Application Form for Gavi NVS support

Submitted by

The Government of Myanmar

for

Rotavirus routine and Measles-rubella follow-up campaign

Gavi terms and conditions

1.2.1 Gavi terms and conditions

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

GAVI GRANT APPLICATION TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

NO LIABILITY

The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programme(s) in the Country; and (ii) the use or distribution of vaccines and related supplies after title to such supplies has passed to the Country.

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

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

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

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

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

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

COMPLIANCE WITH GAVI POLICIES
The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant to the programme(s), including without limitation the Transparency and Accountability Policy (TAP) and complies with the requirements therein. All programme related policies, guidelines and processes are available on Gavi's official website and/or sent to the Country.

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

ARBITRATION

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

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

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

Gavi Guidelines and other helpful downloads

1.3.1 Guidelines and documents for download

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

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

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

A key component of the application is a solid operational plan (New Vaccine Introduction Plan for routine support, or Plan of Action for campaign support), explaining how the country will introduce the vaccine or conduct the envisaged campaign, with a corresponding budget. The New Vaccine Introduction Plan or Plan of Action must be submitted together with this application form and will be considered as the foundation of the support request.

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

Review and update country information

Country profile

2.1.1 Country profile

Eligibility for Gavi support

Eligible

Co-financing group

Preparatory transition

Date of Partnership Framework Agreement with Gavi

4 April 2014

Country tier in Gavi's Partnership Engagement Framework

2

Date of Programme Capacity Assessment

December 2016

2.1.2 Country health and immunisation data

Please provide the following information on the country’s health and immunisation budget and expenditure.
What was the total Government expenditure (US$) in 2016?

21,311,251,314

What was the total health expenditure (US$) in 2016?

894,468,980

What was the total Immunisation expenditure (US$) in 2016?

11,642,434

Please indicate your immunisation budget (US$) for 2016.

4,400,000

Please indicate your immunisation budget (US$) for 2017 (and 2018 if available).

58,322,998

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

The government planning cycle starts on the

1 April

The current National Health Sector Plan (NHSP) is

From	2017
To	2021

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

2017-2021

Is the cMYP we have in our record still current?

Yes☒	No☐

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

From	2017
To	2021

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

No Response

2.1.4 National customs regulations

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

Import permit and tax exemption documents are required for import of vaccine into the country.
cEPI of DoPH will proceed for import permit application to Ministry of Commerce through

Ministry of Health and Sports(MOHS). After obtaining the Import Permit, cEPI of DOPH will apply for Tax Exemption to the Ministry of Finance through the MOHS.
To apply import permit, there must be notification process of the import of vaccines by Food and Drug Administration Department of Ministry of Health and Sports.
1. Following documents should be sent (except for safety boxes) to the Country for all MoHS procurement service/MOHS consignee as early as possible after issuance of the Purchase order (~3 months prior to the delivery date is the best option). FDA notification process normally takes 2-3 weeks.
- Name of supplier (company profile)/Manufacturer license/registration as well (if supplier is from China).
- Country of origin
- Product Summary Information
- Summary Protocol for production
- Certificate of Final Product
- Certificate of Quality Assurance
- Batch release certificate
- Certificate of Analysis
2. Pro-forma Invoice & Packing List should be sent to the country for all MoHS procurement services/consignee as early as possible after issuance of the PO, to enable MOHS to start the application of import permit and tax exemption certificate before the shipment starts since the process takes minimum 4-6 weeks.
3. Invoice and Packing List must also be sent together with the shipment.
4. Shipment is arranged only when country provides green light for both air and sea shipments after assuring all the necessary documents in hand

2.1.5 National Regulatory Agency

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

Food and Drug Administration Department of Ministry of Health and Sports is responsible in ensuring the safety and quality of
Food, Drugs, Medical Devices and Cosmetics in the country.
FDA is responsible for issuing GMP certificate for local food manufacturing businesses, import and export recommendation, import and export health certification. Drug control activities include marketing authorization for new product, variation of existing authorization, quality control laboratory testing, adverse drug reaction monitoring, Good Manufacturing Practice inspection and licensing of manufacturers, wholesalers, enforcement activities, drug promotion and advertisements. FDA issues notification and import recommendation of medical devices and notification of cosmetics.
In the absence of NRA, FDA is responsible for issuing notification letter for the vaccines used in National Immunization Programme.
The contract point of FDA is Dr. Theingi Zin, Director, +9595197673, +95-67-403073 and theingizin9@gmail.com.

National Immunisation Programmes

2.2.2 Financial Overview of Active Vaccine Programmes

IPV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)					
Gavi support (US$)	2,434,000	2,071,462	2,104,606	2,164,582	2,164,477

JEV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	47,146	74,933	83,392	97,593	111,742
Gavi support (US$)	621,500	849,420	811,128	812,713	794,593

PCV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	737,152	915,986	1,070,102	1,259,938	1,441,130
Gavi support (US$)	8,849,500	9,840,500	10,231,000	10,312,500	8,402,258

Pentavalent Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	142,568	241,249	281,849	331,749	376,054
Gavi support (US$)	1,663,500	2,461,000	2,464,000	2,479,000	2,393,977

Summary of active Vaccine Programmes

	2018	2019	2020	2021	2022
Total country co-financing (US$)	926,866	1,232,168	1,435,343	1,689,280	1,928,926
Total Gavi support (US$)	13,568,500	15,222,382	15,610,734	15,768,795	13,755,305
Total value (US$) (Gavi + Country co-financing)	14,495,366	16,454,550	17,046,077	17,458,075	15,684,231

Coverage and Equity

2.3.1 Coverage and equity situation analysis

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

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

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

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

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

Myanmar has made steady progress in improving health outcomes over the past three decades . Life expectancy at birth increased for both males and females increased from 55 (males 53.7 and female 56.5) in 1980 to 65.2 (males 60.2 and female 69.3) in 2014*; along with an increase in the child immunization coverage; and declines in infant and under-5 mortality rates, and maternal mortality ratio Under-5 mortality fell from 103 to 50 deaths per 1,000 live births in the decade or so preceding the survey (DHS 2015-16).

The DHS survey conducted in 2015 revealed that basic vaccination coverage differs slightly by sex of the child; males are more likely to receive all basic vaccinations than females (58% and 51%, respectively). Immunization coverage for all antigens is lowest for sixth- and higher-order births. There is a marked difference in vaccination coverage by residence, especially for the third dose of pentavalent (75% in urban areas and 58% in rural areas). The percentage of children age 12-23 months who received all basic vaccinations varies across the country, ranging from a low of 34% in Ayeyarwady Region to a high of 81% in Mandalay Region.

Vaccination coverage improves substantially with increasing mother's education. For instance, 80% of children whose mothers have more than a secondary education are fully vaccinated, as compared with only 41% of children whose mothers have no education. Children living in households in the highest wealth quintile (77%) are much more likely to be fully vaccinated than those living in households in the lower two quintiles (41%).

Although the DPT3 vaccination coverage was static in past two years and there is discrepancies and difference in coverage across Townships (JRF 2017), and one of the challenges with immunization coverage data is related to unreliable denominator. The head counting that midwives conduct every year may not include hard to reach population, population in conflict zone and migratory population (EPI Evaluation 2017). This poses issue for the MOH given that the Government is committed to achieve universal health coverage as part of its vision 2030, defined as 'the provision of optimal quality of health care for everyone in the country that is accessible, efficient, equitably distributed, adequately funded, fairly financed and appropriately used by an informed and empowered public' (MOH 2014, 'Strategic Directions for Universal Health Coverage).

