September 2003

# Progress Report

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

by the Government of

COUNTRY: UGANDA

Date of submission: SEPTEMBER 30, 2003
Reporting period: JANUARY – DECEMBER 2002 *( Information provided in this report MUST refer to the previous calendar year )*

*( Tick only one ) :*

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

*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.*

Mechanism for management of ISS funds

UNEPI has an annual plan of action developed at the beginning of each calendar year, which is reviewed by a technical committee comprised of officers from UNEPI, UNICEF and WHO. The technical committee identifies critical and unfunded activities for GAVI support which are presented to the ICC for approval. The ICC plays a very active role in reviewing proposed expenditures and guiding the programme on optimal use of funds. No GAVI funds are allocated without the approval of the ICC.

UNEPI requests the Permanent Secretary to authorise release and use of such funds. The requests are reviewed by the MOH and government (internal and external) auditor systems. A cheque is prepared for release of funds according to Government regulations. The signatories for this separate account are the Permanent Secretary – MOH, Principal Accountant – MOH and the UNEPI Program Manager. Funds for the districts are sent by bank drafts to the district health accounts through the district accounting officers (Chief Administrative Officers). District funds are subject to a similar auditing procedure prior to release. At national and district levels, the government auditors certify expenditures and accountability after completion of the activity. The MOH is responsible for overall accountability of funds.

Problems encountered involving the use of ISS funds

1. Delays in accountability at national and district levels.
2. Concerns by the ICC about the sustainability of activities supported by ISS funds after the funds run out.

### 1.1.2 Use of Immunization Services Support

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

**Funds received during the reporting year :**

23rd January 2002, $ 455,000 (ISS)
11th February 2002, $ 100,000 (New vaccine introduction)

**Remaining funds (carry over) from the previous year:** $ 455,000 (Received 4th July 2001)

Total Funds available 2002: $ 1,010,000

**Table 1: Use of funds during reported calendar year 2002**

| Area of Immunization Services Support | Total amount in US $ | Amount of funds | | | |
|---|---|---|---|---|---|
| | | PUBLIC SECTOR | | | PRIVATE SECTOR & Other |
| | | Central | Region/State/Province | District | |
| Vaccines | 0 | 0 | 0 | 0 | 0 |
| Injection supplies | 0 | 0 | 0 | 0 | 0 |
| Personnel | 0 | 0 | 0 | 0 | 0 |
| Transportation<br>▪ Fuel and perdiem for monthly cold chain maintenance and distribution of vaccines/ logistics, and withdrawal of DPT | 100,005 | | | 100% | |
| Maintenance and overheads | | | | | |
| Training | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| IEC / social mobilization<br>▪ Training/ sensitisation of parish mobilisers<br>▪ Subcounty co-ordination/ monitoring of social mobilisation activities by health assistants<br>▪ Subcounty quarterly review meetings by parish mobilisers<br>▪ Mobilisation activities by parish mobilisers<br>▪ Support to Nakasongola district: EPI | 117,783<br>65,760<br>70,670<br>141,339<br>4,032 | | | 100%<br>100%<br>100%<br>100%<br>100% | |
| Outreach<br>▪ Micro planning at district and health sub-district | 31,401 | 100% | | | |
| Supervision | | | | | |
| Monitoring and evaluation<br>▪ Quarterly support supervision by the District Health Team | 29,093 | | | 100% | |
| Epidemiological surveillance | | | | | |
| Vehicles | | | | | |
| Cold chain equipment | | | | | |
| Other *(specify)*<br>▪ Development of Financial Sustainability Plan<br>▪ Bank charges<br>▪ Miscellaneous | 3,070<br>36<br>291 | 100% | | | |
| **Total:** | 563,480 | | | | |
| **Remaining funds for next year (2003):** | 346,520 | | | | |

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

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

Dates of the ICC meetings when allocation of funds was discussed: March 21st 2002, May 16th 2002, September 24th 2002, December 10th 2002

