Annual Progress Report 2009

Submitted by

The Government of

Pakistan

Reporting on year: **2009**

Requesting for support year: **2011**

Date of submission: 15th May 2010

Deadline for submission: 15 May 2010

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

any hard copy could be sent to :

GAVI Alliance Secrétariat,
Chemin de Mines 2.
CH 1202 Geneva,
Switzerland

Enquiries to: **apr@gavialliance.org** or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public.

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

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

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

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

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

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

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

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

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

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

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

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

By filling this APR the country will inform GAVI about :

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

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

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

For the Government of [*Name of Country*].....

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

Minister of Health (or delegated authority):

Title: Secretary, Ministry of Health

Signature: .....

Date: April 21, 2010.....

Minister of Finance (or delegated authority):

Title: .....

Signature: .....

Date: .....

This report has been compiled by:

Full name: Dr. Altaf Hussain Bosan Position: National Programme Manager EPI Telephone: +9251-9255101 Fax 9255086. E-mail: altafbosan@gmail.com	Full name: Dr. Assad Hafeez Position: Chief, HSSPU, MoH Telephone. +92 51 925 5648-49 E-mail: az10@hotmail.com
Full name: Dr. Quamrul Hasan Position: WHO Medical Officer, EPI Telephone:+9251-9255101,+923008504178 E-mail: quamrulh@gmail.com hasanq@pak.emro.who.int	Full name: Dr. Ayesha Khan Position: Monitoring & Evaluation Specialist HSSPU, MoH Telephone +9251 9255648-49 E-mail Ayesha@khans.org

National Interagency Coordination Committee (NICC) for EPI Pakistan and National Health Sector Coordinating Committee (NHSCC)

A joint meeting of the NICC and NHSCC was held on 5th April 2010 in the Ministry of Health, Islamabad under the chairmanship of Mr. Khushnood Akhtar Lashari, Federal Secretary, Ministry of Health and participated by the following and endorsed the APR 2009

Name/Title	Agency/Organisation	Signature	Date
Prof. Dr. Rashid Jooma	DG- Health		5/4/2010
Dr. FAROOQ AKHTAR	NPM-MNCH		//
Dr. QUAMRUL HASAN	MO-EPI/WHO		05/04/10
DR ASSAD HAFEEZ	Chief HSSPU		
Dr. Altaf Hussain Bosan	NPM- EPI		
Dr Agha Ashfaq	Dy. NPM- EPI		
Manzoor Ahmad Mallal	GAVI Unit, EPI		
Dr. Arshad Chandio	Dy N.C. PHC		
Lubna Hashmat	CHIP		5/4/10
Zahid Memon	Save the children		5/4/10
Dr Mohamed Cisse	Unicef		5/4/10
Dr. Ayesha Khan	HSSPO-MOH	A. Khan	5/4/10
Dr. Rozina Mistry	Aga Khan Health Service, Pakistan		5/4/10
Dr Hiroto Miyagi	JICA		5/4/10
Dr Hans Frey	Rotary Internat.		
Nima Abid	WHO		
Melissa Corkum	UNICEF		
Huma Khawar	GAVI CSO/MOH		

Name/Title	Agency/Organisation	Signature	Date
Obaidul Islam	WHO		
Dr. Salma	Gavi, Cold/EPI		
Dr Huma Qureshi	PMRC		
Agha Nadeem - Additional Sec	MOH		5-4-2010
Mr Shahzad Nasir	MoH		
Prof Tariq Pervaiz	NTAG		

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

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

Name: Huma Khawar

Post: Co-ordinator

Organisation: GAVI CSO Alliance

Date: 12 April 2010

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

All components of GAVI support were endorsed on the above meeting held on 5th April 2010 in the Ministry of Health, Pakistan.

Annual Progress Report 2009: Table of Contents

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

List of Tables in 2009 APR

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

List of supporting documents attached to this APR

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

Document N°	Title	APR Section
1	Calculation of ***Pakistan's*** ISS-NVS support for 2011 *(Annex 1)*	1.1; 2.4; 3.7
2, 3, 4	Minutes of all the ICC meetings held in 2009	1.5
5	Financial statement for the use of ISS funds in the 2009 calendar year	2.3
6	External audit report of ISS funds during the most recent fiscal year (if available)	2.3
Not applicable	Financial statement for the use of New Vaccines Introduction Grant funds in the 2009 calendar year	3.2.3
7	Total allocation of fund for EPI during 2011 – 12 in PC-1	
8	Report of the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA)	3.4
9	Status of last Effective Vaccine Management Recommendations	
Not applicable	Minutes of the ICC meeting endorsing the change of vaccine presentation (if not included among the above listed minutes)	3.5
10	New cMYP for the years 2011 – 2015	3.6
11	Minutes of the ICC meeting endorsing the country request for extension of new vaccine support for the years 2011 – 15	3.6
2, 3, 4	Minutes of the HSCC meetings held in 2009 including those on discussion/endorsement of this report	5.1.8
14	Latest Health Sector Review Report	5.1.8
15a & 15b	Financial statement for the use of HSS funds in the 2009 calendar year	5.8
	External audit report for HSS funds during the most recent fiscal year (Not available)	5.8
	CSO mapping report (Not available)	6.1.1
12	Terms of Reference for cluster coordinator, GAVI CSOs	
13	Financial statement for the use of CSO 'Type B' funds in the 2009 calendar year	6.2.4
	External audit report for CSO 'Type B' funds during the most recent fiscal year (Not available)	6.2.4

1. General Programme Management Component

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

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

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

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

The numbers of birth and surviving infants for 2009 in Table 1 is consistent with JRF 2009.

The numbers of birth and surviving infants for 2010 – 2015 in Table 1 is not consistent with APR 2008 but is consistent with Pakistan's application for Penumococcal vaccine (PCV10) and cMYP 2011 – 15.

The cMYP was developed after submission of APR 2008 and during its development the number of annual birth and surviving infants was revised according to latest available statistics. This was done with technical assistance of WHO/EMRO. Accordingly, the revised numbers for birth and surviving infants were used in the application for NVS support for Pneumococcal (PCV10) vaccine. The current APR used the same figures for birth and surviving infants as in the cMYP and Pnumo application. This is the reason for discrepancy among the numbers in last APR (2008) and this APR.

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

Achievements in 2009 for different antigens are in consistent with the official estimate in JRF 2009 (sheet 5. Official estimate).
Please note that exact figure for number of children vaccinated with BCG, OPV3, DPT1 & 3 in 2009 as mentioned in JRF 2009 (sheet 4A. Routine Coverage) will not match with Annex – 1, Table 1 because official coverage estimate mentioned in sheet 5 of JRF is used for these antigens to calculate exact number of children vaccinated.

Target by vaccines for 2010 – 2015 are consistent with the cMYP 2011 – 2015 and Pnumo Application but not consistent with the APR 2008 for the above mentioned reason.

*Provide justification for any changes **in Wastage by vaccine**:*
Wastage factors for Pentavalent and Pneumo vaccine are same in this document as mentioned in the last year APR (2008) and Pnumo application.