Despite all available efforts in reaching all children with quality immunisation services, about 200 townships (out of 330 nationwide) have continuously reported Measles coverage under 95% for at least two years between 2015 and 2017 (low performing areas). Low coverage rates have resulted in measles outbreaks in 2016 and 2017, with over 1929 cases and 1 death and sporadic cases of diphtheria are reported each year (EPI annual report. The main reason for low immunization coverage (2012- Year of intensification of RI action plan) was mobile population/hard to reach population, lack of human resources, geographically hard to reach population and low/no local community involvement.

Demand Creation or social mobilization

Inadequate knowledge and demand for immunisation services by caregivers and limited interpersonal communication skills (IPC) of Basic Health Staff (BHS) has created limited demand generation). The general public is not well informed about the importance of vaccines and immunisation services. The existing communication and demand creation activities are not tailored to special groups limiting demand for services targeted advocacy for populations with high dropout rates and migrant populations are not enhanced followed by

limited involvement of NGOs (PIE-2014) However, campaigns are successful due to intense support in terms of funding logistics, operations and social mobilization.
Human resources for health
According to the 2017 Joint Appraisal (JA), contextual barriers to immunisation includes intermittent geographical access due to poor road and communications, insecurity in some areas, remoteness contributing to large extent the lack of adequate numbers of BHS in remote areas and border regions. The Government has not yet approved or fulfilled the vacant positions resulted from the creation of the new DoPH. The EPI evaluation 2017 pointed out the over-workload of BHS, disproportionate ratio of BHS and population size, extension of city/urban areas without change in human resource and vacant post as well as lack of performance incentives.
Service delivery
More than 80% of immunization services are provided through outreach. There is no housing facility for midwives to stay at RHC & SCs. There is no regular or inadequate number of outreach services in hard to reach, conflict and peri urban areas. The micro plan does not cover poor, migratory population and are developed without participation of community (cMYP and EPI evaluation 2017). The limited access to immunisation services is compounded by limited number of facilities equipped with cold chain services (<22% according to EPI data).
Only 13,000 Midwives have been appointed resulting in work overload often limiting their availability to provide immunisation services beyond a day or two a month through outreach. This set up has increased the wastage given that vaccines are only able to be kept in the cold chain for a few days. Vaccine product related waste disposal was also reported to be a problem. In hard to reach, areas of conflict and border areas where access is limited, there are expected lower levels of coverage. Lack of vaccine transportation and operation cost results in low service delivery (EPI evaluation 2017 and cMYP). Outreach services not integrated with other services (HSS assessment report)

Supply Chain System
The Myanmar EVM Assessment and the comprehensive improvement plan (cIP) (copies attached), point out to the lack of cold chain capacity, vaccine management skills and maintenance capacity has not kept pace with population growth or with increased storage demands for new vaccine introductions (Rota and HPV are planned to be introduced in 2019 and 2020). Dry store capacity requirement will also double by 2018. As mentioned above, only 22% of facilities are equipped with cold chain outreach, immunisation services are limited. The information management system is well kept but in a manual form which prevent the EPI from having real time information on stock availability.

Country documents

2.4.1 Upload country documents

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

Note that only general country documents are uploaded here; at the end of section 3 (sub-

section “Upload new application documents”) you will be required to provide those documents that are specific to the support requested (for example the new vaccine introduction plan and/or campaign plan of action, new budget, application endorsements etc.)

Country and planning documents

✓	**Country strategic multi-year plan** Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan	1Country docMyanmar cMYP 20172021_01-05-18_15.09.15.pdf
✓	**Country strategic multi-year plan / cMYP costing tool**	2Country doccMYPV39.13 Myanmar20160428Updated JE_01-05-18_15.10.12.xlsx
✓	**Effective Vaccine Management (EVM) assessment**	3Country docMyanmar 2015 EVMA Report12061716.38.12_01-05-18_15.15.01.pdf
✓	**Effective Vaccine Management (EVM): most recent improvement plan progress report**	4Country docMyanmar EVM improvement plan implementation status final01051815.16.21_04-06-18_17.06.28.pdf Attach 2 Myanmar Effective Vaccine IP Update report June 2018_04-06-18_17.05.04.docx Attach 1 Copy of EVM IP updates simple format as of 3 June 2018_04-06-18_17.04.19.xlsx
✓	**Data quality and survey documents: Final report from**	5Country docMyanmar DQSA Final report_01-05-18_16.59.52.pdf

	most recent survey containing immunisation coverage indicators	
✓	**Data quality and survey documents: Immunisation data quality improvement plan**	6 Country docData Improvement plan workshop summary_01-05-18_15.41.54.docx data improvement plan22 April 2018cEPI_26-04-18_17.23.45.pdf
	Data quality and survey documents: Report from most recent desk review of immunisation data quality	**No file uploaded**
	Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation	**No file uploaded**
	Human Resources pay scale If support to the payment of salaries, salary top ups, incentives and other allowances is requested	**No file uploaded**

Coordination and advisory groups documents

✓	**National Coordination Forum Terms of Reference** ICC, HSCC or equivalent	Revised ICC TOR burmese_04-06-18_19.08.32.PDF Country documentEnglish versionNational Coordination Forum Terms of Reference_04-06-18_18.57.26.pdf

✓	**National Coordination Forum meeting minutes of the past 12 months**	12018ICC meeting minutes 28.2.2018_01-05-18_15.23.36.pdf 9Country docICC meeting minutesJA2017_01-05-18_15.22.56.pdf 9Country docICC Meeting Minutes 3rd 2017_01-05-18_15.22.34.pdf 9 Country doc2nd ICC meeting mintues 2017endorsing CCEOP_01-05-18_15.22.03.pdf 2nd ICC meeting mintues 2017endorsing CCEOP_26-04-18_14.05.46.pdf

Other documents

✓	**Other documents (optional)** Please also provide other country documents to support the review of the applications, for example Health Facility Assessment Reports, Knowledge-Attitude-Practice surveys or other demand-related surveys, if available.	21Report of Communication Assessment in Rakhine01052018_01-05-18_15.25.06.pdf

Rotavirus routine

Vaccine and programmatic data

3.1.1.1 Choice of presentation and dates

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

Preferred presentation	RV1, 1 dose/plastic tube, liq
Is the presentation licensed or registered?	Yes ☒ No ☐

2nd preferred presentation	RV5, 1 dose/plastic tube, liq
Is the presentation licensed or registered?	Yes ☐ No ☒
Required date for vaccine and supplies to arrive	15 October 2019
Planned launch date	1 January 2020
Support requested until	2024

3.1.1.2 Vaccine presentation registration or licensing

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

Rotarix has been already licensed with FDA by private company. For programme use , cEPI need new vaccine notification letter for rota vaccine from FDA. Notification process requires between 2 to 4 weeks. To apply FDA notification, vaccine sample needs to be arrived 3 months before the introduction date. Therefore, the licensing procedure will be completed ahead of the introduction or campaign.

3.1.1.3 Vaccine procurement

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

Yes☐	No☒

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

Target Information

3.1.2.1 Targets for routine vaccination

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

under one year birth cohort, first dose forecasted coverage is based on 2017 Penta 1 coverage and second dose is based on same year Penta 2 coverage.

