GAVI Alliance

Annual Progress Report 2014

Submitted by

The Government of

Myanmar

Reporting on year: **2014**
Requesting for support year: **2016**
Date of submission: **28/05/2015**

Deadline for submission: 27/05/2015

Please submit the APR 2014 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavi.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: **2014**

Requesting for support year: **2016**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	Measles second dose, 10 dose(s) per vial, LYOPHILISED	Measles second dose, 10 dose(s) per vial, LYOPHILISED	2016
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2016
Routine New Vaccines Support	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2016
Preventive Campaign Support	MR, 10 dose(s) per vial, LYOPHILISED	Not selected	2014

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

Type of Support	Vaccine	Start year	End year
Routine New Vaccines Support	Measles second dose, 10 dose(s) per vial, LYOPHILISED	2017	No extension
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2017	No extension
Routine New Vaccines Support	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2017	No extension

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2014	Request for Approval of	Eligible For 2014 ISS reward
COS	Yes	Not applicable	No
VIG	Yes	Not applicable	No
HSS	Yes	next tranche of HSS Grant No	No

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2013 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 High Level Review Panel (HLRP) 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	HE Dr. Than Aung	**Name**	HE U Win Shein
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
Dr. Kyaw Kan Kaung	Project Manager	+9595039008	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.Soe Lwin Nyein	Department of Public Health		
Dr. Jorge Mario Luna	World Helath Organization		

Mr. Bertrand Bainvel	UNICEF		
Ms Pennlope Campbell	UNICEF		
Dr. Daniel Ngemera	UNICEF		
Dr. Ye Hla	World Helath Organization		
Dr. Than Win	Department of Public Health		
Dr Wai Mar Mar Htun	Ministry of Health		
Dr. Than Tun Aung	Department of Public Health		
Dr. Kyaw Kan Kaung	Department of Public Health		
Dr. Htar Htar Lin	Department of Public Health		
Dr. Thida Kyu	Department of Medical Care		
U Win Oo	Department of Medical Care		

ICC may wish to send informal comments to: apr@gavi.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), 8-5-2015 , 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.Soe Lwin Nyein	Department of Public Health		
Dr.Yin Thandar Lwin	Department of Public Health		
Dr.War Mar Mar Htun	Ministry of Health		
Dr.Thida Kyu	Department of Medical Care		
Dr.Thuzar Chit Tin	Department of Public Health		
Dr.Theingi Myint	Department of Public Health		
Dr.May Khin Than	Department of Public Health		
Dr.Thet Thet Mu	Department of Public Health		
Dr.Kyaw Kan Kaung	Department of Public Health		
Dr.Kyaw Thida	Department of Public Health		
Dr.Thandar Lwin	Department of Public Health		

Dr.Tin Tun Aung	Department of Public Health		
Dr.Khin Mi Mi Hlaing	Budget Department		
Daw Cho Cho Aung	Office of the Auditor General of the Union		
U Tin Win	MOBA		
Daw May Chan Myay Aung	MOBA		
Daw Moh Moh Naing	FERD		
U Than Tun	Myanmar Health Assistant Association		
U Hla Win	MRCS		
M Maung Maung Hla	MRCS		
Sangay Wangmo	WHO		
Dr Maharajan Muthu	UNICEF		
Dr.Khin Mae Ohn	MWAF		
Daw Khin Mar Kyi	MNMA		

Dr.Nang Ingyin Soe	MMCWA		
Dr.Khin Maung Thwin	Save the Children		
Mayumi Omachi	JICA HSS project		

HSCC may wish to send informal comments to: apr@gavi.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 2015

3. Table of Contents

This APR reports on Myanmar's activities between January – December 2014 and specifies the requests for the period of January – December 2016

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.

Please also note that if the country applies the WHO multi-dose vial policy for IPV, the maximum indicative wastage rates are 5%, 15% and 20% for the 1-dose, 5-dose and 10-dose presentations respectively.

Number	Achievements as per JRF		Targets (preferred presentation)			
	2014		2015		2016	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation
Total births	1,527,254	958,495	1,521,058	1,521,058	1,513,433	1,513,433
Total infants' deaths	51,972	29,536	50,195	50,195	46,916	46,916
Total surviving infants	1475282	928,959	1,470,863	1,470,863	1,466,517	1,466,517
Total pregnant women	1,588,344	1,008,943	1,566,689	1,566,689	1,558,836	1,558,836
Number of infants vaccinated (to be vaccinated) with BCG	1,450,891	857,356	1,445,005	1,445,005	1,437,761	1,437,761
BCG coverage*[1]*	95 %	89 %	95 %	95 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,386,808	814,130	1,382,611	1,382,611	1,393,190	1,393,190
OPV3 coverage*[2]*	94 %	88 %	94 %	94 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1*[3]*	1,415,110	855,572	1,410,828	1,410,828	1,421,622	1,421,622
Number of infants vaccinated (to be vaccinated) with DTP3*[3][4]*	1,386,808	813,390	1,382,611	1,382,611	1,393,190	1,393,190
DTP3 coverage*[2]*	94 %	88 %	94 %	94 %	95 %	95 %
Wastage*[5]* rate in base-year and planned thereafter (%) for DTP	15	28	15	15	15	15
Wastage*[5]* factor in base-year and planned thereafter for DTP	1.18	1.39	1.18	1.18	1.18	1.18
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	1,417,287	855,572	1,412,998	1,412,998	1,423,810	1,423,810
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	1,417,287	813,390	1,386,611	1,386,611	1,393,190	1,393,190
DTP-HepB-Hib coverage*[2]*	96 %	88 %	94 %	94 %	95 %	95 %
Wastage*[5]* rate in base-year and planned thereafter (%) *[6]*	20	15	15	15	15	15
Wastage*[5]* factor in base-year and planned thereafter (%)	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	0 %	0 %	0 %	25 %	0 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Pneumococcal (PCV10)		0		0		946,610

Number	Achievements as per JRF		Targets (preferred presentation)			
	2014		2015		2016	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation
Number of infants vaccinated (to be vaccinated) with 3rd dose of Pneumococcal (PCV10)		0		0		757,288
Pneumococcal (PCV10) coverage*[2]*	0 %	0 %	0 %	0 %	0 %	52 %
Wastage*[5]* rate in base-year and planned thereafter (%)		0		0		5
Wastage*[5]* factor in base-year and planned thereafter (%)	1	1	1	1	1	1.05
Maximum wastage rate value for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	0 %	10 %	0 %	10 %	0 %	10 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	0	814,135	1,367,902	1,367,902	1,378,525	1,378,525
Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles	1,180,262	765,001	1,206,107	1,206,107	1,246,539	1,246,539
Measles coverage*[2]*	80 %	82 %	82 %	82 %	85 %	85 %
Wastage*[5]* rate in base-year and planned thereafter (%)	40	40	38	38	0	0
Wastage*[5]* factor in base-year and planned thereafter (%)	1.67	1.67	1.61	1.61	1	1
Maximum wastage rate value for Measles second dose, 10 dose(s) per vial, LYOPHILISED	0.00 %	40.00 %	0.00 %	40.00 %	0.00 %	40.00 %
Pregnant women vaccinated with TT+	1,461,277	857,810	1,457,021	1,457,021	1,465,305	1,465,305
TT+ coverage*[7]*	92 %	85 %	93 %	93 %	94 %	94 %
Vit A supplement to mothers within 6 weeks from delivery	1,126,352	197,606	1,146,064	1,146,064	1,166,120	1,166,120
Vit A supplement to infants after 6 months	675,811	447,444	687,638	687,638	699,672	699,672
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	2 %	5 %	2 %	2 %	2 %	2 %

[1] Number of infants vaccinated out of total births

[2] Number of infants vaccinated out of total surviving infants

[3] Indicate total number of children vaccinated with either DTP alone or combined

[4] Please make sure that the DTP3 cells are correctly populated

[5] 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.

[6] 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.

[7] Number of pregnant women vaccinated with TT+ out of total pregnant women

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 2014 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2014.** The numbers for 2015 - 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**

  The country has been using the population data based on the projected population and target population data was estimated as a proportion of the total population
  In 2014 nationwide census has been conducted and EPI encourage to use head counting data before detail reports has been enumerated.
  Total population from Preliminary result of census is 52,800,000 . According to headcount population , the surviving infant in 2014 is 928960 , that figure is largely different from the estimated or projected data which is around 1,400,000 in 2013 and the projection was made by standard or constant growth rate over the years

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

  As the number of birth of the children has reduced , the surviving infant aslo changed . Now the actual counted data at the year end of previous year was projected using local growth rate and used as denominator.

