Annual Progress Report 2009

Submitted by

The Government of

[*GHANA*]

Reporting on year: **2009**

Requesting for support year: **2011**

Date of submission: ....15TH MAY, 2010....................

Deadline for submission: 15 May 2010

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

any hard copy could be sent to :

GAVI Alliance Secrétariat,
Chemin de Mines 2.
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.

Note: *Before starting filling out this form get as reference documents the electronic copy of the APR and any new application for GAVI support which were submitted the previous year.*

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

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

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

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

SUSPENSION/ TERMINATION
The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

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

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

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY
The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

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

ARBITRATION
Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.
For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.
The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application..

By filling this APR the country will inform GAVI about :
- *accomplishments using GAVI resources in the past year*
- *important problems that were encountered and how the country has tried to overcome them*
- *Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners*
- *Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released*
- *how GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.*

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

By signing this page, the Government hereby attest the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in page 2 of this Annual Progress Report (APR).

For the Government of [……………GHANA……………..]…… ………………………

Please note that this APR 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.

Minister of Health (or delegated authority):	**Minister of Finance (or delegated authority):**
Title: MINISTER OF HEALTH………..	Title: MINISTER OF FINANACE……
Signature: ……………………………………	Signature: ……………………………………
Date: 11TH MAY 2010……………	Date: …14TH May 2010…………

This report has been compiled by:

Full name .....DR. K. O. ANTWI-AGYEI..... Position......EPI MANAGER...................... Telephone.......233-302-678 078................ E-mail....epighana@africaonline.com.gh...	Full name .....DANIEL OSEI................ Position......DEPUTY DIRECTOR, BUDGET, POLICY PLANNING DIV.. Telephone...233 24 436 4221.................. E-mail...... dan.osei@ghsmail.org.............
Full name .... Position... Telephone.. E-mail..	Full name .... Position... Telephone.. E-mail...

ICC Signatures Page

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

We, the undersigned members of the immunisation Inter-Agency Co-ordinating Committee (ICC) 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.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

Name/Title	Agency/Organisation	Signature	Date
DR. GEORGE AMOFAH, DEPUTY DIRECTOR GENERAL & CHAIRMAN OF ICC	GHANA HEALTH SERVICE		
DR. FRANK NYONATOR, DIRECTOR PPME	GHANA HEALTH SERVICE		
DR. DANIEL KERTESZ, COUNTRY REPRESENTATIVE	WORLD HEALTH ORGANIZATION		
DR. YASMIN ALI HAQUE, COUNTRY REPRESENTATUVE	UNICEF		
W. A. MENSAH, CHAIRMAN, GHANA NATIONAL ROTARY POLIO PLUS COMMITTEE	ROTARY INTERNATIONAL		
DR. VICTORIA ADABAYERI	PAED. SOCIETY OF GHANA		
DR. K. O. ANTWI-AGYEI, EPI MANAGER	GHANA HEALTH SERVICE		

ICC may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

Comments from partners:
WE ARE PLEASED TO ENDORSE THE ANNUAL PROGRESS REPORT FOR 2009 AND RECOMMEND THAT SOCIAL MOBILIZATION ACTIVITIES ARE STEPPED UP TO FURTHER IMPROVE ON PERFORMANCE
……………………………………………………………………………………………………

Comments from the Regional Working Group:

..THE SUB-REGIONAL WORKING GROUP ORGANIZED A PEER REVIEW MEETING ON THE GAVI APR IN DAKAR FOR COUNTRY TEAMS. COMMENTS WERE RECEIVED FROM OTHER COUNTRY TEAMS AS WELL AS THE SRWG AND OTHER OFFICERS FROM WHO, UNICEF AND GAVI WHICH HAVE IMPROVED THE QUALITY OF THE APR .

HSCC Signatures Page

If the country is reporting on HSS

We, the undersigned members of the **National Health Sector Coordinating Committee (HSCC),** endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organisation	Signature	Date
CAMILLA CHRISTENSEN, HEALTH SECOR LEAD, (ON BEHALF OF HEALTH PARTNERS)	DANISH EMBASSY		14/5/10

HSCC may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

Comments from partners:

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Comments from the Regional Working Group:

………

………

………

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

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

Name: DR. CECILIA BENTSI…………………………………………

Post: CHAIRMAN……………………………………………………

Organisation:.……COALITION OF HEALTH NGOs……………………………..

Date: …14TH MAY, 2010……………………………………………………

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 to help implement the GAVI HSS proposal or cMYP (for Type B funding).

We, the undersigned members of the National Health Sector Coordinating Committee, ……………………………………… (insert name of committee) endorse this report on the GAVI Alliance CSO Support.

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.

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List of supporting documents attached to this APR

1. *Expand the list as appropriate;*
2. *List the documents in sequential number;*
3. *Copy the document number in the relevant section of the APR*

Document N°	Title	APR Section
	Calculation of ***[Country's]*** ISS-NVS support for 2011 *(Annex 1)*	1.1; 2.4; 3.7
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1. General Programme Management Component

1.1 *Updated baseline and annual targets (fill in Table 1 in Annex1-excell)*

The numbers for 2009 in Table 1 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2009.** The numbers for 2010-15 in Table 1 should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In the space below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

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

The slight changes are caused by mathematical projections arising from summation of various district level populations especially when the number of districts increased from 138 to 170 in 2009. The new levels are then projected with the National growth rate of 2.7%.

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

For 2008 "Demographic and Health Survey (DHS)" the Infant Mortality Rate reduced to 50 per 1000 live births compared to 64 per 1000 live births in 2003 DHS.

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

No change

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

No change

1.2 *Immunisation achievements in 2009*

Please comment on the achievements of immunisation programme against targets (as stated in last year's APR), the key major activities conducted and the challenges faced in 2009 and how these were addressed:

1.2.0 **Highlights of 2009 Achievements were as follows:**

1. No reported death from measles since 2003
2. Reduction of Neonatal tetanus cases
3. For the third 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%
4. Penta 3 coverage increased by 2% from 87% in 2008 to 89% in 2009. However, in terms of absolute numbers, 50,498 additional children were immunized: Penta 3 immunization

increased from 817,154 in 2008 to 867,652 in 2009.

5. The coverage of Penta 3 and other antigens in 2009 are shown below:

ANTIGEN	2008 Coverage	Target for 2009	2009 coverage	Remarks on target
BCG	967,579 (103%)	**100%**	**1,000,183 (104%)**	**exceeded**
OPV3	812,630 (92%)	**94%**	**861,220 (93%)**	**not achieved**
PENTA 3	817,154 (93%)	**94%**	867,652 (94%)	**achieved**
PENTA 1	**846,574 (96%)**	**96%**	**887,014 (96%)**	**achieved**
MEASLES	815,617 (92%)	**94%**	**865,472 (94%)**	**achieved**
YELLOW FEVER	811,012 (92%)	**94%**	**861,967 (93%)**	**not achieved**
TT2 (for pregnant women)	719,811 (76%)	**85%**	**783,284 (81%)**	**not achieved**

6. Challenges:

- **Three rounds of polio NIDs had to be conducted in 2009 in response to re-emergence of wild polio cases in Ghana due to importation** (from September-November 2008 there were 8 cases of confirmed wild polio virus from the Northern Region) : the campaigns pose a challenge to routine EPI
- **Cancellation of 2007 Immunization Services Support (ISS) reward for Ghana by the Global Alliance for Vaccines and Immunizations (GAVI) because of late submission of ISS application**
- **Poor cash flow to regions and districts (in 2008 districts received only 67% of approved budget)**
- **Weak district vehicle (the 2008 Ghana Health service report indicate an average vehicle age of 8.1 years compared to standard of 5 years)**

7. 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. We are very hopeful of reducing incidence of vaccine preventable diseses in Ghana as a means of contributing to achievement of Goal 4 of the MDGs.

Details of EPI performance are presented below:

1.2.1 *Demographic and Epidemiological Profile of Ghana*

Ghana shares common borders with Republics of Togo to the East, Burkina Faso to the North, and

La Cote d'Ivoire to the West. The South is bounded by the Gulf of Guinea. The country has a projected population (2009) of 23,855,922 based on the 2.7% annual growth rate indicated in the National Population and Housing Census conducted in March 2000. The country is divided into 10 administrative regions and 170 decentralized administrative districts consisting of about 2,925 health sub-districts.

Table 1.2.1 : Summary of health indicators

Indicator	2002	2003	2004	2005	2006	2007	2008
infant mortality rate per 1000 live births	57	64	64	64	64	64	50
under five mortality rate per 1000 live births	108	111	111	111	111	111	80
maternal mortality ratio per 100,000 live births	214	214	214	214	214	214	451
EPI coverage – Penta 3 (DPTHepBHib3)	77.9	76	76	85	84	88	87
EPI coverage – Measles	83.7	79	78	83	85	89	86
EPI Coverage - BCG	96	92	92	100	100	102	103
EPI coverage - OPV3 e	79	76	76	85	84	88	86
EPI Coverage - Yellow Fever	71	73	76	82	84	88	86
EPI Coverage - TT2+	68	66	62	71	68	71	76
AFP non polio rate (%)	2.4	1.44	1.49	1.76	1.65	1.7	2.4

NB: Coverage estimates in table above uses "birth cohort" as denominator and instead of "surviving infants"

1.2.2 *Immunization in Ghana*

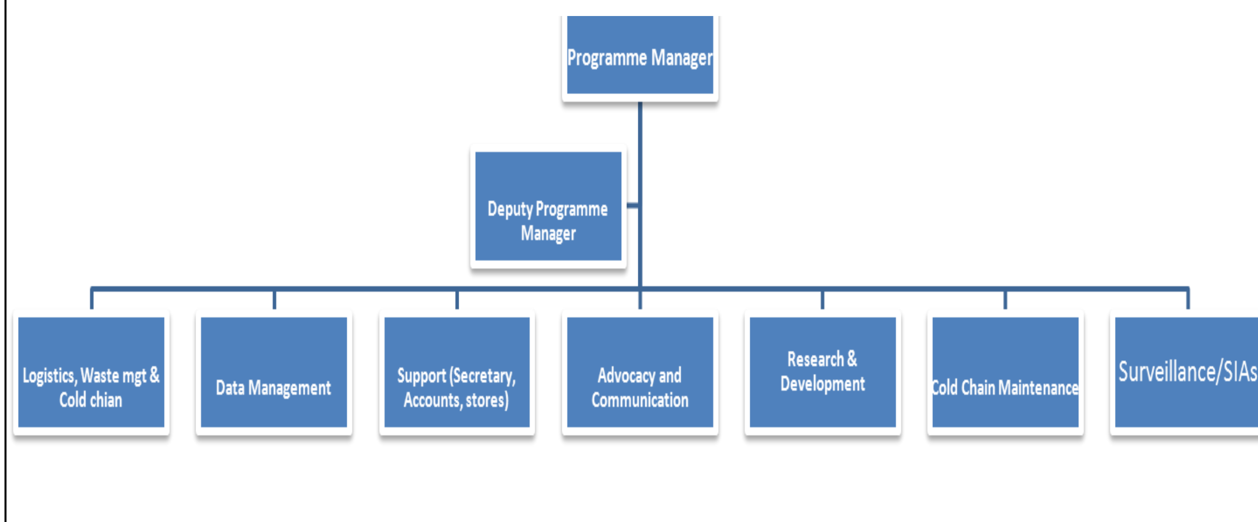
One of the major benchmark of health in Ghana is the immunization programme. The Expanded Programme on Immunization (EPI) is responsible for immunization in Ghana. The programme is within the Diseases Control Department (DCD) of the Public Health Division of the Ghana Health Service. It is headed by a Public Health Specialist and assisted by trained personnel who are specialists in areas that include logistics management, data management, cold chain management, injection safety, social mobilization and communication.

