GAVI Alliance

Annual Progress Report 2013

Submitted by

The Government of

Myanmar

Reporting on year: **2013**
Requesting for support year: **2015**
Date of submission: **15/05/2014**

Deadline for submission: 22/05/2014

Please submit the APR 2013 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: **2013**

Requesting for support year: **2015**

1.1. NVS & INS support

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

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

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 2013	Request for Approval of	Eligible For 2013 ISS reward
ISS	Yes	next tranche: N/A	Yes
HSS	Yes	next tranche of HSS Grant Yes	N/A
VIG	Yes	Not applicable	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2012 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 Win Oo
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
Dr Kyaw Kan Kaung	Dy Director cum EPI Mananger	+95 67 421205	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
Dr. Min Than Nyunt / Director General	Department of Health		
Dr.Htun Naing Oo / Director General	Department of Health Planning		

Dr. Soe Lwin Nyein /Deputy Director General	Department of Health		
Dr.Thar Htun Kyaw/ Director	Department of Health		
Dr.Yin Thandar Lwin / Director	Department of Health		
Dr.San San Aye/ Director	Department of Health Planning		
Dr. Thet Thet Mu /Director	Department of Health Planning		
Dr.Nwe Ni Ohn / Director	Department of Health		
Dr. Win Naing / Director	Department of Health		
U Win Oo / Deputy Director	Department of Health		
Dr. Maung Maung Than Htike/ Deputy Director	Ministry of Health		
Dr. Nu Nu Kyi/ Deputy Director	Department of Health		
Dr. Kyaw Kan Kaung/Deputy Director	Department of Health		
Dr. Htun Tin/ Deputy Director	Department of Health		
Dr.Khin Khin Gyi/ Assistant Director	Department of Health		

Dr. Htar Htar Lin/Assistant Director	Department of Health		
Dr. Toe Thiri Aung / Assistant Director	Department of Health		
Dr. Yan Lin Aung/ Medical Office	Department of Health		
Dr. Aung Naing Oo/Medical Officer	Department of Health		
Dr. Kron gthong Thimasong /Acting Country Representative	World Health Organization		
Dr. Vinod Kumar Bura/ Medical Officer -EPI	World Health Organization		
Dr. Ye Hla / National Technical Officer	World Health Organization		
Mr. Bertrand Bainvel / REpresentative	UNICEF		
Ms Penelope Campbell / Chief	UNICEF		
Dr. Daniel Ngemera/ Immunization Specialist	UNICEF		
Dr. Tin Htut / Health Specialist	UNICEF		
Dr. Mon Mon Aung/ Chair	Myanamr Maternal and Child Welfare Association		
Dr. Thar Hla Shwe/ Chair	Myanmar RedCross Society		

U Noel / Chair	Myanamr Health Assistant Association		
Dr. Nan Htun Hla / Chair	Myanamr Nursres and Midwife Association		

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), 7-5-2014 , 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
Dr Min Than Nyunt, Director General	Department of Health		
Dr Than Win, Deputy Director General	Department of Health		
Dr Win Htay Aung, Deputy Director General	Department of Health		
Dr Nwe Ni Ohn, Director	Department of Health		
Dr Yin Thandar Lwin, Director	Department of Health		
Dr Win Naing, Director	Department of Health		

Dr San San Aye, Director	Department of Health Planning		
Dr Thet Thet Mu, Director	Department of Health Planning		
Dr Theingi Myint, Deputy Director	Department of Health		
Dr Myint Myint Than, Deputy Director	Department of Health		
Dr Kyaw Kan Kaung, Deputy Director	Department of Health		
Dr May Khin Than, Deputy Director	Department of Health		
U Htay Win, Deputy Director	Department of Health		
Daw Nwe Nwe Win, Director	Budget Department		
Daw Cherry Mang Man, Director	FERD		
Daw Htay Htay Myint, Staff Officer	Progress of Border Area and National Races Department		
Daw Khin May Yee, Staff Officer	Progress of Border Area and National Races Department		
Dr Salma Burton, Public Health Administrator	WHO		
Dr San Shway Wynn, National Professional Officer	WHO		

Ms. Sangay Wangmo, Technical Officer	WHO		
Dr Yee Yee Cho, Technical Officer	WHO		
Dr Tin Htut, Health Specialist	UNICEF		
Penelope Campbell, Chief (YCSD)	UNICEF		
Daniel Ngenera, Immunization Specialist (YCSD)	UNICEF		
Dr Maung Maung Hla, Director	Myanmar Redcross Society		
U Hla Win, Senior Engineer	Myanmar Redcross Society		
U Noel, President	Myanmar Health Assistant Association		
Daw Mya Mya, President	Myanmar Women Affair Federation		
Susannah Pritlhard, HSS advisor	Merlin/Save the Children		
Alyssa Davis, Health Advisor	Save the Children		
Fiona Campbell, Consutant/Researcher	Merlin/Save the Children		

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 2014

3. Table of Contents

This APR reports on Myanmar's activities between January – December 2013 and specifies the requests for the period of January – December 2015

Sections

4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Number	Achievements as per JRF		Targets (preferred presentation)					
	2013		2014		2015		2016	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2013	Current estimation	Previous estimates in 2013	Current estimation
Total births	1,519,321	1,494,169	1,527,254	1,527,254	1,521,058	1,521,058	1,513,433	1,513,433
Total infants' deaths	54,696	52,257	51,972	51,972	50,195	50,195	46,916	46,916
Total surviving infants	1464625	1,441,912	1,475,282	1,475,282	1,470,863	1,470,863	1,466,517	1,466,517
Total pregnant women	1,580,093	1,556,426	1,588,344	1,588,344	1,566,689	1,566,689	1,558,836	1,558,836
Number of infants vaccinated (to be vaccinated) with BCG	1,412,968	1,266,291	1,450,891	1,450,891	1,445,005	1,445,005	1,437,761	1,437,761
BCG coverage	93 %	85 %	95 %	95 %	95 %	95 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,362,101	1,065,180	1,386,808	1,386,808	1,382,611	1,382,611	1,393,190	1,393,190
OPV3 coverage	93 %	74 %	94 %	94 %	94 %	94 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,397,027	1,257,414	1,415,110	1,415,110	1,410,828	1,410,828	1,421,622	1,421,622
Number of infants vaccinated (to be vaccinated) with DTP3	1,362,101	1,049,844	1,386,808	1,386,808	1,382,611	1,382,611	1,393,190	1,393,190
DTP3 coverage	93 %	73 %	94 %	94 %	94 %	94 %	95 %	95 %
Wastage*[1]* rate in base-year and planned thereafter (%) for DTP	25	24	15	15	15	15	15	15
Wastage*[1]* factor in base-year and planned thereafter for DTP	1.33	1.32	1.18	1.18	1.18	1.18	1.18	1.18
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	1,392,037	1,257,414	1,417,287	1,417,287	1,412,998	1,412,998	1,423,810	1,423,810
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	1,392,037	1,049,844	1,417,287	1,417,287	1,386,611	1,386,611	1,393,190	1,393,190
DTP-HepB-Hib coverage	95 %	73 %	96 %	96 %	94 %	94 %	95 %	95 %
Wastage*[1]* rate in base-year and planned thereafter (%) *[2]*	20	24	20	15	15	15	15	15
Wastage*[1]* factor in base-year and planned thereafter (%)	1.25	1.32	1.25	1.18	1.18	1.18	1.18	1.18
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,142,407	1,208,286	1,180,262	1,180,262	1,367,902	1,367,902	1,378,525	1,378,525

Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles	1,397,027	1,102,737	1,180,262	1,180,262	1,206,107	1,206,107	1,246,539	1,246,539
Measles coverage	95 %	76 %	80 %	80 %	82 %	82 %	85 %	85 %
Wastage*[1]* rate in base-year and planned thereafter (%) *{0}*	40	38	40	38	0	0	0	0
Wastage*[1]* factor in base-year and planned thereafter (%)	1.67	1.61	1.67	1.61	1	1	1	1
Maximum wastage rate value for Measles second dose, 10 dose(s) per vial, LYOPHILISED	40.00 %	40.00 %	40.00 %	40.00 %	50.00 %	40.00 %	50.00 %	40.00 %
Pregnant women vaccinated with TT+	1,437,885	1,234,229	1,461,277	1,461,277	1,457,021	1,457,021	1,465,305	1,465,305
TT+ coverage	91 %	79 %	92 %	92 %	93 %	93 %	94 %	94 %
Vit A supplement to mothers within 6 weeks from delivery	1,106,980	754,892	1,126,352	1,126,352	1,146,064	1,146,064	1,166,120	1,166,120
Vit A supplement to infants after 6 months	664,183	6,573,851	675,811	675,811	687,638	687,638	699,672	699,672
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	3 %	17 %	2 %	2 %	2 %	2 %	2 %	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.

2 GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

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 2013 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2013.** The numbers for 2014 - 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 are no major changes in no. of births, only minor changes but current census will be a good guide to estimate the target population.

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

  There are no major changes in no. of surviving infants , only minor changes , the surviving infant could be best estimated after nationwide census . The result would be released in 2015.

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

  no changes in targets of coverages.

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

  The Vaccine wastage rates have declined more than the expected targets rates Eg Penta wastage rates were planned at 25% but the actual wastage rates in 2013 was around 24% . This was due to introduction of open vial policy, better planning of EPI sessions.

