Gavi

Application Form for Country Proposals

For Support to:

Preventive Campaign Support

Submitted by

The Government of

Viet Nam

Date of submission: **8 September 2015**

Deadline for submission: 8 September 2015

Select Start and End Year of your Comprehensive Multi-Year Plan (cMYP)

Start Year	2016	End Year	2020

Form revised in 2015

(To be used with Guidelines of October 2014)

Please submit the Proposal using the online platform

https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: proposals@gavi.org or representatives of a Gavi partner agency. Unless otherwise specified, the documents can be shared with Gavi partners, collaborators and the general public. The Proposal and attachments must be submitted in English, French, Spanish, or Russian.

Note: Please ensure that the application has been received by Gavi on or before the day of the deadline.

Gavi is unable to return submitted documents and attachments to countries.

Gavi
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the 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 the Gavi. All funding decisions for the application are made at the discretion of the Gavi Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application.The Gavi will document any change approved by the Gavi, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the Gavi all funding amounts that are not 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 the Gavi, within sixty (60) days after the Country receives the Gavi's request for a reimbursement and be paid to the account or accounts as directed by the Gavi.

SUSPENSION/ TERMINATION

The 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 programmes described in the Country's application, or any Gavi-approved amendment to the application.The Gavi retains the right to terminate its support to the Country for the programmes described in its application if a misuse of Gavi funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the 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.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the Gavi, as requested. The 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 the Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the Gavi Transparency and Accountability Policy (TAP) and complies with the requirements therein.

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 the 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 the 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 the Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The 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.

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

1. Application Specification

Please specify for which type of Gavi support you would like to apply to.

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]
Preventive Campaign Support	JE, 5 dose(s) per vial, LYOPHILISED	2017	2017	
	If the selected vaccine is not your 1st preference, please state your preferred vaccine and presentation			If the selected vaccine is not your 1st preference, please state your preferred vaccine and presentation
	live-attenuated recombinant (chimeric) JE vaccine, 4 doses/vial, from Sanofi Pasteur (IMOJEV®)			

[1] Gavi may not be in a position to accommodate all countries first product preferences, and in such cases, Gavi will contact the country and partners to explore alternative options. A country will not be obliged to accept its second or third preference, however Gavi will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine. If a country does not indicate a second or third preference, it will be assumed that the country prefers to postpone introduction until the first preference is available. It should be noted that this may delay the introduction in the country.

2. Table of Contents

3. Executive Summary

Please provide a summary of your country's proposal, including the following the information:

- For each specific request, NVS routine support or NVS campaign :
  - The duration of support
  - The total amount of funds requested
  - Details of the vaccine(s), if applicable, including the reason for the choice of presentation
  - Projected month and year of introduction of the vaccine
- Relevant baseline data, including:
  - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Birth cohort, targets and immunisation coverage by vaccines
- Country preparedness
  - Summary of EVM assessment and progress on EVM improvement plan
- The nature of stakeholders' participation in developing this proposal
  - Inter-Agency Coordinating Committee
  - Partners, including CSO involvement

The Ministry of Health (MOH) of the Socialist Republic of Vietnam is requesting support from Gavi, the Vaccine Alliance (Gavi), to conduct a preventive campaign of Japanese Encephalitis vaccine.

Sentinel surveillance of Japanese encephalitis (JE) shows that JE disproportionately affects children less than 15-years-old and other vulnerable populations throughout Vietnam, especially those living in Vietnam's rural, rice-producing areas. In addition, acute encephalitis syndrome (AES) of unknown etiology in this same age group has also been identified throughout rural Vietnam. It is believed that a significant proportion of these AES cases are JE that are not diagnosed because of the complexity of JE laboratory confirmation.

Nearly one-third of persons with JE die and half of the survivors are left with serious, life-long neurologic sequelae. In addition, because JE more greatly affects Vietnam's poorest, rural populations, death or long-term care can be financially devastating to rural families.

Vietnam introduced locally-produced inactivated, mouse brain-derived (mbd) JE vaccine in 1997. In 2006, WHO stated that, compared to the live, attenuated JE vaccine, mbd JE vaccine has a limited duration of vaccine-induced protection, requires multiple doses from infancy through adolescence, and, in most countries, is expensive. Despite these limitations, in 2014, Vietnam expanded their existing mbd JE vaccination program to a national program whereby all 1- to 5-year-old children receive three primary vaccine doses. At the same time, the Vietnam MOH announced plans to locally produce one of the newer generation JE vaccines in the future.

Because of the limited duration of protection induced by mbd JE vaccines and limited vaccine delivery in the past, older children and adolescents are not adequately protected against JE. To protect these older children, Vietnam plans catch-up JE vaccine campaigns to vaccinate 6- to 14-year-old children with a single dose of live vaccine in a national supplementary immunization activity (SIA) from January 2017 through June 2017. The goal of the JE campaign is to immediately reduce JE morbidity and mortality by rapidly immunizing 6- to 14-year-old children who are currently not protected against JE.

The Vietnam MOH proposes giving a single dose of IMOJEV, a live chimeric JE vaccine manufactured by Sanofi Pasteur in partnership with Thailand's Government Pharmaceutical Organization, to **12,654,583** 6- to 14-year-old children in all 63 of Vietnam's provinces (see Section 5, Plan of Action for this calculation)**.** If IMOJEV is not available for the campaigns, another JE vaccine prequalified by WHO and procured by UNICEF through Gavi support will be considered.

The major activities of the campaign will include procurement of vaccine, supplies and logistics, training on JE vaccine, JE campaign and micro planning, strengthening of Adverse Event Following Immunization (AEFI) surveillance and reporting, advocacy and social mobilization. Particular focus will be given to extending access to hard-to-reach populations and strengthening AEFI reporting. This focus should also bring gains to routine immunization.

Vietnam has demonstrated capacity to successfully conduct campaigns of this scale and achieved greater than 95% coverage. The lessons learned from the 2010 measles campaign and especially in MR campaign in 2014-2015 indicated that it's challenging to reach mobile population not only in remote areas but also in urban areas. During the micro planning exercises, effort will be made to identify mobile population and strategies to reach this group. Based on the MR campaign that successfully conducted recently in 2014-early 2015 (with target cohort of 20,095,947 children from 1 through 14), the current cold chain system was able to accommodate 27,052,100 doses of MR vaccine (10 dose-vial). During recent MR campaign, a total amount of 420 refrigerators TCW300 AC, 120 freezers TWW800, and 16000 vaccine carriers were procured to increase cold chain capacity to meet the demand of the campaign), so with smaller target group of 12,654,583 children for JE campaign, a smaller volume of cold chain will be required for JE campaign (as the volume per dose is similar, JE: 2.5 cm3 per dose versus with MR: 2.611 cm3 per dose), the current capacity of cold chain system should be adequate to accommodate the amount of JE vaccine needed for this campaign. No additional cold-chain equipment is required for this JE campaign.