	2020	2021	2022	2023	2024
Population in the target age cohort (#)	1,035,227	1,044,440	1,053,736	1,063,114	1,072,575
Target population to be vaccinated (first dose) (#)	983,465	992,218	1,001,049	1,009,958	1,018,946
Target population to be vaccinated (last dose) (#)	962,761	971,329	979,974	988,696	997,495
Estimated wastage rates for preferred presentation (%)	5	5	5	5	5

Co-financing information

3.1.3.1 Vaccine and commodities prices

Price per dose (US$) - Rotavirus routine

	2020	2021	2022	2023	2024
1 dose/plastic tube,liq	2.25	2.25	2.25	2.25	1

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

	2020	2021	2022	2023	2024
AD syringes	0.04	0.04	0.04	0.04	0.04
Reconstitution syringes	0.04	0.04	0.04	0.04	0.04
Safety boxes	0.47	0.47	0.47	0.47	0.47

Freight cost as a % of device value	0.07	0.07	0.07	0.07	0.05

3.1.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support

	2020	2021	2022	2023	2024
Country co-financing share per dose (%)	11.28	12.97	14.92	17.16	
Minimum Country co-financing per dose (US$)	0.25	0.29	0.34	0.39	
Country co-financing per dose (enter an amount equal or above minimum)(US$)	0.25	0.29	0.34	0.39	0.39

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

Rotavirus routine

	2020	2021	2022	2023	2024
Vaccine doses financed by Gavi (#)	2,280,000	1,809,000	1,779,000	1,750,500	1,320,000
Vaccine doses co-financed by Country (#)	274,500	258,000	306,000	354,000	802,500
AD syringes financed by Gavi (#)					
AD syringes co-financed by Country (#)					
Reconstitution syringes financed by Gavi (#)					

Reconstitution syringes co-financed by Country (#)					
Safety boxes financed by Gavi (#)					
Safety boxes co-financed by Country (#)					
Freight charges financed by Gavi ($)	171,557	136,144	133,960	131,811	44,145
Freight charges co-financed by Country ($)	20,645	19,378	22,916	26,532	26,759

	2020	2021	2022	2023	2024
Total value to be co-financed (US$) Country	639,000	599,500	709,000	821,000	828,000
Total value to be financed (US$) Gavi	5,307,500	4,212,000	4,144,500	4,078,000	1,366,000
Total value to be financed (US$)	5,946,500	4,811,500	4,853,500	4,899,000	2,194,000

3.1.3.4 Co-financing payment

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

MOHS has been co-financing for Penta, PCV and JE. MOHS has requested co-financing for newly introduced vaccines through Vaccine Independent Initiative (VII) and up to 2021. proposal for another five year will be developed in 2020 to get approval in time for future years.

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

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

Month	December
Year	2018

Financial support from Gavi

3.1.4.1 Routine Vaccine Introduction Grant(s)

Rotavirus routine
Live births (year of introduction)

1,035,227

Gavi contribution per live birth (US$)

0.7

Total in (US$)

724,658.9

Funding needed in country by	30 June 2019

3.1.4.2 Operational budget

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

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

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

654499

Total amount - Other donors (US$)

36300

Total amount - Gavi support (US$)

724658.9

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

0.63

Amount per target person - Other donors (US$)

0.04

Amount per target person - Gavi support (US$)

0.7

3.1.4.3 Financial management procedures

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

In line with standard Government procedures, all Gavi support, whether direct financial support or vaccines [and whether disbursed directly to the GoM or through an intermediary such as UNICEF or WHO] will be included in the GoM annual budgetary estimates,.including, where necessary, supplementary budgets.

3.1.4.4 Fiduciary management

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

require administrative fees as follows.

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

UNICEF bilateral agreement 8%; WHO bilateral 7%

3.1.4.5 Use of financial support to fund additional Technical Assistance needs

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

Not required additional assistant.

Strategic considerations

3.1.5.1 Rationale for this request

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

Please see section III of Rota Introduction plan

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

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

Rota Virus Vaccine (Rv vaccine) introduction plan is in alignment with current National Health Plan (2017-2021) as well as cMPY (2017-2021.
Goal of NHP 2017-2021 is to extend access to a Basic Essential Package of Health Services (BEPHS) to the entire population by 2020 while increasing financial protection. This is to fulfill the two main objectives of the comprehensive NHP (UHC 2030 vision), which are: 1) to enable every citizen to attain full life expectancy and enjoy longevity and, 2) to ensure that every citizen is free from diseases. To contribute these vision, EPI has been formulating five yearly cMYP. Current cMYP (2017-2021) goal is to reduce mortality and morbidity due to

VPDs. cMYP goal will directly contribute in realizing the second objective of NHP as the prevention of vaccine preventable diseases will further protect citizens and ensure that they are free from diseases. To realize that goal, one of the key objectives set in cMYP is to introduce new and underused vaccines and new technology into routine immunization supported by evidence of disease burden. As diarrhea is one of the main causes of under five mortality and morbidity and as current available vaccine, Rotarix, proven effective and highly likely to be cost effective in Myanmar, RV vaccine introduction is in line with cMYP objectives to attain its goal to reduce under five morbidity and mortality which will directly contribute to second vision of NHP. Currently thirteen antigens are included in NHP classified BEHPS and RV vaccine is one of these.

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

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

NCIP, which was set up in 2009, has been looking for ways to complement diarrhea prevention efforts as diarrhea has been one of main causes of mortality and morbidity. In 2012, based on diseases prevalence, NCIP suggested to add following vaccines: rata Virus, Pneumococcal conjugate, Rubella (after Catch up campaign), JE, HPV, Influenza and Hepatitis A and collect epidemiological evidences since then. Up till now, Rubella has been introduced as part of MR vaccine in 205, PCV in 2016 and JE in 2018. The current proposal has been developed through an intensive consultative process between the National EPI programme, Department of Medical Research which leads the Rota Surveillance as part of Global/Regional Rota lab Surveillance Network, related programmes staff on Child Health and development partners. National EPI programme regularly collects in country diarrhea disease situation as well as global and regional updates about RV especially situations of neighboring countries and their plans. National Programme shared all these information together with opportunity to apply GAVI fund to NITAG. NITAG members reviewed country disease burden as well as economic burden and endorsed to submit this proposal in March 2018. National EPI programme then inform GAVI and work together with UNICEF and WHO to outline RV introduction plan. NITAG review and decision, and introduction plan prepared by EPI together with partners are then shared to ICC meeting convened in last week of April. After deliberation and suggestion especially to set up mechanism to monitor impact of RV vaccine, ICC approved this proposal to submit in current window.

3.1.5.4 Financial sustainability

Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation

measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?