5.2. Immunisation achievements in 2013

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 2013 and how these were addressed:

- 2013 was a very challenging year for Central EPI program, as new vaccines were introduced along with no of policy and programatic changes were undertaken, there was not much improvment in issues of access to un covered areas, Many areas in Rakhine state were un covered due to social unrest , Kachin, Shan , states continued to have un reached areas, aslo with opening up of country there is marked increase in movememt of population from one area to another and urban areas are seeing more familes coming from rural areas. The BCG was 85%, DPT 1 coverages was good 88% but there was a marked drop in DPT3 coverages 73%. In many areas Health workers were not clear on the reporting of DPT and Penta doses and also the switch from DPT to Penta also posed some reporting probelm, and missed oppurtunities /drop outs.
- Measles 2nd dose which was introduced as NVI in Nov 2012 has good acceptance and coverage. Measles 1st dose was 84% and 2nd dose was 77% coverage and TT2 coverage was 79%
- In Shan and Kachin MOH has signed a MOU with HPA Health poverty Action, INGO to start Routine Immunization services for border areas, govt will be providing all vaccines , cold chain and along with WHO / UNICEF technical trainings will be provided to this INGO to facilitate EPI in border / under served areas
- Is planned to do an extensive trainings of all PHS -II Public health supervisiors to ensure HW have clear understanding of immunization sessions plannning and reporting.
- Although AEFI were reported after Penta introductions, all the cases were very well managed by medical teams and no adverse imact was reported from such areas.
- the change of immunization sehedule from 6,10,14 weeks to 2,4,6 months had resulted in some confusion among HW , some HW reduced their outreach session to adjust according to new EPI Sehedule thus reducing the out reach session numbers and immunization oppurtunities. The drop out rates increased.
- Induction and Quarterly meeting of Regional surveillance officers to review and strengthen Vaccine preventable disease surveillance strengthen routine immunization, AEFI surveillance and enhance capacity for outbreak investigations <?xml:namespace prefix = o />
- Technical meeting of Committees of Polio Eradication Immunization , National laboratory containment

meeting's National committee on Immunization practices, National expert group on Polio certification were conducted by DOH to support MoH preparedness for regional

- PolioFree certification process, Myanmar along with other SEARO countries was declared Polio free on March 27th 2014. A big Public Health milestone for country
- National level Workshop was also done for on evaluation and Strengthening of communicable/ VPD Surveillance and Response
- Polio Immunization in Rakhine state was also support and activites such as State level Advocacy meeting for Polio Catch Up Campaign in Rakhine, State level Training for Polio Catch Up Campaign , Vaccine Transportation from Central to Sittwe, Sub depot to Township and within Township Vaccine Transport support
- Efforts were made to strengthen cold chain through procurement of 13 set of solar panel systems, 40 ILR and 5 freezers and spare parts sets together with 2504 vaccine carriers and 225 cold boxes for vaccine distribution.
- IRC donated 22 Solar units of ILR to Rakhine state
- SERO survey feild activites completed to assess immunity for polio, measles and rubella

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

- In 2013 there was no shortage of vaccine or logistics, however there were a number of external and progrmatic factors which hampered the EPI program reaching its targets. A major factor was EPI services were not functional in many areas of Rakhine state due to multipal social / political / security reasons.
- With an increase in health budget both from internal and external sources, there has been a sudden increase in health related activites in MMR, this has increased and lack of proper coordination , limited Health workers at village levels has resulted in HW missing EPI session and resultint in drop in coverages.
- It was planned that Political situation / security will improve in many conflict areas, How ever EPI program still has not been able to reach parts of Kachin, Shan and Kayin states as conflict in border areas plus a weak health system does not favour EPI
- Some Health workers were not clear on the switch over plans from DPT to Penta , this resulted in some children being missed for 2nd or 3rd dose of DPT.
- With the opening up and reforms in Myanmar, lot of population movements is seen along with migration of people to urban areas, these have resulted in large no of drop out of children from routine EPI . Peri urban areas microiplans need to be constantly revised in major townships.
- Frequent transfer of health staff at Health center level has also affected the EPI coverages and in some places the no of drop out is significantly higher than last years
- Heath Workers were confused due to change in EPI policy of vaccination sehedule, in 2012 it was 6,10,14 weeks and sessions were being done every month in every village, how ever in 2012 Nov the policy for EPI sehedule was revised to 2,4,6 months, and HW resuced the no of EPI session from monthly to bi montly which reduced the vaccination oppurtunites and contacts beteen HW and communites, This needs to be corrected with fresh traininigs
- Traditional REC activites during open season could not be implemented due to varoius reasons,
- HB birth dose scale up is difficult was most of deliveries are at home and not in hospitals

5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **no, not available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

In Myanmar EPI services are Free of cost for all, there is no gender difference, also no seperate data is collected for males and females for vaccination. VPD surveillance does not show any major difference in immunity levels or disease burden in any particular gender.

How ever efforts are being made to collect and analyis data for immunization by boys and girls

There is no anti vaccination lobby or group opposing vaccination program in country,

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **No**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

No gender related barriers have been reported in EPI program ,and the vaccination is provided Free of cost for all population in all areas of the country. Awareness among parents/ caretakers is high on the benifits of immunization program. How ever efforts are ongoing to start analysis of coverages based on gender and conduct through analysis to verifiy that servises are acessed and provided to one and all in all parts of country.

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)

A major challenge in Myanmar is the figues for total population and EPI , all EPI figures are on based on estimates figures given by goverment. In many places the Health workers also do a annual head count of no of PW and under one in their catchment areas every year. In many areas Head count is reported lower than official estimated , how ever the head count has limitation as its not done for areas not accessed by Health workers specfically conflict areas, insecure areas, physically hard to reach areas etc. Also in some areas the head count is higher than the estimated /projected numbers.

Myanmar has not conducted any EPI coverage survey for a long time, the last was in 2009 MICS by UNICEF, Presently there is no difference in reported data and Joint WHO/UNICEF estimates.

* Please note that the WHO UNICEF estimates for 2013 will only be available in July 2014 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2012 to the present? **Yes**

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

In 2013 a serological assesment (SERO SURVEY) was done in 3 high risk state, Yangon, Chin and Kayin to assess Immunity in children against Polio , Measles and Rubella, A total of 6 townships were selected and random blood and oral fliuds samples were collected. (0-15 years and mother of the children) The samples are in the process of being tested in CDC Atalnta lab and Depertament of Medical Research lab in Yangon. Results will be ready by fall of 2014 . This will also give good information on protection levels among children for Polio, measles and rubella susceptible among girls of adolecent age group.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2011 to the present.

Microsoft Access based data software was been developed and is being used at all state/ regional level for compilation and data analysis, Data managers from all States and region were trainined on data quality issues, how to minimize entry errors, mapping, and data analysis. Lack of internet facility is a major barrier for this, plus at sub centers and townships all data is entered by hand by HW and this may result in entry errors.

Population figures in Myanmar still remain a major challange, Govt of Myanmar is in the process on conducting a Nation Wide General Census. This is for the first time in last 30 years a population count is being undertaken. The results will be avaiable in 2014 and hopefully this will guide the program with more

realistic figures and data.

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.

In 2014 DHS has been planned in Myanmar supported by USAID Also WHO/ UNICEF has joinlty planned to support a more extensive detailed EPI coverage survey by state and regions to identify areas of low coverage and steps needed to increase coverage. As Myanmar will be conducting MR SIA in last quarter of 2014, its being planned to do a Coverage survey after SIA so that both EPI and SIA coverage are collected in this survey and country has better or more accurate data on coverage figures.

Its proposed to support the States /regions/ townships with computers and data entry software to minimize entry errors and speedy transfer of EPI coverages to national levels, Also data unit at national levels needs to be strengthed to enhance quality of data collection, analysis and reporting (feed back to all levels).

There is a plan start collecting monthly data from private sectors in major townships specfically in Yangon and Mandalay for EPI as well as Disease surveillance

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** 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$ = 960	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 2013	Source of funding						
		Country	GAVI	UNICEF	WHO	JCV	AusAID	-
Traditional Vaccines*	1,855,076	0	0	789,514	0	813,746	251,816	0
New and underused Vaccines**	1,072,929,478	1,047,830	1,071,881,648	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	3,650,766	0	3,017,534	196,323	0	436,909	0	0
Cold Chain equipment	361,643	0	104,350	124,277	0	133,016	0	0
Personnel	2,127,188	2,089,242	22,946	15,000	0	0	0	0
Other routine recurrent costs	446,721	0	127,090	177,400	120,138	22,093	0	0
Other Capital Costs	176,027	0	176,027	0	0	0	0	0
Campaigns costs	210,037	0	55,747	29,635	124,655	0	0	0
RSO Surveillance net work support		0	0	0	900,000	0	0	0
Total Expenditures for Immunisation	1,081,756,936							
Total Government Health		3,137,072	1,075,385,342	1,332,149	1,144,793	1,405,764	251,816	0

* 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.

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2014 and 2015

There has been an increasing trend of Govt contribution for EPI Vaccine , starting from Penta, Hep B, cold

chain, Commitment for Rubella, PCV and MOH has instructed EPI to prepare and submit plan for procurement of traditional vaccine in coming years.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **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?

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

FMA conducted and signed

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 2013? **2**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2014 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

The ICC met in May 2014 to endorse this APR and reviewed the EPI program , its achievements and challenges , contraints faced by the program specifically in Hard to reach areas, conflict affected pockets of population such as Rakhine, . ICC congratulated the program on achieving Polio free certification in SEAR and emphasize the need to maintain strong routine coverages in all areas, specifically reaching the un reached. All efforts should be made to identify migrant population, new settlements and include these in Microplans.

In 2013 the ICC had two meetings in **May and July 2013.** Key discussion points in both these meetings were

- Rubella vaccine to be introduced in Myanmar along with MR campaign
- To start school based Immunization for Td as a step for MNT sustainability and booster for Diphtheria ,
- Strengthen Hep Birth dose HB 0 from all institutional deliveries
- Strengthen Cold Chain capacity and management, strengthen CCL in Rakhine
- Strengthen EPI in Rakhine, Kachin and Kayin state
- Trainings of new PHS II , in-service training on EPI
- Establish CRS surveillance after MR SIA in 2014
- Strengthen Community demand generation for EPI, specifically in areas with low coverage and high drop out

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

If Yes, which ones?

List CSO member organisations:
Myanmar Maternal and Child Welfare Association
Myanmar Red Cross Society
Myaanmar Health Assistant Association
Myanmar Nurses and Mid Wife Association

5.8. Priority actions in 2014 to 2015

What are the country's main objectives and priority actions for its EPI programme for 2014 to 2015

In 2014-2015 : Some of the major EPI planned activities are

- MNT sustainability review mission , review of data, identification of High risk areas for MNT and response activities (done in Feb 2014)
- Post introduction evaluation of New Vaccines (done in March 2014)
- MR National SIA ;targeting around 17 million children 9-14 years in Q4 of 2014
- Comprehensive CCL evaluation and expansion plan , follow up on EVM improvement plan (CCKP training, SOP etc) , procurment of CCL
- EPI coverage survey in 2014-2015
- Intensification of EPI in pockets of low coverages ,specifically Rakhine, Kachin, Kayin, Shan etc , INGO colloboration in High risk areas.
- Submission of GAVI HSS for EPI strengthening in Sept 2014
- IPV application Q4 of 2014
- Trainings of Mid Level managers and HW in HRA
- Capacity buildling of INGO./NGO to strengthen EPI in border , urban areas microplans to be reviewed to incorporate new settelments, migrant populations
- Trainings of PHS II
- Strengthening Measles / CRS surveillance

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 2013

Vaccine	Types of syringe used in 2013 routine EPI	Funding sources of 2013
BCG	ADS	UNICEF
Measles	ADS	UNICEF and GAVI
TT	ADS	UNICEF
DTP-containing vaccine	ADS	Govt and 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)

The country has an injection safety plan in place and these points are being taught in HW EPI trainings.