1.2 *Immunisation achievements in 2009*

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

Key activities and achievements in 2009:

1. Immunization month has been observed in October 2009 to trace and vaccinate all defaulters
2. 61% of the districts had reached 80% coverage for DPT (Penta) 3rd dose against only 30% districts in 2008 reaching the same coverage
3. 54% districts had reached 80% coverage for Measles 1st dose against 46% districts in 2008 reaching the same coverage
4. DPT (Penta) 1 – 3 dropout has been reduced from 14% in 2008 to 10% in 2009
5. Measles 2nd dose has been introduced in routine immunization schedule from government's own resource
6. Pentavalent vaccine introduction completed all over the country
7. Country successfully procured all its due share of Pentavalent vaccine and injection equipments under co-financing agreement and came out of default status

Key challenges faced in 2009:

1. Completion of training for vaccinators for newly introduced Pentavalent vaccine was a serious challenge due to not release of the New Vaccine Introduction grant by GAVI. The training was completed with WHO support
2. Expansion of cold chain system for Pentavalent vaccine couldn't be done as planned. Expansion was done only at federal store with government's own resources
3. Payment of Operational fund for the Immunization month to the districts is still pending. This cost was supposed to be borne using left over of the GAVI ISS reward 2 which was lying with GAVI. This decision was endorsed by the NICC on its 10 July 2009 meeting but the fund had not been released yet.

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

Targets were not reached due to challenges mentioned above and overall operational challenges like poor supervision and monitoring, lack of sincere and commitment of the parties involved.

1.3 *Data assessments*

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

No recent survey data is available for such comparison.
WHO/UNICEF estimate for National Immunization coverage is available up to 2008 and that matches with official country estimate.

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

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

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

Yes.
Review of administrative data is being regularly conducted at provincial level. Resultantly data inconsistency has been reduced especially in Sindh and NWFP province. This is a continuous process and will continue for further improvement.

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

Monthly review of administrative data send by districts at provincial level to check for inconsistency and discrepancy. If so are found, those are corrected with appropriate feedback.
Evaluation of coverage also took place after observing the Immunization month in October 2009 in 36 districts of Punjab, 22 districts and 18 towns of Karachi district of Sindh and 19 districts of NWFP province by independent monitors hired and supervised by WHO Polio team.

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

Independent coverage evaluation will be continued time to time at district level with partners' support and Federal initiative.
Any suggestion from partners to improve this further are welcome.

1.4 *Overall Expenditures and Financing for Immunisation*

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

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

Expenditures by Category	**Expenditure Year 2009**	**Budgeted Year 2010**	**Budgeted Year 2011**
Traditional Vaccines[2]	20,102,942	25,375,608	24,820,087
New Vaccines	9,074,231	5,376,000	11,257,245
Injection supplies with AD syringes	0	4,901,822	4,463,404
Injection supply with syringes other than Ads	0	1,040,866	1,048,148
Cold Chain equipment		4,178,554	2,508,258
Operational costs	129,000		
Other (please specify)	129,000*	1,411,125	1,414,013
Total EPI	29,435,173	42,283,975	45,511,155
Total Government Health			

Note: operational cost mentioned in the above table pertain only GAVI resources. Total allocation of funds for 2010 and 2011 are shown in the ***Document No: 7***

Exchange rate used	Rs.80 = US$ 1

Please describe trends in immunisation expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunisation program over the next three years; whether the funding gaps are manageable,

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

challenging, or alarming. If either of the latter two is applicable, please explain the strategies being pursued to address the gaps and indicate the sources/causes of the gaps.

EPI Pakistan during Fiscal Year 2009-10 has made expenditure of around Rs. 3.7 billion (US$ 45 million) to cover all expenses of routine immunization including co-financing share of pentavalent vaccine.

EPI Pakistan has developed a five year financial and activity document namely PC-1 which has been passed from different forums. The Central Development Working Party (CDWP) has recommended this document worth Rs. 26.422 billion for 5 years period. This mostly covers expenditures on routine immunization services in the country. However, there will be gap to conduct supplemental immunization activities for eradication of polio and elimination of measles and MNT.

1.5 *Interagency Coordinating Committee (ICC)*

How many times did the ICC meet in 2009? .Three (3) times
Please attach the minutes **(Document N° 2, 3, 4)** from all the ICC meetings held in 2009, including those of the meeting endorsing this report.

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

a) ICC expressed concern for suspension of GAVI fund including New vaccine introduction grant and approved ISS rewards
b) ICC expressed concern on country data discrepancy and recommended to make improvement in this regard with assistance of WHO and UNICEF

Are any Civil Society Organisations members of the ICC ?: **Yes.** If yes, which ones?

List CSO member organisations:
1. Rotary International
2. Aga Khan University

1.6 *Priority actions in 2010-2011*

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

1. Achieve antigen wise coverage target set in this document for routine immunization
2. Expansion of cold chain system at all levels to accommodate the need for introduction of new vaccines (Pneumo in 2011)
3. Achieving WHO/UNICEF certification for vaccine store management for Federal and at least 2 provincial stores
4. Introduction of Pneumococcal (PCV10) vaccine in 2011
5. Conduction of National Measles Follow-up campaign in 2011
6. Conduction of MNT campaign in one high risk district in Sindh province and remaining intermediate risk districts in Punjab province

All these activities are linked with cMYP

2. Immunisation Services Support (ISS)

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

Funds received during 2009: US$ Nil
Remaining funds (carry over) from 2008: US$ 3.738 million
Balance carried over to 2010: US$ 2.517 million

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

1. Hiring Technical Assistance by provinces
2. Salaries to additional staff
3. Human resource development/training
4. Social Mobilization
5. Performance rewards
6. Procurement

2.2 *Management of ISS Funds*

Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2009 calendar year? **Yes**

[IF YES] : please complete **Part A** below.
[IF NO] : please complete **Part B** below.

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

GAVI completed Financial Management Assessment (FMA) in 2009 and the draft report has been shared with Government of Pakistan. Ministry of Health has sent feedback on the report. Afterwards, GAVI has sent a draft Aide Memoire to the Government of Pakistan and that has been returned with feedback and approval from the ministry to GAVI.
Now country is waiting for the final signature of the Aide Memoire to be sent from GAVI.

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

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

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

Please attach a detailed financial statement for the use of ISS funds during the 2009 calendar year **(Document N° 5).** *(Terms of reference for this financial statement are attached in Annex 2).*

Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your ISS programme during your government's most recent fiscal year, this must also be attached **(Document N°6)**.

2.4 *Request for ISS reward*

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

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

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

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

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

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

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

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

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

	[A]		[B]	
Vaccine Type	**Total doses for 2009 in DL**	**Date of DL**	**Total doses received by end 2009 ***	**Total doses of postponed deliveries in 2010**
Pentavalent (DPT-Hep B-Hib) liquid vaccine in single dose vial	**18,406,100**	**18 December 2007**	**18,583,400**	**3,606,100**

* *Please also include any deliveries from the previous year received against this DL: In 2009, 3,783,400 doses was received from 2008 quota and 14,800,000 doses was received from 2009 quota. The remaining 3,606,100 doses of 2009 quota to be supplied in 2010.*

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

What are the main problems encountered? *(Lower vaccine utilisation than anticipated? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date?)*	• The first shipment of 2008 was delayed due to non-registration of the product in the country and thus country suffered stock-out for certain time. Later on upon completion of the registration of the vaccine, the supply started. That's why some portion of the 2008 quota was supplied in 2009. • Due to additional supply of vaccine from 2008 quota in 2009 Federal EPI store ran out of storage space and thus supply of the part of the 2009 quota was delayed up to 2010.
What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF SD)	• Vaccine supply schedule was adjusted with the prevailing scenario as described above • Additional cold storage capacity has been added in the Federal EPI store. Total 14 cold rooms were installed which added 410 m^3 ($+2^0$ to $+8^0$ C) and 110 m^3 (-15^0 to -25^0 C) additional gross capacity to the federal store. All these equipments were procured by government's own resource at an approximate cost of US$ 316,450.