Myanmar currently allocates 3.65 percent of its total budget on health (MoPF). Some reprioritization towards social sectors in general, and the health sector in particular, has already taken place in recent years. (e.g., for government health expenditure) amount was increased nine-fold increase in absolute amount from 94 million US$ in 2010-11 to 850 million US$ in 2016-17. Consequently, government took over funding to procure traditional vaccines which were previously procured with UNICEF and other partners' support since 2016. This pattern is expected to continue with civilian government. Together with strong possibility of GDP increase (WB latest estimate forecasts about 7.8% annual increase for near term, even though there are some challenges), MOHS capacity to co-finance will increase significantly. Currently, vaccine cost is around 1% of total health expenditure and with market shaping by GAVI and UNICEF, it is expected that vaccines' price might be substantially reduced further. To take that advantage, procurement through UNICEF should be available after Gavi graduation for Myanmar.
Even though, budget estimate and allocation is done annually, MOHS with MOPF support, has secured commitment from Cabinet to allocate funding for traditional vaccines and co-financing for new vaccines up till 2021 as part of commitment to initiate Vaccine Independent Initiative (VII). As all thirteen antigens provided under EPI programme, including RV vaccine, are among the basic essential health package of services, government has a commitment to ensure availability of RV as part of fulfillment to Universal Health Coverage.
(please also see section XI. Resources, costs, financing, and sustainability of RV vaccine introduction plan)

3.1.5.5 Programmatic challenges

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

(1) Safety concerns / AEFI regard to rotavirus vaccines:
Even though Global Advisory Committee on Vaccine Safety concluded that the benefits of RV vaccine outweighed the small potential risk of intussusception (in the range of 1–2 cases per 100 000 first doses). (Extract from report of GACVS meeting of 6-7 December 2017, published in the Weekly Epidemiological Record on 19 January 2018), WHO recommends country should develop a strategy to inform relevant health staff that the benefits outweigh the risks of a small potential risk of intussusception and set up mechanism to ensure that caregivers are adequately counseled to recognize danger signs of dehydration or intussusception that should prompt immediate medical consultation. In line with WHO recommendation following measures will be undertaken: (a) key messages of Rota Virus and RV vaccine will be elaborated in all training materials. Training will also cover interpersonal communication skills to improve counselling; (b) set up intussusception surveillance site in selected hospital with pediatrics surgical unit to collect base line information and monitor situation after introduction; and (c) identify/assign focal person for risk communication.

(2) To reach under reached/un-reached children who are probably among poorest:
cEPI is planning to develop tailored micro-plans, which will be updated regularly (annually),

to ensure to reach all communities: those living in urban slums, living in geographically remote mountainous areas, living in conflict ethnic areas depending on barriers.
To ensure to reach urban unreached, activities being implemented are: recruit MWs to complement government staff so that more outreach could be done at time and place convenient to local population; to expand the number of fixed posts in hospitals/urban health centers so that immunization service could be arranged more frequently instead of only once in a month; and use volunteers for exploring social barriers, social mobilization and defaulter tracking.
For ethnic areas, cEPI has been start working closely with Ethnic Health Organizations (EHO) even though some have direct link to ethnic armed groups. EHOs will be invited to join all aspects starting from microplanning exercise, support service delivery together with BHS or themselves after training, engage with their owned communities etc,. In addition, all IEC materials including those with RV messages will be translated into major ethnic languages.
Not to miss population living in remote mountainous areas, cEPI will provide transport support either in kind (e.g, motorcycle) or cash (to buy fuel). Local volunteers will also be recruited, trained and used to support BHS. EPI will also expand the cold chain network in Rural Health Centres and Sub-Centres prioritizing hard-to-reach areas to increase vaccine availability and number of immunization sessions.

(3) Cold Chain Storage Capacity:
CEPI has already planned to expand cold chain storage capacity to be ready for introduction of RV vaccine and HPV during current cMYP period – 2017 to 2021. Cold chain gap analysis was done in 2017 using Cold Chain Equipment inventory available at that time and considering introduction of RV in 2018, HPV in 2019 together with possible MR campaign in 2018/2019. Capacty required to expand to accommodate new vaccines introduction was estimated. CEPI is planning to address capacity requirement for Central Cold Room (CCR) and two sub-depots with HSS II support and CCEOP platform.

3.1.5.6 Improving coverage and equity of routine immunisation

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

Proposed activities to be implemented with introduction grant will contribute to improve coverage and equity by:
Improved planning:
Future microplans will also take into account availability of BHS and compares it to national norms defined in terms of population and area and suggest ways to meet norms (e.g., use of relieving MW) in addition to considering usual factors: target population, number of villages to cover, existing infrastructure of catchment areas. Microplan development process will be bottom-up with participation from local community and all relevant stakeholders to guarantee that “no one is left out” and helps to identify the gaps, and increase community sense of ownership. Geospatial information system based mapping will also be gradually incorporated in microplanning.
Improved Implementation: –
• By using community health volunteers who can speak local languages/know local context for head counting, defaulter tracking and social mobilization before and during immunization session.

• Through provision of support for staff mobility either by kind fuel for motorcycle and/or cash)
• Through the engagement of Ethnic Health Organizations (EHOs), Non- Governmental Organizations (NGOs), private-for-profit providers to complement service delivery and improve ownership
• Initiating vaccine distribution outsourcing at township and below. Distribution of vaccine up to BHS rather than asking them to collect from township or storage site, will significantly reduce burden and relieve MW to concentrate on service provision and interaction with caregivers.(This could be one of synergies if this is planned to implement with HSS support)
• Increasing frequency of immunization service delivery at fixed posts.

Improved Supportive Supervision & Monitoring:
Training will also cover how to fill new records and progress monitoring chart. In addition, with introduction grant there will be more frequent field supervision and joint review in the field as well as in the RHCs and Township Offices. Together with flexibility of funding to reallocate as needed to address gaps identified, coverage with equity will ensure.

3.1.5.7 Synergies

Describe potential synergies across planned introductions or campaigns. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines in a year. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions.

RV vaccine is planned to launch in January 2020. Preparation activities to introduce RV vaccine is expected to start in 2019. System strengthening activities to improve coverage and equity:, improve data quality; expand cold chain capacity and vaccine management; and improve coordination and management will be ongoing by that time. RV introduction focus activities in 2019 will refresh/complement these ongoing activities: (a) Incorporation of RV vaccine in updating of each and every RHCs and Townships' micro-plans – to ensure not to miss any eligible children for any eligible vaccines; (b) supportive supervision and monitoring including updating forms and monitoring charts/checklists– to complement quality and use of data and regular review in the field; (c) reinforce AEFI reporting mechanism; (d) Reinforce communication and social mobilization – to ensure to use ethnic health organizations and languages. Readiness assessment for introduction will also ascertain cold chain capacity expansion and forecasting and distribution related activities with HSS and CCEOP support.

3.1.5.8 Integrated disease control, existing interventions

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

Pneumonia is also another major cause of infant and under five mortality and morbidity in Myanmar. As guided by Global Action Plan for Pneumonia and Diarrhoea (GAPPD), which proposes a multi sectoral, integrated approach, all suggested activities with proven efficiencies have been implemented through following programmes;
National Nutrition Center: Promotion of exclusive breastfeeding for six months and continued breastfeeding with appropriate complementary feeding and provision of Vitamin A

EPI: Provision of Hib and Pertussis vaccines as Pentavalent, Measles as MR vaccines and Pneumococcal Vaccines. These antigens are now contributing to the prevention of Acute Respiratory Infection (ARI). EPI is now planning to enhance integration with RV vaccine introduction. All combined, EPI will be contributing significantly for reduction of under five mortality and morbidity as ARI and Diarrhea are leading causes accounting around 50% of illness among under five.
Environmental Sanitation: Promotion of Handwashing with soap, provision of Safe drinking-water and sanitation and Reduce household air pollution
National AIDS Program (NAP): HIV prevention and provision of Cotrimoxazole prophylaxis for HIV-infected and exposed children
Maternal & Child Health: Development of simple, standardized guidelines for the identification and treatment of pneumonia and diarrhoea in the community, at first-level health facilities and at referral hospitals, Improved care seeking and referral, and provision of Low-osmolarity ORS, zinc, antibiotics and oxygen
Health Literacy Promotion Unit is working with all programmes to deliver messages to inform, to change behavior and to increase demand for above mentioned services while service delivery in the field is carried out by BHS.

