# Application Form for Gavi NVS support

Submitted by

## The Government of Uganda

## for

Measles-rubella 1st dose routine, with catch-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

Initial self-financing

Date of Partnership Framework Agreement with Gavi

28 June 2013

Country tier in Gavi's Partnership Engagement Framework

1

Date of Programme Capacity Assessment

March 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?

3195477208

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

184137464

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

42735043

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

105662393

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

243315682

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

The government planning cycle starts on the

1 July

The current National Health Sector Plan (NHSP) is

From 2016

To 2020

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

2016-2020

Is the cMYP we have in our record still current?

Yes☒ No☐

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

From 2016

To 2020

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

Uganda Finincial Year cycle is July to June

### 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.

All vaccines delivered into the country shall be sourced ONLY from manufactures that are registered and approved by the National Drug Authority (NDA) in Uganda. The entity importing the vaccine must ensure that each antigen being imported appears on the NDA list

of WHO pre-qualified vaccines which that entity is licensed to import. Prior to arrival of the vaccine consignment at the port of entry, the supplier shall provide certificates of analysis (CoA) for all batches plus a Supplier's Invoice. For new vaccines, it is recommended that these documents be shared at-least 14 days before goods arrival date. This documentation is useful to secure in advance a Verification Certificate from NDA. The timely acquisition of this certificate facilitates the quick processing of goods through customs once they are received at the airport. Additional requirements for vaccine shipments must comply with the UNICEF/WHO vaccine arrival procedures.

### 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.

The Uganda National Drug Authority (NDA) was established in 1993 by the National Drug Policy and Authority Statute which in 2000 became the National Drug Policy and Authority (NDP/A) Act, Cap. 206 of the Laws of Uganda (2000 Edition). The Act established a National Drug Policy and National Drug Authority to ensure the availability, at all times, of essential, efficacious and cost-effective drugs to the entire population of Uganda as a means of providing satisfactory healthcare and safeguarding the appropriate use of drugs. National Drug Authority controls the manufacture, importation, distribution and use of both human and veterinary drugs in the country.

## Coverage and Equity

### 2.2.1 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).

Coverage and equity situation analysis
In order to identify the reasons behind the stagnating performance mentioned above and as part of shifting from “Reaching Every District” (RED), to “Reaching Every Community” (REC) as a strategy to address immunization inequities, in 2016 the Ministry of Health, with immunisation partners, conducted a coverage and equity assessment. This aimed to identify factors that may be impacting immunisation performance, underserved communities and provide a more detailed understanding of the barriers to access and uptake of immunization services in Uganda.
The assessment found that 36 of Uganda’s 116 districts contained important immunization inequities and that these districts also contained 53% of the total under-immunized children in Uganda. The Eastern region contained the largest number, at 32%, followed by Central at 30%, (with South West at 21% and Northern at 17%).
Key factors effecting low coverage and equity in districts included: low social community mobilization, due to low Village Health Team (VHT) involvement; socio-economic factors, including certain religious beliefs, individual’s distance from health facilities, low education levels of mothers and the wealth levels of parents. Wider system factors identified included: inadequate gas supplies for health facilities; the creation of new sub-counties/districts without health facilities; health staff absenteeism, and the non-distribution of vaccines to sub-district levels by District Health Teams (DHTs) causing vaccine shortages.
The high-risk communities / underserved communities identified were: urban poor settlements, migrants, ethnic minorities, some religious sects (especially Muslims, Bisaka sect and triple 6), upcoming town settlements, fishing communities, refugee communities, remote rural, island and mountainous communities. Kampala district had a lot of urban poor settlements and was found to have the largest number of under immunized children for DPT3 for the period 2013 to 2015.
The assessments recommendations included: better facilitation of VHT involvement in community mobilization, children registration and defaulter tracking; increasing dialogue with religious leaders and communities holding negative views on immunization; increasing outreaches in under-served areas and to high risk communities; carrying out micro planning at facility level and ensuring planned activities are actually implemented, through regular supervision and monitoring by DHTs; conducting targeted equity assessments in each of the 36 districts identified with immunization inequities, using an equity assessment tool tailored to Uganda’s specific context. The equity assessment tool for identifying high risk communities

has been incorporated into health facility micro planning template.
The Ministry of health and health development partners have put in place interventions aimed at reaching the urban poor communities through microplanning to identify the marginalized communities, use of local structures for community mobilization, establishing outreaches in underserved parishes, conducting community dialogue meetings with refugee communities and religious leaders.