3.2 *Introduction of a New Vaccine in 2009*

3.2.1 If you have been approved by GAVI to introduce a new vaccine in 2009, please refer to the vaccine introduction plan in the proposal approved and report on achievements.

No new vaccine has been introduced in 2009 with GAVI support. The latest new vaccine introduced with GAVI support is Pentavalent (DPT-Hep B- Hib) liquid vaccine in single dose vial was introduced in 2008 and continued in 2009.

Vaccine introduced:	Pentavalent (DPT-HebB-Hib) liquid vaccine
Phased introduction [YES / NO] YES	Date of introduction: Sept. 2008
Nationwide introduction [YES / NO] YES	Date of introduction: Jan 2009
The time and scale of introduction was as planned in the proposal? If not, why?	• NO • The Pentavalent vaccine was not supplied as scheduled due to delay in the registration process of the vaccine. Due to non-availability of NVI grant from

	GAVI, training of vaccinators was also delayed.

3.2.2 Use of new vaccines introduction grant (or lumpsum)

New vaccine introduction grant for Hib (Pentavalent) vaccine (US$ 1.811 million) was not released by GAVI which is still kept pending for completion of signing of the Aid Memoir based on FMA between GAVI and Government of Pakistan.

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

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

No activity was undertaken using GAVI New vaccine introduction grant as that grant was not released by GAVI yet.
Country had undertaken some crucial activities for the introduction of the new Pentavalent vaccine with support from WHO (training of vaccinators) and using its own resource (cold chain expansion at federal vaccine store).

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

Due to withholding the fund by GAVI, EPI Pakistan couldn't make the cold chain expansion as planned. Moreover, social mobilization and communication activities for the introduction of the new vaccine were seriously compromised. Training of the vaccinators on the new vaccine was delayed due to non availability of NVI grant from GAVI and later completed with extra-ordinary support provided by WHO and UNICEF.

Is there a balance of the introduction grant that will be carried forward? **YES**
If YES, how much? US$ 1.811 million (balance lying with GAVI)

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

1. Cold chain expansion at Federal, provincial and district levels
2. Procurement of equipments and software for Improved vaccine management at federal and provincial levels and training on vaccine management of the focal persons at provincial and district levels.
3. Refresher training for the vaccinators
4. Social mobilization and communication activities for routine immunization

3.2.3 Detailed expenditure of New Vaccines Introduction Grant funds during the 2009 calendar year.

No funds received during 2009 in this head.

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

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

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

Q. 1: How have the proposed payment schedules and actual schedules differed in the reporting year?

Schedule of Co-Financing Payments	Planned Payment Schedule in 2009	Actual Payments Date in 2009	Proposed Payment Date for 2010
	(month/year)	(day/month)	(month/year)
1st Awarded Vaccine (Pentavalent)	Oct 2009	30th Sept 2009	October 2010
2nd Awarded Vaccine (specify)			
3rd Awarded Vaccine (specify)			

Q. 2: Actual co-financed amounts and doses?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (Pentavalent)	6.005 million	1.610 million
2nd Awarded Vaccine (specify)		
3rd Awarded Vaccine (specify)		

Q. 3: Sources of funding for co-financing?
1. Government: The whole amount of co-financing share of vaccine and injection equipments were covered by Government of Pakistan's own resource
2. Donor (specify)
3. Other (specify)

Q. 4: What factors have accelerated, slowed or hindered mobilisation of resources for vaccine co-financing?
1. According to the National Public Procurement Rules, Ministry of Health was bound to procure the co-financing share of the vaccine through open bidding instead of through UNICEF. The procurement was delayed due to the tender process and identifying appropriate eligible supplier of the Pentavalent vaccine.
2. Government's own financial cycle is July to June of the next calendar year. That's why release of fund for procuring vaccine for a specific calendar year couldn't be made before the respective financial year starts.
3.
4.

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

The country was in default status in 2009 for late procurement of its co-financed share of vaccine of 2008 due to above mentioned constrains. However, country successfully came out of the default status in 2009 by procuring all its co-financed share of vaccine for 2008 and 2009 as well on time.

3.4 *Effective Vaccine Store Management/Vaccine Management Assessment*

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? ***May – June 2009***

If conducted in 2008/2009, please attach the report. (**Document N° 8**)
An EVSM/VMA report must be attached from those countries which have introduced a New and Underused Vaccine with GAVI support before 2008.
Was an action plan prepared following the EVSM/VMA? ***YES***

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

The WHO Mission made total 51 recommendation in 9 broad areas. Implementation status of these recommendations are attached in **Document No:9**

When is the next EVSM/VMA* planned? *[October 2010]*

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

3.5 *Change of vaccine presentation*

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

Please specify below the new vaccine presentation:

EPI-Pakistan doesn't have any plan to change any vaccine presentation in 2011. Pentavalent vaccine is to be continued as single dose liquid vaccine presentation as present.

Please attach the minutes of the ICC meeting **(Document N°.....)** that has endorsed the requested change. **Not applicable**

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

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

The country hereby request for an extension of GAVI support for Pentavalent*. [liquid single dose vial]* vaccine for the years 2011-2015*.* At the same time it commits itself to co-finance the procurement of Pentavalent*. [liquid single dose vial]* vaccine in accordance with the minimum GAVI co-financing levels as summarised in Annex 1.

The multi-year extension of Pentavalent*.[liquid single dose vial]* vaccine support is in line with the new cMYP for the years 2011 – 2015 which is attached to this APR **(Document N°10).**

The country ICC has endorsed this request for extended support of Pentavalent*.[liquid single dose vial]* vaccine at the ICC meeting whose minutes are attached to this APR. **(Document N° 11)**

3.7 *Request for continued support for vaccines for 2011 vaccination programme*

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

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

YES, I confirm

If you don't confirm, please explain:

4. Injection Safety Support (INS)

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

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

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

If INS supplies are received, please report on receipt of injection safety support provided by the GAVI Alliance during 2009 (add rows as applicable).

Table 7: Received Injection Safety Material in 2009

Injection Safety Material	Quantity	Date received

Please report on any problems encountered:

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

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

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

Table 8: Funding sources of Injection Safety material in 2009

Vaccine	Types of syringe used in 2009 routine EPI	Funding sources of 2009
BCG	AD syringe (0.05 ml)	Government's own resources
Measles	AD syringe (0.5 ml)	Government's own resources
TT	AD syringe (0.5 ml)	Government's own resources
DTP-containing vaccine	AD syringe (0.5 ml)	Government's own resources

Please report how sharps waste is being disposed of:

Sharp wastes are collected in safety box at the site of fixed/outreach vaccination centres which are later stored at the nearest vaccine distribution point (health facility). On monthly basis, all filled safety boxes are finally disposed off by burn and burry method at a pre-designated pit within the premises of the health facility at a secured place. In places, where standard incinerator is available that is used for final disposal of the safety boxes.