Please explain in 2013 how sharps waste is being disposed of, problems encountered, etc.

The country has a EPI waste disposal plan. which is in line with medical waste disposal plan. There plans are based on the local field conditions. In EPI majority of sessions are held in outreach settings and the Injection safety boxes in burnt and buried. How ever in PIE it was noticed that at some sites specifically in Sub RHC and RHC the open pit burial site is not well fenced. Also disposal pits are shallow, and need to be more deep. There is also need for additional incinerators at Townships levels

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2013

	Amount US$	Amount local currency
Funds received during 2013 *(A)*	0	0
Remaining funds (carry over) from 2012 *(B)*	1,759,812	1,689,419,520
Total funds available in 2013 *(C=A+B)*	1,759,812	1,689,419,520
Total Expenditures in 2013 *(D)*	375,309	360,296,640
Balance carried over to 2014 *(E=C-D)*	1,384,503	1,329,122,880

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 fund has transferred to DoH, MOH Myanmar upon proposal received for the immunization service strengthening activities from Department of Health , EPI unit and office being approved by ICC.
All procurement of supplies are being managed by concerned S&E unit of WHO country office .
ISS fund has put in national health sector plan , the yearly costed plan of immunization programme has developed in collaboration with partners and being financed from government, WHO, UNICEF and GAVI ISS fund.
Once the programme has developed the proposal, it has to take 2-3 weeks to release fund from WHO to EPI unit and all payments are by A/C payee checque to MOH account . DOH submits a detailed report on activites undertaken along with Finiancial report along with all receipts and vouchers.

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

WHO use the bank account in Govt of Myanmar, MFTB (Myanmar Forgeian Trade Bank) and EPI unit use the account of department of health ,that is government account of Ministry of health.
ISS funds are used for Immunization program needs. ICC endorses the ISS funded activities. The budget are approved once the proposed amount has been endorsed from Ministry of Health through the IHD department. The fund received from WHO has to be transfered to department of health account and the fund are managed by DOH budget management committee.The fund are allocated to State and Regional (sub-national level) and also to township level ,the basic health care management

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2013

1. Annual EPI Evaluation Workshops were supported at central level and in all 14 state and regions using ISS funds. Township medical officers and key cold chain persons meeting were organized to review the EPI coverage's, gaps and ways to reach the unreached.
2. Implementation activities of sero survey for poliomyelitis, Measles and Rubella among children and women of child bearing age: <?xml:namespace prefix = st1 />Myanmar has been reporting good administrative coverage's. How ever there has been no independent coverage evaluation survey to validate these reports/ data. In 2013 MOH in collaboration with Department of medical research lower Myanmar and technical support of WHO/ CDC conducted a serological survey in three high risk states (Yangon, Chin and Kayin in 6 townships) to asses immunity for Polio Measles in Children and Rubella in mothers of Child bearing age group. The field study has been completed and lab testing is in progress.
3. Support for Polio Immunization on 12 townships of Rakhine to boost polio immunity in children less than 5 years in social conflict affected areas of Rakhine where routine immunization services are severely affected. Operational cost for Health workers to reach the session site and cost for development of IEC materials
4. Ops support for implementation of intensification of Routine Immunization (IRI) in 42 townships from States and Regions, to reach the unreached with three rounds of Vaccination, identified Health centers in these townships have hard to reach areas where DPT3 Immunization coverage's were below 80%. This activity was done jointly with UNICEF
5. ISS funds were also used to support strengthening of Emergency cold chain maintenance in central cold Store, Sub Cold Stores and Sub Depots including conflict area, where cold chain engineers / mechanics were supported to do repair and undertake preventive work for Cold chain in townships and RHC levels

6. ISS funds were also used to procure 150 two wheelers for EPI health workers in hard to reach areas. Infrastructure, Roads are poor in many rural places and health workers find it difficult to access these areas in with out a good reliable transport. EPI program will prove two wheelers to 150 health workers/ supervisors to facilitate delivery of not only EPI but other life saving interventions to mothers and children
7. Cost for technical support / travel of MOH officials/ supervision and logistics were also supported through ISS funding,

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 2013 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2013 calendar year (Document Number 7) (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? **Yes**

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 8).

6.3. Request for ISS reward

Request for ISS reward achievement in 2013 is applicable for Myanmar

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

7.1. Receipt of new & under-used vaccines for 2013 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2013 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2013 vaccinations against approvals for 2013

	[A]	[B]		
Vaccine type	**Total doses for 2013 in Decision Letter**	**Total doses received by 31 December 2013**	**Total doses of postponed deliveries in 2013**	**Did the country experience any stockouts at any level in 2013?**
DTP-HepB-Hib	5,858,000	3,358,000	2,500,000	No
Measles	1,907,900	0	1,907,900	No

**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? ...)

  Penta :

  - Myanmar planned to Introduce Penta vaccine in its EPI program from 1st July 2012 and accordingly Penta vaccines were requested for 2012 for six months. How ever the Penta vaccine came late and the new vaccine was intorduced in only Nov 2012, hence there was excess vaccines and balance of vaccine around 2.5 million doses from 2012 stocks which was carried over to 2013. This was reported in 2012 APR under section 7.11.1 as closing balance of Penta vaccine in country stock
  - In 2013 the program aimed to reach 1,397,027 (93%) of children , how ever by end of 2013 it was able to reach on only 1,04,9844 (73%) children , this resulted in saving of vaccines. A total 1.4 million doses of Penta vaccine would have been used if these children were to be vaccinated, hence the supply shipment was postpone in 2013
  - In 2013 Multidose open vial policy was introduced in EPI program and all HW were trainined on the use of MDOPV, the wastage rate has been below the expected
  - In some parts of Myanmar like Rakhine, Kachin, Shan and some pockets in other state EPI program has not been satisfactory due to multipal reasons

- 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)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

  MoH has been keeping working closely with UNICEF country office and supply divison to update them on the existing stock and timeline for new stocks requiments. From 2013 a Monthly cooridnation mechenism has been put in place between program and UNICEF to trakc vaccine utilization and stock levels, its expected to provide more robust and timely accurate information on vaccine shipment plan as needed by program

Myanmar is fine with using a 10 dose penta

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

- there were no reports of vaccine stock outs for any antigen from all levels.

7.2. Introduction of a New Vaccine in 2013

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2013, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Phased introduction	No	
Nationwide introduction	Yes	
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	No NVI was planned for 2013

Measles second dose, 10 dose(s) per vial, LYOPHILISED		
Phased introduction	No	
Nationwide introduction	Yes	
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	Measles Second Dose had been introduced since Nov 2012.

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **March 2014**

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° 9))

Strengths of PIE;

-
  - Strong Government support, well organised introduction
  - Penta and MCV2 introduction overall running smoothly
  - Planning done well in advance, civil society organizations engaged, all guidelines and materials including new vaccination cards available
  - Key topics covered in training including other EPI topics
  - State launches with Senior Officials, professional Medical Societies and others
  - Revised schedule (2-4-6 mo) introduced and well accepted
  - Good plan for transition of vaccines
  - MDVP adapted to local conditions
  - Opportunity for integrated service provision with curative and public health services at the health service delivery level
  - **Challanges in Penta introductions**
-
  - Written plan for transition of DTP to Penta has not reached some areas
  - Microplan quality not uniform. No mircroplan at State level
  - No budget line for immunization for RHC staff (for operational costs)
  - Inadequate integration of EPI activities with other health services
  - Materials partly arrived after vaccine introduction
  - BHS need refresher training on routine and new vaccine issues
  - Vaccine administration sometimes only 2-monthly (not sufficient)
  - Inadequate advocacy visuals in the community (e.g. bill boards, street banners)

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**

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

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **Yes**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

Does your country conduct special studies around:

a. rotavirus diarrhea? **No**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **Yes**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

Myanmar conducted Sero Survey for Polio, measles, Rubella to look into Immunity levels in children and mothers in 3 high risk township 6 townships. Field work has been completed and the samples are being tested in CDC Atlanta, Department of medical research labs in Yangon. the results will provide very usefull information on the coverage levels and performance of PEI progrma in high risak areas plus risk of rubella among adoloest girls and women of child bearing age group. The results are expected soon in 2014

ICC has strongly reomended EPI program to have a EPI coverage survey done asap, DHS is being planned in Myanmar in 2014-2015

7.3. New Vaccine Introduction Grant lump sums 2013

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2013 (A)	0	0
Remaining funds (carry over) from 2012 (B)	2,121,990	2,037,110,400
Total funds available in 2013 (C=A+B)	2,121,990	2,037,110,400
Total Expenditures in 2013 (D)	110,851	106,416,960
Balance carried over to 2014 (E=C-D)	2,011,139	1,930,693,440

Detailed expenditure of New Vaccines Introduction Grant funds during the 2013 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2013 calendar year (Document No 10,11) . 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

1. Clinical Advocacy meeting with pediatricians in Yangon and <?xml:namespace prefix = st1 ns = "urn:schemas-

microsoft-com:office:smarttags" />Mandalay regions on Pentavalent vaccine and second dose of measles and vaccine preventable diseases

2. 50 Units of ILR, fridge and freeze tags were procured using ISS funds to be distributed at Townships levels for strengthening cold chain storage capacity in EPI program
3. 14 generators were also procured using this support for strengthening cold chain and proper maintenance of cold chain in sub depots in states and regional levels

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

There were WHO and UNICEF supported activites in 2012 which have covered / over lapping with similar objectives ,there were implemented, these activites have also contributed to direct contributions in NVI and were funded by WHO/ UNICEF regular support.

Polio certification was a top priority of the MOH in 2013 and a number of very polio specific activities were undertaken to full fill all required conditions for polio certification , including scaling up of surveillance, immunization on high risk areas, and laboratory containment activities. These along with on going crisis in Rakhine, Kachin and other border areas have resulted in low implementation of NVI funds and substaintial delays in implementing NV activities

Major cold chain expension was planned but the inventry and forcasting for needs was delayed, its been done currently in March 2014 and the procurments will be done this year. Also procurment of vaccine van has bben delayed cox of non avaialibitiy of driver post in Cold room

Many of the planned activities of 2013 for penta and measles second dose intorduction have not been implemented due to various reasons, Limited capacity of EPI at central level has been one of the main factors. Post inroduction evaluation for NVI planned in 2013 has been been done recently in early 2014

Please describe the activities that will be undertaken with any remaining balance of funds for 2014 onwards

In 2014-2015 Health workers trainings and Medical Officers MLM trainings will be given priority, Also through NGO MMCWA efforts will be made for increasing demand and awareness for EPI services in specific health centers / areas where there has been high droup outs and low coverages.

