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| *GAVI Alliance* |

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| **Application Form for Country Proposals** |

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| *For Support to:* |

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| *Routine New Vaccines Support – Pneumococcal Vaccines* *(graduated and graduating countries)* |
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| The Government of |

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| ***Mongolia*** |

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| **Deadline for submission: 15 September 2013** |

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| **Form revised in 2013** |

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| **(To be used with Guidelines for Applications – Access to pneumococcal vaccines for graduating and graduated countries, 2013)**  |

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| **All boxes shaded in blue should be completed or marked n/a if not applicable. Please use additional rows or additional pages, as required.****This application is to be submitted as a Word document and not through the online platform. The completed proposal should be sent to** **proposals@gavialliance.org** |
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| Enquiries to: proposals@gavialliance.org or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public. The Proposal and attachments must be submitted in English, French, Spanish, or Russian. |
| Note: Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline. |
| The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with GAVI Alliance partners and the general public.  |

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| **GAVI ALLIANCEGRANT TERMS AND CONDITIONS** |
| Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country:***FUNDING USED SOLELY FOR APPROVED PROGRAMMES***The applicant country (“Country”) confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds. ***AMENDMENT TO THIS PROPOSAL***The Country will notify the GAVI Alliance in the Annual Progress Report or in writing (in case GAVI support to the country other than pneumococcal vaccine has ended) if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.***RETURN OF FUNDS***The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country’s reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance’s request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance. ***SUSPENSION/ TERMINATION***The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.***ANTICORRUPTION***The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.***AUDITS AND RECORDS***The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance 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 Alliance 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 Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit. ***CONFIRMATION OF LEGAL VALIDITY*** The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country’s law, to perform the programmes described in this application.***CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARENCY AND ACCOUNTABILITY POLICY***The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements. ***ARBITRATION***Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance 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 language of the arbitration will be English. For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson. The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in this application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application. ***Use of commercial bank accounts***The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants.  The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event. |

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| Product presentation |
| Please specify for which type of GAVI support you would like to apply. |

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| **Vaccine product** | **Designation** | **Vaccine formulation** | **Admin route** | **No. Of doses in the schedule** | **Presentation (doses/vial, prefilled)** | **Packed volume vaccine (cm3/dose)** |
| Pneumo. conjugate vaccine 10-valent | PCV-10 | liquid | IM | 3 | 2 | 4.8 |
| Pneumo. conjugate vaccine 13-valent | PCV-13 | liquid | IM | 3 | 1 | 12 |

Additional information on the available vaccines can be found in the accompanying guidelines.Please specify product preference (PCV10 or PCV13):

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| **PCV Vaccine** | **Start Year** | **Preferred second presentation[1]** |
| PCV-13 | 2016 |  |

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

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| Executive summary[Please provide a summary of your country's proposal, including the following information:](#ApplicationSpecification)[**General**](#ApplicationSpecification) **information*** Reason(s) for the choice of presentation.
* Projected month and year of introduction of the vaccine.
* Justification for introduction of the vaccine, including national or regional data on disease burden, if available.

**Relevant baseline data, including:*** DTP3 coverage data (as reported on the WHO/UNICEF Joint Reporting Form).
* Birth cohort and targets for first and third doses.
* Current vaccination schedule and proposed changes.

**Cold chain assessment*** A description of the country’s cold chain capacity status and overview of any required cold chain expansion plans, including information on financing.