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

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

The following major areas of activities have been funded (specify the amount) with the GAVI Alliance injection safety support in the past year:

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

Table 9: Expenditure for 2009 activities

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

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

Table 10: Planned activities and budget for 2010

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

5. Health System Strengthening Support (HSS)

Instructions for reporting on HSS funds received

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

Background to the 2010 HSS monitoring section

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

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

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

5.1 *Information relating to this report*

5.1.1 Government fiscal year (cycle) runs from July (month) to June (month).
5.1.2 This GAVI HSS report covers 2009 calendar year from January to December
5.1.3 Duration of current National Health Plan (National Health Policy) is from May 2010 – June 2015 (month/year) to …….(month/year).

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

5.1.4 Duration of the current immunisation cMYP is from Jan 2011 (month/year) to Dec 2015 (month/year)

5.1.5 Person(s) responsible for putting together this HSS report who can be contacted by the GAVI secretariat or by the IRC for possible clarifications:

[It is important for the IRC to understand key stages and actors involved in the process of putting the report together. For example: '*This report was prepared by the Planning Directorate of the Ministry of Health. It was then submitted to UNICEF and the WHO country offices for necessary verification of sources and review. Once their feedback had been acted upon the report was finally sent to the Health Sector Coordination Committee (or ICC, or equivalent) for final review and approval. Approval was obtained at the meeting of the HSCC on 10th March 2008. Minutes of the said meeting have been included as annex XX to this report.*']

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any programmatic clarifications:			
Dr. Assad Hafeez, Chief	HSSPU-MOH	Lead	Az10@hotmail.com +92 51 925 5648-49
Focal point for any accounting of financial management clarifications:			
Mr. Sharafat Zia	Ministry of Health	Financial Statements of Accounts	
Other partners and contacts who took part in putting this report together:			
Dr. Ayesha Khan	HSSPU-MOH	Report compilation	ayesha@khans.org +92 51 925 5648-49
Dr. Farah Sabih	HSSPU-WHO	Report compilation	Farahsabih95@gmail.com + 92 51 920 3714

5.1.6 Please describe briefly the main sources of information used in this HSS report and how was information verified (validated) at country level prior to its submission to the GAVI Alliance. Were any issues of substance raised in terms of accuracy or validity of information (especially financial information and indicators values) and, if so, how were these dealt with or resolved?

[This issue should be addressed in each section of the report, as different sections may use different sources. In this section however one might expect to find what the MAIN sources of information were and a mention to any IMPORTANT issues raised in terms of validity, reliability, etcetera of information presented. For example: *The main sources of information used have been the external Annual Health Sector Review undertaken on (such date) and the data from the Ministry of Health Planning Office. WHO questioned some of the service coverage figures used in section XX and these were tallied with WHO´s own data from the YY study. The relevant parts of these documents used for this report have been appended to this report as annexes X, Y and Z.*]

The information quoted and mentioned in this Report have been taken from PDHS 2006-07, monthly reports by the EPI Program Pakistan, and supervisory visits and evaluation of activities by WHO and Ministry of Health.

In addition other key sources of information for the Report were the minutes of the following meetings:

1. Minutes 4th Core Committee meeting 16.1.2009
2. Minutes 5th Core Committee meeting 15.04.2009
3. Minutes 6th Core Committee meeting 30.07.2009
4. Funds re-appropriation table 21.6.2008
5. Minutes NHSCC meeting 19.9.2008
6. Minutes NHSCC meeting 10.07.2009

7. Minutes of the NHSCC meeting 2.09.2009

Training reports from LHW-EPI project (available on lhw-epi.pakqualitycare.ne)

5.1.7 In putting together this report did you experience any difficulties that are worth sharing with the GAVI HSS Secretariat or with the IRC in order to improve future reporting? Please provide any suggestions for improving the HSS section of the APR report? Are there any ways for HSS reporting to be more harmonised with existing country reporting systems in your country?

The APR reporting requirements are quite lengthy with fair amount of repetition. It would be helpful to simplify and reduce the number of tables. Sometimes it is not possible to assign a realistic percentage to the task accomplished.

Another issue is that sometimes the status of activities in-progress/process i.e funds have been released but activity is still in process and does not correlate with financial disbursement status

For the next phase of GAVI supported activities the HSSPU is planning to develop an integrated M&E framework for all Health system activities undertaken or supervised by the Ministry of Health

5.1.8 Health Sector Coordinating Committee (HSCC)

How many times did the HSCC meet in 2009? .3
Please attach the minutes **(Document N° 2, 3, 4 and 11)** from all the HSCC meetings held in 2009, including those of the meeting which discussed/endorsed this report
Latest Health Sector Review report is also attached **(Document N° 14).**

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

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

Table 11: Receipt and expenditure of HSS funds

	2007	2008	2009	2010	2011	2012	2013	2014	2015
Original annual budgets (per the originally approved HSS proposal)		1,254.712	0.00	55.661*					
Revised annual budgets (if revised by previous Annual Progress Reviews)									
Total funds received from GAVI during the calendar year		1,254.712	0.00						
Total expenditure during the calendar year		259.350	645.565						
Balance carried forward to next calendar year		995.362	349.797						
Amount of funding requested for future calendar year(s)									

* US $ 6.626 million converted into Pak Rs at 1US $ = Rs 84.

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

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

At the Country Level - Lack of well defined financial mechanisms in the Ministry of Health to transfer allocated funds to the respective programs has adversely affected GAVI HSS activities. For example, majority of the activities to be implemented by the MNCH program are still pending. Some of the bottlenecks in this regard include the lengthy procedural requirements within the MOH and need to be addressed for timely processing in the future.

At the GAVI Secretariat Level – Delays in release of 2nd tranche GAVI HSS funds have resulted in gaps in salary and office support for the technical staff, HSSPU and provincial HSS units which has been temporarily compensated by WHO Pakistan.

Delayed funding has also affected the continuity of some ongoing GAVI HSS activities since funds had to be diverted into other critical areas.

5.3 *Report on HSS activities in 2009 reporting year*

Note on Table 12 below: *This section should report according to the original activities featuring in the HSS application. It is very important to be precise about the extent of progress, so please allocate a percentage to each activity line, from 0% to 100% completion. Use the right hand side of the table to provide an explanation about progress achieved as well as to bring to the attention of the reviewers any issues relating to changes that have taken place or that are being proposed in relation to the original activities. It is very important that the country provides details based on the M& E framework in the original application and approval letter.*