3.1.5.9 Integrated disease control, barriers

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

One of the areas RV vaccine introduction could strengthen overall health system is communication. Training focusing on community interaction and interpersonal communication along with disease and vaccine topics to facilitate RV vaccine Introduction for BHS will improve interactive MWs' skills making them to be better source of information for all interventions for parents and community.
RV vaccine introduction will attract community interest and willingness to seek services from public health facilities. Even though RV vaccine is available in private sector, it is very expensive and availability is limited to urban areas. RV vaccine free of charge availability from public health facilities will highly influence community service seeking behavior, preferring more to low cost but highly efficient services from public facilities.
RV vaccine introduction could also create opportunity to integrate and improve the planning and delivery of comprehensive package as training topics will remind requirement and complementarity of Vitamin A, safe water and improve sanitation and necessity to provide low osmolality ORS, Zinc and continue breast feeding to reduce diarrhea related mortality and morbidity.
RV vaccine introduction will also strengthen overall disease surveillance mechanism and sentinel sites and risk communication.

Report on Grant Performance Framework

3.1.6.1 Grant Performance Framework – Application Instructions

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

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

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

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

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

Upload new application documents

3.1.7.1 Upload new application documents

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

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

Application documents

✓	**New vaccine introduction plan (NVIP) and/or campaign plan**	Rota Introduction Plan final doc 1am_02-05-18_01.39.02.doc

	of action (PoA), including checklist & activity list and timeline If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication.	To attache Rota Intro Plan Annex 3 _01-05-18_23.44.57.xlsx checklist Rota. 152018xls_01-05-18_23.18.32.xls Activities and time line for Rotaxls accepted to submit _01-05-18_23.17.22.xls
✓	**Gavi budgeting and planning template**	REVFINAL MYN Budget Template Rota VIG MR OpsMMR04062018_04-06-18_19.33.44.xlsm
✓	**Most recent assessment of burden of relevant disease** If not already included in detail in the Introduction Plan or Plan of Action.	Dr. TGWM Rotavirus full paperMMA _29-04-18_13.11.15.pdf

Endorsement by coordination and advisory groups

✓	**National coordination forum meeting minutes, with endorsement of application, and including signatures**	22018 ICC Attendance List_04-06-18_19.36.35.pdf 2MandatoryNational coordination forum meeting minutes with endorsement of application and including signatures_01-05-18_15.31.57.pdf
✓	**NITAG meeting minutes** with specific recommendations on the NVS introduction or campaign	NITAG 12018_26-04-18_17.14.45.pdf

Vaccine specific

✓	**Other documents (optional)**	Attach 1 Copy of EVM IP updates simple format as of 3 June 2018_04-06-18_17.11.29.xlsx Attach 7 Activities and time line for Rotaxls accepted to submit_04-06-18_17.11.07.xls Attach 2 Myanmar Effective Vaccine IP Update report June 2018_04-06-18_17.11.50.docx Attach 6Rota Budget Note_04-06-18_17.10.37.docx Attach 4 Addressing Equity Concerns_04-06-18_17.09.23.docx Attach 3 NITAG memo translation English _04-06-18_17.08.50.docx Attach 3 NITAG Formation official memo Myanmar _04-06-18_17.08.17.pdf

Measles-rubella follow-up campaign

Vaccine and programmatic data

3.2.1.1 Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.
Measles-rubella follow-up campaign

Preferred presentation	MR, 10 doses/vial, lyo
Is the presentation licensed or registered?	Yes ☒ No ☐
2nd preferred presentation	MR, 5 doses/vial, lyo

Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	15 August 2019
Planned launch date	13 October 2019
Support requested until	2019

3.2.1.2 Vaccine presentation registration or licensing

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

MR vaccine was introduced and used in Myanmar since January 2015 . cEPI procuring MR vaccine for routine through UNCIEF and the procedure of notification to FDA is applied and once it is notified the validity is one year. The notification process takes around 2-4 weeks but it needs to get done before 3-5 months of vaccine arrival to the country. if the supplier or manufacturer for MR SIA is same as the MR vaccine for routine, the import of vaccines could be done in 2-3 months ahead of the desired arrival time to country

3.2.1.3 Vaccine procurement

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

Yes☐ No☒

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

Target Information

3.2.2.1 Targets for campaign vaccination

Gavi will always provide 100% of the doses needed to vaccinate the population in the target age cohort.
Please describe the target age cohort for the Measles-rubella follow-up campaign:

From	9	weeks ☐	months ☒	years ☐
To	59	weeks ☐	months ☒	years ☐

	2019
Population in target age cohort (#)	4,731,730
Target population to be vaccinated (first dose) (#)	4,731,730
Estimated wastage rates for preferred presentation (%)	10

3.2.2.2 Targets for measles-rubella routine first dose (MR1)

To be eligible for measles and rubella vaccine support, **countries must be fully financing with domestic resources the measles mono-valent vaccine component of MCV1** which is already in their national immunisation schedule, or have firm written commitments to do so.
Please provide information on the targets and total number of doses procured for measles first dose.

	2019
Population in the target age cohort (#)	967,612
Target population to be vaccinated (first dose) (#)	919,232
Number of doses procured	1,532,053

Co-financing information

3.2.3.1 Vaccine and commodities prices

Price per dose (US$) - Measles-rubella follow-up campaign

	2019
10 doses/vial,lyo	0.64

Commodities Price (US$) - Measles-rubella follow-up campaign (applies only to preferred presentation)

	2019
AD syringes	0.04
Reconstitution syringes	0.04
Safety boxes	0.47
Freight cost as a % of device value	0.01

3.2.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support

	2019
Country co-financing share per dose (%)	10
Minimum Country co-financing per dose (US$)	0.03
Country co-financing per dose (enter an amount equal or above minimum)(US$)	0.03

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

Measles-rubella follow-up campaign

	2019
Vaccine doses financed by Gavi (#)	5,031,500

Vaccine doses co-financed by Country (#)	220,800
AD syringes financed by Gavi (#)	4,986,200
AD syringes co-financed by Country (#)	218,800
Reconstitution syringes financed by Gavi (#)	553,500
Reconstitution syringes co-financed by Country (#)	24,300
Safety boxes financed by Gavi (#)	60,950
Safety boxes co-financed by Country (#)	2,675
Freight charges financed by Gavi ($)	139,730
Freight charges co-financed by Country ($)	6,132

	2019
Total value to be co-financed (US$) Country	158,000
Total value to be financed (US$) Gavi	3,591,500
Total value to be financed (US$)	3,749,500

3.2.3.4 Estimated projection of the required domestic financing for the measles monovalent component of MCV1

Countries are required to domestically finance the first dose in their measles containing vaccine routine (MCV1) in order to be able to receive Gavi support for any measles/ measles-rubella

programmes. Below is the estimated projection of the required domestic financing for MCV1, based on the information provided in the previous sections.

	2019
Minimum number of doses financed from domestic resources	
Country domestic funding (minimum)	980,513.92

3.2.3.5 Co-financing payment

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

Ministry of Health and Sports has been co-financing the vaccine cost for Penta and PCV vaccine through UNICEF. since 2012. Based on the experiences, the co-financing payment will be transferred to UNICEF SD in last quarter of 2018. Ministry of Health and Sports already approved and earmarked the co-financing requirement for 2019 MR SIA. The budget focal person from cEPI will ensure timely and accurate transfer or co-financing payments to UNICEF.