The mission of the programme is to contribute to the overall poverty reduction goal of the government through the decrease in the magnitude of vaccine-preventable diseases. This is carried out through the use of cost effective, efficacious and safe vaccines, new and under used vaccines and technologies to protect more people whilst contributing to the overall health systems strengthening in an integrated manner. Ghana has been at the forefront of showcasing immunization as the platform for health systems strengthening.

1.2.3 Programme Management and Coordination

The EPI Programme is managed by a public health specialist who is referred to as the Programme Manager. As stated already, there are a number of other specialists who are in charge of specific areas in the programme. In 2009, the programme had 10 officers and 3 drivers at the national office. These are shown in the organizational structure below;

Figure 1 : Organizational Structure of National EPI



1.2.4 *Global Coverage Goals for National Immunization Programmes*

- The Global Alliance for Vaccines and Immunization (GAVI) 2000: 80% of Penta 3 coverage in every district of 80% of developing countries by 2005
- United Nations General Assembly Special Session (UNGASS) 2002: Full immunization of children less than one year of age with Penta 3 coverage at 90% nationally, with at least 80% coverage in every district by 2010.
- Millennium Development Goal 4 – To reduce the 1990 U5MR by 2/3 by 2015

We believe that these goals are based on levels which make epidemiological impact!

1.2.5 *Programme Objectives for 2009*

- The Policy goal of EPI is to protect all children and pregnant women living in Ghana against vaccine preventable diseases. The specific objectives for the programme set with reference to the global goals were:
- To attain an operational target of 90% nationally for all antigens
- More than 80% of districts to attain Penta3 coverage of 80% and above
- To reduce morbidity and mortality due to vaccine-preventable diseases
- To maintain zero mortality due to measles
- To maintain a polio free Ghana
- To improve AEFI and Vitamin A reporting
- To commemorate Child Health Promotion Week (CHPW)
- To support hard-to-reach districts to improve routine immunization coverage
- To improve technical support and supervision at all levels
- To prepare for the introduction of New vaccines (Pneumococcal vaccine introduction) in 2012
- To reduce burden of diseases in under 5 through **integration and collaborative** efforts of all stakeholders (reduced measles and polio morbidity and mortality)
- To encourage use of data for planning and management decision-making in at least 25% of districts in the country

1.2.6 Key Strategies for 2009

The key strategies used by the programme were the following;

- Improved access through strengthening of RED approach in all districts
- Improved quality of service through strengthening of supervision and monitoring
- Strengthened integration with other Child health related programmes –CHPW, IMCH, Polio NID etc.
- Training in data generation and use for decision-making.
- Improved surveillance systems through regular review meetings, clinician's sensitization etc.
- Strengthened collaborations with stakeholders to improve surveillance performances

- The EPI Programme as part of its strategies to improve the quality of data also:
- Held RED orientation and micro planning meetings with regions
- Supported more activities on capacity building for cold chain and vaccine management in all the districts
- Focused attention on supervision in the districts

1.2.7 Main Interventions carried out in 2009

- The EPI Programme was able to do the following at the end of the year;
- Nationwide routine vaccination throughout the year
- Outreach/Mop-up vaccination services
- Market days/Lorry park vaccinations
- Conducted three rounds of National Immunization Days (NIDs)
- Commemorated CHPW nationwide in May

1.2.8 Service Delivery Strategies

In order to improve routine EPI coverage, a number of innovative strategies were used. Static immunization was the main service delivery strategy. Every health facility has a static clinic responsible for daily routine immunizations. The availability of such clinics in the country has made access to routine immunization easier. Where such facilities are not available outreach programmes are used. Outreach immunization services are organized to reach children in communities where static clinics are not available. The outreach program has contributed immensely towards bridging the gap between communities with health facilities and those who do not have. Thus, increasing access to EPI services to all eligible children and women. Mop up are done in areas with low coverage and difficult to reach areas (Areas not accessible during the rainy season) with the aim of reaching every child. Transit point vaccination including vaccinations done at Lorry parks, markets, churches, mosques etc was also used. Campaigns were also conducted to reach out to all eligible groups.

1.2.9 Routine EPI Performance in 2009

1.2.9.1 EPI Target Population

EPI monthly and annual target population for children less than 1 year using 4% of the total population is shown in the table below.

Table : EPI target population for 2008/2009

Regions	2008		2009	
	Monthly Target	Annual Target	Monthly Target	Annual Target
Ashanti	15,736	188,837	16,077	192,925
Brong-Ahafo	7,373	88,476	7,615	91,375
Central	6,274	75,285	6,405	76,866
Eastern	7,848	94,181	7,958	95,500
Greater Accra	13,669	164,028	14,270	171,245
Northern	7,570	90,838	7,788	93,456
Upper East	3,347	40,170	3,601	43,217
Upper West	2,199	26,393	2,237	26,842
Volta	6,339	76,073	6,453	77,437
Western	8,254	99,045	8,518	102,214
Ghana	78,611	943,326	80,923	971,078

1.2.10 Timeliness of Reports

A total of Two thousand and forty (2,040) reports expected from 1st January to 31st December 2009 from districts have been received. Out of these reports exactly 1,893 were received on time representing 93 % timeliness. This shows a significant improvement over 2008 where 86% of reports were timely. Table 3 shows the timeliness and completeness of reports:

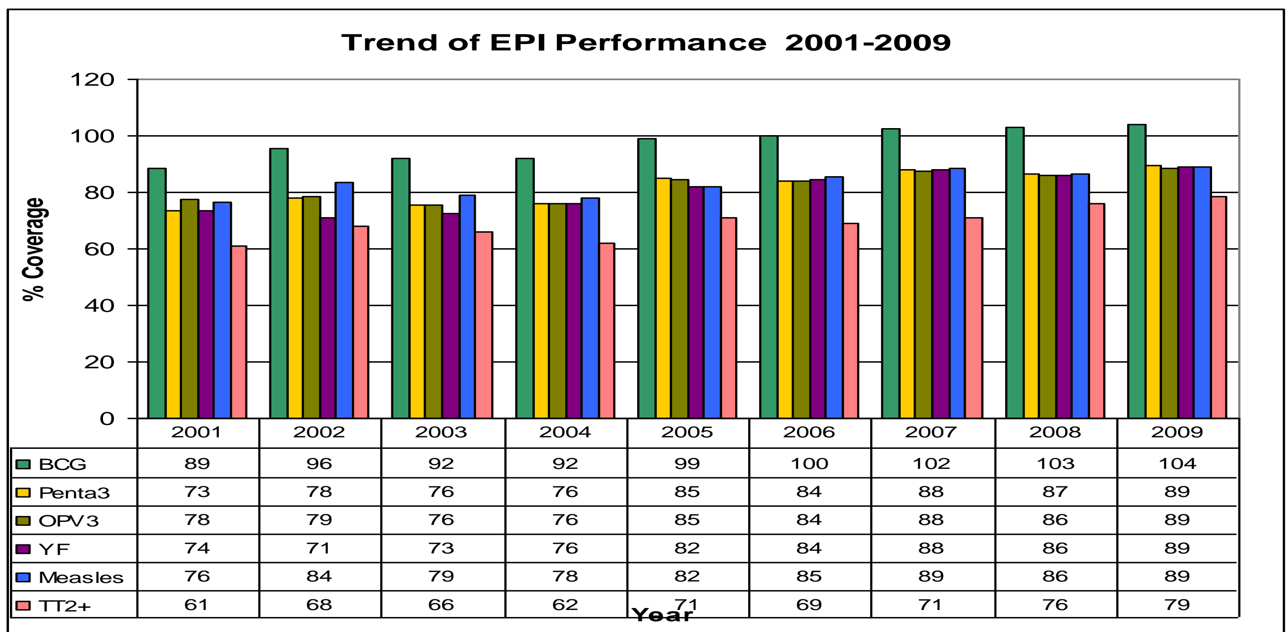
Table : Timeliness and Completeness of districts' Reports

Timeliness and Completeness of districts' Reports							
Regions	No of Districts	Total reports expected Jan-Dec	No Timely	%Timeliness	No Late	% Late	% Complete
Ashanti	27	324	317	98	7	2	100
Brong-Ahafo	22	264	256	97	8	3	100
Central	17	204	197	97	7	3	100
Eastern	22	264	264	100	0	0	100
Greater Accra	10	120	80	67	40	33	100
Northern	19	228	226	99	2	1	100
Upper East	9	108	77	71	31	29	100
Upper West	9	108	103	95	5	5	100
Volta	18	216	190	88	26	12	100
Western	17	204	183	90	21	10	100
Ghana	170	2040	1893	93	147	7	100

1.2.11 Immunization Coverage

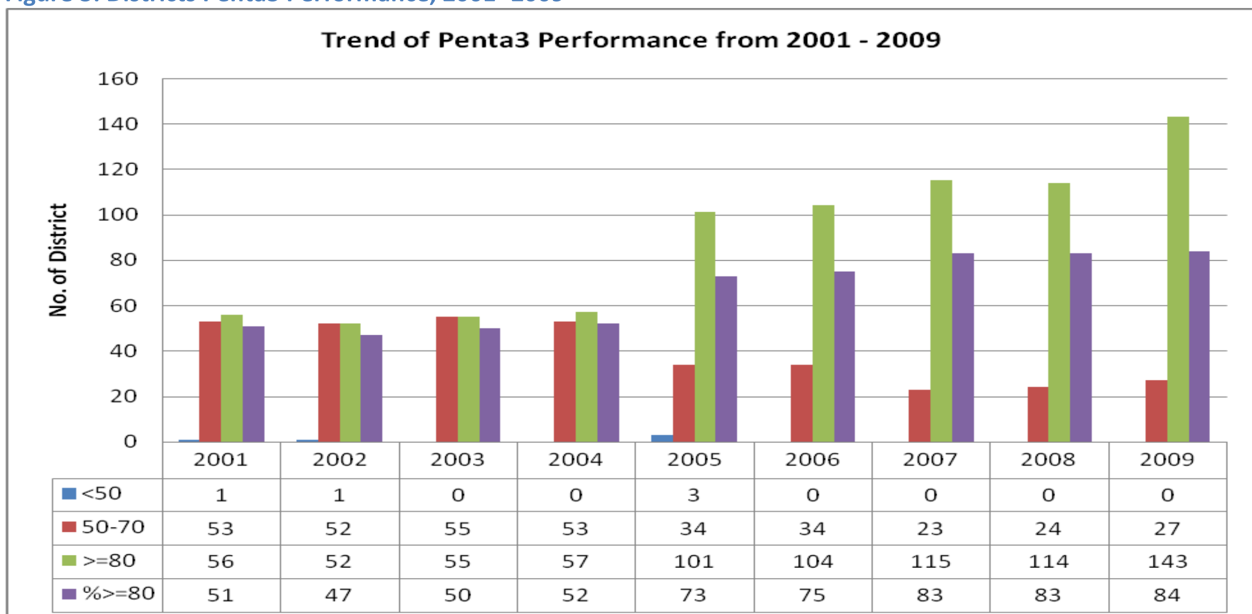
The EPI Programme recorded higher coverages in 2009 than in 2008 in all antigens. For Penta 3, the extra children vaccinated were 50,498. It was only in BCG that the programme achieved its target of 90%. The rest of the antigens performed below the set target as shown in the figure below.