- 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.** For IPV, supporting documentation must also be provided as an attachment(s) to the APR to justify ANY changes in target population.

  The change of target has been followed after the nationwide census . EPI has been reported from region and state health department for head counted data that is significantly redued compared to the projected population figure.
  The target for IVP introduction, EPI use the census data but there is still discrepancies between the UN population assumption and the census again.

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

  The vaccine wastage has not changed significantly.

5.2. Monitoring the Implementation of GAVI Gender Policy

5.2.1. 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

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

The immunization program in Myanmar advocates for reaching all communities and groups in different context. As such in Myanmar there is no sex discrimination and immunization performance is not different to boys and girls.

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

5.2.4. 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/)

Immunization in Myanamr has been mostly conducted by Midwife and this practice has no impact on immunization coverage.
And there is no gender related barrier in immunzation.

5.3. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.3a** 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$ = 1120	Enter the rate only; Please do not enter local currency name

Table 5.3a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	Expenditure Year 2014	Source of funding						
		Country	GAVI	UNICEF	WHO	JCV	-	-
Traditional Vaccines*	1,410,956	0	0	1,143,050	0	267,906	0	0
New and underused Vaccines**	9,320,726	948,226	8,372,500	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	334,811	0	179,539	155,272	0	0	0	0
Cold Chain equipment	1,783,813	0	346,289	1,007,524	0	430,000	0	0
Personnel	348,642	71,789	31,175	245,678	0	0	0	0
Other routine recurrent costs	399,418	0	80,844	127,654	190,920	0	0	0
Other Capital Costs	134,156	0	0	134,156	0	0	0	0
Campaigns costs	2,294,955	1,800,000	494,955	0	0	0	0	0
IT equipments , Stationary and IEC		0	555,221	0	0	0	0	0
Total Expenditures for Immunisation	16,027,477							
Total Government Health		2,820,015	10,060,523	2,813,334	190,920	697,906	0	0

Traditional vaccines: BCG, DTP, OPV, 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

5.4. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2014? **2**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2015 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 5.3 Overall Expenditures and Financing for Immunisation

The ICC members commended efforts being made by the immunization program especially in strengthening immunization services delivery, some the critical recommendations made included the following:

a) CEPI with support from UNICEF, WHO and other partners should ensure that all efforts are made in planning and implementation of nationwide measles and rubella campaign. Working groups should be established to coordinate the planning for logistics, communication and financial management.

b) The Ministry should initiate the process for application of GAVI HSS2 proposal which will be focusing on immunization outcome according to new GAVI guidelines on HSS proposal application procedures

c) The immunization coverage in low performing Townships should be monitored closely and necessary support provided to increase coverage.

d) Efforts should be made to develop communication plan for routine immunization to increase demand and uptake of immunization services.

e) Ministry of Health and UNICEF should accelerate the implementation of the cold chain expansion and replacement in preparation for introduction of pneumococcal vaccine and measles and rubella campaign.

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

5.5. Priority actions in 2015 to 2016

What are the country's main objectives and priority actions for its EPI programme for 2015 to 2016

1.To strengthen routine immunization in urban areas, hard to reach and border areas through strengthened micro-planning for Reach Every Community (REC) strategy

2. To introduce PCV 10 into routine immunization schedule in 2016

3. To maintain the polio free status and withdrawal of OPV2 and introduction of Inactivated Polio vaccine into routine immunization schedule in 2015 and replacing trivalent OPV (tOPV) with bivalent

OPV (bOPV)

4. To strengthen the measles elimination and rubella control activities and establish sentinel hospital surveillance of congenital rubella syndrome including and Introduction of the measles rubella vaccine in to routine immunization at 9 month

5. Implementation of the cold chain replacement and expansion plan in preparation for PCV-10 introduction

6. Effective vaccine management assessment, development of the comprehensive EVM improvement plan and accelerate its implementation.

7. Communication strategy for routine immunization to create demand and uptake of immunization services.

8. Provide support for strengthening EPI data management and monthly performance monitoring especially for areas with low immunization coverage.

5.6. 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 2014

Vaccine	Types of syringe used in 2014 routine EPI	Funding sources of 2014
BCG	AD syringe	UNICEF
Measles	AD syringe	UNICEF and GAVI (Measles Second Dose)
TT	AD syringe	UNICEF
DTP-containing vaccine	AD syringe	GAVI
IPV	Not introduced yet	

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 not experience any major obstacles in the implementation of the injection safety policy and existing plans since there has been regular guidance sent to the Basic Health Staff (BHS) and all hospitals on the importance of adherence to the injection safety policy.

Please explain in 2014 how sharps waste is being disposed of, problems encountered, etc.

Sharp wastes are disposed by burning and burying in covered open pits. but in some areas sharps are disposed on the shallow surface pits. Old batches of incinerators are not working properly and need to be improved or new design of incinerators should be built. The disposal is also difficult in big cities with limited space and not environmentally friendly> Sharp disposal in big cities can be collaborated with the sharp waste or medical waste disposal system of city development committee.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2014

Myanmar is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.2. Detailed expenditure of ISS funds during the 2014 calendar year

Myanmar is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.3. Request for ISS reward

Request for ISS reward achievement in Myanmar is not applicable for 2014

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

7.1. Receipt of new & under-used vaccines for 2014 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2014 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2014 vaccinations against approvals for 2014

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

	[A]	[B]	[C]	
Vaccine type	**Total doses for 2014 in Decision Letter**	**Total doses received by 31 December 2014**	**Total doses postponed from previous years and received in 2014**	**Did the country experience any stockouts at any level in 2014?**
Measles second dose	1,986,900	1,907,900	1,907,900	Not selected
DTP-HepB-Hib	4,412,800	1,700,000	1,700,000	Not selected
Pneumococcal (PCV10)		0	0	Not selected

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? ...)
- 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.

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.

7.2. Introduction of a New Vaccine in 2014

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2014, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Nationwide introduction	No	
Phased introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Myanmar has not introduced new vaccine in 2014.

When is the Post Introduction Evaluation (PIE) planned? **June 2014**

Measles second dose, 10 dose(s) per vial, LYOPHILISED		
Nationwide introduction	No	
Phased introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	MSD has already introduced since 2012.

When is the Post Introduction Evaluation (PIE) planned? **June 2014**

Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID		
Nationwide introduction	No	
Phased introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Plan to introduced in 2016.

When is the Post Introduction Evaluation (PIE) planned? **January 2017**

7.2.2. 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))

Myanmar has conducted PIE in 2014 .
The report has been attached in the document .

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? **Yes**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **No**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

Does your country conduct special studies around:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

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? **No**

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:

Surveillance of bacterial meningitis was done as the meningitis and encephalitis as disease under national surveillance and few cases are confirmed by culture or latex agglutination test. For pneumococcal diseases septicemia cases were studied and blood culture was done. Streptococcus pneumonia and Haemophilus influenzae type b were isolated. Those results are presented in the proposal for introduction of PCV10.

7.3. New Vaccine Introduction Grant lump sums 2014

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2014 (A)	1,216,846	1,362,867,520
Remaining funds (carry over) from 2013 (B)	2,011,139	2,252,475,680
Total funds available in 2014 (C=A+B)	3,227,985	3,615,343,200
Total Expenditures in 2014 (D)	781,030	874,753,600
Balance carried over to 2015 (E=C-D)	2,446,955	2,740,589,600

Detailed expenditure of New Vaccines Introduction Grant funds during the 2014 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2014 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

Not relevant

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

Not relevant

Please describe the activities that will be undertaken with any remaining balance of funds for 2015 onwards

Adovcacy at all level of public adminstration
Technical training for introduction of new vaccine (central to grassroot level)
Communication activities
Strengthening supervision function
Cold chain equipment maintenance and repair
Production of communication materials and training manuals
Strengthening Vaccine Preventable Disease Surveillance
Capacity Building of vaccine handlers
Upgrade reporting facilities

7.4. Report on country co-financing in 2014

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2014?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED		
Awarded Vaccine #3: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID		
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2014 from the following sources?	
Government		
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ 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		
Awarded Vaccine #3: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID		
	Q.4: When do you intend to transfer funds for co-financing in 2016 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2016	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED		
Awarded Vaccine #3: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID		

	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing

*__Note:__ co-financing is not mandatory for IPV

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Not selected**

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/programmes_systems/supply_chain/evm/en/index3.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? **No**

If yes, provide details

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

7.6. Monitoring GAVI Support for Preventive Campaigns in 2014

7.6.1. Vaccine Delivery

Did you receive the approved amount of vaccine doses for MR Preventive Campaigns that GAVI communicated to you in its Decision Letter (DL)?

