Annual Progress Report 2009

Submitted by

The Government of

Madagascar

Reporting on year: **2009**

Requesting for support year: **2011**

Date of submission: ……

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 TRANSPARENCY 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 attests 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 [*Name of Country*]……..……

Please note that this APR will not be reviewed or approved by the Independent Review Committee without the signatures of both the Ministers of Health & Finance or their delegated authority.

Minister of Health (or delegated authority):

Title: ……

Signature: ……

Date: ……

Minister of Finance (or delegated authority):

Title: ……

Signature: ……

Date: ……

This report has been compiled by:

Full name: RANDRIAMANALINA Bakolalao Marie Joséphine Position: Head of Immunisation Service Telephone: 261 22 564 72/ 261 32 04 603 38 E-mail: sv@moov.mg / svaccination@sante.gov.mg	Full name: RAKOTO Mitsimbina Isidore Position: Director of Health Districts Telephone: 261 33 07 582 41 E-mail: ddds@sante.gov.mg
Full name: RAKOTONDRAZAKA Célestin Position: Logistics Coordinator, National EPI Telephone: 261 32 02 484 44 E-mail: rakotocelestin@yahoo.fr	Full name: ANDRIAMBOLANORO Voahangy Position: Project accounts manager, GAVI HSS Telephone: 043 03 621 40 E-mail: joharynyaina@yahoo.fr

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

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

Comments from partners:

.....

.....

Comments from the Regional Working Group:

.....

.....

.....

HSCC Signatures Page

If the country is reporting on HSS

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), …… *[insert name]* 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

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

Comments from partners:

.....

.....

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: ……

Post: ……

Organisation:……...

Date: ……

Signature: ……

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

Annual Progress Report 2009: Table of Contents

This APR reports on activities between January - December 2009 and specifies requests for the period January - December 2011

ABREVIATIONS ET ACRONYMES

AO	Appel d'Offre (Invitation to tender)
ASC	Agents de Santé Communautaire (Community health workers)
AWP	Annual Work Plan
CDE	Contrôle des Dépenses Engagés
CEI	Comité d'Examen Indépendant
cMYP	Comprehensive multi-year plan for immunization
COSAN	Comité de Santé
CSB	Centre de santé de base (Basic health centre)
DDS	Directeur des Districts Sanitaires (Director of Health Districts)
DEP	Directeur des Etudes et de la Planification (Directorate for Policy and Planning)
DGA	Directeur Général Adjoint
DGS	Directeur Général de la Santé (Directorate General for Health)
DP	Direction du Partenariat
EPI	Expanded Program on Immunization
HR	Human resources
DRSP	Direction Régionale de la Santé (Regional Health Directorate)
DSE	Directeur de la Santé de l'Enfant (Director of Child Health)
EMAD	Equipe de Management du District (District Management Team)
EMAR	Equipe de Management de la Région (Regional management team)
GAR	Gestion Axée sur les résultats (Results-based management)
GAVI	Global Alliance for Vaccines and Immunization
HAC	Harmonisation de l'Approche Communautaire
HSCC	Health Sector Coordination Committee
HSS	Health System Strengthening
IEC	Information, Education, Communication
KM	Kaominina Mendrika
KMS	Kaominina Mendrika Salama
MAR	Monthly Activity Report
MDGs	Millenium Development Goals
MFB	Ministry of Finances and Budget
NF	Non Fonctionnel (non-operational)
NGO	Non-governmental organisation
ONM	Ordre National des Médecins (National Order of Doctors)
OSC	Organisation de la Société Civile (Civil Society Organisation)
PAC	Paquet d'Activité Communautaire (Community Activities Package)
PMA	Paquet Minimum d'Activités (Minimum Activities Package)
PMO	Plan de Mise en Œuvre (Implementation Plan)
PMU	Project Management Unit
PNSC	Politique Nationale de Santé Communautaire (National policy on community health)
PRMP	Personne Responsable des Marchés Publiques
SAF	Service Administratif et Financier (Administrative and financial service)
SG	Secrétaire Général
SIGS	Système d'Information et de Gestion Sanitaire
SIG	Système d'Information pour la Gestion (Management Information System)
SMS	Service Médico-Sanitaire
SSD	Service de Santé de District (District Health Service)
SSME	Semaine de la Santé de la Mère et Enfant (Mother and child health week)
SV	Service de la Vaccination (Immunisation Service)
ToR	Terms of Reference
UDD	Utilisation des Données (Data Use)
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

List of Tables in 2009 APR

APR Section	Table N°	Where-about	Title
1.1	Table 1	Annex 1	Updated Baseline and Annual Targets
1.4	Table 2	APR form	Overall Expenditure and Financing for Immunisation in US$.
2.5	Table 3	Annex 1	Calculation of ISS reward
3.1	Table 4	APR form	Vaccines received for 2009 vaccinations
3.3	Table 5	APR form	Four questions on country co-financing in 2009
3.7	Table 6	Annex 1	Request for vaccines for 2011
4.1	Table 7	APR form	Received Injection Safety supply in 2009
4.2	Table 8	APR form	Funding sources of Injection Safety supply in 2009
4.3	Table 9	APR form	Expenditure for 2009 activities (for INS in cash)
4.3	Table 10	APR form	Planned activities and budget for 2010
5.2	Table 11	APR form	Receipt and expenditure of HSS funds
5.3	Table 12	APR form	HSS Activities in 2009 reporting year
5.4.3	Table 13	APR form	Planned HSS activities for 2010
5.4.3	Table 14	APR form	Planned HSS Activities for next year (ie. 2011 FY)
5.8	Table 15	APR form	Indicators listed in original application approved
5.8	Table 16	APR form	Trend of values achieved
5.9	Table 17	APR form	Sources of HSS funds in a pooled mechanism
6.2.1	Table 18	APR form	Outcomes of CSOs activities
6.2.1	Table 19	APR form	Planned activities and expected outcomes for 2010/2011
6.2.5	Table 20	APR form	Progress of project implementation
7.	Table 21	APR form	Checklist of a completed APR form

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
01	Calculation of ***[Country's]*** ISS-NVS support for 2011 *(Annex 1)*	1.1; 2.4; 3.7
02	Minutes of all the ICC meetings held in 2009	1.5
03	Financial statement for the use of ISS funds in the 2009 calendar year	2.3
NA	External audit report of ISS funds during the most recent fiscal year (if available)	2.3
N/A	Financial statement for the use of New Vaccines Introduction Grant funds in the 2009 calendar year	3.2.3
04	Report of the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA)	3.4
05	Minutes of the ICC meeting endorsing the change of vaccine presentation (if not included among the above listed minutes)	3.5
06	New cMYP for the years 2010-2014	3.6
N/A	Minutes of the ICC meeting endorsing the country request for extension of new vaccine support for the years..... (if not included among the above listed minutes)	3.6
07	Minutes of the HSCC meetings held in 2009 including those on discussion/endorsement of this report	5.1.8
08	Latest Health Sector Review Report	5.1.8
09	Financial statement for the use of HSS funds in the 2009 calendar year	5.8
NA	External audit report for HSS funds during the most recent fiscal year (if available)	5.8
N/A	CSO mapping report	6.1.1
N/A	Financial statement for the use of CSO 'Type B' funds in the 2009 calendar year	6.2.4
N/A	External audit report for CSO 'Type B' funds during the most recent fiscal year (if available)	6.2.4

1. General Programme Management Component

1.1 *Updated baseline and annual targets (fill in Table 1 in Annex 1 - Excel)*

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**: no change*

*Provide justification for any changes **in surviving infants**: no change*

*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:

In 2009, the number of children receiving the DTP/HepB/Hib3 vaccine was 625,041 with a coverage rate of 89%, thus 24,976 more children received the vaccine than in 2008, when the number was 600,065.

As a result, we did not reach the goal set for 2009, a 95% coverage rate for DTP/HepB/Hib3. This can be attributed to the political and social upheaval throughout the year; immunisation activities were affected to a certain extent, particularly in centres administering vaccinations during the first semester.

Despite this situation, an analysis of the data from 2009 shows that overall, according to the indicators, the situation of vaccinations and surveillance of vaccine-preventable diseases, was satisfactory.

Regarding routine EPI, coverage rates were: 87,5% for BCG, 89% for DTP/HepB/Hib3 ; 88,6% for VPO3 and 85% for the anti-measles vaccine.

Regarding surveillance of Acute Flaccid Paralysis (AFP), the rate of non-polio AFP is 2.21, but 31% of districts have not reported. The appropriateness rate is 92%. The completeness rate of active research reports is 45% versus 14.48% of promptness; 25%, or 28/111, of districts have not yet categorised their sites in accordance with WHO regulations.

Compared to previous years, there has been improvement in case-by-case surveillance of measles, as the rate of suspected cases of measles has dropped to 1 per year. 69% of districts reported at least one suspected case of measles, or 77/111 districts.

Nevertheless, in order to remedy certain weaknesses in the way services are run, the Surveillance Focal Points and the EPI personnel who were replaced in some regions received training during 2009.

Despite the circumstances, the partnership of humanitarian support established between the Ministry of Health and the international agencies supporting sanitation development has been an opportunity to reinforce immunisation strategies.

➔ ***To reach the 2009 target goals and increase vaccination coverage***, different strategies were implemented:

1. Improvement in performance, access and coverage in immunisation services

- 1.1*. Availability of vaccines and injection materials at all levels*
    - Remittance of funds to provide vaccination supplies and supplies to CSB (basic health centres) in the 29 lowest-performing districts
    - Partner support for provision of vaccines and supplies to regional storage centres and district hubs
    - 100% coverage for the purchase of vaccines, participation of the government despite regulation limiting expenses to 70% for state budgets (the operating budget for the immunisation service was not subject to regulation)
- 1.2**.** *Establishment of quality and performance data for follow-up systems :*
    - Regular provision of management tools at all levels
    - Provision of computerised materials to the 22 EPI regional managers
    - Setting up EPI data management software in 22 regions and districts. Formative monitoring of this implementation was undertaken at the district level in 7 regions (Analamanga, Bongolava, Itasy, Androy, Anosy, Atsimo Andrefana, Vakinankaratra).
    - Supervisory training visits carried out at all levels.
    - Organisation of data quality control meetings at the national level
- 1.3. *Development of the abilities of managers through* :
    - Training of EPI managers and refresher courses on handling vaccines at the regional level for 11 regions (Anosy, Androy, Atsimo Andrefana, Menabe, Ihorombe, Haute Matsiatra, Amoron'Imania, Vakinanakaratra, Atsinanana, Alaotra Mangoro, Analanjirofo), the maintenance of cold equipment for EPI managers and refresher courses in 18 regions

- Training for vaccinators in basic health centres on EPI management, including the development of the "Reaching Every Village" approach (REV) in the regions of Atsimo Andrefana and Anosy.