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

Major activities to strengthen immunisation

- Capacity building: training of EPI managers in micro planning, vaccine management and communication skills. Trained district health authorities, health workers, community vaccinators and cold chain assistants. Computer training of EPI staff conducted.
- Grass-roots social mobilisation: training and support for parish mobilisers to conduct house-to-house mobilisation
- Cold chain strengthening – replacement of old cold chain equipment with non-CFC refrigerators. Equipped 11 new districts with 50 solar fridges; Established 13 radio call systems.
- Distribution of vaccines on a regular basis to the districts and this was strengthened by adding a vaccine truck.
- Support supervision to districts, health sub-districts and health units.
- Developed and printed an OPL training manual.
- Developed and disseminated communication strategy for EPI and mass production of IEC materials (print and electronic).
- Strengthened outreach service delivery points including Sustainable Outreach Services.
- Introduction of pentavalent vaccine.
- Developed a strategic plan for Maternal and Neonatal Tetanus elimination; conducted 2 rounds of mass TT campaigns among women of child bearing age in 5 districts.
- Developed a 5 year Measles Control Strategy plan
- Conducted Sub National Immunisation Day (SNIDs) campaigns for polio eradication in 18 districts bordering Congo and Sudan.
- Conducted integrated disease surveillance and response.

Problems encountered

1. Physical access barriers in remote, rural, mountainous and insecure areas creating a challenge to service delivery.
2. Insufficient transport in districts and health sub-districts to deliver and supervise immunisation services.
3. Insufficient capacity for vaccine and cold chain management at district and lower levels.
4. Primary Health Care (PHC) funds are not adequate to carry out all immunisation activities.
5. Human resource constraints. The current immunisation programme staff are inadequate to carry out the tasks required to achieve the programme

objectives.

6. Rumours against immunisation.

### 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* [ ]

*If yes, please attach the plan and report on the degree of its implementation. [Plan attached]*

Following the DQA in September/ October 2002, the activities implemented in 2002 based on the recommendations made included:

- DQA findings were widely disseminated and discussed in various meetings with district officials
- An integrated training programme on data management was developed. It covers all aspects of data management that were found weak during the DQA such as storage of data, policy on late reports from health units, filling in of HMIS forms and the reporting channel, data analysis, feedback and support supervision. Training has been conducted in a phased approach. Central trainers from EPI, Resource Centre, and Epidemiology Surveillance Division, have been trained. Training was been conducted in 6 districts up to the health sub-district level.
- EPI and Resource Centre started sending monthly feedback to all districts, including data on immunisation, surveillance, completeness and timeliness of reporting.
- Development and introduction of vaccine management monitoring tools to monitor and document vaccine wastage regularly. The tools have been introduced in 12 districts.

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

A meeting among stakeholders involved in Health Management Information System was held during which recommendations from the DQA and plan of action for implementation were discussed [Minutes and plan of action attached]

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

1. Vaccine Utilisation Monitoring, Kiboga district, September 2002
2. Vaccine Quality Control Assessment, EPI-UVRI Laboratory, 2002
3. Cold chain assessment (prior to pentavalent vaccine introduction), 2002
4. Impact of Mass Measles Campaigns among children less than 5 years old in Uganda. Published in the Journal of Infectious Diseases.
5. Rapid assessment of Knowledge, Attitudes and Practices on Maternal and Neonatal Tetanus in the Busoga region, September 2002

## 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.*

The DPT-Hep B + Hib vaccine was introduced in June 2002. The dates of receipt of the vaccines in 2002 were:

| | | |
|---|---|---|
| 1. | 27th January 2002 | 1,406,200 doses |
| 2. | 29th September 2002 | 688,000 doses |
| 3. | 17th October 2002 | 725,400 doses |
| | TOTAL | 2, 819, 600 doses |

Problems encountered

1. The first shipment of pentavalent vaccine (buffer stock included), which was meant to last for six months, lasted four months. Stocks from the shipment were used by the end of September, instead of end of November. At the request of the Ministry of Health, UNICEF delivered a second consignment on September 29th (instead of October as previously planned).