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

Table 12: HSS activities in the 2009 reporting year

Major Activities	Planned Activity for 2009	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Objective 1:	Improve the national maternal health to more than 70% and EPI coverage for improved child health	
Activity 1.1:	Strengthen the drug procurement system by supplementing 30% IMNCI recommended drugs in BHUs on cost sharing basis	Activity delayed due to procedural requirements in the MOH and will be undertaken in 2010 – 2011.
Activity 1.2:	Strengthen the logistics/procurement system by supplementing 50% IMNCI recommended equipment in BHUs	Activity completed. IMNCI equipment received and awaiting distribution through MNCH program
Activity 1.3:	Establish neonatal units in 26 (20%) First Referral Facilities (THQ/DHQHs) to strengthen referral.	Activity is in progress and will be accomplished in 2010
Activity 1.4:	Establish ORT corners in 6,561 FLCFs (50%)	Redirected into LHW training for Zinc Sulphate (approved by the NHSCC meeting minutes attached)
Activity 1.5:	Procure and replace 100,000 weighing scales of children for LHWs. (01 per LHW) Activity 1.5 (a) Procurement of 58000 Weighing scales for LHWs	58,000 weighing scales procured and distributed to the LHWs.
Activity 1.5b	Additional baby weighing scales 42000	42,000 additional weighing scales have also been procured and are awaiting distribution
Activity 1.6	Procure and supply computers and equipment for MIS section of the Federal program implementation unit (FPIU), LHW program	Activity is planned for 2010
Activity 1.7	Strengthen the district transport system by replacing 100 off road pick ups for the Lady health supervisors for supervision and monitoring (50 Sindh, 25 Punjab, 25 NWFP)	Redirected into procurement of Zinc Sulphate
Activity 1.8	Procure and supply Zinc suspension 20mg to the LHWs (100,000 x 15/LHW/month x 24 months)	Activity completed
Activity 1.9	TA from an international consultant for conducting national IMNCI planning workshop and monitoring pre-service training (02 visits x 1 person x 1 week)	Activity completed

Activity 1.10	National orientation and planning workshop for academia for the introduction of IMNCI in pre-service training of medical and paramedical (1 course x 24 participants)	Activity completed
Activity 1.11	National orientation and planning workshop for academia for introduction of EMONC in the pre-service training of medical and paramedical (1 course x 24 participants)	Activity completed
Activity 1.12	Training of teaching staff on imparting training on IMNCI (4 courses x 6 days x 16 persons)	Activity completed
Activity 1.13	Training of teaching staff on imparting training on EmONC training (4 courses x 6 days x 16 persons)	Activity completed
Activity 1.14	Develop Instructors manual for IMNCI training of medical/paramedical students	Activity completed
Activity 1.15	Develop Students manual for IMNCI training of medical/paramedical students	Activity completed
Activity 1.16	Develop Instructors manual for EmONC training of medical/paramedical students	Activity completed
Activity 1.17	Develop Students manual for EmONC training of medical/paramedical students	Activity completed
Activity 1.18	Print 100 instructor and 5000 student manuals for training medical/paramedical students in IMNCI and EmONC	Activity completed
Activity 1.19	Training of 21500 LHWs (22%) in vaccination (1075 trainings x 3 weeks x 20 participants)	Activity completed
Activity 1.20	Train private sector health providers on IMNCI (32 courses x 11 days x 24 participants)	Activity completed
Activity 1.21	Train private sector health providers on EmONC (32 courses x 11 days x 24 participants)	Activity completed

Objective 2:	Enhance effectiveness of district health care delivery through strengthening human resource development, organizational management and leadership capacity, logistics, supplies and infrastructure	
Activity 2.1:	Conduct comprehensive district mapping for public and private health manpower, facilities, and support systems in 130 districts and analyze information	Partial funds have been redirected to trainings for LHWs on role of Zinc Sulphate in diarrheal management
Activity 2.2:	District health management training for 672 district health managers including M&E with exposure to the district team problem solving approach (28 courses x3 weeks x 24 persons) through HSA, IPH, provincial HSA and DHDCs.	Activity complete however partial funds have been redirected for trainings for LHWs on the role of Zinc Sulphate in diarrheal management
Activity 2.3	Training of 129 Zillah Monitoring Committee (ZMCs) on health system management and monitoring (129 x 5 days x 5 persons) through DTCE and DHDCs	Funds have been redirected to trainings for LHWs on role of Zinc Sulphate in diarrheal management
Activity 2.4	Strengthening of HSS unit by WHO at a cost of Rs 20 million	Unit established and funds utilized
Activity 2.5	Support for district MNCH training coordinator	Recruitment completed and awaiting release of funds from MOH
Activity 2.6	Support for the District MNCH public health specialist	Recruitment completed and awaiting release of funds from MOH
Activity 2.7	Workshop on the information use of district health managers	Additional funds transferred to WHO in September 2009. Activities in progress
Activity 2.8	LHW-MIS software trainings and implementation in AJK, FANA and FATA, ICT	Activity near completion by June 2010
Activity 2.9	Support to WMO at the DHQ/THQ	Recruitment completed and awaiting release of funds from MOH
Activity 2.10	Support to provincial and federal level in supervision, monitoring and evaluation of health system performance	To be undertaken in 2010
Activity 2.11	Support to external review and evaluation	To be undertaken in 2010
Objective 3:	Improve community and civil society organizations involvement in health system decision making mechanisms	
Activity 3.1:	Revitalization of LHWs Health committees	Redirected to training of LHWs on role of Zinc Sulphate in diarrheal management
Activity 3.2:	Establish, develop and revitalize female health volunteers and CSOs in supervision and monitoring of MNCH scaled up services	To be undertaken in 2010
Activity 3.3	Community based emerging operational needs assessment and gap analysis for the 2nd phase GAVI HSS	To be undertaken in 2010

5.4 *Support functions*

*This section on **support functions** (management, M&E and Technical Support) is also very important to the GAVI Alliance. Is the management of HSS funds effective, and is action being taken on any salient issues? Have steps been taken to improve M&E of HSS funds, and to what extent is the M&E integrated with country systems (such as, for example, annual sector reviews)? Are there any issues to raise in relation to technical support needs or gaps that might improve the effectiveness of HSS funding?*

5.4.1 Management

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

As part of the Ministry of Health's efforts to streamline and coordinate the management of current and future GAVI HSS activities and funds the PC 1 of the Health System Strengthening and Policy Unit has been approved. The HSSPU's coordination role to oversee implementation by various partners i.e WHO, UNICEF and MOH is still evolving and is envisioned to be formalized once the new PC 1 becomes fully operational.

The management has also been enhanced by the presence of a fulltime finance manager housed in the Ministry of Health. The Finance Manager serves as a coordinator between various partners for the GAVI HSS activities.

5.4.2 Monitoring and Evaluation (M&E)

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

M&E of activities was regularly undertaken by the implementing partners i.e WHO and MOH with close coordination between the Lady Health Worker program, MNCH, the Federal HSSPU and provincial HSS units.

For some key activities for example, training of LHWs on routine EPI, well defined coordinated mechanisms were established between WHO, EPI and LHW program for ensuring quality assurance for the training activity. Efforts have been made to focus on outcomes and their impacts on improving health systems and towards improving maternal/child health outcomes.

Some challenges in this process have been inadequate funds allocated for M&E, lack of an integrated M&E system with other ongoing MOH activities, and lack of an institutionalized M&E process.

Future GAVI investments should focus on designating separate budget heads for M&E activities. There should be emphasis on devising in-built M&E processes for GAVI HSS supported activities which are in line with existing monitoring set ups in Pakistan. Validation of M&E information should also be undertaken through external 3rd party evaluations.

5.4.3 Technical Support

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

Priority areas for health system strengthening can be further strengthened through 1) short term skill specific technical assistance i.e health economist, policy reform specialist etc, 2) integrated M&E framework in line with the new National Health Policy 2010, and 3) proposal development for the next phase of GAVI HSS funds As part of the proposal development for the next phase of the GAVI HSS consultations will be undertaken with development partners, private sectors, academia, and national health institutes to define their potential roles in the future.