Measles surveillance will be strengthened to ensure case based fever and rash surveillance is functionall in all townships, trainings for surveillance, outbreak investigations, data managmemt trainings, AEFI guidelines revisions are being planned for 2014-2015

7.4. Report on country co-financing in 2013

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2013?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	1,008,230	
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED		
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2013 from the following sources?	
Government	1,008,230	
Donor	nil	
Other	nil	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**

Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED		
	Q.4: When do you intend to transfer funds for co-financing in 2015 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2015	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	March	Govt of Myanmar
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED		from GAVI
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	Yes Myanmar needs TA for developing FSS and for resource mobilization for EPI program	

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 support from GAVI, in form of new and under-used vaccines and injection supplies, reported in 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 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

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

Are there any changes in the Improvement plan, with reasons? **Yes**

If yes, provide details

There has been progress in implementation of EVM plan. a updated EVM and coverage improvement plan is attached. Limited funds are avaiable for implementing the scale up of EVM plan, the current GAVI HSS does not support any EPI /Cold chain activities.

When is the next Effective Vaccine Management (EVM) assessment planned? **April 2015**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

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 2014

Renewal of multi-year vaccines support for Myanmar is not available in 2014

7.9. Request for continued support for vaccines for 2015 vaccination programme

In order to request NVS support for 2015 vaccination do the following

Confirm here below that your request for 2015 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don't confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	200,000$		250,000$	
			<=	>	<=	>
DTP-HepB	HEPBHIB	2.00 %				
HPV bivalent	HPV	3.50 %				
HPV quadrivalent	HPV	3.50 %				
Measles second dose	MEASLES	14.00 %				
Meningococcal type A	MENINACONJUGATE	10.20 %				
MR	MR	13.20 %				
Pneumococcal (PCV10)	PNEUMO	3.00 %				
Pneumococcal (PCV13)	PNEUMO	6.00 %				
Rotavirus	ROTA	5.00 %				
Yellow Fever	YF	7.80 %				

Vaccine Antigens	VaccineTypes	500,000$		2,000,000$	
		<=	>	<=	>
DTP-HepB	HEPBHIB				
DTP-HepB-Hib	HEPBHIB	25.50 %	6.40 %		
HPV bivalent	HPV				
HPV quadrivalent	HPV				
Measles second dose	MEASLES				
Meningococcal type A	MENINACONJUGATE				
MR	MR				
Pneumococcal (PCV10)	PNEUMO				
Pneumococcal (PCV13)	PNEUMO				
Rotavirus	ROTA				
Yellow Fever	YF				

7.11. Calculation of requirements

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

ID		Source		2013	2014	2015	2016	TOTAL
	Number of surviving infants	Table 4	#	1,464,625	1,475,282	1,470,863	1,466,517	5,877,287
	Number of children to be vaccinated with the first dose	Table 4	#	1,392,037	1,417,287	1,412,998	1,423,810	5,646,132
	Number of children to be vaccinated with the third dose	Table 4	#	1,392,037	1,417,287	1,386,611	1,393,190	5,589,125
	Immunisation coverage with the third dose	Table 4	%	95.04 %	96.07 %	94.27 %	95.00 %	

	Number of doses per child	Parameter	#	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.25	1.25	1.18	1.18	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	2,937,390				
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	2,937,390				
	Number of doses per vial	Parameter	#		10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

Closing balance for Penta for 2013 is 2,937,390 doses of vaccine and same was the opennig balance for 2014

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

Not defined

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

Co-financing group	Low

	2013	2014	2015	2016
Minimum co-financing	0.20	0.20	0.20	0.20
Recommended co-financing as per APR 2012			0.20	0.20
Your co-financing	0.20	0.20	0.20	0.20

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

		2014	2015	2016
Number of vaccine doses	#	4,828,100	4,055,200	4,501,700
Number of AD syringes	#	4,716,200	4,104,700	4,664,000
Number of re-constitution syringes	#	0	0	0

Number of safety boxes	#	51,900	45,175	51,325
Total value to be co-financed by GAVI	$	10,101,500	8,594,500	9,220,000

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

		2014	2015	2016
Number of vaccine doses	#	522,500	432,900	499,900
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country [1]	$	1,070,500	898,000	1,000,500

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

		Formula	2013	2014		
				Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	9.76 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,392,037	1,417,287	138,394	1,278,893
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,392,037	1,417,287	138,394	1,278,893
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	4,176,111	4,251,862	415,181	3,836,681
E	**Estimated vaccine wastage factor**	*Table 4*	1.25	1.25		
F	**Number of doses needed including wastage**	*D X E*		5,314,828	518,976	4,795,852
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.375) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.375)*		35,509	3,468	32,041
H	**Stock to be deducted**	*H1 - F of previous year x 0.375*				
H1	**Calculated opening stock**	*H2 (2014) + H3 (2014) - F (2014)*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	0	2,937,390		
H3	**Shipment plan**	*UNICEF shipment report*		4,412,800		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		5,350,500	522,459	4,828,041
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*		4,716,109	0	4,716,109
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*		51,878	0	51,878
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		10,299,713	1,005,734	9,293,979
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		212,225	0	212,225
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)*		260	0	260
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		659,182	64,367	594,815
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*		11,171,380	1,070,100	10,101,280
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		1,070,100		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*		9.76 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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

		Formula	2015			2016		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.64 %			9.99 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	1,412,998	136,276	1,276,722	1,423,810	142,283	1,281,527
B1	Number of children to be vaccinated with the third dose	*Table 4*	1,386,611	133,731	1,252,880	1,393,190	139,223	1,253,967
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	4,201,789	405,239	3,796,550	4,228,256	422,534	3,805,722
E	Estimated vaccine wastage factor	*Table 4*	1.18			1.18		
F	Number of doses needed including wastage	*D X E*	4,958,112	478,182	4,479,930	4,989,343	498,590	4,490,753
G	Vaccines buffer stock	*((D - D of previous year) x 0.375) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.375)*	- 18,777	- 1,810	- 16,967	11,712	1,171	10,541
H	Stock to be deducted	*H1 - F of previous year x 0.375*	451,547	43,550	407,997			
H1	Calculated opening stock	*H2 (2014) + H3 (2014) - F (2014)*	2,332,994	225,004	2,107,990			
H2	Reported stock on January 1st	*Table 7.11.1*						
H3	Shipment plan	*UNICEF shipment report*						
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	4,488,000	432,842	4,055,158	5,001,500	499,805	4,501,695
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	4,104,612	0	4,104,612	4,663,965	0	4,663,965
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	45,151	0	45,151	51,304	0	51,304
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	8,747,112	843,609	7,903,503	9,407,822	940,132	8,467,690
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	184,708	0	184,708	209,879	0	209,879
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)*	226	0	226	257	0	257
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	559,816	53,992	505,824	602,101	60,169	541,932
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	9,491,862	897,600	8,594,262	10,220,059	1,000,300	9,219,759
U	Total country co-financing	*I x country co-financing per dose (cc)*	897,600			1,000,300		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.64 %			9.99 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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

ID		Source		2013	2014	2015	2016	TOTAL
	Number of surviving infants	Table 4	#	1,464,625	1,475,282	1,470,863	1,466,517	5,877,287
	Number of children to be vaccinated with the first dose	Table 4	#	1,142,407	1,180,262	1,367,902	1,378,525	5,069,096
	Number of children to be vaccinated with the second dose	Table 4	#	1,397,027	1,180,262	1,206,107	1,246,539	5,029,935
	Immunisation coverage with the second dose	Table 4	%	95.38 %	80.00 %	82.00 %	85.00 %	
	Number of doses per child	Parameter	#	1	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	1.67	1.67	1.00	1.00	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	2,106,850				
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	2,106,850				
	Number of doses per vial	Parameter	#		10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.00	0.00	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		14.00 %	14.00 %	14.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	10.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

no difference

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

Co-financing group	Low

	2013	2014	2015	2016
Minimum co-financing			0.00	0.00
Recommended co-financing as per APR 2012			0.00	0.00
Your co-financing	0.00	0.00		

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

		2014	2015	2016
Number of vaccine doses	#	- 120,000	- 199,200	- 383,600
Number of AD syringes	#	- 1,001,800	- 219,200	- 422,000
Number of re-constitution syringes	#	- 13,200	- 21,900	- 42,100
Number of safety boxes	#	- 11,150	- 2,650	- 5,100
Total value to be co-financed by GAVI	$	- 83,000	- 69,500	- 138,000

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

		2014	2015	2016
Number of vaccine doses	#	0	0	0
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country [1]	$	0	0	0

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

		Formula	2013	2014		
				Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	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	1,180,262	0	1,180,262
E	**Estimated vaccine wastage factor**	*Table 4*	1.67	1.67		
F	**Number of doses needed including wastage**	*D X E*		1,971,038	0	1,971,038
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		15,805	0	15,805
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	0			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		- 120,000	0	- 120,000
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*		- 1,001,861	0	- 1,001,861
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*		- 13,200	0	- 13,200
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*		- 11,165	0	- 11,165
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		- 29,400	0	- 29,400
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		- 45,083	0	- 45,083
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		- 52	0	- 52
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		- 55	0	- 55
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		- 4,116	0	- 4,116
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		- 4,519	0	- 4,519
T	**Total fund needed**	*(N+O+P+Q+R+S)*		- 83,225	0	- 83,225
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 second dose, 10 dose(s) per vial, LYOPHILISED (part 2)

		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 4*	1,367,902	0	1,367,902	1,378,525	0	1,378,525
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1			1		
D	**Number of doses needed**	*B x C*	1,367,902	0	1,367,902	1,378,525	0	1,378,525
E	**Estimated vaccine wastage factor**	*Table 4*	1.00			1.00		
F	**Number of doses needed including wastage**	*D X E*	1,367,902	0	1,367,902	1,378,525	0	1,378,525
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	46,910	0	46,910	2,656	0	2,656
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*	1,614,091	0	1,614,091	1,764,875	0	1,764,875
H2	**Reported stock on January 1st**	*Table 7.11.1*						
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	- 199,200	0	- 199,200	- 383,600	0	- 383,600
J	**Number of doses per vial**	*Vaccine Parameter*	10			10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	- 219,206	0	- 219,206	- 422,063	0	- 422,063
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	- 21,912	0	- 21,912	- 42,196	0	- 42,196
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*	- 2,652	0	- 2,652	- 5,106	0	- 5,106
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	- 51,592	0	- 51,592	- 102,804	0	- 102,804
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	- 9,864	0	- 9,864	- 18,992	0	- 18,992
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	- 87	0	- 87	- 168	0	- 168
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	- 13	0	- 13	- 25	0	- 25
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	- 7,222	0	- 7,222	- 14,392	0	- 14,392
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	- 996	0	- 996	- 1,918	0	- 1,918
T	**Total fund needed**	*(N+O+P+Q+R+S)*	- 69,774	0	- 69,774	- 138,299	0	- 138,299
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)

This window of support is no longer available

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 2013**. All countries are expected to report on:

   a. Progress achieved in 2013

   b. HSS implementation during January – April 2014 (interim reporting)

   c. Plans for 2015

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

For countries that received HSS funds within the last 3 months of 2013, or experienced other delays that limited implementation in 2013, 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 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **15th May 2014**. 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 2014, the HSS reports are expected by GAVI Alliance by September 2014.