- 1.4. *Generalisation of the "Reaching Every Village" approach*

- Strengthened advanced strategies at the health centre level in 17 districts, targeting isolated and remote populations who do not have access to health services: Ankazoabo, Ambalavao, Vatomandry, Fianarantsoa II, Antalaha, Vohemar, Antsirabe II, Antanifotsy Toamasina II, Anjozorobe, Manjakandriana, Mahanoro, Vohipeno, Manakara, Andramasina, Ambatondrazaka and Nosy Be. Likewise, certain districts received support from regional mobile health teams (6 regions: Sofia, Melaky, SAVA, Atsimo Andrefana, Atsimo Atsinanana).

- The search for patients who are lost to follow-up, leading to a decrease in the rate of abandonment, carried out with the cooperation of community representatives. For the community programme "Kaominina Mendrika Salama", the use of the "Reaching Every Child" approach allowed for coverage of 1081 fokontany located more than 5 km from a health facility. The fokontany is the local unit of administration; 162 rural communes in 27 districts of 9 regions thus benefitted from this strategy with 2 community representatives selected from among the fokontany health committees by the social development committee in each commune. Non-vaccinated children are referred to basic health centres in the commune or benefit from advanced strategies, in accordance with the participative planning of the social development committee.

-Remittance of funds for the implementation of the "Reaching Every District" approach, or RED, and/or revival of EPI in 15 districts : (Vohipeno, Midongy Atsimo, Maroantsetra, Soavinandriana, Arivonimamo, Marolambo, Mandritsara, Antsirabe I, Antsirabe II, Antalaha, Ambatofinandrahana, Sambava, Tsihombe, Bekily and Beloha Androy).

2. Improvement and strengthening of vaccine and resource management

- 2.1. *Availability of the cold chain*

-Bringing the cold chain up to standards by the partial replacement of materials at the national, regional, district and health facility levels level with the donation by the Japanese government of 200 refrigerator-freezers, 22 medium-sized refrigerators, 406 small refrigerators and 29 solar refrigerators.
-Receiving and dispatching of cold equipment, a gift from the Japanese government, at the national level and in 22 regions and 111 districts.

- 2.2. *Operation of the cold chain:*

-Provision of fuel to health centres administering vaccines.
-Provision of maintenance kits to 6 regions (Analamanga, Haute Matsiatra, Boeny, Atsinanana, Atsimo Andrefana and Diana) and provincial administrative centres.
-Provision of spare parts for refrigerators and freezers at all levels.
-Training in cold maintenance for district managers in the regions of Menabe, Anosy, Androy, Atsimo Andrefana, Ihorombe, Amoron'I Mania, Vakinankaratra, Haute Matsiatra and Alaotra Mangoro.
-Training of maintenance managers in 18 regions on solar refrigerators.
-Preventive maintenance at all levels.

3. **Increased control activities and epidemiological surveillance of EPI target diseases**

3.1. *Eradication of poliomyelitis*

-Developing the ability of health personnel to plan, implement and follow up a surveillance plan for vaccine-preventable diseases through training of regional focal points (PFR) and district focal points (PFD) and clinicians from District Hospital Centres with surgical facility (CHD2) and Regional Hospital Centres of Reference (CHRR) in the regions of Vakinankaratra, Analamanga, Bongolava, Itasy, Analanjirofo, Atsinanana, Betsiboka and Sofia.

-Implementation of recommendations made by an external review of disease surveillance, including

* update of the list of sites with categorisation according to priorities
* transfer of funds for active research on diseases targeted by EPI
* regular meetings with the National Committees of Experts, Certification and Containment for the Elimination of the Poliovirus
* Monthly data comparison AFP/measles/EMNT (elimination of maternal and neonatal tetanus)

-Supervisory training visits at all levels

-Follow-up and evaluation through reviews at the national and regional levels.

3.2. *Measles control*

- Financing of case-by-case measles surveillance activities, with serological confirmation in the laboratory, at the district level
- Enhancing the capabilities of health personnel through refresher courses on case-by-case measles surveillance of regional focal points (PFR) and district focal points (PFD) and clinicians from District Hospital Centres with surgical facility (CHD2) and Regional Hospital Centres of Reference (CHRR) from the regions of Vakinankaratra, Analamanga, Bongolava, Itasy, Analanjirofo, Atsinanana, Betsiboka, Sofia
- Weekly verification of surveillance data
- Increased routine EPI
- Preparation of a first draft of the plan of the measles immunisation campaign for 2010

3.3. *Elimination of maternal and neonatal tetanus (EMNT)*

- Review of data for a re-evaluation of the risk of maternal and neonatal tetanus and choice of regions for validating the elimination of MNT
- Validation study for the elimination of MNT in the districts of Tsaratanana (north and south), Maevatanana and Kandreho in the Betsiboka region. With the finding of 02 deaths diagnosed as stemming from neonatal tetanus, Madagascar was not validated as having eliminated MNT.
- A workshop to plan activities for the elimination of MNT, to be held in November, with the participation of the regional directors and EPI/PFR (regional focal points) managers from the 22 regions
- Increased routine EPI

4. Monitoring and evaluation

- 4.1. Regular follow-up meetings
  - Monthly meetings of the national technical subcommittee on EPI
  - Semi-annual reviews at the national level with the participation of regional managers
  - EPI review at the regional and district levels
- 4.2. Creation of a contingency plan in light of the political situation
- 4.3. Update of national EPI policies and adaptation of the WHO EPI guide

- 4.4. Review of the preparation of an action plan for the elimination of MNT
- 4.5. Supervisory training visits at all levels
- 4.6. Participation in regional meetings

5. Improvements in mother-child health

- **5.1.** Combination of other actions related to child survival and immunisation activities with the implementation of activities for **Mother & Child Health Week (SSME)** twice annually, in April and October. In 2009, the activities were divided into:
    - Package of *obligatory* interventions (Vitamin A supplementation for children aged 6-59 months and for women having recently given birth, deworming of children aged 12-59 months as well as pregnant women, detection of malnourished children in the target districts, vaccination of children aged 0-11 months and pregnant women/women of childbearing age, while searching for those lost to follow-up)
    - Package of *optional* interventions: prenatal consultation with related activities: malaria prevention, prevention of HIV/AIDS transmission from mother to child, family planning

➔<u>The problems encountered in the implementation of the multiyear plan are</u> :
1. Logistical :
* **Difficulty in sending vaccines and injection materials to the peripheral level,** especially at the beginning of the political-social crisis (roadblocks, crime, problems with flights, etc.).
This problem was resolved when UNICEF rented trucks belonging to private companies. To send vaccines by air, agreements were reached with private air companies.
* **Deficiencies in the operation of the cold chain** due to problems acquiring fuel, caused by a delay in the release of funds by the government and restructuring of credit with a 30% blockage of credit from the state. This problem was resolved by the purchase of fuel using funds from GAVI and financing from UNICEF.
* **Stock shortages of BCG** due to a wastage rate of more than 50% and to an underestimation of population (projection RGPH 1993), as well as over-ordering of vaccines for certain districts.
This problem was resolved by re-placing orders with UNICEF/Supply in Copenhagen, and by having a logistics staff member at the central level verify quantities ordered by districts and regions.
2. Geographical :
***Isolation of certain districts,** making access to health centres difficult for the more than 40% of the population who live more than 10 km from a health facility, hence the establishment of advanced and mobile strategies, support from regional mobile health teams in districts where there is need and the involvement of community mobilisers and leaders.

3. Organisational :
* **Delay in the implementation of certain activities**: implementation of the RED approach, training and refresher courses for regional managers, supervision, resulting from a shortage of human resources. This problem was resolved by integrated formative supervision at the peripheral level and by the release of funds to the peripheral level when the situation improved
* **Low rate of promptness and completeness of data**, resolved by the follow-up of districts at the central level (coaching system), the sending of the monthly EPI report

by electronic mail, telephone and BLU radio before sending it by post, especially for isolated and remote districts, collection of monthly district reports at the time of supervisions and other on-site visits and during reviews at all levels

*__Low use and accessibility of health services__ due to the political-social situation**,** particularly during the first semester, reflected in the decrease in the number of immunisation sessions in some basic health centres; difficulties in supplying vaccines, especially during the first months of the crisis; difficulties in transferring funds for the central and regional level. This problem was solved at the peripheral level:

- 1. By recruiting students graduating from the Interregional Institute for Paramedic Training as contracted health workers. These newly-recruited workers were sent to health centres that were not functioning due to a lack of personnel or as additional staff where there was only one worker on-site (regions of Atsimo Andrefana, Atsinanana, Anosy, Androy, Alaotra Mangoro).

- 2. By transporting vaccines and other resources using trucks from private companies for the central level, and by sending district funds to the heads of basic health centres so they could take delivery of vaccines at the district level.

-3. The problem of the transfer of funds for the central and regional level was resolved through the reimbursement of funds used for an activity.