[A]	[B]	[C]
Total doses approved in DL	**Campaign start date**	**Total doses received (Please enter the arrival dates of each shipment and the number of doses of each shipment)**
20618000	19/01/2015	December 2014 = 12494400 Doses , January 2015 = 4000000 Doses and February 2015 = 1000000 Doses

If numbers [A] and [C] above are different, what were the main problems encountered, if any?

The MR campaign target has been estimated from the projected population in 2013 while submission to GAVI for campaign proposal and MR introduction.The country conduct nationwide census in 2014 and the target estimated from census data is 14000000 .EPI has planned to conduct the campaign by headcounting the children to be vaccinated.Total registeded / headcounted data reported is 1358963.

If the date(s) indicated in [C] are after [B] the campaign dates, what were the main problems encountered? What actions did you take to ensure the campaign was conducted as planned?

The vaccine has been scheduled to be received in three batches (50%,30% and 20%). The campaign has been phased into two phases. The first phase being conducted in January 2015 and the second phase in February 2015. The first shipment has been received in December 2014 before the first phase and the second shipment in January 2015 before the second phase.The intial plan of three batches to be received has been changed to 60%, 20% and 5%. The last shipment being in February 2015.The remaining 15% of the supply has been planned to receive in third quarter of 2015 for the use in routine programme.

7.6.2. Programmatic Results of MR preventive campaigns

Geographical Area covered	Time period of the campaign	Total number of Target population	Achievement, i.e., vaccinated population	Administrative Coverage (%)	Survey Coverage (%)	Wastage rates	Total number of AEFI	Number of AEFI attributed to MenA vaccine
330 Townships (100%)	17 days (10 plus 7)	13958963	13160764	94	0	13	3466	0

*If no survey is conducted, please provide estimated coverage by indepenent monitors

Has the campaign been conducted according to the plans in the approved proposal?" **No**

If the implementation deviates from the plans described in the approved proposal, please describe the reason.

The campaign has been initially planned to be conducted by the end of 2014. The cEPI could inititate the campaign planning in mid 2014 and the funding was received in October 2014.The cold chain and logistics preparation has been accomplished by November 2014. The cooperation with Ministry of Education, higher level approval took considerable duration. The pre-campaign preparation activities were accordingly delayed for about one to two months.

Has the campaign outcome met the target described in the approved proposal? (did not meet the target/exceed the target/met the target) If you did not meet/exceed the target, what have been the underlying reasons on this (under/over) achievement?

The MR campaign target has been estimated from the projectedpopulation in 2013 while submission to GAVI for campaign proposal and MR introduction.EPI has planned to conduct the campaign by head counting the children to be vaccinated.The target children from schools and community have been counted by health careworkers in collaboration with school administrators, NGO and INGOs. Total registered/ head counted data reported is 1358963. The campaign did not meet the targetdescribed in the approved proposal due to above reasons.

What lessons have you learned from the campaign?

The Steering and Guidance of CentralExecutive Committee for MR campaign and the roles and functions ofsub-committee were critical to successful implementation of the campaign.

This model of leading and organizingcampaign can be a show case for future mass public health campaign.

The Media involvement has been veryinstrumental in successful implementation of the Measles Rubella campaign. Thepositive approach of most of the media in addressing the importance of thecampaign, the Regional targets for Measles Elimination and Rubella Control arebeneficial to the programme.

The positive role of the media indealing the adverse event following immunization in this campaign is very crucialfor successful implementation.

School based approach is very effectiveto reach the majority of the targeted children and it created good lessons forfurther school-based immunization programme.

The joint planning with Department ofEducation Ministry at all level of Health Care Administration, master listingof the children, communication to the families through school teachers andjoint supervision of the campaign are the basic elements for the school-basedroutine immunization such as Japanese Encephalitis Campaign, HPV introduction, and other boosterdose for the school going age.

Invitation cards are the major source ofinformation reaching the caregivers and mothers.

Experience of using variouscommunication channels and the strength and weakness of each methods in thecampaign leads to identity the appropriate method and strategy for socialmobilization activities for other health care intervention including demandgeneration in routine immunization.

The supportive role of NCIP and the collaborationof hospitals in dealing with AEFI cases were fundamental for high coverage andsafety and timely and effective management of AEFI.

The causality assessment of AEFI casesby NCIP has strengthened the AEFI management and this practice has to be maintainedin the Routine Immunization Programme.

7.6.3. Fund utilsation of operational cost of MR preventive campaigns

Category	Expenditure in Local currency	Expenditure in USD
to be submitted with missing attachments	0	0
Total	**0**	**0**

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 2015

Renewal of multi-year vaccines support for Myanmar is not available in 2015

7.9. Request for continued support for vaccines for 2016 vaccination programme

In order to request NVS support for 2016 vaccination do the following

Confirm here below that your request for 2016 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 Antigen	Vaccine Type	2012	2013	2014	2015	2016
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID			3.40 %	4.30 %	3.60 %
Measles second dose, 10 dose(s) per vial, LYOPHILISED	Measles second dose, 10 dose (s) per vial, LYOPHILISED			13.80 %	13.00 %	12.60 %
MR, 10 dose(s) per vial, LYOPHILISED	MR, 10 dose(s) per vial, LYOPHILISED			12.70 %	12.10 %	11.60 %
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	Pneumococcal (PCV10), 2 dose (s) per vial, LIQUID			4.40 %	4.50 %	4.40 %

7.11. Calculation of requirements

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

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	1,475,282	1,470,863	1,466,517	4,412,662
	Number of children to be vaccinated with the first dose	Parameter	#	1,417,287	1,412,998	1,423,810	4,254,095
	Number of children to be vaccinated with the third dose	Parameter	#	1,417,287	1,386,611	1,393,190	4,197,088
	Immunisation coverage with the third dose	Parameter	%	96.07 %	94.27 %	95.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.25	1.18	1.18	
	Stock in Central Store Dec 31, 2014		#	778,540			
	Stock across second level Dec 31, 2014 (if available)*		#				
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#				
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.20	0.20	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	
fv	**Freight cost as % of vaccines value**	Parameter	%		4.30 %	3.60 %	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

The stock of vaccine has been counted 2 times physically in a year.The stock has been recorded manually using the excel format.

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.

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

Co-financing group	Low

	2014	2015	2016
Minimum co-financing	0.20	0.20	0.20
Recommended co-financing as per			0.20
Your co-financing	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	#	3,981,900	4,038,000	6,408,300
Number of AD syringes	#	3,684,700	4,100,900	7,059,800
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	40,900	45,125	78,975
Total value to be co-financed by GAVI	$	8,372,500	8,342,000	12,213,000

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

		2014	2015	2016
Number of vaccine doses	#	430,900	446,500	771,300
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]***	$	883,000	897,000	1,470,000

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

		Formula	2014	2015		
				Total	Government	GAVI
A	Country co-finance	*V*				
B	Number of children to be vaccinated with the first dose	*Table 4*	1,417,287	1,412,998		
B 1	Number of children to be vaccinated with the third dose	*Table 4*	1,417,287	1,412,998		
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))*	4,251,862	4,201,789		
E	Estimated vaccine wastage factor	*Table 4*	1.25	1.18		
F	Number of doses needed including wastage	*D x E*		4,958,111		
G	Vaccines buffer stock	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.5* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.5* • *else: (F - D - ((F - D) of previous year original approved)) x 0.5 >= 0*				
H	Stock to be deducted	*H1 - (F (2015) current estimation x 0.5)*				
H 1	Calculated opening stock	*H2 (2015) + H3 (2015) - F (2015)*				
H 2	Reported stock on January 1st	*Table 7.11.1*	2,469,260	778,540		
H 3	Shipment plan	*Approved volume*		4,484,500		
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		4,484,500		
J	Number of doses per vial	*Vaccine Parameter*				
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*				
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*				
M	Total of safety boxes (+ 10% of extra need) needed	*(I / 100) x 1.10*				
N	Cost of vaccines needed	*I x vaccine price per dose (g)*				
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*				
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*				
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*				
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*				
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*				
T	Total fund needed	*(N+O+P+Q+R+S)*				
U	Total country co-financing	*I x country co-financing per dose (cc)*				
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*				