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 objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

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 2013

   b. Minutes of the HSCC meeting in 2014 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2013 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 2013 and request of a new tranche

For countries that have previously received the final disbursement of all GAVI approved funds for the HSS grant and have no further funds to request: Is the implementation of the HSS grant completed ? **No**

If NO, please indicate the anticipated date for completion of the HSS grant.

Activity completion date - 31st December 2015

Reporting date - 30th June 2016

*** Performance assessment of GAVI HSS interventions in Myanmar and Mid Term Review of MCH Voucher Scheme, attached in annexure I and II.

Please attach any studies or assessments related to or funded by the GAVI HSS grant.

Please attach data disaggregated by sex, rural/urban, district/state where available, particularly for immunisation coverage indicators. This is especially important if GAVI HSS grants are used to target specific populations and/or geographic areas in the country.

If CSOs were involved in the implementation of the HSS grant, please attach a list of the CSOs engaged in grant implementation, the funding received by CSOs from the GAVI HSS grant, and the activities that they have been involved in. If CSO involvement was included in the original proposal approved by GAVI but no funds were provided to CSOs, please explain why not.

Myanmar Maternal and Child Welfare Association:

Myanmar Red Cross Society: will be taking up the construction component(Grant Agreement signed)

Please see http://www.gavialliance.org/support/cso/ for GAVI's CSO Implementation Framework

Please provide data sources for all data used in this report.

Please attach the latest reported National Results/M&E Framework for the health sector (with actual reported figures for the most recent year available in country).

9.1.1. Report on the use of HSS funds in **2013**

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: **14124749** US$

These funds should be sufficient to carry out HSS grant implementation through December 2015.

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)$

	2008	2009	2010	2011	2012	2013
Original annual budgets	0	0	0	3649218	6653666	9883249

(*as per the originally approved HSS proposal*)						
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	3649218	7459586	8353249
Total funds received from GAVI during the calendar year (*A*)	0	0	0	2833405	5061666	392500
Remaining funds (carry over) from previous year (*B*)	0	0	0	0	1947752	5764492
Total Funds available during the calendar year (*C=A+B*)	0	0	0	2833405	7009418	6156992
Total expenditure during the calendar year (*D*)	0	0	0	885653	1244926	3666855
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	1947752	5764492	2490137
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	8353249

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	12594749			
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	14124749			
Total funds received from GAVI during the calendar year (*A*)	9220749			
Remaining funds (carry over) from previous year (*B*)	2490137			
Total Funds available during the calendar year (*C=A+B*)	11710886			
Total expenditure during the calendar year (*D*)	2897409			
Balance carried forward to next calendar year (*E=C-D*)	8813477			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	14124749	0	0	0

Table 9.1.3b (Local currency)

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	2819020905	5656946833	9500767263
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	2819020905	6342140017	8029978263
Total funds received from GAVI during the calendar year (*A*)	0	0	0	2188805363	4303428433	377310250
Remaining funds (carry over) from previous year (*B*)	0	0	0	0	1655978750	5541406159
Total Funds available during the calendar year (*C=A+B*)	0	0	0	2188805363	5959407183	5918716409
Total expenditure during the calendar year (*D*)	0	0	0	684166943	1058436085	3524947711
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	1504638420	4900971098	2393768698
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	6342140017	8029978264

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	1210733221			
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	1357812121			
Total funds received from GAVI during the calendar year (*A*)	8863906013			
Remaining funds (carry over) from previous year (*B*)	2393768698			
Total Funds available during the calendar year (*C=A+B*)	1125767471			
Total expenditure during the calendar year (*D*)	2785279271			
Balance carried forward to next calendar year (*E=C-D*)	8472395440			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	1357812121	0	0	0

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	2008	2009	2010	2011	2012	2013
Opening on 1 January				851	807.5	854.5
Closing on 31 December				791	850	988

Detailed expenditure of HSS funds during the 2013 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2013 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: 19)**

If any expenditures for the January April 2014 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: 20)**

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.

Financial Management of GAVI HSS funds are done as per the Aid Memoire signed between CEO GAVI on 26/1/2011 and Ministry of Health Myanmar on 4/2/2011.

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

In addition, a third agency (MRCS) will be now engaged by MOH-Myanmar and GAVI to implement Construction Component.

Funds are managed as follows:

a. UNICEF received a total of USD 2,768,500 for year three 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 6,844,749 for the third 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. MRCS (Infrastructure): The agreement for construction of sub RHCs was already signed by GAVI, MRCS and Ministry of Health for first 2 years(2011-12-2012-2013) budget. MRCS is yet to receive USD 682,515(60% of total amount)

*** there are still a balance of USD 2,883,858 earmarked for infrastructure for year 3 and 4(2014-2015), after reprogramming the rest to WHO management cost and other ISS activities.

Funds managed by UNICEF

UNICEF is responsible for procurement of supplies for the GAVI-supported townships. A Letter of Agreement covering the 4 year 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 has also supported the MOH Myanmar at CMSD level in supervision and monitoring of distribution 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 significant portion of the HSS programme in Myanmar is implemented jointly by WHO and the MoH-Myanmar. This has been agreed in a Letter of Agreement, 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.

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, 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 for Health System Strengthening (NHSC), sometimes referred to as Health Sector Coordination 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 and the GAVI-HSS Focal Point, Director of Planning, Department of Health, Ministry of Health, Myanmar. <?xml:namespace prefix = o />

b. Prior to disbursement, all the GAVI HSS activities are incorporated in the WHO details work plan. 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).

Funds managed by MRCS:

1. Conditions of Payment

GAVI will make the Grant payments to MRCS subject to and conditional on the availability of funds, MRCS providing GAVI with relevant reporting, receipt of APRs from the Government, fulfillment of obligations by MRCS, and necessary GAVI Board approvals.

2. Payment of Grant

GAVI will deposit the Grant payments under this Agreement in following US dollar bank account of MRCS for general donors at

Myanmar Foreign Trade Bank (the “MFTB Account”).

3. MRCS will charge 6.5% to cover all these costs related to administering the funds (programme support costs).

4. Grant funds will be transferred by MRCS from the MFTB Account to a designated bank account for GAVI in the local currency with the Myanmar Economic Bank (the “MEB”) (the “Project Bank Account”) based on cash flow projections endorsed by the NHSC.

5. Payments for construction of the Health Centres will be made directly from the Project Bank Account to the contractors based on the certificate of completion at various stages of the construction of the Health Centres from MoH.

NHSC:

The National Health Sector Coordinating (NHSC) body, convened to support GAVI HSS proposal development and implementation and which has been operational since the beginning of 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 development partners, meets on a quarterly basis.

In 2013-2014, 2 NHSC meetings (6th and 7th) were held.

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 the programme;

- Review and approve the Annual Progress Report submitted to GAVI by 15th May each year, 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 that any issues raised in the internal or external audit letters to management are addressed in a timely way;

- Ensure representation on the NHSC from all of the 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.

Financial management 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 010566 Government Account at Myanmar Economic Bank, Tarmwe, <?xml:namespace prefix = st1 />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 secretary of 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 within 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 the HSS 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 budgets at 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 Finance Officer) using formats provided by GAVI. These are prepared on quarterly basis for central level and township level expenditure. The statements are presented to 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 to submission to the GAVI Secretariat. A copy of the MOH year-end financial statement that includes expenses on GAVI HSS is 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 for health facilities using GAVI funds) and include details of purchase price, purchase date, invoice reference and payment reference at time of purchase and supplier details, description of equipment, identifying serial number, make and model, unique asset register number (recorded on the item of equipment with secure 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 will undertake 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 year of 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

a. 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 INGOs implementing health activities in the township. The Township Health Committee is a committee formed at every township health system in the country and chaired by the chief of the township local authority.

b. At every township where refurbishment and rehabilitation of facilities activities will take place, 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 is placed in the TMO office. These accountants are local, have an accounting degree, and are well known to the THSC in a personal and professional capacity.

c. The THSC are given additional responsibility of recording and managing GAVI inflow and outflow of funds for the township activities to the township health department. This has been applied to all GAVI supported townships through a standing order signed by the DG of the Department of 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 of these funds, a supervisory committee, overseen by the township health committee, 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).

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: 21)

9.2. Progress on HSS activities in the 2013 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 2013 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Objective1: By 2015, 180 selected townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%			
Health System Assessments in year two 40 townships.	Activity 1.1: Conduct survey to establish base line indicators & outcome, impact and research for operations	100	Health System Assessment for 40 townships- Annexure III
Procurement and distribution of essential medicines to 60 townships till sub-centre level	Activity 1.2: Increase availability of Essential Supplies and equipment based on needs identified in CTHP	100	UNICEF (List of medicines and equipments procured/ disbursed to CMSD) CMSD (Distribution breakdown of medicines and euipments to 40 townships) - Annexure IV UNICEF Progress Report - Annexure V
Construction of Subcentres in 20 townships	Activity 1.3: 30 subcenters 12 HSS-targeted Townships will be constructed by 2015, based on Grant Agreement between MOH-GAVI-MRCS	10	Grant Agreement Signed between MOH- MRCS- GAVI. Annexure VI
Increased access to EPI, MCH, Nutrition and Environmetnat Health through coordinated efforts by providing package of services to hard to reach areas. Transportation allowance to BHS for delivering package of services and to senior supervisors for supervision of service delivery.	Activity 1.4: 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 CTHP.	100	Final technical report on supporting TA, DA for BHS.
Supply of motorcycles to BHS of 60 townships.	1.4.2 Supply of transport capital to Townships based on needs identified in CTHP	100	Distribution List of motorcycles to 60 townships- Annexure VII
Quarterly review meeting held at RHCs and township level participated by BHS, TMOs, and township/village health committee, INGOs, NGOs and volunteers. Recruitment and training of 600 AMWs and 600 CHWs, and refresher training of 2000 AMWs and 2000 CHWs at 40 townships	Activity 1.5: Social Mobilization involving NGOs, local authorities and Community Health Workers in developing and implementing CTHP in 100% of HSS-targeted townships by 2015	100	Quarterly meeting minutes at township level. Annexure VIII List of AMW and CHW for recruitment and refresher training.
Objective 2: By the end of 2015, 180 selected			