Figure 2: EPI Performance, 2001-2009



	2001	2002	2003	2004	2005	2006	2007	2008	2009
BCG	89	96	92	92	99	100	102	103	104
Penta3	73	78	76	76	85	84	88	87	89
OPV3	78	79	76	76	85	84	88	86	89
YF	74	71	73	76	82	84	88	86	89
Measles	76	84	79	78	82	85	89	86	89
TT2+	61	68	66	62	71	69	71	76	79

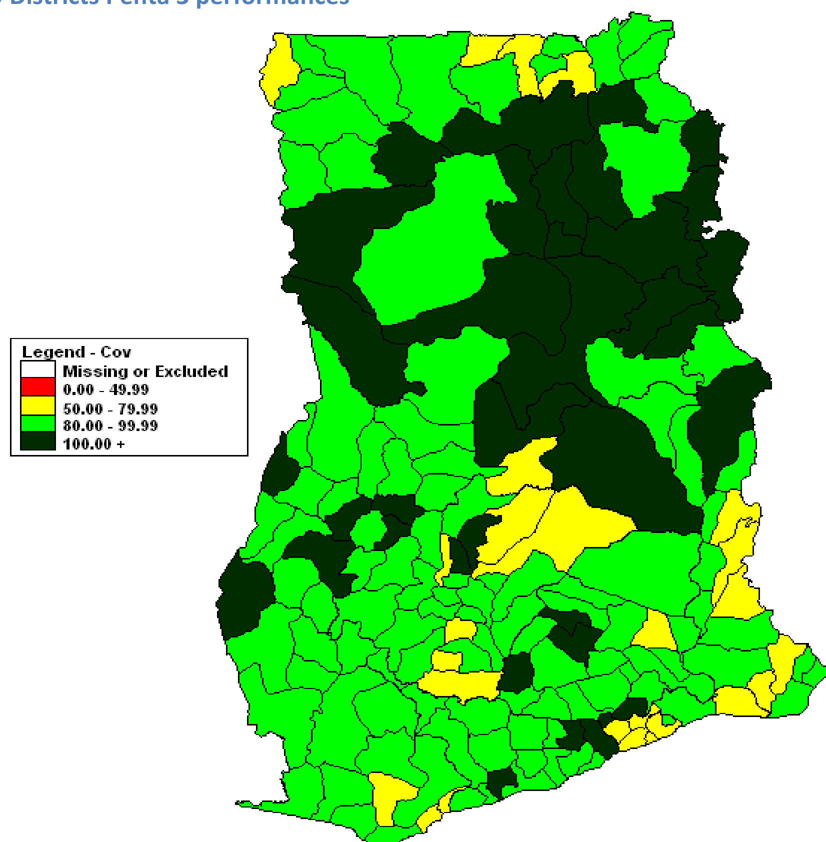
Figure 3: Districts Penta3 Performance, 2001- 2009



	2001	2002	2003	2004	2005	2006	2007	2008	2009
<50	1	1	0	0	3	0	0	0	0
50-70	53	52	55	53	34	34	23	24	27
>=80	56	52	55	57	101	104	115	114	143
%>=80	51	47	50	52	73	75	83	83	84

Figure 3 shows Penta3 performance by districts. From the figure, no districts had less than 50% Penta 3 coverage. Only 27 districts recorded coverages between 50 and 70%. A majority of 143 districts had more than 80% coverage. The proportion of districts with Penta 3 coverage above 80% for the 3rd successive year is above 80% though the number of districts has been increased. The proportion rose from 83% in 2008 to 84% in 2009.

Figure 4: 2009 Districts Penta 3 performances



The figure above illustrates the geographical distribution of Penta 3 performance. As indicated on the map, no district had less than 50% coverage. The few districts that had between 50 and 80% coverage are scattered in Ashanti, Greater Accra, Eastern, Western, Volta, Upper East and Upper West Regions.

Table : Trend of Regional Penta 3 Performance 2007 - 2009

3 YEAR TREND OF REGIONAL PENTA3 PERFORMANCE						
Region	2007		2008		2009	
	performance	%Cov	Performance	% Cov	Performance	% Cov
Ashanti	131,988	72	144,964	77	161,519	84
Brong-Ahafo	86,516	100	86,085	97	86,810	95
Central	68,285	93	69,426	92	74,239	97
Eastern	86,253	93	87,568	93	90,261	95
Greater Accra	106,549	68	112,021	68	124,509	73
Northern	109,293	124	103,970	114	114,949	123
Upper East	40,333	102	38,096	95	45,790	106
Upper West	24,312	94	23,095	88	24,192	90
Volta	62,508	84	63,777	84	64,225	83
Western	89,042	93	88,152	89	90,596	89
National	805,079	88	817,154	87	867,652	89

The table above shows a three year trend of Penta 3 performance by region. From the table, the number of children vaccinated increases each year. The 89% coverage achieved in 2009 is an improvement on the 87% recorded in 2008. In 2009, the regional coverages ranged from 73% in Greater Accra Region to 123% in Northern Region. It is evident from the table that denominators for regions are still problematic as some regions are still performing above 100%.

Table 2: Trend of Regional Measles Performance 2007 – 2009

3 YEAR TREND OF REGIONAL MEASLES PERFORMANCE 2007-2009						
Region	2007		2008		2009	
	performance	%Cov	Performance	% Cov	Performance	% Cov
Ashanti	141,915	78	152,326	81	167,991	87
Brong-Ahafo	88,029	102	85,449	97	85,775	94
Central	69,331	94	71,091	94	75,384	98
Eastern	88,637	96	89,533	95	89,797	94
Greater Accra	108,739	69	110,254	67	126,666	74
Northern	102,856	116	99,213	109	111,902	120
Upper East	40,567	102	37,414	93	45,755	106
Upper West	25,307	98	23,744	90	24,304	91
Volta	58,836	79	59,934	79	60,645	78
Western	87,866	92	86,659	87	87,031	85
National	812,083	89	815,617	86	865,472	89

Nationally, the performance for measles has improved significantly from 86% in 2008 to 89% in 2009. The coverages ranged from 74% in Greater Accra Region to 120% in Northern Region. The absolute figures also increased from 815,617 in 2008 to 865,472 in 2009. However, the proportion of children vaccinated decreased in Brong-Ahafo, Eastern, Volta and Western Regions.

Table 3: Vitamin A Supplementation in Children 6-59 months

	2008			2009		
Regions	**Target**	**Performance**	**% Coverage**	**Target**	**Performance**	**% Coverage**
Ashanti	849,765	116,650	14	868,163	124,609	14
B-Ahafo	398,142	151,787	38	411,186	66,441	16
Central	338,781	135,729	40	345,895	49,467	14
Eastern	423,817	165,686	39	429,750	74,757	17
Gt. Accra	738,127	171,520	23	770,605	85,404	11
Northern	408,772	143,468	35	420,554	48,099	11
Upper East	180,764	62,644	35	194,475	31,550	16
U. West	118,769	30,859	26	120,788	14,258	12
Volta	342,212	118,696	35	348,468	42,249	12
Western	445,703	121,304	27	459,965	47,333	10
National	4,244,850	1,218,343	29	4,369,849	578,358	13

The above table is the routine vitamin A supplementation in children 6 – 59 months. From the table, there was a significant reduction in the absolute figures and the proportion of children supplemented. In 2008, out of a target of 4,244,850 children, about 1,218,343 were supplemented giving a proportion of 29%. In 2009 however, out of a target of 4,369,84 children, only 578,358 were dosed giving a 13% coverage. The lowest of 10% was recorded in Western Region while Eastern Region achieved the highest of 17%.

Table : Vitamin A Supplementation in post-partum women

Regions	2008			2009		
	Target	Performance	% Coverage	Target	Performance	% Coverage
Ashanti	188,837	43,776	23	192,925	31,191	16
B-Ahafo	88,476	33,295	38	91,375	18,395	20
Central	75,285	43,329	58	76,866	54,162	70
Eastern	94,181	43,941	47	95,500	53,185	56
Gt. Accra	164,028	68,340	42	171,245	57,916	34
Northern	90,838	46,522	51	93,456	44,461	48
Upper East	40,170	18,740	47	43,217	24,381	56
U. West	26,393	14,888	56	26,842	16,469	61
Volta	76,073	38,947	51	77,437	26,319	34
Western	99,045	28,307	29	102,214	28,244	28
National	943,326	380,085	40	971,078	351,989	36

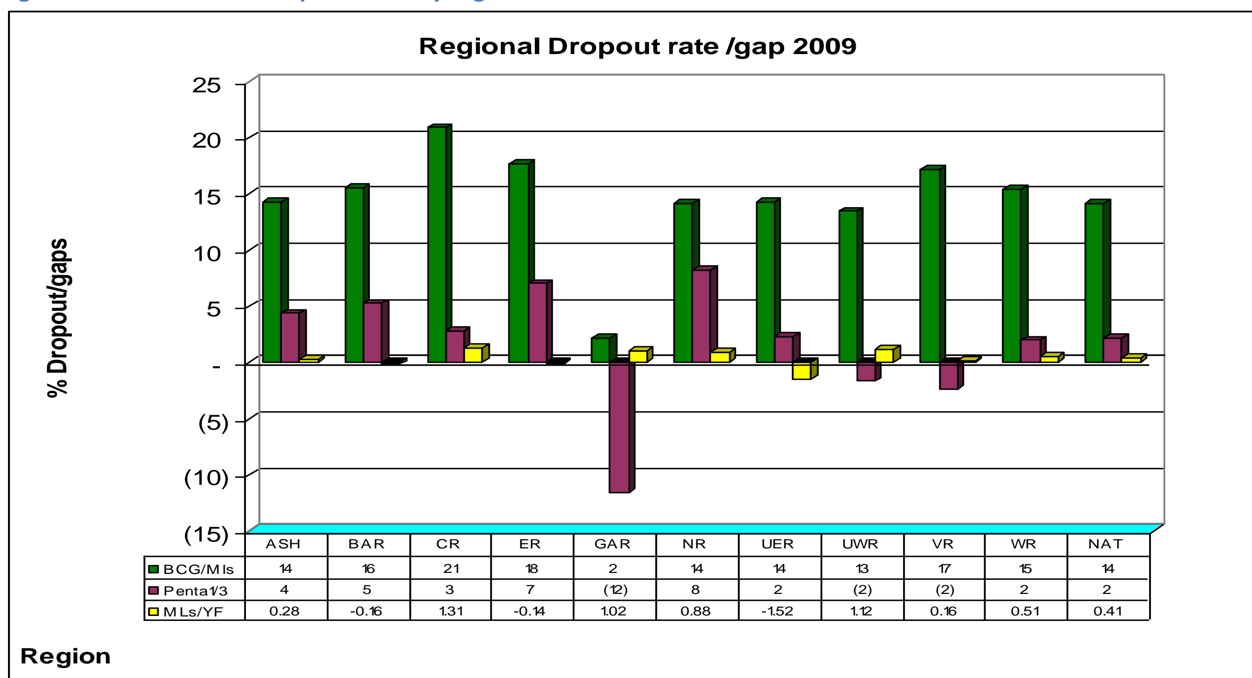
Vitamin A supplementation in post-partum mothers was also not encouraging as in children 6-59 months. From table 7, there was a reduction in post-partum vitamin A in 2009 both in absolute figures and coverage. Whereas 40% was achieved in 2008, only 36% was managed in 2009. The coverages ranged from 16% in Ashanti Region to 70% in Central Region.