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	2016		
			Total	Government	GAVI
A	Country co-finance	*V*	10.74 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	1,423,810	152,959	1,270,851
B 1	Number of children to be vaccinated with the third dose	*Table 4*	1,393,190	149,670	1,243,520
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	4,228,256	454,238	3,774,018
E	Estimated vaccine wastage factor	*Table 4*	1.18		
F	Number of doses needed including wastage	*D X E*	4,989,342	536,001	4,453,341
G	Vaccines buffer stock	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.5* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.5* • *else: (F - D - ((F - D) of previous year original approved)) x 0.5 >= 0*	15,616	1,678	13,938
H	Stock to be deducted	*H1 - (F (2015) current estimation x 0.5)*	- 2,174,125	- 233,564	- 1,940,561
H 1	Calculated opening stock	*H2 (2015) + H3 (2015) - F (2015)*	304,930	32,759	272,171
H 2	Reported stock on January 1st	*Table 7.11.1*			
H 3	Shipment plan	*Approved volume*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	7,179,500	771,288	6,408,212
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	7,059,797	0	7,059,797
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(I / 100) x 1.10*	78,975	0	78,975
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	12,901,562	1,386,004	11,515,558
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	316,279	0	316,279
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)*	430	0	430
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	464,457	49,897	414,560
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)*	13,682,728	1,469,924	12,212,804
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,435,900		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	10.74 %		

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		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	1,475,282	1,470,863	1,466,517	4,412,662
	Number of children to be vaccinated with the first dose	Parameter	#	0	1,367,902	1,378,525	2,746,427
	Number of children to be vaccinated with the second dose	Parameter	#	1,180,262	1,206,107	1,246,539	3,632,908
	Immunisation coverage with the second dose	Parameter	%	80.00 %	82.00 %	85.00 %	
	Number of doses per child	Parameter	#	1	1	1	
	Estimated vaccine wastage factor	Parameter	#	1.67	1.61	1.00	
	Stock in Central Store Dec 31, 2014		#	709,280			
	Stock across second level Dec 31, 2014 (if available)*		#				
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#				
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.00	0.00	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	
fv	**Freight cost as % of vaccines value**	Parameter	%		13.00 %	12.60 %	

fd	**Freight cost as % of devices value**	Parameter	%				

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

The stock of vaccine has been counted 2 times physically in a year.The stock has been recorded manually using the excel format.

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

Co-financing group	Low

	2014	2015	2016
Minimum co-financing			
Recommended co-financing as per			
Your co-financing			

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

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-finance**	*V*				
B	**Number of children to be vaccinated with the second dose**	*Table 4*	1,180,262	1,206,107		
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1	1		
D	**Number of doses needed**	*B x C*	0	1,367,902		
E	**Estimated vaccine wastage factor**	*Table 4*	1.67	1.61		
F	**Number of doses needed including wastage**	*D x E*		2,202,323		
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*				
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*				
H 2	**Reported stock on January 1st**	*Table 7.11.1*	0	709,280		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		0		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*				
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*				
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*				
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*				
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*				
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*				
T	**Total fund needed**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*				

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

		Formula	2016		
			Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %		
B	**Number of children to be vaccinated with the second dose**	*Table 4*	1,246,539	0	1,246,539
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1		
D	**Number of doses needed**	*B x C*	1,378,525	0	1,378,525
E	**Estimated vaccine wastage factor**	*Table 4*	1.00		
F	**Number of doses needed including wastage**	*D x E*	1,378,525	0	1,378,525
G	**Vaccines buffer stock**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** = *(F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*	- 205,949	0	- 205,949
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*	158,700	0	158,700
H 2	**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*	1,013,900	0	1,013,900
J	**Number of doses per vial**	*Vaccine Parameter*	10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	1,115,264	0	1,115,264
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	111,530	0	111,530
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	11,153	0	11,153
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	272,740	0	272,740
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	49,964	0	49,964
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	3,904	0	3,904
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	61	0	61
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	34,366	0	34,366
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)*	361,035	0	361,035
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 7.11.1: Specifications for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	1,475,282	1,470,863	1,466,517	4,412,662
	Number of children to be vaccinated with the first dose	Parameter	#	0	0	946,610	946,610
	Number of children to be vaccinated with the third dose	Parameter	#			757,288	757,288
	Immunisation coverage with the third dose	Parameter	%	0.00 %	0.00 %	51.64 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.00	1.00	1.05	
	Stock in Central Store Dec 31, 2014		#	0			
	Stock across second level Dec 31, 2014 (if available)*		#				

	Stock across third level Dec 31, 2014 (if available)*	Parameter	#				
	Number of doses per vial	Parameter	#		2	2	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.00	0.20	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	
fv	**Freight cost as % of vaccines value**	Parameter	%			4.40 %	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

Not applicable

Co-financing tables for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID

Co-financing group	Low

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

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

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-finance**	*V*				
B	**Number of children to be vaccinated with the second dose**	*Table 4*	1,180,262	1,206,107		
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1	1		
D	**Number of doses needed**	*B x C*	0	1,367,902		
E	**Estimated vaccine wastage factor**	*Table 4*	1.67	1.61		
F	**Number of doses needed including wastage**	*D x E*		2,202,323		
G	**Vaccines buffer stock**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** = *(F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*				
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*				
H 2	**Reported stock on January 1st**	*Table 7.11.1*	0	709,280		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		0		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*				
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*				
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*				
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*				
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*				
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*				
T	**Total fund needed**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*				

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

		Formula	2016		
			Total	Government	GAVI
A	Country co-finance	*V*	0.00 %		
B	Number of children to be vaccinated with the second dose	*Table 4*	1,246,539	0	1,246,539
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	1,378,525	0	1,378,525
E	Estimated vaccine wastage factor	*Table 4*	1.00		
F	Number of doses needed including wastage	*D x E*	1,378,525	0	1,378,525
G	Vaccines buffer stock	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** = *(F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*	- 205,949	0	- 205,949
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	158,700	0	158,700
H 2	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*	1,013,900	0	1,013,900
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	1,115,264	0	1,115,264
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	111,530	0	111,530
M	Total of safety boxes (+ 10% of extra need) needed	*(I / 100) x 1.10*	11,153	0	11,153
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	272,740	0	272,740
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	49,964	0	49,964
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	3,904	0	3,904
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	61	0	61
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	34,366	0	34,366
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)*	361,035	0	361,035
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 %		

8. 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 2014**. All countries are expected to report on:

   a. Progress achieved in 2014

   b. HSS implementation during January – April 2015 (interim reporting)

   c. Plans for 2016

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

For countries that received HSS funds within the last 3 months of 2014, or experienced other delays that limited implementation in 2014, 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 2014 fiscal year starts in January 2014 and ends in December 2014, HSS reports should be received by the GAVI Alliance before **15th May 2015**. 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 2015, the HSS reports are expected by GAVI Alliance by September 2015.

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@gavi.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 8.1.2.

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 2014

   b. Minutes of the HSCC meeting in 2015 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2014 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

8. 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.

8.1. Report on the use of HSS funds in 2014 and request of a new tranche

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

8.1.1. Report on the use of HSS funds in **2014**

Please complete Table 8.1.3.a and 8.1.3.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 8.1.3.a and 8.1.3.b.

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

If yes, please indicate the amount of funding requested: **3338883** US$

These funds should be sufficient to carry out HSS grant implementation through December 2016.