The Government of Vietnam is requesting financial support of US$15,258,972 from Gavi for vaccine (as the price of IMOJEV, the first choice vaccine for this campaign, is not available, so we use the current price of Japanese Encephalitis Vaccine Live (SA14-14-2) of Chengdu Institute of Biological Products Co. Ltd, China for the calculation purpose) and related supplies to be used in the campaign (see the PoA document, Section 5 for a full discussion of this calculation). A request is also being made to Gavi to contribute US$ 8,225,479 towards campaign operational costs from the total of US$11,425,479. The remaining cost will be contributed by government of Vietnam and it's development partners. Both requests are to support the JE campaign planned for January 2017.

This proposal has been endorsed by ICC for Immunization in Vietnam on September 4th, 2015. This same group will provide oversight and monitoring and supervision for the activities in this proposal.

4. Signatures

4.1. Signatures of the Government and National Coordinating Bodies

4.1.1. Government and the Inter-Agency Coordinating Committee for Immunisation

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

JE, 5 dose(s) per vial, LYOPHILISED preventive campaigns

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

Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NUMBER : 1 and 2 in Section 10. Attachments.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Nguyen Thi Kim Tien	**Name**	Dinh Tien Dung
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the Gavi Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr. Duong Thi Hong	Vice Director, National Institue of Hygiene and Epidemiology	+84 936255696	hong_epi@yahoo.com

4.1.2. National Coordinating Body - Inter-Agency Coordinating Committee for Immunisation

Agencies and partners (including development partners and NGOs) supporting immunisation services are co-ordinated and organised through an inter-agency coordinating mechanism (ICC, Health Sector Coordinating Committee (HSCC), or equivalent committee). The ICC, HSCC, or equivalent committee is responsible for coordinating and guiding the use of the GaviGavi NVS routine support and/or campaign support. Please provide information about the ICC, HSCC, or equivalent committee in your country in the table below.

Profile of the ICC, HSCC, or equivalent committee

Name of the committee	Interagency Coordinating Committee for Immunization (ICC)
Year of constitution of the current committee	2000
Organisational structure (e.g., sub-committee, stand-alone)	stand alone
Frequency of meetings	3-6 months

The Terms of Reference or Standard Operating Principles for the ICC, including details on the ICC membership, quorum, dispute resolution process and meeting schedules is attached as DOCUMENT NUMBER : 4.

Major functions and responsibilities of the ICC/HSCC:

- Review and endorse EPI annual and five-year plans, country proposals and reports and other relevant documents prepared by the National EPI

- Review progress in achieving milestones/objectives

- Co-ordinate actions needed to overcome constraints and achieve milestones/objectives

- Mobilize funding and assist in planning and monitoring in areas of priority as determined by the National Steering Committee for EPI

Please describe how partners have provided support in preparation of the proposal:

National EPI of Vietnam and PATH are taking lead in preparation of the proposal. The Application has been sent to Ministry of Health and ICC members for review and input before finalization. The ICC meeting was organized on September 4th, 2015 for endosing the Application.

4.1.3. Signature Table for the Coordinating Committee for Immunisation

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **04/09/2015** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 6 (please use the list for signatures in the section below).

Please refer to Annex C of the 'Gavi HSS and NVS General Guidelines' for more information on ICCs.

Function	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Deputy Representative/UNICEF	Jesper MOLLER		
Secretary	Maternal and Neonatal Specialist, UNICEF	Nguyen Huy Du		
Members	Medical Officer/WHO	Toda KOHEI		
	Technical Director/PATH	Huong Vu		

By submitting the proposal we confirm that the quorum has been met. **Yes**

The minutes from the three most recent ICC meetings are attached as DOCUMENT NUMBER : 7.

4.2. National Immunization Technical Advisory Group (NITAG)

Has a NITAG been established in the country ? **Yes**

We the members of the NITAG met on the to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation describing the decision-making process through which the recommendations were reached, attached as Document number 9.

4.2.1. The NITAG

Profile of the NITAG

Name of the NITAG	National Immunization Technical Advisory Group
Year of constitution of the current NITAG	2015
Organisational structure (e.g., sub-committee, stand-alone)	stand-alone

Frequency of meetings	ad-hoc based on the needs

Function	Title / Organisation	Name
Chair	Senior Advisor, Ministry of Health of Vietnam	Trinh Quan Huan
Secretary	First Secretary	Nguyen Van Cuong
Members	Director, National Institute of Hygiene and Epidemiology (NIHE)	Dang Duc Anh
	Director, General Department of Preventive Medicine	Tran Dac Phu
	Director, Administration of Medical Service	Luong Ngoc Khue
	Director, Administration of Science Technology and Training	Nguyen Cong Khan
	Vice Director, General Department of Preventive Medicine	Nguyen Minh Hang
	Vice Director, Drug Administration of Vietnam	Nguyen Tat Dat
	Director, Nghe An Provincial Department of Health	Bui Dinh Long
	Director, National Hospital of Tropical Diseases	Nguyen Van Kinh
	Vice Director, National Pediatric Hospital	Le Thi Minh Huong
	Director, Pasteur Institute in Ho Chi Minh City	Phan Trong Lan
	Director, Institute of Preventive Medicine and Public Health	Doan Huu Thien
	Director, Center for Allergology and Clinical Immunology, Bach Mai Hospital	Nguyen Van Doan
	Former Director, NIHE	Nguyen Tran Hien
	Former Director, The Company for Vaccines and Medical Biologicals No. 1	Nguyen Thu Van
	Former EPI manager, National EPI	Do Sy Hien

Major functions and responsibilities of the NITAG

1. Considering and making proposal to MOH leaders regarding the target population, immunization schedule, dosage, route of administration, immunization technique of the vaccines and biomedicals, forms of execution and practices for EPI and non-EPI vaccines
2. Analyzing and making proposal regarding the national polices on the usage of vaccines and biomedicals to MOH leaders for orienting the research institutions and Government agencies in formulating the research policies, strategies, plans and development of the new vaccines as well as vaccine delopment technology in the future
3. Providing advises to MOH leaders regarding study and assessment of the efficiency of vaccine usage in EPI, making proposal in complementing or adjustment of vaccines used in EPI
4. Developing and providing recommendations for revision of contents, mechanism, organizatinal structure and activities of NITAG

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as **(Document Number: 10)**

5. Immunisation Programme Data

5.1 Background information

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

- Please refer to the Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan) and attach a complete copy (with an Executive Summary) as DOCUMENT NUMBER 11. Please attach the cMYP costing tool as DOCUMENT NUMBER 12.
- Please attach relevant Vaccine Introduction Plan(s) as DOCUMENT NUMBER : 14
- Please refer to the two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases
- Please refer to Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.
- Please refer to the attached risk assessments in the case of yellow fever and meningitis A mass preventive campaigns.

Please use the most recent data available and specify the source and date.

