide. However, there have been gaps observed in some locations in accuracy and consistency across levels. Incomplete vaccination data was seen in some locations, and sometimes the number of children immunized outside commune health centres (in hospitals, other CHCs or fee-based immunization service) are not updated in immunization registers.
The issues get amplified in the population dense areas of modern cities. Tracking populations is a major issue in the urban setting, given the high rate of internal migration and mobility of the population. People residence is not necessarily the places where they will try to access immunisation. Coverage data is further complicated by the high level of immunisation provided through the fee for service immunisation outlets. Additionally, with a fast-growing fee-based immunization services developing in the big cities, the immunization coverage may not be truly reflected. Vietnam towards a paperless reporting system and should do more works on this area.

o Demand generation / demand for immunisation services, immunisation schedules, etc
- Challenges in reaching the most disadvantaged populations were observed, despites the fact that overall immunisation coverage is high in Vietnam. Geographic, social-economic, immigration and poor knowledge of benefits of immunization are key barriers related to vaccine accessibility.
- Vaccine hesitancy among community: No vaccination or delayed vaccination of HepB birth dose, pentavalent, measles, DPT vaccine caused by hesitancy especially in urban and remote areas. Parents paid less attention to vaccination for their children after the first year of life. Consequently, low coverage of MR and DTP booster at two years of age was mentioned in the 2015 EPI review. However, there is no immunization program at present for older children who missed the primary series or booster doses. This led to accumulation of susceptive population at risk of infection.
In the hospital setting, over contraindications for immunisation with hepatitis B birth dose were documented. In some remote areas, absence of mobile / outreach strategy (due to lack of operational financing and inadequate human resources) means that for those who still deliver at home, a timely hepatitis B birth dose is not possible in some circumstances. In other locations, is still evident due to fear of AEFI.
The complexity and diversity of the equity issues highlighted the type of population groups who are most at risk of not accessing immunisation services. These include the following:
- Migrant populations who move to provinces or cities and who may not be registered with local authorities
- Mobile populations who come and go from their place of residence on a periodic basis in search of employment in other locations
- Remote area residents cut off from health services by poor road access, natural disaster such as typhoon, seasonal flooding, land sliding and very high vaccine wastage which affect seriously to provide services. These mountainous communes organize outreach immunization

session at villages on quarterly basis in rainy season.
- Ethnic minority populations who may not always understand the main language and immunisation messages that links to health knowledge inequity, difficulty of health communication and vaccine inaccessibility.

o Leadership, management and coordination
- Leaders and EPI staff at provincial and district level have high turnover because of changes in healthcare system structure. These changes may cause challenges in management and coordination, planning, advocacy and implementation of immunization activities.
- Quality of VPDs surveillance in Vietnam is improved recently but some performance indicators have not met WHO's criteria yet. It is necessary to have a better collaboration between preventive medicines facilities and hospitals across levels that are coordinated by MoH.
o Financing issues related to the immunisation programme that impact the ability to increase coverage, including bottlenecks related to planning, budgeting, disbursement and execution of resources
National government remained highly committed to the co-financing of GAVI supported vaccination programme. There is an overall trend of increased immunisation financing as Vietnam was phasing out of GAVI support. The annual budget was provided for EPI covered amount of co-finance to pentavalent vaccine. Besides, a successful advocacy was recognized as MoH reallocated additional budget for an approximation of 4 million doses of MR vaccine needed for follow-up sub-national SIA and for Td vaccine introduction targeted children aged 7 years old. However, commitment by local government to operational financing (outreach, IEC, transport, supervision and surveillance) remains highly variable, and in some locations is absent.

### 2.4 Country documents

#### Upload country documents

Please provide **country documents** that are relevant for the national immunisation programme and for multiple vaccines, to be taken into account in the review of your application. If you have already provided one or more of these country documents, you do not need to upload it/them again unless the document version changed. If documents cannot be provided, please use the comment functionality to explain why, or by when they will be available.

Note that only general country documents are uploaded here; at the end of section 3 (sub-section "Upload new application documents") you will be required to provide those documents that are specific to the support requested (for example the new vaccine introduction plan and/or campaign plan of action, new budget, application endorsements etc.)

## 3 Rotavirus routine

### 3.1 Vaccine and programmatic data

#### Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.

*Note 3*

Rotavirus routine

| | |
|---|---|
| Preferred presentation | Rotarix produced by GSK<br>Liquid, 1 dose/vial |
| Is the presentation licensed or registered? | Yes ☒ No ☐ |
| 2nd preferred presentation | Frozen, 3 doses/vial, domestically produced |
| Is the presentation licensed or registered? | Yes ☒ No ☐ |
| 3rd preferred presentation | Liquid, 3 doses/vial |
| Is the presentation licensed or registered? | Yes ☐ No ☒ |
| Required date for vaccine and supplies to arrive | July 1st , 2021 |
| Planned launch date | Feb, 2022 |
| Support requested until | 2024 |

### 3.1.2 Vaccine presentation registration or licensing

**If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines, and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.**

- *Co-finance by Vietnam Government budget*

Vietnam will use its local produced rota virus vaccine (Rotavin-M1) made by POLYOVAC. Rotavin-M1 was firstly licensed in Vietnam in 2012 with two presentations of 1 and 3doses/vial. EPI planned to use the Rotavin-M1 presented in 3 doses/vial.