Challenges underlying the performance of the immunisation system
• Inadequate health work force
Delivery of immunisation services is integrated with wider Primary Health Care services, with health workers at operational levels providing services across a continuum of programs. Health human resource gaps exist across Uganda, with the health worker-to-population ratio in Uganda at 1.49 health workers per 1,000 population. This is still considerably below the WHO recommended minimum of 2.3 health workers per 1,000 population , . A Human Resource (HR) for immunization supply chain, rapid assessment was conducted in September 2016. This found several key HR challenges affecting immunisation service delivery, including:
- High levels of staff attrition and turn-over
- Inadequate levels of supportive supervision at facility level
- Inadequate health care worker training in first line maintenance
To address these challenges, MoH has ongoing recruitment drive at national and district levels to cover the HR gap from 61% (2013) to 73% (2017). The current existing HR is adequate to implement the MR NVI and campaign.
MoH has worked with Intra-Health/USAID to strengthen support supervision system. Between 2016 and 2017, a total of 1,100 health workers from 290 health facilities were trained in planning and conducting effective support supervision. In addition, regular and improved supportive supervision and mentorship drive in the districts are ongoing. The ministry plans to introduce performance based financing which will incentivise performers.
Inadequate leadership, coordination and Management (LMC) in the district
This affects managerial competencies and program management at all levels of the district health system affecting immunisation service delivery. MoH through health development partner support has conducted trainings and support supervision in 35% of district with focus on the low performing districts.
• Supply chain
The EPI review 2015, EVMA report 2014, Cold Chain Inventory update 2017 have all been a source to inform challenges and develop interventions for the supply chain management. Key cited issues affecting supply chain include:
• Aged and suboptimal equipment: While functionality of equipment was noted to be at ~94% as of 2017, majority is cold chain equipment is aged (37%>10yrs, 38% between 6-10yrs), non PQS and suboptimal (gas). This requires fast tracking the implementation of the CCEOP platform which will address any gaps with in the cold chain system. Currently, the country is implementing year one of the cold chain equipment optimization platform which replace suboptimal equipment, extend cold chain storage and bridge capacity gaps for new vaccines
• Inadequate cold chain performance monitoring: Continuous temperature monitoring (Fridge tags) was introduced in 2016 at scale at subnational level to monitor performance of the cold chain by enabling health workers to identify and response to temperature alarms in order to prevent vaccines from damage. However, temperature monitoring control performance is still suboptimal; low reporting rates (<10% by Sept 2017), inconsistency in reporting (79% of districts reported 4 times or less, 21% between 5 to 9 times with only 1 district consistently reporting month to month) and lack of standardized reports to ease aggregation and analysis of data (68% of reports are in excel (previous version) & 32% of reports are in other formats).