	Figure	Year	Source
Total population	90,700,000	2014	World Bank
Birth cohort	1,780,133	2014	National EPI, Vietnam
Infant mortality rate (per 1000)	19	2013	World Bank
Surviving infants*[1]*	1,750,358	2014	National EPI, Vietnam
GNI per capita (US$)	1,890 %	2014	World Bank
Total Health Expenditure (THE) as a percentage of GDP	186 %	2014	World Bank
General government expenditure on health (GGHE) as % of General government expenditure	6 %	2013	World Bank

[3] Surviving infants = Infants surviving the first 12 months of life

5.1.1 Lessons learned

Routine New Vaccines Support

Preventive campaign support

If campaigns with JE vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. If they are included in the Introduction Plan or Plan of Action, please cite the section only.

Lessons Learned	Action Points
Please refer to section 1.5 in the Plan of Action	

5.1.2 Health planning and budgeting

Please provide information on the planning and budgeting cycle in your country

Among various national target health programs, 10 priority programs are ranked in the 2011-2015 health 5-year plan including the expanded program on immunization (EPI), malaria control, TB control, dengue fever

control, HIV/AIDS control, nutrition program, mental health and food safety and hygiene, reproductive health, school health and military civilian health collaboration. These programs are established to achieve the objectives of the Government Policy and Strategy for Protection and Care of the People's health in the period of 2011-2015. The specific objectives are to reduce morbidity and mortality due to epidemic diseases, prevent, control and manage non-infectious diseases, enhance equity in access to and use of health care services and to improve quality of care

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

Five year plan for protection, care and promotion of people's health for 2011-2015, December 2010. The new plan is under development for the period of 2016-2020.

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

Yes, cMYP (2011-2015) is aligned with this document in timing (both national health plan and cMYP are for years 2011-2015). The new cMYP is under development with support from WHO for the period 2016-2020.

Please indicate the national planning budgeting cycle for health

Multiyear health sector plans are prepared for five year period. The current plan is from 2011 to 2015. Annual plans with annual budget are prepared every year on the basis of multiyear plan. The budget for the implementation of health sector is approved on annual basis by the government. The financial year of Vietnam starts from January 1st and ends December 31st. The new plan cycle for health sector is under development for the period 2016-2020.

Please indicate the national planning cycle for immunisation

The EPI prepares a multi-year plan to coincide with the national multiyear plan for the health sector. The current multiyear plan is from 2011 to 2015. In addition, EPI program prepares annual work plans based on the multiyear plan for annual budgeting and implementation purposes. The new cMYP is under development with support from WHO for the period 2016-2020.

5.1.3 Preparatory activities

Please provide an outline of all **preparatory** activities for vaccine(s) introduction or campaigns. If they are included in detail the Introduction Plan and/or Plan of Action, please cite the sections only.

All preparatory activities are listed in section 4.0 (from 4.1-4.9) of Plan of Action and the same section 4.0 of Introduction Plan and listed in the Campaign Operational Costs and the Vaccine Introduction Grant spreadsheets provided as attachments.

5.1.4 Gender and equity

Please describe any barriers to access, utilisation and delivery of immunisation services at district level (or equivalent) that are related to geographic, socio-economic and/or gender equity. Please describe actions taken to mitigate these barriers and highlight where these issues are addressed in the vaccine introduction plan(s).

Experiences from implementation of EPI and the results from the recent National EPI Review (with participation from several international agencies including WHO, UNICEF, PATH) in June-July 2015 highlighted the complexity and diversity of the equity issue, 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 seasonal flooding due to poor road access
- *Ethnic minority populations* who may not always understand Vietnamese language and immunisation messages

To address this complex issue, National EPI with support from UNICEF, an Action Plan To Strengthen Immunization services In Hard To Reach Areas in Vietnam using Reaching Every Community Stretegy has been developed and under finalization. In this Action Plan, a total of 91 districts with <80% coverage for DPT-Hep B-Hib and MCV2 IN 2014 has been indentified, the immunization barriers have been analysed to find out the root causes such as no micro-plan to reach hard to reach regularly, poor quality outreach children missed in hard to reach areas, reported coverage does not show village inequities, low demand from community not socially connected to health center services, media, printed messages do not reach hard to reach areas and some health centers need replacement of cold chain equiment to increase vaccine availability.

From analysis, 5 strategies have been developed to address the issue including National Immunization Program identifies and map all communities affected by inequities, Health Centers update miroplans to prioritize "high risk communities", Health Centers and "high risk communities" work together to reduce social distance, National Immunization Program establishes a system to minitor immunity gaps in "high risk communities", and National Immunization Program ensures Health Centers have edequate resources for "high risk communities" activities.

Discuss how equity issues (geographic, socio-economic and/or gender) are being taken into account in the design of social mobilisation and other strategies to increase immunisation coverage. Highlight where these issues are addressed in the vaccine introduction plan(s).

The current cMYP for the period 2011-2015 included providing additional resources for hard to reach areas such as conducting SIAs in the hard to reach areas, providing more funding for supplement activities in hard to reach areas, retraining for health workers, providing more cold chain equipment (fridges and vaccine carriers) for health centers in hard to reach areas (supported by Luxembourg Government).

The new cMYP for the period 2016-2020 is under development with support from WHO will address the recommendations from recent National EPI Review, EVM assessment and Improvement Plan, strategies and actions identified in the Action Plan To Strengthen Immunization services In Hard To Reach Areas in Vietnam as well as the priorities of the National Immunization Program.

Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems.

The rate of immunization coverage by sex not include in immunization routine reporting systems. However, this information is always included in coverage survey conduct every 5 years in EPI review.

In some parts of the world, gender has been identified as an important factor limiting access to immunization services for girls. However, results from these national EPI reviews always indicate that in Vietnam gender is not a significant factor affecting immunization services utilization and there is little disparity between the two groups. A one percent difference is observable between BCG coverage (100% for boys and 99% for girls) and a one percent difference between DTP3 coverage (99% for boys and 98% for girls).

Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought or others)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities.

Flooding often happens in central region of Vietnam in typhoon season (July to September annualy), it causes many difficulties for EPI program in implementing EPI activities during this flooding season as it often follows with power cut and some communes, villages may be isolated and can not access for immunization activities. So, the planning for conducting campaign should be carefully taken this into account to make sure that it should be completed before flooding season (before July).

If available, please provide additional information and documents on subnational coverage data, e.g. comparing urban/rural districts or districts with highest/lowest coverage, etc.

The subnational coverage data is always presented in Annual EPI Report. The data from 2014 Annual EPI Report shown that the fully immunized children coverage (FIC) from the Northern, Central, Central Highlands and Southern region is 97.0, 97.1, 94.1, and 97.7% respectively. The same coverage data broken down by province and district shown that there were 2/63 provinces (3.2%) having this coverage less than 90% and 2/331 districts (0.6%) in the Nothern Region, 4/110 districts (3.6%) in the Central Region, and 16/214 districts (7.5%) having this coverage less than 80%.

Please describe what national surveys take place routinely in country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers.

National EPI review is usually conducted in 4-5 years with one section to assess equity in accessing immunization services,

Multi-Indicator Survey (MIC) supported by UNICEF is usually conducted in 5 years looking at equity perpective by indicating disparities by sex, region, area, ethnicity, living standards and other characteristics.