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

While the number of children vaccinated against DTP/HepB/Hib3 reached 624,642 with a coverage rate of 89%, we did not reach the anticipated objective, which was a coverage rate of 95%. This fact is related to the political-social situation throughout the year; immunisation activities were disrupted to a certain extent, particularly in centres administering vaccines during the first semester. Thus, we saw:

* a decrease in the number of immunisation sessions in some basic health centres (personnel leaving their post or disruption by a third party)
* difficulty in supplying vaccines and injection materials, especially during the first months of the crisis (roadblocks and disruption of flights)
* problem of operation of the cold chain (government budget regulation)
* problem of transferring funds for the regional and central level for some partners (UNICEF).
    - Likewise, the annual report of vaccine coverage shows that 31% of districts have a coverage rate in DTP3 of less than 80%

Even when material and financial resources are available, districts still encounter difficulties in immunization promotion and surveillance. The shortage of health personnel was felt in almost every health sector. Shifting of personnel can only cause failures in service operations, since new staff members replace managers who have already been trained. There are still critical problems caused by the isolation of certain sites. Low community participation, among other things, is a major element of failure.

1.3 *Data assessments*

1.3.1 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 WHO/UNICEF estimate of national vaccine coverage differs from that of administrative coverage.
WHO and UNICEF use the results of the 2008 national vaccine coverage survey as a reference.

1.3.2 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.

A self-assessment of data quality was carried out only in some districts in 2008

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

- In 2009, to improve the quality of administrative data, several activities were conducted :
    - Regular provision of management tools at all levels (scorecards, cards for mothers and children, monitoring curve for vaccine coverage)
    - Provision of computerised materials to the 22 EPI regional managers for data compilation
    - Setting up EPI data management software in 22 regions and districts. Formative follow-up of this implementation was undertaken at the district level in 7 regions (Analamanga, Bongolava, Itasy, Androy, Anosy, Atsimo andrefana, Vakinankaratra).
    - Supervisory training visits conducted at all levels.
    - Organisation of data quality control meetings at the national level

[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*

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

- Refresher courses for EPI regional managers on the data management software (surveillance and EPI)
- Software training for district EPI managers
- Training of central and regional managers on the use of the stock management tool, with the help of an international consultant
- Formative supervision on the use of the 2 tools at the regional and district level
- Data quality control meetings at the central and regional level
- Data quality self-assessment

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]	589,422.61	992,382	1,132,267
New Vaccines	8,218,700	8,834,760	33,378,334 (if introduction of PCV vaccine granted)
Injection supplies with AD syringes	207,501.94	572,990	942,565
Injection supply with syringes other than ADs	80,104.20	N/A	N/A
Cold Chain equipment	1,750,000	574,872	171,874
Other equipment	54,031	272,544	70,744
Vehicles		81,600	37,975
AVS		4,571,812	
Operational costs	2,135,006	6,996,232	6,722,956
Other (please specify)			
Total EPI	13,034,765	25,334,367	44,670,021
Total Government Health	125,489,000	118,763,000	130,639,300

Exchange rate used	1 $US=2000 Ariary

[2] *Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 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.*

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.

I. In 2009, while expenses were projected at $US 15,968,387, actual expenditures amounted to $US 13,034,765 or 82%. This decrease can be explained by the reduction in operating cost and of estimated cost for vaccines and injection materials.

- The reduction in operating cost was due to a slowdown in some activities caused by the political and social crisis, especially during the first semester (insufficient supervision, implementation of the RED approach...)
- Drop in operating cost because there was no participation from PDSSP (Sustainable Health System Development Project) for integrated supervision and the advanced and mobile strategies as a result of the political and economic crisis.
- However, for the Government, actual expenditures were greater than projected (fuel to run the refrigerators and for the transportation of vaccines and injection materials),
- Likewise, the cost of equipment also rose as a result of the donation of cold equipment by the Japanese government.

For 2010 and 2011

The trend is toward a general increase in needs and financial resources. The additional costs fall into the following categories:

- Cost of vaccines and injection materials: growth of the target population, and increase in cost of the transport of vaccines and injection materials to the storage centres as a result of the increased volume
- Equipment costs
- The 2010 anti-measles campaign, which raises operating costs considerably.
- Introduction of the pneumococcal conjugate vaccine (PCV) in the routine immunisation calendar: cost of the new vaccines and operating costs for 2011 (escalation of activities to promote the new vaccine)

II. Financial viability strategies, to compensate for the gaps (which are nonetheless manageable), are defined in the EPI cMYP 2007-2011 and in the updated cMYP 2010-2014:

1. *Self-sufficiency,* in order to guarantee the regular increase of funds allocated to the EPI, along with:

1.1. Make an appeal to financial and planning directors of the Deputy Prime Minister in charge of Public Health and the Minister of Finances and Budget (Budget of operations and investment, different Multilateral Debt Relief Initiatives : MDRI).

➔Operating budget resources will go toward the purchase of routine vaccines and new vaccines at the central level, covering expenses for maintenance of cold-chain equipment, the purchase of fuel for the operation of the cold chain and supervisory training visits at the peripheral level.

➔Investment budget resources will cover personnel expenses and the purchase of spare parts for rolling stock.

Contributions from the Multilateral Debt Relief Initiative will serve to finance shared costs, the renovation and upkeep of health centres that have immunisation services, the purchase and maintenance of rolling stock, supervisory missions and the expenses of newly-recruited personnel.

- **1.2. Implementation of the national policy on community health**

An escalation of social mobilization activities is planned in order to increase community participation in immunisation activities so that communities will take it upon themselves to cover the costs of actively searching for children lost to follow-up and educating the community about the importance of vaccinations, the need to accept new vaccines and the need to notify authorities in the case of an incidence of one of the diseases targeted by the program.

- **1.3. Mobilisation of other health financial partners**

Despite increased financing by the state for immunisation-related activities, support from partners remains very important. The financial viability strategies aim to maintain or even raise the current level of support of traditional partners. Likewise, in order to

reduce the gap, the Government, through the Ministry of Health, will mobilise other potential partners within the framework of bilateral cooperation. The involvement of NGOs and non-profit organisations will be strengthened. The growth in partner contributions and the mobilisation of new support to finance vaccinations will occur through the following activities: increase the involvement of CCIA in follow-up of activities, performance and emerging EPI demands;

- Increase government appeals to ICC members in order to increase partner financing ;
- Integrate immunisation activities in the new frameworks of economic and technical cooperation
- Strengthen the position of EPI in the health-sector strategy

2. *Reliability of resources* with:

- 2.1. Appeal to government decision-makers so there is no blockage of resources allocated to EPI and to avoid commitment delays particularly in the purchase of vaccines, for the upholding of procedures of inclusion of immunisation in the budget in the Medium Term Development Framework (MTDF)
- 2.2. Educating members of the ICC for the continuation and the timely mobilisation of their contribution to the cMYP budget
- 2.3. Improvement of good governance in managing mobilised resources

3. *Adequate use of available resources*

- 3.1. Guaranteed by regular budget inspections at all levels, periodic monitoring and evaluation of programme performance the adjustment to scale of the "RED" approach. This approach will allow for :
  - activities planning with the participation of local beneficiaries
  - enhancement of the technical capabilities of service providers at all levels in programme management, planning, coordination, supervisory training and integrated monitoring

- 3.2. Reduction of vaccine wastage, by putting in place a computerised system of vaccine management, from 50% to 30% between 2008 and 2011 for lyophilised vaccines and from 15% to 5% for liquid vaccines over the same period, through reinforced use of the open-vial policy (for liquid vaccines) by field personnel

- 3.3. Increase in supervisory activities in order to guarantee the quality of services

- 3.4. The extension of the system of immunisation data quality control to all regions and districts

- 3.5. Reduction of the abandonment rate by the reinforcement of monitoring and evaluation with the help of community members

- 3.6. Putting incentives in place to incite staff members in charge of vaccination to remain at their work posts.

1.5 *Interagency Coordinating Committee (ICC)*

How many times did the ICC meet in 2009? .... The senior ICC met one time (26/08/2009) because of the political situation; however, the technical ICC met **10 times** (*08/01/09 ; 05/02/09 ; 24/02/09 ;03/03/09 ; 16/03/09 ; 07/04/09 ; 08/07/09 ; 21/08/09 ;20/11/09 ; 24 and 25/11/09)*
Please attach the minutes **(Document N° 02)** from all the ICC meetings held in 2009, including those of the meeting endorsing this report. (04/05/2010)

List the key concerns or recommendations, if any, made by the ICC on items 1.1 through 1.4

1. The denominator used for vaccine coverage: pending the next general census, harmonise the number of total population, use the population of the micro-planning established for the Mother & Child Health Week
2. Operation of the cold chain and the problem of fuel acquisition: involve the state budget as early as possible

3. Community participation: implement a community health policy
4. Make an appeal to the Ministry of Finance and Budget so that there not be any blockage for the purchase of vaccines on the state's part and that there not be payment delays in the scheduled calendar

Are any Civil Society Organisations members of the ICC ?: **[Yes / No].** If yes, which ones?

List CSO member organisations:
Ordre National des Médecins : Dr Rakotovao Ravahatra Kalory (2009) **AMIT** : Dr Randriambololona Karl **Salfa** : Randriamahazosoa Olivier
Red Cross : Rakotoson Hery Manantsoa **HMET** : Raherinampinaina Clara Gladys **ASOS :** Rakotomalala Jean Claude **Marie Stopes :** Randrianasolo Bakoly **ADRA :** Rajaobelina Tantely

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?

