GAVI Alliance

Annual Progress Report 2011

Submitted by

The Government of

Myanmar

Reporting on year: **2011**
Requesting for support year: **2013**
Date of submission: **5/28/2012**

Deadline for submission: 5/22/2012

Please submit the APR 2011 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

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 the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) 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 APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by 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.

1. Application Specification

Reporting on year: **2011**

Requesting for support year: **2013**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	Measles, 10 dose(s) per vial, LYOPHILISED	Measles, 10 dose(s) per vial, LYOPHILISED	2016
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2016

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2011	Request for Approval of
ISS	Yes	ISS reward for 2011 achievement: Yes
HSS	Yes	next tranche of HSS Grant Yes
CSO Type A	No	Not applicable N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2011: N/A

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2010 is available here.

2. Signatures

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

By signing this page, the Government of Myanmar 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 this Annual Progress Report (APR).

For the Government of Myanmar

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

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Professor Dr. Pe Thet Khin	**Name**	U Kyaw Htay
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

Full name	Position	Telephone	Email
Dr. Kyaw Kan Kaung	Project Manager/Assistant Director	0095-9-8702267	kyawkankaungmo@gmail.com

2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) 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.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating 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.

Name/Title	Agency/Organization	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:

2.3. HSCC signatures page

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

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

Name/Title	Agency/Organization	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:

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

Myanmar is not reporting on CSO (Type A & B) fund utilisation in 2012

3. Table of Contents

This APR reports on Myanmar's activities between January – December 2011 and specifies the requests for the period of January – December 2013

Sections

4. Baseline & annual targets

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Total births	1,508,265	1,586,789		1,510,745		1,519,321		1,527,254		1,521,058
Total infants' deaths	58,822	61,030		55,898		54,696		51,972		50,195
Total surviving infants	1449443	1,525,759		1,454,847		1,464,625		1,475,282		1,470,863
Total pregnant women	1,598,761	1,647,819		1,586,282		1,580,093		1,588,344		1,566,689
Number of infants vaccinated (to be vaccinated) with BCG	1,402,687	1,411,894	1,404,993	1,404,993	1,412,968	1,412,968	1,450,891	1,450,891	1,445,005	1,445,005
BCG coverage	93 %	89 %	93 %	93 %	93 %	93 %	95 %	95 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,318,993	1,366,303	1,353,008	1,353,008	1,362,101	1,362,101	1,386,808	1,386,808	1,382,611	1,382,611
OPV3 coverage	91 %	90 %	93 %	93 %	93 %	93 %	94 %	94 %	94 %	94 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,347,982	1,350,134	1,353,008	1,353,008	0	1,397,027	0	1,415,110	0	1,410,828
Number of infants vaccinated (to be vaccinated) with DTP3	1,318,993	1,318,388	1,323,911	1,323,911		1,362,101		1,386,808		1,382,611
DTP3 coverage	91 %	86 %	80 %	91 %	0 %	93 %	0 %	94 %	0 %	94 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	44	0	40	0	25	0	15	0	15
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.79	1.00	1.67	1.00	1.33	1.00	1.18	1.00	1.18
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib		0	669,070	669,070	1,392,037	1,392,037	1,417,287	1,417,287	1,412,998	1,412,998
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib		0	654,681	654,681	1,362,101	1,362,101	1,386,808	1,386,101	1,382,611	1,386,611
DTP-HepB-Hib coverage		0 %	45 %	45 %	93 %	93 %	94 %	94 %	94 %	94 %
Wastage[1] rate in base-year and planned thereafter (%)		0	25	25	20	20	20	20	15	15
Wastage[1] factor in base-year and planned thereafter (%)		1	1.33	1.33	1.25	1.25	1.25	1.25	1.18	1.18
Maximum wastage rate value for DTP-HepB-Hib, 10 doses/vial, Liquid	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,304,499	1,344,922	1,309,363	1,309,363	1,332,809	1,332,809	1,357,301	1,357,301	1,367,902	1,367,902
Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles		0	1,163,878	1,163,878	1,142,407	1,142,407	1,180,262	1,180,262	1,206,107	1,206,107
Measles coverage	90 %	0 %	80 %	80 %	91 %	78 %	92 %	80 %	93 %	82 %
Wastage[1] rate in base-year and planned thereafter (%)	0	45	40	40	0	0	0	0	0	0

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Wastage[1] factor in base-year and planned thereafter (%)	1	1.82	1.67	1.67	1	1	1	1	1	1
Maximum wastage rate value for Measles, 10 dose (s) per vial, LYOPHILISED	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %
Pregnant women vaccinated with TT+	1,406,910	1,413,659	1,427,654	1,427,654	1,437,885	1,437,885	1,461,277	1,461,277	1,457,021	1,457,021
TT+ coverage	88 %	86 %	90 %	90 %	91 %	91 %	92 %	92 %	93 %	93 %
Vit A supplement to mothers within 6 weeks from delivery	0	1,069,230	0	1,087,941	0	1,106,980	0	1,126,352	0	1,146,064
Vit A supplement to infants after 6 months	N/A	641,538	N/A	652,765	N/A	664,183	N/A	675,811	N/A	687,638
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	2 %	2 %	2 %	2 %		3 %		2 %		2 %

Number	Targets (preferred presentation)	
	2016	
	Previous estimates in 2011	Current estimation
Total births		1,513,433
Total infants' deaths		46,916
Total surviving infants		1,466,517
Total pregnant women		1,558,836
Number of infants vaccinated (to be vaccinated) with BCG	1,437,761	1,437,761
BCG coverage	95 %	95 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,393,190	1,393,190
OPV3 coverage	95 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1	0	1,421,622
Number of infants vaccinated (to be vaccinated) with DTP3		1,393,190
DTP3 coverage	0 %	95 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	15
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.18
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	1,423,810	1,423,810
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	1,393,190	1,393,190

Number	Targets (preferred presentation)	
	2016	
	Previous estimates in 2011	Current estimation
DTP-HepB-Hib coverage	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%)	15	15
Wastage[1] factor in base-year and planned thereafter (%)	1.18	1.18
Maximum wastage rate value for DTP-HepB-Hib, 10 doses/vial, Liquid	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,378,525	1,378,525
Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles	1,246,539	1,246,539
Measles coverage	94 %	85 %
Wastage[1] rate in base-year and planned thereafter (%)	0	0
Wastage[1] factor in base-year and planned thereafter (%)	1	1
Maximum wastage rate value for Measles, 10 dose (s) per vial, LYOPHILISED	50.00 %	50.00 %
Pregnant women vaccinated with TT+	1,465,305	1,465,305
TT+ coverage	94 %	94 %
Vit A supplement to mothers within 6 weeks from delivery	0	1,166,120
Vit A supplement to infants after 6 months	N/A	699,672
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100		2 %

*

** Number of infants vaccinated out of total surviving infants

*** Indicate total number of children vaccinated with either DTP alone or combined

**** Number of pregnant women vaccinated with TT+ out of total pregnant women

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

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2011 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2011.** The numbers for 2012 - 2016 in Table 4 Baseline and Annual Targets 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 fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  There is change of birth as the 2011 data reported in annual evaluation . Other base line data for 2012 onwards remain unchanged as mentioned in cMYP(2012-2016).

- Justification for any changes in **surviving infants**

  The data compiled from annual evaluation shows that there is change of surviving infants .Other base line data for 2012 onwards remain unchanged as mentioned in cMYP(2012-2016).

- Justification for any changes in **targets by vaccine**

  The target children for each antigen has been changed due to change of reported figure in the annual evaluation.Other base line data for 2012 onwards remain unchanged as mentioned in cMYP(2012-2016).

- Justification for any changes in **wastage by vaccine**

  The wastage rate for every antigen remain unchanged.

5.2. Immunisation achievements in 2011

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2011 and how these were addressed:

Routine immunization coverage for 2011 is as follows; BCG- 93 % , DTP1 88 % , DTP3 86 %, OPV3 90 % and Measles 1st dose 88 %.The immunization activities of Mobile session in physically hard to reach areas where the session were planned in 3 months in open season could not be conducted due to inadequate supply of DTP vaccine and Hep B and delay in receiving the operational costs from partners (UNICEF/ WHO) .

Antigen Achievement in 2011

BCG
93%Challenges : Hep B vaccine for new born is very difficult as only 8-10 % of deliveries are in hospitals

DPT 1
88%

DPT3
86%

OPV3

90%

MCV
88%

Challenges faced:-

- No operational cost from government budget, donor dependent activities, including supply of all vaccines,
- A single case of VPDP was reported in Dec 2010 in Mandalay region,With support from UNICEF and WHO govt conducted a Sub national Polio immunization campaign in 129 townships targeting around 2.9 million children 0-5 years with two doses of OPV.
- With the new government in place there are changes in the administrative set up, Regional Health departments are being strengthened, how ever still there are unclear areas and roles and responsibilities
  In parts of country the security situation is still not very good, specifically in areas of Kachin state and Shan state. There are pockets where EPI services were conducted. A total of 17 townships had no routine immunization services conducted in 2011 approx (20,000) children under 1 missed in there townships. There area are very hard to reach and remote very sparse population and poor infra-structure , road communication is limited and also health man power is limited.
- Correct estimation of target population is not known ,
- Shortage of Mid wifes / HW specifically in rural hard to reach areas.
- Cold chain capacity is limited, electricity supply is poor in most part of country and hence vaccines are kept only at sub depots (state level). Vaccine transportation cost is very high as it has to be delivered by special trucks and Air (with on operational cost its again donor depended). Mainteiance cost for generators / IEC not available
- Vaccines are not stored at township level or at Rural Health center level there by Health workers get vaccine once a month and they have to rush to complete immunization in 3-4 days , first week of every month. Missed oppurtunitites are high, sessions are short timed and hurriedly conducted as cold chain is a mjot concern
- In 2011 24% of townships had less than 80% coverages and auonf 100,000 missed children in these areas.
- Large measles outbreak were seen in 2011 , a total of 32 measles lab confirmed outbreaks were reported. where 890 cases were reported some 7 children also died beacuse of measles complication
- Case based measles surveillance has also reported more han 1857 cases last year. Subsequesnlty in ealry 2012 a nation wide mass measles capmaign has been conducted to protect all under 9- 5 years children from measles

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

- National Immunization programme could not provide the Hepatitis B vaccine since April 2011 and the expected delivery of DTP vaccine in August 2011 was not materialized . Consequently buffer stock has started to use since September 2011and all stock was completed in December 2011.
- Consequently the coverage of these two antigen were significantly reduced all over the country . However the remaining antigens were available and Immunization sessions were continued as planned
- On going armed insurgency and conflict in some border areas of country has resulted in interruption of EPI vaccination and a total of 17 townships could not implement EPI program in 2011
- Lack of funds to support travel of health workers to session site, poor supervision of activities are also reasons for low coverages in some pockets
- No NGO's in EPI ,Limited no of partners

5.3. Monitoring the Implementation of GAVI Gender Policy

In the past three years, were the sex-disaggregated data on immunisation services access available in your country? Choose one of the three: **no, not available**

If yes, please report all the data available from 2009 to 2011

Data Source	Timeframe of the data	Coverage estimate

How have you been using the above data to address gender-related barrier to immunisation access?

In Myanmar there are no gender related barriers for routine EPI , The immunization program is free service to population, how ever this issue is being seriously considered, At last ICC on 11th May Members have also raised this issue and urged to address this point at the earliest

If no sex-disaggregated data is available at the moment, do you plan in the future to collect sex-disaggregated data on routine immunisation reporting? **Yes**

What action have you taken to achieve this goal?

The country is planning to conduct census on 2013-2014 . EPI is planning to collect and analyze the immunization coverage data for sex-disaggregation in future . As part of Nev vaccine introduction and intensification of routine program

- Revision of EPI recording , reporting formats,charts
- Revision of micro-planning formats, registers
- Revision of EPI guidelines

In all these documents revision are being made in 2012 , for future to capture and report EPI data sex disaggregated

5.4. Data assessments

5.4.1. 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)

Myanmar has not had a population census since last 30 years, all programs work on best estimates only In 2011 there is discrepancies between reported data and collected data in some survey areas where the date collection was done for other purpose such as assessment of integrated household and livelihood survey and rapid assessment in disaster affected areas. Also due to rapidly changing political situation in country there is quite a lot internal migration of population, urbanization construction etc, this is resulting in denominator and reported coverages

* Please note that the WHO UNICEF estimates for 2011 will only be available in July 2012 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2010 to the present? **Yes**

If Yes, please describe the assessment(s) and when they took place.

in 2009-2010 **UNICEF** in collaboration with Ministry of Health and National Planning and Economic Development Ministry conducted MICS survey in Myanmar . The report was released in 2011, This survey reported a very high level of EPI coverage, almost on line with reported coverages or even more. The methodology ,quality of this coverage survey has been questioned by partners specifically WHO , since the survey results and data is misleading its not being used, reported

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2009 to the present.

- Regular supportive supervision at field level supervisors by Central, Regional and Township level in high risk townships.
- Head counted activities were instructed to do at the end of every year to ensure denominator to reflect the field reality.
- In crease in no of EPI evaluation meeting at central and state level.
- Computerization of EPI data, (in progress)

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

The Government of Union of Myanmar is planning to conduct a national census in 2013-2014 and the stratified data will be available for better planning

Sub national EPI reviews are being planned in two states for 2012-2013

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** and **Table 5.5b** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 825	Enter the rate only; Please do not enter local currency name

Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	Expenditure Year 2011	Source of funding						
		Country	GAVI	UNICEF	WHO	JCV	EU&Aus Aid	CERF/UNF
Traditional Vaccines*	2,250,198	0	0	1,722,313	0	527,885	0	0
New and underused Vaccines**	89,000	0	0	0	89,000	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	226,866	0	0	102,784	0	124,082	0	0
Cold Chain equipment	161,833	0	0	53,388	0	0	108,445	0
Personnel	1,368,280	1,242,780	0	60,500	65,000	0	0	0
Other routine recurrent costs	92,720	0	0	42,720	50,000	0	0	0
Other Capital Costs	50,000	0	0	0	50,000	0	0	0
Campaigns costs	4,013,072	0	0	3,804	250,000	641,975	749,578	2,367,715
Procurement of IT equipment and Immunization Cards		0	0	75,002	0	0	0	0
Total Expenditures for Immunisation	8,251,969							
Total Government Health		1,242,780	0	2,060,511	504,000	1,293,942	858,023	2,367,715

* 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 state if an Annual Action Plan for the year 2011, based on the cMYP, was developed and costed.

5.5.1. If there are differences between available funding and expenditures for the reporting year, please clarify what are the reasons for it.