Demographic and Health Survey (DHS) is usually conducted in 10 years also looks at equity issue similarly with MIC survey by indicating disparities by sex, region, area, ethnicity, living standards and other characteristics.

5.1.5 Data quality

Please attach a data quality assessment (DQA), report if one has been completed within the previous 48 months (DOCUMENT NUMBER: 13). If available, an improvement plan and progress report on the implementation of the improvement plan should also be submitted (DOCUMENT NUMBER: 16, DOCUMENT NUMBER: 17).

If DQA not available, please briefly describe plans to establish mechanisms for data quality assessment.

Although DQA is not available but several mechanisms have been established for data quality assessment such as independent coverage surveys (usually conducted together with National EPI review and by independent research institution), MIC survey conducted by General Statistics Office (GSO) supported by UNICEF and DHS conducted by GSO. These surveys will give independent data for assessing the quality of data recorded and reported by routine EPI information systems.

For this moment as no DQA conducted, instead of submitting DQA report, we wil submit the most recent results of MIC survey conducted in 2014 for reference.

Please indicate what routine mechanisms to independently assess the quality of administrative data are in place, and if so what these mechanisms are and how they enable the country to track changes in data quality over time.

As mentioned above, several mechanisms have been established for data quality assessment such as independent coverage surveys (usually conducted together with National EPI review and by independent research institution), MIC survey conducted by General Statistics Office (GSO) supported by UNICEF and DHS conducted by GSO. These surveys will give independent data for assessing the quality of data recorded and reported by routine EPI information systems.

Please detail what household surveys have been conducted in recent years to independently assess immunisation coverage and equity, and describe any survey plans for the coming five year period.

The national EPI household coverage survey was conducted recently in June-July, 2015, preliminary results shown that the national FIC is 94%, no different in coverage by sex, but one province with hard to reach areas (Binh Phuoc) with low coverage compared to national coverage (84%).

The MIC survey conducted in 2014, the preliminary results shown that the percentage of children age 12-23 months who received all vaccinations recommended in the national immunization schedule by their first birth day was 75.6%.

These 2 household surveys usually plans for conducting in 4-5 years.

5.2. Baseline and Annual Targets (NVS Routine Support)

No NVS Routine Support is requested

5.3. Targets for Preventive Campaign(s)

5.3.1 Targets (JE campaign)

Please specify cohort for Japanese Encephalitis vaccines (JEV):

JE Start **6 years**

JE End **14 years**

Cohort population = population 6 years - 14 years old

Gavi will only provide support to countries for Japanese encephalitis catch-up campaign by providing JE vaccine for a target population of males and females aged 9 months to 14 years (the exact range in the scope of 9 months to 14 years old will depend on Japanese encephalitis in the country).

Table 5.3.1 Baseline NVS preventive campaign figures for JE

Number	Targets
	2017
Total target population	12,654,583
Wastage rate (%) for JE (campaign)	10

6. New and Under-Used Vaccines (NVS Routine)

No NVS Routine Support is requested

7. NVS Preventive Campaigns

7.1. Assessment of burden of relevant diseases related to campaigns (if available)

Disease	Title of the assessment	Date	Results
Japanese Encephalitis	Viral Encephalitis (VE) reporting system, JE sentinel surveillance, hospitals and national labs	since 1991 for VE system, 2006-2014 for others	The existing data proves that JE disease is widely distributed in all regions of Vietnam, JE accounts for approximately 10% of all AES cases, the high risk group is from 1-15 years of age and the pick season of JE cases is from May to July. In recent years (2013-2014), an increasing the number of JE cases was observed in the North and Central Highlands and the rate of JE positive from AES cases also increased (18.5% in 2014 compared to 10% in 2013) from all samples sent by provincial hospitals. Please refer to section 1.6 in the Plan of Action for more details

Please attach the Plan of Action for each campaign as Document No. 30,29 in Section 10.

7.1.1 Epidemiology and disease burden for JE

Please select at least one of the following information sources to justify JEV diseases burden results:

Epidemiological information on burden of disease:

☑ 1 - JE data from the JE/AES surveillance system including the definition of the geographical extent of high risk areas for JE

☐ 2 - Reports on outbreak or clustering of cases in the past three years

☐ 3 - In case of absence of data from JE/AES surveillance, data from rapid assessments and/or an argumentation on environmental and biological plausibility.

7.2.Request for JE, 5 dose(s) per vial, LYOPHILISED campaign support

7.2.1. Summary for JE campaign support

When is the country planning to conduct this campaign? **January 2017**

When is the country planning to introduce JE into routine immunisation? **January 2017**

Please give a summary of the cMYP and/or the JE, 5 dose(s) per vial, LYOPHILISED introduction plan sections that refer to the introduction of JE, 5 dose(s) per vial, LYOPHILISED. Outline the key points that informed the decision-making process (data considered etc) and describe the plans for social mobilisation and microplanning, including strategies for insecure or hard-to-reach areas. If they are included in the introduction plan or plan of action, please cite the sections only.

Refer to the following sections in the Plan of Action:

Decision-making process: 1.7
Plans and activities for the campaign from 4.1 through 4.9

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain and other logistic requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. Please describe how the surge capacity for campaigns will be managed. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled. The Independent Review Committee requires a certain level of assurance that the cold chain is ready or will be ready for the campaign, and evidence/plans need to be provided (if they are included in detail in the plan of action, please cite the section here).
New Requirement: As approved by Gavi in June 2014 all future proposals (2015 and beyond) that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure equipment pre-qualified by WHO under their Performance Quality and Safety (PQS) program. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi. Please note that all Gavi-financed cold chain equipment needs to be WHO pre-qualified. The purchase of non-PQS equipment will only be considered on exceptional basis, with justification and advance agreement from Gavi.

Refer to section 4.3 as well as to an additional document attached to this proposal: Vietnam DOSES COSTS_price update_September 1st which specifies the volumes required at the central JE campaign.

Please describe any plans for expanding measles surveillance to include rubella and plans for the introduction of Congenital Rubella Syndrome (CRS) surveillance.

The proposed JE campaign is expected to strengthen routine immunization through the following:

- Strengthening the collaboration between MOH and MOET, between health sector with People's Committee at all levels and between health sector with social organizations (Women's Union, Youth's Union)
- The capacity of health workers will be strengthened through training on micro-planning, AEFI, vaccine safety, waste management, disease surveillance, cold chain, etc. This should benefit not only for JE campaign but also the for routine immunization program.
- Further strengthening of strategies to improve equitable access to vaccines building upon efforts already initiated in identifying and reaching hard-to-reach populations.
- Monitoring focused on improving routine coverage and equity:An additional rapid coverage assessment activity focused on hard-to-reach populations will focus on immunization coverage of routine infant vaccines in these populations.

Coverage survey: Gain experience with statistical methods to estimate coverage that can be adapted and utilized for routine household coverage surveys.