Table 8.1.3a (US)$

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)			3649218	6653666	9883249	12594749
Revised annual budgets (*if revised by previous Annual Progress Reviews*)			3649218	7459586	8353249	14124749
Total funds received from GAVI during the calendar year (*A*)			2833405	5061666	392500	21144066
Remaining funds (carry over) from previous year (*B*)			0	2054920	5689309	2375583
Total Funds available during the calendar year (*C=A+B*)			2833405	7116586	6081809	23519649
Total expenditure during the calendar year (*D*)			778485	1427277	3706226	6656254
Balance carried forward to next calendar year (*E=C-D*)			2054920	5689309	2375583	16863395
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	7459586	8353249	14124749	0

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	0	0		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0		
Total funds received from GAVI during the calendar year (*A*)	0			
Remaining funds (carry over) from previous year (*B*)	16863395	5420749		
Total Funds available during the calendar year (*C=A+B*)	16863395			
Total expenditure during the calendar year (*D*)	2411558			
Balance carried forward to next calendar year (*E=C-D*)	14451837			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	3338883	0	0	0

Table 8.1.3b (Local currency)

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)			2819021	5656947	9186381	12351796
Revised annual budgets (*if revised by previous Annual Progress Reviews*)			2819021	6342140	7764261	13852283
Total funds received from GAVI during the calendar year (*A*)			2188805	4303428	364825	20736197
Remaining funds (carry over) from previous year (*B*)			0	1747093	5288156	2329758
Total Funds available during the calendar year (*C=A+B*)			2188805	6050521	5652981	23065955
Total expenditure during the calendar year (*D*)			601380	1213471	3444900	6527855
Balance carried forward to next calendar year (*E=C-D*)			1587426	4837051	2208081	16538100
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	5762530	7101932	13128813	0

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	0	0		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0		
Total funds received from GAVI during the calendar year (*A*)	0			
Remaining funds (carry over) from previous year (*B*)	16538100	5316183		
Total Funds available during the calendar year (*C=A+B*)	16538100			
Total expenditure during the calendar year (*D*)	2365039			
Balance carried forward to next calendar year (*E=C-D*)	14173061			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	3274476	0	0	0

Report of Exchange Rate Fluctuation

Please indicate in the table Table 8.3.c below the exchange rate used for each calendar year at opening and closing.

Table 8.1.3.c

Exchange Rate	2009	2010	2011	2012	2013	2014
Opening on 1 January			851	807.5	854.5	989
Closing on 31 December			791	850	988	1030

Detailed expenditure of HSS funds during the 2014 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2014 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 2015 period are reported in Tables 8.1.3a and 8.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

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)

8.2. Progress on HSS activities in the 2014 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 8.2. 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 8.2: HSS activities in the 2014 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Objective 1: By 2016, 120 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%			
Conduct National Service Availability and Readiness Assessment(SARA)	Activity 1.1: Conduct survey to establish base line indicators & outcome, impact and research for operations	80	SARA preliminary reports ready-final report to be ready by August 2015.
Procurement and distribution of essential medicines to 60 townships till subcentre level	Activity 1.2: Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	10	UNICEF Progress Report. Annexure I
Construction of subcenters in 12 townships	Activity 1.3: Construction of 30 subcenters in 12 HSS targeted township will be completed by end of 2015, based on Grant Agreement between MOH-GAVI-MRCS	75	MRCS Progress Report. Annexure II
Increase access to EPI, MCH, Nutrition and Environmental 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 area 1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans.	80	Financial & technical report on supporting outreach sevrices to hard to reach areas.
Quarterly review meeting held at RHCs and township level participated by BHS, TMO, and township/village health committee, INGOs, NGOs and volunteers. Recruitment and training of AMWs and CHWs, and refresher training of AMWs and CHWs at 60 townships	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 2016	100	Quartly review meeting minutes at township level. List of AMW and CHW recruited and provided refresher training. Annexture
Objective 2: By the end of 2016, 120 selected townships with identified hard to reach areas will have developed and implemented coordinated township micro-plans			

Printing the CTHP guidelines, CHW manuals, AMW manuals	Activity 2.1: Develop national guidelines for coordinated township health planning (including financial management and health financing) & supervision at all levels	100	Distribution Lists. Annexture III
Implementation of Maternal Voucher Scheme	Activity 2.3: Training and Piloting of health financing schemes, according to national guidelines in 2 townships by 2016	60	Prpgress report from pilot townships
Capacity building on management and leadership	Activity 2.4: Implement the training program on management and leadership in HSS-targeted townships by 2016.	100	Reference material on leadership and management for TMO and BHS. Annexture IV
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, NHSC meetings.	Activity 2.6: Assess process and impact of coordinated State & Township coordinated health planning, and then disseminate findings	50	8th and 9th NHSC meeting minutes. Annexture V
Objective 3: By the end of 2016, 120 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to the National HR Standards.			
Activities to support for HR Information System strengthening	Activity 3.1: Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2016	20	detailed activity planning/discussion ongoing.
Activities to support for HR Information System strengthening	Activity 3.3: 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	20	detailed activity planning/discussion ongoing
Increase access to EPI, MCH, Nutrition and Environmental sanitation through coordinated efforts by providing outreach services to hard to reach areas. Daily allowance to BHS for delivering package of services,	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)	80	Financial & technical report on supporting outreach sevrices to hard to reach areas.
Technical skill upgrading	Activity 3.4.1: Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines	100	Technical report from MOH
short course at University of Public Health	3.4.2 International Short Courses Health Financing	10	

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
Recruitment of Health System Strengthening Officers (HSSOs) at township level as well as central level	3.4.4 Leadership Development Program	60	list of HSSOs
Support Cost			
Procurement of office equipment	Computers Townships	100	Distribution List. Annexure VI
Administration and Management Cost (WHO)	Administration and Management Cost (WHO)	100	
Administration Costs Central Level (DOH)	Administration Costs Central Level (DOH)	100	
M&E support cost			
International Technical Assistant	Health Systems Advisor (WHO)	100	
International Technical Assistant on Township Health Planning Review	Operational Health Systems Research	100	Report on Township Health Planning Review. Annexure VII

8.2.1 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:	
Service Availability and Readiness Assessment	Progress Achieved: - training of staffs and data collection from 201 health facilities across all States/Regions complete. - conducted SARA data analysis workshop - preliminary SARA report produced and discussed with partners -MOH(Department of Medical research) to finalise and disseminate the final SARA report within August 2015. -HMIS Data quality analysis workshop planned in August 2015. Constraints: limited HR and time.
Procurement and distribution of essential medicine	Progress Achieved: - Essential medicine and equipments procured and distribution to 60 townships up till sub-centre level Constraints: - Late identification of medicine and equipment to avoid over procurement of same medicines due to changed government procurement policy
Construction of subcentres	Progress Achieved: - constructed 6 sub-centres, 22 is under construction. 2 cannot started yet Constraints: some villages are in hard to reach areas and difficult to send construction materials
Increase access to hard to reach areas	Progress Achieved: - Access to essential component of EPI, MCH, Nutrition and Environmental Health for the hard to reach communities increased through coordinated efforts and service delivery. - Transportation allowance provided to Basic Health Staffs (BHS) from 120 townships for provision of outreach services, and also supported senior supervisors for supervision of service delivery in hard to reach areas.

Social Mobilization Activities	Progress Achieved: - Quarterly review meeting conducted at all 120 GAVI HSS townships - 2 NHSC meetings conducted : one to discuss detalied activity planning& progress status/ fund reallocation/ request for No Cost Extension of year 4 budget and another to Review and Endorse APR 2014. - Recruited 1334 AMWs in 72 townships and 900 CHWs in 60 townships. Refresher training provided to 50 AMWs and 50 CHWs in 60 townships.
Objectives 2:	
Development of coordinated township health plan	Progress Achieved: - Printing of coordinated township health plans (CTHP)guidelines for 60 new HSS townships - About 3600 BHS including TMOs from 60 townships were trained on using the CTHP guideline. CTHPs drafted by TMO, BHS and HSSOs in 60 townships. Constraints: - many positions for Health system strengthening Officers remained vacant due to change in government policy. Hence it impeded the development of CTHPs followed by monitoring, supervision and reporting of GAVI HSS activities from many difficult to reach townships.
MVS implementation at 2 townships	Progress Achieved: - implemented in 2 townships (Yedarshay and Paukkaung township)
Leadership and management training	Progress Achieved: - developed reference material on leadership and management for TMO and BHS in Myanmar version - TOT and multiplier training on leadership and management provided to TMOs and BHS from 60 townships.
Hospital Equity Fund	Progress Achieved: - HEF implemented in all 120 townships. Constraints: -limited financial and management capacity at townships level leading to under utilisation of funds and delay in financial reporting by many townships. This created funding gap in other well performing townships(WHO does not release funds without receiving complete financial and technical reports from all townships as per DFC agreement between MOH and WHO).
Annual review at townships, NHSC meetings	Progress Achieved: - Annual review meeting conducted in all HSS townships - 8th and 9th NHSC meeting conducted
Objective 3:	
Technical skill upgrading	Progress Achieved: - workshops conducted on Technical skill upgrading for BHS on EPI, MCH, Nutrition and EH through TOT and multipler training for these technical program
International Short Courses	Progress Achieved: MOH and WHO agreed on course design –University of Public Health, Yangon agreed as the institute - external faculties from renowned universities abroad will be invited to teach. Candidate identification ongoing
Experience sharing among HSS countries	Progress Achieved: - MOH already identified candidates and proposed countries for visit. WHO country office is collaborating with countries for study visit (activity planned completed within August 2015).