There are difference between available funding and expenditures.GAVI ISS fund to strengthen routine immunization is available but the fund was received in last quarter of 2011.Please see the attachments for detail expenditures from UNICEF and WHO since the table 5.5 a allows to enter only 3 donors.

5.5.2. If less funding was received and spent than originally budgeted, please clarify the reasons and specify which areas were underfunded.

NA.

5.5.3. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2012 and 2013

There is no funding from the Government for the traditional vaccine . Government support for immunization programme is currently focused on human resource and basic salary for immunizers and supervisors and the facilities for immunization in term of health center . Government has agreed to start to co-finance for new vaccine introduction in 2012 -2016 for Pentavalent vaccine targeting all eligible children.

There are no govt funds for supporting routine EPI services in Myanmar . Health workers have to pay out of pocket for Iec cost, transportation cost to visit session aites .Hence many a times HW do not conduct sessions in hard to reach areas, Simailarly supervsiors are not paid for any viasit including

Table 5.5b: Overall Budgeted Expenditures for Immunisation from all sources (Government and donors) in US$.

Expenditure by category	Budgeted Year 2012	Budgeted Year 2013
Traditional Vaccines*	2,787,216	2,236,124
New and underused Vaccines**	6,253,795	10,541,926
Injection supplies (both AD syringes and syringes other than ADs)	1,269,276	1,290,124
Injection supply with syringes other than ADs	0	0
Cold Chain equipment	3,875,495	4,056,865
Personnel	4,796,757	4,892,692
Other routine recurrent costs	5,501,452	5,658,109
Supplemental Immunisation Activities	4,874,069	923,633
Total Expenditures for Immunisation	29,358,060	29,599,473

* 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.

If there are major differences between the cMYP projections and the budgeted figures above, please clarify the main reasons for it.

5.5.4. Are you expecting to receive all funds that were budgeted for 2012 ? If not, please explain the reasons for the shortfall and which expenditure categories will be affected.

No.

5.5.5. Are you expecting any financing gaps for 2013 ? If yes, please explain the reasons for the gaps and strategies being pursued to address those gaps.

Yes. The costing in cMYP are based on the optimal standard for the immunization programme and there are gaps for implementation of the addressed activities especially for operational costs and maintenance of building and equipments.Currently the programme has being planned for donor advocacy and fund raising activities.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2011 calendar year? **Yes, fully implemented**

If Yes, briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

Action plan from Aide Mémoire	Implemented?
As outlined in FMA, ISS fund management has been done as in last years.	Yes

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

If none has been implemented, briefly state below why those requirements and conditions were not met.

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2011? **3**

Please attach the minutes **(Document N°)** from all the ICC meetings held in 2011, including those of the meeting endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.5 Overall Expenditures and Financing for Immunisation

Are any Civil Society Organisations members of the ICC? **Yes**

If Yes, which ones?

List CSO member organisations:
Myanmar Women's Affairs Federation
Myanmar Maternal and Child Welfare Association
Myanmar Red Cross Society
Japan International Co-operation Agency

5.8. Priority actions in 2012 to 2013

What are the country's main objectives and priority actions for its EPI programme for 2012 to 2013?

- Intensification of Routine Immunization by identifying the gap coverage, using Reaching Every Community Strategy implementation
- Introduction of New Vaccine (Pentavalent) in mid 2012 and Mid Level manager training at national level followed by comprehensive Immunization trainings for all Township medical officers, Health workers in entire country.
- Advocacy meeting with medical associations on NVI and RI intensification
- Support to field staff in by provision of two wheelers in HRA and jeeps for regional / state level supervisiors to enhance supervision
- Sub national EPI review in two provinces
- Updating of EPI guidelines , new HW guidelines planning tools, microplanning formats, recording and reporting formats
- New communication strategy for reaching all areas of community , new posters, baners, branding
- Introduction of regular Measles second dose in routine immunization at 18 months
- Nationwide Mass Measles Campaign (Conducted in March 2012)
- Improvement Activities of cold chain system based on EVM assessment report and identification of strategic options for cold chain and logistics
- Temperature monitoring study on vaccines
- Strengthening of AEFI management, revision of guidelines
- MNTE maintenance strategies life long TT cards , school plan & TT SIA in High risk areas
- Strengthening National Comminitee on Immunizatin Practices (NCIP)
- EPI coverage Survey (2013)
- Sero Survey for Polio and measles in slect identified high risk ares
- Strengthening of VPD surveillance specifically in silent areas
- Invasive Bacterial Disease surveillance and Rota surveillance initiation
- Typhoid surveillance in tow townships (in collaboration with Medical research departments)

Are they linked with cMYP? **Yes**

5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2011

Vaccine	Types of syringe used in 2011 routine EPI	Funding sources of 2011
BCG	BCG AD syringe	UNICEF
Measles	AD syringe	UNICEF
TT	AD syringe	UNICEF
DTP-containing vaccine	AD syringe	UNICEF
Hepatitis B	AD syringe	GAVI

Does the country have an injection safety policy/plan? **Yes**

If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

If No: When will the country develop the injection safety policy/plan? (Please report in box below)

There is limitation of materials for safe disposal of injection devices such as incinerators and shortage of fund for transport of waste products to the sites for proper disposal . Limited incinitators at township level

Please explain in 2011 how sharps waste is being disposed of, problems encountered, etc.

The sharp wastes are collected in the safety boxes and burnt i and buried in pit at Rural Health centers and disposed by incinerators in Urban areas where the facility is available. How ever in many townships incinerators are not available or non functional . This is a major concern .

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2011

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	2,628,038	2,168,131,350
Remaining funds (carry over) from 2010 *(B)*	0	0
Total funds available in 2011 *(C=A+B)*	2,628,038	2,168,131,350
Total Expenditures in 2011 *(D)*	0	0
Balance carried over to 2012 *(E=C-D)*	2,628,038	2,168,131,350

6.1.1. 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.

The ISS programme is managed by the Inter Agency Coordinating Committee (ICC). After receipt, from GAVI, of notification of approval of GAVI ISS reward money to the country, the central EPI unit at the DoH will develop a plan of action with budget for immunization services strengthening in the country. The ICC, chaired by Director General DOH, MOH-M and with members drawn from the MoH-Myanmar, WHO and UNICEF and in-country development partners (tbc), will meet 3-4 timers annualy or more yearly to: • Review and endorse plans and budgets to be submitted to WHO through Planning Division, DoH using Direct Financial Cooperation (DFCs) or Agreement for Programme of Work (APWs) • Oversee, through receipt of progress reports and financial statements prepared by the MoH-Myanmar
EPI Manager, programme implementation and approve financing arrangements of the programme;

6.1.2. 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

a.ISS proposals will be reviewed by the MO-EPI in WHO and passed on to WHO Budget and Finance unit to release the funds (by cheque in local currency). The DoH will receive the funds and further release them to Central, State/ Region and township levels depending upon the activity implementation status.
b. ICC will oversee programme and financial implementation including the review of quarterly financial monitoring submitted by MOH, WHO, and UNICEF, containing the analysis of expenditure against budget.
c. ICC will receive and review end of year financial statements of ISS and provide comments and/or raise issues.
d. ICC will request when considered necessary that internal MOH audit of MOH managed funds of ISS funding mechanisms are undertaken at an appropriate time through-out the year.
e. ICC will ensure that the external audit of MOH of ISS programmes is conducted within agreed time frames and that external audit reports are submitted to the GAVI Secretariat no later than 6 months following the end of the financial year. The ICC will also ensure that any issues raised in the internal or external audit letters to management are addressed in a timely way;
f. ICC will request UNICEF to take responsibility for procurement of new vaccine, cold chain equipment and safe injection support and WHO to act as administrator and manager of ISS funds.
g. An MoH internal audit team will be formed with representatives from the MoH to undertake random, unannounced reviews of the townships which are part of the HSS and ISS programmes. Internal audit responsibility will be extended to the management arrangements established by the Township Health Committees, the TMO and his/her accounting staff. This audit plan will be risk-based and will set out which aspects of internal control will be tested, how many auditors will be deployed to do the work (audit man days) and the geographical areas to be covered. Subsequent audit findings and audit reports will be presented to the Director General and the ICC for information and follow-up.
h. The Office of Auditor General (Ministerial Level) will conduct an external audit of the MOH HSS and ISS programme financial statements. The Auditor General will be notified well in advance of the end of the financial year of the obligations to GAVI for external audit and the Terms of Reference for the external audit (to be provided by GAVI before the end of the first year of implementation). External Audit reports on HSS and ISS programmes will be provided to the NHSC and ICC respectively, and to the DG MoH. An independent 3rd party firm of accountants or auditors (preferably from within Myanmar) will be employed to undertake an enhanced external audit of the MOH ISS and HSS programmes if required.
• Internal audits are carried out by concerned government department and then final reports submitted to GAVI.

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2011

There were no activities undertaken using ISS fund in 2011 . ISS funds were recieved only in later part of 2011, and the ICC has decided to use ISS rewards to strengthen supervision at all level by supporting transportation facilities in 2012 and this is in process

6.1.4. Is GAVI's ISS support reported on the national health sector budget? **Yes**

6.2. Detailed expenditure of ISS funds during the 2011 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2011 calendar year (Document Number 13) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **No**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number 19).

6.3. 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 original target set in the approved ISS proposal), 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, which will be published at http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tscoveragedtp3.htm

If you may be eligible for ISS reward based on DTP3 achievements in 2011 immunisation programme, estimate the $ amount by filling **Table 6.3** below

The estimated ISS reward based on 2011 DTP3 achievement is shown in Table 6.3

Table 6.3: Calculation of expected ISS reward

				Base Year**	2011
				A	B***
1	Number of infants vaccinated with DTP3* (from JRF) **specify**			1356921	1318388
2	Number of **additional** infants that are reported to be vaccinated with DTP3				-38533
3	Calculating	$20	per additional child vaccinated with DTP3		0
4	**Rounded-up estimate of expected reward**				0

* Number of DTP3: total number of infants vaccinated with DTP3 alone plus the number of those vaccinated with combined DTP-HepB3, DTP-HepB-Hib3.

** Base-year is the previous year with the highest DTP3 achievement or the original target set in the approved ISS proposal, whichever is higher. Please specify the year and the number of infants vaccinated with DTP3 and reported in JRF.

*** Please note that value B1 is 0 (zero) until **Number of infants vaccinated (to be vaccinated) with DTP3** in section 4. Baseline & annual targets is filled-in

7. New and Under-used Vaccines Support (NVS)

7.1. Receipt of new & under-used vaccines for 2011 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2011 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below **Table 7.1**

Table 7.1: Vaccines received for 2011 vaccinations against approvals for 2011

	[A]	[B]	
Vaccine type	**Total doses for 2011 in Decision Letter**	**Total doses received by 31 December 2011**	**Total doses of postponed deliveries in 2012**
Measles		0	0

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

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

  Note :

  - Myanmar's 2nd dose of Measles vaccine has been approved by GAVI in 2011, How ever the country is yet to receive the supply of Measles vaccine, The country recenlty completed its nation wide mass measles campaign in March 2012 and plans to start the 2nd dose of routine measles vaccine at 18 months .

- 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 Supply Division)

  EVM was conducted in August 2012, based on the findings an Cold chain and Vaccine improvment plan has been finalised. UNICEF is the lead agency supporting MOH on this. UNICEF is also hiring an consultant in July- Aug to conduct Temp study to look in to vaccine temperatures duriing storage, transportation at all level

  - New monitoring tools Freeze tags (7800) and Fridge tags(730) , log tag (255) have been procured and will be used in feild. (after traininigs)
  - Data loggers 8/12 senors for sub depots

  Its proposed to procure 3 Vaccine vans (by re-programning HSS) to give a VV to central cold room and two sub depots for transportation of vaccines and logistics. How ever need is quite high and all the 17 state and region need at least one vaccine van to ensure continuous, and timely supply of vaccines to all townships of country through out the year. Can HSS support this ? its a njor constrian

7.1.2. For the vaccines in the **Table 7.1**, has your country faced stock-out situation in 2011? **No**

If **Yes**, how long did the stock-out last?

Please describe the reason and impact of stock-out, including if the stock-out was at the central level only or at lower levels.

7.2. Introduction of a New Vaccine in 2011

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2011, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

Vaccine introduced	Approved for Measles Dose	
Phased introduction	No	
Nationwide introduction	Yes	15/07/2012
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	The Measles second dose introduction was approved by GAVI in 2011.However Myanmar is still awaiting Vaccine and Logistics from UNICEF SD, no confirmed date has been informed by SD.It is requested to please follow up with SD to get the vaccine according to vaccine arrival schedule. • However the country was engaged to conduct Mass Measles Campaign in first quarter of 2012 and the vaccine has not arrived to the country. • It is planed to start regular routine second dose of Measles in the mid of 2012 tentatively 15th July 2012. • Preparation for Measles Second dose introduction is on track along with Penta introduction.Hopefully in coming months , both vaccines will be part of EPI vaccines.

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **January 2013**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 20))

No new vaccine had been introduced last 2 years.

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFI expert review committee? **Yes**

Does the country have an institutional development plan for vaccine safety? **No**

Is the country sharing its vaccine safety data with other countries? **No**

7.3. New Vaccine Introduction Grant lump sums 2011

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2011 (A)	0	0
Remaining funds (carry over) from 2010 (B)	0	0
Total funds available in 2011 (C=A+B)	0	0
Total Expenditures in 2011 (D)	0	0
Balance carried over to 2012 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2011 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2011 calendar year (Document No 14) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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

Myanmar did not receive new vaccine introduction grant from GAVI in 2011.

Please describe any problem encountered and solutions in the implementation of the planned activities

Myanmar did not receive new vaccine introduction grant from GAVI in 2011.

Please describe the activities that will be undertaken with any remaining balance of funds for 2012 onwards

Myanmar did not receive new vaccine introduction grant from GAVI in 2011.

7.4. Report on country co-financing in 2011

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2011?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED	0	0
	Q.2: Which were the sources of funding for co-financing in reporting year 2011?	
Government	NA	
Donor	NA	
Other	NA	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED	0	
	Q.4: When do you intend to transfer funds for co-financing in 2013 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2013	Source of funding
1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED		GAVI has approved 5 yrs of Measles Second Dose
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	• Myanmar would like to conduct cost effectiveness study for selected vaccine such as Hepatitis B and Pentavalent in near future to advocate the health policy makers and health authority. • Study tours of senior officials from MoH and Ministry of Finance to have some experience to developing countries (ASEAN and others) where EPI programme has developed good financial sustainability strategies. • High level advocacy visit to Myanmar to sensitize senior policy makers on investment in EPI. • Donors sensitization in the needs for Myanmar EPI programme.	