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

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

Month	December
Year	2018

Financial support from Gavi

3.2.4.1 Campaign operational costs support grant(s)

Measles-rubella follow-up campaign
Population in the target age cohort (#)

4,731,730

Gavi contribution per person in the target age cohort (US$)

0.55

Total in (US$)

2,602,451.5

Funding needed in country by	30 January 2019

3.2.4.2 Operational budget

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

If Gavi's support is not enough to cover the full needs please indicate how much and who will be complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.
Total amount - Gov. Funding / Country Co-financing (US$)

486067

Total amount - Other donors (US$)

631134

Total amount - Gavi support (US$)

2602452

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

0.09

Amount per target person - Other donors (US$)

0.14

Amount per target person - Gavi support (US$)

0.55

3.2.4.3 Financial management procedures

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

In line with standard Government procedures, all Gavi support, whether direct financial support or vaccines [and whether disbursed directly to the GoM or through an intermediary such as UNICEF or WHO] will be included in the GoM annual budgetary estimates,.including, where necessary, supplementary budgets.

3.2.4.4 Fiduciary management

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

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

For the MR campaign it is being proposed for the funds to be managed as per the GMR (annex 6 of PFA) where UNICEF, being responsibility of financial management, and with support from the coordination unit from MOHS, will oversee the preparation of consolidated periodic financial reports for the HSS program and all Gavi grants. The reports will include all grant expenditures. UNICEF will have bilateral agreement with Gavi: 8% administrative fees. WHO will be responsible for the management of a portion of campaign which will fund technical support in the areas of developing policy, strategies and plans, training packages, capacity building, surveillance, data management, survey, evaluations and assessments, etc. WHO will have bilateral agreement with Gavi: 7% administrative fees.

3.2.4.5 Use of financial support to fund additional Technical Assistance needs

Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the “One TA plan”) with a view to assess that required support for the implementation of the new vaccine support is contained in the

approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template. In addition, please indicate the programmatic areas for additional technical assistance needs and the respective agencies providing the technical assistance (if already identified) below.

In TCA 2018, there is an activity for providing technical support to cEPI to develop the proposals for MR follow up campaign and Rota vaccine introduction under technical assistance of WHO country office.In addition, WHO and UNICEF national staff will be working closely with cEPI to prepare and finalize proposal for timely submission .

Strategic considerations

3.2.5.1 Rationale for this request

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

Myanmar will be conducting Nationwide Measles Rubella (MR) follow up campaign in October and November 2019. 4,731,730 children 9 months to 59 months will be vaccinated with MR vaccines regardless of the previous immunization status. The first phase is to conduct in Regions and States which are accessible by routine immunization while the second phase is to conduct the campaign in Regions and States with underserved population which need special attention and innovative ways and strategies for example conflicted affected areas such as Kachin and Shan States with armed conflicts and Rakhine State with communal conflicts. (Please refer to M-R campaign plan of action, Objectives, targets and justification for the campaign)

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

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

Ministry of Health and Sports has already developed the National Strategic Plan for Measles elimination and Rubella/CRS control (2016-2020) since 2016 and it is aligned with Regional plan for Measles elimination and Rubella/CRS control and the existing country epidemiology and health system in 2016. To achieve and maintain high levels of population immunity it is essential to maintain high level of vaccination coverage (≥95%) with two doses of measles and rubella containing vaccines through routine or supplementary immunization activities in each township.
cMYP (2017-2021) is also aligned with National Strategic plan for Measles elimination and highlighted resources required for SIAs. MR SIAs have been planned and budgeted in 2018 and 2021 respectively with target age groups of 9 months to 5 years of age. As MR SIA could not be conducted in 2018, it will be carried over to 2019.

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

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

As the high coverage townships had sporadic outbreaks of Measles and Diphtheria in low immunization pocket/ community, National Immunization Technical Advisory Committee (NITAG) and National Verification Committee (NVC) for Measles elimination and Rubella/CRS control have consistently recommended to implement cMYP (2017-2021) and the five-year strategy plan for Measles elimination and Rubella/CRS control (2016-2020) which includes strategies to strengthen routine immunization, to improve the surveillance activities and to conduct timely MR SIA in 2019.

3.2.5.4 Financial sustainability

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

The Government of Myanmar has been contributing co-financing portion of Pentavalent and PCV vaccines since 2013. The routine immunization vaccines were fully financed since 2017 and the Government has already committed for five years (2017-2021).
Myanmar is expected to graduate from Gavi support in 2025 but more investment in co-financing will increase by 2021. Therefore, by the financial year 2024/2025, Government will finance all vaccines by 100. Further work on the availability of earmarked funds from Government budget to finance for the vaccines in coordination with Budget Department (BD), Ministry of Planning and Finance is ongoing.
In addition , the Ministry of Health and Sports is signing MOU with UNICEF on the vaccine independent initiatives (VII) which will allow the National Programme to access to the revolving fund to address the contingency or emergency situation and stock out situation could be avoided.

3.2.5.5 Programmatic challenges

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

Although several efforts had been made through EPI mobile session and CRASH programme, the number of townships with MCV1 coverage of 95% and above was only 63 (i.e., 19% of all townships) in 2015. The coverage status of MCV in routine immunization is still static except in 2016 when CRASH programme is implemented in all low performing townships.In 2017, only 5% of all townships have MCV1 coverage of 95%.
More than 80% of immunization services are provided through outreach. There is no housing facility for midwives to stay at RHC & SCs. There is no regular or inadequate number of outreach services in hard to reach, conflict and peri urban areas. The micro plan does not cover poor, migratory population and are developed without participation of community (cMYP and EPI evaluation 2014). The limited access to immunisation services is compounded by limited number of facilities equipped with cold chain services (<22% according to EPI data).
Population instability is the main reason of problem for the microplanner/ vaccinator. The coverage of each antigen in specific Region/ State and Township is being affected. The number of children especially those to have the later dose of routine immunization schedule and to have the number of fully-immunized children are the significant uncertainty for service providers with migrants if they do not have immunization card and for parents who will not willing to seek immunization services as a newcomer to the area. Most of the opportunities have been missed especially in areas with more migration rate.

Expansion of EPI services through fixed posts at hospitals, MCH and UHC and through outreach services will reach the unreached children. Target populations are urban/peri-urban, mobile/migrant workers and physically and geographically hard to reach. Fixed sites will be increased through establishing immunisation services in hospitals, MCH clinics and UHC and through outreach services to reach the un-immunized children. The inequality in the distribution and retention of health worker in hard to reach will be addressed by recruiting and training MWs and BHS from local residents. Furthermore, the service will be strengthened and scaled to reach the hard to reach, conflict affected and migrant population who are more likely to miss the immunization services. In addition, the program will ensure that the immunization services are accessed and utilized equally by boys and girls in all areas of the country regardless of geography, ethnicity, religion or economic status.

Inadequate knowledge and demand from community for immunization services and Inadequate Interpersonal skills (IPC) skills of Basic Health Staff one of the factors which weakens customer satisfaction to next immunization clinics. KAP survey will be conducted to update and implement Communication plan of action through tailored approach to population who are at risk of vaccine preventable disease, diagnosis of supply and demand site barriers.

Due to the fact that the inadequate head counting in the target setting, population data in geographically hard to reach and conflict are not always available. EPI data auditing and verification are limited also. Information systems are mainly manual and there is a requirement for dual reporting. The data quality issue will be addressed by implementing data quality improvement plan; establish electronic information management system for immunization and real time stock management system (eLMIS) in harmonization with DHIS2 as well as integration of immunisation reporting system of hospitals into the mainstream immunisation HMIS.