townships with identified hard to reach areas will have developed and implemented coordinated township micro-plans			
Printing of CTHP guidelines and development of CTHP at 40 townships	Activity 2.1: Develop national guidelines for coordinated township health planning & supervision at all levels	100	CTHPs for 40 townships.
Mid-term review on MVS	Activity 2.2: Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships by 2015.	100	Draft Report on Mid-term Review of MCH Voucher Scheme. Annexure II
Implementation of Maternal Voucher Scheme	Activity 2.3: Health financing training and Piloting of health financing schemes, according to national guidelines in 2 townships by 2015	70	Progress Report from Pilot township.
Capacity building on Management and Leadership	Activity 2.4: Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2015.	100	User friendly manual on Leadership and Management training to TMO and BHS. Annexure IX
Hospital Equity Fund	Activity 2.5: Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines and framework at all levels	80	Data from townships
Annual Program Review and NHSC meetings. Three Health System Researchs is conducting at 10 townships after the Operational Research training at central level	Activity 2.6: Assess process and impact of coordinated State & Township coordinated health planning, and then disseminate findings	80	6th and 7th NHSC meeting minutes. Annexure X 3 research protocols. Annexure XI
Objective 3: By the end of 2015, 180 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to the National HR Standards.			
Supportive activity for creating HR unit	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2015.	0	
	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	0	
Technical skill upgrading	Activity 3.4: Conduct coordinated MCH, EPI, Nutrition & FH training	100	Technical report from MOH

	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		
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	40	List of participants and official communication with host countries.
Recruitment of Health System Strengthening Officers (HSSOs) at township level as well as central level	3.4.4 Leadership Development Program	100	Technical Report
Support costs			
Procurement of office equipments	Computers Central and States/ Divisions	100	Distribution List of Desktop computers, copiers and Auto voltage regulators to townships. Annexure XII, XIII and XIV.
Procurement of office equipments	Computers Townships	100	Distribution List of Desktop computers, copiers and Auto voltage regulators to townships. Annexure XII, XIII and XIV.
Administration and Mangaement cost (WHO)	Administration and Mangaement cost (WHO)	100	
Administration cost (DOH) and support for accountants of townships	Administration cost central level (DOH)	100	
M&E support cost			
International technical assistant	Health System Advisor (WHO)	100	
International technical assistant	Financial Management Consultancies	100	Draft Report on Mid-term Review of MCH Voucher Scheme. Annexure II
International technical assistant	Planning Consultancies	0	
International technical assistant	Management Effectiveness Program Consultancies	0	
International technical assistant	Operational Health System Consultancies	0	
International technical assistant	Drug Supply System Consultancies	0	

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**
Objective 1:	
Health System Assessments	Progress achieved: - Health system assessment at 40 townships completed. - Compilation and documentation of survey results completed
Procurement and distribution of essential medicine	Progress achieved:

	- Essential medicine and equipments procured and distributed to 60 townships up till sub-centre level.
Construction of Subcentres	Progress achieved: - Grant Agreement signed Constraints: - Delay in grant agreement signing between MOH-GAVI-MRCS
Increased access to hard to reach areas	Progress achieved: - Access to essential components of EPI, MCH, Nutrition and Environmental Health for the hard to reach communities increased through coordinated efforts and service delivery. - Transportation allowance provided to BHS for provision of package of services, senior supervisors for supervision of service delivery.
Procurement and supply of Motorcycles	Progress achieved: distributed 166 motorcycles to 60 HSS townships.
Social Mobilization Activities	Progress achieved: - Quarterly Review Meetings conducted at all HSS townships. - 2 NHSC meetings conducted- one for planning year 3 budget and another for endorsing the APR 2013. - Recruitment of 15 AMWs and 15 CHWs and refresher training of 50 AMWs and 50 CHWs was also conducted at each new township
Objective 2:	
Development of Coordinated Township Health Plan	Progress achieved: - Printing of CTHP guidelines for 40 new HSS townships. - About 2400 BHS including TMO from 40 townships were trained on using the CTHP guideline. Development of CTHPs by TMOs, BHS and HSSOs at 40 townships.
Mid-term review on piloting MVS	Progress achieved: - Mid-term review on MVS was conducted by international consultant HiTAP and findings disseminated.
MVS implementation at piloted townships	Progress achieved: - Piloting MVS at Yedarshay township. - Preparation to expand piloting MVS to an additional township(Pauk Kaung township). - one finance officer recruited to monitor the MVS activity.
Development of Leadership and Management Module.	Progress achieved: - Leadership and Management Module developed. - TOT and multipler training on Leadership and Management to TMOs and BHS.
Hospital Equity Fund	Progress achieved: -HEF implemented in all 60 townships.
Annual Program Review and NHSC meetings. HSR	Progress achieved: - Annual Program Review meeting for year 2 was held on 25th March 2014. - Dissemination workshop on performance assessment of GAVI HSS intervention in 20 townships and Mid-term review on MVS was conducted in 1st week of March 2014.
Objective 3:	

Technical skill upgrading	Progress achieved: - Technical skill upgraded for BHS on EPI, MCH, Environmental Sanitation and Nutrition through TOT and multipler training of these technical program.
Experience sharing among HSS countries.	Progress achieved: - Sirilanka and Nepal identified as host countries to visit. - Participants selected by government and WCO Myanmar is now processing the visit.
Recruitment of Health System Strengthening Officer	Progress achieved: - Health System Strengthening Officers (HSSOs) recruited by WCO Myanmar through Special Service Agreement, to facilitate implementation GAVI health system strengthening activities at all levels (central, state/region and townships)
Support cost	
Procurement of Office Equipments	Progress achieved: - Procured computers, printers, copiers to 40 townships.
International Technical Assistance	- we have managed through the fund balance from past yr. we are planning to use these in the coming months.

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

we have performed almost all the activities, except consultancies. However, technical tasks planned for consultancies were performed by the WHO technical unit and external experts, by using balance funds from the past year. Remaining consultancy work will be performed within the coming months(2014).

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?

It was planned to support creation of Human Resource Management unit at the ministry and also to provide incentive mechanism for the best performing health workers. These activities are under process.

Study was conducted to review the effectiveness of Community Health workers(AMW and CHWs). Findings from the study was presented to the ministry and it has guided the policy makers in strengthening Community Health Workforce in Myanmar.

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 2012 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	2013 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2009	2010	2011	2012	2013		
Impact and Outcome Indicators											
1. National DTP3 coverage (%)	70%	2006	90%	90%	90%	90%	86%	85%	73%	EPI unit, MOH	
2. Number / % of districts achieving >80% DTP3	75 t0wnships 23%	WHO UNICEF Joint Report Dept. of	325 townships	330 townships	289	283	252	211	155	EPI evaluation, MOH	

coverage		Health/ 2006									
3. Under five mortality rate (per 1000) (National)	66.1/1000LB	HMIS; Dep of Health Planning. Survey DOH UNICEF/ 2003	38.5/1000LB MDG target by 2015	NA		**46.1/ 1000LB	NA	NA	NA	** MICS (2009-2010)	Next MICS will be able to give this data
4. Delivery by Skilled Birth Attendants (HSS targeted townships)	67.5%	Union of Myanmar MDG report 2006. Fertility Reproductive Health Survey/ 2003	80%	NA	64.4%	64.8%	67.1%	67.9%	NA	HMIS 2013	National data will be available after June 2014
5. Rate of ORT use of <5 childre (National)	53%	Dept of Health Planning Public Health Statistics Annual Report 2006	80%	NA	95.6%	96.4%	97.1%	97.1%	NA	HMIS 2013	National data will be available after June 2014
6. % of 6-59 months children having Vitamin A during past 6 months (National)	80%	Bi Annual Report of Nutrition Dep/ 2007	90%	95.1%	94.5%	94%	95.74%	96.08%	95.23%	Bi annual report of Nutrition	
Output Indicators											
1. % of townships have developed and implemented coordinated Township Health Plans according to national framework	0	Annual Program Review (Annual Evaluation Report)/ 2005	55% (180 townships out of 325)	60 townships				20 townships	60 townships	DOH	
2. Number/% of RHC visited at least 6 times in the last year using a quantified checklist	0	Baseline Survey	100%	344 RHCs in 2012				67 RHCs	145 RHCs	HSS Assesssment	344 includes all easy and hard to reach RHCs. However, the program budget could cover supervisory visits to only hard to reach RHCs
3. Number of managers/ trainers / BHS trained for MEP at each level per year	300 BHS and 50 mangers and trainers for MEP	Annual Program Review		3600 BHS including TMOs. Trained on CTHP and Leadership & management				1137	3600	HSS Assessment	
4. Proportion of RHCs with no stock out of essential supplies (availability, service access, utilization, quality) in the last 6 months.	0	Baseline Survey	100% of RHCs in HSS investment area.	344 RHCs				115 RHCs	344 RHCs	DOH	
5. No of RHC and sub RHC renovated	30 RHCs (renovated) and 90 sub-	Dep of Health	540 RHCs renovated and 324	30 sub RHCS				0	0	DOH	MRCS is going to construct 30

and/or constructed per ye	RHCs (constructed)		Sub-RHC constructed in HSS investment area (180 townships)								sub RHCs
6. Percent of selected Townships with identified hard to reach areas staffed by midwives and PHS2 according to the National HR Standards	0	Baseline Survey	50%	NA					NA	NA	No computerized personal information system in place to help track this indicator. Ministry is working on developing this system.

9.4. Programme implementation in 2013

9.4.1. Please provide a narrative on major accomplishments in 2013, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

- 60 townships implemented coordinated township health plans and delivered package of Primary Health Care services (EPI. MCH, Nutrition and EH) to hard to reach areas. Through the package of service delivery:

1. 27,304 ANC performed

2. 3,163 PNC performed

3. 49,052 doses immunized (BCG, OPV, DPT, measles) but the number of fully immunized could not be elaborated.

4 Nutritional status of 236,310 under 5 children measured

5. Health education service enhanced the advocacy on immunization especially for hard to reach areas. HSS program identified and immunized 3687 unreached children

- Hospital Equity Fund (total amount $ 600,000 benefited the following vulnerable groups in 60 townships):

1. 1009 mothers treated for obstetric cases and 4 cases for gynaecological cases.