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/about/governance/programme-policies/co-financing/

NA

Is GAVI's new vaccine support reported on the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **August 2011**

Please attach:

(a) EVM assessment **(Document No 15)**

(b) Improvement plan after EVM **(Document No 16)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 17)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Kindly provide a summary of actions taken in the following table:

Deficiency noted in EVM assessment	Action recommended in the Improvement plan	Implementation status and reasons for for delay, if any
Central store-Temperature & Stock Management + MIS	Temperature Mapping & Temp. monitoring Study	Rercritment of Consultant is in process
Central store-Temperature & Stock Management + MIS	Computerized stock management system	Computers has been procured & installed
Central store-Temperature & Stock Management + MIS	Vaccine Management Training at all Levels	in preparation process
Sub- National stores-Vaccine Management	Install continuous temp. traces	Procured and installed

Are there any changes in the Improvement plan, with reasons? **No**

If yes, provide details

When is the next Effective Vaccine Management (EVM) assessment planned? **August 2014**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2011

Myanmar does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

Myanmar does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2012

Renewal of multi-year vaccines support for Myanmar is not available in 2012

7.9. Request for continued support for vaccines for 2013 vaccination programme

In order to request NVS support for 2013 vaccination do the following

Confirm here below that your request for 2013 vaccines support is as per 7.11 Calculation of requirements **Yes**

If you don't confirm, please explain

Myanmar requests GAVI to continue supporting for both vaccines Measles 2nd dose and Penta for 2013 as outlined in table 7.11 .

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2012	2013	2014	2015
DTP-HepB, 10 dose(s) per vial, LIQUID	10				
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1	2.182	2.017	1.986	1.933
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10	2.182	2.017	1.986	1.933
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2	2.182	2.017	1.986	1.933
HPV bivalent, 2 dose(s) per vial, LIQUID	2	5.000	5.000	5.000	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5.000	5.000	5.000	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10	0.242	0.242	0.242	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10	0.520	0.520	0.520	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10	0.494	0.494	0.494	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	3.500	3.500	3.500	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	3.500	3.500	3.500	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	0.900	0.900	0.900	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	0.900	0.900	0.900	0.900
Rotavirus, 2-dose schedule	1	2.550	2.550	2.550	2.550
Rotavirus, 3-dose schedule	1	5.000	3.500	3.500	3.500
AD-SYRINGE	0	0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-PENTAVAL	0	0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-YF	0	0.004	0.004	0.004	0.004
SAFETY-BOX	0	0.006	0.006	0.006	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2016
DTP-HepB, 10 dose(s) per vial, LIQUID	10	
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1	1.927
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10	1.927
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2	1.927
HPV bivalent, 2 dose(s) per vial, LIQUID	2	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	0.900
Rotavirus, 2-dose schedule	1	2.550
Rotavirus, 3-dose schedule	1	3.500
AD-SYRINGE	0	0.047
RECONSTIT-SYRINGE-PENTAVAL	0	0.047
RECONSTIT-SYRINGE-YF	0	0.004
SAFETY-BOX	0	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	500,000$	
			<=	>
DTP-HepB	HEPBHIB	2.00 %		
DTP-HepB-Hib	HEPBHIB		23.80 %	6.00 %
Measles	MEASLES	14.00 %		
Meningogoccal	MENINACONJUGATE	10.20 %		
Pneumococcal (PCV10)	PNEUMO	3.00 %		
Pneumococcal (PCV13)	PNEUMO	6.00 %		
Rotavirus	ROTA	5.00 %		
Yellow Fever	YF	7.80 %		

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2011	2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	1,525,759	1,454,847	1,464,625	1,475,282	1,470,863	8,857,893
	Number of children to be vaccinated with the first dose	Table 4	#	0	669,070	1,392,037	1,417,287	1,412,998	6,315,202
	Number of children to be vaccinated with the third dose	Table 4	#	0	654,681	1,362,101	1,386,101	1,386,611	6,182,684
	Immunisation coverage with the third dose	Table 4	%	0.00 %	45.00 %	93.00 %	93.95 %	94.27 %	
	Number of doses per child	Parameter	#	3	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.00	1.33	1.25	1.25	1.18	
	Vaccine stock on 1 January 2012		#	0					
	Number of doses per vial	Parameter	#		10	10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.18	2.02	1.99	1.93	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.20	0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0058	0.0058	0.0058	0.0058	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.00 %	6.00 %	6.00 %	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	10.00 %	10.00 %	

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2016	TOTAL
	Number of surviving infants	Table 4	#	1,466,517	8,857,893
	Number of children to be vaccinated with the first dose	Table 4	#	1,423,810	6,315,202
	Number of children to be vaccinated with the third dose	Table 4	#	1,393,190	6,182,684
	Immunisation coverage with the third dose	Table 4	%	95.00 %	
	Number of doses per child	Parameter	#	3	
	Estimated vaccine wastage factor	Table 4	#	1.18	
	Number of doses per vial	Parameter	#	10	
	AD syringes required	Parameter	#	Yes	
	Reconstitution syringes required	Parameter	#	No	
	Safety boxes required	Parameter	#	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$	1.93	
cc	**Country co-financing per dose**	Co-financing table	$	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$	0	
cs	**Safety box price per unit**	Table 7.10.1	$	0.0058	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%	10.00 %	

Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group	Low

	2011	2012	2013	2014	2015
Minimum co-financing		0.20	0.20	0.20	0.20
Recommended co-financing as per Proposal 2011			0.20	0.20	0.20
Your co-financing			0.20	0.20	0.20

	2016
Minimum co-financing	0.20
Recommended co-financing as per Proposal 2011	0.20
Your co-financing	0.20

2016
0.20
0.20
0.20

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2012	2013	2014	2015
Number of vaccine doses	#	3,337,000	5,309,900	4,831,400	4,513,800
Number of AD syringes	#	2,968,900	5,343,300	4,745,900	4,705,300
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	32,975	59,325	52,700	52,250
Total value to be co-financed by GAVI	$	7,870,500	11,626,500	10,414,000	9,490,000

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2016
Number of vaccine doses	#	4,555,500
Number of AD syringes	#	4,752,000
Number of re-constitution syringes	#	0
Number of safety boxes	#	52,750
Total value to be co-financed by GAVI	$	9,548,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2012	2013	2014	2015
Number of vaccine doses	#	0	548,000	507,200	488,300
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country	$	0	1,172,000	1,068,000	1,000,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2016
Number of vaccine doses	#	494,500
Number of AD syringes	#	0
Number of re-constitution syringes	#	0
Number of safety boxes	#	0
Total value to be co-financed by the Country	$	1,010,000

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	0	669,070	0	669,070
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B X C*	0	2,007,210	0	2,007,210
E	Estimated vaccine wastage factor	*Table 4*	1.00	1.33		
F	Number of doses needed including wastage	*D X E*	0	2,669,590	0	2,669,590
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		667,398	0	667,398
H	Stock on 1 January 2012	*Table 7.11.1*	0			
I	Total vaccine doses needed	*F + G – H*		3,336,988	0	3,336,988
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		2,968,815	0	2,968,815
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		32,954	0	32,954
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		7,281,308	0	7,281,308
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		138,050	0	138,050
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		192	0	192
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		436,879	0	436,879
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		13,825	0	13,825
T	Total fund needed	*(N+O+P+Q+R+S)*		7,870,254	0	7,870,254
U	Total country co-financing	*I x country co-financing per dose (cc)*		0		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		0.00 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.35 %			9.50 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,392,037	130,218	1,261,819	1,417,287	134,649	1,282,638
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	4,176,111	390,653	3,785,458	4,251,861	403,947	3,847,914
E	Estimated vaccine wastage factor	*Table 4*	1.25			1.25		
F	Number of doses needed including wastage	*D X E*	5,220,139	488,316	4,731,823	5,314,827	504,934	4,809,893
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	637,638	59,648	577,990	23,672	2,249	21,423
H	Stock on 1 January 2012	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	5,857,777	547,963	5,309,814	5,338,499	507,183	4,831,316
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	5,343,262	0	5,343,262	4,745,842	0	4,745,842
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	59,311	0	59,311	52,679	0	52,679
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	11,815,137	1,105,242	10,709,895	10,602,260	1,007,265	9,594,995
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	11,815,137	0	248,462	10,602,260	0	220,682
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	345	0	345	306	0	306
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	708,909	66,315	642,594	636,136	60,436	575,700
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	24,881	0	24,881	22,099	0	22,099
T	Total fund needed	*(N+O+P+Q+R+S)*	12,797,734	1,171,556	11,626,178	11,481,483	1,067,700	10,413,783
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,171,556			1,067,700		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.35 %			9.50 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 3)

		Formula	2015			2016		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.76 %			9.79 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,412,998	137,923	1,275,075	1,423,810	139,411	1,284,399
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	4,238,994	413,767	3,825,227	4,271,430	418,231	3,853,199
E	Estimated vaccine wastage factor	*Table 4*	1.18			1.18		
F	Number of doses needed including wastage	*D X E*	5,002,013	488,245	4,513,768	5,040,288	493,513	4,546,775
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	0	0	0	9,569	937	8,632
H	Stock on 1 January 2012	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	5,002,013	488,245	4,513,768	5,049,857	494,450	4,555,407
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	4,705,284	0	4,705,284	4,751,909	0	4,751,909
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	52,229	0	52,229	52,747	0	52,747
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	9,668,892	943,777	8,725,115	9,731,075	952,804	8,778,271
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	218,796	0	218,796	220,964	0	220,964
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	303	0	303	306	0	306
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	580,134	56,627	523,507	583,865	57,169	526,696
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	21,910	0	21,910	22,127	0	22,127
T	Total fund needed	*(N+O+P+Q+R+S)*	10,490,035	1,000,403	9,489,632	10,558,337	1,009,972	9,548,365
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,000,403			1,009,972		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.76 %			9.79 %		

Table 7.11.1: Specifications for Measles, 10 dose(s) per vial, LYOPHILISED

ID		Source		2011	2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	1,525,759	1,454,847	1,464,625	1,475,282	1,470,863	8,857,893
	Number of children to be vaccinated with the first dose	Table 4	#	1,344,922	1,309,363	1,332,809	1,357,301	1,367,902	8,090,822
	Number of children to be vaccinated with the second dose	Table 4	#	0	1,163,878	1,142,407	1,180,262	1,206,107	5,939,193
	Immunisation coverage with the second dose	Table 4	%	0.00 %	80.00 %	78.00 %	80.00 %	82.00 %	
	Number of doses per child	Parameter	#	1	1	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	1.82	1.67	1.00	1.00	1.00	
	Vaccine stock on 1 January 2012		#	0					
	Number of doses per vial	Parameter	#		10	10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		0.24	0.24	0.24	0.24	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.00	0.00	0.00	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0058	0.0058	0.0058	0.0058	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		14.00 %	14.00 %	14.00 %	14.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	10.00 %	10.00 %	

Table 7.11.1: Specifications for Measles, 10 dose(s) per vial, LYOPHILISED

ID		Source		2016	TOTAL
	Number of surviving infants	Table 4	#	1,466,517	8,857,893
	Number of children to be vaccinated with the first dose	Table 4	#	1,378,525	8,090,822
	Number of children to be vaccinated with the second dose	Table 4	#	1,246,539	5,939,193
	Immunisation coverage with the second dose	Table 4	%	85.00 %	
	Number of doses per child	Parameter	#	1	
	Estimated vaccine wastage factor	Table 4	#	1.00	
	Number of doses per vial	Parameter	#	10	
	AD syringes required	Parameter	#	Yes	
	Reconstitution syringes required	Parameter	#	Yes	
	Safety boxes required	Parameter	#	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$	0.24	
cc	**Country co-financing per dose**	Co-financing table	$	0.00	
ca	**AD syringe price per unit**	Table 7.10.1	$	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$	0	
cs	**Safety box price per unit**	Table 7.10.1	$	0.0058	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%	14.00 %	
fd	**Freight cost as % of devices value**	Parameter	%	10.00 %	

Co-financing tables for Measles, 10 dose(s) per vial, LYOPHILISED

Co-financing group	Low

	2011	2012	2013	2014	2015
Minimum co-financing	0.00	0.00	0.00	0.00	0.00
Your co-financing			0.00	0.00	0.00

	2016
Minimum co-financing	0.00
Your co-financing	0.00

2016
0.00
0.00

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2012	2013	2014	2015
Number of vaccine doses	#	2,429,600	1,142,500	1,189,800	1,212,600
Number of AD syringes	#	1,831,300	1,268,100	1,320,600	1,346,000
Number of re-constitution syringes	#	269,700	126,900	132,100	134,600
Number of safety boxes	#	23,325	15,500	16,125	16,450
Total value to be co-financed by GAVI	$	765,500	381,000	396,500	404,500

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2016
Number of vaccine doses	#	1,256,700
Number of AD syringes	#	1,394,900
Number of re-constitution syringes	#	139,500
Number of safety boxes	#	17,050
Total value to be co-financed by GAVI	$	419,000

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2012	2013	2014	2015
Number of vaccine doses	#	0	0	0	0
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country	$	0	0	0	0

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2016
Number of vaccine doses	#	0
Number of AD syringes	#	0
Number of re-constitution syringes	#	0
Number of safety boxes	#	0
Total value to be co-financed by the Country	$	0

Table 7.11.4: Calculation of requirements for Measles, 10 dose(s) per vial, LYOPHILISED (part 1)

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	0	1,163,878	0	1,163,878
C	Number of doses per child	*Vaccine parameter (schedule)*	1	1		
D	Number of doses needed	*B X C*	0	1,163,878	0	1,163,878
E	Estimated vaccine wastage factor	*Table 4*	1.82	1.67		
F	Number of doses needed including wastage	*D X E*	0	1,943,677	0	1,943,677
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		485,920	0	485,920
H	Stock on 1 January 2012	*Table 7.11.1*	0			
I	Total vaccine doses needed	*F + G – H*		2,429,597	0	2,429,597
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		1,831,276	0	1,831,276
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		269,686	0	269,686
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		23,321	0	23,321
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		587,963	0	587,963
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		85,155	0	85,155
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		998	0	998
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		136	0	136
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		82,315	0	82,315
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		8,629	0	8,629
T	Total fund needed	*(N+O+P+Q+R+S)*		765,196	0	765,196
U	Total country co-financing	*I x country co-financing per dose (cc)*		0		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		0.00 %		

Table 7.11.4: Calculation of requirements for Measles, 10 dose(s) per vial, LYOPHILISED (part 2)