• Stock outs at district and facility level: Despite an optimized ordering process of vaccines at the DVS level, many districts continue to fall below minimum stock levels or stock out. Furthermore, distribution of vaccines below the district level also remains unstructured affecting stock availability at facility level.
Demand generation / demand for vaccination
Demand generation for routine immunisation is conducted through advocacy, communication and social mobilisation to increase support and uptake of immunisation services in the communities. Key challenges include:
Limited use of key stakeholders and non- health stake holders, to raise awareness and increase demand for RI
• demand generation has been left to VHTs, political, religious and other stakeholders, who play a voluntary role in mobilising communities and in demand generation.
• UNEPI does not have a full time dedicated officer for Advocacy Communication and Social Mobilization (ACSM) limiting focused support to the program
In addition to the existing community structures (village health teams district leader cultural, political, religious leaders) the EPI program will use the Community Health Extension Workers (CHEWs), District Health Inspectors and Assistants to support immunisation demand creation and mobilisation for immunisation services.
Gender-related barriers - limited involvement of men in RI activities: in Uganda household decision-making is often dominated by men, who often need to give their support before mothers are allowed to seek health services, such as immunisation for children. Deliberate efforts have been made in 2016 by government and development partners to ensure that within broader district and sub-county Communication For Development (C4D) plans, men are specifically targeted through mobilisation, health education and participatory guidance thus empowering them to support their families in immunisation uptake and demand generation.
Inadequate knowledge among the health workers at operational level and training institutions. MR New vaccine introduction and campaign is an opportunity to decentralise training and interact directly with the primary people offering vaccination. Training of the health workers and community resource persons strengthens immunisations service delivery. Use the new vaccine introduction of MR including the campaign as a platform to sensitise the pre-service medical institutions.
Some of the Lessons learnt
• National level performance can mask subnational performance
• Good performing districts have competent Human resource
• Management competencies are important in districts performance
• Public Private Partnership engagement is important for improved immunization services in urban settings
• In Urban settings, there is a preference of public health facilities for immunization services due to free service provision
• Local community leaders are very important in planning and mobilization for immunization

## Country documents

### 2.3.1 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.)

## Coordination and advisory groups documents

| | | |
|---|---|---|
| ✓ | **National Coordination Forum Terms of Reference**<br>ICC, HSCC or equivalent | UNICC ToR_FINAL November 2017_16-01-18_18.15.54.docx<br><br>HSSIP Compact Uganda final_16-01-18_18.07.43.pdf |
| ✓ | **National Coordination Forum meeting minutes of the past 12 months** | HPAC MINUTES_16-01-18_17.52.59.zip |

## Other documents

| | | |
|---|---|---|
| ✓ | **Other documents (optional)**<br>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. | Human_Resource_for_Health ANNUAL PERFORMANCE REPORT2016_2017_16-01-18_17.07.49.docx<br><br>UNITAG_Signatures_16-01-18_17.04.01.pdf<br><br>UNITAGs Minutes_16-01-18_17.03.08.pdf |

## Country and planning documents

| | | |
|---|---|---|
| ✓ | **Country strategic multi-year plan**<br>Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan | cMYP Costing tool _UG__To Update Feb 2018_16-01-18_17.52.48.xlsx |
| ✓ | **Country strategic multi-year plan / cMYP costing tool** | cMYP Costing tool _UG__To Update Feb 2018_16-01-18_17.01.51.xlsx |
| ✓ | **Effective Vaccine Management (EVM) assessment** | UG_EVMA Final_15-01-18_20.47.01.pdf |
| ✓ | **Effective Vaccine Management (EVM): most recent improvement plan progress report** | Uganda EVMA Improvement plan_NVS,LD and SP_Progress Update_15-01-18_20.49.52.xls |
| ✓ | **Data quality and survey documents: Final report from most recent survey containing immunisation coverage indicators** | UDHS 2016_18-01-18_18.56.58.pdf<br><br>Final Uganda DQS Report_15-01-18_20.51.46.doc |
| ✓ | **Data quality and survey documents: Immunisation data quality improvement plan** | Data Quality Improvement Plan 13.10.2017_15-01-18_20.53.23.xlsx |
| ✓ | **Data quality and survey documents: Report from most recent desk review of immunisation data quality** | Data Quality Improvement Teams_14AUG2017_16-01-18_16.38.15.docx |

| | | |
|---|---|---|
| ✓ | **Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation** | UDHS 2016_16-01-18_17.13.41.pdf |
| ✓ | **Human Resources pay scale**<br>If support to the payment of salaries, salary top ups, incentives and other allowances is requested | Salary structure 2017 20180001-4_16-01-18_16.14.14.pdf |

## Measles-rubella 1st dose routine, with catch-up campaign

### Vaccine and programmatic data

#### 3.1.1 Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.
Measles-rubella 1st dose routine

| | |
|---|---|
| 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 | 29 August 2018 |
| Planned launch date | 29 October 2018 |
| Support requested until | 2020 |

Measles-rubella catch-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 | 29 August 2018 |
| Planned launch date | 17 October 2018 |
| Support requested until | 2018 |

### 3.1.2 Vaccine presentation registration or licensing

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

No Response

### 3.1.3 Vaccine procurement

Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund.

Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?

| | |
|---|---|
| Yes☐ | No☒ |

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

problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

## Target Information

### 3.2.1 Targets for routine vaccination

Please describe the target age cohort for the MR 1st dose routine immunisation:

| | | | | |
|---|---|---|---|---|
| | 9 | weeks ☐ | months ☒ | years ☐ |

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| Population in target age cohort (#) | 1,779,411 | 1,832,793 | 1,887,777 |
| Target population to be vaccinated (first dose) (#) | 409,265 | 1,649,514 | 1,793,388 |
| Target population to be vaccinated (last dose) (#) | 1 | 1 | 1,062,636 |
| Estimated wastage rates for preferred presentation (%) | 40 | 40 | 40 |

### 3.2.2 Targets for campaign vaccination

Gavi will only provide support to countries for Rubella Containing Vaccine catch-up campaign by providing doses of MR vaccine for a target population of males and females aged 9 months to 14 years (the exact range in the scope of 9 months to 14 years old will depend on MR in the country). 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 catch-up campaign: (from 9m-14y).

| | | | | |
|---|---|---|---|---|
| From | 9 | weeks ☐ | months ☒ | years ☐ |
| To | 14 | weeks ☐ | months ☐ | years ☒ |

| | 2018 |
|---|---|
| Population in target age cohort (#) | 16,849,450 |

| | |
|---|---|
| Target population to be vaccinated (first dose) (#) | 16,006,978 |
| Estimated wastage rates for preferred presentation (%) | 15 |

## Co-financing information

### 3.3.1 Vaccine and commodities prices

Price per dose (US$) - Measles-rubella 1st dose routine

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| 10 doses/vial,lyo | 0.62 | 0.62 | 0.62 |

Commodities Price (US$) - Measles-rubella 1st dose routine (applies only to preferred presentation)

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| AD syringes | 0.04 | 0.04 | 0.04 |
| Reconstitution syringes | 0.04 | 0.04 | 0.04 |
| Safety boxes | 0.47 | 0.47 | 0.47 |
| Freight cost as a % of device value | 0.02 | 0.02 | 0.02 |

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

| | 2018 |
|---|---|
| 10 doses/vial,lyo | 0.62 |

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

| | 2018 |
|---|---|
| AD syringes | 0.04 |
| Reconstitution syringes | 0.47 |
| Safety boxes | 0.04 |
| Freight cost as a % of device value | 0.02 |

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

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

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| Country co-financing share per dose (%) | 48.39 | 48.39 | 48.39 |
| Minimum Country co-financing per dose (US$) | 0.3 | 0.3 | 0.3 |
| Country co-financing per dose (enter an amount equal or above minimum)(US$) | 0.3 | 0.3 | 0.3 |

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

Measles-rubella 1st dose routine

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| Vaccine doses financed by Gavi (#) | 455,400 | 1,744,300 | 1,628,500 |
| Vaccine doses co-financed by Country (#) | 399,000 | 1,528,200 | 1,426,600 |
| AD syringes financed by Gavi (#) | 638,200 | 2,384,100 | 2,038,900 |
| AD syringes co-financed by Country (#) | | | |
| Reconstitution syringes financed by Gavi (#) | 94,000 | 360,000 | 336,100 |
| Reconstitution syringes co-financed by Country (#) | | | |

| | | | |
|---|---|---|---|
| Safety boxes financed by Gavi (#) | 8,075 | 30,200 | 26,125 |
| Safety boxes co-financed by Country (#) | | | |
| Freight charges financed by Gavi ($) | 11,859 | 45,295 | 41,875 |
| Freight charges co-financed by Country ($) | 10,392 | 39,682 | 36,686 |

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| Total value to be co-financed (US$) Country | 256,500 | 982,000 | 917,000 |
| Total value to be financed (US$) Gavi | 326,500 | 1,247,500 | 1,156,000 |
| Total value to be co-financed (US$) | 583,000 | 2,229,500 | 2,073,000 |