Reasons for the underestimation of the vaccine requirements were:

i) Increased demand for the vaccine beyond the expected targets. The DPT3 coverage target used for estimation of the vaccine requirement for 2002 was 67%, which was lower than the achieved annual coverage of 72%. This created a vaccine difference of approximately 160,000 doses. The introduction of the DPT-Hep B + Hib vaccine may have contributed to the increased demand.

ii) An underestimated target population, using information available prior to the 2002 census: 110,000 additional births/ year, or approximately 260,000 doses.

iii) The GAVI calculation for number of vaccine doses required did not cater for the DPT1 – DPT3 dropout rate. The vaccine requirement was obtained by multiplying DPT3 doses used by three. This created a difference of 341,564 doses.

iv) The GAVI calculation for vaccine requirement caters for children under one year of age and does not consider children who are late in starting or completing the three-dose schedule. In accordance with the national policy, children over 12 months of age (up to 59 months) who have not completed the immunisation schedule should receive the required vaccine dose at the first possible contact. In Uganda, 13% of DPT doses administered in 2002 were given to children over the age of 12 months (approximately 300,000 doses).

v) The vaccine wastage allowance proposed by GAVI at 5% for 2-dose vials is lower than the national estimate of 16%. This estimate takes into account the national policy on providing immunisation at every clinical contact so as to reduce missed opportunities, wastage due to breakage or unexplained loss of vials, cold chain failure or accidental freezing and discarding of vaccines six hours after reconstitution. A difference of 300,400 doses above the projected requirement for 2002 was obtained.

A pilot study conducted in 2002 to assess vaccine wastage in Kiboga district, found the wastage for doses administered to children under one year of age was 16% in the first completed month of usage. A difference of 300,400 doses above the projected requirement for 2002 was obtained.

vi) The use of the estimated number of surviving infants (number of children surviving to 12 months of age) as a target population for calculating the DPT-Hep B + Hib vaccine requirement instead of the birth cohort resulted in a difference in the denominators. The vaccine is given at 6, 10 and 14 weeks of age and so it may be more appropriate to use the birth cohort for the calculations if DPT1, DPT2 and DPT3 are used to determine

coverage. This created a difference of 95,110 doses.

2. Some fridges (1%) at the health units (Sibir V110 EG type) could not be adjusted to meet the temperatures for storage of the DPT-Hep B + Hib vaccines. These health units were provided with additional functional RCW-42-EG fridges.

### 1.2.2 Major activities

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

Activities undertaken in relation to introduction of new vaccine

Planning

- Developed the new vaccine introduction plan, which was reviewed during various ICC, NCC and other sub-committee meetings. Micro planning and phasing in/ out guidelines were developed. Districts and Health Sub-districts (HSDs) were supported in conducting micro planning.

Training

- Developed a field guide for health workers for integration of the new vaccine into routine immunisation.
- Training of trainers conducted at the central and district levels. Operational level health workers trained at lower levels.

Advocacy

- Prepared and submitted a cabinet memo which was presented by the Minister of Health informing the cabinet of the rationale for introduction of the new vaccine.
- Meetings were held with district political, religious, cultural and civic leaders.
- Sensitised top and senior MOH officials through various departmental meetings.

Social mobilisation

- Developed, translated, pre-tested and disseminated IEC materials including radio and television messages at different levels.
- Launching of the new vaccine by his Excellency the President of Uganda on 17th June 2002 at a national conference attended by Ministers, Parliamentarians, Development Partners, MOH Officials, cultural, religious, political and civic leaders from all districts and district health team members.