Recruitment of Health System Strengthening Officer	Progress Achieved: - 13 HSSOs recruited by WCO Myanmar through special service agreement, to facilitate implementation GAVI HSS activities at all level (central, state/region and townships) Constraints: - Positions for 15 HSSOs remained vacant as yet, due to government policy change . This contributed to delay in activity implementation in the townships. - MOH still pursuing to fill the vacant positions.
Support cost	
Procurement of office equipment	Progress Achieved: - Procured computer, printers, copies and will be soon distributed to townships planned for DHIS II implementation.
International technical assistance	Progress Achieved: - Conducted review of township health planning system in Myanmar in collaboration with all development partners.

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

Explanation for delay in implementation:

- GAVI HSS interventions stopped at 120 townships and did not expand to 180 townships as originally planned. This was done as per the recommendation from GAVI based on findings from Performance Assessment of GAVI HSS interventions. Per capita expenditure from GAVI funding was found very low (1.18- 2. 35 USD) and spreading thin would not bring adequate results. However, the absorption capacity in the 120 townships was quite low despite community need. Hence, all the funds could not be utilized within 2015 as planned. **8th NHSC then endorsed to request GAVI for NO Cost extension for additional 12 months (2016) to continue the implementation of current GAVI HSS activities. GAVI has already agreed to this.**

- With the recent restructuring in MOH, some of the activities related to health workforce strengthening could not be initiated earlier. Now with the restructuring complete, ministry has prioritized to strengthen health workforce information system and GAVI funding will be used to support this activity. <?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

- MOH and WHO could not recruit the Health System Strengthening Officers due to change in civil service policy. 15 positions at State/Region and Townships remained vacant for one year - budget allocated for leadership development program remained underutilized. MOH still processing to fill the vacant positions.

- Hospital Equity Fund implementation remained low due to limited planning and management capacity at the township level- many townships couldn't use the allocated funds and also could not submit technical and financial reports on time. This further created funding gaps in other well performing townships (WHO do not release fund unless technical and financial reports from all townships are submitted on time as per DFC agreement).

-Health Research funds also remained underutilized due to limited research capacity at the township level. MOH is now planning to liaise with National Research Institutes to utilize this funds

Explanation for modification of activities:

- Some unutilized funds will be reallocated to 1) procure 330 ILRs to support EPI program; 2) strengthen the procurement and supply chain system for the newly established department of Public Health (EPI related procurement and supplies comes under this department); 3) update the roles and responsibilities of Public Health supervisors II (eg: PHS II to support midwives in delivering EPI, Envt Health and other disease control services). 4) Train PHS II in performing updated roles . Activity 1, 3 and 4 were already endorsed by 8th NHSC meeting and was indicated to GAVI Secretariat (refer 8th NHSC minutes). Activity 2 is approved by 9th NHSC.

8.2.3 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?

HSS funds were utilized to support operational cost for basic health staffs to deliver PHC services in hard to reach areas in 120 GAVI HSS townships. Funds were also used to recruit and train voluntary health workers (Auxiliary Midwives and Community Health Workers) to fill HR gap in the hard to reach areas in 120 townships. Currently MOH is processing to GAVI HSS funds to support in establishment of electronic Health workforce information system. <?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

GAVI HSS funds are used to facilitate the leadership program(recruitment of health system strengthening officers); HSSOs supports Township Medical Officers to plan, manage, monitor and report progress of GAVI HSS interventions at township level.

Funds are allocated to revise and update roles/responsibilities of Basic Health staffs including Public Health supervisor II, and their training.

8.3. General overview of targets achieved

Please complete **Table 8.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2013 from your original HSS proposal.

Table 8.3: 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	2014 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2010	2011	2012	2013	2014		
Impact and Outcome Indicators											
1. National DPT3 (Penta 3) coverage (%)	70%	2006	90%	90%	90%	86%	85%	73%		EPI unit, MOH	
2. Number / % of districts achieving ≥80% DTP3 (Penta 3) coverage (National)	75 Townships 23%	WHO UNICEF Joint Report Dept. of Health/ 2006	325 townships	330 townships	283	252	211	155			
3. Under five mortality rate (per 1000) (national	66.1/1000LB	HMIS: Dept of Health Planning. Survey DOH UNICEF / 2003	38.5 MDG target by 2015	NA	46.1/1000LB	33.93/1000LB	NA	51	NA	- Health in Myanmar 2014 (CSO data) - Trend in child mortality survey	
4. Delivery by Skilled Birth Attendants (HSS targeted Townships)	67.5%	Union of Myanmar MDG report 2006 Fertility Reproductive Health Survey/2003	80%	NA	64.8%	67.1%	67.9%	72.3%	74.8	HMIS	
5. Rate of ORS Use of < 5 children (National)	53%	Dept. of Health Planning Public Health Statistics Annual Report 2006	80%	NA	96.4%	97.1%	97.1%	97.6%	98.3	HMIS	
6. % of 6-59 months children having Vitamin A during past 6 months (National)	80%	Bi Annual Report of Nutrition Dept/2007	90%		94%	95.74 %	96.08 %	95.23 %	95.19	National Nutrition Program	
Output Indicators											
1. % of townships have developed and implemented coordinated plans according to national framework	0%	Annual Program Review (Annual Evaluation Report)/2006	55%(180 townships out of 325)	120 townships			20 townships	60 townships	120 townships	DOH	
2. Number/% of RHC(in 180 HSS townships) visited at least 6 times in the last year using a quantified checklist	0%	Base line survey	100%				67 RHCs	145 RHCs			

3. Number of managers/ trainers / BHS trained for MEP at each level per year	300 BHS and 50 managers and trainers for MEP	Annual Program Review	9000 BHS and 100 Managers & trainees	5000 BHS including TMOs trained on CTHP			1137	3600	5115	DOH	
4. Proportion of RHCs with no stock out of essential supplies in the last 6 months (availability, service access, utilization, quality)		Base line survey	100% of RHCs in HSS investment area.				115 RHCs	344 RHCs	757 RHCs		
5. No of RHC and sub RHC renovated and/or constructed per year	30 RHCs (renovated) and 90 sub RHCs (constructed)	Dept. Health	540 RHC renovated and 324 Sub RHC constructed in HSS investment area(180 townships)	30 sub RHCs	NA	NA	NA	NA	starting to construct 30 sub-centres		
6. Percent of selected Townships with identified hard to reach areas staffed by midwives and PHS2 according to the National HR Standards.		Base line survey	50%	NA	NA	NA	NA	NA	NA	No computerized personal information system in place to help track this indicator. Myanmar is working on developing this system.	

8.4. Programme implementation in 2014

8.4.1. Please provide a narrative on major accomplishments in 2014, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

- 120 τοωνσηιπσ ιμπλεμεντεδ χοορδινατεδ τοωνσηιπ ηεαλτη πλανσ ανδ δελιωερεδ παχκαγε οφ πριμαρψ ηεαλτη χαρε σερωιχεσ(ΕΠΙ, ΜΧΗ, Νυτριτιον ανδ ΕΗ)□το ηαρδ το ρεαχη αρεασ (ουτπυτ δατα χομπιλατιον ονγοινγ).
- Τοταλ οφ□□□ 488 ζερο δοζε χηιλδρεν ωερε ιμμυνιζεδ□τηρουγη□ ουτρεαχη προγραμ□ιν □ηαρδ το ρεαχη αρεασ.□
- Hospital equity fund implemented in 120 townships and benefited 10,452 patients. out of this 70% of patients are OG cases and 20% are under five children.
- Total of 1334 AMWs and 900 CHW are recruited and trained in 72 townships.
- TMO and BHS from 60 townships trained on leadership and management (TOT program- they will train all the basic health staffs at their respective townships.
- Supplies of medicine and medical equipment to 120 townships.
- Joint Review on Township Health planning system in Myanmar conducted in collaboration with all development partners.
- MCH Voucher scheme expanded and implemented in two townships provided 9918 ANC and 1678 delivery , 1641 PNC and 4501 immunization.