Measles-rubella catch-up campaign

| | 2018 |
|---|---|
| Vaccine doses financed by Gavi (#) | 18,888,300 |
| AD syringes financed by Gavi (#) | 17,607,700 |
| Reconstitution syringes financed by Gavi (#) | 2,077,800 |
| Safety boxes financed by Gavi (#) | 216,550 |
| Freight charges financed by Gavi ($) | 504,934 |

| | 2018 |
|---|---|

| | |
|---|---|
| Total value to be financed (US$) Gavi | 13,001,000 |
| Total value to be co-financed (US$) | 13,001,000 |

### 3.3.4 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.

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| Minimum number of doses financed from domestic resources | 854,400 | 3,272,500 | 3,743,697 |
| Country domestic funding (minimum) | 230,688 | 883,575 | 1,010,798 |

### 3.3.5 Co-financing payment

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

MR vaccine introduction is a priority of Government of Uganda. Ministry of Health and Ministry of Finance and Economic Development are committed to the introduction. A vote for MR vaccine co-financing will be included in the Ministry of Health annual budget FY 2018/2019. Funds will be released from Ministry of Finance, Planning and Economic Development to Ministry of Health (MOH). Upon approval by Permanent Secretary of the Ministry of Health, MOH will transfer funds to UNICEF Supply Division that manages the procurement of Gavi approved vaccines.

| | |
|---|---|
| Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co- | January |

| | |
|---|---|
| financing funds in the month of: | |

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

### 3.4.1 Routine Vaccine Introduction Grant(s)

Measles-rubella 1st dose routine
Live births (year of introduction)

No Response

Gavi contribution per live birth (US$)

0.8

Total in (US$)

100,000

| | |
|---|---|
| Funding needed in country by | 1 July 2018 |

### 3.4.2 Campaign operational costs support grant(s)

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

16,849,450

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

0.65

Total in (US$)

10,952,142.5

| | |
|---|---|
| Funding needed in country by | 1 July 2018 |

### 3.4.3 Operational budget

Please complete the Gavi budgeting and planning template to document how the Gavi Vaccine Introduction Grant and the Campaign Operational Costs support grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the campaign and the introduction of the new vaccine(s).

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.

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

0

Total amount - Other donors (US$)

0

Total amount - Gavi support (US$)

1423501

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

0

Amount per target person - Other donors (US$)

0

Amount per target person - Gavi support (US$)

0.8

### 3.4.4 Financial management procedures

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

The Ministry of Finance, Planning and Economic Development (MoFPED) is the Principal Recipient(PR) of GAVI funds similar to all funds received by the Government of Uganda (GoU) according to Article153 (1) of the Constitution of The Republic of Uganda of 1995 and the Public Finance and Accountability Act of 2003.
The MoFPED maintains a GAVI specific bank account(USD account) in BoU as a 'Collection Account' where all the funds from GAVI alliance are disbursed. The name of the account is the Global Alliance for Vaccines Initiative Health Systems Strengthening (GAVI HSS) Grant. When funds are received (MR VIG) by the MoFPED collection account, they are transferred to the GAVI US Dollar account (GAVI Vaccines Fund USD Account) on request by the PS (MoH) to PSST (MoFPED).
The Uganda shillings account (GAVI Vaccines Fund UGX) is then used for payment of transactions in local currency for GAVI supported activities to all Sub Recipients (SR) including but not limited to local governments.
Funds disbursed to local governments are transferred from the MoH GAVI UGX account directly to the District General Collection bank accounts (receipt of which is confirmed in writing by the local government accounting officers to the MoH).

### 3.4.5 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.

Based on the current challenges in implementing the FMA recommendations, the country is suggesting the VIG to be channelled through UNICEF. However, if the FMA recommendations are resolved before the VIG disbursement, then the country would prefer the funds to be sent through the government financial system.