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %			0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,142,407	0	1,142,407	1,180,262	0	1,180,262
C	Number of doses per child	*Vaccine parameter (schedule)*	1			1		
D	Number of doses needed	*B X C*	1,142,407	0	1,142,407	1,180,262	0	1,180,262
E	Estimated vaccine wastage factor	*Table 4*	1.00			1.00		
F	Number of doses needed including wastage	*D X E*	1,142,407	0	1,142,407	1,180,262	0	1,180,262
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	0	0	0	9,464	0	9,464
H	Stock on 1 January 2012	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	1,142,407	0	1,142,407	1,189,726	0	1,189,726
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,268,072	0	1,268,072	1,320,596	0	1,320,596
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	126,808	0	126,808	132,060	0	132,060
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	15,484	0	15,484	16,125	0	16,125
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	276,463	0	276,463	287,914	0	287,914
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	276,463	0	58,966	287,914	0	61,408
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	470	0	470	489	0	489
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	90	0	90	94	0	94
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	38,705	0	38,705	40,308	0	40,308
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	5,953	0	5,953	6,200	0	6,200
T	Total fund needed	*(N+O+P+Q+R+S)*	380,647	0	380,647	396,413	0	396,413
U	Total country co-financing	*I x country co-financing per dose (cc)*	0			0		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	0.00 %			0.00 %		

Table 7.11.4: Calculation of requirements for Measles, 10 dose(s) per vial, LYOPHILISED (part 3)

		Formula	2015			2016		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %			0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,206,107	0	1,206,107	1,246,539	0	1,246,539
C	Number of doses per child	*Vaccine parameter (schedule)*	1			1		
D	Number of doses needed	*B X C*	1,206,107	0	1,206,107	1,246,539	0	1,246,539
E	Estimated vaccine wastage factor	*Table 4*	1.00			1.00		
F	Number of doses needed including wastage	*D X E*	1,206,107	0	1,206,107	1,246,539	0	1,246,539
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	6,462	0	6,462	10,108	0	10,108
H	Stock on 1 January 2012	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	1,212,569	0	1,212,569	1,256,647	0	1,256,647
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,345,952	0	1,345,952	1,394,879	0	1,394,879
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	134,596	0	134,596	139,488	0	139,488
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	16,435	0	16,435	17,032	0	17,032
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	293,442	0	293,442	304,109	0	304,109
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	62,587	0	62,587	64,862	0	64,862
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	499	0	499	517	0	517
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	96	0	96	99	0	99
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	41,082	0	41,082	42,576	0	42,576
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	6,319	0	6,319	6,548	0	6,548
T	Total fund needed	*(N+O+P+Q+R+S)*	404,025	0	404,025	418,711	0	418,711
U	Total country co-financing	*I x country co-financing per dose (cc)*	0			0		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	0.00 %			0.00 %		

8. Injection Safety Support (INS)

Myanmar is not reporting on Injection Safety Support (INS) in 2012

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2011**. All countries are expected to report on:

   a. Progress achieved in 2011

   b. HSS implementation during January – April 2012 (interim reporting)

   c. Plans for 2013

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2011, or experienced other delays that limited implementation in 2011, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2011 fiscal year starts in January 2011 and ends in December 2011, HSS reports should be received by the GAVI Alliance before **15th May 2012**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2012, the HSS reports are expected by GAVI Alliance by September 2012.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved activities and budget (reprogramming) please explain these changes in this report (Table/Section 9.5, 9.6 and 9.7) and provide explanations for each change so that the IRC can approve the revised budget and activities.**Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval. The changes must have been discussed and documented in the HSCC minutes (or equivalent).**

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2011

   b. Minutes of the HSCC meeting in 2012 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2011 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

9.1. Report on the use of HSS funds in 2011 and request of a new tranche

9.1.1. Report on the use of HSS funds in **2011**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.

9.1.2. Please indicate if you are requesting a new tranche of funding **Yes**

If yes, please indicate the amount of funding requested: **7459586** US$

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	3649218	6653686
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	3649218	7459586
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	2807506	0
Remaining funds (carry over) from previous year (*B*)	0	0	0	0	0	1950586
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0	2807506	1950586
Total expenditure during the calendar year (*D*)	0	0	0	0	856920	757563
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0	1950586	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	7459586	9883249

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	2819020905	5139972435
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	2819020905	5762530185
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	2168798848	0

Remaining funds (carry over) from previous year (*B*)	0	0	0	0	0	1506827924
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0	2168798848	1506827924
Total expenditure during the calendar year (*D*)	0	0	0	0	661970924	585217417
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0	1506827924	0
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	5762530185	7639751477

Report of Exchange Rate Fluctuation

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January					851	807.5
Closing on 31 December					791	

Detailed expenditure of HSS funds during the 2011 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2011 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 9)**

If any expenditures for the January April 2012 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 22)**

Financial management of HSS funds

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 HSCC in this process.

FinancialManagement of GAVI HSS funds are done as per the Aide Memoire signed betweenCEO GAVI on 26/1/2011 and Minister of Health, Myanmar on 4/2/2011(annexure IV).

HSS support approved by the GAVI Board is disbursed to and managed by MoH-Myanmar'sprinciple development partners namely WHO and UNICEF. Since It is mandatory torecord all the external funding(grants) coming into the country in the nationalhealth sector budget, GAVI HSS funds are then reflected in our National Health Sector Budget.(Referannexure I)

Inaddition, a third agency will be engaged by MOH-Myanmar to implement "renovation and construction works" .

Detailed budget by implementing partners are included in annexure III.

Funds are managed as follows:

a. UNICEF received a total of USD 396,000 in year one, and it has been used for the procurement of life saving drugs and supplies in the implementation of the strategy of reaching every community;

b. WHO received a total of USD 2,437,405 for the first year of the HSS programme. WHO is responsible for the overall

management and administration of the GAVI HSS programme and activities; provision of technical assistance to all aspects of the programme including cross cutting support in capacity building, research, planning and monitoring and evaluation; and, recruitment of technical staff and international consultants;

c. Third Party is to be identified to manage and implement the construction part. In 2011, government had negotiated with UNOPs as third party, but due to the high management cost (more than 20%) proposed by UNOPs, Government had to reconsider this option. Government re-visited the need of construction through health system assessment conducted in first year in 20 townships. The assessment results from the 20 GAVI HSS townships showed 117 sub-centers with no building at all to facilitate the staff to work and also proper storage of essential medicines and equipment. Considering the need for construction of sub-centers as an essential factor to motivate the midwives for providing services to the communities especially EPI, Government is negotiating with one of the National NGO named "Myanmar Red-Cross Society " (MRCS) for the construction of the new sub-centers for year two with management cost within 7%. After signing the letter of agreement between MOH and MRCS, the proposal will be submitted to GAVI board for approval. If approved by GAVI board, MRCS will undertake the construction for year two 2012-2013. **Further the country is now preparing for the introduction of 2 new vaccines and many challenges with cold chain improvements are noticed. Hence, funds ($ 1.26 Million) budgeted for construction, refurbishments and Management Training for year one 2011 ($ 780,000) and $ 480,000 budgeted for refurbishment of health centers in year two 2012, has been re-programmed to support vaccine introduction.**

Funds managed by UNICEF

UNICEF is responsible for procurement of supplies for the GAVI-supported townships. A Letter of Agreement covering the 4year period dated April 2009 between MOH-Myanmar and UNICEF has been signed for UNICEF's role in procurement of supplies. UNICEF Country Office has procured the supplies through UNICEF Supply Division at Copenhagen. The MoH-Myanmar receives at the port of entry, gets customs clearance and distributes all supplies to township level. UNICEF supports the government in supervision and monitoring of distribution and usage of these supplies. UNICEF provides utilization of funds reports annually to the Focal Point for GAVI-HSS in the MoH-Myanmar.

Funds managed by WHO

A portion of the HSS programme in Myanmar is implemented jointly by WHO and the MoH-Myanmar. This has been agreed in a Letter ofAgreement, dated 4 June 2009 between MoH-Myanmar and the WHO Country Office,which outlines in detail WHO's role in the administration and management of the HSS GAVI funds and the different contractual mechanisms that will be used by WHO in the implementation of the HSS programme (summarized in Annex V).

WHO Country Office has recruited staff, both national and international, through the existing HR arrangements and procedures used by WHO. WHO is directly responsible for procurement of supplies and equipment, special service agreements, fellowships and study tours, and recruitment and travel of WHO staff.

The bulk of the activities is implemented by MoH-Myanmar with technical support from WHO. Funds are therefore disbursed to MoH-Myanmar using one of the modalities (summarized in Annex VI) subject to the following conditions:

a. Each contract signed between WHO and the MoH-Myanmar has a clear time frame for implementation. Monitoring of implementation are undertaken through generation of regular reports in WHO's GSM system as well as through monitoring officers in WHO. Quarterly statements of expenditure/progress reports of WHO are compiled and consolidated by MoH-Myanmar and WHO respectively and presented to the National Health Sector Coordinating Body forHealth System Strengthening (NHSC), sometimes referred to as Health SectorCoordination Committee (HSCC). Contractual arrangements for Agreements for the Performance of Work (APWs) and Direct Financial Cooperation (DFCs) between WHO and MoH are signed by both the WHO Representative to Myanmar, 12A Floor,Traders Hotel, 223 Sule Pagoda Road, Kyauktaga Township, Yangon, 11182, Myanmarand the GAVI-HSS Focal Point, Director of Planning, Department of Health, Ministry of Health, Building 4, Zeyartheikdi, Naypyitaw, Myanmar.

b. Prior to disbursement, all the GAVI HSS activities are incorporated in the WHO details work plan (Biennium 2010-11 and2012-13). WHO then receives a proposal from MoH-Myanmar for the specific activity in the agreed work plan. WHO conducts technical review of the proposals and process fund transfer through its finance and administration office. The administrations of the funds are in accordance with WHO Financial Regulations and Financial Rules as well as its financial procedures and practices (including financial monitoring).

NHSC:

The National Health Sector Coordinating (NHSC) body, convened to support GAVI HSS proposal development and implementation and which has been operational since the beginningof 2007, oversees the GAVI HSS programme. The NHSC, chaired by the Director General of the Department of Health and with members drawn from the MoH-Myanmar and in-country developmentpartners, meets on a quarterly basis.

In 2011-12, (3) NHSC meetings were held to :

•□□□□□□□□Oversee, through receipt of financial statements/progress reports prepared by the MoH-Myanmar GAVI HSS Focal Point/WHO, programme implementation and approve financing arrangements of theprogramme;

•□□□□□□□□Review and approve the Annual Progress Report submitted to GAVI , including year-end financial statements in a format prescribed by GAVI and included in the APR guidelines;

•□□□□□□□□Request that MoH-Myanmar's internal audit department undertake, at appropriate times throughout the year, periodic reviews of the funding mechanisms (detailed below) used to manage HSS funds received by the MoH-Myanmar from WHO;

•□□□□□□□□Ensure that the external audit of the MOH-Myanmar HSS programme is conducted within agreed time frames and that

external audit reports are submitted to the GAVI Secretariat no later than 6 months following the end of the financial year. The NHSC will also ensure thatany issues raised in the internal or external audit letters to management areaddressed in a timely way;

•□□□□□□□□Ensure representation on the NHSC from all ofthe main development partners in the health sector including, amongst others,WHO, UNICEF, and representation from development partners/donors;

•□□□□□□□□NHSC stimulates information sharing, partnership and coordination between NHSC, CCM and ICC in order to ensure stronger collaborative processes.

Financialmanagement arrangements established by the MoH-Myanmar for HSS

At central level

a. Funds from WHO are disbursed to MOH through cheques according to arrangements described above (section 'Funds managed by WHO') and set out in Annex IV and in line with workplan schedules for activities. These cheques in the name of GAVI Focal Point (Director Planning) are submitted to the Budget Management Committee (BMC) for information. The Director of Planning (as secretary to the BMC) reviews the cheques (amount to be implemented for activity) and forwards them to Head of the Budget Section (DoH).

b. The Budget Section DOH then produces a consolidated cash book for GAVI HSS, record all income and expenditures, and reconcile bank accounts at least monthly. Budget section then deposits the cheques into **Ministry and Department MD 010556 Government Account at Myanmar Economic Bank, Tarmwe, Yangon through the"Chalan" system.**

c. In order to withdraw the fund for specific activities, a Program Officer of GAVI HSS submits a withdrawal of cash form with budgetary breakdown to the BMC. The Director of Planning, as the secretaryof BMC, reviews the form and forwards it to the Head of Budget section with approval for the withdrawal of funds for specific activities. All the activities in the work plan and detailed budget are presented to NHSC for approval at the start of GAVI HSS implementation.

d. These forms are reviewed by Budget section who then submit a budget withdrawal form, with mode of delivery of funds (disbursement mechanism), to the BMC. At least three responsible persons from the committee are required to sign for approval after checking the form i.e.the Director of Finance, the Director of Planning and the Director of Administration. The Director General of DoH must give final approval and signature.

e. At the central MoH, in order to support preparation and monitoring of budgets, a financial officer is recruited by WHO as one of the HSSO placed at the central level, designated from within the Division of Finance and Planning DoH as part of the Leadership programme for GAVI HSS. Three other Health System Strengthening officers (HSSO) from with in the DoH are recruited by WHO to focus exclusively on GAVI HSS programming.These officers are also responsible for training and research, monitoring and evaluation (including supplies and assets), financing and programme management.They are working together in the preparation of proposals for implementation of the activities in the townships. The proposals are developed in line with theHSS assessments and the Coordinated Township Health Plan (CTHP). 14 HSS Officers are recruited by WHO and deployed in the townships to support the Township Medical Officer in implementing and monitoring GAVI HSS activities and compiling plans and budgetsa t township level.

f. The consolidated plans and detailed budgets for each year are then presented to the NHSC for approval before the start of activities.

g. The MoH HSS Focal Point (Director of Planning) ensures the preparation of statements of income and expenditure (by FinanceOfficer) using formats provided by GAVI. These are prepared on quarterly basis for central level and township level expenditure. The statements are presentedto the quarterly NHSC meetings for approval. At the end of the financial year,and as part of GAVI's APR process, the MOH year-end financial statements are presented to the NHSC along with the APR, and approved by them prior tosubmission to the GAVI Secretariat. A copy of the MOH year-end financial statement that includes expenses on GAVI HSSis submitted to the Auditor General's office.

h. A fixed asset register is maintained by the HSS Finance Officer, recording items of capital expenditure (vehicles, medical equipment, office equipment, IT equipment, all other equipment purchased forhealth facilities using GAVI funds) and include details of purchase price,purchase date, invoice reference and payment reference at time of purchase andsupplier details, description of equipment, identifying serial number, make andmodel, unique asset register number (recorded on the item of equipment withsecure labeling for audit purposes), location of equipment (section in MoH,township, health centre etc) and, details of the asset manager (person responsible for taking delivery, maintenance and reporting faults).

i. The existing MoH internal audit team willundertake random, unannounced reviews of the townships which are part of the HSS and ISS programmes in Early May. Internal audit's responsibility will be extended to the management arrangements established by the Township Health Committees, the TMO and his/her accounting staff in near future. Subsequent audit findings and audit reports are presented to the Director General and the NHSC for information and follow-up.

j. The Office of Auditor General (Ministerial Level) conducted an external audit of MOH HSS programme financial statements.The Auditor General was notified well in advance of the end of the financial year of the obligations to GAVI for external audit and the Terms of Reference for the external audit (to be provided by GAVI before the end of the first yearof implementation). An external Audit report on MOH HSS is provided to the NHSC and to the DG MoH. An independent 3rd party firm of accountants or auditors (preferably from within Myanmar) will be employed to undertake an enhanced external audit of the MOH HSS programmes if required.