Table : Un-vaccinated Children in 2009

Region	Target 0-11month	BCG		Penta3		Measles	
		Vacc.	Not vacc.	Vacc	Not vacc.	Vacc	Not Vacc.
Ashanti	192,925	195,953	(3,028)	161,519	31,406	167,991	24,934
Brong Ahafo	91,375	101,532	(10,157)	86,810	4,565	85,775	5,600
Central	76,866	95,270	(18,404)	74,239	2,627	75,384	1,482
Eastern	95,500	109,099	(13,599)	90,261	5,239	89,797	5,703
Gt. Accra	171,245	129,499	41,746	124,509	46,736	126,666	44,579
Northern	93,456	130,377	36,921)	114,949	(21,493)	111,902	(18,446)
Upper East	43,217	53,382	10,165)	45,790	(2,573)	45,755	(2,538)
Upper West	26,842	28,082	(1,240)	24,192	2,650	24,304	2,538
Volta	77,437	73,173	4,264	64,225	13,212	60,645	16,792
Western	102,214	102,883	(669)	90,596	11,618	87,031	15,183
National	971,078	1,008,183	(37,105)	867,652	103,426	865,472	105,606

Utilization of immunization services has remained a challenge in the Ghana Health Service. About 37,105 extra children were given BCG which indicates that more children have access to immunization services. On the contrary, a considerable number of children did not receive measles. This shows that there is problem with access to immunization services and that more efforts should be made to improve utilization of services.

Figure 5: Immunization drop-out rate by region



The acceptable maximum drop-out rate for Pentavalent Vaccine is between 0-5 percent. Nationally the Penta dropout is within the acceptable range, however, Greater Accra, Upper West and Volta Region recorded negative drop-out. The acceptable range for measles and YF and BCG is between 0-10percent. Most regions have recorded unacceptable rate and need to work on the data in 2010.

Table : Regional Vaccine Wastage Rates 2009

Accepted rate	50%	5%	25%	15%	15%	25%
Region	BCG	Penta	OPV	Measles	YF	TT
Ashanti	39%	4%	26%	24%	18%	17%
Brong Ahafo	35%	3%	22%	31%	16%	23%
Central	33%	6%	27%	26%	23%	24%
Eastern	43%	8%	28%	30%	23%	47%
Gt. Accra	45%	9%	32%	28%	21%	34%
Northern	21%	1%	17%	14%	12%	8%
Upper East	49%	1%	24%	44%	26%	44%
Upper West	51%	4%	28%	36%	29%	39%
Volta	52%	6%	28%	41%	25%	42%
Western	41%	5%	24%	25%	20%	32%
National	40%	5%	26%	28%	20%	30%

Table above shows the vaccine wastage rates for all antigens by region. From the table, the national wastage rates for BCG and Penta were within the acceptable rate. The country however exceeded the acceptable rates for OPV, Measles, Yellow fever and Tetanus Toxoid. On the Penta vaccine, the regional wastage rates range from 1% in Northern and Upper East Regions to 9% in the Greater Accra region.

If targets were not reached, please comment on reasons for not reaching the targets:

Targets were met for most antigens but for OPV3. Measles and Yellow fever targets were narrowly missed. This could be attributed to pressure of work due to the unplanned conduct of 3 rounds of NIDs in response to polio outbreak the previous year. Fund flow to the district remain poor and the 2007 ISS funds which was to be used to mitigate such events was cancelled for Ghana because of late submission of application for ISS which arose from mis-understanding. Poor funding is a real issue on the ground and Ghana continues to do well because of the decentralization system and dedication of staff to EPI (in some instances staff use their own money for outreaches hoping for refunds later)

1.3 Data assessments

1.3.4 Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)[1].

The main problem with routine data is the denominator. Whereas estimation of regional and district 0 – 11 months target group is based on 4% of the population across board it is known that growth rates vary among the various regions and districts. Thus whereas some regions (like Ashanti and Greater Accra) and some districts are disadvantaged with a high denominator the Northern region has a lower denominator and is always achieving coverages of over 100% even though they it has a high number of unvaccinated children. Such discrepancies show up when coverage survey results are compared with administrative data.

1.3.5 Have any assessments of administrative data systems been conducted from 2008 to the present? [YES / NO]. If YES:

Please describe the assessment(s) and when they took place.

Health System data quality audit which covered EPI data in 2009
A data quality audit of the Ghana Health Service (GHS) was carried out between 12th October and 2nd November 2009 for three program areas: EPI, Nutrition and Reproductive Health by a team of 10 trained national auditors headed by the Principal Auditor, Dr Agana Nsiire. A four-day training took place earlier (22 – 25 September) including a field pretest in Dodowa in the Dangme West District. The objectives were to assess the quality of data and the monitoring and evaluation (M&E) functional systems with a view to determining any gaps based on which to make recommendations to improve data quality and management. Any best practices found would also be highlighted for promotion. Tools used were the GAVI Data Quality Audit Excel Workbook for quality of data, the USAID Data Quality Audit Excel Workbook for M&E system functions and logbooks for recording all details and reasons for observed gaps or best practices.

The key recommendations are as follows.

- Reorientation of managers and staff at all levels on M&E and data management principles

[1] *Please note that the WHO UNICEF estimates for 2009 will only be available in July 2010 and can have retrospective changes on the time series*

and

- practices followed by closer supervision at all levels are needed to ensure quality management
- and effective use of data and information.
- Human and material capacity at all levels should be strengthened to manage DHIMS better. This
- includes numbers and skills of personnel and the upgrading of the DHIMS software to collect
- and disseminate data promptly for program activities. Parallel reporting should stop.
- PPME and programs should collaborate to write SOPs detailing data management procedures
- and channels and reporting and feedback deadlines. In this connection Nutrition should be
- supported to develop a comprehensive M&E plan detailing growth monitoring variables and
- other indicators clearly and how they should be collected, analyzed, interpreted and decisions
- taken. Other programs should review and update their M&E plans to respond to important gaps
- found in this study and during their monitoring rounds.
- Too many forms, too many variables, repeated variables on different forms take so much staff
- time and result in many errors. In the short term these forms should be reviewed to capture
- fewer and critical indicators for each program area. In the long term transactional data with
- PDAs or similar tools should be used to cut out the hundreds of reporting forms for intermediate
- collation.
- A system of adequate supply of data tools should be operational (tally books, registers etc.).
- Revised tools should not go out patchily over a long period.
- The energy, time and money spent in data collection and reporting is too much waste if not
- matched by effective supervision to ensure that quality data is collected, collated, information
- generated and interpreted and PROMPT action taken as necessary. Supervision is all the more
- important in a system known for its very poor reading culture. This should be aggressively
- pursued by the Ghana Health Service Management partly through adequate budgetary allocation
- both for services and for M&E activities.
- Maintenance of electronic hard and software should be considerably improved to safeguard data
- and facilitate data management processes

Report included in supporting documents

1.3.6 Please describe any activities undertaken to improve administrative data systems from 2008 to the present.

1. Training of regional and district teams in data management
2. Regions are encouraged to conduct data quality audits
3. Monthly feedback on data to regions and districts
4. Facilitative supervision to districts
5. Use of tally books for recording immunizations
6. Procurement of computers to support Regional EPI Coordinators

1.3.7 Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

1. Data Quality Audit in 2011
2. Training of new staff in the data management tools (DVDMT)
3. Quarterly review meetings
4. Procurement of computers and Personal Digital Assistants (PDAs)

1.4 *Overall Expenditures and Financing for Immunisation*

The purpose of Table 2 is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Table 2: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$.

Expenditures by Category	**Expenditure Year 2009**	**Budgeted Year 2010**	**Budgeted Year 2011**
Traditional Vaccines[2]	$2,552,322	$2,614,934	1,838,496
New Vaccines	$11,096,088	$38,541,612	22,627,149
Injection supplies with AD syringes	1,237,036	1,603,788	1,047,378
Injection supply with syringes other than ADs			300,000
Cold Chain equipment	1,200,000	1,200,000	600,000
Operational costs	13,295,662	14,000,000	16,000.000
Other (please specify)			
Total EPI	29,187,294	57,960,334	42,413,023
Total Government Health	$519,193,000	$533,820,000	$592,343,000

Exchange rate used	$1=GH¢1.4

Please describe trends in immunisation 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 immunisation program over the next three years; whether the funding gaps are manageable, challenging, 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.

Planned construction of cold rooms could not be done because of inadequate funds.

1.5 *Interagency Coordinating Committee (ICC)*

How many times did the ICC meet in 2009? ....4 times................

Please attach the minutes **(Document N°.....)** from all the ICC meetings held in 2009, including those of the meeting endorsing this report.

[2] *Traditional vaccines: BCG, DTP, OPV (or IPV), Mealses 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.*

List the key concerns or recommendations, if any, made by the ICC on items 1.1 through 1.4 The denominator problem is of concern to the ICC. The ICC hopes the Health Sector will address the problem as it is not limited to the EPI alone.

Are any Civil Society Organisations 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.

1.6 *Priority actions in 2010-2011*

What are the country's main objectives and priority actions for its EPI programme for 2010-2011? Are they linked with cMYP?

1. Strengthening routine immunization 2. Conducting polio NIDs 3. Conducting Measles campaign 4. Child Health Promotion week 5. Construction of cold rooms 6. Preparation for introduction of pneumococcal, rotavirus vaccines and second dose measles 7. Validation of MNT Elimination The priority actions are linked to the CMYP. The only exception is the polio NIDs which had to be conducted in response to polio outbreak in order to break transmission.

2 Immunisation Services Support (ISS)

2.1 Report on the use of ISS funds in 2009

Funds received during 2009: US$...............................$........NIL......................
Remaining funds (carry over) from 2008: US$...............................$.52,072.74...................
Balance carried over to 2010: US$..-11,330.68.............................

Please report on major activities conducted to strengthen immunisation using ISS funds in 2009.

- The Upper East Region was supported construction of cold rooms in preparation for the introduction of new vaccines
- Cold chain spare parts were also procured for maintenance of effective cold chain
- Two districts in the Northern Region were provided with computers to improve on their data management
- Part of the funds was used to establish letters of credit to enable us pre-finance procurement of 21 TCW 2000 refrigerators for use by sub-districts. This is part of the expansion of cold nchain iin preparation for introduction of new vaccines USAID will refund this expenditure and the funds will be available for use in 2010

2.2 Management of ISS Funds

Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2009 calendar year? **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of ISS funds.

Part B: briefly describe the financial management arrangements and process used for your ISS funds. Indicate whether ISS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of ISS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the ICC in this process.

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 work-plan 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.