Principal objectives

- Reach and maintain a national coverage rate of 95% for DTP/HepB/Hib3 and a coverage rate of 80% for DTP/HepB/Hib3 in at least 90% of districts
- Speed up the fight against, and control of, measles
- Eliminate MNT
- Eradicate poliomyelitis

Prioritised activities defined in the cMYP 2010-2014

- Implementation of a plan to reduce the number of non-vaccinated children (implementation of the RED approach, refresher courses for health personnel, supervisory training visits, operational research)
- National measles follow-up vaccination campaign for children aged 9 to 47 months 2010
- Implement an action plan to eliminate MNT and preparation of the pre-assessment for the validation of this elimination
- Documentation for the certification of the eradication of the poliovirus (2010)

2. Immunisation Services Support (ISS)

2.1 *Report on the use of ISS funds in 2009*

Funds received during 2009: **$US 0**.
Remaining funds (carry over) from 2008: $US 472,322.66 with an exchange rate of: $US 1=1826 Ariary in 2008**, but in 2009, the exchange rate was $US 1 =2000 Ariary, thus $ US 431,230.58**
Balance carried over to 2010: **$US 69,459.26**

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

The principal activities which were conducted to strengthen the immunisation activities with the Immunisation Service (SSV) are linked to the management of the political-social crisis, so to compensate for regulation or blockage of state credit, the money was primarily used for:

- the operation of the cold chain with the purchase of fuel for districts and health centres carrying out vaccinations

- supplies of vaccines, injection materials and management tools to all levels

- preventive maintenance of the cold chain at the peripheral level

- programme monitoring and evaluation at all levels

- maintenance and general expenses and coordination of the central level

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.

Assessment of the financial management for 2008 was conducted in March-April 2010, but the audit report is not yet available.
For 2009, the assessment will be conducted in May 2010

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.
Support for Immunisation Service (SSV) funds are wired to a commercial account at the BFV/SG Bank.
In 2009, the country received no funding from GAVI. However, an outstanding balance from funding received previously was in the GAVI/EPI account at the beginning of the year. This balance was jointly managed by the Director of Mother and Child Health and the head of the Immunisation service, who are cosignatories on the account.
The funds were used at the central, regional (DRSP: Regional Public Health Department) and district levels. The procedures for handling funds require two signatures for project management. The funds are wired directly to bank accounts for the peripheral level (districts and DRSP), following requests asking for financing of activities projected in their annual work plan. Project managers are advised by letter of the amount transferred.

Upon completion of activities, the supporting documents along with financial and technical reports are sent to the Immunisation Service; users keep a copy for 4 years. A reminder by letter or BLU radio is sent by the Immunisation Service or by the Mother and Child Health Directorate if these documents do not arrive within 6 months of completion of activities.
The national financial report is compiled by the national coordinators.
The general coordination of EPI is provided by the Interagency Coordination Committee (ICC) headed by the Deputy Minister of Public Health or his/her representative. In theory, the members of the ICC meet every three months and approve EPI's annual work plan as well as the use of funds. The report on the use of funds is presented to the members of the ICC. In 2009, the political and social crisis that prevailed in the country did not allow for regular meetings of the ICC, unlike for the members of the EPI technical subcommittee, who were able to hold their regular meetings.

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° 3).** *(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]

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

3. 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**
DTP/HepB +Hib Vial, 2 doses	2,219,400	06 October 2008 GAVI/08/237/sc	2,219,400	
DTP/HepB +Hib Vial, 2 doses	128,800 Madagascar's share	06 October 2008 GAVI/08/237/sc	128,800	

* *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?...)*	•
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)	•

3.2 *Introduction of a New Vaccine in 2009*

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.

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 lump sum)

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

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)	
1er Awarded Vaccine : **DTP/HepB/Hib**	June 2009	July and October 2009	July and October 2010
2nd Awarded Vaccine (specify)			
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)	469,640	128,800
2nd Awarded Vaccine (specify)		
3rd Awarded Vaccine (specify)		

Q. 3: Sources of funding for co-financing?
1. Government
2. Donor (specify)
3. Other (specify)

Q. 4: What factors have accelerated, slowed or hindered mobilisation of resources for vaccine co-financing?
1. The payment of the participation of the government of Madagascar toward the purchase of traditional vaccines delayed Madagascar's payment for the purchase of pentavalent vaccines (anticipated in June with actual payment in October)
2.
3.
4.

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

If the country is in default :

1. The heads of the Department of Health will appeal to the Ministry of Finance and Budget to accelerate the process and make EPI a priority programme, thus necessitating exceptional measures

2. An appeal will also be made to our partners so they can cover our part of the financing (UNICEF, the World Bank, etc.)

3. Representatives from the office of the Deputy Minister of Public Health will make an appeal to GAVI for a deferment of payments.

3.4 *Effective Vaccine Store Management/Vaccine Management Assessment*

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? **November 2008**

If conducted in 2008/2009, please attach the report. (**Document N° 04**)
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.

The primary activities in the framework of vaccine management are:

- Ensure permanent availability of safe, quality vaccines
- Strengthen the safety of injections and waste management, in accordance with standards
- Establish quality data at the regional and district level

The activities to implement the recommendations of the evaluation of vaccine management are:

- ✓ Conduct regular Vaccine Management Assessment (VMA): ***not carried out in 2009, rescheduled for 2010***
- ✓ Train new managers in mid-level EPI management (MLM): ***not carried out; to be rescheduled for 2010***
- ✓ Conduct regular supervision on the use of the logistics management manual created in 2007 : ***carried out during EPI and integrated supervision***
- ✓ Improve the use of the computerised data programme by providing the 22 regional EPI managers with the most efficient computer programme and in conducting follow-up: ***carried out by providing computers to the 22 regional EPI managers and follow-up on use of the computer programme in 7 of the 10 regions planned (70%)***
- ✓ Put in place a regular equipment maintenance system: ***accomplished with preventive maintenance at all levels.***
- ✓ Put a system in place to monitor stocks of vaccines and resources: ***accomplished with the use of the Stock Management Tool at the central level***

When is the next EVSM/VMA* planned? **November 2010**

*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:

DTP/HepB/Hib Vaccine: vial containing 1 liquid dose (received in 2010)

Please attach the minutes of the ICC meeting **(Document N° 02)** that has endorsed the requested change. (05/02/2010)

3.6 *Renewal of multi-year vaccines support for those countries whose current support is ending in 2010*

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 **DTP/HepB/Hib** vaccine, **1-dose liquid vial**, for the years **2011-2014.** At the same time it commits itself to co-finance the procurement of **DTP/HepB/Hib** vaccine, **1-dose liquid vial**, in accordance with the minimum GAVI co-financing levels as summarised in Annex 1.

The multi-year extension of **DTP/HepB/Hib** vaccine support is in line with the new cMYP for the years **2010-2014** which is attached to this APR **(Document N° 07).**

The country ICC has endorsed this request for extended support of **DTP/HepB/Hib** vaccine at the ICC meeting whose minutes are attached to this APR. **(document n° 02 :** Procès Verbal de la réunion du 26/08/09 pour approbation du PPAC 2010-2014 et du proposal pour l'introduction du vaccin contre les pneumocoques et les rota virus)**.**

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**]**

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).

Table 7: Received Injection Safety Material in 2009

Injection Safety Material	Quantity	Date received

Please report on any problems encountered:

Since 2003, auto-disable (AD) syringes have been used exclusively for all injections at the time of vaccination sessions in fixed and advanced strategies and during vaccination campaigns. The purchase of these auto-disable syringes for traditional vaccines (BCG, anti-measles vaccine (VAR) and anti-tetanus vaccine (VAT)) has been covered by UNICEF and the government.

From 2006 to 2008, Madagascar received GAVI support for the safety of all injections all of the antigens with injection.

Since 2009, purchases of injection materials and safety boxes have been made according to the vaccine and injection materials purchasing plan via UNICEF/Copenhagen. The Government's share is included in the operating budget of the Immunisation Service under item 6122 of P1 : 00 -710-1-00000 (purchase of medications) for AD intended for new vaccines, AD intended for traditional vaccines, dilution syringes and security boxes, in accordance with the 2007-2011 cMYP and the updated 2010-2014 cMYP.

The financing is wired directly to the "Supply/Approvisionnement" division of UNICEF/Copenhagen in 4 quarterly payments, in accordance with Plan of Use of the Immunisation Service

UNICEF will cover part of the purchase of these syringes, in accordance with the 2007-2011 cMYP, replaced by the updated 2010-2014 cMYP, and in accordance with the Cooperation Programme between the Government of Madagascar and the United Nations Children's Fund (UNICEF) 2008-2011 (Country Action Plan Programme 2008-2011), Programme YK 201 "Mother and Child Survival and Development".

The DTI (duties and import taxes) are taken up by the investment budget/PIP (Public Investment Programme), whose secondary coordinator is the Mother and Child Health Directorate in 2008.

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	AD 0.05ml	UNICEF and government
BCG	2 ml dilution syringe	government
Measles	AD 0.5ml	government
Measles	5 ml dilution syringe	government
TT	AD 0.5ml	UNICEF and government
DTP/HepB and Hib	AD 0.5ml	government (cofinancing)
DTP/HepB and Hib	Dilution syringe	government (cofinancing)

Please report how sharps waste is being disposed of:

*A national policy on management of sharps waste and injection safety was validated and disseminated in September 2005.
According to this policy, sharps waste must be collected in a safety box to be burned or incinerated and buried in a secure site.
*However, the progress report on the situation of supplying health facilities with equipment for the elimination of medical waste has revealed that only 22% on average possess elimination equipment that conforms to the standards of the national policy (PN) :

*University Hospital Centres(CHU), Regional Hospital Centres of Reference (CHRR) and District Hospital Centres 1 (CHD1) and District Hospital Centres 2 (CHD2) must have a de Monfort-type dual-chamber incinerator

*Urban Basic Health Centres 2 (CSB2) must have an incinerator

*Basic Health Centres 1 and 2 (CSB1 and CSB2) must have an elimination system of the metallic barrel type and/or a secure burial pit.