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

- Decrease in program quality due to scale up and coverage expansion. This is happening due to the limited planning and financial management capacity at township level. Further, the program implementation depends on staff attitude and interest, which varies across townships in Myanmar.<?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

- The recent organizational restructuring of MOH also in some way contributed to delay in activity process and implementation.

- Solution found for this problem was to reallocate unutilized funds to priority areas and request GAVI for **"No Cost Extension** " for additional 12 months to complete activity implementation (Dec 2016).

- since one of the main problem for delay in implementation was due to limited township capacity in planning,M&E and Financial management, GAVI HSS funds supported Comprehensive Review of Township Health Planning system in Myanmar and suggested short term and long term strategies to address these issues.

8.4.3. 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:

Monthly supervision visits by TMOs to the RHCs and Sub RHCs to track progress status on delivering outreach services (EPI, MCH, Nutrition and Environmental Health) to hard to reach areas. <?xml:namespace prefix = "o" />

17 Health System Strengthening Officers (HSSOs) and support staff are recruited and deployed by WHO: 11 officers at the townships level and 3 officers and 3 financial support staff at central. HSSOs conducts field visit to monitor and supervise the delivery of package and submit monthly report to central. Since these HSSO's are recruited by WHO, they also submit their duty travel report to the WHO technical unit for every visit they make.

Further, random Monitoring visits are also made by Planning Unit, under Department of Health to review the status of implementation at townships; this is also complemented by random auditing by the finance unit of DoH together with the HSSO designated for financial management.

Fund release for each activity to ministry is subject to receipt of proposal (APW and DFC) by WHO from Ministry. Proposal for every activity highlights the timeline and budget breakdown for implementation. GAVI HSS technical unit in WHO then tracks the implementation status referring to the timeline and budget breakdown highlighted in the proposal. WHO does not accept any delay in the activity implementation and deviation in budget use by MOH, unless proper technical justification is provided by the central team of the Ministry to WHO.

Monitoring of the services is done through Quarterly Review Meetings held at the townships and National Health Sector Coordination Committee at the central levels. As of now, three NHSC meetings are conducted at the central level and one Quarterly Review Meeting is held at each GAVI HSS township. (Minutes from these meetings are shared for reference).

In addition other health system assessments like National Service Availability and Readiness Assessments (SARA) are conducted to assess service availability and readiness of health facilities to deliver those available services.

Updates on GAVI HSS implementation are also presented to the National HSS TSG meetings.

8.4.4. 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. <?xml:namespace prefix = "o" />

Much of the GAVI HSS activities are implemented in collaboration with WHO and is incorporated in the WHO detailed work plans. WHO's end of biennium review reports the progress status of HSS activities. HSS activities that were implemented in 2014 were reflected in (2014-2016 biennium) and it will be reviewed by end of 2015.

Since the procurement of essential medicines and equipments are done by UNICEF, the annual program review by UNICEF tracks 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 National Health Plan by 2015.

In addition, GAVI HSS supported National M&E strengthening by conducting National Service Availability and Readiness Assessment along with Data Verification for key indicators including EPI.

8.4.5. 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 <?xml:namespace prefix = "st1" ns = "urn:schemas-microsoft-com:office:smarttags" />Myanmar are WHO, UNICEF and MRCS for construction of subcentres. 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.

National SARA and Township Planning Review were done in very close collaboration with all UN agencies , National and International implementing partners and donors in Myanmar.

8.4.6. 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 deliver package of services (EPI, MCH, Nutrition and environmental health) for those population residing in hard to reach areas. Myanmar Medical Association and Myanmar Red Cross Association are members of NHSC and contributes in decision making and M&E of the GAVI HSS interventions. <?xml:namespace prefix = "o" />

These local NGOs actively participate in quarterly review meetings held at townships to plan the delivery of package of service (EPI,MCH, Nutrition and Environmental Health) for hard to reach areas in the townships.

8.4.7. 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 along with internal funds disbursement and management mechanism established at various levels of MOH (as per Financial Management Assessment), the HSS fund management has been effective so far.

However.stringent financial rules by WHO also effects 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.

8.5. Planned HSS activities for 2015

Please use **Table 8.5** to provide information on progress on activities in 2015. If you are proposing changes to your activities and budget in 2015 please explain these changes in the table below and provide explanations for these changes.

Table 8.5: Planned activities for 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2015 actual expenditure** (as at April 2015)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
Objective 1: By 2016, 120 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%						

	Activity 1.1: Conduct survey to establish base line indicators & outcome, impact and research for operations	65725	42204			
Procurement and distribution of essential drugs and equipment	Activity 1.2: Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	4063474	225452			
Construction of subcentres	Activity 1.3: Infrastructure: Renovation of RHC and construction of subcentres in HSS targeted townships	682426	420107			
Increase access to EPI/ MCH	1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans.	550000	0	balance fund of this activity will be used for procurement of ILRs for EPI.	Since program coverage stopped at 120 townships- township capacity was limited to absorb additional funds despite community need.	
Recruitment of AMW/CHWs	1.4.2 Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan	350000				
Quarterly review meeting, AMW/CHW recruitment and refresher training	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 2016	137701	37701			
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						

Printing the guidelines	Activity 2.1: GUIDELINES DEVELOPMENT	35919	4245			
Implementing MVS in 2 townships	Activity 2.3: HR FINANCINGTraining and Piloting of health financing schemes, according to national guidelines in 50 townships by 2016	350157	157			
Hospital Equity Fund in 120 townships	Activity 2.5: Management support includes supervision and planning activities ($10,000 per township)	677659	177659	balance will be used for the strengthening supply and procurement system for Department of Public Health		
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.						
	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing)	20000	0			
	Activity 3.2: HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas.	40000	0			
	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)	150000	0	balance fund of this activity will be used for procurement of ILRs for EPI and strengthening supply and procurement system for newly created department- this includes procurement of EPI supplies.		

	3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines	181099	1099	this budget will be used to review and revise the guidelines on duties and responsibilities of BHS especially Public Health Supervisors I and training of PHSII on immunization and other related activies		
	3.4.2 International Short Courses Health Financing	118847	0			
	3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems	68864	0			
	3.4.4 Leadership Development Program	352373	242373			
Support costs						
	Computers Townships	102165	102165			
Management costs						
	Administration and Management Cost (WHO)	553807	199605			
	Consultancies	6136	6136			
		8506352	1458903			0

8.6. Planned HSS activities for 2016

Please use **Table 8.6** to outline planned activities for 2016. 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 8.6: Planned HSS Activities for 2016

Major Activities (insert as many rows as necessary)	**Planned Activity for 2016**	**Original budget for 2016** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2016** (if relevant)

Objective 1: By 2016, 120 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%					
	Activity 1.1: SURVEY Conduct survey to establish base line indicators & outcome, impact and research for operations	170000			
Increase access to EPI/MCH	Activity 1.4: TRANSPORT Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans	550000			
Quarterly review meeting and NHSC	Activity 1.5: SOCIAL MOBILIZATIO N:	100000			
Objective 2: By the end of 2016, 120 selected townships with identified hard to reach areas will have developed and implemented coordinated township micro-plans					
Printing AMW/ CHW/ MVS guidelines etc...	Activity 2.1: GUIDELINES DEVELOPME NT Develop national guidelines for coordinated township health planning	30000			

Maternal Voucher Scheme	Activity 2.3: HR Financing: Piloting of Health Financing Scheme according to national guidelines in 50 townships	350000			
Hospital Equity Fund	Activity 2.5: PLAN DEVELOPMENT 2.5.1 Management Support (from Township Coordinated Plans) Includes supervision and planning activities ($10,000 per Township per annum scaling up to 120 Townships by 2016)	1164079			
Health System Research and Annual Programme Review	Activity 2.6: RESEARCH & EVALUATION	160000			
Objective 3 By the end of 2016, 120 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to the National HR Standards.					
Increase access to EPI/MCH	Activity 3.3: HR costs (HR Finance incentive scheme for health staff in remote areas - identified in Township Coordinated Plans) ($5,500 per Township per Year)	300000			
Recruitment of HSSOs at States/Regions and township level	3.4.4 Leadership Development Program	195945			
Support costs					
Technical and Management Cost (WHO)	Technical and Management support (WHO)	553329			
Administration Costs Central Level (DOH)		11721			

International Technical Assistance					
	International Consultancies	65675			
Reallocation activities					
	Strengthen supply and procurement system for Department of Public Health	1000000			
PHSII training	Training of new PHSII at States/ Regions and Districts	350000			
PHSII refresher training	Refresher Training of PHSII focused on revised job description at States/Regions and Districts (5 States/Regions)	420000			
		5420749			

8.7. 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@gavi.org

8.8. 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 8.8: Sources of HSS funds in your country

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

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

8.9. Reporting on the HSS grant

8.9.1. 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 8.9.1: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
HMIS Indicators and Program data	- Published reports	- discrepancies in data from different sources
Office of Auditor General of the Union of Myanmar: Audit Report GAVI HSS funds	Office of Auditor General of the Union of Myanmar	
UNICEF Country Office: Essential drugs and Equipments	- Confirmation with UNICEF focal point	

WHO GSM, GAVI HSS Technical unit (Financial Statement and S&E) Finance and Budget Section of DOH, MOH; Financial Statement and S&E	- Validated by WCO- GAVI HSS technical unit. Accountants and Finance section, followed by endorsement from Budget and Finance Office in WHO SEARO - Validation by MOH focal point and Finance, DOH, MOH	- Changes in exchange rate

8.9.2. 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.