2. 471 under 5 children treated for life saving conditions.

3. 334 men treated for surgical and medical cases.

-Data quality and service quality assessment conducted in 40 townships facilitated in streamlining data recording system for DPT3/ Penta 3, ANC, PNC and TT.

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

- Not enough funding to expand the program as planned. Budget was planned almost uniformly across all four years, but coverage expanded from 20 to -60 and to 120 townships by 2014. we had to reprogram within activities.

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

Different Monitoring and Evaluation mechanisms are instituted at different levels as explained below:

23 Health System Strengthening Officers (HSSOs) were recruited and deployed by WHO; 17 at the township level and 6 at the central level. HSSOs work very closely with the State and township health authorities. They conduct field visits to monitor and supervise the delivery of Outreach services in hard-to-reach areas, and they also supervise the implementation of the hospital equity fund and submit monthly reports to the MOH. Since these HSSO's are recruited by WHO, they also submit their duty/travel reports to WHO for every visit

they make. <?xml:namespace prefix = o />

TMOs, Health Assistants and Lady Health Visitors also make monthly visits to the RHCs and Sub-RHCs to track progress status of package of services delivery (EPI, MCH, Nutrition and Environmental Health) in hard-to-reach areas. Furthermore, random monitoring visits are made by the Planning Unit, Department of Health, MOH, to review the status of implementation in the townships.

The fund release for each activity from WHO to MOH is subject to receipt of proposals (APW and DFC) by WHO from the MOH. Proposals must detail every activity and highlight the timeline and budget breakdown for their implementation. The GAVI HSS technical unit in WHO monitors the implementation status of each activity in line with timelines and budgets as highlighted in the proposal. WHO does not accept any delay in activity implementation and

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 captured in 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 in collaboration with WHO and is incorporated in the WHO detailed work plans. Accordingly the end of biennium review by WHO captures the progress status of HSS activities. <?xml:namespace prefix = o />

Most of the HSS activities that were implemented in 2013 were reflected (2012-2013 biennium) and were reviewed during the end of biennium review for (2012-2013) in December 2013. The rest of the activities are planned in 2014-2015 biennium and it will be reviewed by end of 2014.

Since the procurement of essential medicines and equipments are done by UNICEF, the annual program review by UNICEF will tab the progress status on the distribution and utilization of medicines and equipment at the townships.

Further the impact of GAVI HSS interventions will be evaluated 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 the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

Major organizations that were involved in the implementation of GAVI HSS in Myanmar are WHO and UNICEF. Further JICA, Save the Children and MERLIN, ACF, representative from Donor Consortium (CCM) are the NHSC members and contribute in 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 to access package of services (EPI, MCH, Nutrition and environmental health), especially in hard to reach areas. Myanmar Medical Association and Myanmar Red Cross Association are members of NHSC and contribute in decision making and M&E of the GAVI HSS interventions.

*** Grant Agreement is signed between Myanmar Red Cross Society(MRCS)- MOH-GAVI . MRCS will undertake the construction component of GAVI HSS.

These local NGOs actively participates in the quarterly review meetings held at the townships to review the package of service (EPI,MCH, Nutrition and Environmental Health) delivery for the hard to reach areas in the townships.<?xml:namespace prefix = o />

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 established at various levels (as per Financial Management Assessment), the HSS fund management has been effective so far.

However, stringent Financial Rules of WHO hampers the program implementation. This is because without complete technical and financial report submission, WHO does not release funds for the continuation of activities beyond the agreed timeline. There are gaps in activity implementation.

9.5. Planned HSS activities for 2014

Please use **Table 9.5** to provide information on progress on activities in 2014. If you are proposing changes to your activities and budget in 2014 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2014 actual expenditure** (as at April 2014)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
Objective1: By 2015, 180 selected townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%						
Health System Assessment	Activity 1.1: Survey Conduct survey to establish baseline indicators & outcome, impact and research for operations	120000	10551			120000
Procurement and distribution of essential drugs and equipments	Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	2376000	1926981			2160000
Construction of subcentres	Activity 1.3: INFRASTRUCTURE 30 sub-RHCs in 12 HSS-targeted Townships will be constructed based on Grant Agreement signed in Early 2014.	2667525	0	This was already cleared as per 2012 APR	- This figure is the balance of infrastructure funds after reprogramming to others from year 1,2 and yr 3. - As per the Grant Agreement signed between GAVI-MOH-MRSC in early 2014, total amount of USD 1,137,525 will be soon released to MRCS.	2667525
Increase access to EPI/ MCH	1.4.1 Supply of Recurrent Transport costs based on needs identified in CTHPs	600000	65225			600000
Procurement and supply of motorbikes	1.4.2 Supply of transport capital to Townships based on needs identified in CTHP	150000	195998		- Government plans to procure motorbikes for hard to reach health facilities. Hence, $ 150,000 planned for procurement of motorbikes will be reprogramed to fill the	0

					budget gap for recruitment of AMWs under activity 1.5.	
Social mobilization activities	Activity 1.5: Social mobilization involvingNGOs, local authorities and Community Health Workers in developing and implementing CTHP in 100% of HSS-targeted townships by 2015	600000	111335		- recruitment of AMWs and CHWs needs more budget than planned. - $ 150,000 from procurement of motorbikes is used for recruitment of AMWs.	750000
Objective 2: By the end of 2011, 180 selected townships with identified hard to reach areas will have developed and implemented coordinated township micro-plans						
Development of CTHPs	Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for CTHP(including financial management and health financing) & supervision at all levels	20000	89827		planned budget of $20,000 was not enough for printing and development of CTHP at the township level. total budget required was $ 120,000. The additional budget was reprogramed from Activity 2.3: planned for Implementation of MVS	120000
Piloting MVS in 2 townships.	Activity 2.3: HR FINANCING Training and Piloting of health financing schemes, according to national guidelines in 2 townships by 2015	600000	90494	Recruitment of HSSOs. Development of CTHPs at township level.	- All the budget planned for this activity will not be utilized for this only purpose(MVS scheme is piloted only in 2 townships) - On the other hand, Budget planned for leadership program was not enough. Equal amount of Budget was planned for all 4 years, where as interventions expanded to 120 across the years.. with the increase in township, we had to recruit more health system strengthening officers. Hence there was budget shortage of $ 83,800. NHSC approved to reprogram USD 83,800 from activity 2.3 to Activity 3.4.4(leadership development program). - Further USD 100,000 was also reprogramed to support activity 2.1(details explained above).	416200
Leadership and management training based on HSS in HSS	Activity 2.4: TRAINING Implement the training program on coordinated management	90000	27516			90000

townships	through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2015.					
Hospital Equity Fund	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 2015	1200000	-6255			1200000
Annual Program Review at central level and NHSC meetings	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	20251			20000
Annual Program Review at township level	2.6.2 Annual Program Review State and Division Level	51000	9800			51000
Review outcomes of MVS and HEF	2.6.3 External Review of progress of HSS	50000	0			50000
HSR	2.6.4 Establish Health Systems Research Fund	72049	27364			72049
Objective 3: By the end of 2011, 20 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to the National HR Standards.						
Performance assessment tools development	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2015	10000	0			10000
Increase access to EPI/MCH	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	11309			693000
Technical skill upgrading for BHS	Activity 3.4: CONTINUING TRAINING 3.4.1 Continuing training	120000	52746			120000

	and dissemination of Coordinated Township Planning and Programme Implementation Guidelines					
International short course	3.4.2 International Short Courses Health Financing	50000	0			50000
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	14158			40000
Recruitment of Health System Strengthening Officers (HSSOs) at township level as well as central level	3.4.4 Leadership Development Program	331200	155935		- had budget shortage and reprogramed from activity 2.3. Plz see explanation given under activity 2.3	415000
Support costs						
	Transport/Vehicles for DOH and local transport costs	60000	-13637			60000
Procurement of office equipments	Computers Central and States/Divisions	30000	0			30000
Procurement of office equipments	Computers Townships	120000	17729			120000
Administration and Management Cost (WHO)	Administration and Management Cost (WHO)	806000	49864		this was cleared by IRC as per APR 2012. Also this is officially endorsed as per the new Grant Agreement signed between WHO and GAVI in 2014.	806000
	Administration Costs Central Level (DOH) (Communications, Printing, Staff Hire 2)	30000	10085			30000
	International Technical Assistance Health Systems Advisor (WHO)	99000	47888			99000
	Operational Health Systems Research Consultant	15000	0			15000
		11020774	2915164			10804774

9.6. Planned HSS activities for 2015

Please use **Table 9.6** to outline planned activities for 2015. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval 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 2015

Major Activities	Planned Activity	Original budget for 2015	Revised activity (if	Explanation for proposed changes to	Revised

(insert as many rows as necessary)	**for 2015**	(as approved in the HSS proposal or as adjusted during past annual progress reviews)	relevant)	**activities or budget** (if relevant)	**budget for 2015** (if relevant)
Objective 1: By 2015, 180 selected townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%					
Health System Assessment	Activity 1.1: SURVEY Conduct survey to establish base line indicators & outcome, impact and research for operations (including mapping)	120000			120,000
Procurement and distribution of essential drugs and equipment	Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	3564000			3,240,000
Construction of subcentres	Activity 1.3: INFRASTRUCTURE 30 sub-RHCs in HSS-targeted Townships will be constructed based on Grant Agreement signed in Early 2014.	1353858	This was already cleared as per 2012 APR and Grant Agreement 2014.	This figure is the balance of infrastructure funds after reprogramming to WHO management cost for year 4.	1,353,858
Increase access to EPI/ MCH	Activity 1.4: TRANSPORT 1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans.	900000			900,000
Procurement of motorcycles	1.4.2 Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan	150000			0
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 2015	600000			750,000

Objective 2: By the end of 2015, 180 selected townships with identified hard to reach areas will have developed and implemented coordinated township micro-plans					
Development of CTHPs	Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) & supervision at all levels	20000			
Implementation of MVS at 2 piloted townships	Activity 2.3: HR FINANCING Training and Piloting of health financing schemes, according to national guidelines in 2 townships by 2011	900000			
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			
Hospital Equity FUnd	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))	1800000			
Annual Program Review (Central) and NHSCs	Activity 2.6: RESEARCH & EVALUATION2.6.1 Annual Program Review Central Level	20000			
Annual Program Review at townships	2.6.2 Annual Program Review State and Division Level	51000			
Health System Research	2.6.4 Establish Health Systems Research Fund	72049			
Objective 3: By the end of 2015, 180 selected townships with identified hard to reach areas will be staffed					

by midwives and PHS2 according to the National HR Standards.					
Supportive activity for HR unit	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010.(	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	30000			
	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	10000			
Increase access to EPI/ MCH	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)	1039500			
Technical skill upgrading for BHS	Activity 3.4: CONTINUING TRAINING 3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines	180000			
International short course	3.4.2 International Short Courses Health Financing	50000			
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			
Recruitment of HSSOs	3.4.4 Leadership Development Program	331200			
Support costs					
	Computers Central and States/Divisions	30000			
	Computers Townships	120000			