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

The column on planned expenditure in the coming year should be as per the estimates provided in the APR report of last year (Table 4.6 of last year´s report) or –in the case of first time HSS reporters- as shown in the original HSS application. Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right, documenting when the changes have been endorsed by the HSCC. Any discrepancies between the originally approved application activities / objectives and the planned current implementation plan should also be explained here

Table 13: Planned HSS Activities for 2010

Major Activities	Planned Activity for 2010	Original budget for 2010 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews) PKR Rs in Millions	Revised budget for 2010 (proposed)	2010 actual expenditure as at 30 April 2010	Explanation of differences in activities and budgets from originally approved application or previously approved adjustments
Objective 1:					
Activity 1.1:	Strengthen the drug procurement system by supplementing 30% IMNCI recommended drugs in BHUs	70.425	220.731	0	1st year funding could not be utilized and has been redirected into the 2nd year
Activity 1.3:	Establish neonatal units in 26 (20%) First referral facilities (THQ/DHQ) to strengthen referral	23.4	29.40	0	1styear funding could not be utilized and has been redirected into the 2nd year
Activity 1.6	Computers and equipment for FPIU of LHW program	1	5	0	1styear funding could not be utilized and has been redirected into the 2nd year
Activity 1.19	Training of LHWs on vaccination	129	162.17	0	
Activity 1.20	Training of private sector providers on IMNCI (24 participants each course)	15.897	8.217	0	
Activity 1.21	Training of private sector providers on EmONC (24 participants each course)	15.897	8.217	0	

Objective 2:					
Activity 2.1:					
Activity 2.2:	Training of District health managers including M&E and exposure to district team solving approach methodology	29.994	74.31	0	
Activity 2.3	Training of Zillah monitoring committees on health system management and monitoring	12.150	6.28	0	
Objective 3:					
Activity 3.2	Establish, develop and involve female health volunteers and CSOs in supervision and evaluation for MNCH scaled up services	6	6	0	To be initiated in 2nd year
Activity 3.3:	Community based emerging operational need assessment and gap analysis for 2nd phase of GAVI HSS	6	6	0	To be initiated in the 2nd year
Activity 4.1	Research, survey and assessment	29.306	288.079	0	
TOTAL COSTS					

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

Major Activities	Planned Activity for 2011	Original budget for 2011 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Revised budget for 2011 (proposed)	Explanation of differences in activities and budgets from originally approved application or previously approved adjustments
Objective 1:				
Activity 1.1:				
Activity 1.2:				
Objective 2:				
Activity 2.1:				
Activity 2.2:				
Objective 3:				
Activity 3.1:				
Activity 3.2:				
TOTAL COSTS				

5.5 *Programme implementation for 2009 reporting year*

5.5.1 Please provide a narrative on major accomplishments (especially impacts on health service programs, notably the immunisation program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. Any reprogramming should be highlighted here as well. This should be based on the original proposal that was approved and explain any significant differences – it should also clarify the linkages between activities, output, outcomes and impact indicators.

*This section should act as an executive summary of performance, problems and issues linked to the use of the HSS funds. This is the section where the reporters point the attention of reviewers to **key facts**, what these mean and, if necessary, what can be done to improve future performance of HSS funds.*

Learning from the initial experience of managing GAVI HSS activities, the Ministry of Health (MoH) improved its management systems using the Health System Strengthening and Policy Unit as the main coordinating body to oversee the various GAVI HSS activities by WHO, UNICEF and MoH. Furthermore, by establishing the HSSPU-MOH the technical capacity and expertise within the Ministry of Health and provincial Departments of Health was enhanced within the domains of health financing, monitoring and evaluation, and medical products and technologies, which are critical for proper oversight and strategic planning of the current and future HSS activities. Summarized below are the key GAVI HSS activities including their achievements and outcomes:

The Health System Strengthening and Policy Unit (HSSPU) was created with effect from 15th May 2009 through recruitment of technical staff including experts on Health Systems Reform, Health Financing, Medical Technology and M&E. In addition to placement of technical staff, WHO also provided the necessary logistics and office equipment to the HSSPU. Ministry of Health appointed the Chief Policy Adviser of the HSSPU signifying its ownership for the new initiative.

The unit is envisioned to provide technical and health policy guidance to the MoH through analysis of data from various information sources, operational research, interpretation of programmatic achievements and bottlenecks, and developing mechanisms to enhance the monitoring, supervisory and evaluation role of the MoH. The HSSPU is also coordinating and monitoring the implementation and progress activities carried out through GAVI HSS support. WHO is also assisting the efforts to ensure long term sustainability and institutionalizing of HSSPU as an integral part of the Ministry of Health.

Major accomplishments by the HSSPU include: i) development and costing of the Essential Health Services Package, ii) analysis of National Health Accounts, iii) coordination/secretariat for the National Health Policy 2010, iv) coordinating the Human Resource for Health study, v) facilitating and coordinating the external 3rd party evaluation of PPHI.

The development of the HSSPI PC 1 has now been completed after an extensive consultative process involving all relevant stakeholders at the national and provincial levels. The PC 1 at the cost of Rs 6.5 billion for 5 years (2008 – 2013) is under submission for approval by the competent authority.

Support to MoH and Provincial Health Departments through HSS officers: Five National Program Officers have been recruited by WHO who have played a pivotal role in the implementation of the EPI, Zinc Sulphate, and MIS trainings for Lady Health Workers including IMNCI and EmONC for various cadres of health care providers.

Integration and collaboration towards HSS Implementation: The implementation of GAVI HSS interventions through MoH, WHO and UNICEF has enabled different programs within the Ministry to work together and given an opportunity to development partners to align their strategies and programs within priorities outlined by the MoH.

Capacity building of Lady Health Workers: One of the key objectives of the GAVI HSS project relates to increasing routine EPI coverage through training of LHWs on vaccination. The GAVI project has been critical in jumpstarting this process by providing funding support for training of

20% of LHWs and will be scaled up through the PC 1 for the remaining 100,000 LHWs in the next phase.

Zinc Supplementation: Through GAVI-HSS support, 4.2 million bottles of Zinc Sulphate syrup (20mg/ 5ml in 60 ml bottles), worth Rs.182 million have been supplied to the LHWs program. The activity has been complemented with orientation / training of LHWs on the administration of Zinc Sulphate to children during diarrheal episodes. The addition of Zinc Sulphate along with ORT/ORS is expected to contribute substantially in reducing the childhood mortality and morbidity associated with diarrheal diseases.

LHW MIS Software Training: Ministry of Health additionally entrusted WHO with implementing three other activities under GAVI HSS project (Activity no 2.7, 2.8 and 3.1), which were originally a responsibility of the LHWs Program/

In this context an amount of Rs. 2.5 million has been made available and is near completion in conducting four LHW MIS soft ware training workshops in AJ&K, FATA and FANA..

Procurements: GAVI HSS funding has enabled procurement of critical items such as weighing scales, IMNCI recommended equipment. Furthermore IMNCI recommended medicines and equipment for neonatal units will also be completed in 2010. By purchasing through UNICEF, quality assurance has been assured. However, some challenges exist in terms of defining more efficient custom clearance mechanism, including timely supply and distribution of drugs and commodities to the end user.