At Township level

k. In each of the GAVI HSS implementing townships, a Coordinated Township Health Plan (CTHP) was developed once HSS

assessments have been conducted. These plans were developed by Township Medical Officer (TMO)and Basic Health Staff in close consultation with the Township Health Committee(THC), representatives from Central GAVI, HSSO and local NGO and INGO simplementing health activities in the township. The Township Health Committeeis a committee formed at every township health system in the country andchaired by the chief of the township local authority.

l. At every township where refurbishment and rehabilitation of facilities activities will takeplace, there will be a Township Hospital Supervisory Committee (THSC) that oversees the general management of reconstruction and financial management of GAVI HSS funds, including reporting to the township health department and the GAVI HSS Focal Point. In order to fulfill this financial monitoring responsibility the clerical staffs at the townships are trained on financial management and they supports the THSC in managing GAVI HSS funds at the townships. He/she isplaced in the TMO office. These accountants are local, have an accounting degree, and are well known to theTHSC in a personal and professional capacity.

m. The THSC are given additional responsibility of recording and managing GAVI inflow and outflow of funds for the townshipactivities to the township health department. This has been applied to all GAVI supported townships through a standing order signed by the DG of the Departmentof Health. Funds earmarked for the "Management Support Fund" which is now termed as "Hospital Equity Fund" is deposited into the Other Account (OA) at the township bank with TMO as a drawing officer. In order to ensure accountability of use ofthese funds, a supervisory committee, overseen by the township healthcommittee, is formed at the AVI supported townships.

At least two persons from the monitoring committee will be required to approve the withdrawal by TMO of cash from the OA account for community needs to support poor mother and children for accessing emergency inpatient care (food, transportation and medical care).

Delay inFund Receipt:

In spite of late arrival of funds to Myanmar , the implementation and progress of HSS activites in first year is reasonanly good at (57% financial rate as of March 31st 2012) .Initially agreement was that GAVI HSS program will commence soon after thesigning of the final Aide Memoire. Aide Memoire (signed between CEO GAVI on 26/1/2011and Minister of Health, Myanmar on 4/2/2011). However, funds reached the WHO Country Office only in June 2011. Fund disbursement process between MoH and WHO begun in later part of June 2011 following WHO's financial procedures. Implementationfor first activity started only in July 2011.

Has an external audit been conducted? Yes

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 26)

9.2. Progress on HSS activities in the 2011 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2011 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2011**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Health System Assessment and CTHP Development	Activity 1.1: SURVEY Conduct survey to establish base line indicators & outcome, impact and research for operations (including mapping)	100	Division of Planning, DOH, MOH Myanmar (HSS assessment guideline- Annexure VIII Health System Assessment results of 20 townships- Annexure IX
Procurement and distribution of essential drugs	Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	90	UNICEF (list of medicines and equipments procured/ disbursed to CMSD- Annexure X) CMSD (Distribution breakdown of medicine and equipments to 20 townships- Annexure XI)

Infrastructure	Activity 1.3: INFRASTRUCTURE 540 RHCs and 324 sub-RHCs in 180 HSS-targeted Townships will be renovated /constructed including construction of sanitary latrines and improve access to safe water source by 2015, based on needs identified in coordinated township health plans. Installation of solar at the RHC at HTR areas	20	All NHSC meeting minutes- Annexure XIII
- Identification of 3rd party			Letter from MoH to UNOPs- Annexure XII
- Need assessment for construction			Health System Assessment results of 20 townships- Annexure IX
- Reprogramming to ISS			3rd NHSC meeting minutes- Annexure XIV
Increased access to EPI, MCH	Activity 1.4: TRANSPORT Provision of essential transport for township and BHS to reach hard-to-reach areas 1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans	100	Quarterly meeting minutes from townships- Annexure XV NHSC meeting minutes- Annexure XIV
Identify hard to reach			Sample CTHP from the townships- Annexure XVII
Transportation support			Breakdown of transportation allowance to BHS from 20 towhships Annexure XIII Quarterly meeting minutes from townships- Annexure XV M &E reports from townships- Annexure XVI
Procurement & Supply of Motorcycles	Activity 1.4.2: Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan	50	NHSC minutes (10th May 2012)- Annexure XIV
Social Mobilization activities	Activity 1.5: SOCIAL MOBILIZATION: Involving NGOs, local authorities and Community Health Workers in developing and implementing coordinated township Health plans in 100% of HSS-targeted townships by 2011)	100	NHSC meeting minutes- Annexure XIV
- Establish Review Mechanisms			Quarterly meeting minutes from 20 townships- Annexure XV
Recruitment and training of AMWs and CHWs			List of AMW and CHW from 20 townships- Annexure XVIII
Production of guidelines.	Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) & supervision at all levels (including checklists)	100	CTHP guideline- Annexure XIX Guideline for Hospital Equity Fund: Annexure XX. Supervision checklist- Annexure XXI

Explore strategic Health Financing options	Activity 2.2: HEALTH FINANCING RESEARCH Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships by 2012.	70	Finding of feasibility study of community health initiative for maternal and child health in Myanmar: Annexure XXII. Policy brief of MVS, Guideline and SOP of MVS From Department of Health Planning (DHP), MOH: Annexure XXIII Report on Mapping of Health Financing Schemes in Myanmar: Annexure XXIV
Management Training (Reprogram to ISS)	Activity 2.4: TRAINING Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011	10	NHSC meeting minutes- Annexure XIV
Hospital Equity Fund	Activity 2.5: PLAN DEVELOPMENT Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines (activity 2.1) and framework at all levels 2.5.1 Management Support (from Township Coordinated Plans) Includes supervision and planning activities ($10,000 per Township per annum scaling up to 180 Townships by 2011)	80	2nd NHSC meeting minutes Annexure XIV Guideline from DOH for formation of budgetary sub-committee- Annexure XX V. Guideline for Hospital Equity Fund Refer Annexure XX
Annual Program Review (Central) and NHSCs.	Activity 2.6: RESEARCH & EVALUATION Assess process and impact of coordinated State & Township coordinated health planning, and then disseminate findings 2.6.1 Annual Program Review Central Level	70	NHSC meeting minutes. Annexure XIV
Annual Program Review at townships	2.6.2 Annual Program Review State and Division Level	100	Evaluation reports Annexure XX VI.
Health System Research	2.6.4 Establish Health Systems Research Fund	30	
Research on motivation and retention of MWs	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010.(complementary Funding through AAAH, but with specific research studies funded by GAVI - evaluation of financial -allowances, research on performance based systems and motivational factors of rural health workforce)	50	Draft report on motivation and retention of MWs in hard to reach rural areas of selected townships Annexure XX VII Health system assessment results of 20 townships. 2nd NHSC meeting Minutes (Annexure XIV)

Development of HR strategic plan	Activity 3.2: HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1 (complementary Funding through AAAH, but with National HR Conference funded through GAVI)	20	Draft Nation Health Plan (2011-2016) HR component Annexure XX VIII
Policy brief for retention Health workforce	Activity 3.3: HR PROPOSAL Development of Proposal to MOH recommending appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives. (complementary Funding through AAAH)	20	Expression of interest (EOI) on policy mapping and analysis on rural retention policy selected by AAAH Annexure XXIX
Provision of package of services to HTR areas	3.3.1 HR costs (HR Finance incentive scheme for health staff in remote areas - identified in Township Coordinated Plans) ($5,500 per Township per Year)	100	Reports from HSSOs- Annexure XXX Expenditure statements of Package of Services- Annexure XXXI
Dissemination workshop	Activity 3.4: CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition & EH training programs applying the principles of MEP (Capacity Building (from Township Coordinated Plans) (complementary Funding through UN Agencies) 3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines	50	
Training workshop on economic evaluation	3.4.2 International Short Courses Health Financing	100	Economic Evaluation, Health Communication Campaign Workshop for MCH Voucher Scheme in Myanmar -Annexure XXXII
Experience sharing among HSS countries:	3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems	30	
Recruitment of HSS Officers (HSSOs)	3.4.4 Leadership Development Program	100	Human Resource for GAVI HSS Unit (WHO)- Annexure XXXIII.
Office equipments (Central)	Support costs Office Equipment Central	100	List of office equipments procured - Annexure XXXIV
Logistic support	Transport/Vehicles for DOH and local transport costs	30	
Office equipments (States and Regions)	Computers Central and States/Divisions	100	List of office equipments procured - Annexure XXXIV
Office equipments (Townships)	Computers Townships	100	List of office equipments procured - Annexure XXXIV
Management support (WHO)	Management costs Administration and Management Cost (WHO)	100	

Management support (DOH)	Administration Costs Central Level (DOH) (Communications, Printing, Staff Hire 2)	100	
International Technical Assistance	International Technical Assistance Health Systems Advisor (WHO)	100	As agreed in Aid Memorie
External consultant (Financial Management)	Financial Management Consultancies	30	
External consultant (Planning)	Planning Consultancies	100	Income and Expenditure HSS (WHO) Annexure III
External consultant (HR)	Management Effectiveness Programme Consultancies		3rd NHSC minutes: Annexure XIV

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
Health System Assessment and CTHP Development	Progress □ HSS Assessment Guideline developed in both English and Myanmar language. □ 80 Surveyors trained before assessment. □ Health System Assessment survey conducted □ Compilation and Documentation of survey results completed. □ Assessment findings incorporated in coordinated Township Health Plans(CTHPs)
Procurement and distribution of essential drugs	Progress □ Essential medicine and equipment procured and distributed to 20 townships up till sub-RHC level.
Infrastructure	Constraints: Identification and Negotiating with the third party was difficult, much of time is lost in the process
- Identification of 3rd party	Progress □ Identification of third party for construction/ renovation of infrastructure Negotiation with UNOPs dropped due to the high management cost (more than 20%). Government is now negotiating with one of the National NGO named Myanmar Red-Cross Society for the construction of the new sub-centers with management cost within 7%. After signing the letter of agreement between MOH and MRCS, the proposal will be submitted to GAVI board for approval.
- Need assessment for construction	Progress Infrastructure needs assessment in 20 townships: The health system assessment results from the 20 GAVI HSS townships showed 117 sub-centers with no building at all. It demonstrates the need for construction of sub-centers as essential to motivate the midwives for providing services (especially EPI) to the communities
- Reprogramming to ISS	□ Reprogramming certain portion of the HSS funds to support ISS to facilitate introduction of new vaccines (pentavalent & measles 2nd dose). □ Total of $ 780,000 from year one HSS funds is reprogrammed to ISS. Country is now preparing for the introduction of 2 new vaccines. To facilitate the new vaccine introduction funds budgeted for construction of sub centers and refurbishments of RHCs for year one 2011 ($ 750,000 USD) is reprogrammed for ISS.
Increase access to EPI,MCH	Progress
- Identify hard to reach	Hard to reach areas in twenty townships mapped. Mapping hard to reach areas was done through a participatory approach by involving BHS, TMOs & central surveyors. Access to essential components of EPI, MCH, and Nutrition and Environmental health for the hard to reach communities increased through coordinated efforts and package of service delivery.

- Transportation support	Transportation allowance provided to: - BHS for provision of package of service. - Senior supervisors for supervision of service delivery (EPI, MCH, Nutrition and Environmental health).
Procurement & Supply of Motorcycles	Progress: Need for transportation facility identified through assessments and focus group discussions. Originally it was planned to provide bicycles and trolley jeeps. Now with the recent developments on roads and easy availability of motorcycles, BHS demanded motorcycles instead of bicycles and trolley jeeps. Considering the cost efficiency and better utility of motorcycles to support the coordinated approach by group of health workers, it was decided to provide motorcycles(65 numbers) to 20 townships (refer 3rd NHSC minutes). - Provision of 65 motocycles to 20 townships. Purchasing order for motorcycles placed by WHO Procurement section.
Social Mobilization activities	Progress: CTHP for twenty townships drafted in collaboration with the relevant stakeholders(UN agencies- WHO, UNICEF, INGOs and NGOs, BHS, Township Health committees).
- Establish Review Mechanisms	Review Mechanisms in place Quarterly review meetings conducted at RHCs and township level participated by BHS, TMOs, Township/village health committees, INGOS,NGOs and volunteers.
- Recruitment and training of AMW and CHWs	Recruited Auxiliary Midwives and Community Health Workers (800 in total) for 20 townships. Refresher training: 40 trainers trained as Training of Trainers to train AMW and CHW conducted in April 2012. Identified 800 AMWs and CHWs by the local communities and they will be trained in respective townships in later part of May 2012.
Production of guidelines	Progress: Production of CTHP guideline. Finalized and printed the CTHP guideline. Around 1200 BHS including TMOs from 20 townships were trained on using the guide. CTHP drafted according to the guidelines at 20 township. Guideline for Hospital Equity Fund drafted. Around 40(TMOs & Accountants) were trained on financial management at the township level. Developed the supervision checklists to monitor the service quality of EPI, MCH,Nutrition and environmental health at the HSS townships Package service delivery supervised byTMOs (Township Medical Officers) and Health system strengthening Officers (HSSOs) using the supervision checklist since January 2012.
Explore strategic Health Financing options	Progress Feasibility study of community health initiative for maternal and child health in Myanmar conducted in collaboration with HITAP through WHO support. Findings disseminated through dissemination workshop. Report Published. Policy brief, guidelines and SOP for Maternal Voucher Scheme (MVS) developed. Preparation for MVS to be completed by end May 2012. (Advocacy meeting, training and community mobilization) Voucher model will be reviewed and revised by the external technical experts in early June 2012. Implementation of Maternal Voucher Scheme in one pilot township will start in June 2012: This scheme is also designed with the objective to expand EPI services for poor mother and children from the unreached areas. Mapping of Health Financing Schemes in Myanmar conducted - Funded by DFID.
Management Training (Reprogrammed to ISS)	Progress Fund reprogrammed to support capacity building to facilitate new vaccine introduction