8.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2014?2

Please attach:

1. The minutes from the HSCC meetings in 2015 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

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

9.1. 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 2014

9.2. 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 2014

10. 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 has been planned to conduct in 4th June 2015 , The comment from the chair will be sent by e mail in further communication since the portal deadline could not allow to submit the comment.

11. Annexes

11.1. 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 2014 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.2. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	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.

11.3. 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 2014 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.4. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	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.

11.5. 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 2014 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.6. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	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. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Myanmar APR Delay.pdf **File desc:** **Date/time :** 28/05/2015 01:27:21 **Size:** 50 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Myanmar APR Delay.pdf **File desc:** **Date/time :** 28/05/2015 01:27:21 **Size:** 50 KB
3	Signatures of members of ICC	2.2	✓	Myanmar APR Delay.pdf **File desc:** **Date/time :** 28/05/2015 01:28:15 **Size:** 50 KB
4	Minutes of ICC meeting in 2015 endorsing the APR 2014	5.4	✓	Myanmar APR Delay.pdf **File desc:** **Date/time :** 28/05/2015 01:28:15 **Size:** 50 KB
5	Signatures of members of HSCC	2.3	✓	NHSC members signature.pdf **File desc:** Signature of members of HSCC **Date/time :** 15/05/2015 06:28:19 **Size:** 291 KB
6	Minutes of HSCC meeting in 2015 endorsing the APR 2014	8.9.3	✓	Minutes from 9th NHSC Meeting.pdf **File desc:** Minutes of HSCC meeting in 2015 endorsing the APR 2014 **Date/time :** 20/05/2015 11:02:49 **Size:** 59 KB
7	Financial statement for ISS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	ISS Statement.PDF **File desc:** **Date/time :** 28/05/2015 01:55:09 **Size:** 121 KB
8	External audit report for ISS grant (Fiscal Year 2014)	6.2.3	✗	External Audit Report.docx **File desc:** **Date/time :** 28/05/2015 01:36:03 **Size:** 9 KB
9	Post Introduction Evaluation Report	7.2.1	✗	Myanamr Penta PIE 2014 draft 20 July Report .doc_vb.pdf **File desc:** **Date/time :** 28/05/2015 01:55:09 **Size:** 1 MB
10	Financial statement for NVS introduction grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	NVS Statement.PDF **File desc:** **Date/time :** 28/05/2015 01:57:38 **Size:** 121 KB
11	External audit report for NVS introduction grant (Fiscal year 2014) if total expenditures in 2014 is greater than US$ 250,000	7.3.1	✓	External Audit Report.docx **File desc:** **Date/time :** 28/05/2015 01:57:38 **Size:** 9 KB

12	Latest EVSM/VMA/EVM report	7.5	✓	EVM_report-Myanmar v6.docx **File desc:** **Date/time :** 28/05/2015 02:06:47 **Size:** 5 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	EVM-imp-plan-Myanmar 2011 v6.xlsx **File desc:** **Date/time :** 28/05/2015 02:15:17 **Size:** 135 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	Myanmar 2014 EVMA(2011) Status Report v1_daniel ngemera comments.docx **File desc:** **Date/time :** 28/05/2015 02:06:47 **Size:** 504 KB
16	Valid cMYP if requesting extension of support	7.8	✗	cMYP_2012_2016.pdf **File desc:** **Date/time :** 28/05/2015 02:23:02 **Size:** 3 MB
17	Valid cMYP costing tool if requesting extension of support	7.8	✗	cMYP_Costing_Tool_Vs.2.5_EN_12 Nov 11.xlsx **File desc:** **Date/time :** 28/05/2015 02:26:16 **Size:** 1 MB
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	Myanmar APR Delay.pdf **File desc:** **Date/time :** 28/05/2015 02:17:44 **Size:** 50 KB
19	Financial statement for HSS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	HSS Financial Statement for APR 2014.pdf **File desc:** Financial statement for HSS grant (Fiscal year 2014) **Date/time :** 20/05/2015 11:30:47 **Size:** 359 KB
20	Financial statement for HSS grant for January-April 2015 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	HSS Financial Statement for APR 2014.pdf **File desc:** Financial statement for HSS grant **Date/time :** 20/05/2015 11:32:01 **Size:** 359 KB
21	External audit report for HSS grant (Fiscal Year 2014)	8.1.3	✓	External Audit Report.docx **File desc:** **Date/time :** 28/05/2015 02:27:10 **Size:** 9 KB
22	HSS Health Sector review report	8.9.3	✓	Health Planning Review Myanmar.pdf **File desc:** Health Sector Review Report **Date/time :** 15/05/2015 05:38:09 **Size:** 390 KB
23	Report for Mapping Exercise CSO Type A	9.1.1	✗	CSO Type A and B.docx **File desc:** **Date/time :** 28/05/2015 02:28:56 **Size:** 9 KB

24	Financial statement for CSO Type B grant (Fiscal year 2014)	9.2.4	✗	CSO Type A and B.docx **File desc:** **Date/time :** 28/05/2015 02:28:56 **Size:** 9 KB
25	External audit report for CSO Type B (Fiscal Year 2014)	9.2.4	✗	CSO Type A and B.docx **File desc:** **Date/time :** 28/05/2015 02:28:56 **Size:** 9 KB
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 2014 on (i) 1st January 2014 and (ii) 31st December 2014	0	✓	HSS Financial Statement for APR 2014.pdf **File desc:** **Date/time :** 20/05/2015 11:36:20 **Size:** 359 KB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✗	vaccine presentation.docx **File desc:** **Date/time :** 28/05/2015 02:34:52 **Size:** 9 KB
28	Justification for changes in target population	5.1	✗	Change in Target Population.docx **File desc:** **Date/time :** 28/05/2015 02:42:56 **Size:** 10 KB
	Other		✗	Annexure I - UNICEF progress report_May_2015_MM.pdf **File desc:** Annexure I - UNICEF Progress Report **Date/time :** 14/05/2015 09:49:28 **Size:** 442 KB Annexure II - MRCS progress report.pdf **File desc:** Annexure II - MRCS Progress Report **Date/time :** 14/05/2015 09:50:13 **Size:** 218 KB Annexure III - IEC Materials distribution list.pdf **File desc:** Annexure III - IEC Materials distribution list **Date/time :** 14/05/2015 09:50:51 **Size:** 71 KB Annexure IV- Reference Mateial on Leadership and Management for TMO's and BHS.pdf **File desc:** Annexure IV - Reference Material on Leadership and Management for TMO's and BHS (both in English and Myanmar) **Date/time :** 14/05/2015 10:12:42 **Size:** 84 MB Annexure V - 8th and 9th NHSC Meeting minutes.pdf **File desc:** Annexure V - NHSC meeting minutes **Date/time :** 20/05/2015 11:04:25 **Size:** 134 KB

	Other		×	Annexure VI - Distribution list of office equipment.pdf **File desc:** Annexure VI - Distribution list of office equipment **Date/time :** 20/05/2015 11:17:41 **Size:** 19 MB Annexure VII- Township Health Planning Review.pdf **File desc:** Annexure VII- Township Health Planning Review **Date/time :** 20/05/2015 11:18:34 **Size:** 390 KB