The vaccine has been used in the private market for years. There is no safety and quality issue notified by post-marketing surveillance regarding this vaccine in Vietnam. Rotavin-M1 is an oral live-attenuated vaccine that prevents diarrhoea in children under five years of age. It is

produced from rotavirus strains G1P[8] on Vero cells at the POLYVAC. The safety and immunogenicity of the vaccine were found equivalent to other WHO PQ Rotavirus vaccines. Rotavin-M1 was used widely with high effectiveness for disease prevention and economic benefits. Currently, rotavirus vaccine is not included in the National Expanded Immunization program, but it is being used in the country widely to prevent rotavirus diarrhea. More than 1.3 million doses of this vaccine have been used effectively preventing infection and there were no serious side effects reported.

Details on safety and efficacy of Rotavin-M1: Rotavin-M1 is produced by the POLYVAC within the frame of state projects coded as KC10.03/06-10. This vaccine has shown good results for safety and immunogenicity as tested by the National Institute of Vaccines and Biologicals in 3/2009 and approved by the Ethics Council of the Ministry of Health for clinical trials with three phases according to the Health Ministry's GCP. Rotavin-M1 also showed high immune response, equivalent of that of Rotarix vaccine. The phase III of the study among 800 children in Phu Tho and Thai Binh provinces were compared with results from the placebo group. Results of study showed that the mean percentage of children that were positive with the rotavirus-specific serum IgA in the vaccine group are 80.7% (ranging from 77.3% in Phu Tho to 84.3% in Thai Binh children) as compared to the placebo group, which was 13.3% (from 11.1%, 15.2% in Phu Tho and in Thai Binh, respectively), corresponding to the natural virus infection of children. After vaccination with two doses, antibody titers (geometric mean) reached 85.9 (95% CI: 74.5 to 99.1), almost same as for vaccination with Rotarix.

Production Capacity: Based on current GMP standard production line, Polyvac informs that they can produce 5 million doses per year.

A next generation vaccine (Rotavin, liquid formulation) is in the last stage of clinical trial and is intended to replace the current rotavirus vaccine (Rotavin-M1). A new formulation of Rotavirus vaccine, that can be stored at 2-8$^{o}$C, is being under clinical trial and expected to be licensed in Vietnam by 2021. In this case, Vietnam will use the liquid formulation from 2022.

### 3.1.3 Vaccine procurement

**Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund.Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?**

Yes☒ No☐

If you have answered yes, please attach the following in the document upload section:* A description of the mechanism, and the vaccines or commodities to be procured by the country through this mechanism.* A confirmation that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. OR, for the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, a confirmation should be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National

Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

## 3.2 Target Information

### 3.2.1 Targets for routine vaccination

**Please describe the target age cohort for the Rotavirus routine immunisation:**

*Note 4*

Children under 1 year of age

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| Population in the target age cohort (#) | 1,670,314 | 1,670,314 | 1,670,314 |
| Target population to be vaccinated (first dose) (#) | 326,947 | 511,173 | 704,716 |
| Target population to be vaccinated (last dose) (#) | 326,947 | 511,173 | 704,716 |
| Estimated wastage rates for preferred presentation (%) | 23 | 23 | 23 |

## 3.3 Co-financing information

### 3.3.1 Vaccine and commodities prices

Price per dose (US$) - Rotavirus routine

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| 1 dose/plastic tube, liq (strip of 5 tubes) - Rotarix | 2.2 | 2.2 | 2.2 |
| 3 dose/vial, frozen –Rotavin-M1/Rotavine | 1.5 | 1.5 | 1.5 |

Commodities Price (US$) - Rotavirus routine (applies only to preferred presentation)

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| AD syringes | | | |
| Reconstitution syringes | | | |

| | | | |
|---|---|---|---|
| Safety boxes | | | |
| Freight cost as a % of device value | 2.27 | 2.27 | 2.27 |

### 3.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support.
Please note that the values represented in this table do not account for any switches in co-financing group. The calculations for the entire five year period are based on the countries co-financing group in the first year.