Please submit relevant documentation to support the estimates of the size of the campaign target population (as DOCUMENT NUMBER : 23).

7.2.2. Grant Support for Operational Costs of the JE Campaign

Table 7.2.2: calculation of grant to support the operational costs of the campaigns

Year of JE support	Total target population (from Table 5.3)	Gavi contribution per target person in US$	Total in US$
2017	12,654,583	0.65	8,225,479

[1] The Grant will be based on a maximum award of $0.65 per target person

Please describe how the grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population (refer to the cMYP and the Vaccine Introduction Plan).

The grant will finance planning and preparation, including enhanced training in micro planning. It also contains support for training for JE campaigns and integration of JE vaccine into routine EPI. As part of this refresher training in injection technique, injection safety, and AEFI reporting will be included. The development of appropriate communication materials is included. The plan also includes the production and distribution of all necessary materials, and associated human resource costs for the campaign. Finally, a post-campaign coverage survey is included.

Refer to the Campaign Operational Support Grant for details.

Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs.

Total operational costs for the SIA are estimated to be US$ ...(or 0.80 USD per child), with GAVI funding US$ 8,225,479 (0.65 USD per child) and the remainder (US$...) being provided from central, local government and other donors (WHO, UNICEF,...).

It is note that in 2010 Viet Nam received support from UN fund through UNICEF and WHO for measles campaing for cildren from 1 to 5 years old only vaccine and injection equipment. Operation cost for this campaign was coved by central and local gorvement.

Please complete also the 'Detailed budget for VIG / Operational costs' template provided by Gavi and attach as a mandatory document in the Attachment section.

Detailed budget attached as Document No. 28.

7.2.3 Evidence of introduction of JE in routine programme

Will the country initially benefit from donated vaccines in for the introduction of JE vaccines in the routine immunization? **Yes**

Please provide a statement with a commitment that the country can finance the introduction of Japanese Encephalitis Vaccine (JEV) into the routine programme through one of the following:(Please attach available documents AS DOCUMENT NUMBER 22 in Section 10. Attachments)

☐ 1 - A commercial contract for purchase of JE vaccine with or without shipping documents, invoice, etc.

☑ 2 - Integration of JEV into the cMYP with a corresponding increase in the budget line for vaccines in the health sector budget adequate to cover purchase of JEV (please highlight the budget line in the cMYP costing or other document showing the corresponding increase to cover the purchase of JEV)

☐ 3 - A letter from the Minister of Finance or Budget ensuring additional funding for JEV purchase. In this case, the country must show additional evidence that the country will include JE vaccination in the routine after the campaign.

☐ 4 - An MOU between government and donor(s) (or other written document that proves donor commitment) for at least one year for purchase of JE for use in the routine programme

☑ 5 - Other

The Prime Minister of Vietnam (Nguyen Tan Dung) approved National Target Programs on Health including EPI. In that approval letter, there is a specific paragraph mentioning about the inclusion of JE vaccine into routine EPI (we attached this official letter into application)

7.2.4 JE surveillance indicators

Please provide information on the following indicators of the quality of JE surveillance for at least two years prior to application (if available):

Surveillance indicator	2013	2014
Reporting rate at national level *1)*		
	100,000	100,000
Laboratory confirmation rate (%) *2)*	10	18.5

Note:

- 1) Reporting rate at national level: (number of reported AES cases per 100,000 population)
- 2) Laboratory confirmation rate: (% of tested AES cases that were JE igM-positive)

7.2.5 JE Vaccine introduction Grant

Has a JE vaccine already been introduced nationally on a routine basis? **No**

Calculation of Vaccine Introduction Grant for the JE, 5 dose(s) per vial, LYOPHILISED

Please indicate in the tables below how the one-time Introduction Grant***[1]*** will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP). Gavi's support may not be enough to cover the full needs so please indicate in the table below how much and who will be complementing the funds needed.

Year of New Vaccine Introduction	Birth cohort (from Table 5.1)	Gavi contribution per target person in US$	Total in US$
2017	1,780,133	0.80	1,424,106

[1] The Grant will be based on a maximum award of $0.80 per person in the birth cohort with a minimum starting grant award of $100,000

Please describe 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 (refer to the cMYP and the Vaccine Introduction Plan).

The grant will be used for compiling the new guidelines for integrating JE vaccine into routine EPI system as Vietnam currently uses annual campaign model for high risk areas instead of routine JE vaccination, updating the recording and reporting forms, upgrading the web-based reporting system, training/retraining for health workers, program managers on routine JE vaccination, and development and distribution of IEC materials on JE routine vaccination program. Please refer to VIG or Op Costs Detail for details

8. Procurement and Management

8.1 Procurement and Management of New and Under-Used Vaccines Routine

No NVS Routine Support is requested

8.2 Procurement and Management for NVS Preventive Campaign(s)

8.2.1 Procurement and Management for JE, 5 dose(s) per vial, LYOPHILISED campaign

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

Viet Nam will prefer procuring of the JE vaccine and injection supplies which is financed by GAVI through the UNICEF supply system for the JE catch-up campaign.

b) Please describe the financial management procedures that will be applied for the management of the preventive campaign cash support, including any procurement to be incurred.

The cash grant (US$8,225,479) for operation cost ($0.65 per target population) will be received in a bank account held by NIHE (National Institute of Hygiene and epidemiology), which is part of the MOH as specified in annex 1 on the banking form. NEPI, the national EPI steering group and the ICC will provide oversight over implementation of JE catch-up campaign activities and its monitoring and supervision

c) Please indicate if the campaign is going to be phased, and if so, how this will be done.

The JE SIA will be implemented at all provinces simultaneously from January to June, 2017 and will utilize 2 coordinated approaches:

1. School based delivery (collaboration with the Ministry of Education) will focus on children from 6 years old through 14 years and 11 months. Vietnam has high rates of school attendance, and recent measles-rubella SIAs have successfully utilized this delivery option to improve coverage and reduce costs.

2. Health Centers and Outreach, with a focus on children not go to school or miss a chance to get JE vaccine in their school for whatever reasons. Special efforts (planned in the microplanning phase) will be made with outreach strategy to access high risk communities (mobile, rural hard-to-reach, ethnic, and urban poor). Any gaps in coverage identified during the campaign will be addressed through mop-up activities. All efforts to extend access and improve equity will build on prior work of the NEPI during the Measles Rubella SIA to identify and reach high-risk populations

d) Please outline how coverage of the campaign will be monitored, reported and evaluated (refer to the cMYP and/or the JE, 5 dose(s) per vial, LYOPHILISED campaign introduction plan)

Success of the JE SIA will be measured using two indicators:

1. Overall JE vaccination coverage at HC, operational district, province and national level [target 100%].All levels must have JE SIA coverage monitoring chart available with the JE target, and update and monitor this daily during the course of the SIA.