2.3 *Detailed expenditure of ISS funds during the 2009 calendar year*

Please attach a detailed financial statement for the use of ISS funds during the 2009 calendar year **(Document N°..."FINANCIAL REPORT ON GAVI EPI FUNDS – 2009".......).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your ISS programme during your government's most recent fiscal year, this must also be attached **(Document N°.....................).**

2.4 *Request for ISS reward*

In June 2009, the GAVI Board decided to improve the system to monitor performance of immunisation programmes and the related calculation of performance based rewards. Starting from 2008 reporting year, a country is entitled to a reward:

a) if the number of children vaccinated with DTP3 is higher than the previous year's achievement (or the previous high), and

b) if the reported administrative coverage of DTP3 (reported in the JRF) is in line with the WHO/UNICEF coverage estimate for the same year.

If you may be eligible for ISS reward based on DTP3 achievements in 2009 immunisation programme, estimate the $ amount by filling Table 3 in Annex 1.[3]

Table 3 in Annex 1 duly filled : Ghana vaccinated 50,498 extra children with the Penta 3 vaccine and is therefore qualified to receive a rewards of $1,010,000.00

[3] The Monitoring IRC will review the ISS section of the APR after the WHO/UNICEF coverage estimate is made available.

3.0 New and Under-used Vaccines Support (NVS)

3.1 Receipt of new & under-used vaccines for 2009 vaccination programme

Did you receive the approved amount of vaccine doses that GAVI communicated to you in its decision letter (DL)? Fill Table 4.

Table 4: Vaccines received for 2009 vaccinations against approvals for 2009

	[A]		[B]	
Vaccine Type	**Total doses for 2009 in DL**	**Date of DL**	**Total doses received by end 2009 ***	**Total doses of postponed deliveries in 2010**
DPT-HepB+Hib (2 dose)	3,272,100	8th Sept. 2008	2,454,000	818,100
Yellow Fever (5-dose)	804,500	8th Sept. 2008	804,500	0

* *Please also include any deliveries from the previous year received against this DL*

If numbers [A] and [B] are different,

What are the main problems encountered? *(Lower vaccine utilisation than anticipated? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date?...)*	• For **DPT-HepB+Hib (Penta) e**xcessive stocking was anticipated • Some quantity of Pentavalent vaccine expired due to vaccine management problems in the cold room where stocks to expire later were packed in front of stocks with earlier expiry dates • For some shipments we had to accept 10-dose yellow fever instead of 5-dose due to unavailability of the latter
What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF SD)	• We have adjusted our requirement of Penta vaccine for 2011 by estimating the stock at the beginning of 2010 in the excel sheet well. The teams from EPI and UNICEF are now coordinating well and taking cognisance of the GAVI decision letter in planning for vaccines. • We have re-scheduled delivery of some vaccines meant for 2010 to 2011 to prevent over-stocking • Packing of vaccines in the cold room has been re-organized with improved documentation

3.2 Introduction of a New Vaccine in 2009 *NOT APPLICABLE*

3.2.1 If you have been approved by GAVI to introduce a new vaccine in 2009, please refer to the vaccine introduction plan in the proposal approved and report on achievements. *NOT APPLICABLE*

Vaccine introduced:	....
Phased introduction [YES / NO]	Date of introduction ....
Nationwide introduction [YES / NO]	Date of introduction ....
The time and scale of introduction was as planned in the proposal? If not, why?	•

3.2.2 Use of new vaccines introduction grant (or lumpsum) *NOT APPLICABLE*

Funds of Vaccines Introduction Grant received:	US$	Receipt date:

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant.

Please describe any problems encountered in the implementation of the planned activities:

Is there a balance of the introduction grant that will be carried forward? [YES] [NO]
If YES, how much? US$......................

Please describe the activities that will be undertaken with the balance of funds:

3.2.3 Detailed expenditure of New Vaccines Introduction Grant funds during the 2009 calendar year *NOT APPLICABLE*

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2009 calendar year **(Document N°..................).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

3.3 Report on country co-financing in 2009 (if applicable)

Table 5: Four questions on country co-financing in 2009

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 2009	Actual Payments Date in 2009	Proposed Payment Date for 2010
	(month/year)	(day/month)	
1st Awarded Vaccine (specify) YELLOW FEVER	JUNE 2009	NOT PAID	AUGUST 2010
2nd Awarded Vaccine (specify) PENTA	JUNE 2009	DEC 2009	
3rd Awarded Vaccine (specify)			

Q. 2: Actual co-financed amounts and doses?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (specify) YELLOW FEVER	395,500	513,100
2nd Awarded Vaccine (specify) PENTA	330,000	413,500
3rd Awarded Vaccine (specify)		

Q. 3: Sources of funding for co-financing?
1. Government $330,000.00
2. Donor (specify) : The donor funding is part of the "Multi-Donor Budget Support (MDBS)" of the Government. No donor donor specifically support co-financing
3. Other (specify)

Q. 4: What factors have accelerated, slowed or hindered mobilisation of resources for vaccine co-financing?
1. .Increasing wage bill
2. .Competition from emerging diseases such as H1N1 and/or avian influenza
3. .Natural disasters like flooding in the Northern parts of the country
4. .Conflicts in some parts of the country

If the country is in default please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy http://www.gavialliance.org/resources/9___Co_Financing_Default_Policy.pdf

Ghana's part of the 2009 co-payment for yellow fever is still pending and would be paid this year (2010) as part of our overall co-payment for 2010. The non payment was due to some confusion over cost estimates with UNICEF supply Division which has been resolved.

3.4 *Effective Vaccine Store Management/Vaccine Management Assessment*

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? *[mm/yyyy]* *MAY, 2001*

If conducted in 2008/2009, please attach the report. (**Document N°**......................)
An EVSM/VMA report must be attached from those countries which have introduced a New and Underused Vaccine with GAVI support before 2008.
Was an action plan prepared following the EVSM/VMA? *[YES / NO]*

If yes, please summarise main activities to address the EVSM/VMA recommendations and their implementation status.

When is the next EVSM/VMA* planned? *[mm/yyyy] 2010/2011*

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

3.5 *Change of vaccine presentation*

If you would prefer during 2011 to receive a vaccine presentation which differs from what you are currently being supplied (for instance, the number of doses per vial; from one form (liquid/lyophilised) to the other; ...), please provide the vaccine specifications and refer to the minutes of the ICC meeting recommending the change of vaccine presentation. If supplied through UNICEF, planning for a switch in presentation should be initiated following the issuance of Decision Letter for next year, taking into account country activities needed in order to switch as well as supply availability.

Please specify below the new vaccine presentation:

Ghana has already received approval to switch from 2 dose lyophilized Penta Vaccine to one dose fully liquid Penta vaccine. Stocks of the liquid shall be received as soon as our current stocks of lyophilised vaccines are exhausted.

Please attach the minutes of the ICC meeting **(Document N°................)** that has endorsed the requested change.

3.6 *Renewal of multi-year vaccines support for those countries whose current support is ending in 2010* NOT APPLICABLE

If 2010 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support starting from 2011 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby request for an extension of GAVI support for *.........................[vaccine type(s)]* vaccine for the years 2011-*.........[end year].* At the same time it commits itself to co-finance the

procurement of ....*[vaccine type(s)]* vaccine in accordance with the minimum GAVI co-financing levels as summarised in Annex 1.

The multi-year extension of ....*[vaccine type(s)]* vaccine support is in line with the new cMYP for the years .... *[1st and last year]* which is attached to this APR **(Document N°..............).**

The country ICC has endorsed this request for extended support of ....*[vaccine type(s)]* vaccine at the ICC meeting whose minutes are attached to this APR. **(Document N°....................)**

3.7 Request for continued support for vaccines for 2011 vaccination programme

In order to request NVS support for 2011 vaccination do the following:

1. Go to Annex 1 (excel file)
2. Select the sheet corresponding to the vaccines requested for GAVI support in 2011 (e.g. Table4.1 HepB & Hib; Table4.2 YF etc)
3. Fill in the specifications of those requested vaccines in the first table on the top of the sheet (e.g. Table 4.1.1 Specifications for HepB & Hib; Table 4.2.1 Specifications for YF etc)
4. View the support to be provided by GAVI and co-financed by the country which is automatically calculated in the two tables below (e.g. Tables 4.1.2. and 4.1.3. for HepB & Hib; Tables 4.2.2. and 4.2.3. for YF etc)
5. Confirm here below that your request for 2011 vaccines support is as per Annex 1:

[YES, I confirm**]** **/** **[NO**, I don't**]**

If you don't confirm, please explain:

4. Injection Safety Support (INS)

In this section the country should report about the three-year GAVI support of injection safety material for routine immunisation. In this section the country should not report on the injection safety material that is received bundled with new vaccines funded by GAVI.

4.1 Receipt of injection safety support in 2009 (for relevant countries)

Are you receiving Injection Safety support in cash *[YES/NO]* or supplies *[YES/NO]* ?

If INS supplies are received, please report on receipt of injection safety support provided by the GAVI Alliance during 2009 (add rows as applicable). NOT APPLICABLE

Table 7: Received Injection Safety Material in 2009

Injection Safety Material	Quantity	Date received

Please report on any problems encountered:

4.2 Progress of transition plan for safe injections and management of sharps waste.

Even if you have not received injection safety support in 2009 please report on progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report what types of syringes are used and the funding sources:

Table 8: Funding sources of Injection Safety material in 2009

Vaccine	Types of syringe used in 2009 routine EPI	Funding sources of 2009
BCG	0.05ML AUTO DESTRUCT SYRINGE.	GOVT OF GHANA
Measles	0.5 ML AUTO DESTRUCT SYRINGE	GOVT OF GHANA
TT	0.5 ML AUTO DESTRUCT SYRINGE	GOVT OF GHANA / JICA
DTP-containing vaccine	0.5 ML AUTO DESTRUCT SYRINGE	GOVT OF GHANA

Please report how sharps waste is being disposed of:

- 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.
- **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. The cut needles which will be smaller in volume shall then be sent to the district level for incineration.**

Does the country have an injection safety policy/plan? [YES / NO] YES
If YES: Have you encountered any problem during the implementation of the transitional plan for safe injection and sharps waste? (Please report in box below)
IF NO: Are there plans to have one? (Please report in box below)

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 We need to revise our Injection safety plan. The problems we encountered during implementation of the plan are as follows:

- 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 (which are more than 5 years old) need major rehabilitation at the time cash flow is problematic
- Lack of ownership by some districts

4.3 Statement on use of GAVI Alliance injection safety support in 2009 (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:

Fund from GAVI received in 2009 (US$): ....
Amount spent in 2009 (US$):..................
Balance carried over to 2010 (US$):..................

Table 9: Expenditure for 2009 activities

2009 activities for Injection Safety financed with GAVI support	Expenditure in US$
Total	

If a balance has been left, list below the activities that will be financed in 2010:

Table 10: Planned activities and budget for 2010

Planned 2010 activities for Injection Safety financed with the balance of 2009 GAVI support	Budget in US$
Total	

5. Health System Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. This section **only needs to be completed by those countries that have been approved and received funding for their HSS application before or during the last calendar year**. For countries that received HSS funds within the last 3 months of the reported year this section can be used as an inception report to discuss progress achieved and in order to enable release of HSS funds for the following year on time.
2. All countries are expected to report on GAVI HSS on the basis of the January to December calendar year. In instances when countries received funds late in 2009, or experienced other types of delays that limited implementation in 2009, these countries are encouraged to provide interim reporting on HSS implementation during the 1 January to 30 April period. This additional reporting should be provided in Table 13.
3. HSS reports should be received by 15th May 2010.
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** (HSCC or equivalent) in terms of its accuracy and validity of facts, figures and sources used. Inaccurate, incomplete or unsubstantiated reporting may lead the Independent Review Committee (IRC) either to send the APR back to the country (and this may cause delays in the release of further HSS funds), or to recommend against the release of further HSS funds or only 50% of next tranche.
5. Please use additional space than that provided in this reporting template, as necessary.
6. Please attach all required supporting documents (see list of supporting documents on page 8 of this APR form).