*Note 5*

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| Country co-financing share per dose (%) | 80.00 | 100.02 | 100.02 |
| Minimum Country co-financing per dose (US$) | 1.3* | 1.5 | |
| Country co-financing per dose (enter an amount equal or above minimum) (US$) | 1.3 | 1.5 | 1.5 |

** 80% of average price (total vaccine cost (GAVI plus Gov.) divided by quantity of vaccine dose in 2022 equaling US$1.63 per dose)*

### 3.3.3 Estimated values to be financed by the country and Gavi for the procurement of supply

Rotavirus routine

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| Vaccine doses financed by Gavi (#) | 123,586 | | |
| Vaccine doses co-financed by Country (#) | 612,045 | 1,196,145 | 1,649,035 |
| AD syringes financed by Gavi (#) | | | |
| AD syringes co-financed by Country (#) | | | |

| | |
|---|---|
| Reconstitution syringes financed by Gavi (#) | |
| Reconstitution syringes co-financed by Country (#) | |
| Safety boxes financed by Gavi (#) | |
| Safety boxes co-financed by Country (#) | |
| Freight charges financed by Gavi ($) | 6,172 |
| Freight charges co-financed by Country ($) | 0 |

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| Total value to be co-financed (US$) Country | 918,067 | 1,794,217 | 2,473,553 |
| Total value to be financed (US$) Gavi | 278,061 | | |
| Total value to be financed (US$) | 1,196,128 | 1,794,217 | 2,473,553 |

### 3.3.4 Co-financing payment

**Please indicate the process for ensuring that the co-financing payments are made in a timely manner.**

EPI will provide contract and receipt with quantity of domestic vaccine procured from government budget.

The vaccine cost is fully funded by the Vietnam Government from 2023-2024. Therefore, all procedures will follow the regulations of relevant Ministries.

**If your country is in the accelerated transition phase for Gavi support, please answer the following question:**

**Please provide evidence that the co-financing obligations for the new introduction have**

**been budgeted for, and elaborate on how the country plans to pay for the fully self-financing amounts. Please discuss the extent to which medium-term immunisation/health plans and medium-term expenditure frameworks incorporate the additional costs associated with this introduction. Discuss any co-financing defaults that may have happened in the last five years.**

Country is in accelerated Transition Phase. From 2020, Pentavalent vaccine will be fully funded by national government. Regarding Rotavirus vaccine also, it will be fully funded from Government budget.

| | |
|---|---|
| Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of: | April |

The payment for the first year of co-financed support will be made in the month of:

| | |
|---|---|
| Month | June |
| Year | 2021 |

## 3.4 Financial support from Gavi

### 3.4.1 Routine Vaccine Introduction Grant(s)

Rotavirus routine

**Live births (year of introduction)**

1,670,314

**Gavi contribution per live birth (US$)**

0.6

**Total in (US$)**

1,000,000

| | |
|---|---|
| Funding needed in country by | 1 January 2021 |

### 3.4.2 Operational budget

Please complete the Gavi budgeting and planning template to document how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine. Please ensure to upload the completed budgeting and planning template as part of this application.

If Gavi's support is not enough to cover the full needs please indicate how much and who will be complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.

**Total amount - Gov. Funding / Country Co-financing (US$)**

3,476,060

**Total amount - Other donors (US$)**

0

**Total amount - Gavi support (US$)**

1,000,000

**Amount per target person - Gov. Funding / Country Co-financing (US$)**

2.08

**Amount per target person - Other donors (US$)**

0

**Amount per target person - Gavi support (US$)**

0.6

### 3.4.3 Key Budget Activities

**List the key budgeted activities to be undertaken in implementing the requested support. Please provide details on the key cost drivers, inputs and assumptions required for these activities.**

The country requests GAVI support for the following activities:
- Program management and planning
- Providing technical assistance including development of guideline, reporting forms, tools, training
- Advocacy, social mobilization, IEC and advocacy
- AEFI monitoring (especially intussusception). Progress monitoring and supportive supervision
- Post introduction assessment

Details are provided in the sheet of "VIG-ROTA" of the file "Budgeting and Planning template"

### 3.4.4 Financial management procedures

**Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.**

Funds from National EPI should be transferred to province, then to districts and commune health centers (within EPI system). No procurement involved here.
- After receiving GAVI letter confirming its support on Rota vaccine introduction to Vietnam, NIHE develops project and submits to MoH for approval. Implementation of the project follows Vietnam current regulations.
- MoH will organize an inter-Departments meeting to review the Project proposal and issue Decision approving Project propopsal. After submission of proposed Project Management Unit (PMU) members by NIHE, MoH will issue Decision of establishment PMU that assigns NIHE director to be PMU manager, PMU members including Directors of Regional Hygiene and Epidemiology/ Pasteur institutes in 4 regions: north, central, highland and south and heads of NIHE departments.
- After receiving fund transferred by GAVI, NIHE requests MoH, Ministry of Finance to recognize GAVI support as non-returned aid.
- PMU will develop and issue project financial requirements following government regulations such as accounting activity following Accounting law No. 88/2015/QH13 dated 20/11/2015, tendering following Tendering law No. 43/2013/QH13 dated 26/11/2013, decrees, circulars, guideline of government on management and using of international aid.
- Every quarter, PMU develops implementation plan, informs ICC members in Vietnam about action plans strictly followed the Project proposal. ICC meeting is held 2 times per year as well as unexpected meetings to review and approve the Project action plans
- Then, National EPI develop budget estimate for activities, send to NIHE department of planning and international cooperation and accounting department for review. Final budget estimate will be submitted Planning and financing department of MoH for budget and implementation approval.