3.2.5.6 Improving coverage and equity of routine immunisation

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

From the efforts on implementation of MR follow up campaign: the extensive advocacy will be informing the policy makers for sustained commitment on the immunization programme; increased community awareness and vaccine acceptance from the campaign activities will generate demand on routine immunization services; media engagement during the campaign will maintain interest from national/local media on routine immunization programme; micro-planning and training for MR SIA will build the capacity of the micro-planners/midwives to improve routine immunization planning and service delivery including identification of unreached communities; cold chain key person will improve the effective vaccine management practices: supervision and monitoring activities of all basic health workers; health personnel will be equipped with AEFI management and vaccine risk communication. Based on previous campaigns, it has proven that aforementioned areas of routine immunization can be achieved to certain extent. By taking the lessons from 2015 MR SIA and as done in 2017 JE campaign, the missed children will be identified and vaccinated by mopping up activities by planning mopping up activities.
From the exercise of advanced microplanning for MR campaign, the last mile children will be identified as discussed in section 3 of Plan of Action (POA) and the microplan will be reviewed and approved in early 2019 by State and Region teams. Again the pre-campaign assessment teams will review the microplan information by verification of the identified population in low performing areas in order to check the inclusion of last mile children. The exercises will be repeated at least four times in prioritized areas which will address the data quality issue faced by the health system and will build the capacity of supervisor and vaccinators on management of data in microplanning immunisation service in tackling the vaccine preventable diseases.

In the past campaigns, INGOs in Kachin and Shan State and EHOs from Shan, Kayin and Kayah were partnered with MOHS and UNICEF to implement both routine immunization services through catch up immunization approach and campaign activities in the chronically underserved population. Similar model will be applied in MR campaign by ensuring early advocacy and planning activities in the prioritized areas

The Public Health Supervisor 2 (PHS2) will be trained to conduct RCA to inform to supervisors and midwives to do mop-up activities or updating the microplan to ensure targeted children are vaccinated. This experience can be extended to conduct RCA on routine immunization in hard to reach areas or underserved areas to generate evidence for actions for improved planning and implementation of routine immunization activities.

Health personnel at all levels including central DoPH officials will be equipped with AEFI management and vaccine risk communication. In the campaign for wider age groups and huge target population, the health workers sometimes make decisions which led to miss the children due to over contentiousness about adverse effects in apparently healthy children. To mitigate it, the list of some contraindications is reviewed and the restrictions are relaxed for valid conditions.Based on previous campaigns, it has proven that aforementioned areas of routine immunization can be achieved to certain extent.

3.2.5.7 Synergies

Describe potential synergies across planned introductions or campaigns. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines in a year. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions.

Myanmar has introduced MR, IPV, PCV vaccines in 2015 and 2016. The tOPV to bOPV switch was also done successfully in 2016. MR campaign and JE campaign targeting 9 months to 15 years old children were also conducted successfully in 2015 and 2017 respectively. Based on the experiences of introduction of new vaccines and campaigns implementation, the planning, implementation, monitoring and evaluation activities will be designed and tailored to reach the last mile children and reaching the targeted coverage and achievement. There will be series of EPI improvement planning in the areas of advocacy and communication, immunization service delivery through tailored and innovative approach under the funding support of Gavi HSS. During campaign implementation, the training of health workers will be focused not only on the planning and administration of MR vaccines but also in the communication with care-givers on the benefits of vaccines and the importance of completing the routine vaccination schedules.
Bottom up micro-planning exercises will be conducted. By 2018 December, the midwives will collect the headcount data for MR campaign and hard to reach and low performing townships will be prioritized to collect the basic information of the eligible children. During the micro-planning training and annual workplan workshop, the MR follow up campaign will be discussed and included in the microplan with detailed costing.
During campaign the health workers will also identify the missed children of routine immunization programme and low performing areas and proper referral of those population to the immunization posts (hospital based immunization, expanded immunization post in Rural health centers/urban health centers) as well as by amending the microplans to reach to the missed children with routine vaccines.
In the past campaigns, INGOs in Kachin and Shan State and EHOs from Shan, Kayin and Kayah were partnered with MOHS and UNICEF to implement both routine immunization services through catch up immunization approach and campaign activities in the chronically underserved population. Similar model will be applied in MR campaign by ensuring early advocacy and planning activities in the prioritized areas.

In the policy brief to stop measles, children who to to kindergarten will be checked for vaccination against measles and other disease at the school entry and unimmunized children will be referred to the health facility to get the needed does. Through RCAs and PCCS results, the missed children from the MR SIA will be identified for mopping up activities. In addition to mopping up activities, the missed children from campaign will be traced through school entry check on MR vaccine and referred to immunization services.

Media workshop will equip the journalists and reporters in dealing with rumors by providing vignettes on cases from other country and past experiences on JE campaign. It will also allow to conduct simulation exercise with them in responding to AEFI cases, if any, and reassuring the public by providing of correct and concise information. As there is already a plan in GAVI HSS 2 to conduct series of training of media agencies not only on immunization but also on other public health issues, this workshop can be a part of those series of training with a focus on MR campaign.
Since the activities of MR SIA and HSS-2 activities are aligned and synergized, the programmatic challenges of implementing multiple projects will be minimized. Ministry of Health and Sports will comply with the Gavi requirement on the fund management and

utilization. As part of GMR agreed, UNICEF will be acting as fund manager and will provide technical assistance to MOHS for financial management by the time of campaign implementation and the programme capacity improvement plan (PCIP) will be in place.

3.2.5.8 Indicative major Measles-rubella and rubella activities planned for the next 5 years

Summarise in one paragraph the indicative major Measles-rubella and rubella activities planned for the next five years that are reflected in the annual EPI plan (e.g. Measles-rubella second dose introduction, Measles-rubella or Measles-rubella-rubella follow up campaign, etc.).

Measles first dose was given at 9 months of age as MR and Measles second dose was given at 18 months of age since 2008. The second dose of MCV was replaced with MR vaccine from standalone Measles vaccine given at 18 months of age since August 2017.The Government is self-financing both Measles Rubella first dose and second dose starting from 2018 and five years commitment is already received from Government (2017-2021). Ministry of Health and Sports has already developed the National Strategic Plan for Measles elimination and Rubella/CRS control (2016-2020) since 2016 to be aligned with Regional plan for Measles elimination and Rubella/CRS control and the existing country epidemiology and health system in 2016. Various strategies and activities have been incorporated along with means of verification and timeline (section 2.2 Table (9): Milestone for achieving each strategic objective, 2016-2020. in situation analysis and five years plan).