	Administration and Management Cost (WHO)	939142		This budget was reprogramed for this activity from infrastructure component. It was cleared by IRC as per APR 2012. Also this is officially endorsed as per the new Grant Agreement signed between WHO and GAVI in 2014.	939142
	Administration Costs Central Level (DOH) (Communications, Printing, Staff Hire 2)	30000			
	International Technical Assistance Health Systems Advisor (WHO)	99000			
	Financial Management Consultancies	15000			
	Planning Consultancies	15000			
	Drugs Supply System	15000			
		12594749			

9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

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
3 MDG			
JICA			
KOFIH			
MOH(Government of Myanmar)			

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 , Progam Data	- 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.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2013?2

Please attach:

1. The minutes from the HSCC meetings in 2014 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

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 **has NOT received GAVI TYPE A CSO support**

Myanmar is not reporting on GAVI TYPE A CSO support for 2013

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

Myanmar **has NOT received GAVI TYPE B CSO support**

Myanmar is not reporting on GAVI TYPE B CSO support for 2013

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

ICC was updated on the new HSS grant for Immunization, and has strongly recomended that the New GAVI HSS application should be fully foccused to address Health System barriers of Immunization program. As EPI in Myanmar is planning to introduce new vaccines such as Rubella, IPV, PCV by 2016, possiblely Rota, JE ,HPV in near future and also the big MR campgain in 2014. The benifits of these new life saving vaccine will not reach the poorest, remote and children un reached by the program unless the Health system bottle necks specifcally of EPI are urgently addressed such as cold chain expension, support program managmemt, support for HW in hard to reach areas, data managment and VPD surveillnce.

ICC fully support GAVI new strategies, outcome, indicatots for HSS grant and suggest the EPI unit to lead the new HSS proposal (2016-2020).

Managing all the assistance from GAVI by two separate committee is to be review and ICC is very willing to raise this issue to MoH for future direction for management of all GAVI grants.

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 2013 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	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 2013 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	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 2013 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	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	✓	APR Minister Signiture page.PDF **File desc:** **Date/time :** 14/05/2014 04:24:21 **Size:** 237 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signiture of Finance Delegate.pdf **File desc:** **Date/time :** 14/05/2014 04:49:48 **Size:** 159 KB
3	Signatures of members of ICC	2.2	✓	ICC Signature Page Endorsing APR 2013.PDF **File desc:** **Date/time :** 14/05/2014 01:38:11 **Size:** 565 KB
4	Minutes of ICC meeting in 2014 endorsing the APR 2013	5.7	✓	ICC Meeting Minute 12-5-14 pdf.pdf **File desc:** **Date/time :** 15/05/2014 07:02:33 **Size:** 137 KB
5	Signatures of members of HSCC	2.3	✓	Annex_Signature of NHSC members.pdf **File desc:** Siignatures of NHSC members attended HSCC meeting in 2014 **Date/time :** 14/05/2014 12:36:29 **Size:** 306 KB
6	Minutes of HSCC meeting in 2014 endorsing the APR 2013	9.9.3	✓	Minutes _ 7th NHSC Meeting.pdf **File desc:** Minutes of HSCC meeting in 2014 endorsing the APR 2013 **Date/time :** 13/05/2014 02:22:16 **Size:** 75 KB
7	Financial statement for ISS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✓	ISS 2013 Financial Statement.PDF **File desc:** **Date/time :** 14/05/2014 01:40:51 **Size:** 502 KB
8	External audit report for ISS grant (Fiscal Year 2013)	6.2.3	✓	The External Audit report not available yet.doc **File desc:** **Date/time :** 15/05/2014 07:08:22 **Size:** 31 KB

9	Post Introduction Evaluation Report	7.2.2	✓	Myanmar Penta PIE Debriefing.pdf **File desc:** **Date/time :** 08/05/2014 04:33:30 **Size:** 1 MB
10	Financial statement for NVS introduction grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	NVS 2013 Financial Statement.PDF **File desc:** **Date/time :** 14/05/2014 01:49:28 **Size:** 272 KB
11	External audit report for NVS introduction grant (Fiscal year 2013) if total expenditures in 2013 is greater than US$ 250,000	7.3.1	✓	NVS statement.pdf **File desc:** **Date/time :** 14/05/2014 02:05:34 **Size:** 18 KB
12	Latest EVSM/VMA/EVM report	7.5	✓	EVM_report-Myanmar v6TH 3Oct.pdf **File desc:** **Date/time :** 09/05/2014 03:03:56 **Size:** 3 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	EVM-imp-plan-Myanmar 2011 v6.xlsx **File desc:** **Date/time :** 14/05/2014 04:34:46 **Size:** 135 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	EVM-imp-plan-Myanmar progress 2013.xlsx **File desc:** **Date/time :** 09/05/2014 03:31:08 **Size:** 497 KB
16	Valid cMYP if requesting extension of support	7.8	✗	cMYP_2012-2016_Revised Sep 2013 - 6-Oct-13 Edition.pdf **File desc:** **Date/time :** 08/05/2014 04:35:44 **Size:** 1 MB
17	Valid cMYP costing tool if requesting extension of support	7.8	✗	cMYP_Costing_Tool_Vs.2.5_EN__5-Oct-13.xlsm **File desc:** **Date/time :** 08/05/2014 04:37:30 **Size:** 1 MB
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	The vaccine and Logistics support extension_for Penta and MSD in APR.doc **File desc:** **Date/time :** 15/05/2014 07:19:12 **Size:** 31 KB

19	Financial statement for HSS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✓	Annex_ HSS Financial Statement for APR 2013.pdf **File desc:** Financial Statement for HSS grant (Fiscal year 2013) signed by the chief accountant **Date/time :** 14/05/2014 12:55:26 **Size:** 291 KB
20	Financial statement for HSS grant for January-April 2014 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✓	Annex_ HSS Financial Statement for APR 2013.pdf **File desc:** Financial Statement for HSS grant (Fiscal year 2013) signed by the chief accountant **Date/time :** 14/05/2014 01:01:43 **Size:** 291 KB
21	External audit report for HSS grant (Fiscal Year 2013)	9.1.3	✓	The External Audit report not available yet.doc **File desc:** **Date/time :** 15/05/2014 07:11:21 **Size:** 31 KB
22	HSS Health Sector review report	9.9.3	✓	Strategic Directions for UHC-.pdf **File desc:** HSS Health Sector Review Report **Date/time :** 11/05/2014 10:40:00 **Size:** 599 KB
23	Report for Mapping Exercise CSO Type A	10.1.1	✗	No file loaded
24	Financial statement for CSO Type B grant (Fiscal year 2013)	10.2.4	✗	No file loaded
25	External audit report for CSO Type B (Fiscal Year 2013)	10.2.4	✗	No file loaded
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2013 on (i) 1st January 2013 and (ii) 31st December 2013	0	✓	Annex_ HSS Financial Statement for APR 2013.pdf **File desc:** **Date/time :** 14/05/2014 02:59:06 **Size:** 291 KB

27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✗	No file loaded
	Other		✗	Annexure I - Performance Assessment on GAVI HSS year one 20 townships.pdf **File desc:** Annexure I - Performance Assessment on GAVI HSS intervention in Myanmar **Date/time :** 07/05/2014 02:50:27 **Size:** 1 MB Annexure II - Draft report on Mid Term Review of MCH Voucher Scheme.pdf **File desc:** Annexure II - Draft report on Mid Term Review of MCH Voucher Scheme **Date/time :** 07/05/2014 03:13:43 **Size:** 637 KB Annexure III- Health System Assessment for Ann Township _Rakhine State_.pdf **File desc:** Annexure III - Example (Ann township) of Health System Assessment for 40 townships. **Date/time :** 07/05/2014 03:22:13 **Size:** 262 KB Annexure IV- UNICEF procurement list and CMSD distribution list in 2013.pdf **File desc:** Annexure IV - UNICEF Distribution List **Date/time :** 07/05/2014 04:21:31 **Size:** 124 KB Annexure IX - Manual on Leadership and Management.pdf **File desc:** Annexure IX - User friendly manual on leadership and management training to TMOs and BHS **Date/time :** 12/05/2014 12:45:13 **Size:** 572 KB Annexure V - UNICEF Progress Report (2013).pdf **File desc:** Annexure V - UNICEF Progress Report (2013) **Date/time :** 12/05/2014 11:56:25 **Size:** 124 KB

				Annexure VI - Grant Agreement between MOH - MRCS - GAVI for construction of subcentres.pdf **File desc:** Annexure VI - Grant Agreement between MOH- MRCS- GAVI **Date/time :** 12/05/2014 12:37:41 **Size:** 5 MB
				Annexure VII - Distribution List of Yamaha Motorcycles to 60 townships.pdf **File desc:** Annexure VII - Distribution list of motorcycles to 60 townships **Date/time :** 12/05/2014 12:39:58 **Size:** 425 KB
				Annexure VIII - Quarterly Meeting Minutes_Hopone (Shan south).pdf **File desc:** Annexure VIII - Quarterly Meeting Minutes at township level. (Hopone Township) **Date/time :** 12/05/2014 12:42:41 **Size:** 82 KB
				Annexure X - NHSC Meeting Minutes _6th and 7th_.pdf **File desc:** Annexure X - 6th and 7th NHSC meeting minutes **Date/time :** 12/05/2014 12:47:25 **Size:** 114 KB
				Annexure XI - 3 Research Protocols.pdf **File desc:** Annexure XI - Three Research Protocols **Date/time :** 12/05/2014 12:49:15 **Size:** 572 KB
				Annexure XII - Distribution List of Desktop Computers.pdf **File desc:** Annexure XII - DIstribution List of Desktop computers **Date/time :** 12/05/2014 12:52:38 **Size:** 6 MB
				Annexure XIII - Distribution List of Copiers.pdf **File desc:** Annexure XIII - Distribution List of copiers **Date/time :** 12/05/2014 12:55:07 **Size:** 2 MB
				Annexure XIV - Distribution List of Auto Voltage Regulator (5KVA).pdf **File desc:** Annexure XIV - Distribution

				List of Auto Voltage Regulators **Date/time :** 12/05/2014 12:58:34 **Size:** 6 MB