- As financial regulation, during implementation of program and project with international aid, procurement of equipment, materials, hiring consultation service will follow Tendering law and current procurement regulations in Vietnam.
- For activities implemented by localities, PMU (NIHE) will sign responsibility contract with Hygiene and preventive/Pasteur institutes and provincial preventive medicine/CDC centers and transfer 70% of the budget in advance for implementing activities. After completion of activities, a contract conclusion will be signed. The remaining budget (30%) will be transfered then. Original invoices and proof of payment are kept by NIHE
- Cost norm following current cost norm approved by GAVI in the email dated 18 April 2016
- Interest of the project account (if any) will be used to cover bank service expenditures and fees. In the year of closing project, PMU has to report to MoH, MoF and process for recording aid for this additional amount as a new aid and to get agreement with donor to integrate the amount into project activity plan, yearly financial plan
- Project will be implemented following mechanism of public administrative mentioned in Circular No. 107/2017/TT-BTC dated 10 October 2017 and other related legislative documents.
- All original proof of payments including electronic invoice, proof (named accounting proof) will be kept in accounting and financing department in NIHE
- The accounting proof is kept for at least 3 years after finishing the last disbursement of the project.
- Every quarter, MoH will carry out spot check accounting proof of the project.
- At the end of fiscal year (31 December ), department of accounting and financing in NIHE will summary project activities and report MoH. In quarter I, MoH will assign a team to work and check project accounting proof, review to approve NIHE yearly financing report.

Every year NIHE conduct selection of auditing company: Base on list of auditing companies in short list of World Bank announced in the year, PMU will implement auditing company selection process following regulations of Tendering law. NIHE signed with company won the tendering and conduct auditing GAVI projects then sent auditing report to GAVI

### 3.4.5 Compliance with guidelines for use of Gavi financial support for human resources (HR) costs

**Does the submitted application and budget comply with existing guidelines, criteria and requirements for use of Gavi financial support for human resources (HR) costs?**

Yes☒ No☐

**Please provide further information and justification concerning human resources costs, particularly when issues and challenges have been raised regarding the compliance with Gavi guidelines.**

No salary and wage cost involved

### 3.4.6 Fiduciary management

**Please indicate whether funds for operational costs should be transferred to the government or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the government. Please note that UNICEF and WHO will require administrative fees as follows.**

- **UNICEF Tripartite Agreement: 5%**
- **UNICEF Bilateral Agreement: 8%**
- **WHO Bilateral Agreement: 7%.**

Funds for operational costs should be transferred to the government. It will be time consuming if fund is channelled through other agencies

### 3.4.7 Use of financial support to fund additional Technical Assistance needs

**Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the "One TA plan") with a view to assess that required support for the implementation of the new vaccine support is contained in the approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template. In addition, please indicate the programmatic areas for additional technical assistance needs and the respective agencies providing the technical assistance (if already identified) below.**

*Note 7*

No

## 3.5 Strategic considerations

### 3.5.1 Rationale for this request

**Describe the rationale for requesting these new programme(s), including the burden of disease. If already included in detail in the Vaccine Introduction Plan or Campaign Plan of Action, please cite the sections only.**

Globally, rotavirus is the most common pathogen that causes severe diarrhea in young children. Children infected with rotavirus often have severe watery diarrhea, may have vomiting or fever and may become dehydrated. Rotavirus gastroenteritis may require hospital admission for rehydration, and it can lead to death, especially among infants and young children [1]. Recent estimation described that 37.3% (95% confidence interval, 34.2%–40.5%) of diarrheal deaths in children less than 5 years old are due to rotavirus, accounting for 215,000 deaths in this age

group globally in 2013 [2]. More than 90% of all rotavirus-associated fatalities occur in low-income and low-middle-income countries in Africa and Asia.

In Viet Nam, it was estimated that mortality among children <5 years was 42.2 per 1,000 per year, of which 15.4% deaths were attributed to diarrheal diseases in 1992 [3]. In order to monitor rotavirus disease burden, Viet Nam initiated rotavirus sentinel surveillance in 1998. The surveillance revealed that 56% of children <5 years who were hospitalized due to diarrhea had rotavirus infection. Based on this surveillance data, Nguyen et al. estimated in 2001 that rotavirus-related deaths among children <5 years would represent 4%–8% of all deaths among that age groups, accounting for 2700–5400 deaths per year, and 1 death per 280–560 children during the first 5 years of life [4]. An economic evaluation of rotavirus disease burden conducted in Viet Nam in 2004 by Fischer et al. estimated that the economic burden of rotavirus disease hospitalization was $3.1 million in medical direct costs, $685,000 in nonmedical direct costs, and $1.5 million in indirect costs. From a societal perspective, treatment of rotavirus disease costs an estimated $5.3 million per year [5].