- The implementation of this policy allowed the creation of several tools, such as:* *awareness and training tools* for the Regional Hospital Centres of Reference and District Hospital Centres (training module and sorting notices in each department)
**Tool for sharps waste management* : organisation, sorting and collection with a management plan for each establishment: University Hospital Centres, Regional Hospital Centres of Reference and District Hospital Centres
**tool for monitoring elimination devices* : operating book for the de Montfort incinerator in Regional Hospital Centres of Reference and District Hospital Centres 2

* development of management tools for medical waste at the CSB level

Does the country have an injection safety policy/plan? [YES / NO]
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)

I. Problems linked to the implementation of the injection safety plan relate to:
- the difficulty of transporting syringes to isolated and remote zones, in particular those where transport must be made by air due to heavy volume (problems with freight rates), hence transportation by hiring a private air company
- problem with customs clearance and warehousing of materials at the port of Toamasina, Madagascar government participation. This is due to the closing of an agreement between the Ministry of Health and AUXIMAD, who is the authorised forwarding agent. UNICEF has taken over payment of fees for warehousing and customs clearance

II. **Sharps waste management problems (2009 situation)**

*Out of the 11 health facilities attached to University Hospital Centres, 7 have elimination equipment, of which 1 conforms to the National Policy

* Out of the 20 Regional Hospital Centres of Reference, 19 have elimination equipment, of which 15 conform to standards

* Out of the 86 District Hospital Centres 1 and District Hospital Centres 2, 33 have elimination equipment, of which 29 conform to the National Policy

* Out of the 155 urban Basic Health Centres, 17 have elimination equipment, of which none conforms to the National Policy

* Out of the 150 Basic Health Centres 2 serving more than 20,000 habitants, 7 have equipment, of which 7 conform to standards

* The 2176 Basic Health Centres 2 and Basic Health Centres 1 serving less than 20,000 habitants use pits, of which 5% are within norms

➔ We also note the absence or insufficiency of operating finances dedicated to waste management within the health facilities

➔ Delay in scheduled implementation of construction of equipment compliant with standards due to lack of financing

4.3 *Statement on use of GAVI Alliance injection safety support in 2009 (if received in the form of a cash contribution)*

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** to **December 2009.**
5.1.2 This GAVI HSS report covers 2009 calendar year from January to December **2009**
5.1.3 Duration of current National Health Plan is from **2008** to **2011.**
5.1.4 Duration of the current immunisation cMYP is from **2008** to **2014.**

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

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 TAFANGY Philémon Augustin	SG p.i / DGS of the Department of Health		pbtafangy@sante.gov.mg
Dr RAKOTO MITSIMBINA Isidore	DDS of the Department of Health	Coordinator	033 07 582 41 – ddds@sante.gov.mg
Focal point for any accounting of financial management clarifications:			
ANDRIAMBOLANORO Voahangiharisoa Nirina	Project accounts manager for GAVI HSS		034 03 621 40 – ddds@sante.gov.mg
Other partners and contacts who took part in putting this report together:			
RAMAHATANAHARISOA Aristide	DGA - RSS	Resource person	033 11 655 26 awramahatanaharisoa@sante.gov.mg
RAZAFIARIJAONA Robimandimby	DEP	Resource person	032 02 542 59 – joana.robi@gmail.com
NKOLOMONI Léon	WHO	Resource person	032 03 303 10 – nkolomonil@mg.afro.who.int
BARANYIKWA Marie Thérèse	UNICEF	Resource person	033 23 426 53 – mtbaranyikwa@unicef.org
RALAIVAO Josoa Samson		Resource person	033 07 202 82 –
RANDRIANTSIMANIRY Damoela	WHO	Resource person	032 03 303 31
RAVELOARIJAO Noeline	MFB/DPCB	Resource person	032 11 065 81
MARCIENNE J. Aimée	ONM	Resource person	033 15 650 56
RANDRIAMANALINA Bakolalao	SV/DSE	Resource person	032 04 603 38 – sv@moov.mg
Dr RAJAONARIVONY Roland	DDS	Resource person	032 40 097 54
Dr ANDRIAMANANTENASOA Faly	DDS	Resource person	034 36 367 53
Dr ANDRIAMANARIVO Alson	DDS	Resource person	032 04 312 13
Dr RAKOTONIRINA Désiré	DDS	Resource person	032 04 888 10
Dr RAKOTONIRINA Josette	DDS	Resource person	
Dr RAZAFINDRALAMBO Hector	DDS	Resource person	034 04 722 88

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 report was prepared by Mr. MITSIMBINA RAKOTO Isidore, Director of Health Districts under the Deputy Minister of Public Health and sent to the Technical Committee of the GAVI HSS Project for verification of its sources. After observation by the Committee, the report was sent to the Health Sector Coordination Committee (HSCC) for final examination and approval.

[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.*]

All of the information used in this report comes from various documents related to the Project: GAVI HSS Proposal, 2008 Finance Plan for GAVI HSS project, the 2008 GAVI HSS Annual Progress Report, 2009 technical and financial activity reports of the GAVI HSS project, reports from the regular meetings of the Technical Committee of the Direction of Health Districts, 2009 bank records of the GAVI HSS project.
The activities carried out and their related expenses are justified by supporting documents. The validity of these supporting documents is verified by the Project Management Unit.
Programmed activities are conducted in cooperation with our partners (WHO, UNICEF, SantéNet2/USAID, Immunization Basics/ JSI/USAID).

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?

We did not encounter any notable difficulties in preparing the 2009 report, which is based on the structure of the 2008 report.
The final version of the 2009 report was written in a very limited amount of time, given that the definitive structure only arrived in our hands in April 2010.
We ask that in the future, the definitive report structure be available at the beginning of the year in question.
As for sending information and documents, we have e-mail and DHL at our disposal.

5.1.8 Health Sector Coordinating Committee (HSCC)

How many times did the HSCC meet in 2009? .....
Please attach the minutes **(Document N° 07)** 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°.....).**

As a direct result of the political and social climate in Madagascar, which involved changes in personnel at the decision-making level, only one meeting of HSCC members was held relating to approval of this report

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)		810,515.60 USD	690,893.22 USD (outstanding from 2008 budget)						
Revised annual budgets (if revised by previous Annual Progress Reviews)									
Total funds received from GAVI during the calendar year		811,000 USD							
Interest in credit		833.73 USD							
Bank fees		5 USD							
Total expenditure during the calendar year		120,935.51 USD	615,581.18 USD						
Balance carried forward to next calendar year		690,893.22 USD	75,492.45 USD (1)						
Amount of funding requested for future calendar year(s)		3,408,945.30 USD	5,151,397.60 USD or 1,704,500 USD (half of 2009 Budget) + 3,446,897.6 USD (2010 Budget) (2)						

(1) Including 180.41 USD in credit interest and an outstanding balance of 75,312.04 USD from 2008 funding
(2) Half of the 2009 funding, or 1,704,500 USD, was received in April 2010. Validation of the 2009 plan is in progress.

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)*:

2008 financing was received in May 2008. Activities did not start until after validation of the 2008 plan by the Health Sector Coordination Committee (HSCC) in September 2008 and the establishment of the Project Management Unit in October 2008.

Any 2008 activities that were not carried out were conducted in 2009.

The current political and social upheaval in Madagascar began in January 2009 and caused major disruptions at all levels of the Department of Health (central, regional and district).

Moreover, a budget error was noted in the Proposal concerning Activity 3.4: Training community health workers on Community Activities Package (PAC) in 40 target districts (SSD). Only 1200 community health workers were budgeted for (see Proposal, page 30) instead of the 2400 workers mentioned in the 2008 plan. When the Proposal was being prepared, PAC training of the heads of Basic Health Centres (CSB) in the target zones was not taken into consideration; however, project coordinators felt that, as the direct supervisors of the workers being trained, these heads of Basic Health Centres needed to be involved in the training, in addition to the number that had been planned. This situation caused a delay in accomplishing the activities planned and a shortfall in the 2009 budget.

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	Disbursement rate	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Objective 1:	***Strengthen the supply of quality health services to all the population***		
Activity 1.1:			
Objective 2:	***Increase mobilisation and improve the allocation of financial resources***	85.18%	
Activity 2.1:	Training in financial and programme management for managers at the peripheral level in target districts		All managers in the 22 regions have received this training and in addition, supervisory training visits have been carried out at the level of the 6 former provinces thanks to the outstanding balance in the Training Budget
Objective 3:	***Stimulate the demand for, and use of, of health services***	96.69%	
Activity 3.1:	Train Community Health Workers on Community Activities Package (PAC) in 40 target SSD		Only 900 Community Health Workers out of the 2400 planned have been trained in the 15 Health Districts. Scheduled training in the other target zones was not conducted because the allowed budget was not sufficient to cover expenses The difference is due to : - a budgeting error in the Proposal: 1200 Community Health Workers (see Proposal, page 30) instead of the 2400 anticipated in the 2008 plan. - two workshops held simultaneously per target Health District instead of just the one planned in the Proposal (4 Community Health Workers per Basic Health Centre along with the head of the CSB)

Major Activities	Planned Activity for 2009	Disbursement rate	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Objective 4 :	***Strengthen and institutionalise a system of monitoring and evaluation***	92.14%	
Activité 4.1 :	Train health workers on the utility and use of data for planning and decision-making in the target zones		All 640 Health Workers planned for have been trained In addition, supervisory training visits to the Basic Health Centres (2 CSB per District) in the target zones were implemented in April 2009 taking into account the outstanding balance in the Training Budget, on the Use and Utility of SIG/RMA data
	Management Costs	65.65%	
	Management costs		Operating costs for the Project Management Unit office are in this category: office supplies, communication expenses, vehicle maintenance and repair, and personnel salaries

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:

HSS funds have been managed in a rational manner. Expenses are justified after completion of each activity.
Funds are released after validation of an activity form signed by the Director of Health Districts.
Upon completion of an activity, the original supporting documents, including technical reports, are verified and filed by the Project Management Unit.

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:

Involvement of the Monitoring and Evaluation service and the Audit to strengthen the implementation of activities in all of the following stages.

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:

NGOs, CSOs and local partners will be solicited more often for technical assistance to support the implementation of Monitoring and Evaluation activities.