**Financial Sustainability*** An analysis of the future costing and financing of the programme.

**The nature of stakeholders' participation in developing this proposal, including:*** Inter-Agency Coordinating Committee or equivalent.
* Partners.
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| Through submission of this proposal, the Government of Mongolia seeks GAVI AMC access for PCV13 to be introduced into national vaccination schedule starting on January 2016. Mongolia has conducted sentinel surveillance for pneumococcal diseases among children under 5 years old in Ulaanbaatar city since 2008. According to the current genotyping data of pneumococci obtained from the ongoing sentinel surveillance for pneumococcal diseases in the country, some serotypes which include in PCV13 for example genotype 3 represents 1% and 19A represents 2% and genotype 6A/B/C represents 22% of all isolated pneumococci. Due to these rates, the Government of Mongolia is choosing PCV13 for introduction in the national schedule. According to WHO estimates for 2000 published in 2009, pneumococcus causes 3,212 cases of pneumonia, 25 cases of meningitis, and 147 cases of other invasive diseases among children under 5 in Mongolia per year. These diseases cause 192 deaths per year.In 2012, DTP3 coverage was reported to stand at 96.7 % at the national level.In 2012, there were 74,778 births and infant mortality rate stood at 15.3 per 1,000 live births. Estimates show that 83,526-91,806 children will be vaccinated with PCV vaccines annually between 2016-2019, according to the current 96-98% vaccination rate estimates. As PCV is administered at 2, 3 and 4 months of age which coincides with the Penta-valent vaccines and OPV schedules, There is no need to change the current vaccination schedule in relation with PCV introduction.With WHO support, Mongolia conducted the Effective Vaccine Management assessment in August 2012. As a follow-up measure, an Improvement plan was developed based on the assessment results. The main recommendation resulting from the EVM assessment was to install two cold rooms with 40m. cubic volume at the National Centre for Communicable Diseases. National EPI team has developed a proposal on establishment of one cold room and submitted it to WPRO in May 2013. According to the Health Ministerial order 359 dated Nov 07, 2011 there is a national replacement plan for vaccine cold chain equipment and devices.  PCV price per dose is estimated to be 3.5US$ according to the AMC access by GAVI. The Government investment to the State Immunization Fund has been increasing each year. The Government budget for the State Immunization Fund has increased 17-fold in 2013 compared with 2006, going from 412.7 to 7170 (million MNT). The Ministry of Health of Mongolia has committed to fund the supply and safety injection supplies of PCV by using the State Immunization Fund budget. The PCV application for GAVI involves ICC members such as WHO and UNICEF country offices in Mongolia. WHO is supporting surveillance for IBD including PCV impact evaluation in the selected city-districts in collaboration with Murdoch Children’s Research Institute’s team and based on the results of the cost-effectiveness analysis for PCV. Also, WPRO is seeking for potential donors to support the extension of the central vaccine storage. The UNICEF country office in Mongolia will develop a communication strategy prior to the PCV introduction and an fridge tags (Berlinger) for vaccine temperature monitoring. The present proposal has been discussed and approved by ICC on September 11, 2013. |
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*Executive summary continued:*

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| Signatures |

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| 4.1 Signatures of the Government  |

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| Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures should be attached as document numbers 1 and 2, as outlined in section 9. |

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| **Minister of Health (or delegated authority)** | **Minister of Finance (or delegated authority)** |
| **Name** | AMARSANAA Jazag | **Name** | PUREV Surenjav |
| **Date** |  | **Date** |  |
| **Signature** |  | **Signature** |  |

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| This report has been compiled by:*Note that this person may be contacted in case the GAVI Secretariat has queries on this document.*  |

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| **Full name** | **Position** | **Telephone** | **Email** |
| GANTULGA Dugerjav | Head of immunization department, National center for communicable disease | +976-11-451158 (office)+976-99904889 (cell) | dr\_gantulga@yahoo.com |

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| 4.2 Signatures of the National Coordinating Body for Immunisation |

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| We the members of the ICC, HSCC or equivalent committee met to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

| **Name/Title\*** | **Agency/Organisation\*** | **Signature** |
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| AMARSANAA Jazag, Chairperson of ICC, Vice Minister of Health | Ministry of Health |  |
| NARANGEREL Dorj National EPI manager and Director, Public Health Unit, Policy Implementation and Coordination Division | Ministry of Health |  |
| GANCHIMEG Ulziibayar, Director General | Public Health Institute |  |
| MUNKHTUUL Batbaatar, Officer | Ministry of Finance and Economy |  |
| NYUNT-U Soe, Country Representative | WHO in Mongolia |  |
| SODBAYAR Demberelsuren, Technical officer on EPI | WHO in Mongolia |  |
| MOHAMED Malick Fall, Resident Representative | UNICEF in Mongolia |  |
| SURENCHIMEG Vanchinkhuu, Health and Nutrition Specialist | UNICEF in Mongolia |  |
| NARYAD Sainkhuu, Head | Immunization – Health NGO |  |
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| General information5.1. Product preferencePlease outline the reasons for your vaccine product preference.