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

The MR New vaccine Introduction grant and MR catch-up campaign grant will be transfered through the MoH finincial system

### 3.4.6 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.

Technical assistance will be provided by WHO and UNICEF to support New Vaccine Introduction plan and MR catch-up campaign

## Strategic considerations

### 3.5.1 Rationale for this request

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

See section 2 MR New vaccine introduction plan and section 2 & 3 of MR plan of action

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

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

The MR new vaccine introduction plan and the MR catch-up campaign ar contained in the cMYP 2016-2020, well aligned to the Health Sector Development Plan (HSDP) that focus on Health promotion and Disease Prevention.

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

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

Ministry of Health requested UNITAG to make recommendations on the prioritization of various new vaccines to introduce to the routine immunisation schedule. UNITAG made the following recommendations for new vaccine introduction: (i) Introduce Measles Rubella vaccine at 9 months as Measles Containing Vaccine (MR1) to control measles and rubella. However, it is important that Government and Immunisation Partners work to increase and sustain MCV 1 coverage in routine to > 95% as recommended by WHO. In addition, prior to introduction into routine, a large-scale MR campaign targeting children aged 9 months to 15 years is recommended for 2018 (ii) Introduce and achieve high coverage with a 2nd dose of

Measles Rubella vaccine (MR2) at provided between 15-18 months , as a cost-effective measure to provide a second opportunity for measles vaccination , help reduce the burden of measles and rubella epidemics in the country, and eventually reduce the need and frequency of follow-up Supplementary Immunisation Activities .
In 2017, UNEPI presented the decision to introduce the MR vaccine to MoH Senior Management Committee (SMC) which provided technical guidance and approved for Health Policy Advisory Committee (HPAC). The HPAC discussed the MR vaccine proposal and approved the campaign and new vaccine introduction. UNEPI will present the new MR catch-up campaign and MR vaccine introduction to the UNICC committee in January 2018.

### 3.5.4 Financial sustainability

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

The GoU is commited to the inclusion of MR

### 3.5.5 Programmatic challenges

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

To identify the reasons behind the stagnating performance of routine immunization, the Ministry of Health together with immunization partners, conducted a coverage and equity assessment.
The assessments recommendations included: better facilitation of VHT involvement in community mobilization, children registration and defaulter tracking; increasing dialogue with religious leaders and communities holding negative views on immunization; increasing outreaches in under-served areas and to high risk communities; carrying out micro planning at facility level and ensuring planned activities are actually implemented, through regular supervision and monitoring by DHTs; conducting targeted equity assessments in each of the 36 districts identified with immunization inequities, using an equity assessment tool tailored to Uganda's specific context. The equity assessment tool for identifying high risk communities has been incorporated into the health facility micro planning template.
The Ministry of health and health development partners have put in place interventions aimed at reaching the urban poor communities. These interventions include: conducting detailed microplanning to identify the marginalized communities, using of local structures for community mobilization, establishing outreach services in underserved parishes, conducting community dialogue meetings with refugee communities and religious leaders.
Inadequate health work force
Health human resource gaps exist across Uganda, with the health worker-to-population ratio in Uganda at 1.49 health workers per 1,000 population. This is still considerably below the

WHO recommended minimum of 2.3 health workers per 1,000 population. A rapid assessment of Human Resource (HR) for immunization supply chain was conducted in September 2016 and identified several key HR challenges affecting immunisation service delivery, including: High levels of staff attrition and turn-over, inadequate levels of supportive supervision at facility level, inadequate health care worker training in first line maintenance
To address these challenges, MoH conducted recruitment drive at national and district levels to cover the HR gap from 61% (2013) to 73% (2017). In urban areas, where the highest number of unvaccinated children are, the MoH is strengthening partnership with private clinics by training their staff on immunization service delivery and providing refrigerators for cold chain of vaccines.MoH has worked also worked with Intra-Health/USAID to strengthen support supervision system.
Inadequate leadership, coordination and Management (LMC) in the district
This affects managerial competencies and program management (including immunization) at all levels of the district health system service delivery. MoH through health development partners' support has conducted trainings and supportive supervision in 35% of district with focus on the low performing districts.
Supply chain
The EPI review 2015, EVMA report 2014, Cold Chain Inventory update 2017 have all informed challenges and provided valuable lessons to help develop interventions for the supply chain management. Key cited issues affecting supply chain include: stock outs at districts and facility level, aged and sub-optimal cold chain equipment, inadequate cold chain performance monitoring, poor stock management and handling practices and inadequate number of cold chain technicians to provide maintenance services. UNEPI, with the support of immunization partners is implementing year one of the Cold Chain Equipment Optimisation Platform (CCEOP) that seeks to address and challenges identified: training of cold chain technicians; plans to improve stock management practices, replacement of aging, sub-optimal or obsolete cold chain equipment, extension of cold chain storage capacity, and overall, improvement in cold chain management practices are ongoing nationwide.
Demand generation / demand for vaccination
Advocacy, communication and social mobilisation are conducted to rally community support for vaccination and to generate demand and increase uptake of immunisation services in the communities. Key challenges include: Limited involvement of key stakeholders and non-health stakeholders, to raise awareness and increase demand for RI, Gender-related barriers - limited involvement of men in RI activities, Inadequate knowledge among the health workers at operational level and training institutions. Deliberate efforts have been made in 2016 by government and development partners to ensure that within broader district and sub-county Communication For Development (C4D) plans, men are specifically targeted through mobilisation, health education and participatory guidance thus empowering them to support their families in immunisation uptake and demand generation. At the same time, MR New vaccine introduction and campaign is an opportunity to decentralise training and interact directly with the primary people offering vaccination. Training of the health workers and community resource persons strengthens immunisations service delivery. MR vaccine introduction and campaign will be used as a platform to sensitise pre-service medical institutions.
(See section 3 MR New Vaccine plan and section and section 7 MR plan of Action )

### 3.5.6 Improving coverage and equity of routine immunisation

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

Findings of recent assessments (equity assessment, measles outbreak risk assessment, previous campaign reports) and surveillance data have identified priority areas and communities where planning and implementation of MR SIA activities should be intensified. 36 of Uganda's 122 districts contained important immunization inequities and that these districts also hosts 53% of the total under-immunized children in Uganda. The Eastern region contained the largest number, at 32%, followed by Central at 30%, (with South West at 21% and Northern at 17%). In addition, urban slums have also been identified as priority areas for MR planning and implementation. The MR campaign will reach these special population through:

• Mobile units will visit hard to reach areas (mobile communities/nomads)
• Special mobilization, including door to door social mobilization and outreach activities will be conducted in urban slums
• Special border posts will be established
• Door to door strategy will be used for identified hard to reach communities.
• Funds were allocated for districts with inequities(hard to reach) to ensure every child is reached
• Based on the data from the last SIA coverage in 2015, 5 districts were shown to have achieved coverage of less than 80%. For these districts an assessment will be done to understand the reasons/barriers for achieving high coverage. Thereafter, findings will be incorporated into the micro planning and campaign implementation processes.

(See section 7 MR POA and section 4 New Vaccine Introduction Plan)

### 3.5.7 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.

The immunization program is well integrated in the primary health care package delivered in all districts of the country. In accordance with the Reproductive Maternal Neonatal Adolescent Health (RMNCAH) policy which emphasizes a package of health services to be provided through the Prevent, Protect and Treat (PPT) approach.

The GoU has developed a 2015-2020 implementation framework which articulates a holistic approach to controlling and managing pneumonia and diarrhea. Implementation of these PPT activities is ongoing through different programs such as the Integrated Community Case Management (ICCM) for childhood illnesses, diarrhea treatment program, water, sanitation and hygiene (WASH) programs, immunisation for all target age groups, introduction of new vaccines (PCV10 in 2013, Rotavirus vaccine planned introduction quarter 2 of 2018 and MR vaccine in quarter 4 of 2018), as well as strengthening of routine Immunisation in all districts. Measles and Rubella new vaccine introduction is among the key priorities of UNEPI, thus, is expected to further contribute to RMNCAH outcomes. The program has strengthened its capacity in immunisation and surveillance in preparation for Rotavirus vaccine introduction further paving way for the MR vaccine introductions. MR surveillance is integrated in the vaccine preventable disease surveillance in all the districts and a sentinel site for Congenital

Rubella Syndrome (CRS) is functional at the New Mulago National Referral Hospital. (see section 2 MR new vaccine introduction plan and section 4 MR plan of action)