Cold chain management

- Conducted cold chain assessment at all levels.
- Redistributed available equipment to meet the demands in some districts.
- Conducted maintenance of cold chain equipment and radio calls.
- Adjusted fridges to maintain the recommended temperature ranges at the central and district vaccine stores.
- Distributed vaccines, gas and injection safety materials to all districts.

Monitoring and Surveillance

- Revised HMIS forms and child health cards to include DPT-Hep B + Hib vaccine.
- Revised vaccine control books to include DPT-HepB + Hib vaccine, Ads and diluent.
- Established a Hib sentinel site based at the national referral hospital.
- Extended the Adverse Events Following Immunisation (AEFI) monitoring system nation-wide.

Injection safety

- Developed an injection safety plan.

Note: These activities were supported by GAVI and partner agencies.

Activities planned (to be implemented)

- Sensitisation of NGOs, hospitals and private sector. However, operational staff in implementing health units were trained.
- Conduct Hepatitis B baseline studies
- Establish Hepatitis B surveillance
- Expand Hib surveillance sites

Problems encountered

1. National representative baseline data on Hepatitis B disease burden not available. Data from the blood bank and small-scale studies have provided some information on the prevalence of Hepatitis B in Uganda.
2. Competing activities led to inability to accomplish all the activities planned.

### 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.*

| **Activity** | **US $** |
|---|---|
| ▪ Distribution of vaccines to districts | 9,371 |
| ▪ National conference including launching of new vaccine | 34,286 |
| ▪ Post introduction monitoring and supervision | 22,685 |
| TOTAL | **66,342** |
| **BALANCE** | **33,658** |

## *1.3 Injection Safety*

### 1.3.1 Receipt of injection safety support

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

The dates of receipt of injection safety materials and the quantities received were:

1. 16th April 2002 – 782,500 Auto Disable Syringes (2mls)
2. 22nd April 2002 – 28,650 Safety boxes

Problems encountered

- Occasional incidences of stock-outs of ADs at some health units due to poor stock management and irregular distribution from the district to lower health unit levels.

### 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.*

| Indicator | Target | Achievements | Constraints | Updated targets |
|---|---|---|---|---|
| % health units using ADs for routine immunisation | 100% of all health units using ADs for routine immunisation | 100% of all health units using ADs for routine immunisation | ▪ Stockouts of ADs<br>▪ No effective method of safe sharps disposal (i.e. no incinerators) | Provision of an incinerator in every health sub-district |

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

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

There was no cash contribution for injection safety support activities. Uganda received injection safety materials in kind.

## 1. 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<br>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.<br>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.<br>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.<br>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).<br>Highlight assistance needed from partners at local, regional and/or global level |

A draft financial sustainability plan has been made, and is being discussed by various stakeholders. As required for Uganda, the final plan will be submitted by November 30th 2003.

Progress to date as of September 30th, 2003

- Consultation and advocacy at the national level is in progress. Meetings/ discussions have been held involving the Government of Uganda (Ministries of Finance and Health), development partners and donor agencies. The plan is awaiting clearance and approval by top management in the Ministries of Finance and Health.

- Steps towards increasing the reliability of resource flows:
  - Districts are being encouraged to send timely accountabilities for funds disbursed.
  - Financial utilisation is now part of monitoring checklists during support supervisory visits. Items such as payment of allowances to operational staff are included in the checklists.

- Steps towards improving programme efficiency:
  - Vaccine wastage monitoring tools have been developed and piloted in some districts
  - Districts are being encouraged to explore alternative sources of power for fridges like hydroelectric power, which is cheaper than gas.