5.5.2 Are any Civil Society Organisations involved in the implementation of the HSS proposal? If so, describe their participation? For those pilot countries that have received CSO funding there is a separate questionnaire focusing exclusively on the CSO support after this HSS section.

Yes a number of CSOs are involved in implementing the GAVI HSS activities. For details please review the CSO section.

5.6 *Management of HSS funds*

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

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

Yes a external FMA was conducted in October 2009 (Report attached). The external audit as agreed upon in the Aide Memoir (Feb 2010) is in the process of being finalized in collaboration with the GAVI Secretariat.

In addition, the HSSPU PC 1 is submitted for approval by the competent authority and when approved will allow GAVI HSS funds to be channelled through Government accounts (i.e PSDP) as a condition of the Aide Memoir.

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

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

5.7 *Detailed expenditure of HSS funds during the 2009 calendar year*

Please attach a detailed financial statement for the use of HSS funds during the 2009 calendar year **(Document N° 15a & 15b).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

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

External audit reports for HSS, ISS and CSO-b programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your HSS programme during your government's most recent fiscal year, this should also be attached **(Document N°.....)**. **Not Available**

5.8 *General overview of targets achieved*

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

Table 15: Indicators listed in original application approved

Strategy	Objective	Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target	Current status	Explanation of any reasons for non achievement of targets
		Under five mortality rate (per 1000)	Number of annual deaths among children aged under five years	Total number of children aged under five years	Federal Bureau of Statistics	103	Pakistan Family Planning and Reproductive Health Survey 2001 – 02	2001	<65	2012	94%	
		Infant mortality rate (per 1000)	Number of annual deaths among infants aged under one year	Total number of infants aged under one year	Federal Bureau of Statistics	76	Pakistan Family Planning and Reproductive Health Survey 2001 – 02	2001	<55	2012	78%	
		Proportion of deliveries assisted by Skilled Birth Attendants (%)	Number of annual deliveries assisted by Skilled Birth Attendants	Total number of annual deliveries	Federal Bureau of Statistics	30%	Pakistan Family Planning and Reproductive Health Survey 2001 – 02	2001	50%	2012	39%	
		Contraceptive prevalence rate (%)			Federal Bureau of Statistics	28%	Pakistan Family Planning and Reproductive Health Survey 2001 – 02	2001	45%	2012	30%	
		National DPT3 coverage (%)	Number of infants under one year of age received a valid DPT3 dose annually	Total number of infants under one year of age	MoH	64.5%	EPI coverage – third party evaluation	2006	>85%	2012	66%	
		Number/percentage of districts achieving >80% DPT3	Number of districts having DPT3 coverage more than	Total number of districts in the country	Monthly reports EPI	25%	EPI coverage – third party evaluation	2006	80%	2012	61%	

		coverage	80%		program							

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

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

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

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

Table 16: Trend of values achieved

Name of Indicator *(insert indicators as listed in above table, with one row dedicated to each indicator)*	**2007***	**2008**	**2009**	**Explanation of any reasons for non achievement of targets**
Under five mortality rate (per 1000)	94*			Increasing population growth with limited financial resources and sub-optimal health program out-reach and coverage to those most in need have been the main reasons for non-achievement and slowing of desired targets.
Infant mortality rate (per 1000)	78*			
Proportion of deliveries assisted by Skilled Birth Attendants (%)	39%*			
Contraceptive prevalence rate (%)	30%*			
National DPT3 coverage (%)	66%*			
Number/percentage of districts achieving >80% DPT3 coverage	61%*			

- * Pakistan DHS 2006-07, and PSLM

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

- Lack of reliable and real time mechanisms to bring together information at the national level from all the data collected through various health programs, donor funded initiatives and/or NGO contracted programming.

a. Other sources of funding in pooled mechanism for HSS

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

Table 17: Sources of HSS funds in a pooled mechanism

Donor	**Amount in US$**	**Duration of support**	**Contributing to which objective of GAVI HSS proposal**

2. Strengthened Involvement of Civil Society Organisations (CSOs)

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

This section is to be completed by countries that have received GAVI TYPE A CSO support[5]

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

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

APR— Annual Progress Report
CSO -- Civil Society Organization
EPI— Expanded Programme on Immunization
GAVI— Global Alliance for Vaccine and Immunization
HQ – Head Quarter
INGO – International Non Governmental Organization
IRC – Independent Review Committee
MoH – Ministry of Health
NGO -- Non Governmental Organization
NHSCC – National Health Sector Coordination Committee
PBA – Project Budget Allocation
TT -- Tetanus Toxoid
TWG -- Technical Working Group
UNICEF - United Nations Children Fund
WHO -- World Health Organization
NHSCC - National Health Sector Coordination Committee

i. Mapping exercise

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation. Please describe the mapping exercise, the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed (**Document N**°.....).

Mapping Exercise conducted in 2008. Documented in APR for 2008.

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

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

Documented in APR for 2008.

ii. Nomination process

Please describe progress with processes for nominating CSO representatives to the HSCC (or equivalent) and ICC, and any selection criteria that have been developed. Please indicate the initial number of CSOs represented in the HSCC (or equivalent) and ICC, the current number and the final target. Please state how often CSO representatives attend meetings (% meetings attended).

The CSO Consortium is divided into three geographical clusters. One Cluster Coordinator is nominated to sit on the National Health Sector Coordination Committee (NHSCC) CSO seat. One CSO Cluster Coordinator is to sit on the CSO seat on rotational basis.

This was approved by the Secretary of Health, (MoH) who chairs the NHSCC. The NHSCC meeting held in April 2010 was participated by all the three Coordinators.

Besides, one CSO, part of the GAVI CSO Consortium is already a member of the NHSCC in its own accord.

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

The consortium of CSOs is divided into three different clusters and each cluster has an elected cluster coordinator. These are assigned to achieve the following objectives:

- To support and complement each others' strengths and capacities;
- To compile issues and challenges faced by CSOs in the project implementation;
- To represent Pakistani CSOs at the National and Provincial policy forum;
- To tap international and national donor funding; and
- To explore opportunities as CSO consortium for advocacy opportunities.

To achieve the above mentioned activities, the following are the responsibilities of the cluster coordinators. The cluster coordinators are expected to deliver the agreed tasks and will be accountable to each other for the assigned responsibilities.

CSO Support Team Pakistan (MoH) will be on board with all CSO activities and facilitate communication. It will also provide financial resources to fund all Cluster and Consortium meetings for the one year, till the culmination all activities under GAVI Support. The Coordinators will take turns in hosting the Cluster Coordinators Meeting on bi monthly basis.

Other responsibilities of Cluster Coordinators include:

- Initiate and support linkage building for information sharing amongst the CSOs;
- Information sharing between CSOs and CSO Support Team Pakistan;
- Participate in Bimonthly CSO coordinator's meeting; and

- Organize and facilitate assigned CSOs cluster meeting/exposure visits on quarterly basis.

Terms of Reference for Cluster Coordinators attached in **(Document N° 12)**

Each cluster has nominated a partner CSO to be the Coordinator of that cluster.