Hospital Equity Fund	Progress: □ Focus Group Discussion to identify areas to be supported by Management Fund held. Decided to use management fund as an operational investment to improve MCH access in hard to reach area and termed it as Hospital Equity Fund. Hospital Equity Fund is created as a financial instrument to reach the vulnerable group of mothers and children who are deprived of EPI and other basic primary health care services. Budgetary sub-committee formed to manage the fund at the townships in January- February 2012 Clerical staffs (accountants) at townships trained on financial management to support TMO in fund management. Accounts and TMOs (40 numbers) trained on fund management in December 2011. Seed money for Hospital Equity Fund (HEF) for 20 townships ($10,000 per year/township) distributed in May 2012. Contribution by other interested parties (MMCWA) to HEF received. Guideline for hospital equity fund developed.
Annual Program Review (Central) and NHSCs.	Progress: □ Conducted NHSC meetings on a timely manner. 3 NHSC meetings conducted as of now. Annual Program Review at central level will be conducted in November 2012
Annual Program Review at townships	Progress: □ Evaluation at 20 townships conducted by using 63% of the planned budget. The balance fund were used to address the findings from evaluation : Evaluation also showed the need for TOT to provide refresher training to the AMWs and CHWs on the introduction of new vaccines and other innovative MCH interventions. Hence, out of the $ 40,000 budgeted for Evaluation; there was balance of $ 14,873. Out of this balance, ($8000) was reallocated to Train the trainers for AMWs and CHWs. Results showed around 20 refrigerators are needed for vaccine storage in the RHCs with electricity. - The rest of the balance ($6873) from evaluation fund will be used to procure refrigerators.
Health systems Research	Progress: □ HSR training to States/Regions: □ Deputy Health Directors from 17 States and Regions , 10 TMOs from 20 townships are selected to be trained on Health system research: After the training there will be a call for expression of interest from the trainees, develop protocol and submit to Ethical Board of DOH for defense. 3-4 Research grants will be permitted especially to those protocols with HSS issues linking to EPI/MCH.
Research on motivation and retention of MWs	Progress: □ Research on motivation and retention of Midwives in hard to reach rural areas for 6 selected townships is ongoing. □ Dissemination of 20 HSS township assessment results and rural retention research will be done in July, 2012.
Development of HR strategic plan	Progress; Development of HR strategic plan (planned in July 2012): Hire external expert Research and analysis Disseminate the findings Drafting the Plan Finalization and Printing of document □ Need for National Strategic Plan for Human Resource is reflected in Draft National Health Plan 2011-2016. It also came out as one of the major recommendations from the recent conference on Development Policy Option.

Policy brief for retention of Health workforce.	Progress: □ Expression of interest (EOI) for policy mapping and analysis on rural retention policy - submitted to AAAH on 15-3-2012 □ EOI from Myanmar group of researchers headed by GAVI focal point was selected. Attended workshop on development of protocol by group of Researchers from six countries. Finalized the draft protocol and sent to AAAH. Research will be conducted and results be disseminated in the 7th AAAH conference in December 2012 in Bangladesh.
Provision of package of services to HTR areas	Progress: □ Package of service to increase access to essential components of PHC(EPI, MCH,Nutrition and environmental health) for hard to reach population delivered in 20 townships: Previous trends show independent visits by BHS to the community for different programs. This increased burden on the health workers having to make many visits with no transportation costs. It further decreased coverage of services (EPI, MCH, Nutrition and Environmental Health) which were the core elements of PHC especially to the hard to reach areas. In order to make these services available to the hard to reach areas in a cost efficient manner, it is planned to make these services available for the hard to reach population in a package (EPI, Nutrition, MCH and Environmental health) through coordinated efforts. Accordingly, group of health workers now visit the hard to reach community and deliver comprehensive package of PHC (EPI, MCH, Nutrition and Environmental health) services. Transportation costs and per-diem are provided to facilitate visit by BHS to cover the hard to reach areas. This is also practiced to study the feasibility of pay for performance to improve the performance of the health workers and rationalize utilization. If found feasible, strategic policy options will be explored to sustain this system. Constraints: Many stakeholders expressed the need to expand the scope of CTHP and integrate other health interventions/programs, beyond EPI, Nutrition, MCH and Environmental Health.
Dissemination workshop	Progress: □ CTHP drafted and implemented in the townships. □ Dissemination of CTHP along with assessment results planned in July 2012
Training workshop on economic evaluation	Progress □ Training workshop on economic evaluation and health communication regarding MVS by HITAP team (Health Intervention and Technology Assessment Program -Bangkok) conducted in August 2011. Around 40 people (HSSO,TMOs and central medical officers) were trained
Experience sharing among HSS countries:	Progress: □ Experience sharing among HSS countries: HSS Countries to visit identified (Lao PDR and Cambodia), participants selected by government and WCO Myanmar is now processing the visit.
Recruitment of HSS Officers (HSSOs)	Progress: □ Health system strengthening Officers were recruited by WHO through Special Service Agreement, to facilitate implementation GAVI health system strengthening officers at all levels(central, state and region and townships). 4 HSSOs at the Central level and 14 HSSOs at the township level were recruited for year one against the planned number of 20
Office equipments (Central)	Progress □ procured : -Desktop computer + Printer (3), Printer toner (5), Copier (1), Copier toner (9), Multimedia projector (1), Office table (2), Chair (15), Air con (1), Cupboard (1), File shelves (2), Box file (30), A 4 paper (50) rims
Logistic support	Progress: □ Requisition for two cars and 65 motor bikes to support the implementation, monitoring and supervision of HSS interventions. □ WHO is processing procurement as per their procurement rules.

Office equipments (States and Regions)	Progress: □ WHO Procured and distributed: Desktop computer + Printer (17) Copier (17), Copier toner (51), Laptop computer (14)
Office equipments (Townships)	Progress: procured Desktop computer + Printer (17) Copier (17), Copier toner (51), Laptop computer (14) These office supplies facilitated the production CTHPs for 20 townships, assessments results, and evaluation reports. Upgraded the computer skills at the township level.
Management support (WHO)	Progress □ Technical Unit for GAVI HSS established in WCO Myanmar: Four administration and finance support staffs recruited: Provides support the GAVI HSS technical unit in WCO, Myanmar. Two National Technical officers recruited: Provides technical support in implementing GAVI HSS initiatives in the country.
Management support (DOH)	Progress: Financial Management Training conducted for 40 participants (TMOs and Accountants) Administration cost for township accountants: Transportation and per diem for central officials for supervision and monitoring.
International Technical Assistance	Progress: □ WHO Recruited two international Professionals: Technical Officer: provides technical advice and assistance for the overall implementation and management of GAVI HSS interventions. Administration and Finance Officer: Technical advice for the overall financial management of GAVI HSS.
External consultant (Financial Management)	Progress: □ International experts recruited trough the support of WHO SEARO and DFID and conducted: Feasibility study on Community Health Initiative (MCH Voucher scheme) conducted. Mapping of health care financing schemes in Myanmar conducted. External consultants will be recruited to facilitate the implementation of MCH Voucher Scheme and Health Equity Fund by June 2012.
External consultant (Planning)	Progress: WHO recruited an external expert and developed the CTHP plan guideline. Trained the stakeholders on CTHP
External consultant (HR)	Progress: □ Human Resource is noticed as a cross cutting barrier for delivery of health services. Need for strategic intervention to address shortage and capacity of Health Workforce is reflected in the current National Health Plan. The importance of having a National Human Resource strategic plan is recommended as a must by the recent International Conference on Development Policy Options in Myanmar. The fund is reprogrammed to recruit external expert to draft the HR strategic plan.

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Activities

Not Implemented

Modified/Reprogrammed

Activity 1.3: INFRASTRUCTURE

540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source by 2011, based on needs identified in coordinated township health plans.

- Identification of third party for construction/ renovation of infrastructure

- Negotiation with UNOPs dropped due to the high management cost (above 20%). Government is now negotiating with one of the National NGO

named Myanmar Red-Cross Society for the construction of the new sub-centers with management cost within 7% for year two.

After signing the letter of agreement between MOH and MRCS, the proposal will be submitted to GAVI board for approval.

- Number of Construction of Sub-RHC:

As per the original proposal, it was planned to construct 36 Sub-RHC in the year one. However due to high management cost proposed by third party added change in exchange rate over the years the budgeted, this activity was not implemented as planned.

- Meanwhile, country needed support to introduce new vaccines and Total of **$ 750,000** for construction of sub centers and refurbishment of Rural Health centers for year one is reprogrammed to support vaccine introduction. Activity details attached as (annexure XXXV)

Activity 2.4: TRAINING Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011.

- Township Medical Officers and BHS were provided with basic skills on coordinated planning and management during the training on CTHP guideline and drafting of CTHP:

- Reprogrammed $30,000 planned for this to support introduction of new vaccine: (activity details annexure xxxv)

Activity 3.2: HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1 (complementary Funding through AAAH, but with National HR Conference funded through GAVI)

- This activity is very much dependent on the output of activity 3.1 which is ongoing now. Further it is interdependent to activity 3.3, which will start by end of May 2012. Hence, it is planned in the later part of 2012.

- Development of HR strategic plan for Myanmar capturing the health workforce from both p ublic and private sector - planned to start July 2012 onwards:

Hire external expert

Research and analysis

Incorporating findings from Research on motivation and retention of midwives in hard to reach areas.

Disseminate the findings

Drafting the Plan

Finalization and Printing of document

Activity 3.3: HR PROPOSAL

Development of Proposal to MOH recommending appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives. (complementary Funding through AAAH)

- This activity was planned to be conducted through complementary funding by AAAH:

Expression of interest (EOI) for policy mapping and analysis on rural retention policy was called by AAAH in Early March 2012 and likewise proposal from Myanmar was submitted on 15-3-2012

EOI from Myanmar group of researchers headed by GAVI focal point was selected

Attended workshop on development of protocol by group of Researchers from six countries.

Finalized the draft protocol and sent to AAAH.

Research will be conducted and results be disseminated in the 7th AAAH conference in December 2012 in <?xml:namespace prefix = st1 />Bangladesh.

Policy mapping for rural retention of health workforce using the output of activity 3.1 & 3.2 and findings from this research.

Policy options will be field tested through complementary funding by GAVI.

Activity 3.4: CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition & EH training programs applying the principles of MEP (Capacity Building (from Township Coordinated Plans) (complementary Funding through UN Agencies)

3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines

CTHPs for 20 townships drafted and implemented since January 2012.

Currently central team is revisiting the CTHPs to track:

- Whether the targets set were realistic,

- Whether any activities missed, whether there is overlap of activities and cost between the different systems areas, funding gaps etc.

Once revision of CTHPs is completed by end of May, a dissemination meeting is planned in July 2012 to disseminate CTHPs and Health System Assessment Results.

All the relevant stakeholders (UN agencies, INGOs, Donors, NGOs and central, states, regions and townships) will be invited to attend.

Financial Management Consultancies

- Financial Management Consultant is needed mainly to assess the health financing schemes in Myanmar and conduct feasibility study on community health Initiatives.

Fortunately, international experts were recruited trough the support of WHO SEARO and DFID whereby the above activities were implemented already.

Therefore, another financial expert will be recruited to review the guidelines on Maternal Voucher Scheme and Hospital Equity Fund and design appropriate implementation design for the two strategies in June 2012 by WHO.

Management Effectiveness Programme Consultant

HR consultant will be hired to draft National Strategic Plan for Human Resource.

- Human Resource is noticed as a cross cutting barrier for all the programs. Need for strategic intervention to address shortage and capacity of Health Workforce is reflected in the current National Health Plan.

- Hence, need for external expert on Health Human Resource is felt crucial to guide the plan design. It is then decided by the NHSC on 10th May 2012 to reprogram this fund to recruit external expert to draft the HR strategic plan.

Drugs Supply System Consultant

Reallocated to recruit HR consultant.

- External expert for drug supply system is not found essential for year one, since all the essential drugs that has been procured is as per the Kit A&B from WCHD program for year one.

- Later in year two we may need an external expert to review the needs.

Hence, this budget is reprogrammed to fill the funding gap for recruiting external expert for HR(Refer 3rd NHSC meeting Minutes)

Way forward:

- In the Year two the scope of Package of service will be upgraded with inclusion of health education and advocacy on the introduction of new vaccines.

- Any support for the implementation of new vaccines could be included in the Coordinated Township Health Plans of 60 HSS townships.

- The Community Health Workers and Auxiliary Midwives will provide support to ISS on community mobilization and advocacy on new vaccines to the hard to reach areas in 60 HSS townships.

- Health system strengthening Officers will coordinate and monitor immunization campaigns in the 20 HSS townships as they did for Measles Campaign in early March 2012.

- Priority Human Resource needs (capacity building, deployment, management etc) to support immunization services in the country will be addressed in the National Human Resource Strategic Plan.

- Focus will be given to address priority needs for strengthening EPI services while designing comprehensive health system strengthening strategies and researches.

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

Healthsystem assessments showed following barriers in delivering and accessing essentialhealth care service in Myanmar amongwhich Human Resource (low performance and low retention) was observed as across cutting issue :

- **Service Delivery Barriers**: Access to immunizationand child health care service were determined by demand side barriers likecultural, geographic, and economic and security factors in Myanmar. Further itwas compounded by supply side barriers like infrastructure, logistics, HumanResource and transport and supply systems.

- **Organizational, Management and CoordinationBarriers**: fragmentation of healthorganization along vertical program lines, underperformance in the area ofhealth management lead to inefficiencies and inequalities in health serviceprovision. Limited capacity in planningand information management was observed as another concern at thestate/division and township level affecting the service delivery. All theselead to overburdening of the midwives at the peripheral level (sub rural healthcentre). - **-**

HumanResource Barriers: A major barrier to Publichealth service delivery was noted as lack of human resource developmentopportunities (skill up-gradation), excessive workload, no clear jobdescription and no standard distribution of human resources. An essential need is observed to develop an appropriatenational strategy for human resource guiding HR planning, production,deployment and utilization.

Human Resource assessments from 20 townships showed;Out of 115 RHCs, none has standard Human Resource[1] inPlace. The ratio of midwives to PHS 2 is only 10:1, showing huge work burden onthe midwives. There are significant portion of posts vacant for midwife (41%)and PHS 2(43%) across 20 twenty townships, especially in more remote areas.

Another challenge is to deploy and retain health workforce in the rural and hard to reach areas. Government is now exploringstrategic options to retain rural health workforce to strengthen health care servicedelivery in the hard to reach areas. Most recently Government has approvedhardship allowance for the rural health workers.