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| The 63rd World Health Assembly declared that pneumococcal vaccines introduction is one of the safest and cost-effective interventions to reduce childhood morbidity and mortality caused by pneumococci. Introduction of PCV vaccines have been shown to reduce invasive bacterial diseases in many other countries. (Felkin, forthcoming)The ongoing sentinel surveillance for pneumococcal diseases in the country showed that some serotypes, including PCV13 for example genotype 3 and 19A represent 1% each and genotype 6A//B/C represent 22% of all isolated pneumococci. Due to these rates, the Government of Mongolia is choosing PCV13 for introduction in the national schedule. |

5.2. Vaccine introduction strategyPlease describe the projected month and year of introduction and indicate any further preferences on introduction timing.

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| Mongolia plans to introduce PCV into routine vaccination schedule starting from Jan 2016 due to the interim result of the PCV impact evaluation expected in late 2015 and global vaccine availability.  |

Please describe the vaccine introduction strategy, i.e. national rollout or phased rollout. When a phased rollout is planned, please indicate how the timing of the phases and the percentage of the target population to be reached in each phase.

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| The flowing stages are scheduled for the nationwide PCV introduction:1. Preparation for PCV impact evaluation (May - Oct 2013)
2. Conduct the enhanced surveillance for pediatric and adult pneumonia (Oct 2013 – Oct, 2014)
3. Conduct cost-effectiveness analysis for PCV (Nov 2013 – Apr 2014)
4. Pilot PCV vaccination for children under 5 in the selected two city-districts of Ulaanbaatar city (Oct.2014- Dec.2015)
5. Evaluation of PCV vaccination impacts in the selected 4 city-districts (Oct 2014-Oct 2017)
6. Preparation for the nationwide PCV introduction (Jun-Dec 2015). This stage includes aspects such as the strengthening of the cold chain, training on the administration, training on AEFI, awareness-raising campaigns, among other activities.
7. Production of the interim report of the PCV impact evaluation (Dec 2015)
8. Nationwide PCV introduction on Jan 2016 (96-98 % of the target population)
9. Post-Introduction Evaluation for PCV 13, Sep 2016
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| 5.3. ProcurementThe PCV vaccine must be procured through UNICEF Supply Division to be able to access the Advance Market Commitment (AMC) Tail Price. Please confirm that the country plans to procure through UNICEF below. |
| MOH will procure PCV13 vaccine through the UNICEF supply division.  |
| 5.4. Gender and equityPlease describe any barriers in access to immunisation services that are related to geographic, socio-economic and/or gender equity and actions taken to mitigate these barriers. Highlight where these issues are addressed in the vaccine introduction plan(s). |
|  Mongolia has high vaccination coverage rates for all routine antigens. However, due to remoteness, internal migration, poverty, and natural disaster such as heavy snows, the most disadvantaged population occasionally miss routine vaccination doses. Since 1993, Mongolia has organized the National Immunization *Ten Days* Campaign. This catch up vaccination campaign has taken place twice a year (in May and October). Since 2009, the Reaching Every District strategy has been implemented and currently 6 provinces and 5 city-districts are implementing the RED strategy with the goal of delivering an integrated package of health and social welfare services to the hard-to-reach population. Hard to reach population including unregistered or mobile group of population are being detected by RED strategy and get vaccination service accordingly.  Also, UNICEF will support the development and implementation of the communication strategy which would help to reach all parts of the districts equitably including the poorer ger areas.  The RED strategy expansion in other parts of the country catch up vaccination for those who missed from routine PCV vaccination doses and communication strategy are already included in the vaccine introduction plan of 2013-2016.  |
| Discuss how equity issues (geographic, socio-economic and/or gender) are being taken into account in the design of social mobilisation and other strategies to increase immunisation coverage. Highlight where these issues are addressed in the vaccine introduction plan(s). |
|  According to the Law on Immunization of Mongolia, every child is vaccinated with routine antigens free of charge regardless of ethnicity and social status. In addition to the RED strategy implementation in the selected provinces and city-districts, health volunteers are commonly used to reach the community.   |
| Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems. |
| N/A |
| Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities. |
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| 5.5 Disease burden |