Report on Grant Performance Framework

3.2.6.1 Grant Performance Framework – Application Instructions

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

Required

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

Optional

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

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

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

Upload new application documents

3.2.7.1 Upload new application documents

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

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

Application documents

✓	**New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline** If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication.	1Campaign Plan of Action for Measles final04 Jun1823_04-06-18_18.34.54.docx 1MandatoryMR Follow up campaign activities plan01052018revision04062018_04-06-18_18.38.51.xlsx
✓	**Gavi budgeting and planning template**	REVFINAL MYN Budget Template Rota VIG MR OpsMMR04062018_04-06-18_20.04.28.xlsm MR Budget Note_04-06-18_20.04.56.docx Attach 1Rev TRNC circular Ref ORG 130 1 TR dated 31 Oct 2017_04-06-18_20.05.23.pdf

		Attach 3Rev Counterparts Travel Rates 2017 dated 31 Oct 2017_04-06-18_20.05.40.pdf
✓	**Most recent assessment of burden of relevant disease** If not already included in detail in the Introduction Plan or Plan of Action.	Most recent assessment of burden of relevant disease_01-05-18_15.52.12.docx
	Campaign target population (if applicable)	**No file uploaded**

Endorsement by coordination and advisory groups

✓	**National coordination forum meeting minutes, with endorsement of application, and including signatures** The minutes of the national coordination forum meeting should mention the domestic funding of MCV1	2MandatoryNational coordination forum meeting minutes with endorsement of application and including signatures_04-06-18_20.07.00.pdf 22018 ICC Attendance List_04-06-18_19.05.15.pdf 4MandatoryNITAG meeting mintues12018_01-05-18_13.33.27.pdf
✓	**NITAG meeting minutes** with specific recommendations on the NVS introduction or campaign	4MandatoryNITAG meeting mintues12018_01-05-18_13.31.09.pdf 6MandatoryNVC meeting minutesendorsement of MR follow up campaign implementation_01-05-18_15.47.10.docx NITAG memo translation_04-06-18_20.23.40.docx

Vaccine specific

✓	**cMYP addendum** Situation analysis and 5 year plan captured in the cMYP or as an addendum to the cMYP	5MandatorySituation analysis 5 yr planfinal04June1827_04-06-18_18.49.12.docx
✓	**Annual EPI plan** Annual EPI plan detailing planning of all measles and rubella-related activities for the current year, including realistic timelines, designated responsible individual(s) and a budget	2Application docEPI Annual WP2018_01-05-18_13.51.56.xlsx
✓	**MCV1 self-financing commitment letter** If the country is not yet financing the measles monovalent component of MCV1, a letter signed by the Minister of Health and Minister of Finance committing for the country to self-finance MCV1 from 2018 onwards.	3Application docVII MyanmarMOHSsubmission24 Nov 17_01-05-18_13.53.31.pdf 3Application docCE10018955 Rev1 Selffinancing 2018 Vaccines_01-05-18_13.52.49.pdf
✓	**Measles (and rubella) strategic plan for elimination** If available	4Application docMR elimination strategy Myanmar Final_01-05-18_13.55.45.pdf
✓	**Other documents (optional)**	10other docMeeting minutes with DoHRH Measle and MR Meeting Minutes 1322017 English format_01-05-18_14.16.56.pdf 9other docEPO volunteer guideline_01-05-18_14.16.34.pdf 6other docCrash SOP V2_01-05-18_14.15.01.pdf

5other docMeeting Minutes on Reaching the Unreached 29032018_01-05-18_14.06.30.pdf

2other docRoutine Immunization coverage 20142017 1_01-05-18_13.59.39.xlsx

2other docMeasles five years dara for MR proposal_01-05-18_13.59.15.xlsx

11other docConcept Note Strengthening Urban ImmunizationMyanmar 14 Feb 2017_01-05-18_14.17.18.pdf

12other docToR of Midwives temporary stationed TOR Midwives_01-05-18_14.17.55.pdf

13other docCensusAtlasMyanmarthe2014MyanmarPopulationandHousingCensus_01-05-18_14.18.17.pdf

14 other docDHS2016_01-05-18_14.22.23.pdf

21Report of Communication Assessment in Rakhine01052018_01-05-18_14.24.50.pdf

15other docMR SIA Summary Technical Report FINAL 2015May8_01-05-18_14.28.01.docx

16other docFinal C4D Report on Japanese Encephalitis Campaign 1_01-05-18_14.29.02.docx

18other doc IPC manual for printingwith new logo_01-05-18_14.30.30.pdf

16otherJE report190318.docx._01-05-18_14.38.45.docx

20other docNaga Measles Outbreak Response reportLahe Field Report English Version_01-05-18_15.02.05.docx

22other doclow performing areas_01-05-18_15.03.24.xlsx

19other docRevised AEFI committee meeting minutes 16218 Eng HHL 1May_01-05-18_16.05.54.docx

CCEOP Tool Working File 1242018_01-05-18_16.42.19.xlsx

24other docPOLICY BRIEFstop Measles_01-05-18_20.16.55.pdf

1other docConcept note and costed plan for GIS based microplanning and monitoringdraftApril2018_01-05-18_13.57.45.pdf

26other docCommPoA on strengthening RIdraft 2_01-05-18_23.09.16.pdf

other doc EVM IP updates simple format as of 3 June 2018_04-06-18_20.19.08.xlsx

other docMyanmar Effective Vaccine IP Update report June 2018_04-06-18_20.20.17.docx

25other docDraft Plan for PCCSMR Myanmar_01-05-18_23.08.51.docx

Review and submit application

Submission Details

Country vaccine funding summary

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

Active Vaccine Programmes

IPV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)					

Gavi support (US$)	2,434,000	2,071,462	2,104,606	2,164,582	2,164,477

JEV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	47,146	74,933	83,392	97,593	111,742
Gavi support (US$)	621,500	849,420	811,128	812,713	794,593

PCV Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	737,152	915,986	1,070,102	1,259,938	1,441,130
Gavi support (US$)	8,849,500	9,840,500	10,231,000	10,312,500	8,402,258

Pentavalent Routine

	2018	2019	2020	2021	2022
Country Co-financing (US$)	142,568	241,249	281,849	331,749	376,054
Gavi support (US$)	1,663,500	2,461,000	2,464,000	2,479,000	2,393,977

Total Active Vaccine Programmes

	2018	2019	2020	2021	2022
Total country co-financing (US$)	926,866	1,232,168	1,435,343	1,689,280	1,928,926
Total Gavi support (US$)	13,568,500	15,222,382	15,610,734	15,768,795	13,755,305

Total value (US$) (Gavi + Country co-financing)	14,495,366	16,454,550	17,046,077	17,458,075	15,684,231

New Vaccine Programme Support Requested

Measles-rubella follow-up campaign

	2019	2020	2021	2022	2023
Country Co-financing (US$)	158,000				
Gavi support (US$)	3,591,500				

Rotavirus routine

	2019	2020	2021	2022	2023	2024	2025
Country Co-financing (US$)		639,000	599,500	709,000	821,000	828,000	
Gavi support (US$)		5,307,500	4,212,000	4,144,500	4,078,000	1,366,000	-545,500

	2019	2020	2021	2022	2023	2024	2025
Total country co-financing (US$)	158,000	639,000	599,500	709,000	821,000	828,000	
Total Gavi support (US$)	3,591,500	5,307,500	4,212,000	4,144,500	4,078,000	1,366,000	-545,500
Total value (US$) (Gavi + Country co-financing)	3,749,500	5,946,500	4,811,500	4,853,500	4,899,000	2,194,000	-545,500

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

	2018	2019	2020	2021	2022
Total country co-financing (US$)	926,866	1,390,168	2,074,343	2,288,780	2,637,926
Total Gavi support (US$)	13,568,500	18,813,882	20,918,234	19,980,795	17,899,805
Total value (US$) (Gavi + Country co-financing)	14,495,366	20,204,050	22,992,577	22,269,575	20,537,731

Contacts

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

Name	Position	Phone Number	Email	Organisation
Dr. Htar Htar Lin	Deputy Director/Programme Manager	+959428188188	dr.htarhtarlin@googlemail.com	
Dr. Aye Mya Chan Thar	Assistant Director	+959428006027	dr.acha84@gmail.com	

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

No Response

Government signature form

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

Rotavirus routine and Measles-rubella follow-up campaign

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

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

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

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

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

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

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

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

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

Minister of Education (or delegated authority)

Name

Date

Signature