## 3. Request for new and under-used vaccines for year 2004 *(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 | 2006 | 2007 |
| DENOMINATORS | | | | | | | | |
| Births | 1,101,294 | 1,128,104 | 1,227,551 | 1,281,123 | 1,326,666 | 1,374,176 | 1,423,755 | 1,475,512 |
| Infants' deaths | 106,826 | 99,750 | 73,653 | 76,867 | 79,600 | 82,450 | 85,425 | 88,531 |
| Surviving infants | 994,469 | 1,028,354 | 1,153,898 | 1,204,256 | 1,247,066 | 1,291,726 | 1,338,330 | 1,386,981 |
| **Infants vaccinated with DTP3 *** | 572,221 (58%) | 626,204 (61%) | 836,240 (72%) | 986,465[1] (77%) | 1,061,333 (80%) | 1,168,050 (85%) | 1,224,429 (86%) | 1,283,695 (87%) |
| Infants vaccinated with DTP3: administrative figure reported in the WHO/UNICEF Joint Reporting Form | 572,221 (58%) | 620,016 (61%) | 835,044 (72%) | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW VACCINES** | | | | | | | | |
| Infants vaccinated with **DTP -HepB + Hib 1** * (use one row per new vaccine) | - | - | 628,590[2] (55%) | 1,178,633[1] (92%) | 1,233,799 (93%) | 1,291,725 (94%) | 1,352,567 (95%) | 1,401,736 (95%) |
| Infants vaccinated with **DTP -HepB + Hib 3** * (use one row per new vaccine) | - | - | 516,479[2] (42%) | 986,465[1] (77%) | 1,061,333 (80%) | 1,168,050 (85%) | 1,224,429 (86%) | 1,283,695 (87%) |
| Wastage rate of ** **DTP-HepB + Hib** *( new vaccine)* | - | - | 16% | 10%[3] | 9%[3] | 8%[3] | 8%[3] | 8%[3] |
| **INJECTION SAFETY** | | | | | | | | |
| Pregnant women vaccinated with TT | 500,420 (45%) | 534,532 (47%) | 634,943 (50%) | 786,097 (59%) | 910,624 (66%) | 1,043,274 (73%) | 1,095,722 (74%) | 1,150,899 (75%) |
| Infants vaccinated with BCG | 827,970 (83%) | 936,754 (92%) | 1,174,514 (96%) | 1,242,689 (97%) | 1,300,133 (98%) | 1,346,692 (98%) | 1,395,280 (98%) | 1,446,002 (98%) |
| Infants vaccinated with Measles | 605,832 (61%) | 644,840 (63%) | 885,596 (77%) | 1,024,898 (80%) | 1,087,866 (82%) | 1,168,050 (85%) | 1,224,429 (86%) | 1,283,695 (87%) |

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

[1]Due to the global shortage of pentavalent vaccine, DTP vaccine is being used instead of DTP-HepB + Hib from September to December 2003. Therefore the actual number of children receiving the new vaccine during the calendar year 2003 will be lower than the target.
[2]DTP-Hep B + Hib vaccine was introduced in June 2002. The coverage indicates infants who received the vaccine between June and December 2003.
[3]The wastage rates for DTP-HepB + Hib indicated are the targets for 2003 – 2007.

→ *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.*

The changes in base line targets are based on the national census 2002. Population figures from 2003 onwards are projections from the 2002 census.

Immunisation coverage targets for BCG, Measles and TT for pregnant women have been modified from the previously approved plan. Based on

the population census conducted in 2002 and the exceeded planned targets in the UNEPI multi-year plan (2001-2005), it was necessary to prepare a revised multi-year plan (2003-2008).

The DPT3 coverage reported in the joint reporting form for 2001 differs from the reported coverage in the table above: 620,016 children received DPT3 vaccination as opposed to the 611,983 children reported in the joint form. The data was updated following more reports from the districts; only 82% of districts had reported by September 2002.

The wastage rates in the previously approved plan have also been changed. Reasons for this modification are outlined in section 1.2.1.