Since 2006, 2 rotavirus vaccines have been licenced worldwide and have been shown to be effective in preventing severe rotavirus gastroenteritis in both developed and developing countries [6],[7],[8]. In 2009, the World Health Organization (WHO) recommended that all countries introduce rotavirus vaccine into their national immunization programs, particularly those countries with high diarrhea mortality rates in children [9]. In Viet Nam, the two rotavirus vaccines were licenced and available in the private sector, as well as a locally produced vaccine, Rotavin-M1.

The National Institute of Hygiene and Epidemiology (NIHE) has been responsible for rotavirus sentinel surveillance since 2012. The surveillance has been implemented at 4 sentinel hospitals in 3 regions. The surveillance objectives are to update estimates the rotavirus disease burden in children less than 5 years of age hospitalized with acute watery diarrhea, monitor trends, and to determine the distribution of rotavirus genotypes over the years. This analysis aims to describe surveillance findings in 2012-2015 including epidemiological profile and genotyping information that can help decisions of rotavirus vaccine introduction into the national immunization program in Viet Nam.

This prospective, multicentre study was conducted in four sentinel surveillance sites: Two national paediatric hospitals located in the North and in the South and two hospitals located in the Central and Highland region were selected as the surveillance site.

During January 2012 – December 2018, a total of 463,612 children under 5 years old visited or hospitalized for acute watery diarrhea (AWD) at four sentinel hospitals and 16,260 children were enrolled to the study. Of the 16,260 subjects enrolled, 332 cases without adequate stool samples were excluded from the analysis. A total of 15,928 AGE cases with adequate stool specimens (98.0%; range 95.7-100% by year) were tested by ELISA (Table 1). Of the 15,928 specimens tested, 6,994 (43.9%) were positive with rotavirus. Each year rotavirus was detected from 800-1,200 cases, representing 36.0 – 54.7% of AWD. The positivity shows gradually decreased trend since 2015. The positivity varied slightly between sites, which is described below. The Rotavirus positivity is lower than the ones reported in a study conducted in Viet Nam during 1998-2000 (56%; 95%CI: 47%–60%). It also is lower than rates that described in other surveillance and study previously conducted in neighbouring countries [4],[12],[13]. The finding

in our analysis is consistent with report from a surveillance at 6 sentinel hospitals in Thailand [14]. In addition, Western Pacific Region reported that rotavirus positivity was 49% in 2013, 43% in 2014 and 44% in 2015 in the region, which are consistent with the findings in our analysis [15],[16]

The majority (83.9%) of rotavirus-positive AWD were within the first 2 years of life. Most of them were children between 6 months and 23 months, while infants 0-5 months counted as the lowest prevalence (10.6%). Children 0-5mo more likely suffered rotavirus-negative AWD (P <0.001). A lower positivity rate among children <6 months is probable that most of them are considered to be partially protected from rotavirus infections by maternal antibodies through the placenta [17]. However, passive antibody titers wane over time and no longer confer protection after 6 months, which may explain why the majority of children are infected with rotavirus between 6-18 months [18]. Our findings indicated that the timely rotavirus immunization program can protect children before the highest burden of disease. No significant difference was found in the sex distribution of rotavirus infections.

Vomiting and presence of dehydration were less common among children with rotavirus-positive than among those with rotavirus-negative with significant differences (60.7% vs. 64.2%, 37.0% vs. 40.2%, respectively). Duration of hospitalization did not differ for children who did and did not have rotavirus gastroenteritis; however, while rotavirus-negative children received more oral rehydration treatment, rotavirus-positive children were more likely treated with intravenous rehydration (39.5% vs. 28.4%; P=0.001). This could be due to the different case management procedures and public conception on admission between age groups. Regarding to rotavirus vaccination history, less children suffered rotavirus gastroenteritis when fully or partially immunized against rotavirus.

Seasonal distribution by region is shown in Figure 2. Rotavirus was detected every month, but most rotavirus gastroenteritis cases (62.2%) occurred between November and April. In the North, the positivity started decreasing since January and the lowest positivity is from July to August. For the Central region, the peak is in February and March and the lowest positivity is from approximately June to September. In the South, peak is from January to March and the lowest positivity is in June. The seasonality in each region was stable over the 7 years surveillance period. The seasonality is consistent with previous report from other countries.
Genotype distribution.

Of a total 1,117 stool specimens selected for genotyping, ninety-seven percent of strains could be typed for G and P genotypes. Dramatic genotyping shifts were observed between 2015 and 2015. G1P[8] was the most prevalent strain during 2012 and 2013, accounting for 80 and 82% of total genotyped samples, respectively (2012 data not shown) but rapidly reduced since 2014; it was detected in only 7.6% of samples in 2016. G2P[4] was mainly found in 2014-2015. G8P[8] appeared in 2014 (1%), most dominant in 2016 (44.6%) and keeps detected in 12.7% of samples in 2018. Since 2017, G3P[8] became dominant (47.3% in 2017, 46.0% in 9 months of 2018, respectively) (Figure 3). The decrease in prevalence of G1P[8] and its replacement by other genotypes, including G2P[4], is consistent with recently reports from other countries globally, including countries that have and have not introduced rotavirus vaccines. The emergence of G8P[8] was also reported in Thailand during 2013 and 2014 [19]. It would be important to continue monitoring changes in rotavirus strain distributions to help determine the circulating virus, and it will be covered by the rotavirus vaccines chosen [20].