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| Please summarise available studies on the burden of disease: |

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| **Disease** | **Title of the assessment** | **Date** | **Results** |
| IPD | Sentinel surveillance for pneumococcal pneumonia, meningitis and sepsis among children aged less than 5 years old in UB city, Mongolia | 2008-2012 | From 13,991 patients with pneumonia 74 had isolated pneumococcus and 166 patients registered bacterial meningitis, while 26 isolated pneumococcus  |
| IPD | WHO estimation for IPD including pneumonia | 2009 | Pneumococcus causes 3,212 cases of pneumonia, 25 cases of meningitis, and 147 cases of other invasive disease among children under 5 years old in Mongolia annually, resulting in 192 deaths per year. |

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| *Please add further rows if required*Please summarise available information on the burden of disease:

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| Diseases burdenMongolia’s mortality for children under 5 years old in 2008 was estimated by WHO at 31 per 1000 live births (WHS 2011). This rate places Mongolia in the “high-mid” under-5 mortality category and shows the critical importance of interventions to reduce child mortality. Pneumonia is the most common cause of under-5 mortality in Mongolia, accounting for 15% of under-5 deaths; meningitis accounts for 1% of under-5 deaths (WHS 2013, CHERG 2010). In the absence of vaccination, *Streptococcus pneumoniae* (pneumococcus) and *Haemophilus influenzae* type b (Hib) are the most common causes of pneumonia-related deaths in children, and cause a substantial portion of meningitis and sepsis. Mongolia has already introduced Hib vaccine, so the continuing high rate of pneumonia death among children is attributable to pneumococcus more than any other single cause. According to WHO estimates for 2000 published in 2009, pneumococcus causes 3,212 cases of pneumonia, 25 cases of meningitis, and 147 cases of other invasive disease among children under 5 years old in Mongolia annually, resulting in 192 deaths per year. Local surveillance data indicate that Hib vaccination has nearly eliminated Hib as a cause of childhood meningitis, sepsis, and severe pneumonia. Pneumococcus is technically challenging to culture from clinical specimens, and only about 10% of pneumonia cases are bacteremic so diagnosis is very difficult. This difficulty is compounded by use of antibiotics prior to hospital visits. Recent local surveillance data shows that nearly 1% of pneumonia cases among children under 5 years old were blood-culture positive for pneumococcus. Since about 10% of pneumococcal pneumonia cases are bacteremic, this suggests that 10% of clinical pneumonia cases in this group are due to pneumococcus. In addition, recent local surveillance data have found that 2%-7% of sepsis cases in children under 5 years old are blood-culture positive for pneumococcus. However, more than half of patients tested for the surveillance have received antibiotics before reaching the hospital, reducing the opportunity to identify pneumococcus or other bacteria in the blood. PCR or other highly sensitive laboratory techniques will be needed to fully identify the burden of invasive pneumococcal disease. While attempts to improve the diagnosis of pneumococcal pneumonia continue, pneumococcus is clearly the most common cause of bacterial meningitis in children under 5; local surveillance data show that it causes 33%-57% of cases. PCV13 covers the pneumococcal serotypes causing an estimated 74% of invasive cases. Introduction of PCV13 could replicate the success of the Hib vaccine, resulting in the prevention of a large portion of these pneumonia and meningitis deaths and the reduction of the under-five mortality rate in Mongolia. |

*Please continue on to another page, as required* |

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| Immunisation programme data |

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| Please complete the data below:  |
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|  | **Figure** | **Year** | **Source** |
| DTP3 coverage  | 96,7 | % | 2012 | WHO/UNICEF estimates of coverage (published in July 2013) |
| DTP3 drop out rate | 0,6 | % | 2012 | WHO/UNICEF estimates of coverage (published in July 2013) |

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| Dose and funding calculation |  |

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| Please use the following spreadsheet to calculate doses and funding required to support the pneumococcal vaccine introduction.The completed spreadsheet should be submitted with the proposal form. |

Additional requirements8.1 Cold chain assessment  |

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| Please provide a description of the country’s cold chain capacity status and overview of any required cold chain expansion plans, including information on financing. If available, an Effective Vaccine Management (EVM) (or equivalent) assessment report and corresponding improvement plan should be referenced and attached to the application. Alternatively, an assessment of cold chain capacity with confirmation from WHO and/or UNICEF should be attached.

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|  With WHO support, Mongolia conducted the Effective Vaccine Management assessment in August 2012. As a follow-up measure, an Improvement plan was developed based on the assessment results. The main recommendation resulting from the EVM assessment was to install two cold rooms with 40m. cubic volume at the National Centre for Communicable Diseases. In case of new vaccine introduction, the net vaccine storage volume per fully immunized child should be increased by 30-40% more than the current storage capacity. In this regard, national EPI developed a proposal to install one more cold room in May 2013. This proposal was submitted it to WHO in order to seek potential donor support. The implementation status of the improvement plan as of Aug 2013 is attached in the annex. According to the current vaccination schedule, sub-national vaccine storage capacity is sufficient. There is a national replacement plan for vaccine cold chain equipments and devices which intends to replace up to 10% of the devices every year (Health Minister’s order 359 dated on Nov 07, 2011).  The UNICEF country office in Mongolia will develop a communication strategy prior to the PCV introduction and fridge tags for temperature monitoring. |

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| 8.2 Financial sustainability  |

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| Eligible countries will pay the AMC Tail Price from the outset of the programme. Under the AMC, the Tail Price is set at a maximum of US$ 3.50 per dose. In addition, countries will be responsible for paying all fulfillment costs to UNICEF SD. Fulfillment costs are the extra costs incurred in supplying vaccines, in addition to the cost of the vaccine itself, and typically includes the cost of syringes, safety boxes and freight. An estimate of these costs will be provided when the spreadsheet in Section 7 is completed with country data. Given that no Vaccine Introduction Grant will be provided, countries should also provide information as to how vaccine introduction activities will be funded. The Government investment to the State Immunization Fund has been increasing each year. The Government budget for the State Immunization Fund has increased 17-fold in 2013 compared with 2006, going from 412.7 to 7170 (million MNT). The Ministry of Health of Mongolia has committed to fund the supply and safety injection supplies of PCV by using the State Immunization Fund budget. In addition, the scope of the Immunization Fund-funded activities will be expanded starting from 2013. In previous years, the State Immunization Fund was used only for two kinds of activities, namely vaccine procurement and vaccine distribution within the country. Currently, the Fund can support immunization-related operational costs such as trainings, IEC activities, survey and research. Preparation for the nationwide PCV introduction will start in Jan 2015 and will be funded by the State Immunization Fund.  The Immunization Fund budget includes a line item for hepatitis A vaccines. The reduction of a vaccination dose from two to one and reduction of the domestic tender price for hepatitis A vaccines have resulted in savings around US$1 million. These savings allow for the funding of the nationwide PCV introduction preparatory activities including PCV13 procurement. . Please provide a summary of the multi-year financial requirements for the pneumococcal vaccines and how these requirements will be met.  |
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| The Comprehensive Multi-Year Plan on Immunization (cMYP) of Mongolia was initially developed in 2007 for 2008-2012 and revised in 2011 for 2012-2015. In relation with the change of the new vaccine introduction date, cMYP has been just revised in 2013 to include PCV for 2014-2019. (please refer the annex for more details). The revised cMYP for 2014-2019 is in line with the National Programme on Communicable Diseases Control. Currently Government of Mongolia is funding all routine EPI antigens except for the penta-valent vaccines which are co-funded by GAVI until 2015.  |

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| 8.3 Stakeholders’ involvement in proposal development  |

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| Please provide an overview of the stakeholders’ participation in developing this proposal. This should include a reference to the meeting of the ICC or equivalent, during which the proposal was endorsed. The minutes of the endorsement meeting endorsing should also be attached. |

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|  PCV application for GAVI involves ICC members such as WHO and UNICEF country offices in Mongolia. WHO is supporting surveillance for IBD including PCV impact evaluation in the selected city-districts in collaboration with Melbourne University research team and based on the results from the cost-effectiveness analysis for PCV. Also, WPRO is seeking for potential donors to support the extension of the central vaccine storage. The UNICEF country office in Mongolia will develop a communication strategy prior to the PCV introduction and procure fridge tags for vaccine temperature monitoring.The proposal was discussed and approved by ICC on 11 September 2013. |

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## 8.4 Lessons learned

If new or under-used vaccines have already been introduced in your country, please give details of the lessons learned from previous introduction(s) specifically for: storage capacity, protection from accidental freezing, staff training, cold chain, logistics, coverage and drop-out rates, wastage rate, etc., and suggest action points or actions taken to address them. Please refer to previous Post Introduction Evaluations (PIE), if applicable.

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| **Lessons Learned** | **Action Points** |
| One of lessons learnt from HPV pilot introduction in 2 city-districts and 2 provinces targeting girls between 11-14 years old was to that there is a need to intensify and ensure adequate preparation for any new vaccine introduction.  | The UNICEF country office in Mongolia will develop a communication strategy prior to the PCV introduction and an innovative method for vaccine temperature monitoring |
| To have background information of new vaccines introduced in other countries with focus on anti-vaccination movements.  | Develop FAQs on PCV vaccination importance for the general public and broadcast through mass media and awareness-raising campaigns. |
| PIE for HPV pilot vaccination was finalized in Sep 2012 with WHO support. One of the main recommendations, provided that:  “Districts and provinces should develop an annual plan for supervision of health care providers in their area using the NCCD’S guidelines for supportive supervision” | MoH, NCCD will focus on the supervision of preparatory activities and progress on vaccine administration in districts and provinces.  |

*Please add further rows if required*

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| Attachments |

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| Please ensure that all documents listed as mandatory are included and are labelled with the relevant document number. Additional documents are not mandatory but may be submitted in support of an application. Where additional documents are not listed below, please provide the name of the document in the table below. Additional rows can be added to the table if required. |

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| **Doc. #** | **Document** | **Mandatory** | **Document attached?** **(Yes or No)** |
| **1**  | MoH signature (or delegated authority) of Proposal  | Yes | **Yes**  |
| **2** | MoF signature (or delegated authority) of Proposal  | Yes | **Yes** |
| **3** | Minutes of ICC/HSCC meeting endorsing Proposal  | Yes | **Yes**  |
| **4** | Signatures of ICC or HSCC or equivalent in Proposal | Yes | **Yes** |
| **5** | Vaccine introduction plan  | Yes | **Yes** |
| **6** | Completed dose and funding calculation (see Section 7) | Yes | **Yes** |
| **7** | Comprehensive Multi Year Plan (cMYP) | Yes | **Yes** |
| **8** | cMYP costing tool | Yes | **Yes** |
| **9** | Cold chain assessment (endorsed by WHO and UNICEF) | No\* | **NO** |
| **10** | Effective Vaccine Management (EVM) assessment report | Yes | **Yes** |
| **11** | EVM improvement plan  | Yes | **Yes** |
| **12** | EVM improvement plan progress report | Yes | **Yes** |
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*Please add additional rows if required.*

*\* Cold chain assessment can be replaced by an EVM assessment report (completed since September 2010), with accompanying improvement plans and progress report. Specific information should be provided regarding the current status or plans for cold chain capacity expansion required for pneumococcal vaccines.*