2. Rapid coverage assessments (RCA), especially in areas with large populations or uncertain population targets [target is final RCA results for all selected communities pass RCA]

Rapid Coverage Assessments (RCA): RCA is used as the most reliable forms of monitoring progress of SIAs. During this JE campaign, RCA will be conducted at every commune to confirm the quality of implementation, using random samples of 20 children in the target age range. This will be conducted by local level supervisors, and will provide a pass/fail assessment for that area. Areas that fail the RCA require further mop up activities and additional RCA to confirm that no children have been missed.

All vaccination teams will use a standard reporting form with the results to be directly reported to or telephoned to Commune Health Center every evening before 06:00pm. All Commune Health Center are to report the following information for all immunization sites to their District Health Center, then PMC daily. The PMC will report to their regional and National EPI weekly:

- Number of JE doses given
- Rapid Coverage Assessment results for selected villages.

High Risk Communities will also have special reporting requirements:

- Number of JE doses given
- Rapid Coverage Assessment results for ALL High Risk Communities

Post-campaign coverage survey. This will be a statistically representative survey conducted within 2 months after the campaign concludes (plan for August, 2017). International partners such as WHO, UNICEF and PATH will be invited to participate in this survey

8.3 Product Licensure

For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines.

Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.

For each of the vaccine(s) requested, please provide the actual licensure status of the preferred presentation and of any alternative presentations, if required.

Please describe local customs regulations, requirements for pre-delivery inspection, special documentation requirements that may potentially cause delays in receiving the vaccine. If such delays are anticipated, explain what steps are planned to handle these.

Please provide information on NRA in the country, including status (e.g. whether it is WHO-certified). Please include points of contact with phone numbers and e-mail addresses. UNICEF will support the process by communicating licensing requirements to the vaccine manufacturers where relevant.

8.4 Vaccine Management (EVSM/EVM/VMA)

It is mandatory for countries to conduct an Effective Vaccine Management (EVM) assessment prior to an application for introduction of new vaccine. This EVM should have been conducted within the preceding 36 months.

When was the EVM conducted? **August 2015**

Please attach the most recent EVM assessment report (DOCUMENT NUMBER : 25,26,27), the corresponding EVM improvement plan (DOCUMENT NUMBER : 26) and progress on the EVM improvement plan (DOCUMENT NUMBER : 27). The improvement plan should include a timeline, budget of committed resources for these activities and funding gaps, if any, as well as M&E indicators to monitor progress of implementation.

If any of the above mandatory documents (EVM Assessment Report, EVM Improvement Plan, Progress on the EVM Improvement Plan) are not available, please provide justification and reference to additional documents such as PIE and External EPI Reviews.

When is the next Effective Vaccine Management (EVM) Assessment planned? **August Not planned**

8.5 Waste management

Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), the safe handling, storage, transportation and disposal of immunisation waste, as part of a healthcare waste management strategy. Please describe the country's waste management plan for immunisation activities (including campaigns).

A waste management plan exists that involves health workers filling safety boxes with used needles and syringes (uncapped) until 100 syringe capacity, closing the box, and storing it in a safe location. Based on the current practice of health center (it may vary from province to province), the filled safety boxes either be transported to district health center for incinerating together with other curative medical wastes, or to be incinerated at health center if simple brick incinerator is available and in use. In some big cities like Hanoi or Ho Chi Minh city, outsourcing for medical waste management with private companies for incinerating is common.

Training in injection safety: Health worker training prior to the JE campaign will encompass both injection safety and appropriate procedures for waste disposal. Health worker training prior to the JE campaign will encompass both injection safety and appropriate procedures for waste disposal. Training of health workers on injection safety and waste disposal will be integrated with training on JE campaign implementation.

Vaccination teams will have sufficient safety boxes for the number of AD syringes (1 safety box for every 100 AD syringes). Used AD syringes and syringe caps should be placed in safety boxes immediately after the vaccine has been given, and when a safety box is approximately ¾ full it will be closed off and a new one used.

9. Additional Comments and Recommendations from the National Coordinating Body (ICC/HSCC)

Comments and Recommendations from the National Coordinating Body (ICC/HSCC)

The ICC conveyed a meeting on September 4th, 2015. All ICC members agreed the important of having a catch-up JE vaccination campaign and integration of JE vaccine into routine EPI in Vietnam in 2017.

10. List of documents attached to this proposal

10.1. List of documents attached to this proposal

Document Number	Document	Section	Mandatory	File
1	MoH Signature (or delegated authority) of Proposal	4.1.1	☑	Signature of MoH and MoF.docx **File desc:** MoH Signature of Proposal will ba send to GAVI soon. **Date/time :** 08/09/2015 04:29:31 **Size:** 16 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	☑	Signature of MoH and MoF.docx **File desc:** MoF Signature of Proposal will be sent to GAVI soon. **Date/time :** 08/09/2015 04:29:56 **Size:** 16 KB
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	☒	No file loaded
4	Terms of Reference for the ICC	4.1.2	☑	ICC Major functions and responsibilities.pdf **File desc:** **Date/time :** 07/09/2015 04:44:43 **Size:** 192 KB
5	Minutes of ICC/HSCC meeting endorsing Proposal	4.1.3	☑	28 ICC meeting note_4 Sept.pdf **File desc:** **Date/time :** 08/09/2015 12:28:35 **Size:** 457 KB
6	Signatures of ICC or HSCC or equivalent in Proposal	4.1.3	☑	ICC signature_JE.pdf **File desc:** **Date/time :** 07/09/2015 11:48:39 **Size:** 2 MB
7	Minutes of last three ICC/HSCC meetings	4.1.3	☑	25th ICC meeting note.pdf **File desc:** **Date/time :** 08/09/2015 12:29:54 **Size:** 351 KB 26 ICC meeting note.pdf **File desc:** **Date/time :** 08/09/2015 12:30:10 **Size:** 478 KB

				27 ICC meeting note_5 May 2015.pdf **File desc:** **Date/time :** 08/09/2015 12:30:22 **Size:** 373 KB
8	A description of partner participation in preparing the application	4.1.3	☒	No file loaded
9	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	☒	No file loaded
10	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	☑	Decision to establish NITAG_original version in Vietnamese.pdf **File desc:** **Date/time :** 07/09/2015 04:35:43 **Size:** 2 MB Decision to establish NITAG_Vietnam_translated version.pdf **File desc:** **Date/time :** 07/09/2015 04:35:12 **Size:** 125 KB
11	comprehensive Multi Year Plan - cMYP	5.1	☑	cMYP Viet Nam_2016-2020_FINAL DRAFT.pdf **File desc:** As cMYP for 2016-2020 is under finalization supported by WHO. We would like to submit the latest draft cMYP. Once it is finalized, we will send to Gavi the final version **Date/time :** 08/09/2015 12:39:04 **Size:** 2 MB
12	cMYP Costing tool for financial analysis	5.1	☑	VNM cMYP 2015_FINAL DRAFT 31 08 15.xlsx **File desc:** As cMYP for 2016-2020 is under finalization supported by WHO. We would like to submit the latest draft cMYP costing. Once it is finalized, we will send to Gavi the final version **Date/time :** 08/09/2015 12:40:44 **Size:** 3 MB
13	Monitoring and evaluation and surveillance (M&E) plan for the support requested, within the context of the country's existing monitoring plan for the EPI programme	5.1.5	☑	Monitoring and Evaluation Plan for JE vaccination campaign.pdf **File desc:** **Date/time :** 07/09/2015 04:43:08 **Size:** 22 KB