CONCLUSION

There are some limitations in this study. The data could not be representative of the entire country, as we enroll selected acute watery diarrhea cases at sentinel hospitals. Another limitation may be selecting only the first 15 cases each week. This may make the final sample population less representative of general cases because it may introduce weekend or weekday differences. However, in the resource limited circumstance, the consistent surveillance data even from sentinel hospitals would provide well-captured trend in country. Incomplete epidemiological data can be another limitation for comprehensive description of rotavirus disease in Viet Nam.

However, thanks to this surveillance data, endemic pattern of Rotavirus AWD in Vietnam has been revealed with detailed epidemiological and laboratory genotyping information. It clearly showed rotavirus is a leading cause of AWD among children <5 years, especially <2 years which has been detected year-round with seasonal peak for all regions in Viet Nam. Analysis also shows that hospitalized AWD children experienced around 8 times of diarrhea within 24 hours, and rotavirus-positive AWD were more frequently required intravenous hydration even though rotavirus-negative AWD were found more likely to vomit and dehydrated.

Therefore, we concluded that rotavirus infection is the most important cause of acute diarrhea among hospitalized children in Vietnam, and a rotavirus vaccination program for children can significantly reduce this disease burden. Continuation of this surveillance system is crucial to monitor rotavirus disease burden and vaccine introduction impact in the country.

### 3.5.2 Alignment with country strategic multi-year plan / comprehensive multi-year plan (cMYP)

**Please describe how the plans and key assumptions in this request align with the most recent country strategic multi-year plan (cMYP) and other national health and immunisation plans.**

The 2016 – 2020 cMYP for EPI and other national health program had been approved by national government. The Government decided to introduce two new vaccines into EPI. The existing cMYP for EPI includes Rota vaccine introduction. The annual plan of action was approved by MOH for funding year by year.

### 3.5.3 Coordination Forum (ICC, HSCC or equivalent) and technical advisory committee (NITAG)

**Provide a description of the roles of the national Coordination Forum (ICC, HSCC or equivalent body) and national immunization technical advisory group (NITAG) in developing this request.**
**If any of Gavi's requirements to ensure basic functionality of the relevant national Coordination Forum (ICC, HSCC or equivalent) were not met, please describe the reasons and the approach to address this. Requirements can be found in the general application guidelines.**
**In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG.**

In Vietnam, ICC and NITAG are functional. ICC in Vietnam was set up for long time. Advise from ICC support is useful for EPI and MOH. ICC meeting is conducted every 3 to 6 months. ICC members are from MoH, Ministry of Planning and Investment, MOF, WHO, UNICEF, PATH, and CHAI.

NITAG in Vietnam was set up more than 5 years ago. NITAG meeting is conducted every 6 months and any time request by EPI relate with introduce of new vaccine or other issue.

### 3.5.4 Financial sustainability

**Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?**

EPI is one of highest prioritized health programmes. Law of control of infectious diseases confirms that every child has a right of vaccination. Co-finance increases gradually from year to year as Vietnam is in accelerated transition phase. Meanwhile, the Vietnam Government allocates annually enough budget for local vaccine procurement and co-financing committed to GAVI. There is not any default last years.

Currently, MoH is developing a long-term national strategy to support vaccine local production including Rotavine-M1. Vietnam will graduate from GAVI's support from 2020, country intends to scale up Rota vaccine introduction from year to year.

### 3.5.5 Programmatic challenges

**Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.**

***Summary programmatic challenges (mentioned in the situation analysis section)***
Health work force: High turnover of EPI staff and vaccine hesitancy raised at grassroot levels resulting high training needs.

Supply chain readiness: In the areas with unpredictable or increasing migrant populations, insufficient vaccine supply was reported from time to time due to insufficient vaccine forecasting. The current capacity might not be enough when new vaccines would be introduced, particularly bulky vaccines such as rotavirus vaccine.

Data quality and availability: there have been some gaps observed in some locations in accuracy and consistency across levels. Incomplete vaccination data was seen in some locations, and sometimes the number of children immunized outside commune health centres (in hospitals, other CHCs or fee-based immunization service) is not updated in immunization ledgers.

Demand generation / demand for immunisation services, immunisation schedules: Geographic, social-economic, migration and vaccine hesitancy are key barriers related to vaccine accessibility.

***Actions to sustain coverage and equity***

In order to address and mitigate these issues, numbers of efforts have been made by the country with supports from international organizations. EPI mobilizes resources from annual government budget to support hard to reach areas including vaccine, devices, cold chain and operational fund. In bordering districts, collaboration with border army is routinely provided to increase access to health services including immunization. Local authorities such as women's committee or youth groups are also mobilized to increase vaccination coverage especially during campaigns.