Complementing Governments endeavor on retaining the rural health work force, GAVI HSS funds were invested in the following:

Providing Per diem and Travel Allowancefor BHS/TMOs for delivery of package of service, M&E and Supervision to thehard to reach areas.(This in fact is used to test the feasibility of financialincentive in improving the performance of health workers in rural areas. The outcome will be assessed and if foundfeasible, recommendations will be submitted to government to institute theseincentives in the national system).

Training of BHS/TMOs and Statesand Regional Deputy Health Directors on Planning, Financial Management,

To upgrade the capacity ofhealth workers at the state, regions and townships on Health System ResearchMethodology and provision of research grant to conduct operational research atthe township levels.

Recruitment and training of 800 health volunteers (Community Health Workers and Auxiliary Midwives) to supportand help the performance of midwives in the 20 townships.

Supply of essential medicines and kits to BHS.

Supply of transportation means (motorcycles) for the rural health workers to reach the unreached.

Investments are also made toconduct research to identify the underlying causes of attrition of rural healthwork force.

Later in June, investments will be made in formulatinga national strategic Plan on Human Resource for Health using the evidencegenerated from the research and assessments on Health Workforce in Myanmar. Investmentswill be made to support construction of Sub- Rural Health centers and solarpower supply to the selected priority Rural Health Centers in the hard to reachareas to motivate the health workers in delivering basic primary health care service(EPI, MCH, Nutrition and Environmental Health).

[1] 1HealthAssistant, 1Lady Health Visitor, 5 Midwives, 5 public Health Supervisor level 2and 1 watchmen.

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2010 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2011 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2007	2008	2009	2010	2011		
1. National DPT3 coverage (%)	70%	2006	90%	90%						MICS (2009-2010)	achieved 95%
2. No: / % of districts achieving ≥80% DTP3 covera	75 Townships (23%)	WHO-UNICEF joint report,DoH (2006)	325 Townships	330 Townships						c MYP (2006-2011)	284 Townships (86%)
3. Under five mortality rate (per 1000) (national)	66.1%	HMIS,Survey DoH/UNICEF 2003	38.5 MDG Target by 2015	NA						MICS (2009-2010)	46.1/1000 LB in 2009-10 MICS
4. Delivery by Skilled Birth Attendants (HSS targe	67.5%	Union of Myanmar MDG report 2006 Fertility Reproductive Health Survey/2003	80%	NA						MICS (2009-2010)	70.6%
5. Rate of ORS Use of < 5 children (National)	53%	Dept. of Health Planning Public Health Statistics Annual Report 2006	80%	NA						MICS (2009-2010)	National coverage is 66%. The achievement rate for urban is 77% whereas it's only 62% for rural areas.
6. % of 6-59 months children having Vit A during	80%	Bi Annual Report of Nutrition Dept/2007	90%	95.1%						Bi Annual Report of Nutrition Dept/ 2011	achieved
% of townships have developed and implemented coor	0	Annual Program Review (Annual Evaluation Report)/2006	55%(180 townships out of 325)	6% (20 townships out of 330)						DoH	achieved
No:/% of RHC(in 180 HSS tsp) visited at least 6 t	0	Base line survey	100%	(115) RHC in 2012						HSS assessments	Not achieved yet since January 2012, supervision by TMO, HA and LHV using qualified checklist has started.
No: of managers/ trainers / BHS trained for MEP	300 BHS and 50 managers and trainers for MEP	Annual Program Review	9000 BHS and 100 Managers & trainees	1200 BHS including TMOs trained on CTHP						DOH	(1200) BHS and Managers were trained on Coordinated Township Health Planning. Fund budgeted for this in the year one is reprogrammed to support EPI.
Proportion of RHCs with no stock out of essentia	0	Base line survey	100% of RHCs in HSS investment area.	NA						DOH	0% with no stock out till December 2011.Essential supplies are dispatched in 20 townships by January 2012

No of RHC and sRHC renovated &/or constructed	30 RHCs (renovated) and 90 sub RHCs (constructed)	DOH	540 RHC renovated and 324 Sub RHC constructed in HSS investment area(180 townships)	Construction of (30) sub RHC in 2012						DOH	Need assessment for infrastructure in 20 HSS townships conducted. Funds for construction & refurbishment reprogrammed to support ISS.
% of selected Tsp with identified HTR staffed by M	0	Base line survey	50%	NA						Health system Assessment results	0%

9.4. Programme implementation in 2011

9.4.1. Please provide a narrative on major accomplishments in 2011, especially impacts on health service programs, notably the organization program

Myanmar could make substantial improvement in its health system foundations to better manage andimprove the access to Primary HealthCare service for hard to reach areas in priority 20 townships:

Governance:

Streamlined the Planning system at the township level through introduction of Coordinated Township Health Plans. The capacity for theTownship H ealth Managers were upgraded in the field of planning and financialmanagement. Introduced the system of need based planning lead by Health System Strengthening Assessments. Culture of participatory planning approach is introduced at the township level by encouraging participation and involvement of all relevant stakeholders (TMOs,PHS, Midwives and AMWs) community health leaders, INGOs and NGOs.

Serviced elivery:

Realigned the health service delivery mechanism to reach thehard to reach areas by delivering package of service (EPI, MCH, Nutrition and Envt. Health) through coordinated efforts. Health System Strengthening Assessments facilitated in mapping hard to reach areas in 20 townships.

Compared to the past where no visit has been made to thehard to reach areas , today 690[1]hard to reach villages are covered intwenty HSS townships by the package of services(EPI,MCH, Nutrition andEnvironmental Health)

HSS assessments and Coordinated township health plans furtheridentified the need to strengthen health system elements (infrastructure,logistics, transport, social mobilization, human resource and health financing) to address public health issues in a holistic/comprehensive manner.

HumanResource :

Health system strengthening initiatives by GAVI has immensely benefited the Human ResourceDevelopment in Myanmar. Human Resource issues (low skills and less numbers) has been observed as a cross cutting issue for all the programs. Another underpinning HR problem faced inMyanmar is the difficulty in retaining rural health work force, which impeded the delivery of all public health interventions for the hard to reach areas.GAVI HSS funds supported the research on" leading cause of attrition of rural health work force" which is under process (preliminary report attached asannexure XXVII). It is envisaged that the findings from this study will support development of evidence based National Strategic HR plan to address Human Resource Deployment, Development and Management issues in future.

Inadequate planning and management skills of the TMOs led toweak planning and monitoring of all the programs at the townships. Around 1200BHS including TMOs were trained on coordinated township Health Planning andFinancial Management through GAVI HSS support.

Investments were also made to reduce the work burdenof midwives in Myanmar by recruiting and training 1200 numbers of volunteers(Community Health Workers and Auxiliary Midwives). Volunteers will be conducting productive community mobilization activities, whereby Midwives canfocus on delivering basic health care services (EPI, MCH, and Nutrition and Environmentalhealth).

[1] Monthly reports from the Health System Strengthening Officers (figure compiled byPlanning Unit, DOH-MOH)

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

Problem:

The major problem encountered in implementing HSS in Myanmarwas the difficulty in identifying third party to implement infrastructure component. The identified party proposed huge management cost (more than 20% of the fund). Another problem experienced was the increase in construction cost due to inflation and change in exchange rates compared to the time when the original proposal was framed (difference between 2007 and 2011). This lead toreduction in number of products (eg; proposed number of construction of subcenters for year one was 36, howeverwith the current value of money, only 30 sub centers can be constructed in year one).

The Health System Assessment conducted in the twenty townships in 2011 shows 117 midwives with no sub-centers to work in. This demonstrates the need for infrastructure identified as very essential in 2007, still remains valid today. Absence of health infrastructure also makesit difficult to store vaccines and other essential medical equipment.

Even today very few sub centers are connected with electricity supply produced by generators and this further brings in thedifficulty to maintain cold chains and storage of other medical supplies inrequired temperatures.

Now with the introduction of new vaccines, it will be veryessential that these facilities be provided with solar power to facilitatevaccine management.

Solution:

1. Identified a local NGO who has experience in construction of schools and health centers in the country as the third party to undertake constructionfor year two. Their management cost iswithin 7% of the budget. Details of the organization are attached forreference. Annexure XIII.

2. Funds budgeted for construction and refurbishments of (Sub centers and RHCs) and Management Effectiveness training in year one and funds budgeted for refurbishments of health centers in year two are now reprogrammed to support implementation of new vaccines. Refer annexure xxxv

3. As per the Aide-mémoire the funds budgeted forinstalling solar power are to be managed by third party. Now instead of thirdparty, it is proposed through the 3rd NHSC, that the solar beprocured as S&E by WHO and the EPI program to manage the installation.

This is proposed because the solar will be installed mainly to benefit the introduction of new vaccines in the HSS townships.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

Different Monitoring and Evaluation Mechanisms areinstituted at different levels as explained below:

Monthly supervision visits by TMOs to the RHCs and Sub RHCs totrack progress status on delivering package of services (EPI, MCH, Nutritionand Environmental Health) to hard to reach areas.

18 Health System Strengthening Officers (HSSOs) arerecruited and deployed by WHO: 14 at the townships level and 4 at central. HSSOs conducts field visit to monitor andsupervise the delivery of package and submit monthly report to central. Since these HSSO's are recruited by WHO, they alsosubmit their duty travel report to the WHO technical unit for every visit theymake.

Further, random Monitoring visits are also made by the Planning Unit, under Department of Health to review the status ofimplementation at the townships; this will be also complemented by randomauditing by the finance unit of DoH together with the HSSO designated forfinancial management.

Fund release for each activity to ministry is subject to receipt of proposal (APW and DFC) by WHO from Ministry. Proposal for everyactivity highlights the timeline and budget breakdown for implementation. GAVIHSS technical unit in WHO then tracks the implementation status referring tothe timeline and budget breakdown highlighted in the proposal. WHO does notaccept any delay in the activity implementation and deviation in budget use byMOH, unless proper technical justification is provided by the central team of theMinistry to WHO.

Monitoring of the services is done through Quarterly Review Meetingsheld at the townships and National Health Sector Coordination Committee at thecentral levels. As of now, three NHSC meetings are conducted at the centrallevel and one Quarterly Review Meeting is held at each GAVI HSS township.(Minutes from these meetings are shared for reference- annexure XIV & XV).

Annual Auditing was conducted for the GAVI HSS fundsby the Auditor Generals Office, report attachedas annexure VII).

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

Support from GAVI for health System strengthening is capturedin the annual budget of the country and also in the National Plan (2011-2016)of the Country.

Much of the GAVI HSS activities are implemented incollaboration with WHO and is incorporated in the WHO detailed work plans. Accordingly the end of biennium review by WHOcaptures the progress status of HSS activities.

Some of the HSS activities that were implemented in 2010were reflected (2010-2011biennium) and were reviewed during the end of bienniumreview for (2010-2011) in December 2011. The rest of the activities are plannedin 2012-2013 biennium and it will be reviewed by end of 2013.

Since the procurement of essential medicines and equipmentsare done by UNICEF, the annual program review by UNICEF will tab the progressstatus on the distribution and utilization of medicines and equipment at thetownships.

Further the impact of GAVI HSS interventions will beevaluated during the review of the National Health Plan by 2015.

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including Civil Society Organisations). This should include organization type, name and implementation function.

Major organizations that were involved in the implementation of GAVI HSS in Myanmar are WHO and UNICEF (ReferAnnexure IV for their role).

Further JICA, Save the Children and MERLIN, ACF,representative from Donor Consortium (CCM) are the NHSC members and contributein M& E and decision making.

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

Myanmar Maternal and Child Welfare Association (MMCWA) & Myanmar Women's Affairs Federation: facilitates community mobilization toaccess package of services (EPI, MCH, Nutrition and environmental health),especially in hard to reach areas. Myanmar Medical Association and Myanmar Red Cross Association aremembers of NHSC and contribute in decision making and M&E of the GAVI HSSinterventions.

These local NGOs actively participates in the quarterlyreview meetings held at the townships to review the package of service(EPI,MCH, Nutrition and Environmental Health) delivery for the hard to reachareas in the townships.

Myanmar Maternal and Child Welfare Association (MMCWA)has committed to contribute referral fees for the poor pregnant mothers withneed of emergency care (that will be added to Hospital Equity Fund attownships), Clean Delivery Kits (CDK), weighing machines and labour beds and toall HSS 20 townships in year one. (3rd NHSC meeting minutes)

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

With the involvement of WHO and UNICEF as the external partners and internal funds disbursement and management mechanism establishedat various levels (as per Financial Management Assessment), the HSS fund management has been effective so far.

9.5. Planned HSS activities for 2012

Please use **Table 9.5** to provide information on progress on activities in 2012. If you are proposing changes to your activities and budget in 2012 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2012

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Original budget for 2012** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2012 actual expenditure** (as at April 2012)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2012** (if relevant)
Health System Assessment and CTHP Development	Activity 1.1: SURVEY Conduct survey to establish base line indicators & outcome, impact and research for operations (including mapping)	80000	31509		Explanation for Column 3 Original Budget for 2012 (Column 3) is the budget for the activities planned in Year Two (2012-2013) and no expenditure is incurred from this budget since Myanmar did not receive the fund for Year Two yet.	80000

Procurement and Distribution of Essential Drugs	Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	1080000			Explanation for Column 4 Expenses in the Column 4 are not against the budget shown in Column 3. Column 4 shows the expenses incurred from July 2011 to March 2012 against the budget for Year One (2011). Myanmar has just received the fund for Year One (2011) in June 2011 and activity implementation started from July 2011, it will go on till June 2012. Actual expenditure for April 2012 is not available from the Accounting System of WHO and MOH at this point. Annexure III will explain the detail expenses.	1080000
Infrastructure	Activity 1.3: INFRASTRUCTURE 540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source by 2011, based on needs identified in coordinated township health plans.	1586000		$480,000 reprogrammed to fill funding gap for new vaccine introduction. Refer Annex 35	$480,000 reprogrammed to fill funding gap for new vaccine introduction. Refer Annex 35	1586000
Increase access to EPI,MCH	Activity 1.4: TRANSPORT Provision of essential transport for township and BHS to reach hard-to-reach areas 1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans.	300000	99059			300000
Procurement & Supply of Motorcycles	1.4.2 Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan	100000	8231			100000

Social Mobilization Activities	Activity 1.5: SOCIAL MOBILIZATION: Involving NGOs, local authorities and Community Health Workers in developing and implementing coordinated township Health plans in 100% of HSS-targeted townships by 2011)	400000	170580			400000
Production of guidelines	Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) & supervision at all levels (including checklists)	20000	33796			20000
Explore strategic Health Financing options	Activity 2.2: HEALTH FINANCING RESEARCH Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships by 2012.	40000	3321			40000
Health Financing Scheme	Activity 2.3: HEALTH FINANCING Training and Piloting of health financing schemes, according to national guidelines in 50 townships by 2015.	300000				300000