## 3.2 Confirmed/Revised request for new vaccine *(to be shared with UNICEF Supply Division)* **for the year 2004** *(indicate forthcoming year)*

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

Total vaccine doses required for 2004 (DTP-HepB + Hib) : **5,135,690**

Total vaccine doses available at the beginning of 2004: **590,600**

Total vaccine doses requested for 2004 (DTP-HepB + Hib): **4,545,090**

Assumption:
980,600 doses of pentavalent vaccine will be received in the country by December 2003. Of these, 390,000 doses will be distributed to the districts to cover a 6 weeks period.

This request is a revision from the original GAVI application (2000) based on the reasons elaborated in section 1.2.1

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

| | | Formula | For year 2004 |
|---|---|---|---|
| **A** | **Number of children to receive new vaccine** | | *1,233,799 |
| **B** | **Percentage of vaccines requested from The Vaccine Fund taking into consideration the Financial Sustainability Plan** | *%* | 100 |
| **C** | **Number of doses per child** | | 3 |
| **D** | **Number of doses** | *A x B/100 x C* | 3,701,398 |
| **E** | **Estimated wastage factor** | *(see list in table 3)* | 1.11 |
| **F** | **Number of doses ( incl. wastage)** | *A x C x E x B/100* | 4,108,552 |
| **G** | **Vaccines buffer stock** | *F x 0.25* | 1,027,138 |
| **H** | **Anticipated vaccines in stock at start of year 2004** | | 590,600 |
| **I** | **Total vaccine doses requested** | *F + G - H* | 4,745,690 |
| **J** | **Number of doses per vial** | | 2 |
| **K** | **Number of AD syringes (+ 10% wastage)** | *( D + G – H ) x 1.11* | 4,338,536 |
| **L** | **Reconstitution syringes (+ 10% wastage)** | *I / J x 1.11* | 2,633,858 |
| **M** | **Total of safety boxes (+ 10% of extra need)** | *( K + L ) / 100 x 1.11* | 77,394 |

**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 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.*

Note:

- *The number of children targeted to receive the vaccine in 2004 is the DTP-HepB + Hib 1 target (93%) of the birth cohort for 2004.
- The percentage of vaccines requested from the Vaccine Fund may be modified subject to approval of the financial sustainability plan by the government.

## 3.3 Confirmed/revised request for injection safety support for the year **2004** *(indicate forthcoming year)*

**Table 4.1: Estimated supplies for safety of vaccination for the next two years with BCG** *(Use one table for each vaccine BCG, DTP, measles and TT, and number them from 4 to 8)*

| | | Formula | For year 2004 | For year 2005 |
|---|---|---|---|---|
| **A** | **Target of children for BCG vaccination** | # | 1,300,133 | 1,346,692 |
| **B** | **Number of doses per child** | # | 1 | 1 |
| **C** | **Number of BCG doses** | A x B | 1,300,133 | 1,346,692 |
| **D** | **AD syringes (+10% wastage)** | C x 1.11 | 1,443,148 | 1,494,828 |
| **E** | **AD syringes buffer stock [1]** | D x 0.25 | 360,787 | 373,707 |
| **F** | **Total AD syringes** | D + E | 1,803,935 | 1,868,535 |
| **G** | **Number of doses per vial** | # | 20 | 20 |
| **H** | **Vaccine wastage factor [4]** | *Either 2 or 1.6* | 2 | 2 |
| **I** | **Number of reconstitution [2] syringes (+10% wastage)** | *C x H x 1.11 / G* | 144,315 | 149,483 |
| **J** | **Number of safety boxes (+10% of extra need)** | *( F + I ) x 1.11 / 100* | 21,626 | 22,400 |

[1] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero for other years.
[2] Only for lyophilized vaccines. Write zero for other vaccines
4 Standard wastage factor will be used for calculation of re-constitution syringes. It will be 2 for BCG, 1.6 for measles and YF.