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:	**Strengthen the supply of quality health services to all of the population**	**1,988,013.3**	**1,908,864.1**	**995,277.5**	
Activity 1.1:	Contracting of health agents in isolated or remote health facilities	423,885.00	423,885.00	172,532.50	
Activity 1.2:	Identify the factors (geographical, financial, cultural) that limit the use of services, through operational research	162,531.6	162,531.6		
Activity 1.4:	Renovations (paint, purchase furniture to welcome patients, roofing, ceiling, etc.) in 15 CSB (basic health centres) per year with the goal of improving the physical appearance and welcome.	499,702.5	499,702.5		
Activity 1.5:	Lead missions to validate Annual Work Plans (AWPs)	69,520.0	69,520.0	69,520.00	
Activity 1.6:	Equip 10 districts with a 4x4 vehicle, 2 cars for the central supervisors and 120 motorcycles for the CSB	753,225.0	753,225.0	753,225.00	
Activity 1.7:	In 5 Districts, introduce and pilot-test different strategies to increase the population's financial access to health services : system of mutual health insurance through the "Projet Commune Championne" (KM) and vouchers for malaria	79,149.2 (**)			

Objective 2 :	**Increase mobilisation and improve the allocation of financial resources**	**472,335.6**	**472,335.6**		
Activity 2.1	Training in financial and programme management for managers at the peripheral level in target districts				
Activity 2.3	Conduct financial audit and monitoring of priority health activities with EPI entryway (focussed on the continuum of mother and child health care) in the target zones; develop corrective strategies to improve programme management.	472,335.6	472,335.6		
Objective 3	**Stimulate the demand for, and use of, of health services**	**263,948.4**	**343,097.60**	**166,910.5**	
Activity 3.1	Prepare regional mapping of NGOs and associations working at the community level	64,892.30	64,892.30	64,892.30	
Activity 3.2	Hold 3 meetings annually with communes (100) for reviews in the target zones	109,589.70	109,589.70		
Activity 3.3	Hold meetings to prepare policy documents establishing strategies in matters of community health	66,597.40	66,597.40		
Activity 3.4	Train Community Health Workers on Community Activities Package (PAC) in 40 target SSD		79,149.2(**)	79,149.20	
Activity 3.5	Prepare a plan to reinforce Equity Funds	22,869.00	22,869.00	22,869.00	
Objective 4	**Strengthen and institutionalise a system of monitoring and evaluation**	**619,524.1**	**619,524.1**	**477,188.1**	
Activity 4.1	Train health workers on the utility and use of data for planning and decision-making in the target zones	456,185.00	456,185.00	313,849.00	
Activity 4.2	Evaluate the process de transferring health data from Basic Health Centres (CSB) to the Central level in order to identify bottlenecks	9,223.80	9,223.80	9,223.80	
Activity 4.3	Carry out regular monitoring and supervisory reviews in the Basic Hospital Centres (CSB)	87,120.00	87,120.00	87,120.00	
Activity 4.4	Support coaching in the target zones (2 visits per year)	66,995.30	66,995.30	66,995.30	
	Management Costs	**65,123.9**	**65,123.9**	**65,123.9**	
TOTAL COSTS		**3,408,945.3 USD**	**3,408,945.3 USD**	**1,704,500 USD**	

(*) The GAVI HSS project has not yet spent some of the funds in this original 2009 budget, considering that the 2009 plan has not been validated.

(**) **Budget adjustment**: Activity 1.7 was programmed in 2007 when the GAVI HSS Proposal was drawn up. In the meantime, the Ministry of Health, in collaboration with the partners, changed the strategic orientation by adopting the Kaominina Mendrika Salama (KMS) instead of the Commune Championne. As a result, this activity is null and void and the budget assigned to it will be reassigned to Activity 3.4: Train community health workers on Community Activities Package (PAC) in 40 target SSD.

***** Voir “Implementation Plan” ci-joint

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:	**Strengthen the supply of quality health services to all the population**	**2,549,787.70**		
Activity 1.1:	Contracting of health agents in isolated or remote health facilities	466,273.50		
Activity 1.2:	Identify the factors (geographical, financial, cultural) that limit the use of services, through operational research			
Activity 1.3:	Pilot-test strategies in about 5 SSD (Health Districts), with the goal of increasing the use of services, depending on the results of the evaluation study (activity 1.2).	79,149.20		
Activity 1.4:	Renovations (paint, purchase furniture to welcome patients, roofing, ceiling, etc.) in 15 CSB (basic health centres) per year with the goal of improving the physical appearance and welcome.	1,099,345.50		
Activity 1.5:	Lead missions to validate Annual Work Plans	76,472.00		
Activity 1.6:	Equip 10 districts with a 4X4 vehicle, 2 cars for central supervisors, 120 motorcycles for Basic Health Centres	828,547.50		
Objective 2:	**Increase mobilisation and improve the allocation of financial resources**	**519,569.20**		
Activity 2.1:	Conduct financial audit and monitoring of priority health activities with EPI entryway in the target zones; develop corrective strategies to improve programme management.	519,569.20		
Objective 3:	**Stimulate the demand for, and use of, of health services**	**120,548.70**		
Activity 3.1:	Hold 3 meetings annually with communes (100) for reviews in the target zones	120,548.70		
Objective 4:	**Strengthen and institutionalise a system of monitoring and evaluation**	**185,355.80**		

Activity 4.1:	Train health workers on the utility and use of data for planning and decision-making in the target zones			

Activity 4.2	Evaluate the process de transferring health data from Basic Health Centres (CSB) to the Central level in order to identify bottlenecks	9,223.80		
Activity 4.3:	Carry out regular monitoring and supervisory reviews in the Basic Hospital Centres (CSB)	95,832.00		
Activity 4.4:	Support coaching activities in the target zones (2 visits per year)	80,300.00		
	Management Costs	**71,636.2**		
TOTAL COSTS		**3,446,897.60 USD**		

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 request for support from GAVI aims to strengthen the health system, to make it more accessible and more efficient in the interest of fairness and as an entry point for EPI. Planned interventions pertain to three areas: organisation of the health system, increasing the population's demand for services and improvement in the system environment.

GAVI's main objectives are to contribute to the development of a sustainable and efficient health system, the improvement of routine immunisation services and the assurance of fairness in service offering all the way to the peripheral level. The goal is to best respond to the population's needs, especially in the area of mother and child health, including acceptable and sustainable vaccination coverage.

The strategies of utmost importance to the Malagasy Department of Health in 2009 are organised around the following activities in order to respond to the strengths and weaknesses of the health care system:

1) **Strengthen the supply of quality health services to all the population**
This activity has not been implemented during the use of this first project phase.

2) **Mobilisation and allocation of financial resources**

Activity 2.1 : Training in financial and programme management for managers at the peripheral level in target districts

- **Sub-activity :** Training for managers at the peripheral level (regions, districts) in financial and programme management
- **Sub-activity :** Ensure formative monitoring for peripheral managers (regions, districts and Basic Hospital Centres) trained in financial and programme management on how to apply the recommendations and skills from training and provide corrective actions

3) **Stimulate the demand for, and use of, health care services**

Activity 3.4: Train Community Health Workers on Community Activities Package (PAC) in 40 target SSD

4) **Strengthen and institutionalise a system of monitoring and evaluation** giving information about resources, structures, results and impacts.

The strengthening of the system of monitoring and evaluation constitutes one of the priorities for improving Results-Based Management. It aims to develop a sustainable and efficient system of information management. It consists in establishing a dashboard of indicators corresponding to health strategies in order to measure achieved progress, then to align it and incorporate it into the operational work plan. It will also provide necessary information for effective decision-making with an eye to reaching the objectives set and making necessary adjustments in a timely manner.

Activity 4.1 : Train health workers on the utility and use of data for planning and decision-making in the target zones

- **Sub-activity:** Train peripheral managers (regions, districts and Basic Health Centres) on the utility and use of data for planning and decision-making in the target zones
- **Sub-activity:** Ensure formative monitoring for trained peripheral managers (regions, districts and Basic Hospital Centres) on how to apply the recommendations and skills from training.

Work materials and the required skill for Data Use in decision-making and action have already been made available to regional and district instructors in the 10 regions supported by the Project. A spate of training sessions for the heads of the Basic Hospital Centres was carried out in each region.

Following that, central supervisors, in collaboration with the EMAR and the EMAD carried out joint formative monitoring missions in several Basic Hospital Centres to be sure that skills from training at the operational level were being applied. The goal is to provide corrective actions at these levels in order to contribute to performance improvement in all priority activities in the Basic Hospital Centres, the EPI in particular.

Activities carried out in 2009

Activity 2.1 Training in financial and programme management for managers at the peripheral level:

- Training of 30 central instructors in anticipation of training on Financial and programme management
- Training n Financial and programme management of 254 peripheral managers in 21 Regions, all but the Region of Melaky, which was conducted in 2008
- Team Building for the meeting on formative monitoring in Financial and programme management for managers at the Region and District level
- Meeting on formative monitoring in Financial and programme management for managers in the 6 administrative centres of the former provinces.

Activity 3.4 Training for Community Health Workers on Community Activities Package (PAC) in the 40 target SDSAS (District Health Services)

- Preparation workshop for the Training of Community Health Workers on Community Activities Package (PAC). The INTER-MINISTERIAL DECREE regarding the institutionalisation of the Health Committee (COSAN), the National Policy on Community Health (PNSC) and the Harmonisation of the Community Approach (HAC) were brought into general use during the training sessions.
- Out of 1200 Community Health Workers (ASC) intended in the proposal, 900 ASC have been trained in PAC in 8 Regions and 15 Districts.

Activity 4.1 Train health workers on the utility and use of data for planning and decision-making (UDD) in 10 Regions and 40 Health Districts :

- Training of 44 Regional Instructors on Data Use of SIG/RMA (Management Information System/Monthly Activities Report) in the Regions of Sofia, Vatovavy Fitovinany, Atsimo Andrefana
- Training of 495 heads of Basic Hospital Centres in 33 districts in 8 Regions: Anosy, Androy, Betsiboka, Sava, Diana, Sofia, Vatovavy Fitovinany, Atsimo Andrefana.

In total, all 640 health workers planned for in the request for support were trained in 2008 and 2009.

The effects of these accomplished activities on health service programmes

1- Training in Financial and programme management for managers at the peripheral level

Managers from 111 Health Districts in 22 regions received training, with the exception of the Region of Melaky, where health workers were trained in 2008; those from the 21 other regions were trained in 2009.
The ageing of technical personnel and the shortage of personnel to replace them, coupled with shortages from unequal allocation of human resources among the different levels of the health system, justify why this training was conducted.