Management Training	Activity 2.4: TRAINING Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011	60000				60000
Hospital Equity Fund	Activity 2.5: PLAN DEVELOPMENT Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines (activity 2.1) and framework at all levels 2.5.1 Management Support (from Township Coordinated Plans) Includes supervision and planning activities ($10,000 per Township per annum scaling up to 180 Townships by 2011)	600000				600000
Annual Program Review (Central) and NHSCs	Activity 2.6: RESEARCH & EVALUATION Assess process and impact of coordinated State & Township coordinated health planning, and then disseminate findings 2.6.1 Annual Program Review Central Level	20000	5423			20000
Annual Program Review (S/R and Townships)	2.6.2 Annual Program Review State and Division Level	51000				51000
Health systems Research	2.6.4 Establish Health Systems Research Fund	72049	41028			72049

Research on Human Resources for Health	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010. (complementary Funding through AAAH, but with specific research studies funded by GAVI - evaluation of financial allowances, research on performance based systems and motivational factors of rural health workforce)	10000	7263			10000
	Activity 3.2: HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1 (complementary Funding through AAAH, but with National HR Conference funded through GAVI)					
HR Proposal on Appropriate Skillmix	Activity 3.3: HR PROPOSAL Development of Proposal to MOH recommending appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives. (complementary Funding through AAAH)	10000				10000

Provision of package of service to hard to reac	3.3.1 HR costs (HR Finance incentive scheme for health staff in remote areas - identified in Township Coordinated Plans) ($5,500 per Township per Year)	346500	114685			346500
Continuing Training	Activity 3.4: CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition & EH training programs applying the principles of MEP (Capacity Building (from Township Coordinated Plans) (complementary Funding through UN Agencies) 3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines	60000				60000
	3.4.2 International Short Courses Health Financing		32301			
Experience sharing among HSS countries	3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems	40000				40000
Recruitment of HSS Officers	3.4.4 Leadership Development Program	331200	214435			331200
	Support costs Office Equipment Central		10000			
	Transport/Vehicles for DOH and local transport costs		38717			
Computers (Central, S/R)	Computers Central and States/Divisions	30000	42602			30000
Computers (Townships)	Computers Townships	80000	20000			80000

Management Support (WHO)	Management costs Administration and Management Cost (WHO)	366500	177583			366500
Management Support (DOH)	Administration Costs Central Level (DOH) (Communications, Printing, Staff Hire 2)	30000	27110			30000
International Technical Assistance	International Technical Assistance Health Systems Advisor (WHO)	198000	85796			198000
External Consultant (Finance)	Financial Management Consultancies	15000				15000
External Consultant (Planning)	Planning Consultancies	15000	14987			15000
External Consultant (Management)	Management Effectiveness Programme Consultancies	15000	2327	Activity change to recruit International health system analyst instead of MEP trainer	Health system assessments has been conducted for 20 townships in year one and will be conducted for 40 more townships in year 2. An external expert is needed to conduct in-depth analysis of the Health Assessment Findings and generate comprehensive results. This result can be used to guide the revision GAVI HSS activies planned for year 3 and year 4	15000
External Consultant (HSR)	Operational Health Systems Research Consultancies	15000				15000
External Consultant (Drug Supply System)	Drugs Supply System Consultancies	15000				15000
		6286249	1180753			6286249

9.6. Planned HSS activities for 2013

Please use **Table 9.6** to outline planned activities for 2013. If you are proposing changes to your activities and budget (reprogramming) please explain these changes in the table below and provide explanations for each change so that the IRC can approve the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 9.6: Planned HSS Activities for 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)

Health System Assessment and CTHP Development	Activity 1.1: SURVEY Conduct survey to establish base line indicators & outcome, impact and research for operations (including mapping)	120000			120000
External Consultancy	OperationalHealth Systems Research Consultancies	15000			15000
International Technical Assistance	Health Systems Advisor (WHO)	99000			99000
Management Support (DOH)	Management costs Administration Costs Central Level (DOH) (Communications, Printing, Staff Hire 2)	30000			30000
Computers (Townships)	Computers Townships	120000			120000
Computers (Central & S/R)	Computers Central and States/Divisions	30000			30000
Logistic Support	Transport/ Vehicles for DOH and local transport costs	60000			60000
Recruitment of HSS Officers	3.4.4 Leadership Development Program	331200			331200
Experience sharing among HSS countries	3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems	40000			40000
International Short Course	3.4.2 International Short Courses Health Financing	50000			50000

Continuing Trainings	Activity 3.4: CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition & EH training programs applying the principles of MEP (Capacity Building (from Township Coordinated Plans) (complementary Funding through UN Agencies) 3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines	120000			120000
Provision of package of service to hard to reac	3.3.1 HR costs (HR Finance incentive scheme for health staff in remote areas - identified in Township Coordinated Plans) ($5,500 per Township per Year)	693000			693000
Research on HRH	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010. (complementary Funding through AAAH, but with specific research studies funded by GAVI - evaluation of financial allowances, research on performance based systems and motivational factors of rural health workforce)	10000			10000
Health systems Research	2.6.4 Establish Health Systems Research Fund	72049			72049

External Review of Program	2.6.3 External Review of progress of HSS	50000			50000
Annual Program Review at townships	2.6.2 Annual Program Review State and Division Level	51000			51000
Annual Program Review (Central) and NHSCs	Activity 2.6: RESEARCH & EVALUATION Assess process and impact of coordinated State & Township coordinated health planning, and then disseminate findings 2.6.1 Annual Program Review Central Level	20000			20000
Hospital Equity Fund	Activity 2.5: PLAN DEVELOPMENT Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines (activity 2.1) and framework at all levels 2.5.1 Management Support (from Township Coordinated Plans) Includes supervision and planning activities ($10,000 per Township per annum scaling up to 180 Townships by 2011)	1200000			1200000
Management Training	Activity 2.4: TRAINING Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011.	90000			90000

Health Financing Scheme	Activity 2.3: HR FINANCING Training and Piloting of health financing schemes, according to national guidelines in 50 townships by 2011	600000			600000
Production of Guidelines	Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) & supervision at all levels (including checklists)	20000			20000
Social Mobilization Activities	Activity 1.5: SOCIAL MOBILIZATION: Involving NGOs, local authorities and Community Health Workers in developing and implementing coordinated township Health plans in 100% of HSS-targeted townships by 2011)	600000			600000
Procurement and Supply of Motorcycles	1.4.2 Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan	150000			150000
Increase access to EPI, MCH	Activity 1.4: TRANSPORT Provision of essential transport for township and BHS to reach hard-to-reach areas 1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans.	600000			600000

Infrastructure	Activity 1.3: INFRASTRUCTURE 540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source by 2011, based on needs identified in coordinated township health plans.	2336000			2336000
Procurement and Distribution of Essential Drugs	Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	2160000			2160000
		9667249			

9.6.1. If you are reprogramming, please justify why you are doing so.

9.6.2. If you are reprogramming, please outline the decision making process for any proposed changes

9.6.3. Did you propose changes to your planned activities and/or budget for 2013 in **Table 9.6** ? **No**

9.7. Revised indicators in case of reprogramming

If the proposed changes to your activities and budget for 2013 affect the indicators used to measure progress, please use **Table 9.7** to propose revised indicators for the remainder of your HSS grant for IRC approval.

Table 9.7: Revised indicators for HSS grant in case of reprogramming

Name of Objective or Indicator (Insert as many rows as necessary)	Numerator	Denominator	Data Source	Baseline value and date	Baseline Source	Agreed target till end of support in original HSS application	2013 Target

9.7.1. Please provide justification for proposed changes in the **definition, denominator and data source of the indicators** proposed in Table 9.6

9.7.2. Please explain how the changes in indicators outlined in Table 9.7 will allow you to achieve your targets

9.8. Other sources of funding for HSS

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

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
NA			

9.8.1. Is GAVI's HSS support reported on the national health sector budget? **Yes**

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Health System Assessment Reports and Results.	Respective team leaders assigned for assessment at different townships	Compilation of the information from different assessment teams and different townships.
MICS 2009-10 report and HMIS: indicators	published reports	discrepancies in data from different sources.
Office of Auditor General of the Union, Myanmar: Audit report GAVI HSS funds	Office of Auditor General of the Union, Myanmar	
UNICEF Country Office: Essential drugs and Equipments.	Confirmation with UNICEF focal point	
WHO GSM, GAVI HSS Technical Unit (Financial statements and S &E). Budget and Finance section of DOH, MoH: Financial statements, S&E.	Validated by WCO- GAVI HSS technical unit, Accounts and Finance section, followed by endorsement from Budget and Finance Office in WHO SEARO. - Validated by the Director of Planning and Finance, DOH, MoH.	changes in Exchange rate

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

Some of the foot notes and explanation in the tables cannot be put into the online portal and this report in full text has to be put up as Attachment.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2010?? 2

Please attach:

1. The minutes from all the HSCC meetings held in 2010, including those of the meeting which discussed/endorsed this report **(Document Number: 8)**
2. The latest Health Sector Review report **(Document Number: 23)**

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

10.1. TYPE A: Support to strengthen coordination and representation of CSOs

Myanmar is not reporting on GAVI TYPE A CSO support for 2012

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

Myanmar is not reporting on GAVI TYPE B CSO support for 2012

11. 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

12. Annexes

12.1. Annex 1 – Terms of reference ISS

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 2011 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2011, 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 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2011, 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 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

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 ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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	38,987,576	81,375
Total expenditure during 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Signature Page of Health Minister & Deligated Authority from Finance Unit.pdf File desc: File description... Date/time: 5/21/2012 7:39:26 AM Size: 278784
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature Page of Health Minister & Deligated Authority from Finance Unit.pdf File desc: File description... Date/time: 5/21/2012 7:40:00 AM Size: 278784
3	Signatures of members of ICC	2.2	✓	ICC meeting signature.pdf File desc: File description... Date/time: 5/21/2012 7:36:14 AM Size: 841556
4	Signatures of members of HSCC	2.3	✗	NHSC signature page.pdf File desc: File description... Date/time: 5/21/2012 7:36:14 AM Size: 1365270
5	Minutes of ICC meetings in 2011	2.2	✓	ICC meeting minutes in 2011.doc File desc: File description... Date/time: 5/20/2012 2:40:18 AM Size: 70656
6	Minutes of ICC meeting in 2012 endorsing APR 2011	2.2	✓	2nd ICC Meeting Minutes (11.5.2012).pdf File desc: File description... Date/time: 5/26/2012 7:11:25 AM Size: 1927156
7	Minutes of HSCC meetings in 2011	2.3	✗	NHSC Meeting Minutes (2011).doc File desc: File description... Date/time: 5/22/2012 4:22:18 AM Size: 82432
8	Minutes of HSCC meeting in 2012 endorsing APR 2011	9.9.3	✗	3rd NHSC Meeting Minutes (2012).doc File desc: File description... Date/time: 5/22/2012 4:36:30 AM Size: 4142592
9	Financial Statement for HSS grant APR 2011	9.1.3	✗	Expendituren Statement.docx File desc: File description... Date/time: 5/21/2012 9:11:06 AM Size: 788044
10	new cMYP APR 2011	7.7	✓	cMYP_2012-2016 (12 Nov 11).pdf File desc: File description...

				Date/time: 5/26/2012 6:55:02 AM Size: 1144343
11	new cMYP costing tool APR 2011	7.8	✓	cMYP_Costing_Tool_Vs.2.5_EN_ 12 Nov 11.xlsx File desc: File description... Date/time: 5/6/2012 4:54:35 AM Size: 1583601
12	Financial Statement for CSO Type B grant APR 2011	10.2.4	✗	Financial statement for CSO Type B grant.docx File desc: File description... Date/time: 5/21/2012 7:47:46 AM Size: 11774
13	Financial Statement for ISS grant APR 2011	6.2.1	✗	ISS grant in 2011.pdf File desc: File description... Date/time: 5/21/2012 8:46:34 AM Size: 31053
14	Financial Statement for NVS introduction grant in 2011 APR 2011	7.3.1	✓	Financial Statement of NVS grant in 2011.doc File desc: File description... Date/time: 5/21/2012 1:58:58 PM Size: 27648
15	EVSM/VMA/EVM report APR 2011	7.5	✓	EVM_report-Myanmar final t.pdf File desc: File description... Date/time: 5/6/2012 4:55:57 AM Size: 3261889
16	EVSM/VMA/EVM improvement plan APR 2011	7.5	✓	EVM-imp-plan-Myanmar 2011 v6.xlsx File desc: File description... Date/time: 5/6/2012 4:56:28 AM Size: 136915
17	EVSM/VMA/EVM improvement implementation status APR 2011	7.5	✓	EVM improvement plan progress report.docx File desc: File description... Date/time: 5/6/2012 5:02:38 AM Size: 14879
18	new cMYP starting 2012	7.8	✗	cMYP 2012.doc File desc: File description... Date/time: 5/26/2012 7:08:02 AM Size: 26112
19	External Audit Report (Fiscal Year 2011) for ISS grant	6.2.3	✗	ISS grant in 2011.pdf File desc: File description... Date/time: 5/21/2012 8:45:48 AM Size: 31053
20	Post Introduction Evaluation Report	7.2.2	✓	Post Introduction Evaluation Report.doc File desc: File description... Date/time: 5/21/2012 2:05:50 PM

				Size: 27648
21	Minutes ICC meeting endorsing extension of vaccine support	7.8	✓	ICC meeting minute for extention of vaccine for next year.doc File desc: File description... Date/time: 5/21/2012 2:10:35 PM Size: 27648
22	External Audit Report (Fiscal Year 2011) for HSS grant	9.1.3	✗	Auditor General's Report.docx File desc: File description... Date/time: 5/21/2012 9:04:22 AM Size: 692502
23	HSS Health Sector review report	9.9.3	✗	Health Systems Assessment Results from 20 townships.pdf File desc: File description... Date/time: 5/22/2012 4:26:05 AM Size: 1335804
24	Report for Mapping Exercise CSO Type A	10.1.1	✗	Expanation on CSO Type A support.doc File desc: File description... Date/time: 5/21/2012 2:13:33 PM Size: 23552
25	External Audit Report (Fiscal Year 2011) for CSO Type B	10.2.4	✗	Financial statement for CSO Type B grant.docx File desc: File description... Date/time: 5/21/2012 2:14:45 PM Size: 11774
26	HSS expenditures for the January-April 2012 period	9.1.3	✗	Expendituren Statement (January to April 2012).docx File desc: File description... Date/time: 5/27/2012 11:15:43 PM Size: 20504