**Table 4.3: Estimated supplies for safety of vaccination for the next two years with MEASLES** *(Use one table for each vaccine BCG, DTP, measles and TT, and number them from 4 to 8)*

| | | Formula | For year 2004 | For year 2005 |
|---|---|---|---|---|
| **A** | **Target of children for MEASLES vaccination** | # | 1,087,866 | 1,168,050 |
| **B** | **Number of doses per child** | # | 1 | 1 |
| **C** | **Number of MEASLES doses** | A x B | 1,087,866 | 1,168,050 |
| **D** | **AD syringes (+10% wastage)** | C x 1.11 | 1,207,531 | 1,296,536 |
| **E** | **AD syringes buffer stock [3]** | D x 0.25 | 301,883 | 324,134 |
| **F** | **Total AD syringes** | D + E | 1,509,414 | 1,620,670 |
| **G** | **Number of doses per vial** | # | 10 | 10 |
| **H** | **Vaccine wastage factor [4]** | *Either 2 or 1.6* | 1.6 | 1.6 |
| **I** | **Number of reconstitution [4] syringes (+10% wastage)** | *C x H x 1.11 / G* | 193,205 | 207,446 |
| **J** | **Number of safety boxes (+10% of extra need)** | *( F + I ) x 1.11 / 100* | 18,899 | 20,292 |

[3] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero for other years.
[4] Only for lyophilized vaccines. Write zero for other vaccines
4 Standard wastage factor will be used for calculation of re-constitution syringes. It will be 2 for BCG, 1.6 for measles and YF.

**Table 4.4: Estimated supplies for safety of vaccination for the next two years with TT** *(Use one table for each vaccine BCG, DTP, measles and TT, and number them from 4 to 8)*

| | | Formula | For year 2004 | For year 2005 |
|---|---|---|---|---|
| A | **Target of children for TT vaccination (for TT : target of pregnant women)[5]** | # | 910,624 | 1,043,274 |
| B | **Number of doses per child (for TT woman)** | # | 2 | 2 |
| C | **Number of TT doses** | A x B | 1,821,248 | 2,086,548 |
| D | **AD syringes (+10% wastage)** | C x 1.11 | 2,021,585 | 2,316,068 |
| E | **AD syringes buffer stock [6]** | D x 0.25 | 505,396 | 579,017 |
| F | **Total AD syringes** | D + E | 2,526,981 | 2,895,085 |
| G | **Number of doses per vial** | # | 20 | 20 |
| H | **Vaccine wastage factor [4]** | *Either 2 or 1.6* | 1.6 | 1.6 |
| I | **Number of reconstitution [7] syringes (+10% wastage)** | *C x H x 1.11 / G* | - | - |
| J | **Number of safety boxes (+10% of extra need)** | *( F + I ) x 1.11 / 100* | 28,050 | 32,135 |

Note: The Government of Uganda policy requires vaccination of all women of childbearing age (pregnant and non-pregnant). The syringes and needles for non-pregnant women are Purchased by the government.

**Table 5: Summary of total supplies for safety of vaccinations with BCG, TT and measles for the next two years.**

| ITEM | | For the year 2004 | For the year 2005 | **Justification of changes from originally approved supply:** |
|---|---|---|---|---|
| Total AD syringes | for BCG | 1,803,935 | 1,868,535 | The total supply requirements are higher than in the originally approved application due to revised vaccine requirements as detailed in section 1.2.1 |
| | for other vaccines (TT and Measles) | 4,036,395 | 4,515,755 | |
| Total of reconstitution syringes (BCG & Measles) | | 337,520 | 356,929 | |
| Total of safety boxes (BCG, Measles & TT) | | 68,575 | 74,827 | |

[5] GAVI will fund the procurement of AD syringes to deliver 2 doses of TT to pregnant women. If the immunization policy of the country includes all Women of Child Bearing Age (WCBA), GAVI/The Vaccine Fund will contribute to a maximum of 2 doses for Pregnant Women (estimated as total births).

[6] The buffer stock for vaccines and AD syringes is set at 25%. This is added to the first stock of doses required to introduce the vaccination in any given geographic area. Write zero for other years.