Trainings are provided to selected districts with low vaccine coverage and displaced groups for capacity building. EPI also supports for communication activities by village health worker to encourage parents to bring their children to health facilities for vaccination. The Decree no. 104 issued by Government allows EPI to deploy house to house vaccination and to deliver vaccines to the most vulnerable groups; EPI plans mobile team activities as a part of reaching every child strategy.

National Immunization information System is a web-based system launched nationwide recently. There are more than 95% of commune health centres, 80% of health facilities accessing the system. Immunization history of every child is updated in the system. The introduction of the system aims that health care worker can track their movement and find children who missed any dose of vaccine. Introduction of school entry checking system for routine immunization as well as mid-level management capacity training are also planned in order to strengthen micro level immunization deliveries.

In the framework of Post-transition engagement, EPI will implement new approach of vaccination for older children including migrant and mobile populations in collaboration with MOET and other social organizations. Communication activities is for response to anti-vaccine movement and vaccination demand generation.

Rota vaccine introduction will be phased in. In the first year, the introduction will be in mountainous, hard to reach and poor provinces.

### 3.5.6 Improving coverage and equity of routine immunisation

**Explain how the proposed NVS support will be used to improve the coverage and equity of routine immunisation, by detailing how the proposed activities and budget will contribute to overcoming key barriers.**

Improve the coverage and equity of routine immunisation:
Rota vaccine introduction provides chance to improve routine immunization. EPI staff are trained on planning and monitoring. Local government are guided for micro-planning at their own context. The coming new vaccine introduction will be utilized to further strengthen the capacity especially at local government, to enhance routine immunization service in order to close immunization gap among displaced and marginal group. District, provincial, regional and national levels provides technical supports for better implementation.
Children under 1 year old receive Rota, pentavalent and bOPV vaccines at same visit as these vaccines are co-administered. This is a chance to mop-up missed doses of pentavalent and bOPV vaccines. Resources are mobilized for implementation of both new and existing vaccines.

Equity: Hard-to-reach areas are prioritized to introduce Rota vaccine in the first year. This contributes to equity of routine immunisation.

### 3.5.7 Synergies

**Describe potential synergies across planned and existing Gavi support, including planned introductions, campaigns and HSS support. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions. Furthermore, how is the requested support complementary and creating synergies with the support of other Global Health Initiatives, such as the Global Fund and GFF?**

*Note 8*

Training for EPI and health workers staff on Rota vaccine introduction will be integrated with other training activities. Other EPI related trainings will be integrated while conducting trainings for Rotavirus vaccine introduction.

### 3.5.8 Integrated disease control, existing interventions

**Please describe any existing interventions for the prevention and treatment of pneumonia and diarrhoea and the status of implementation.**

The MoH has issued guidelines on the prevention and treatment of acute diarrhoea. The documents have been disseminated nationwide and TOT activity has been conducted for provincial level. Case management including low osmolality ORS, probiotics, zinc, and some biological compounds is included in essential medicine packages. Rotavirus vaccine is already recommended as a tool for diarrhea prevention.

### 3.5.9 Integrated disease control, barriers

**Please provide any considerations for how vaccination could strengthen delivery and communication of additional health interventions. Please highlight any barriers that you may foresee with integrating vaccination with other health interventions.**

Rota vaccination is integrated with pentavalent and bOPV vaccine in routine immunization as they can be co-administered to the same groups aged from 2-4 months old. AEFI due to one vaccine may affect the coverage for other vaccines in the past.

## 3.6 Report on Grant Performance Framework

### Grant Performance Framework – Application Instructions

The Grant Performance Framework (GPF) contains all indicators that will be used to monitor programmatic performance for your requested type of support. Targets that were entered for number to be vaccinated in section 3 on the Target Information tab, have been carried over into their respective indicators in the GPF. Based on these numbers, coverage and dropout rate targets were calculated (where applicable). These appear as “calculated targets”. If you wish to revise these target values, please revise in the application form – they are not editable in the performance framework. In addition, as a part of your application, there are several items to be filled directly into the GPF. These are broken into required and optional items, below:

**Required**

1. In addition to the calculated targets, country targets are required to be submitted for outcome indicators. These targets should align to those in your cMYP or NHSP. If these targets are not in your cMYP or NHSP, or are the same as the calculated targets, please enter “NA” for each target value.
2. Additional indicators that appear in the Performance Framework that are not included in the application form. Please enter targets for these indicators.
3. For many indicators, reporting dates have been pre-populated. For those that have not yet been pre-populated, please add reporting dates.

**Optional**

1. Adding data sources to existing indicators: If there are data sources for indicators that you would like to include, you may add an additional source by clicking on the pencil icon next to the indicator name.
2. Adding new indicators: Gavi requires all countries to report on core indicators, which are already included in the GPF. If you wish to add supplemental indicators to monitor performance, you may do so by clicking the “Add indicator” button at the respective performance level (Outcome, Intermediate Result, or Process).