14	Vaccine introduction plan	5.1	☒	No file loaded
15	Introduction Plan for the introduction of RCV / JE / Men A into the national programme	7.x.4	☑	Vietnam JE NVIP.pdf **File desc:** **Date/time :** 08/09/2015 12:23:41 **Size:** 825 KB
16	Data quality assessment (DQA) report	5.1.5	☒	MICS Key Findings EN 29 August_Vietnam.pdf **File desc:** As DQA has not been conducted in Vietnam. We substitute it by MICS survey report and hope that it will give Gavi an independent source of immunization data **Date/time :** 07/09/2015 04:36:46 **Size:** 676 KB
17	DQA improvement plan	5.1.5	☒	No file loaded
19	HPV roadmap or strategy	6.1.1	☒	No file loaded
20	Introduction Plan for the introduction of RCV into the national programme	7.x.4	☒	No file loaded
21	HPV summary of the evaluation methodology	5.1.6	☒	No file loaded
22	Evidence of commitment to fund purchase of RCV for use in the routine system in place of the first dose of MCV	7.x.3	☑	Commitment from Vietnam Goverment for JE routine vaccination program_original document in Vietnamese.pdf **File desc:** **Date/time :** 07/09/2015 04:37:32 **Size:** 376 KB Commitment from Vietnam Goverment for JE routine vaccination program_translated version.pdf

				File desc: **Date/time :** 07/09/2015 04:37:16 **Size:** 242 KB
23	Campaign target population documentation	7.x.1	☑	Campaign Target Population JE SIA 2017_Vietnam.xlsx **File desc:** **Date/time :** 07/09/2015 04:39:11 **Size:** 14 KB
24	Roadmap or strategy for strengthening a comprehensive approach to pneumonia and/or diarrhoea prevention and treatment	6.x.6	☒	No file loaded
25	EVM report	8.3	☑	EVM 2015 VietnamSummary ReportV3.pdf **File desc:** The final one will be sent to GAVI soon **Date/time :** 07/09/2015 04:39:32 **Size:** 1 MB
26	Improvement plan based on EVM	8.3	☑	EVM Improvement Plan 2016_2020_Vietnam.pdf **File desc:** The final one will be sent to GAVI soon. **Date/time :** 07/09/2015 04:40:50 **Size:** 727 KB Indicative Narrative BudgetV1.docx **File desc:** The final one will be sent to GAVI soon. **Date/time :** 08/09/2015 04:48:50 **Size:** 214 KB
27	EVM improvement plan progress report	8.3	☑	EVM progress report.pdf **File desc:** **Date/time :** 07/09/2015 04:41:53 **Size:** 108 KB
28	Detailed budget template for VIG / Operational Costs	6.x,7.x.2	☑	Budget JE VIG_VNM.xlsx **File desc:** **Date/time :** 07/09/2015 10:18:52 **Size:** 153 KB Cost Detail JE campaign_VNM.xlsx **File desc:** **Date/time :** 07/09/2015 10:18:31 **Size:** 30 KB

29	Risk assessment and consensus meeting report for Meningitis / Yellow Fever: (for yellow fever please include information required in the NVS guidelines on YF Risk Assessment process)	7.1	☒	No file loaded
30	Plan of Action for campaigns	7.1, 7.x.4	☑	Vietnam_Plan of Action.pdf **File desc:** **Date/time :** 07/09/2015 10:19:14 **Size:** 1 MB
	Other		☒	No file loaded

11. Annexes

Annex 1 - NVS Routine Support

No NVS Routine Support is requested

Annex 2 - NVS Routine – Preferred Second Presentation

No NVS Routine – Preferred Second Presentation requested this year

Annex 3 - NVS Preventive campaign(s)

Annex 3.1 - NVS Preventive campaign(s) (JE, 5 dose(s) per vial, LYOPHILISED)

Table Annex 3.1 C: Summary table for CAMPAIGN JE, 5 dose(s) per vial, LYOPHILISED

	Data from		2017
Total target population	Table 5.3.1	#	12,654,583
Number of doses per persons	Parameter	#	1
Wastage Rate	Table 5.3.1	#	10
Estimated vaccine wastage factor		#	1.11
Number of doses per vial	Parameter	#	5
AD syringes required	Parameter	#	Yes
Reconstitution syringes required	Parameter	#	Yes
Safety boxes required	Parameter	#	Yes
AD syringe price per unit	Table Annexes 4A	$	0.448
Reconstitution syringe price per unit	Table Annexes 4A	$	0.035
Safety box price per unit	Table Annexes 4A	$	0.0054
Freight cost as % of vaccines value	Table Annexes 4B	%	5.00 %
Freight cost as % of devices value	Parameter	%	0

Table Annex 3.1 D: Estimated number of JE, 5 dose(s) per vial, LYOPHILISED associated injection safety material and related co-financing budget (page 1)

		Formula	Gavi
			2017
B	Total target population	*Table 5.3.1*	12,654,583
C	Number of doses per persons	*Vaccine parameter (schedule)*	1
D	Number of doses needed	*B x C*	12,654,583
E	Estimated vaccine wastage factor	*100 / (100 - Vaccine wastage rate)*	1.11
F	Number of doses needed including wastage	*D x E*	14,046,588
G	Vaccines buffer stock	*0*	0
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	14,046,600
J	Number of doses per vial	*Vaccine parameter*	5
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.11*	14,046,588
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.11*	3,118,346
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.11*	190,531
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	8,434,529
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	6,292,872
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	109,143
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	1,029
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	421,399
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0
T	Total fund needed	*(N+O+P+Q+R+S)*	15,258,972

Note: There is no co-financing for NVS preventive campaigns

Annex 4

Table Annex 4A: Commodities Cost

Estimated prices of supply are not disclosed

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2017
JE, 5 dose(s) per vial, LYOPHILISED	JE	5.00 %

Table Annex 4C: Graduating - Minimum country's co-payment per dose of co-financed vaccine.

Vaccine

Table Annex 4D: Wastage rates and factors

The following table shows the wastage rates for routine and campaign vaccines, set for 2017.

Vaccine	dose(s) per vial	Maximum Vaccine wastage rate*		Benchmark Wastage Rate**
		Routine	Campaign	
HPV bivalent, 2 dose(s) per vial, LIQUID	2	10 %	10 %	
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5 %	5 %	
JE, 5 dose(s) per vial, LYOPHILISED	5	10 %	10 %	
Measles second dose, 10 dose(s) per vial, LYOPHILISED	10	40 %	40 %	
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	10	50 %	10 %	
MR, 10 dose(s) per vial, LYOPHILISED	10	15 %	15 %	
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	10 %	10 %	
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	5 %	5 %	
Rotavirus, 2-dose schedule	1	5 %	5 %	
Rotavirus, 3-dose schedule	1	5 %	5 %	
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	40 %	40 %	
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	10 %	10 %	

Comments:

* Source - WHO indicative wastage rates

** Source - Country APRs and studies, approved by WHO, UNICEF, and the Gavi Secretariat

Note: HPV demonstration project wastage rates are the same as for the national introduction of the vaccine

Table Annex 4E: Vaccine maximum packed volumes

Kindly note that this table is for reference purposes only and includes Gavi- and non Gavi-supported vaccines.