[7] Only for lyophilized vaccines. Write zero for other vaccines

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

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

The quantity of the current request differs from the GAVI letter of approval because of the changes in the vaccine requirements (See section 1.2.1 for detailed explanation).

The birth cohort has been used for calculation of the target population (for DTP-Hep B + Hib, Measles, and BCG injection materials) instead of surviving infants because birth cohort reflects more accurately the target population at 1-3 months (when DTP/ pentavalent is usually provided).

## 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 | Targets (2002) | Achievements (2002) | Constraints | Updated targets (2003) |
|---|---|---|---|---|
| 1. DTP3 Coverage | 67% | 72% | | 77% (2003) |
| 2. DPT1-3 drop out rate | 27% | 21% | | 16% |
| 3. Completeness of reporting to ESD (% of districts reporting to ESD for the weekly tracking of epidemic prone diseases) | 90% | 92% | Instances of communication breakdown and insecurity hindering reporting to ESD | - |
| 4. % of health units using Ads for routine immunisation | 100% | 100% | Inadequate transport for distribution from districts to lower levels | - |

## 5. Checklist

Checklist of completed form:

| Form Requirement: | Completed | Comments |
|---|---|---|
| Date of submission | | |
| Reporting Period (consistent with previous calendar year) | | |
| Table 1 filled-in | | |
| DQA reported on | | |
| Reported on use of 100,000 US$ | | |
| Injection Safety Reported on | | |
| FSP Reported on (progress against country FSP indicators) | | FSP submission by November 30, 2003 |
| Table 2 filled-in | | |
| New Vaccine Request completed | | |
| Revised request for injection safety completed (where applicable) | | |
| ICC minutes attached to the report | | |
| Government signatures | | |
| ICC endorsed | | |

## 6. Comments

*ICC comments:*

- Availability of vaccines has been identified as a critical issue. Requests from the MOH for vaccines should be made to cater for longer durations. The Ministry of Finance should commit funds for vaccine supply early to allow for enough time for procurement by UNICEF considering the global shortage of vaccines.
- Funding for the EPI programme should be considered within the concept of integration of programmes in the overall MOH Health Sector review process fitting into the Sector Wide Approach (SWAP) and the Poverty Eradication Action Plan (PEAP) review.
- Uganda has shown dramatic improvement in EPI coverage. Coverage exceeded the planned targets in 2002 and this can be attributed to factors such as high level advocacy, increased outreach and grass root social mobilisation.

## 7. Signatures

For the Government of UGANDA

Signature: ……...……...

Title: …….…….

Date: …….…….

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

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

| Agency/Organisation | Name/Title | Date | Signature |
|---|---|---|---|
| Ministry of Health | Hon. Dr.Alex Kamugisha, Minister of State for Health, Primary Health Care | | |
| WHO | Dr. Oladapo Walker, WHO Representative | | |
| UNICEF | Mr. Martin Mogwanja, UNICEF Representative | | |
| USAID | Ms. Suzanne McQueen, Deputy Office of Health, HIV & Education | | |
| World Bank | Dr. Peter Okwero, World Bank, Uganda | | |

| Agency/Organisation | Name/Title | Date Signature |
|---|---|---|
| DFID | Ms. Ros Cooper, Health Advisor, DFID Uganda | |
| European Union/ EDF | Mr. Joaris Alain, Head of Economic and Social Sectors Desk | |
| Embassy of Japan | Mr. Katsuki Morihara, Second Secretary, Embassy of Japan | |
| Rotary International Uganda | Mr. Henry Kyemba, National Chairman, Polio Plus Committee of Rotary International Uganda | |
| Uganda Red Cross Society | Mr. Robert Kwesiga, Secretary General, URCS | |
| Local Authority Council Association | | |
| National Council for Children | Dr. Sam Agatre Okuonzi, Secretary General National Council for Children | |
| Parliamentary Social Sector Committee | | |

~ End ~