But during formative monitoring in the 4th quarter, we observed a drop in the performance of these workers that can be attributed to their frequent job changes and the lack of skills transfer between the outgoing trained workers and the incoming workers who were not trained; thus a refresher course for newly-recruited personnel proves necessary and of the utmost importance for this year in order to strengthen the supply of quality health services to all of the population.
Despite the political context currently raging in Madagascar, some health workers have applied what they learned in training (alert in the case of a change of epidemic threshold, graphics and dashboards displayed).

2- Training for Community Health Workers on Community Activities Package (PAC) in the target districts

The popularisation of the INTER-MINISTERIAL DECREE regarding the Health Committee (COSAN) and the document containing the National Policy on Community Health (PNSC) during training aims to involve the communes more closely and give them a greater sense of responsibility through a revitalisation of the COSAN in their respective jurisdictions.

The goal of the document regarding the strategy of harmonising the community approach is to inform managers at the operational level on the coordination of interventions by different partners.
The idea is to strengthen social-mobilisation activities in the 8 regions and 15 districts that have received training over the last two years, in order to step up community participation in the different activities outlined in the PAC guide, notably those concerning the immunisation programme.

3- Train health workers on the utility and use of data (UDD) for SIG/RMA (Management Information System/Monthly Activities Report)

As far as Data Use in the Monthly Activity Report is concerned at the district and Basic Hospital Centre level, the Service of Health Statistics in the Ministry of Health, in collaboration with USAID/SantéNet, had already trained all the managers at the peripheral level. To this effect, Data Use training led by the HSS project was part of a refresher course for managers who had already been trained and a way to enhance the abilities of health workers new to their posts. Training curricula were not changed, but the use of data for decision-making in monitoring priority health indicators, especially EPI in the Basic Hospital Centres, was looked at in more detail. Moreover, epidemiological disease surveillance was also gone into in depth in order to reinforce health workers' vigilance when it comes to fighting against diseases.

Within the framework of the implementation of the first phase of the GAVI HSS project, an outstanding balance of the UDD training budget was used for formative monitoring of workers with the goal of evaluating the application of recommendations and skills acquired during training. 2 Basic Hospital Centres per district in 8 regions and 33 trained districts were visited. A monitoring table reflecting the expected post-training results was used.

After this follow-up, the points listed below were noted:

In the Basic Hospital Centres that do not have a SIG management tool, notebooks created and adapted by the Centres to compensate for this deficit were used. Preliminary reports were prepared for priority activities. Efforts to improve the reliability and validity of data in the Monthly Activity Reports were evident upon consultation of report archives. Dates for sending the reports have been respected. Regular reviews (monthly or quarterly) to monitor the activities of the Basic Hospital Centres and for retro-information by health district have been reorganised in the districts.

The health workers in the Basic Hospital Centres visited updated their data. Application of recommendations received in training was observed in the preparation of monographs, dashboards and graphics. Monitoring of the Basic Hospital Centres' priority indicators is posted and carried out following norms. A preliminary plan for exploiting, analysing and using data at their level was initiated by the heads of the Basic Hospital Centres. An initiative to calculate epidemic thresholds (acute respiratory infection (IRA), malaria, diarrhea) in their respective Centres by the heads of the Basic Hospital Centres, was noted.

Some Basic Hospital Centres have even prepared and implemented an action plan in collaboration with the community and local Partners after analysis and interpretation of the data (at the Basic Hospital Centres 2 in Antsaravibe and Ambodimotso Sud).

Progress of EPI indicators in target zones *(Source : Immunisation Service 2008 – 2009)*

Regions	SSD (District Health Service)	Coverage rate PENTA 3		Completion rate	
		2008	2009	2008	2009
Vakinankaratra	Antsirabe II	82.9%	88.6%	100.0%	100.0%
	Antanifotsy	89.9%	86.0%	100.0%	100.0%
	Betafo	100.4%	115.0%	100.0%	100.0%
	Faratsiho	84.8%	87.6%	100.0%	100.0%
DIANA	Antsiranana II	93.9%	52.6%	100.0%	100.0%
	Ambilobe	81.7%	78.3%	100.0%	100.0%
SAVA	Sambava	64.9%	63.2%	100.0%	100.0%
	Antalaha	71.9%	85.4%	100.0%	100.0%
	Vohémar	73.3%	94.9%	100.0%	100.0%
SOFIA	Mampikony	101.3%	93.8%	100.0%	100.0%
	Port Bergé	102.8%	105.3%	100.0%	100.0%
	Antsohihy	49.6%	50.6%	100.0%	100.0%
	Befandriana	69.2%	116.0%	100.0%	100.0%
	Mandritsara	88.7%	97.8%	100.0%	100.0%
	Bealalanana	72.6%	91.7%	100.0%	100.0%
	Analalava	102.5%	39.3%	100.0%	83.3%
Vatovavy Fitovinany	Ikongo	72.3%	55.0%	100.0%	100.0%
	Ifanadina	85.1%	106.9%	100.0%	100.0%
	Manakara	85.9%	84.4%	100.0%	100.0%
	Vohipeno	44.8%	49.7%	100.0%	100.0%
	Nosy Varika	98.9%	81.9%	100.0%	91.6%
	Mananjary	71.1%	73.1%	100.0%	100.0%
Betsiboka	Tsaratanana	102.6%	97.7%	100.0%	100.0%
	Kandreho	92.5%	126.9%	83.3%	100.0%
Atsinanana	Mahanoro	82.9%	69.7%	100.0%	100.0%
	Antanambao Manampotsy	92.4%	95.6%	100.0%	100.0%
	Marolambo	109.1%	56.3%	100.0%	100.0%
Atsimo Andrefana	Toliara I	86.3%	89.5%	100.0%	100.0%
	Toliara II	79.6%	59.6%	100.0%	100.0%
	Morombe	84.3%	64.4%	91.6%	100.0%
	Betioky	75.2%	38.8%	91.6%	100.0%
	Ampanihy	59.9%	53.3%	91.6%	100.0%
	Ankazoabo	87.8%	66.4%	100.0%	100.0%
Anosy	Taolagnaro	87.3%	93.7%	100.0%	100.0%
	Amboasary	100.2%	113.0%	100.0%	100.0%
	Betroka	88.1%	58.1%	100.0%	100.0%
Androy	Ambovombe	81.4%	110.7%	100.0%	100.0%
	Tsihombe	90.5%	87.8	100.0%	100.0%
	Beloha	127.2%	109.9	100.0%	100.0%
	Bekily	79.5%	92.6	100.0%	100.0%

Clear improvement has been noted in the vaccination coverage rate, which can be justified by the effectiveness of nearly 100% sending of monthly reports to the central level, whereas the promptness of monthly activity reports (MAR) depends on accessibility problems in remote areas. This constantly creates a bottleneck.

Problems encountered and proposed solutions

1. FOR TRAINING IN FINANCIAL AND PROGRAMME MANAGEMENT

The unavailability of managers at all levels (Central, Region, District) through overlapping of prioritised activities in each Directorate concerned and the political-social situation remain the greatest hindrances to the accomplishment of planned activities.

2- FOR TRAINING COMMUNITY HEALTH WORKERS ON PAC

Two workshops per target district were held simultaneously instead of just one workshop per district planned in the proposal due to the number of participants per district. Participants included community workers, members of civil society and the heads of Basic Health Centres, including four community workers for each target Basic Health Centre, fifteen CSB per health district.

Training planned in the other target zones was not carried out because the planned budget was insufficient to cover costs.

3- FOR TRAINING HEALTH WORKERS IN DATA USE

The political-social situation that the country is currently going through has provoked disruptions and unforeseen hitches in the implementation of activities and in the release of funds. GAVI HSS Project activities did not begin until October 2008. Many managers and health workers practising in target areas have been redeployed or replaced during the political crisis taking place in Madagascar. Some health facilities were closed due to a lack of doctors, obliging those in charge to propose other health facilities in the place of those targeted in the proposal.

As a result of the current political-social context in the country, 30% of trained peripheral managers have been frequently replaced. This situation has had a considerable impact on the process of putting the project into place. The shortage of resources, rolling stock in particular, is a major hindrance to organisers at the level of the Directorate for Health Districts (DDS).

Monitoring and supervision by the Regional Management Team (EMAR) and the District Management Team (EMAD) is insufficient, especially on Data Use. The budget planned for monitoring to be conducted by the intermediate level was not taken into account in the request for support. The outstanding balance from the training budget permitted the formative monitoring of health workers to be carried out. Integrating monitoring and supervision with that of the vertical programmes has been proposed.

During this situation, a significant disturbance in activities, causing variations in general performance in the districts, has been observed.

For that purpose, an assessment of the progress of the indicators was conducted during formative monitoring visits to workers in the target districts and Basic Health Centres.

Recommendations / suggestions for GAVI with the goal of improving future performance

We call upon GAVI to provide financial support to ensure the follow-up and supervision of trained workers in the framework of the GAVI HSS Project in view of the inability of intermediate levels (regions and health districts), faced with an insufficiency of resources, to take on this allocation. Furthermore, the strategy of integration into other programmes, which has already been implemented at these levels, is not sufficient to cover everything if we really want to have the products, results and impact on the indicators for the improvement in performance in the target zones.

General conclusions

Operational-level manager training on the activities described in the proposal and implemented in the use of this first block of financing, is within the framework of the strengthening of the health system anticipated after the project and constitutes the basis for improvement of health services, notably in the immunisation programme. It also represents an opportunity for real application of decentralisation and the GAR approach: “performance-based results”.

On the whole, the regions are undergoing radical transformation and it is worth supervising and supporting them to prevent a waning of energy and enthusiasm on the part of the teams. It has been observed that the EMAD (District Management Teams) have made real efforts to support their respective teams despite a lack of resources and means at their disposal. For the most part, managers in Basic Health Centres also strive to follow instructions and recommendations as much as possible.