Vaccine product	Designation	Vaccine formulation	Admin route	No. Of doses in the schedule	Presentation (doses/vial, prefilled)	Packed volume vaccine (cm3/dose)	Packed volume diluents (cm3/dose)
BCG	BCG	lyophilized	ID	1	20	1.2	0.7
Diphtheria-Tetanus	DT	liquid	IM	3	10	3	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	20	2.5	
Diphtheria-Tetanus-Pertussis	DTP	liquid	IM	3	10	3	
DTP liquid + Hib freeze-dried	DTP+Hib	liquid+lyop.	IM	3	1	45	
DTP-HepB combined	DTP-HepB	liquid	IM	3	1	9.7	
DTP-HepB combined	DTP-HepB	liquid	IM	3	2	6	
DTP-HepB combined	DTP-HepB	liquid	IM	3	10	3	
DTP-HepB liquid + Hib freeze-dried	DTP-Hib	liquid	IM	3	10	2.5	
DTP-HepB liquid + Hib freeze-dried	DTP-HepB+Hib	liquid+lyop.	IM	3	1	22	

DTP-HepB-Hib liquid	DTP-HepB+Hib	liquid+lyop.	IM	3	2	11	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	10	4.4	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	2	13.1	
DTP-HepB-Hib liquid	DTP-HepB-Hib	liquid	IM	3	1	19.2	
DTP-Hib combined liquid	DTP+Hib	liquid+lyop.	IM	3	10	12	
DTP-Hib combined liquid	DTP-Hib	liquid	IM	3	1	32.3	
Hepatitis B	HepB	liquid	IM	3	1	18	
Hepatitis B	HepB	liquid	IM	3	2	13	
Hepatitis B	HepB	liquid	IM	3	6	4.5	
Hepatitis B	HepB	liquid	IM	3	10	4	
Hepatitis B UniJect	HepB	liquid	IM	3	Uniject	12	
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	1	13	35
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	2	6	
Hib freeze-dried	Hib_lyo	lyophilized	IM	3	10	2.5	3
Hib liquid	Hib_liq	liquid	IM	3	1	15	
Hib liquid	Hib_liq	liquid	IM	3	10	2.5	
Human Papilomavirus vaccine	HPV	liquid	IM	3	1	15	
Human Papilomavirus vaccine	HPV	liquid	IM	3	2	5.7	
Japanese Encephalitis	JE_lyo	lyophilized	SC	1	5	2.5	2.9
Measles	Measles	lyophilized	SC	1	1	26.1	20
Measles	Measles	lyophilized	SC	1	2	13.1	13.1
Measles	Measles	lyophilized	SC	1	5	5.2	7
Measles	Measles	lyophilized	SC	1	10	3.5	4
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	1	26.1	26.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	2	13.1	13.1
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	5	5.2	7
Measles-Mumps-Rubella freeze dried	MMR	lyophilized	SC	1	10	3	4
Measles-Rubella freeze dried	MR	lyophilized	SC	1	1	26.1	26.1
Measles-Rubella freeze dried	MR	lyophilized	SC	1	2	13.1	13.1
Measles-Rubella freeze dried	MR	lyophilized	SC	1	5	5.2	7
Measles-Rubella freeze dried	MR	lyophilized	SC	1	10	2.5	4
Meningitis A conjugate	Men_A	lyophilized	IM	1	10	2.6	4
Meningitis A/C	MV_A/C	lyophilized	SC	1	10	2.5	4
Meningitis A/C	MV_A/C	lyophilized	SC	1	50	1.5	3
Meningitis W135	MV_W135	lyophilized	SC	1	10	2.5	4
Meningococcal A/C/W/	MV_A/C/W	lyophilized	SC	1	50	1.5	3

Meningococcal A/C/W/Y	MV_A/C/W/Y	lyophilized	SC	1	10	2.5	4
Monovalent OPV-1	mOPV1	liquid	Oral		20	1.5	
Monovalent OPV-3	mOPV3	liquid	Oral		20	1.5	
Pneumo. conjugate vaccine 10-valent	PCV-10	liquid	IM	3	1	11.5	
Pneumo. conjugate vaccine 10-valent	PCV-10	liquid	IM	3	2	4.8	
Pneumo. conjugate vaccine 13-valent	PCV-13	liquid	IM	3	1	12	
Polio	OPV	liquid	Oral	4	10	2	
Polio	OPV	liquid	Oral	4	20	1	
Polio inactivated	IPV	liquid	IM	3	PFS	107.4	
Polio inactivated	IPV	liquid	IM	3	10	2.5	
Polio inactivated	IPV	liquid	IM	3	1	15.7	
Rota vaccine	Rota_liq	liquid	Oral	2	1	17.1	
Rota vaccine	Rota_liq	liquid	Oral	3	1	45.9	
Tetanus Toxoid	TT	liquid	IM	2	10	3	
Tetanus Toxoid	TT	liquid	IM	2	20	2.5	
Tetanus Toxoid UniJect	TT	liquid	IM	2	Unijject	12	
Tetanus-Diphtheria	Td	liquid	IM	2	10	3	
Yellow fever	YF	lyophilized	SC	1	5	6.5	7
Yellow fever	YF	lyophilized	SC	1	10	2.5	3
Yellow fever	YF	lyophilized	SC	1	20	1.5	2
Yellow fever	YF	lyophilized	SC	1	50	0.7	1

12. Banking Form

In accordance with the decision on financial support made by the Gavi, the Government of Viet Nam hereby requests that a payment be made via electronic bank transfer as detailed below:

Name of Institution (Account Holder):			
Address:			
City Country:			
Telephone no.:		**Fax no.:**	
	Currency of the bank account:		
For credit to:			
Bank account's title:			
Bank account no.:			
Bank's name:			

Is the bank account exclusively to be used by this program? False

By who is the account audited?

Signature of Government's authorizing official

Name:		**Seal**
Title:		
Signature:		
Date:		

FINANCIAL INSTITUTION		**CORRESPONDENT BANK (In the United States)**	
Bank Name:			
Branch Name:			
Address:			
City Country:			
Swift Code:			
Sort Code:			
ABA No.:			
Telephone No.:			
FAX No.:			

I certify that the account No is held by at this banking institution

The account is to be signed jointly by at least (number of signatories) of the following authorized signatories:

1		
	Name:	
	Title:	
2		
	Name:	
	Title:	
3		
	Name:	
	Title:	

Name of bank's authorizing official
Signature:
Date:
Seal: