Annual Progress Report 2008

Submitted by

The Government of

[**GHANA**]

Reporting on year: __**2008**__

Requesting for support year: _2010/2011_

Date of submission: ___14TH MAY 2009_____

Deadline for submission: 15 May 2009

Please send an electronic copy of the Annual Progress Report and attachments to the following e-mail address: **apr@gavialliance.org**

and any hard copy could be sent to :

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CH 1202 Geneva,
Switzerland

Enquiries to: **apr@gavialliance.org** or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public.

Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

Please note that Annual Progress reports will not be reviewed or approved by the Independent Review Committee without the signatures of both the Minister of Health & Finance or their delegated authority.

By signing this page, the whole report is endorsed, and the Government confirms that funding was used in accordance with the GAVI Alliance Terms and Conditions as stated in Section 9 of the Application Form.

For the Government of [*Name of Country*]……GHANA……

Minister of Health:		**Minister of Finance:**	
Title:	……	Title:	……
Signature:	……	Signature:	……
Date:	……	Date:	……

This report has been compiled by:

Full name: .....DR. KWADWO ODEI ANTWI-AGYEI.....

Position:.. NATIONAL PROGRAMME MANAGER, EXPANDED PROGRAMME ON IMMUNIZATION.....

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ICC Signatures Page

If the country is reporting on ISS, INS, NVS support

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

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The ICC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date

Comments from partners:
You may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

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As this report been reviewed by the GAVI core RWG: y/n

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HSCC Signatures Page

If the country is reporting on HSS, CSO support

We, the undersigned members of the National Health Sector Coordinating Committee, …… (insert name) endorse this report on the Health Systems Strengthening Programme and the Civil Society Organisation Support. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The HSCC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date

Comments from partners:
You may wish to send informal comment to: apr@gavialliance.org
All comments will be treated confidentially

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Signatures Page for GAVI Alliance CSO Support (Type A & B)

This report on the GAVI Alliance CSO Support has been completed by:

Name: ……

Post: ……

Organisation:……...

Date: ……

Signature: ……

This report has been prepared in consultation with CSO representatives participating in national level coordination mechanisms (HSCC or equivalent and ICC) and those involved in the mapping exercise (for Type A funding), and those receiving support from the GAVI Alliance fund to help implement the GAVI HSS proposal or cMYP (for Type B funding).

The consultation process has been approved by the Chair of the National Health Sector Coordinating Committee, HSCC (or equivalent) on behalf of the members of the HSCC:

Name: ……

Post: ……

Organisation:……...

Date: ……

Signature: ……

We, the undersigned members of the National Health Sector Coordinating Committee, …… (insert name) endorse this report on the GAVI Alliance CSO Support. The HSCC certifies that the named CSOs are bona fide organisations with the expertise and management capacity to complete the work described successfully.

Name/Title	Agency/Organisation	Signature	Date

Signature of endorsement does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Annual Progress Report 2008: Table of Contents

This APR reports on activities between January - December 2008 and specifies requests for the period January - December 2010.

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided

Table A: Latest baseline and annual targets (*From the most recent submissions to GAVI)*

Number		Achievements as per JRF	Targets						
		2008	2009	2010	2011	2012	2013	2014	2015
Births		943.326	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
Infants' deaths		60,373	61,557	63,059	64,598	66,174	67,789	69,443	71,137
Surviving infants		882953	905,164	929,764	955,031	980,985	1,007,644	1,035,026	1,063,152
Pregnant women		941,306	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
Target population vaccinated with BCG		967,579	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
BCG coverage*		103%	100%	100%	100%	100%	100%	100%	100%
Target population vaccinated with OPV3		812,630	850,854	873,978	897,729	922,126	947,185	972,925	999,363
OPV3 coverage**		92%	94%	94%	94%	94%	94%	94%	94%
Target population vaccinated with DTP (DTP3)***		817,154	850,854	873,978	897,729	922,126	947,185	972,925	999,363
DTP3 coverage**		92.5%	94%	94%	94%	94%	94%	94%	94%
Target population vaccinated with DTP (DTP1)***		846,574	868,957	892,573	916,830	941,746	967,338	993,625	1,020,626
Wastage[1] rate in base-year and planned thereafter		4%	4%	4%	4%	4%	4%	4%	4%
Duplicate these rows as many times as the number of new vaccines requested									
Target population vaccinated with **3rd dose** of …Pneumococcal …….				873,978	897,729	922,126	947,185	972,925	999,363
…….. Coverage**				94%	94%	94%	94%	94%	94%
Target population vaccinated with **1st dose** of … Pneumococcal ……..				892,573	916,830	941,746	967,338	993,625	1,020,626
Wastage[1] rate in base-year and planned thereafter				5%	4%	4%	4%	4%	4%
Target population vaccinated with **1st dose** of Measles		815,617	850,854	873,978	897,729	922,126	947,185	972,925	999,363
Target population vaccinated with **2nd dose** of Measles		Not Applicable							
Measles coverage**		92.3%	94%	94%	94%	94%	94%	94%	94%
Pregnant women vaccinated with TT+		719,811	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
TT+ coverage****		76%	100%	100%	100%	100%	100%	100%	100%
Vit A supplement	Mothers (<6 weeks from delivery)	391,088	483,361	496,411	509,815	523,580	537,716	552,235	567,145
	Infants (>6 months)	432,816	454,359	466,627	479,226	492,165	505,453	519,100	533,116
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100		3%	5%	5%	5%	5%	5%	5%	5%
Annual Measles Drop out rate (for countries applying for YF) Measles/Yellow fever gap		1%	0%	0%	0%	0%	0%	0%	0%

* Number of infants vaccinated out of total births ** Number of infants vaccinated out of surviving infants *** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women

[1] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check table α after Table 7.1.

Table B: Updated baseline and annual targets

Number		Achievements as per JRF	Targets						
		2008	2009	2010	2011	2012	2013	2014	2015
Births		941,306	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
Infants' deaths		47,065	48,336	49,641	50,981	52,358	53,772	55,223	56,714
Surviving infants		894,241	918,385	943,182	968,648	994,801	1,021,661	1,049,246	1,077,575
Pregnant women		941,306	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
Target population vaccinated with BCG		**967,579**	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
BCG coverage*		**103%**	100%	100%	100%	100%	100%	100%	100%
Target population vaccinated with OPV3		**812,630**	863,282	886,591	910,529	935,113	960,361	986,291	1,012,921
OPV3 coverage**		90.8%	94%	94%	94%	94%	94%	94%	94%
Target population vaccinated with DTP (DTP3)***		**817,154**	863,282	886,591	910,529	935,113	960,361	986,291	1,012,921
DTP3 coverage**		**92.5%**	94%	94%	94%	94%	94%	94%	94%
Target population vaccinated with DTP (DTP1)***		**846,574**	881,650	905,454	929,902	955,009	980,794	1,007,276	1,034,472
Wastage[2] rate in base-year and planned thereafter		**4%**	4%	4%	4%	4%	4%	4%	4%
Duplicate these rows as many times as the number of new vaccines requested									
Target population vaccinated with **3rd dose** of ……				886,591	910,529	935,113	960,361	986,291	1,012,921
……. Coverage**				94%	94%	94%	94%	94%	94%
Target population vaccinated with **1st dose** of ……..				905,454	929,902	955,009	980,794	1,007,276	1,034,472
Wastage[1] rate in base-year and planned thereafter				5%	4%	4%	4%	4%	4%
Target population vaccinated with **1st dose** of Measles		**815,617**	863,282	886,591	910,529	935,113	960,361	986,291	1,012,921
Target population vaccinated with **2nd dose** of Measles		**Not Applicable**							
Measles coverage**		**92.3%**	94%	94%	94%	94%	94%	94%	94%
Pregnant women vaccinated with TT+		**719,811**	966,721	992,823	1,019,629	1,047,159	1,075,432	1,104,469	1,134,290
TT+ coverage****		**76%**	100%	100%	100%	100%	100%	100%	100%
Vit A supplement	Mothers (<6 weeks from delivery)	**391,088**	483,361	496,411	509,815	523,580	537,716	552,235	567,145
	Infants (>6 months)	**432,816**	454,359	466,627	479,226	492,165	505,453	519,100	533,116
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100		**3%**	5%	5%	5%	5%	5%	5%	5%
Annual Measles Drop out rate (for countries applying for YF) Measles/yellow fever gap		**1%**	0%	0%	0%	0%	0%	0%	0%

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants
*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women

[2] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check table α after Table 7.1.

1. Immunization Programme Support (ISS, NVS, INS)

1.1 Immunization Services Support (ISS)

Were the funds received for ISS on-budget in 2008? (reflected in Ministry of Health and/or Ministry of Finance budget): Yes/No
If yes, please explain in detail how the GAVI Alliance ISS funding was reflected in the MoH/MoF budget in the box below.
If not, please explain why the GAVI Alliance ISS funding was not reflected in the MoH/MoF budget and whether there is an intention to get the ISS funding on-budget in the near future?

The 2006 ISS reward of $355,000 was located only in March, 2008. Due to temporary suspension of the ISS support Ghana is yet to receive her support for 2007.

The situation as reported last year has not changed.
ISS funds are not predictable since we are on reward and the funds are regarded as extra-budgetary earmarked funds and when we receive confirmation of funds a budget is prepared and submitted to the ICC for approval.

The immunisation service support reflects in the Programme of Work (POW) of the Ministry of Health (MoH). Currently the Ministry of Finance and Economic Planning (MoFEP) are aware of all resource inflows into the health sector. However not all of them reflect in the MoFEP budget (including GAVI ISS). However they are reported on and audited in the MoH financial statement, which is widely circulated.

There are discussions with the MoFEP to include a number of inflows from Donor Pooled Sources and Global Health Initiatives that are not reflected in the Government Medium Term Expenditure Framework (MTEF) budget.

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC).
Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

Management of the ISS funds followed the same mechanism as reported in previous reports, i.e., GAVI funds are lodged in the dollar account of the MINISTRY OF Health and then transferred to the Ghana Health Service (GHS) Aid-Pool Account.. This account is a pooled one and has funds from other donors lodged in it. The signatories are the Director General and the Financial Controller of the Ghana Health Service. A proposal for the disbursement of GAVI funds for 2006 was presented by the EPI secretariat to the ICC. The proposal was extensively discussed and endorsed by the ICC. The release of funds follows the procedures of the Ministry of Health with checks by Internal Audit/External Audit and also from Health Partners.

The budget and workplan for using the ISS funds are approved by the ICC. Requests are then submitted to the director PHD who oversees the EPI programme for approval. Processing for payment is done through the central accounting system and funds are then released to the EPI office or to Regions/districts, as appropriate, for implementation.
This mechanism for management of the ISS funds is working well.

As reported last year the procurement procedure remains cumbersome and slow; but is not peculiar to GAVI funding alone.

1.1.2 Use of Immunization Services Support

*In 2008, the following major areas of activities have been funded with the GAVI Alliance **Immunization Services Support** contribution.*

Funds received during 2008 _____Nil_____
Remaining funds (carry over) from 2007 _____$355,000_____
Balance to be carried over to 2009 _____$355,000_____

Table 1.1: Use of funds during 2008*

Area of Immunization Services Support	Total amount in US $	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines	0				
Injection supplies	0				
Personnel	0				
Transportation	4,686	4,686(100%)			
Maintenance and overheads	118,000	110,000 (93%)	0	8,000 (7%)	
Training	3,508			3,508 (100%)	
IEC / social mobilization					
Outreach					
Supervision					
Monitoring and evaluation					
Epidemiological surveillance	13,236.53	13,236.53(100%)	0	0	
Vehicles	55,661	17,701(32%)	0	37,960(68%)	
Cold chain equipment	61,469	0	0	61,469 (100%)	
Other ……. *(specify)*	54,476			54,476(100%)	
Total:	311,037	145,624(47%)	0	165,413(53%)	0
Remaining funds for next year:	43,963				

1.1.3 ICC meetings

How many times did the ICC meet in 2008? ___5 times_____
Please attach the minutes (DOCUMENT N°.....) from all the ICC meetings held in 2008 specially the ICC minutes when the allocation and utilization of funds were discussed.
NB: Utilization of ISS funds was discussed at the ICC meeting of 12th May 2008
Are any Civil Society Organizations members of the ICC: ***[Yes/No]***
if yes, which ones?

List CSO member organisations The Civil Society Members on the ICC so far are 1. Paediatric Society of Ghana 2. Ghana Registered Midwives Association 3. Ghana Red Cross Society 4. Rotary International - Ghana National Polio-Plus Committee 5. The Christian Health Association of Ghana (CHAG) has been invited but is yet to take his seat due to pressure of work.

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

Background: The Policy goal of Expanded Programme on Immunization in Ghana (EPI) is to protect all children and pregnant women living in Ghana against vaccine preventable diseases. Diseases being vaccinated against include: tuberculosis , poliomyelitis, diphtheria ,neonatal tetanus, whooping cough, hepatitis B, haemophilus influenza type B, measles and yellow fever.
Thus immunization of children within the EPI target population (0-11 months) was carried out in all Health facilities and outreach sites. Tetanus Toxoid (TT) was also administered to pregnant women during the period. Other strategies include: Child Health Promotion Week (CHPW) celebration, Integrated Maternal and Child Health (IMCH) campaign, Static, Outreach, Mop up, Visit to island and lake communities (hard to reach), Reaching Every District (RED) Approach (monitoring for action, supervision and support to districts) and addressing system wide barriers to immunization.

EPI objectives for 2008

- To attain an operational target of 90% nationally for all antigens by the end of Year 2007.
- To reduce morbidity and mortality due to vaccine-preventable diseases
- More than 80% of districts to attain Penta3 coverage of more than 80% and 90% nationally
- To maintain Ghana as a polio-free country
- To maintain zero mortality due to measles
- To improve AEFI and Vitamin A reporting
- To reduce vaccine wastage rates

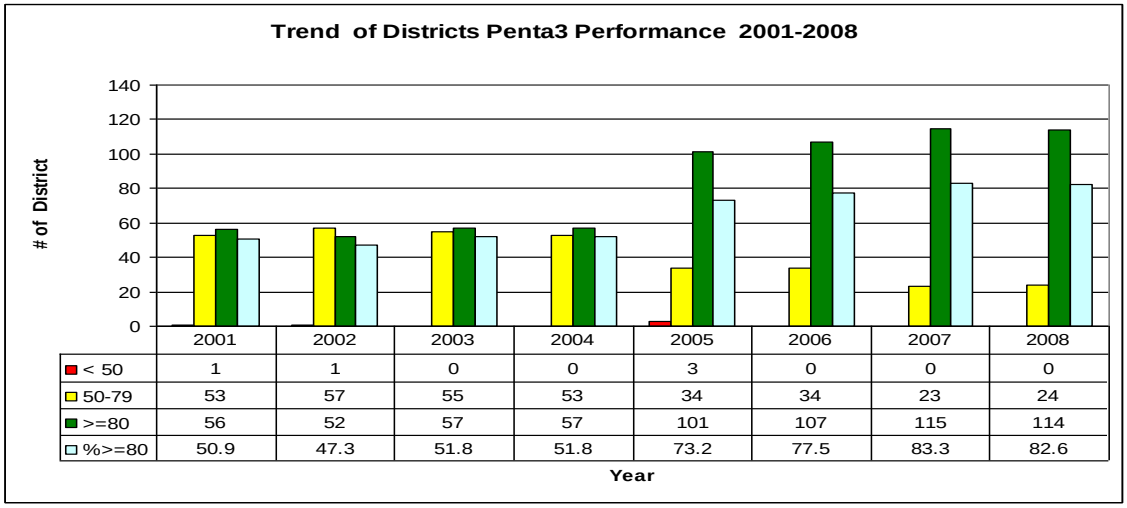
- To promote injection safety
- To conduct an integrated maternal and child health campaign
- To collaborate with other programmes and Partners
- To increase immunization coverage through Reaching Every District (RED)
- To address high and negative dropout rates
- To support hard-to-reach districts
- To improve technical support and supervision
- To carry out accelerated Disease Control Activities
- To strengthen surveillance for Vaccine Preventable Diseases
- To prepare for the introduction of New vaccines and Innovations (Pneumococcal vaccine introduction in 2010)
- Evaluate the Routine EPI Performance through coverage survey

- Address system-wide barriers to immunization

Highlights of 2008 Achievements were as follows:

1. No reported death from measles since 2003
2. Reduction of Neonatal tetanus cases
3. Penta 3 coverage decreased by 1% from 88 in 2007to 87% in 2008. However, in terms of absolute numbers, 12,075 additional children were immunized: Penta 3 immunization increased from 805,079 in 2007 to 817,154 in 2008
4. For the second time Ghana has achieved the Global target of more than 80% of districts attaining coverage of more than 80% for Penta3 and no district in Ghana is below 50%

District Penta 3 Performance, 2001-2008



	2001	2002	2003	2004	2005	2006	2007	2008
< 50	1	1	0	0	3	0	0	0
50-79	53	57	55	53	34	34	23	24
>=80	56	52	57	57	101	107	115	114
%>=80	50.9	47.3	51.8	51.8	73.2	77.5	83.3	82.6

83% of districts achieved Penta 3 coverage of more than 80%.

5. The coverage of other antigens in 2008 are shown below:

a. BCG 967,579 (103%)

b. OPV 3 812,630 (86%)

c. Penta3 817,154 (87%)

d. Measles 815,617 (86%)

e. Yellow Fever 811,012 (86%)

f. TT2+ for Pregnant Women 719,811 (76%)

6. Trend on vaccine preventable diseases (VPD)

Year /Diseases	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Measles	34273	37281	23335	15895	23068	13457	12130	2642	933	439	420	588	1305
Confirmed Measles	NA	NA	NA	NA	NA	NA	NA	NA	60	66	81	8	81
Confirmed Rubella	NA	NA	NA	NA	NA	NA	NA	NA	146	32	32	175	459
NNT Cases	105	109	100	78	80	57	70	39	42	30	29	12	8
NNT Death	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	14	10	4
Y F Suspected	13	6	0	0	0	1	0	0	1	2	7	0	174
Pertusis	1141	600	819	794	636	150	572	417	437	277	21	628	4
Confirmed polio	9	2	23	3	1	NA	NA	8	0	0	0	0	8
AFP	25	35	180	108	265	345	230	193	157	171	168	167	254

Diseases show reducing trends over ther years, However measles, rubella and suspected yellow fever cases increased in 2008

7. Challenges:

- **Re-emergence of wild polio cases in Ghana due to importation: f**rom September-November 2008 there were 8 cases of confirmed wild polio virus from the Northern Region
- **Suspension of Immunization Services Support (ISS) funding by the Global Alliance for Vaccines and Immunizations (GAVI)**
- **Poor cash flow to regions and districts**

8.0 Conclusion:

Generally, performance was good and we do encourage all stake holders to put in their best to promote good health for all people leaving in Ghana especially children.

Attachments:

Three (additional) documents are required as a prerequisite for continued GAVI ISS support in 2010:

a) Signed minutes (DOCUMENT N°……) of the ICC meeting that endorse this section of the Annual Progress Report for 2008. This should also include the minutes of the ICC meeting when the financial statement was presented to the ICC.
b) Most recent external audit report (DOCUMENT N°……) (e.g. Auditor General's Report or equivalent) of **account(s)** to which the GAVI ISS funds are transferred.
c) Detailed Financial Statement of funds (DOCUMENT N°……) spent during the reporting year (2008).
d) The detailed Financial Statement must be signed by the Financial Controller in the Ministry of Health and/or Ministry of Finance and the chair of the ICC, as indicated below:

1.1.4 Immunization Data Quality Audit (DQA)

If a DQA was implemented in 2007 or 2008 please list the recommendations below:

List major recommendations Not applicable

Has a plan of action to improve the reporting system based on the recommendations from the last DQA been prepared? Not applicable

YES ☐ *NO* ☐

If yes, what is the status of recommendations and the progress of implementation and attach the plan.

Please highlight in which ICC meeting the plan of action for the last DQA was discussed and endorsed by the ICC. *[mm/yyyy]*

Please report on any studies conducted and challenges encountered regarding EPI issues and administrative data reporting during 2008 (for example, coverage surveys, DHS, house hold surveys, etc).

List studies conducted: (copies of reports accompanying APR)

1. *EPI COVERAGE SURVEY IN ALL 138 DISTRICTS*
2. *DEMOGRAPHIC AND HEALTH SURVEY*

List challenges in collecting and reporting administrative data:

1. *Shortage of tally books*
2. *Staff do not use data for decision making at the facility, sub-district and in some districts*
3. *Denominators are still problematic (over-estimations in some cases and under-estimations in others*
4. *Lateness in submitting data*

A. *EPI COVERAGE SURVEY*

The objectives of the study are to validate EPI administrative coverage and determine the access and quality of EPI services. It also includes determining ITN availability and use, ACT treatment of fever in children, and an assessment of the quality of injection waste management.

The WHO EPI cluster sampling survey methodology was used. The method is described in details in the WHO manual 'Immunization Service Cluster Survey'.[3] In each district, a total of 40 clusters were selected and a total of 5,800 were surveyed from the ten regions of Ghana. For the Infant survey, a total of 7 to 8 children, aged 12 – 23 months, were surveyed in each selected cluster. Similarly, in the Tetanus toxoid coverage survey, a total of 7 or 8 children aged 0 – 11 months per cluster were studied.

Administrative EPI coverage figures are generally higher than those of the coverage survey except in the most populous regions of Ashanti and Greater Accra. The widest variations are in the Northern, Brong Ahafo, and Western regions (Fig 6).

Although access to immunization services, as measured by Penta 1 coverage (card and history) is not a major challenge, huge numbers of children are being left out in the Accra and Kumasi sub metros (Fig 10).

The proportion of children that were fully immunized before the age of 52 weeks with valid doses of all the antigens in the national child immunization schedule is 47.1%. All the regions, except Western region, showed some improvement on the 2004 performance. The rate varied from a low of 17.8% in Karaga Zabzugu Tatale to a high of 72.5% in the Builsa districts. The Penta 3 (DPT-Hib-Hep 3) coverage, similarly, ranged from 40.4% in the Asante Akim North district to 88.9% in the Builsa district.

[3] http://www.who.int/vaccines-documents/DocsPDF05/www767.pdf

The national median coverage of OPV3 is 71% and the least performing regions (less than national median) are the Brong Ahafo, Eastern, Northern, and Western regions.
Only 18% of districts in Ghana have a DOR(valid Penta 1/Penta3) of 10% or less. This quality indicator ranges from 2% in Bawku West district to 41% in Zabzugu Tatale. The national median is 15%. The Penta1/Penta 3 DOR is higher than the national median in the Brong Ahafo, Greater Accra, Volta, and the Western regions.
The rate of invalid measles doses varies from 4.9% in Yendi district to 67.8% in Sawla Tuna Kalba districts.
The reasons for failure to immunize those missed or left out are due generally to 'Obstacles' (52.4%) and Lack of information (35.4%). See fig 17.

The level of protection of children at birth is underestimated in this study due to poor record keeping on TT vaccinations. The regional medians vary from 11.3% in Ashanti region to 44.5% in Northern region(Fig 18).
The national median for the house hold availability and use of ITNs in children 12 – 23 months are 82.2% and 61.3% respectively.
The Greater Accra and Ashanti regions have the lowest rates of ITN household availability and use amongst mothers of children 0-11months. (fig19). Fever, as a suspected malaria is most appropriately treated with ACTs in the UER, GAR, NR, and AS (Fig 19).
Although the rate of availability of injection safety boxes has improved from 76.9% in 2004 to 88% in 2008, a lower proportion of facilities have no injection waste littering around them or around the disposal sites. (Section 4.1).

1.1.1. Recommendations

1. **The strength** of Ghana's immunization system, as measured by the coverage of eligible children fully immunized with the required antigens by the age of one year, has improved as compared with the coverage rate for 2004. Similarly the overall performance, as measured by Penta 3 proxy indicator, has also improved.

    a. It is however recommended that the Greater Accra and the Western regions, that have shown early signs of decline, should be supported to identify and address the bottlenecks responsible for these early declines. The Greater Accra region should investigate the relatively low performance in the Ablekuma Central, Ayawaso Central, Okai Koi North, and Osu Klottey districts. The Western region should investigate further reasons for poor performance in the sub metros, Juabeso and Wassa Amenfi.

2. **Access** to Immunization services has generally improved (Fig 9), but much more work needs to be done in the districts with a relatively high number of eligible children being left out (using Survey Pent 1 left out rate and the 2006 target population as a reference points). See Fig 10.

    a. **It is recommended that t**he regional teams should support the Accra, Bawku, Kumasi, Ga East, Ga West, and Shama Ahanta East districts in identifying and defining strategies to cover hard to reach populations.

3. **The quality** of immunization services, as measured by dropout rate, rate of invalid doses (especially of measles vaccine), variance between Yellow Fever and Measles coverage could be better. About half of the districts in Ghana have a rate of invalid doses of measles vaccine higher than 27.1%, (the national median).

    a. It is recommended that the Brong Ahafo and Western regions, particularly, should further investigate the high DOR

    b. It is also recommended that staffs are trained to appreciate the immunology of vaccination and to understand the importance of not giving vaccines earlier than scheduled. The National and Regional teams should especially target the high risk regions and districts (Zabzugu Tatale, Techiman, Sekyere East, Asante-Akim North, Adansi South, Fantekwa, Kpando and Hohoe) for this training.

4. The administrative data is generally higher than the survey data.

    a. It is recommended that administrative coverage figures are estimated based on the accurate population of the 0-11month age group.

    b. Efforts should also be made (in collaboration with the Statistical services) to determine a more

accurate population denominators for all, especially the newly created districts.

c. Steps should be taken by the district and sub district teams to improve data quality in the domains of documentation, collation, and analysis.

5. It is recommended that the documentation of TT2 plus be improved through training and mothers be educated on the importance of keeping their Yellow Cards (where records of TT should be recorded) for the purpose of evaluation of their level of protection from Tetanus.

6. It is recommended that all regions further analyse the reasons of failure to reach children with the required antigens. Further qualitative studies could be done to identify the region or district specific reasons underlying the 'Obstacles' and 'Lack of information' and strategically respond to them.

7. Although the ITN penetration and use have improved, more work needs to done especially with reducing the 'ITN penetration and Use gap'. This calls for concerted intensification of behaviour change communication (BCC) nationwide but especially in the Eastern and Central regions.

8. The rate of Artesuanate Amodiaquine Combination treatment for malaria is low in the general population but worse in some regions It is also recommended that the use Artesuanate-Amodiaquine combination treatment for malaria be improved generally but especially the Eastern, Brong Ahafo, and Western regions.

B. DEMOGRAPHIC AND HEALTH SURVEY

Overall, 79 percent of children 12-23 months are fully vaccinated (70 percent were fully vaccinated by 12 months of age). Only 1 percent of children have not received any vaccines. Looking at coverage for specific vaccines received at any time before the survey, 96 percent of children have received the BCG vaccination, 98 percent the first DPT dose and 97 percent the first polio dose (polio 1). Coverage declines for subsequent doses, with 89 percent of children receiving the recommended three doses of DPT and 86 percent receiving all three doses of polio. These figures reflect dropout rates of 9 percent for DPT and 11 percent for polio; the dropout rate represents the proportion of children who receive the first dose of a vaccine but do not go on to get the third dose. The proportion of children vaccinated against measles and yellow fever is 90 percent and 89 percent, respectively.

Differentials in coverage levels are also presented:There is little difference in the proportions of children fully vaccinated by sex of the child or by urban/rural residence. Boys and rural children (80 percent and 79 percent, respectively) are slightly more likely to be fully vaccinated compared with girls and urban children (78 percent each). Coverage falls to below 60 percent for children residing in the Northern Region. Children whose mothers attended only primary or middle/JSS school are more likely to be fully vaccinated, than children whose mothers have no education. Surprisingly, children born to mothers who attended secondary school or higher are among the least likely to be fully vaccinated, similarly to those born to mothers with no education (74 and 73 percent, respectively).

The data indicate that there has been a marked increase in vaccination coverage since 2003, from 69 percent fully immunized at any time before the survey in 2003 to 79 percent in 2008. The coverage levels for various vaccines have also improved, with the proportion not receiving any of the vaccines dropping from 5 percent to 1 percent over the past five years.

1.2. GAVI Alliance New & Under-used Vaccines Support (NVS)

1.2.1. Receipt of new and under-used vaccines during 2008

When was the new and under-used vaccine introduced? Please include change in doses per vial and change in presentation, (e.g. DTP + HepB mono to DTP-HepB)

[List new and under-used vaccine introduced in 2008]

Not applicable)

[List any change in doses per vial and change in presentation in 2008]

Dates shipments were received in 2008.

Vaccine	Vials size	Total number of Doses	Date of Introduction	Date shipments received (2008)
DTP-HepB+Hib	**2-dose**	3,213,400	**2002**	
Yellow Fever	**10-Dose/5-dose**	790,100	**1992**	
Syringes Ad		3,984,700		
Syringes 5ml		175,400		
Syringes 2ml		1,783,500		
Safety Boxes/25		66,000		

GAVI deliveries dates in 2008			
Vaccine/Devices	Indicative Delivery Date	Quantity in doses/pcs.	Arrival Dates
DTP-HepB+Hib (2 dose vial)	Mar-08	1,606,750	20/05/2008
DTP-HepB+Hib (2 dose vial)	Jun-08	1,606,750	27/06/2008
Yellow Fever (5 dose vial)	Mar-08	790,100	08/11/2008
AD Syringes	Mar-08	3,283,400	03/08/2008
AD Syringes	Mar-08	701,300	14/09/2008
Reconstitution Syringes (5.0 ml)	Sep-08	175,400	08/09/2008
Reconstitution Syringes (2.0 ml)	Mar-08	1,783,500	01/03/2008
Safety Boxes	Mar-08	56,250	08/03/2008
Safety Boxes	Mar-08	9,750	08/09/2008

Please report on any problems encountered.

[List problems encountered]
No major problem encountered

1.2.2. Major activities

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

[*List activities*]

Key Activities – The following are some of the key activities to be implemented to ensure successful introduction of the pneumococcal vaccine in the country:

1. ***Advocacy*** - Sensitization through consensus building meetings and briefing of key decision makers and stakeholders such as on the public health importance and their support

- Policy makers - Cabinet & Parliament
- ICC and Development partners
- Media practitioners
- Health managers, Leaders of civil society and traditional leaders

2. ***Social Mobilization***

- Development of guidelines for introduction of Pneumococcal vaccine.
- Media briefing - Press conferences etc
- Community Durbars, TV & Radio discussions
- Development of IE&C materials, jingles, fact sheets, banners leaflets, posters
- National Launching –

3 ***Review, print and distribution of recording materials***

- Revise immunization tally sheets to incorporate Pneumococcal vaccine for the health facilities
- Revise child health records to include Pneumococcal vaccination records
- Print revise records materials and distribute to all levels.
- Revise monitor chart to include Pneumococcal
- Revise Immunization Schedule chart to include Pneumococcal

4 ***Training*** - Training of Health Staff in:

- Completion of data tools (tally sheet)
- Monthly reporting form
- Completion of AEFI form and report
- Management of AEFI
- Injection safety measures and waste management practices

5 ***Service Delivery*** -Introduction of Pneumococcal vaccine to all Health Facilities and outreach centres.

6 ***Surveillance*** – the following activities are to ensure effective surveillance measures at all levels

- Sensitization of clinicians and other health staff on surveillance measures and the need for adequate reporting and documentation
- Develop and distribute standard case definition charts
- Strengthening routine surveillance and monitoring of AEFI
- Monitoring of monthly reports and feedback to districts and regions
- Incorporating pneumococcal surveillance in monthly VPD data validation meeting
- Incorporating pneumococcal surveillance in EPI/Surveillance Review meetings

7 Post introduction evaluation- This will be conducted 18 months after introduction of Pneumococcal vaccine in the country to document lessons, gains and implications for future programmes.

8. **Monitoring and evaluation** - The national Immunization programme will use the existing monitoring mechanisms for Penta and other antigens to monitor the coverage, drop out and wastage rates for the pneumococcal vaccine.

9. **Sustainability** - In Ghana, co-payment mechanism exists between the government and GAVI on the introduction of the DPT-HepB+Hib in 2002 and that has continued up to date. The proportion for yearly payment is documented in the Financial Sustainability Plan (FSP) developed in 2002. The same principle will be followed with the introduction of the pneumococcal vaccine as stated in the cMYP 2007-2011.

10. **Procurement and management** - In Ghana, all vaccines for the immunization programme are estimated based on WHO-UNICEF guideline and also procured by UNICEF. The estimation and procurement of the pneumococcal vaccines and any others will be done by the same principle. Vaccine distribution will be done according to the quarterly supply schedule from national level to regions for re-distribution to districts and to sub-districts and facilities in same order. Vaccine management will follow same principles as already practiced at all storage and service delivery points of the levels in the country.

1.2.3. Use of GAVI funding entity support for the introduction of the new vaccine

These funds were received on: *[dd/mm/yyyy]*

Please report on the proportion of introduction grant used, activities undertaken, and problems encountered such as delay in availability of funds for programme use. *Not applicable*

Year	Amount in US$	Date received	Balance remaining in US$	Activities	List of problems

1.2.4. Effective Vaccine Store Management/Vaccine Management Assessment

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? *[mm/yyyy]* *2002*

If conducted in 2007/2008, please summarize the major recommendations from the EVSM/VMA.

[List major recommendations]

Was an action plan prepared following the EVSM/VMA? Yes/No

If yes, please summarize main activities under the EVSM plan and the activities to address the recommendations and their implementation status.

[List main activities]

When will the next EVSM/VMA* be conducted? *[mm/yyyy]* *2010*

**All countries will need to conduct an EVSM/VMA in the second year of new vaccines supported under GAVI Phase 2.*

Table 1.2

Vaccine 1: .....yellow fever.....	
Anticipated stock on 1 January 2010	**.....9000 doses.....**
Vaccine 2: .....DPTHepB+Hib.....	
Anticipated stock on 1 January 2010	**..100,000 doses....**
Vaccine 3: .....Pneumoccocal.....	
Anticipated stock on 1 January 2010	**.....Nil.....**

1.3 Injection Safety

1.3.1 Receipt of injection safety support (for relevant countries)

Are you receiving Injection Safety support in cash or supplies?.....Not Apllicable.....

If yes, please report on receipt of injection safety support provided by the GAVI Alliance during 2008 (add rows as applicable).

Injection Safety Material	Quantity	Date received

Please report on any problems encountered.

[List problems]

1.3.2. Even if you have not received injection safety support in 2008 please report on progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report how injection safety supplies are funded.

[List sources of funding for injection safety supplies in 2008]

Our injection safety support ended in 2005. Since then the Government of Ghana has been paying for injection safety supplies.
We received some safety boxes from the JICA

Please report how sharps waste is being disposed of.

[Describe how sharps is being disposed of by health facilities]

1. Incinerators have been constructed for all the older districts and we are in the process of constructing incinerators for the 32 newer districts. Sharps waste are destroyed by incineration and for areas where there are no incinerators they are burnt in pits.
2. Complete incineration of the needles has been problematic because high temperatures are not achieved during burning. As a further step towards injection safety we introduced into the system a needle destruction device upon positive recommendation by the Clinical Engineering Unit of the Ghana Health Service. We are also considering needle cutters for areas without incinerators to facilitate burning.

Please report problems encountered during the implementation of the transitional plan for safe injection and sharps waste.

[List problems]

- Inadequate funding is a major problem
- Creation of new districts – 32 newer districts have been created in 2007 by the government and each of them is demanding an incinerator, which is outside our original plan.
- Some of the old incinerators need major rehabilitation at the time cash flow is problematic
- Lack of ownership by some districts

2.3.2. Statement on use of GAVI Alliance injection safety support in 2008 (if received in the form of a cash contribution) Not applicable

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

[List items funded by GAVI Alliance cash support and funds remaining by the end of 2008]

2. Vaccine Immunization Financing, Co-financing, and Financial Sustainability

Table 2.1: Overall Expenditures and Financing for Immunization

The purpose of Table 2.1 is to guide GAVI understanding of the broad trends in immunization programme expenditures and financial flows.
Please the following table should be filled in using US $.

	Reporting Year 2008	Reporting Year + 1	Reporting Year + 2
	Expenditures	Budgeted	Budgeted
Expenditures by Category			
Traditional Vaccines	$2,490,539	$2,552,322	$2,614,934
New Vaccines	$10,831,181	$11,096,088	$38,541,612
Injection supplies	1,191,770	1,237,036	1,603,788
Cold Chain equipment	500,000	1,200,000	1,200,000
Operational costs	13,101,848	13,295,662	14,000,000
Other (please specify)			
Total EPI	28,115,338	29,187,294	57,960,334
Total Government Health	$987,290,000	$1,188,680,000	NA

Exchange rate used	$1=GHC1.3

Please describe trends in immunization expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunization program over the next three years; whether the funding gaps are manageable, challenge, or alarming. If either of the latter two is applicable, please explain the strategies being pursued to address the gaps and indicate the sources/causes of the gaps.

The financing of immunisation expenditure for vaccines and injection supplies were met for the reporting year. Though this was a challenge, it was possible because the sector has immunisation as a top priority among its programmes. In 2008, funding to the district and sub district levels was a big challenge. There still remain gaps in the area of meeting the entire need of cold chain equipment and incinerators (especially as 32 new districts have been created in 2007), This may affect our timeline for the introduction of the pneumococcal vaccine. We hope to address this situation once we receive our ISS reward for 2007.

Future Country Co-Financing (in US$)

Please refer to the excel spreadsheet Annex 1 and proceed as follows:

- Please complete the excel sheet's "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.

- Then please copy the data from Annex 1 (Tab "Support Requested" Table 2) into Tables 2.2.1 (below) to summarize the support requested, and co-financed by GAVI and by the country.

Please submit the electronic version of the excel spreadsheets Annex 1 (one Annex for each vaccine requested) together with the application.

Table 2.2.1 is designed to help understand future country level co-financing of GAVI awarded vaccines. If your country has been awarded more than one new vaccine please complete as many tables as per each new vaccine being co-financed (Table 2.2.2; Table 2.2.3; ….)

Table 2.2.1: Portion of supply to be co-financed by the country (and cost estimate, US$)

1st vaccine:……YELLOW FEVER…….		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose		$0.30	$0.40	$0.40	$0.40	$0.40	$0.40
Number of vaccine doses	#	542,800	606,000	622,500	623,100	640,000	657,400
Number of AD syringes	#	482,100	506,900	520,700	521,200	535,300	549,900
Number of re-constitution syringes	#	120,500	134,600	138,200	138,400	142,100	146,000
Number of safety boxes	#	6,700	7,125	7,325	7,325	7,525	7,725
Total value to be co-financed by country	**$**	**$433,500**	**$481,000**	**$494,000**	**$507,500**	**$521,500**	**$535,500**

Table 2.2.2: Portion of supply to be co-financed by the country (and cost estimate, US$)

2nd vaccine:……DPTHepB+Hib……		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose		$0.15	$0.20	$0.20	$0.20	$0.20	$0.20
Number of vaccine doses	#	166,600	198,300	217,600	281,400	316,300	346,400
Number of AD syringes	#	170,100	198,400	217,700	281,600	316,500	346,700
Number of re-constitution syringes	#	92,500	110,100	120,800	156,200	175,600	192,300
Number of safety boxes	#	2,925	3,425	3,775	4,875	5,475	6,000
Total value to be co-financed by country	**$**	**$558,000**	**$623,500**	**$640,500**	**$658,000**	**$675,500**	**$693,500**

Table 2.2.3: Portion of supply to be co-financed by the country (and cost estimate, US$)

3rd vaccine:……PNEUMOCOCCAL……		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose		$0.15	$0.20	$0.20	$0.20	$0.20	$0.20
Number of vaccine doses	#	77,500	85,500	87,800	90,200	92,600	95,100
Number of AD syringes	#	79,200	85,500	87,800	90,200	92,600	95,100
Number of re-constitution syringes	#	0	0	0	0	0	0
Number of safety boxes	#	900	950	975	1,025	1,050	1,075
Total value to be co-financed by country	**$**	**$565,500**	**$623,500**	**$640,500**	**$658,000**	**$675,500**	**$693,500**

Table 2.3: Country Co-Financing in the Reporting Year (2008)

Q.1: How have the proposed payment schedules and actual schedules differed in the reporting year?			
Schedule of Co-Financing Payments	Planned Payment Schedule in Reporting Year	Actual Payments Date in Reporting Year	Proposed Payment Date for Next Year
	(month/year)	(day/month)	
1st Awarded Vaccine (specify)-YF	MARCH 2008	APRIL 2008	APRIL 2010
2nd Awarded Vaccine (specify)-DPTHepBHib	MARCH 2008	APRIL 2008	APRIL 2010
3rd Awarded Vaccine (specify)	NA	NA	

Q. 2: How Much did you co-finance?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (specify)	$366,976	390,503
2nd Awarded Vaccine (specify)	$502,685	150,059
3rd Awarded Vaccine (specify)	NA	NA

Q. 3: What factors have slowed or hindered or accelerated mobilization of resources for vaccine co-financing?
1. Increasing wage bill
2. Competition from emerging diseases such as avian influenza
3. Natural disasters like flooding in the Northern parts of the country
4.

If the country is in default please describe and explain the steps the country is planning to come out of default.

Ghana is however not in default despite the challenges

3. Request for new and under-used vaccines for year 2010

*Section 3 is to the request for new and under-used vaccines and related injection safety supplies for **2010**.*

3.1. Up-dated immunization targets

*Please provide justification and reasons for changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the **WHO/UNICEF Joint Reporting Form** in the space provided below.*

Are there changes between table A and B? Yes/no

If there are changes, please describe the reasons and justification for those changes below:

Provide justification for any changes ***in births**:*

_____
_____
_____
_____
_____

*Provide justification for any changes **in surviving infants**:*

According to the 2008 DHS Infant mortality rate has decreased from 64/1000 live births to 50/1000 live births

*Provide justification for any changes **in Targets by vaccine**:*

_____
the reduction in IMR has resulted in increases in surviving infants
_____

*Provide justification for any changes **in Wastage by vaccine**:*

_____
_____
_____
_____
_____

Vaccine 1: .....YELLOW FEVER.....

Please refer to the excel spreadsheet Annex 1 and proceed as follows:

- Please complete the "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.

- Please summarise the list of specifications of the vaccines and the related vaccination programme in Table 3.1 below, using the population data (from Table B of this APR) and the price list and co-financing levels (in Tables B, C, and D of Annex 1).

- Then please copy the data from Annex 1 (Tab "Support Requested" Table 1) into Table 3.2 (below) to summarize the support requested, and co-financed by GAVI and by the country.

Please submit the electronic version of the excel spreadsheets Annex 1 together with the application.

(Repeat the same procedure for all other vaccines requested and fill in tables 3.3; 3.4; .....)

Table 3.1: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#	NA	NA	NA	NA	NA	NA
Target immunisation coverage with the third dose	*Table B*	#	NA	NA	NA	NA	NA	NA
Number of children to be vaccinated with the first dose	*Table B*	#	873,978	897,729	922,126	947,185	972,925	999,363
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#	1.33	1.33	1.33	1.33	1.33	1.33
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$	$0.30	$0.40	$0.40	$0.40	$0.40	$0.40

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.2: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#	900,800	595,900	612,100	645,100	662,600	680,600
Number of AD syringes	#	800,100	498,400	512,000	539,600	554,200	569,300
Number of re-constitution syringes	#	200,000	132,300	135,900	143,300	147,100	151,100
Number of safety boxes	#	11,125	7,025	7,200	7,600	7,800	8,000
Total value to be co-financed by GAVI	**$**	**$719,000**	**$473,000**	**$486,000**	**$525,500**	**$539,500**	**$554,500**

Vaccine 2: .....DPTHepBHib.....

Same procedure as above (table 3.1 and 3.2)

Table 3.3: Specifications of vaccinations with new vaccine

	Use data in:		2010	2011	2012	2013	2014	2015
Number of children to be vaccinated with the third dose	*Table B*	#	886,591	910,529	935,113	960,361	986,291	1,012,921
Target immunisation coverage with the third dose	*Table B*	#	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%
Number of children to be vaccinated with the first dose	*Table B*	#	905,454	929,902	955,009	980,794	1,007,276	1,034,472
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#	1.11	1.11	1.11	1.11	1.11	1.11
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$	$0.15	$0.20	$0.20	$0.20	$0.20	$0.20

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.4: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	2011	2012	2013	2014	2015
Number of vaccine doses	#	3,552,400	2,918,800	2,983,600	3,006,200	3,060,100	3,121,100
Number of AD syringes	#	3,626,400	2,920,900	2,985,700	3,008,400	3,062,300	3,123,400
Number of re-constitution syringes	#	1,971,600	1,619,900	1,655,900	1,668,500	1,698,400	1,732,200
Number of safety boxes	#	62,150	50,425	51,525	51,925	52,850	53,900
Total value to be co-financed by GAVI	**$**	**$11,897,000**	**$9,180,000**	**$8,781,500**	**$7,026,000**	**$6,534,000**	**$6,249,000**

Vaccine 3: .....PNEUMOCOCCAL.....

Same procedure as above (table 3.1 and 3.2)

Table 3.5: Specifications of vaccinations with new vaccine

	Use data in:		2010	2011	2012	2013	2014	2015
Number of children to be vaccinated with the third dose	*Table B*	#	886,591	910,529	935,113	960,361	986,291	1,012,921
Target immunisation coverage with the third dose	*Table B*	#	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%
Number of children to be vaccinated with the first dose	*Table B*	#	905,454	929,902	955,009	980,794	1,007,276	1,034,472
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#	1.11	1.11	1.11	1.11	1.11	1.11
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$	$0.15	$0.20	$0.20	$0.20	$0.20	$0.20

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.6: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	2011	2012	2013	2014	2015
Number of vaccine doses	#	3,691,600	3,031,600	3,113,400	3,197,500	3,283,800	3,372,500
Number of AD syringes	#	3,772,800	3,033,700	3,115,600	3,199,800	3,286,200	3,374,900
Number of re-constitution syringes	#	0	0	0	0	0	0
Number of safety boxes	#	41,900	33,675	34,600	35,525	36,500	37,475
Total value to be co-financed by GAVI	**$**	**$26,945,500**	**$22,122,500**	**$22,719,500**	**$23,333,000**	**$23,963,000**	**$24,610,000**

4. Health Systems Strengthening (HSS)

Instructions for reporting on HSS funds received

1. As a Performance-based organisation the GAVI Alliance expects countries to report on their performance – this has been the principle behind the Annual Progress Reporting –APR- process since the launch of the GAVI Alliance. Recognising that reporting on the HSS component can be particularly challenging given the complex nature of some HSS interventions the GAVI Alliance has prepared these notes aimed at helping countries complete the HSS section of the APR report.
2. All countries are expected to report on HSS on the basis of the January to December calendar year. Reports should be received by 15th May of the year after the one being reported.
3. This section **only needs to be completed by those countries that have been approved and received funding for their HSS proposal before or during the last calendar year**. For countries that received HSS funds within the last 3 months of the reported year can use this as an inception report to discuss progress achieved and in order to enable release of HSS funds for the following year on time.
4. It is very important to fill in this reporting template thoroughly and accurately, and to ensure that **prior to its submission to the GAVI Alliance this report has been verified by the relevant country coordination mechanisms** (ICC, HSCC or equivalent) in terms of its accuracy and validity of facts, figures and sources used. Inaccurate, incomplete or unsubstantiated reporting may lead to the report not being accepted by the Independent Review Committee (IRC) that monitors all APR reports, in which case the report might be sent back to the country and this may cause delays in the release of further HSS funds. Incomplete, inaccurate or unsubstantiated reporting may also cause the IRC to recommend against the release of further HSS funds.
5. Please use additional space than that provided in this reporting template, as necessary.

4.1 Information relating to this report:

a) Fiscal year runs from ……(month) to …….(month).

b) This HSS report covers the period from ……..(month/year) to ……..(month year)

c) Duration of current National Health Plan is from ……..(month/year) to …….(month/year).

d) Duration of the immunisation cMYP:

e) Who was responsible for putting together this HSS report who may be contacted by the GAVI secretariat or by the IRC for any possible clarifications?

It is important for the IRC to understand key stages and actors involved in the process of putting the report together. For example: '*This report was prepared by the Planning Directorate of the Ministry of Health. It was then submitted to UNICEF and the WHO country offices for necessary verification of sources and review. Once their feedback had been acted upon the report was finally sent to the Health Sector Coordination Committee (or ICC, or equivalent) for final review and approval. Approval was obtained at the meeting of the HSCC on 10th March 2008. Minutes of the said meeting have been included as annex XX to this report.'*

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any clarifications			
Other partners and contacts who took part in putting this report together			

f) Please describe briefly the main sources of information used in this HSS report and how was information verified (validated) at country level prior to its submission to the GAVI Alliance. Were any issues of substance raised in terms of accuracy or validity of information and, if so, how were these dealt with or resolved?

This issue should be addressed in each section of the report, as different sections may use different sources. In this section however one might expect to find what the MAIN sources of information were and a mention to any IMPORTANT issues raised in terms of validity, reliability, etcetera of information presented. For example: *The main sources of information used have been the external Annual Health Sector Review undertaken on (such date) and the data from the Ministry of Health Planning Office. WHO questioned some of the service coverage figures used in section XX and these were tallied with WHO´s own data from the YY study. The relevant parts of these documents used for this report have been appended to this report as annexes X, Y and Z.*

g) In putting together this report did you experience any difficulties that are worth sharing with the GAVI HSS Secretariat or with the IRC in order to improve future reporting? Please provide any suggestions for improving the HSS section of the APR report? Are there any ways for HSS reporting to be more harmonised with existing country reporting systems in your country?

4.2 Overall support breakdown financially

Period for which support approved and new requests. For this APR, these are measured in calendar years, but in future it is hoped this will be fiscal year reporting:

	Year								
	2007	2008	2009	2010	2011	2012	2013	2014	2015
Amount of funds approved									
Date the funds arrived									
Amount spent									
Balance									
Amount requested									

Amount spent in 2008:
Remaining balance from total:

Table 4.3 note: This section should report according to the original activities featuring in the HSS proposal. It is very important to be precise about the extent of progress, so please allocate a percentage to each activity line, from 0% to 100% completion.. Use the right hand side of the table to provide an explanation about progress achieved as well as to bring to the attention of the reviewers any issues relating to changes that have taken place or that are being proposed in relation to the original activities.

Please do mention whenever relevant the **SOURCES** of information used to report on each activity. The section on **support functions** (management, M&E and Technical Support) is also very important to the GAVI Alliance. Is the management of HSS funds effective, and is action being taken on any salient issues? Have steps been taken to improve M&E of HSS funds, and to what extent is the M&E integrated with country systems (such as, for example, annual sector reviews)? Are there any issues to raise in relation to technical support needs or gaps that might improve the effectiveness of HSS funding?

Table 4.3 HSS Activities in reporting year (ie. 2008)						
Major Activities	**Planned Activity for reporting year**	**Report on progress[4] (% achievement)**	**Available GAVI HSS resources for the reporting year (2008)**	**Expenditure of GAVI HSS in reporting year (2008)**	**Carried forward (balance) into 2009)**	**Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements**
Objective 1:						
Activity 1.1:						
Activity 1.2:						
Objective 2:						
Activity 2.1:						
Activity 2.2:						
Objective 3:						
Activity 3.1:						

[4] For example, number of Village Health Workers trained, numbers of buildings constructed or vehicles distributed

Activity 3.2:						
Support Functions						
Management						
M&E						
Technical Support						

Table 4.4 note: This table should provide up to date information on work taking place in the first part of the year when this report is being submitted i.e. between January and April 2009 for reports submitted in May 2009.

The column on Planned expenditure in coming year should be as per the estimates provided in the APR report of last year (Table 4.6 of last year´s report) or –in the case of first time HSS reporters- as shown in the original HSS proposal.
Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right.

Table 4.4 Planned HSS Activities for current year (ie. January – December 2009) and emphasise which have been carried out between January and April 2009					
Major Activities	**Planned Activity for current year (ie.2009)**	**Planned expenditure in coming year**	**Balance available (To be automatically filled in from previous table)**	**Request for 2009**	**Explanation of differences in activities and expenditures from original application or previously approved adjustments****
Objective 1:					
Activity 1.1:					
Activity 1.2:					
Objective 2:					
Activity 2.1:					
Activity 2.2:					
Objective 3:					
Activity 3.1:					
Activity 3.2:					
Support costs					
Management costs					

M&E support costs					
Technical support					
TOTAL COSTS				(This figure should correspond to the figure shown for 2009 in table 4.2)	

Table 4.5 Planned HSS Activities for next year (ie. 2010 FY) This information will help GAVI's financial planning commitments					
Major Activities	**Planned Activity for current year (ie.2009)**	**Planned expenditure in coming year**	**Balance available (To be automatically filled in from previous table)**	**Request for 2010**	**Explanation of differences in activities and expenditures from original application or previously approved adjustments****
Objective 1:					
Activity 1.1:					
Activity 1.2:					
Objective 2:					
Activity 2.1:					
Activity 2.2:					
Objective 3:					
Activity 3.1:					
Activity 3.2:					
Support costs					
Management costs					
M&E support costs					
Technical support					
TOTAL COSTS					

4.6 Programme implementation for reporting year:

a) Please provide a narrative on major accomplishments (especially impacts on health service programs, notably the immunization program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. Any reprogramming should be highlighted here as well.

   This section should act as an executive summary of performance, problems and issues linked to the use of the HSS funds. This is the section where the reporters point the attention of reviewers to **key facts**, what these mean and, if necessary, what can be done to improve future performance of HSS funds.

b) Are any Civil Society Organizations involved in the implementation of the HSS proposal? If so, describe their participation? For those pilot countries that have received CSO funding there is a separate questionnaire focusing exclusively on the CSO support after this HSS section.

4.7 Financial overview during reporting year:

4.7 note: In general, HSS funds are expected to be visible in the MOH budget and add value to it, rather than HSS being seen or shown as separate "project" funds. These are the kind of issues to be discussed in this section

a) Are funds on-budget (reflected in the Ministry of Health and Ministry of Finance budget): Yes/No If not, why not and how will it be ensured that funds will be on-budget ? Please provide details.

b) Are there any issues relating to financial management and audit of HSS funds or of their linked bank accounts that have been raised by auditors or any other parties? Are there any issues in the audit report (to be attached to this report) that relate to the HSS funds? Please explain.

4.8 General overview of targets achieved

Table 4.8 Progress on Indicators included in application												
Strategy	**Objective**	**Indicator**	**Numerator**	**Denominator**	**Data Source**	**Baseline Value**	**Source**	**Date of Baseline**	**Target**	**Date for Target**	**Current status**	**Explanation of any reasons for non achievement of targets**

4.9 Attachments

Five pieces of further information are required for further disbursement or allocation of future vaccines.

a. Signed minutes of the HSCC meeting endorsing this reporting form
b. Latest Health Sector Review report
c. Audit report of account to which the GAVI HSS funds are transferred to
d. Financial statement of funds spent during the reporting year (2008)
e. This sheet needs to be signed by the government official in charge of the accounts HSS funds have been transferred to, as below.

Financial Comptroller Ministry of Health:

Name:

Title / Post:

Signature:

Date:

5. Strengthened Involvement of Civil Society Organisations (CSOs)

1.1 TYPE A: Support to strengthen coordination and representation of CSOs

This section is to be completed by countries that have received GAVI TYPE A CSO support[5]

Please fill text directly into the boxes below, which can be expanded to accommodate the text.

Please list any abbreviations and acronyms that are used in this report below:

5.1.1 Mapping exercise

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation. Please identify conducted any mapping exercise, the expected results and the timeline (please indicate if this has changed).

[5] Type A GAVI Alliance CSO support is available to all GAVI eligible countries.

Please describe any hurdles or difficulties encountered with the proposed methodology for identifying the most appropriate in-country CSOs involved or contributing to immunisation, child health and/or health systems strengthening. Please describe how these problems were overcome, and include any other information relating to this exercise that you think it would be useful for the GAVI Alliance secretariat or Independent Review Committee to know about.

5.1.2 Nomination process

Please describe progress with processes for nominating CSO representatives to the HSCC (or equivalent) and ICC, and any selection criteria that have been developed. Please indicate the initial number of CSOs represented in the HSCC (or equivalent) and ICC, the current number and the final target. Please state how often CSO representatives attend meetings (% meetings attended).

Please provide Terms of Reference for the CSOs (if developed), or describe their expected roles below. State if there are guidelines/policies governing this. Outline the election process and how the CSO community will be/have been involved in the process, and any problems that have arisen.

Please state whether participation by CSOs in national level coordination mechanisms (HSCC or equivalent and ICC) has resulted in a change in the way that CSOs interact with the Ministry of Health. Is there now a specific team in the Ministry of Health responsible for linking with CSOs? Please also indicate whether there has been any impact on how CSOs interact with each other.

5.1.3 Receipt of funds

Please indicate in the table below the total funds approved by GAVI (by activity), the amounts received and used in 2008, and the total funds due to be received in 2009 (if any).

ACTIVITIES	Total funds approved	2008 Funds US$			Total funds due in 2009
		Funds received	Funds used	Remaining balance	
Mapping exercise					
Nomination process					
Management costs					
TOTAL COSTS					

5.1.4 Management of funds

Please describe the mechanism for management of GAVI funds to strengthen the involvement and representation of CSOs, and indicate if and where this differs from the proposal. Please identify who has overall management responsibility for use of the funds, and report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

This section is to be completed by countries that have received GAVI TYPE B CSO support[6]

Please fill in text directly into the boxes below, which can be expanded to accommodate the text.

Please list any abbreviations and acronyms that are used in this report below:

5.2.1 Programme implementation

Briefly describe progress with the implementation of the planned activities. Please specify how they have supported the implementation of the GAVI HSS proposal or cMYP (refer to your proposal). State the key successes that have been achieved in this period of GAVI Alliance support to CSOs.

Please indicate any major problems (including delays in implementation), and how these have been overcome. Please also identify the lead organisation responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

[6] Type B GAVI Alliance CSO Support is available to 10 pilot GAVI eligible countries only: Afghanistan, Burundi, Bolivia, DR Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan.

Please state whether the GAVI Alliance Type B support to CSOs has resulted in a change in the way that CSOs interact with the Ministry of Health, and or / how CSOs interact with each other.

Please outline whether the support has led to a greater involvement by CSOs in immunisation and health systems strengthening (give the current number of CSOs involved, and the initial number).

Please give the names of the CSOs that have been supported so far with GAVI Alliance Type B CSO support and the type of organisation. Please state if were previously involved in immunisation and / or health systems strengthening activities, and their relationship with the Ministry of Health.

For each CSO, please indicate the major activities that have been undertaken, and the outcomes that have been achieved as a result. Please refer to the expected outcomes listed in the proposal.

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2008	Outcomes achieved

Please list the CSOs that have not yet been funded, but are due to receive support in 2009/2010, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

Please also indicate the new activities to be undertaken by those CSOs already supported.

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2009 / 2010	Expected outcomes

5.2.2 Receipt of funds

Please indicate in the table below the total funds approved by GAVI, the amounts received and used in 2008, and the total funds due to be received in 2009 and 2010. Please put every CSO in a different line, and include all CSOs expected to be funded during the period of support. Please include all management costs and financial auditing costs, even if not yet incurred.

NAME OF CSO	Total funds approved	2008 Funds US$ (,000)			Total funds due in 2009	Total funds due in 2010
		Funds received	Funds used	Remaining balance		
Management costs (of all CSOs)						
Management costs (of HSCC / TWG)						
Financial auditing costs (of all CSOs)						
TOTAL COSTS						

5.2.3 Management of funds

Please describe the financial management arrangements for the GAVI Alliance funds, including who has overall management responsibility and indicate where this differs from the proposal. Describe the mechanism for budgeting and approving use of funds and disbursement to CSOs,

Please give details of the management and auditing costs listed above, and report any problems that have been experienced with management of funds, including delay in availability of funds.

5.2.4 Monitoring and Evaluation

Please give details of the indicators that are being used to monitor performance. Outline progress in the last year (baseline value and current status), and the targets (with dates for achievement).

These indicators will be in the CSO application and reflect the cMYP and / or GAVI HSS proposal.

Activity / outcome	Indicator	Data source	Baseline value	Date of baseline	Current status	Date recorded	Target	Date for target

Finally, please give details of the mechanisms that are being used to monitor these indicators, including the role of beneficiaries in monitoring the progress of activities, and how often this occurs. Indicate any problems experienced in measuring the indicators, and any changes proposed.

6. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission		
Reporting Period (consistent with previous calendar year)		
Government signatures		
ICC endorsed		
ISS reported on		
DQA reported on		
Reported on use of Vaccine introduction grant		
Injection Safety Reported on		
Immunisation Financing & Sustainability Reported on (progress against country IF&S indicators)		
New Vaccine Request including co-financing completed and Excel sheet attached		
Revised request for injection safety completed (where applicable)		
HSS reported on		
ICC minutes attached to the report		
HSCC minutes, audit report of account for HSS funds and annual health sector review report attached to Annual Progress Report		

7. Comments

ICC/HSCC comments:

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review.

~ End ~