### 3.5.8 Indicative major measles and rubella activities planned for the next 5 years

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

The MR 5 year plan of action outlines the key program activities which includes:
• Conduct a wide age MR catch-up campaign for the age group 9 months to 14 years in October 2018
• Introduce MR 1st dose vaccination at 9 months in the EPI schedule in October 2018
• Introduce a 2nd dose of the MR vaccine at 18months in October 2020
• Conduct a wide age MR catch-up campaign for the age group 9 months to 5 years in October 2021
• Strengthen routine immunization to achieve high coverage with MCV1 and MCV2
• Strengthen surveillance to meet and sustain MR surveillance performance indicators
• Build capacity to conduct timely outbreak

## Report on Grant Performance Framework

### 3.6.1 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.
If you have any questions, please send an email to countryportal@gavi.org.

## Upload new application documents

### 3.7.1 Upload new application documents

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

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

### Vaccine specific

| | | |
|---|---|---|
| ✓ | **cMYP addendum**<br>Situation analysis and 5 year plan captured in the cMYP or as an addendum to the cMYP | cMYP Addendum-FINAL on Measles-Rubella_16_1_2018_Final_v1_16-01-18_23.18.06.doc |
| ✓ | **Annual EPI plan**<br>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 | Annual workplan_16-01-18_21.56.50.docx |
| ✓ | **MCV1 self-financing commitment letter**<br>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. | Funding_MCV1_16-01-18_21.59.33.docx |
| ✓ | | Uganda_MR plan of action_ Final_v1_16-01-18_23.27.51.docx |

| | | |
|---|---|---|
| | **Measles (and rubella) strategic plan for elimination**<br>If available | |
| ✓ | **Other documents (optional)** | Measles_FInal MRAT report_16-01-18_19.11.21.pdf |

## Endorsement by coordination and advisory groups

| | | |
|---|---|---|
| ✓ | **National coordination forum meeting minutes, with endorsement of application, and including signatures**<br>The minutes of the national coordination forum meeting should mention the domestic funding of MCV1 | HPAC_signatures_16-01-18_18.40.11.pdf<br>HPAC MINUTES_16-01-18_18.36.40.zip |
| ✓ | **NITAG meeting minutes**<br>with specific recommendations on the NVS introduction or campaign | UNITAGs Minutes_16-01-18_18.35.39.pdf |

## Application documents

| | | |
|---|---|---|
| ✓ | **New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline**<br>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. | MR New Vaccine Introduction plan 16-01-2019_Final_V1_16-01-18_23.00.49.doc |
| ✓ | **Gavi budgeting and planning template** | FINAL_Budgeting and Planning Template Uganda MR Campaign NVI 1612018_16-01-18_22.18.38.xlsm |

| | | |
|---|---|---|
| ✓ | **Most recent assessment of burden of relevant disease**<br>If not already included in detail in the Introduction Plan or Plan of Action. | Epidemiological Evidence for Measles Control in Uganda_16-01-18_19.06.48.pdf |
| ✓ | **Campaign target population (if applicable)** | UBOS MR target Campaign Population projection_16-01-18_19.03.53.pdf |

## Review and submit application

### Submission Details

#### Country vaccine funding summary

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

**New vaccine support requested**

Measles-rubella 1st dose routine, with catch-up campaign

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| Country Co-financing (US$) | 256,500 | 982,000 | 917,000 |
| Gavi support (US$) | 13,327,500 | 1,247,500 | 1,156,000 |

| | 2018 | 2019 | 2020 |
|---|---|---|---|
| Total country co-financing (US$) | 256,500 | 982,000 | 917,000 |
| Total Gavi support (US$) | 13,327,500 | 1,247,500 | 1,156,000 |
| Total value (US$) (Gavi + Country co-financing) | 13,584,000 | 2,229,500 | 2,073,000 |

#### 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 |
|---|---|---|---|

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

The portal still has some errors in navigation. Needs perfection for better usability

## Government signature form

The Government of (country) 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:

(enter type of application)

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

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

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

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

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

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

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

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

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

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