Despite the political and social context in Madagascar that has caused disruptions in the implementation and

accomplishment of all the activities planned, along with the exceedingly heavy load of work borne by the Basic Health Centres, real application of the training has been observed during follow-up visits. A change in the behaviour of health care workers is being felt and should be accompanied and supported.

Support from the EMAR (Regional Management Team) is insufficient, or supervision is necessary at the higher level if we want to truly improve performance and obtain the expected results.

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.

Within the framework of training carried out on programming and using data, operational planning was developed. In the implementation process, civil society organisations were taken into account. These organizations are key players in strengthening the health system.

The Civil Society and the NGOs validated the technical proposal. They participated in the implementation of activities related to training community health workers on the Community Activities Package (PAC), which consists in developing community strategies.
In addition, they are part of the HSCC and will always be involved in the process of monitoring GAVI HSS activities and the dissemination of the results.

5.6 *Management of HSS 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 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.

The GAVI HSS programme opened a commercial bank account. This account includes one account in local currency (Ariary) and a second one in foreign currency (Dollars).
Funds from GAVI Alliance are deposited in a foreign currency account. The account in local currency is used, on the one hand, to receive transfers of money from the foreign currency account and, on the other hand, to take care of expenses at the regional and district levels in the scope of the HSS activities described in the proposal and the plan.

Since the month of January 2009, management of the HSS programme has been carried out by the Ministry's Directorate of Health Districts (DDS). There is a Project Management Unit based at the DDS working under the supervision of the General Secretariat and the General Director of Health.

HSS funds are integrated into the annual work plan (AWP) of the DDS which itself is inscribed in the AWP of the Ministry's General Health Directorate.

Moreover, these HSS funds are released after validation of an activity request signed by the Director of Health Districts, the Coordinator of the HSS programme.

The Project Management Unit designated an administrative person from the Ministry to manage the funds for each activity.
The political and social crisis in Madagascar obliged us to apply this procedure in order to avoid delays in the sending of supporting documents on the part of the Regional Public Health Department (DRSP) and the District Public Health Service (SDSP).
Furthermore, frequent changes in management within the Department of Health, especially at the peripheral level, led us to this decision.

Once activities have been completed, the original supporting documents are verified and filed away by the Project Management Unit.

This Unit will prepare expense reports indicating the sources and use of funds as well as any supporting documents justifying the expenses and accompanying bank records.

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° 09).** *(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

Name of Objective or Indicator *(Insert as many rows as necessary)*	**Numerator**	**Denominator**	**Data Source**	**Baseline Value and date**	**Baseline Source**	**2009 Target**
Objective 1: Strengthen the supply of quality health services to all the population						
1.1 Percentage of contracted health workers	Number of contracted workers	Anticipated number of workers to be contracted	Contracts signed and counted by the Partner Service and the Director for Health Districts (DDS)	0 - 2007	n.a.	
1.2 Presence of an evaluation report and a protocol for pilot-testing strategies	n.a.	n.a.	Report furnished by DDS	n.a.	n.a.	
1.3 Identification of strategies having contributed to increased use of services	n.a.	n.a.	Report furnished by DDS	n.a.	n.a.	
1.4 Percentage of CSB renovated, among the 45 planned	Number of CSB renovated	45	Acknowledgements of work performed and work follow-up reports, obtained by DRS and DDS	0 – 2007	n.a.	
1.5 Percentage Annual Work Plans (AWP) validated before the end of the year, by year	Number of AWP validated before the end of the year	133 (111 districts + 22 regions) per year	Validation mission reports – DGS/DDS and regions	79% - 2007	Mission report DGS/DDS	
1.6 Percentage of districts and CSB equipped with 4x4 vehicles and motorcycles	Number of districts and CSB equipped with 4x4 vehicles and motorcycles	132 (10 SSD + 2 central et 120 CSB)	Delivery confirmations and invoices furnished by HSS activities coordinating team	0 - 2007	DGS/DDS	
Percentage of districts and CSB in which the vehicles are operational	Number de SSD et de CSB in which the vehicles are operational	132 (10 SSD + 2 central et 120 CSB)	Usage report and maintenance and fuel invoices produced by the Medical Inspector and the doctor in charge of the CSB (holder)	0 - 2007	DGS/DDS	
1.7 Identification of strategies having contributed to increased financial access	n.a.	n.a.	Report furnished by DGS/DDS	n.a.	n.a.	
Objective 2 : Increase mobilisation and improve the allocation of financial resources						

2.1 Percentage of managers trained	Number of managers trained (266)	Total number of managers (266)	Training report. Attendance sheet.	100% - 2009	Proposal RSS GAVI PMO /RSS 2009	Training in financial and programme management for peripheral managers in the 22 regions and 111 districts
Percentage of peripheral managers having received formative monitoring	Number of peripheral managers having received formative monitoring (266)	Total number of peripheral managers targeted (266)	Monitoring grids for districts Mission reports	100% - 2009	PMO/RSS 2009	Ensure formative monitoring for managers trained in financial and programme management in the 22 regions and 111 districts
2.2 Percentage of health facilities having undergone audit and monitoring	Number of health facilities audited	Total number of health facilities	Audit reports furnished by EMAR (Regional Management Teams) and DGS/DDS	0 - 2009	DGS/DDS	
List of corrective strategies at the national level			Analysis and consolidation of audit reports by the DGS/DDS			
Guide for practical use of corrective strategies						
Objective 3: Stimulate the demand for, and use of, of health services						
3.1 List of NGOs and associations working at the community level by region			DGS/DDS			
3.2 Percentage of meetings held in each commune annually	Number of communes in which 3 meetings were held	160	Meeting minutes furnished by district	0 - 2007		
3.3 Existence of a community health policy			DGS/DDS			
3.4 Percentage of community health workers trained	Number of community workers trained in target zones (900)	Total number of community workers to be trained in target zones (2400)	GAVI HSS proposal Training reports	37.5% - 2009	GAVI HSS proposal PMO/RSS 2009	Train 2400 community workers in target zones
Objective 4: Strengthen and institutionalise a system of monitoring and evaluation						

4.1 Percentage of health workers trained	Number of health workers trained (640)	Total number of health workers targeted (640)	GAVI HSS proposal Training reports	100% - 2009	GAVI HSS proposal PMO/RSS 2009	Train 640 health workers in target zones
Percentage of CSB having received formative monitoring	Number of CSB having received formative monitoring (68)	Number of CSB targeted (80)	GAVI HSS proposal Mission reports	85% - 2009	PMO/RSS 2009	Ensure formative monitoring for workers trained in Data Use (UDD) in 80 CSB
4.2 Evaluation report identifying bottlenecks			DGS/DDS	0	2007	
4.3 Percentage of CSB having received 4 reviews per year	Number of CSB having received 4 reviews per year	Total number of CSB=600	District (SSD)	0	2007	
4.4 Percentage of regions and districts receiving coaching	Number of districts and regions visited 4 times per year	50 (10 regions and 40 districts)	DGS/DDS	0	2007	
Percentage of districts targeted by GAVI HSS having received computer materials	Number of districts having received computer materials	40	Invoices and receipts for materials, obtained by DRS and DGS/DDS	0	2007	

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

Generally speaking, no change was made in the use of the projected indicators from the original request

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**
2.1 : Percentage of peripheral managers trained in financial and programme management		4.5% 12 peripheral managers trained in the Region of Melaky	95.5% 254 peripheral managers trained in 21 Regional Health Directorates	
Percentage of trained peripheral managers having received formative monitoring in financial and programme management			100% 22 DRSP and 111 SSD received formative monitoring in 2009	
3.4 : Percentage of community workers trained on Community Activities Package (PAC) in the target zones			37.5% 900 community workers and 225 CSB heads trained on PAC in the target zones (out of 2400 to be trained)	900 Community Health Workers out of 2400 anticipated and 225 CSB heads were trained in 15 Districts. Scheduled training in the other target zones was not conducted because the allowed budget was not sufficient to cover expenses The difference is due to : - a budgeting error in the Proposal: 1200 Community Health Workers (see Proposal, page 30) instead of the 2400 anticipated in the 2008 plan. - two workshops held simultaneously per target Health District instead of just the one planned in the Proposal (4 Community Health Workers per Basic Health Centre (CSB) along with the head of the CSB)
4.1 : Percentage of health workers trained in Data Use (UDD)		17.5% 112 health workers trained on Date Use in the 7 Districts	82.5% 528 health workers trained in Data Use in the 33 Districts	**4.1 :** Number of health workers trained in Data Use
Percentage of Basic Hospital Centres (CSB) having received formative monitoring on Data Use (UDD)			85% 68 CSB in 34 SSD in 2009	Remaining to be supervised: 12 CBS in 6 SSD

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

A planning error has been noted in the Proposal in Objective 3 – Activity 3.4: Train health workers on Community Activities Package (PAC) in 40 target SSD.

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

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**°.....).

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

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

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).

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

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

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

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

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

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

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

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	N/A
2	Signature of Minister of Finance (or delegated authority) of APR	Y	Y	Y	N/A
3	Signatures of members of ICC/HSCC in APR Form	Y	Y	Y	
4	Provision of Minutes of ICC/HSCC meeting endorsing APR	Y	Y	Y	
5	Provision of complete excel sheet for each vaccine request		Y		
6	Provision of Financial Statements of GAVI support in cash	Y		Y	N/A
7	Consistency in targets for each vaccines (tables and excel)		Y		
8	Justification of new targets if different from previous approval (section 1.1)		N/A		
9	Correct co-financing level per dose of vaccine		Y		
10	Report on targets achieved (tables 15,16, 20)			Y	N/A
11	Provision of cMYP for re-applying				

	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/A		ND	
15	Provide information on procedure for management of cash	Y		Y	
16	Health Sector Review Report			Y	
17	Provision of new Banking details	N/A	N/A	N/A	N/A
18	Attach VMA if the country introduced a New and Underused Vaccine before 2008 with GAVI support		Y		
19	Attach the CSO Mapping report (Type A)				N/A

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

~ 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**