Please note that the GPF is filtered by default to only show indicators that are relevant to the specific types of support contained in the application. You may view the entire GPF by using the “Grant Status” filter. Please ensure your pop-up blocker is disabled when launching the GPF.

If you have any questions, please send an email to countryportal@gavi.org.

### 3.7 Upload new application documents

#### 3.7.1 Upload new application documents

Below is the list of **application specific documents** that must be provided with your application.

In the case a document cannot be provided, please use the comment box to explain why, or by when it will be available.

## 4 Review and submit application

### 4.1 Submission Details

#### Country vaccine funding summary

Please review the estimated projections for new vaccine programmes included in this application.

**Active Vaccine Programmes**

*Note 9*

IPV Routine

| | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|
| Country Co-financing (US$) | | | | |
| Gavi support (US$) | 1,940,253 | 1,931,577 | 1,920,261 | 1,904,839 |

Pentavalent Routine

| | 2019 |
|---|---|
| Country Co-financing (US$) | 5,873,083 |
| Gavi support (US$) | 922,500 |

**Total Active Vaccine Programmes**

| | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|
| Total country co-financing (US$) | 5,873,083 | | | |
| Total Gavi support (US$) | 2,862,753 | 1,931,577 | 1,920,261 | 1,904,839 |
| Total value (US$) (Gavi + Country co-financing) | 8,735,836 | 1,931,577 | 1,920,261 | 1,904,839 |

**New Vaccine Programme Support Requested**

Rotavirus routine

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| Country Co-financing (US$) | 2,182,492 | 2,663,372 | 3,816,033 |
| Gavi support (US$) | 613,309* | 263,719 | 401,033 |

*: Including vaccine cost and operational cost for year 1 funded by GAVI

| | |
|---|---|
| Total country co-financing (US$) | |
| Total Gavi support (US$) | |
| Total value (US$) (Gavi + Country co-financing) | |

**Total Portfolio Overview – Existing Programs + New Vaccine Support Requested (US$)**

Below data will be automatically updated in the portal

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Total country co-financing (US$) | | | | | |
| Total Gavi support (US$) | | | | | |
| Total value (US$) (Gavi + Country co-financing) | | | | | |

## Contacts

Person(s) who should be contacted in case Gavi needs to ask for more information in regard to the application.

| Name | Position | Phone Number | Email | Organisation |
|---|---|---|---|---|
| Duong Thi Hong | NIHE Vice Director<br>EPI Deputy manager | +84936255696 | hongepi2010@gmail.com | National Institute of Hygiene and Epidemiology |

## Comments

Please let us know if you have any comments about this application

No

## Government signature form

The Government of Viet Nam would like to expand the existing partnership with Gavi for the improvement of the immunisation programme of the country, and specifically hereby requests Gavi support for:

Rotavirus routine

The Government of Viet Nam commits itself to developing national immunisation services on a sustainable basis in accordance with the national health and immunisation strategic plans. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

The co-financing commitments in this application include the amount of support in either supplies or cash that is requested from Gavi, and the financial commitment of the Government for the procurement of this new vaccine.

Please note that Gavi will not review this application without the signatures of both the Minister of Health and Minister of Finance (and Minister of Education, if applicable) or their delegated authority.

*We, the undersigned, affirm that the objectives and activities in this request are fully aligned with the national health and immunisation strategic plans (or equivalent), and that funds for implementing all activities, including domestic funds and any needed vaccine co-financing will be included in the annual budget of the Ministry of Health.*

*We, the undersigned, further affirm that the requested funding for salaries, salary top-ups/allowances, per diems and incentives does not duplicate funding from other sources (e.g. from other donors).*

*We, the undersigned, further affirm that the terms and conditions of the Partnership Framework Agreement between Gavi and the Country remain in full effect and shall apply to any and all Gavi support made pursuant to this application.*[1]

| **Minister of Health (or delegated authority)** | **Minister of Finance (or delegated authority)** |
|---|---|
| Name | Name |
| Date | Date |
| Signature | Signature |

For countries requesting HPV support, with a school linked strategy, the signature of the Minister of Education (or delegated authority) is also required.

**Minister of Education (or delegated authority)**

Name

Date

Signature

[1] *In the event the Country has not yet executed a Partnership Framework Agreement, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.*

# Appendix

### NOTE 1
The new cMYP must be uploaded in the country document section.

### NOTE 2
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.

### NOTE 3
* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* Due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the "support requested until" field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

### NOTE 4
* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* The wastage rate applies to first and last dose.

### NOTE 5
Co-financing requirements are specified in the guidelines.

### NOTE 6
https://www.gavi.org/support/process/apply/additional-guidance/#leadership

### NOTE 7
A list of potential technical assistance activities in each programmatic area is available here: http://www.gavi.org/support/pef/targeted-country-assistance/

### NOTE 8
E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.

### NOTE 9
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.