Background to the 2010 HSS monitoring section

It has been noted by the previous monitoring Independent review committee, 2009 mid-term HSS evaluation and tracking study[4] that the monitoring of HSS investments is one of the weakest parts of the design.

All countries should note that the IRC will have difficulty in approving further trenches of funding for HSS without the following information:

- Completeness of this section and reporting on agreed indicators, as outlined in the approved M&E framework outlined in the proposal and approval letter;
- Demonstrating (with tangible evidence) strong links between activities, output, outcome and impact indicators;
- Evidence of approval and discussion by the in country coordination mechanism;
- Outline technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year
- Annual health sector reviews or Swap reports, where applicable and relevant
- Audit report of account to which the GAVI HSS funds are transferred to
- Financial statement of funds spent during the reporting year (2009)

5.1 Information relating to this report

5.1.1 Government fiscal year (cycle) runs from …January……(…………(month) to ……December………….(……………….(month).

5.1.2 This GAVI HSS report covers 2009 calendar year from January to December

[4] All available at http://www.gavialliance.org/performance/evaluation/index.php

5.1.3 Duration of current National Health Plan is from January 2007………..(month/year) to …December 2011……….(………….(month/year).

5.1.4 Duration of the current immunisation cMYP is from ………..(month/year) to ………….(month/year)

5.1.5 Person(s) responsible for putting together this HSS report who can be contacted by the GAVI secretariat or by the IRC for 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 programmatic clarifications:			
Dr Frank Nyonator	Ghana Health Service	Team Leader	frank.nyonator@ghsmail.org
Focal point for any accounting of financial management clarifications:			
Mrs Ramatus Udeumanta	Ghana Health Service	Team Member	ramatu.udeumanta@ghsmail.org
Other partners and contacts who took part in putting this report together:			
Mr. Selassie D'Almeida	WHO-Ghana Office	Team member	dalmeidas@gh.afro.who.int
Mr. Dan Osei	Ghana Health Service	Team Member	dan.osei@ghsmail.org

5.1.6 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 (especially financial information and indicators values) 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.*]

The reporting process in GHS is bottom up. All district and regional data are compiled from the annual review process and validated by the regional director. National level data, e.g. persons trained by national level are obtained from relevant divisions and validated by the Director during the HQ review process. Financial data (unaudited) are obtained from the GHS financial statement.

5.1.7 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?

There is difficulty in merging documents when different people work on different sections of the APR and we are to merge them into one report. Some tables remain which are not needed

5.1.8 Health Sector Coordinating Committee (HSCC)

How many times did the HSCC meet in 2009? ..12 times (Monthly)........................
Please attach the minutes **(Document N°.....)** from all the HSCC meetings held in 2009, including those of the meeting which discussed/endorsed this report
Latest Health Sector Review report is also attached **(Document N°...........).**

5.2 Receipt and expenditure of HSS funds in the 2009 calendar year

Please complete the table 11 below for each year of your government's approved multi-year HSS programme.

Table 11: Receipt and expenditure of HSS funds

	2007	2008	2009	2010	2011	2012	2013	2014	2015
Original annual budgets (per the originally approved HSS proposal)		**1,035,500**	**7,230,500**	**767,000**	**637,000**				
Revised annual budgets (if revised by previous Annual Progress Reviews)									
Total funds received from GAVI during the calendar year									
Total expenditure during the calendar year			546,548.00						
Balance carried forward to next calendar year			312,662.68						
Amount of funding requested for future calendar year(s)				3,615,250.00	5,018,962				

Please note that figures for funds carried forward from 2008, income received in 2009, expenditure in 2009, and balance to be carried forward to 2010 should match figures presented in the financial statement for HSS that should be attached to this APR.

Please provide comments on any programmatic or financial issues that have arisen from delayed disbursements of GAVI HSS *(For example, has the country had to delay key areas of its health programme due to fund delays or have other budget lines needed to be used whilst waiting for GAVI HSS disbursement)*:

Because of the delays in receiving funds for 2009 from GAVI, a number activities were held up. The procurement activities were critical. Key procurement activities were the procurement of vehicles (to replace the motorbikes), PDAs and service delivery kits. For example in anticipation of the funds, procurement activities for the vehicles were included in the sector procurement plan with other vehicles started. However the procurement of PDAs and Service delivery kits for CHOs had to be suspended.

5.3 Report on HSS activities in 2009 reporting year

Note on Table 12 below: *This section should report according to the original activities featuring in the HSS application. 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. It is very important that the country provides details based on the M& E framework in the original application and approval letter.*

Please do mention whenever relevant the **SOURCES** of information used to report on each activity.

Table 12: HSS activities in the 2009 reporting year

Major Activities	Planned Activity for 2009	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
	Objective 1: Strengthening District and Sub-districts to support Service Provision	
	Objective 1.1: Strengthen Management Capacity in Leadership and Management	
	Activity 1 : Equip national and regional in-service training units to improve the quality of in-service training programmes organised by 2011	Ten regional training units were planned in 2009. However due to late disbursement of funds and non-availability of funds, *The National level (Ministry of Health and Ghana Health Service Headquarters) in-service training units have been equipped. Funds have been provided for one Region (Upper East Region) to begin works on rehabilitating their training unit*
	Train District Directors and Senior managers in leadership and management	
	Train Selected NGOs, RHMT and DDHS in team building	
	Develop simplified Financial management and procurement operational manual for sub districts, CHOs and NGOs	There are no variations from orignal activity. The subdistrict manual has been completed. The procurement process to print the manuals has started.
	Train District, sub districts managers and CHO in procurement and financial management	This activity will be implemented in 2010. There are no variations from approved proposal
	Objective 1.2 :Strengthen District Health Planning, prioritisation & Resource Allocation	
	Technical Assistance to update the DHA tools support DSS sites	Each year, support is provided to develop the the intervention profile for the districts in the DSS sites.

	Train senior managers including National, Regional and District Directors in the use of DHIP and DHA in for priority setting and decision-making	In 2009, capacity building through training for the research centres to develop the intervention profile was undertaken.
	Objective 1.3: Strengthen Support & Supervision Systems	
	Train district, subdistricts and NGOs in supportive supervision	
	Provide fuel and stationery to districts, subditsricts and NGOs to undertake supportive supervision	Funds were sent to all the districts to support service delivery in 2009. In total, about 115 districts received funds
	Objective 2: Expand functional CHPS coverage to deliver essential services especially for MDG 4 and 5	
	Procure Vehicles for Districts/Subdistricts	The procurement process started in 2009 as part of the sector procurement process for vehicles.
	Procurement of Service delivery kits for CHOs	
	Objective 3: Strengthening sub-district Health Information Systems especially at the CHPS zone level using District Wide Information Management System (DWIMS)	
	Customise and Integrate PDA data into existing health management information system	
	Procure PDA for CHOs	
	Train CHOs in the use of PDA equipment	
	Objective 4 : Strengthening Information management, M&E and operational and implementation research	
	Undertake operational and implementation research	
	Support national & regional level M&E	
	Review and Evaluation of HSS support	
	Total	

5.4 Support functions

*This 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?*

5.4.1 Management

Outline how management of GAVI HSS funds has been supported in the reporting year and any changes to management processes in the coming year:

There has not been any changes in the management arrangement of the GAVI funds. Funds are received into the MoH Aide pool account. Activities are approved by the Director General of GHS, processed and paid through the Finance Division. The request goes through pre approval and auditing by divisional director and internal audit respectively. Financial returns are managed by the finance division and progress report submitted as part of monthly/regional reporting to the Director General. The management of GAVI funds is very much integrated and supported by the health system.

5.4.2 Monitoring and Evaluation (M&E)

Outline any inputs that were required for supporting M&E activities in the reporting year and also any support that may be required in the coming reporting year to strengthen national capacity to monitor GAVI HSS investments:

In 2009, the GHS integrated the M&E activities of GAVI HSS into the GHS M&E system designed by the DG. All senior managers at HQ undertook visits to the regions and districts (Mandatory) using GAVI funds. The teams were briefed on GAVI support but also used the opportunity to support districts in all other areas.

5.4.3 Technical Support

Outline what technical support needs may be required to support either programmatic implementation or M&E. This should emphasise the use of partners as well as sustainable options for use of national institutes:

Note on Table 13: This table should provide up to date information on work taking place during the calendar year during which this report has been submitted (i.e. 2010).

The column on planned expenditure in the 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 application. Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right, documenting when the changes have been endorsed by the HSCC. Any discrepancies between the originally approved application activities / objectives and the planned current implementation plan should also be explained here

Table 13: Planned HSS Activities for 2010

Major Activities	Planned Activity for 2010	Original budget for 2010 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Revised budget for 2010 (proposed)	2010 actual expenditure as at 30 April 2010	Explanation of differences in activities and budgets from originally approved application or previously approved adjustments
Objective 1	**Objective 1: Strengthening District and Sub-districts to support Service Provision**	**507,000**	**985,000**		
Objective 1.1	***Objective 1.1: Strengthen Management Capacity in Leadership and Management***	**175,000**	**465,000**		
Activity 1.1	Activity 1 : Equip national and regional in-service training units to improve the quality of in-service training programmes organised by 2011		200,000.00		The activity was to be completed in 2009. However due to delays in receipts of funds on 2008 activity was implemented. In view of Ghana receiving 50% of the funds, the activity has been scaled down from 400,000 (8 units) to 200,000.
Activity 1.2	Train District Directors and Senior managers in leadership and management	50,000	75,000.00		This is to scale up the activity from originally planned due to delays in funds from GAVI.
Activity 1.3	Train Selected NGOs, RHMT and DDHS in team building	25,000	50,000.00		Most of the funds was concentrated to this target group in 2008. We are on course to continue as planned.
Activity 1.4	Develop simplified Financial management and procurement operational manual for sub districts, CHOs and NGOs	-			This was completed in 2009.
Activity 1.5	Train District, sub districts managers and CHO in procurement and financial management	100,000	140,000.00		This will be implemented as planned.
Objective 1.2	***Objective 1.2 :Strengthen District Health Planning, prioritisation & Resource Allocation***	**52,000**	**85,000**		
Activity 1.2.1	Technical Assistance to update the DHA tools support DSS sites	30,000	45,000.00		This will be implemented as planned

Activity 1.2.2	Train senior managers including National, Regional and District Directors in the use of DHIP and DHA in for priority setting and decision-making	22,000	40,000.00		Most of the training that did not take place in 2009 due to the fund flow challenges has been reduced for 2010 and shifted to 2011
Objective 1.3	***Objective 1.3: Strengthen Support & Supervision Systems***	**280,000**	**435,000**		
Activity 1.3.1	Train district, subdistricts and NGOs in supportive supervision	80,000	120,000.00		This has been scaled up to address the gap in 2009 when funds were not available
Activity 1.3.2	Provide fuel and stationery to districts, subditsricts and NGOs to undertake supportive supervision	200,000	315,000.00		Increase in orignal budget is due to non receipt of funds in 2009.
Objective 2	**Objective 2: Expand functional CHPS coverage to deliver essential services especially for MDG 4 and 5**	**0**	**2,100,000**		
Activity 2.1	Procure Vehicles for Districts/Subdistricts		1,200,000.00		This shuld have taken place in 2009. Total budget has been scaled down as a result of 50% receipts of 2009 funds in 2010.
Activity 2.2	Procurement of Service delivery kits for CHOs		900,000.00		
Objective 3	**Objective 3: Strengthening sub-district Health Information Systems especially at the CHPS zone level using District Wide Information Management System (DWIMS)**	**0**	**160,795**		
Activity 3.1	Customise and Integrate PDA data into existing health management information system		-		This has been completed
Activity 3.2	Procure PDA for CHOs		100,000.00		Orignally scheduled for 2009.
Activity 3.3	Train CHOs in the use of PDA equipment		60,794.69		Orignally planned to follow the procurement of the PDAs.
Objective 4	**Objective 4 : Strengthening Information management, M&E and operational and implementation research**	**260,000**	**369,743**		
Activity 4.1	Undertake operational and implementation research	200,000	200,000.00		
Activity 4.2	Support national & regional level M&E	60,000	69,743.00		
Activity 4.3	Review and Evaluation of HSS support		100,000.00	58,000	Orignally scheduled in 2009 but did not happen due to funds flow challenges from GAVI. About 60% of funds has been spent to review progress with implementation of GAVI HSS
	Total	**767,000**	**3,615,538**	58,000	

Table 14: Planned HSS Activities for next year (ie. 2011 FY) *This information will help GAVI's financial planning commitments*

Major Activities	Planned Activity for 2011	Original budget for 2011 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Revised budget for 2011 (proposed)	Explanation of differences in activities and budgets from originally approved application or previously approved adjustments
Objective 1	**Objective 1: Strengthening District and Sub-districts to support Service Provision**	**487,000**	**1,009,467**	
Objective 1.1	***Objective 1.1: Strengthen Management Capacity in Leadership and Management***	**155,000**	**414,467**	
Activity 1.1	Activity 1 : Equip national and regional in-service training units to improve the quality of in-service training programmes organised by 2011		200,000.00	This will cover the remaining 7 regions. Difference is due to non availability of funds for which the activity did not take place in 2009.
Activity 1.2	Train District Directors and Senior managers in leadership and management	50,000	42,735.00	The difference is due to slight over expenditure against budget in 2009. 2010 will scale up activities with the budget balance being spent in 2011 which accounts for the reduction in budgeted amount
Activity 1.3	Train Selected NGOs, RHMT and DDHS in team building	25,000	25,000.00	
Activity 1.4	Develop simplified Financial management and procurement operational manual for sub districts, CHOs and NGOs	-		
Activity 1.5	Train District, sub districts managers and CHO in procurement and financial management	80,000	146,732.00	This activity is being scaled up in 2010 and 2011 to catch up with targets as a result of non receipt of funds in 2009.
Objective 1.2	***Objective 1.2 :Strengthen District Health Planning, prioritisation & Resource Allocation***	**52,000**	**85,000**	
Activity 1.2.1	Technical Assistance to update the DHA tools support DSS sites	30,000	45,000.00	Increased spending is to address non receipt of funds for 2009.
Activity 1.2.2	Train senior managers including National, Regional and District Directors in the use of DHIP and DHA in for priority setting and decision-making	22,000	40,000.00	Increased spending is to address non receipt of funds for 2009.
Objective 1.3	***Objective 1.3: Strengthen Support & Supervision Systems***	**280,000**	**510,000**	

Activity 1.3.1	Train district, subdistricts and NGOs in supportive supervision	80,000	195,000.00	Increased spending is to address non receipt of funds for 2009.
Activity 1.3.2	Provide fuel and stationery to districts, subditsricts and NGOs to undertake supportive supervision	200,000	315,000.00	Increased spending is to address non receipt of funds for 2009.
Objective 2	**Objective 2: Expand functional CHPS coverage to deliver essential services especially for MDG 4 and 5**	**0**	**3,600,000**	
Activity 2.1	Procure Vehicles for Districts/Subdistricts		3,000,000.00	Increased spending is to address non receipt of funds for 2009.
Activity 2.2	Procurement of Service delivery kits for CHOs		600,000.00	Increased spending is to address non receipt of funds for 2009.
Objective 3	**Objective 3: Strengthening sub-district Health Information Systems especially at the CHPS zone level using District Wide Information Management System (DWIMS)**	**0**	**0**	
Activity 3.1	Customise and Integrate PDA data into existing health management information system			
Activity 3.2	Procure PDA for CHOs		-	
Activity 3.3	Train CHOs in the use of PDA equipment		-	
Objective 4	**Objective 4 : Strengthening Information management, M&E and operational and implementation research**	**150,000**	**409.495**	
Activity 4.1	Undertake operational and implementation research		211,495	Increased spending is to address non receipt of funds for 2009.
Activity 4.2	Support national & regional level M&E	50,000	98,000.00	Increased spending is to address non receipt of funds for 2009.
Activity 4.3	Review and Evaluation of HSS support	100,000	100,000.00	
	Total	**637,000**	**5,018,962**	

5.5 Programme implementation for 2009 reporting year

5.5.1 Please provide a narrative on major accomplishments (especially impacts on health service programs, notably the immunisation 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 should be based on the original proposal that was approved and explain any significant differences – it should also clarify the linkages between activities, output, outcomes and impact indicators.

*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.*

The disbursement of funds to the sub-districts and CHOs for service delivery has been very useful. This was highlighted during the 2009 review meetings.

The management, leadership and team building training/coaching has been nationally accepted to be scaled to all new managers.

5.5.2 Are any Civil Society Organisations 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.

5.6 Management of HSS funds

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year ? *NO* **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: further describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of HSS funds.

Part B: briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the ICC in this process.

5.7 Detailed expenditure of HSS funds during the 2009 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2009 calendar year **(Document N°..”FINANCIAL REPORT ON GAVI HSS FUNDS – 2009”..).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

If any expenditures for the January – April 2010 period are reported above in Table 16, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document N°..................)**.

External audit reports for HSS, ISS and CSO-b programmes are due to the GAVI Secretariat six months following the close of your government’s fiscal year. If an external audit report is available for your HSS programme during your government’s most recent fiscal year, this should also be attached **(Document N°.....................)**.

5.8 General overview of targets achieved

The indicators and objectives reported here should be exactly the same as the ones outlined in the original approved application and decision letter. There should be clear links to give an overview of the indicators used to measure outputs, outcomes and impact:

Table 15: Indicators listed in original application approved

Indicator	Numerator	Denominator	Data Source	Baseline Value[14]	Source	2009 Target
1. Proportion of Regional and District Directors in management and leadership Trained	Number of Regional & District Directors Trained	Total number of Regional & District Directors	Training report	6.70%/2005	Training report/quarterly Reports	100
2. Number of Health teams trained in team building skills	Number of 'District Heath Management Teams'	138 DHMT's	Training Report	0% / 2007	Training Report	25
3.proportion of functional CHPS zones with full complement of service delivery kits	Number of CHOs supplied with service delivery kits	Total number of functional zones in the target Districts (50)	CHPS and M&E	11% / 2007	CHPS and M&E	100%
4.Proportion of Districts using DHAP and MBB Tool	Number of Districts with Budgets in DHA format	Total number Districts trained in the use of DHA and MBB Tools	M&E Reports	12% / 2007	M&E Reports	100
5. Number of CHOs using PDAs	Number of CHOs using PDA for primary data collection	Total number of CHOs in functional CHPS zones in targeted districts	Routine Reports	7% / 2007	Routine Reports	40%
Number of NGOs participating in district performance review	Number of NGO's reported by Districts participating in District Reviews	Number of NGO's determined by the Mapping	DHMT Annual Report	25% / 2007	DHMT Annual Report	50%

In the space below, please provide justification and reasons for those indicators that in this APR are different from the original approved application:

Provide justification for any changes in the **definition of the indicators:**

Provide justification for any changes in **the denominator:**

Provide justification for any changes in **data source:**

Table 16: Trend of values achieved

Name of Indicator *(insert indicators as listed in above table, with one row dedicated to each indicator)*	**2007**	**2008**	**2009**	**Explanation of any reasons for non achievement of targets**
1. Proportion of Regional and District Directors in management and leadership Trained		100	100	20 (20%) directors (10 national & 10 regional) have been trained. Senior staff below the Director level scheduled to be trained were added to the team building training. This accounts for the low numbers trained because they could not attend both due to time constrains (note: the team building is a six month training and coaching)
2. Number of Health teams trained in team building skills		25	25	The number of districts has increased from 138 as at the time of the proposal to 170. The denominator is now 170 districts. As at the time of reporting, 50% funds had just been received for 2009. The targets are for 2008 but the actual performances are as at the end of 2009. 23 districts have been trained in team building skills. Seven more districts are in the second stage of the training. With the funds for 2009 available, they will complete by the end of July 2010.
3.proportion of functional CHPS zones with full complement of service delivery kits			1500	The target was for 2009. The funds for 2009 were received at the end of 2009. Currently 12 PDAs procured for the pilot is in use. The number of CHOs using the PDA is six by CHOs at the community level and three at the health centres and 3 at the district level.
4.Proportion of Districts using DHAP and MBB Tool		136	136	The target was to cover the 50 (now 77) districts. With support from GoG all districts (170) were trained in the new tool. The

				tool was used in the 2010 planning process. The districts will receive training each year to cover updates to the tool.
5. Number of CHOs using PDAs			1500	The training is to happen after the procurement of the PDAs. This will take place in 2010.

Proposal Outcome Indicators

Outcome Indicators	Source	2008	2009
1. National DTP3 coverage (%)	MoH Annual review report 2009	86.6	89.3
2. Percentage of districts achieving ≥80% DTP3 coverage	EPI annual Report	83%	84%
3. Under five mortality rate (per 1000)	DHS 2008	80	-
4. % Maternal Death Audited	DHS 2008	451	-
5. % Tracer Drug Availability			-
6. Proportion of births attended by skilled health personnel	MoH Annual review report 2009	39.3	45.6

Explain any weaknesses in links between indicators for inputs, outputs and outcomes:

None

5.9 *Other sources of funding in pooled mechanism for HSS*

If other donors are contributing to the achievement of objectives outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 17: Sources of HSS funds in a pooled mechanism

Donor	Amount in US$	Duration of support	Contributing to which objective of GAVI HSS proposal
USAID through MSH	Total funds unknown	2010	Objective 1: strengthening management capacity in leadership and management

6. Strengthened Involvement of Civil Society Organisations (CSOs)

6.1 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:

6.1.1 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 describe the mapping exercise, the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed (**Document N°**................).

The CSO Type A fund was accessed by the Ghana Health Service for the Mapping of CSOs involved in health care delivery in Ghana. The School of Public Health at the University of Ghana has been contracted to undertake this mapping exercise.

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.

Challenges

Almost all NGOs and CBVs interviewed during the CSO Mapping indicated that they had challenges. The identified challenges could be summed up under the following broad headings:

1. **Organizational management:** (i.e., low motivation/incentives/remunerations, lack of recognition, lack of logistics and means of transportation, financial assistance, lack of CBV community register, inadequate job aids, lack of drug storage facilities, no systematic reporting procedure to DHMT, poor records keeping);
2. **Attitudinal:** (i.e., apathy of community members, lack of community cooperation, lack of

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

commitment to work);
3. **Low educational level:** (i.e., high illiteracy); and
4. **Geographical access:** (i.e., large areas to cover)

Policy Recommendations

1. Most of the NGOs need more financial support to enable them function well. It appears many of them depend on small grants for short-term projects. Long-term programmes with proper monitoring could bring real impacts of the NOGs' activities on the communities.
2. There is the need to build the capacity of the NGOs in terms of knowledge building (training), records keeping skills and provision of basic office equipment to enable them deliver appropriate and effective services to the communities they operate in. It would be appropriate if the activities of the NGOs are streamlined with regards to their existing capacities instead of each of them jumping into any area where funding is available.
3. There is critical need to closely monitor the activities of the NGOs as some just exist in name and only resurface when they hear of funding availability for programmes they might not have the capacity to implement. The GHS should have a unit or office in charge of carrying out this monitoring activity to ensure that programme guidelines are adhered to and also that funds are appropriately applied/used.
4. There is the need for some NGOs operating in the same district or adjoining districts to merge to help enhance their capacity to deliver their needed services. Currently many of them are operating as one-man organisations and without the founders nothing really goes on. It also makes the issues of accountability quite difficult since such individuals could not be traced when needed.
5. There is an urgent need to budget for the payment of some allowances to the community-based volunterrs. This will motivate them to work as expected. The current situation where occasional allowances and/or programme T-shirts are provided does not encourage them to give their best. The District Assemblies and DHMTs must collaborate in this area to ensure that the concept of using volunteers to assit in the delivery of health services really work.

Conclusion

There is no doubt that NGOs and Community-based Volunteers are contributing to health care delivery in the country as they have been involved in public health interventions, particularly in the area of malaria, HIV/AIDS, TB and general public health educaion. However, their capacity to deliver such vital services needs to be improved. It is about time the smaller NGOs mostly manned by one person merged and their activities streamlined as part of efforts to enhance their capaity to perform. The GHS/DHMTs and the District Assemblies appear not to be collaborating in the area of monitoring and motivation of Community-based volunteers inspite of the needed services at the community level. The motivations the DHMTs are currently giving are woefully inadequate and this is demotivating a number of the volunteers from working as indicataed by some District Directors during the field work.

6.1.2 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).

HSCC: The Ghana HSCC has over the years nominated CSO that are involved in health services delivery. Hence the HSCC had had International NGOs such as Action Aid International, Red Cross, Save the Children Fund represented. However, since 2000, the local NGOs are represented by the Ghana Coalition of NGOs in Health. The Coalition is an umbrella civil society organisation whose genesis can be traced to the WHO-Africa Region 'Accra Declaration of 5th October 1999'. The Coalition is made up of NGOs in the health sector and currently has a membership of over 300 NGOs and NGO networks spread all over the 10 regions of the country.

ICC: The ICC presently have the following CSOs represented on the committee:

a) *Red Cross*
b) *Rotary International*
c) *CHAG*
d) *Paediatric Society of Ghana*

The Ghana Coalition of NGOs in Health have now been invited to join the ICC as well.

The leaders/Chairpersons/Presidents of the various CSOs are expected to be there or represented on these committees.

Attendance to ICC meetings by CSOs

a) *Red Cross - 50%*
b) *Rotary International - 100%*
c) *CHAG – yet to attend though invited always*
d) *Paediatric Society of Ghana – 100%*
e) *Coalition of NGOs in Health was invited only for 2010*

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.

The key mission of the Coalition is to positively influence health policy formulation and implementation – highlighting its watch-dog role – and as part of its process also play an advocacy role – especially for the poor, vulnerable and marginalised groups in society – with the aim of ensuring quality health for all.

There are no guidelines/policies governing this

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.

The visibility of CSO through the Coalition has been enhanced, and its platform strengthened since its participation in the national level coordination mechanisms.

Again, since 2000, the Ministry of Health has created the Private Sector Unit which is responsible for linking CSOs.

There has been unique impact in terms of CSOs interacting with each other through the Coalition. To achieve its mandate, the Coalition seeks to promote networking and information and experience sharing among NGOs in Ghana and beyond, facilitate capacity building and institutional strengthening of local NGOs in the health sector and to complement government efforts in health service delivery.

6.1.3 Receipt and expenditure of CSO Type A funds

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type A funds for the 2009 year.

Funds received during 2009: US$...67,909............
Remaining funds (carried over) from 2008: US$..0...........
Balance to be carried over to 2010: US$..0..............

6.2 TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP   *NOT APPLICABLE*

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:

6.2.1 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 change in the level and type of involvement by CSOs in immunisation and health systems strengthening (give the current number of CSOs involved, and the initial number).

Please outline any impact of the delayed disbursement of funds may have had on implementation and the need for any other support.

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.

Table 18: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2009	Outcomes achieved

Please list the CSOs that have not yet been funded, but are due to receive support in 2010/2011, 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.

Table 19: Planned activities and expected outcomes for 2010/2011

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2010 / 2011	Expected outcomes

6.2.2 Receipt and expenditure of CSO Type B funds

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type B funds for the 2009 year.

Funds received during 2009: US$................
Remaining funds (carried over) from 2008: US$............
Balance to be carried over to 2010: US$................

6.2.3 Management of GAVI CSO Type B funds

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year ? **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: further describe progress against requirements and conditions for the management of CSO Type B funds which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of CSO Type B funds.

Part B: briefly describe the financial management arrangements and process used for your CSO Type B funds. Indicate whether CSO Type B funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of CSO Type B funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the HSCC in this process.

6.2.4 Detailed expenditure of CSO Type B funds during the 2009 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2009 calendar year **(Document N°...................).** *(Terms of reference for this financial statement are attached in Annex 4).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

External audit reports for CSO Type B, ISS, HSS programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your CSO Type B programme during your government's most recent fiscal year, this should also be attached **(Document N°......................)**.

6.2.5 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.

Table 20: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	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.

7. Checklist

Table 21: Checklist of a completed APR form

Fill the blank cells according to the areas of support reported in the APR. Within each blank cell, please type: Y=Submitted or N=Not submitted.

	MANDATORY REQUIREMENTS (if one is missing the APR is NOT FOR IRC REVIEW)	ISS	NVS	HSS	CSO
1	Signature of Minister of Health (or delegated authority) of APR	Y	Y	Y	Y
2	Signature of Minister of Finance (or delegated authority) of APR	Y	Y	Y	Y
3	Signatures of members of ICC/HSCC in APR Form	Y	Y	Y	Y
4	Provision of Minutes of ICC/HSCC meeting endorsing APR	Y	Y	N	Y
5	Provision of complete excel sheet for each vaccine request		Y		
6	Provision of Financial Statements of GAVI support in cash	Y	Y	Y	N
7	Consistency in targets for each vaccines (tables and excel)		Y		
8	Justification of new targets if different from previous approval (section 1.1)		Y		
9	Correct co-financing level per dose of vaccine		Y		
10	Report on targets achieved (tables 15,16, 20)			Y	N
11	Provision of cMYP for re-applying		Y		

	OTHER REQUIREMENTS	ISS	NVS	HSS	CSO
12	Anticipated balance in stock as at 1 January 2010 in Annex 1		Y		
13	Consistency between targets, coverage data and survey data	Y	Y		
14	Latest external audit reports (Fiscal year 2009)	N		N	N
15	Provide information on procedure for management of cash	Y		Y	N
16	Health Sector Review Report			Y	
17	Provision of new Banking details	N	N	N	N
18	Attach VMA if the country introduced a New and Underused Vaccine before 2008 with GAVI support		N		
19	Attach the CSO Mapping report (Type A)				Y

8. Comments

Comments from ICC/HSCC Chairs:

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. These could be in addition to the approved minutes, which should be included in the attachments

FROM THE ICC CHAIRMAN
We shall be grateful if GAVI could re-consider Ghana's ISS reward for 2007, which was not paid because the application for ISS was submitted after the APR for 2007. The error was due to communication problems and we are humbly requesting that the country which is encountering cash flow problems is not unduly punished. We hope this our humble appeal will receive favourable consideration and payment effected accordingly. Thank you.

~ End ~

GAVI ANNUAL PROGRESS REPORT ANNEX 2
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR IMMUNISATION SERVICES SUPPORT (ISS) AND NEW VACCINE INTRODUCTION GRANTS

I. All countries that have received ISS /new vaccine introduction grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 2 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2009 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local Currency (CFA)	**Value in USD[7]**
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to 2010*)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[8] – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditure						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2009	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

[7] An average rate of CFA 479.11 = USD 1 applied.
[8] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own system for economic classification.

GAVI ANNUAL PROGRESS REPORT ANNEX 3
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR HEALTH SYSTEMS STRENGTHENING (HSS)

I. All countries that have received HSS grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

   a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
   b. Income received from GAVI during 2009
   c. Other income received during 2009 (interest, fees, etc)
   d. Total expenditure during the calendar year
   e. Closing balance as of 31 December 2009
   f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2009 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR HSS FINANCIAL STATEMENTS:
An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local Currency (CFA)	**Value in USD[9]**
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[10] – GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
HSS PROPOSAL OBJECTIVE 1: EXPAND ACCESS TO PRIORITY DISTRICTS						
ACTIVITY 1.1: TRAINING OF HEALTH WORKERS						
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
TOTAL FOR ACTIVITY 1.1	**24,000,000**	**50,093**	**18,800,000**	**39,239**	**5,200,000**	**10,854**

[9] An average rate of CFA 479.11 = USD 1 applied.
[10] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own HSS proposal objectives/activities and system for economic classification.

ACTIVITY 1.2: REHABILITATION OF HEALTH CENTRES						
Non-salary expenditure						
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditure						
Equipment	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Capital works	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR ACTIVITY 1.2	**18,000,000**	**37,570**	**11,792,132**	**24,613**	**6,207,868**	**12,957**
TOTALS FOR OBJECTIVE 1	**42,000,000**	**87,663**	**30,592,132**	**63,852**	**11,407,868**	**23,811**

GAVI ANNUAL PROGRESS REPORT ANNEX 4
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR CIVIL SOCIETY ORGANISATION (CSO) TYPE B

I. All countries that have received CSO 'Type B' grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2009 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR CSO 'Type B' FINANCIAL STATEMENTS:
An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO 'Type B'		
	Local Currency (CFA)	**Value in USD**[11]
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[12] – GAVI CSO 'Type B'						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
CSO 1: CARITAS						
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
TOTAL FOR CSO 1: CARITAS	**24,000,000**	**50,093**	**18,800,000**	**39,239**	**5,200,000**	**10,854**
CSO 2: SAVE THE CHILDREN						
Salary expenditure						
Per-diem payments	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131

[11] An average rate of CFA 479.11 = USD 1 applied.
[12] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own CSO 'Type B' proposal and system for economic classification.

Non-salary expenditure						
Training	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Other expenditure						
Capital works	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR CSO 2: SAVE THE CHILDREN	**18,000,000**	**37,570**	**11,792,132**	**24,613**	**6,207,868**	**12,957**
TOTALS FOR ALL CSOs	**42,000,000**	**87,663**	**30,592,132**	**63,852**	**11,407,868**	**23,811**