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

The CSOs have up till now only attended one NHSCC meeting, however, through this support, CSOs participation at three different levels i.e., federal, provincial and district level has developed and increasing day by day. A change can be seen, as at federal level, CSOs are successful in developing credibility to support Ministry of Health. At provincial level CSOs have developed a good network where they seek support in terms of resource sharing. Whereas the district governments are duly involved by the CSOs in the process by organizing launch ceremonies and through a very close liaison CSOs and district governments are supporting each other. Overall CSO-Govt interaction has helped break ice and build trust and confidence between the two. And there has been a lot of confidence building between the Ministry of Health and the CSOs.

There is a specific team (called as GAVI CSO Support Unit) in place by Ministry of health to look after the GAVI CSO Support Pakistan. This GAVI CSO Support Unit consists of three member CSO Support team including Coordinator, Monitoring & Evaluation officer and Finance & Administration officer.

Cluster meetings on quarterly basis are organize to facilitate the coordination among the CSOs. These cluster meetings are informal where CSOs share challenges and issues and they were overcome (if not how other partner CSOs can facilitate in meeting the challenges). Best practices are also shared among the cluster CSOs. The cluster meetings are attended by different tiers of government health departments.

iii. Receipt and expenditure of CSO Type A funds

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

Funds received during 2009: US$ 83,370
Remaining funds (carried over) from 2008: US$ Nil
Balance to be carried over to 2010: US$ Nil.

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

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

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

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

BHU - Basic Health Unit
CSO -- Civil Society Organization
EmOC – Emergency Obstetric Care
EmONC -- Emergency Obstetric Neonatal Care
FLCF – First Level Care Facility
HSS -- Health System Strengthening
KAP – Knowledge Attitudes & Practices
RHC -- Rural Health Centre
SBA – Skilled Birth Attendant
TWG --Technical Working Group
IRC – Independent Review Committee
NHSCC – National Health System Coordination Committee

i. Programme implementation

Briefly describe progress with the implementation of the planned activities. Please specify how they have supported the implementation of the GAVI HSS proposal or cMYP (refer to your proposal). State the key successes that have been achieved in this period of GAVI Alliance support to CSOs.

The activities with CSOs started in February 2009 when the funds under Type B were transferred from GAVI to UNICEF Pakistan. Proposals of the 15 CSOs were translated into Project Agreements between individual CSO and Ministry of Health. This was a lengthy process involving many stages of revisions and fine tuning. Finally Ministry of Health signed Agreements with eleven CSOs in May 2009. And after many revisions in proposals regarding monitoring and evaluation and budget allocation four CSOs signed Agreements in November 2009.

All CSOs activities support GAVI HSS proposals as the objectives of CSOs are similar to that of HSS. Therefore the outcomes of CSOs objectives and activities are linked with HSS.

One of the foremost successes from the perspective of Government is relationship building between government and CSOs. This relationship can be seen due to increased interaction between the two which has helped in breaking the ice and as a result trust and confidence has been gained of civil society in supporting the Ministry of Health. Successes from CSO perspective could not be measured since the implementation started in the second half of 2009. It is too early to have any concrete results or measure successes within such a short duration of time.

Please indicate any major problems (including delays in implementation), and how these have been overcome. Please also identify the lead organisation responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

[6] Type B GAVI Alliance CSO Support is available to 10 pilot GAVI eligible countries only: Afghanistan, Burundi, Bolivia, DR Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan.

The major problems encountered so far are mentioned below:

- Delay in funds transfer from GAVI to UNICEF (the lead organization for managing the funds) led to cutting down the timeline for completion of activities under GAVI CSO Support from two years to eighteen months since according to GAVI, all activities are to be completed by 31st December 2010 with the end of support. This was further reduced to 14 months for four CSOs who were late in signing agreements as their proposals needed to be revised; and
- Due to the Financial Management Assessment (FMA), followed by delay in signing of Aid Memoire the second tranche of funds for 2010 under GAVI CSO Support Type B are still awaited. The activities of CSOs will therefore be extended till July 2011 without involving any further costs. The extension is foreseen to allow CSOs to complete the agreed activities/tasks so that results could be achieved.

The overall management of the GAVI CSO support funds is through the Federal EPI Cell, Ministry of Health. The Ministry has requested UNICEF Pakistan to be the fund managers for this pilot initiative. Therefore, the GAVI CSO Support funds are channelled through UNICEF Headquarter through a Project Budget Allocation (PBA) to UNICEF country office. On receipt of request from the MoH, funds are released by UNICEF for the activity through a bank to bank transfer to the CSO bank account given in the original Agreement signed with MoH.

National Health Sector Coordination Committee (NHSCC) is a standalone body comprising a variety of partners both government and non-government. Its role and responsibilities include: recommending proposals for GAVI funds to Ministry of Health and Ministry of Finance for approval; periodically monitor utilization of GAVI funds as per the approved proposals and identified indicators; provide technical and administrative support where needed, for timely implementation of the planned activities under GAVI HSS; and examine and approve the progress reports required by GAVI.

Please state whether the GAVI Alliance Type B support to CSOs has resulted in a change in the way that CSOs interact with the Ministry of Health, and or / how CSOs interact with each other.

Change in the way the CSOs interact with the Ministry of Health is visible at different levels. At the Federal level, the civil society in general and the GAVI supported CSOs in particular have been able to establish their credibility with the Ministry of Health through their hard work. At the provincial and districts levels, inviting the Health officials to the CSO launch ceremonies and later on to the Cluster meetings that followed, was instrumental in bridging the gap between the two.

Moreover, letters requesting support were written by the Federal Programme Manager to the provincial Director Generals of Health of all the four provinces and AJK and FANA. The support letters were also copied to provincial programme managers of different government programmes, MNCH, Nutrition, EPI, HIV and AIDS etc. This was a turning point in the CSO Government relationship at the field level. The DGs of Health were informed about the CSOs focus in their particular province and the contact persons representing the CSO. The CSOs were also given copies of the letter.

CSOs meeting at Cluster level have improved CSO relations amongst each other. These meetings are informal and interactive in which CSOs share their challenges and how they were able to overcome them. The cluster meeting are attended by different tiers of government health departments.

Please outline whether the support has led to a change in the level and type of involvement by CSOs in immunisation and health systems strengthening (give the current number of CSOs involved, and the initial number).

15 CSOs are on board to support the Ministry of Health to fill the existing gaps in the health sector including delivery of immunizations, health system strengthening and for mother and child health. All the CSOs placed great efforts to secure cooperation from the relevant government departments. They got commitment from local governments either in verbal or written form. Thus one milestone had been successfully achieved as CSOs have actively involved government departments in executing the activities. The following could be referred as change:

-The government's interest and participation is acknowledged by the CSOs during cluster meetings (conducted at cluster level where local government officials are also present).

-It has been also noted that various government's national programs (like MNCH, EPI, Nutrition, HIV and AIDS etc) has also supported in providing IEC material, training manuals, etc to the CSOs who placed a request. At some places government has helped CSOs in the selection of Union Councils (UC) to cover under this support.

-CSOs have placed health committees at district level to develop a communication between community and government. A number of trainings of public health care providers are a part of CSOs activity chart. CSOs, whether providing vaccination to children (like THF) or creating awareness among communities for vaccination (like CHIP, SABAWON, PAVHNA, etc), are all working for health system strengthening.

-By involving government at different spheres, it has begun to realize the potential of CSOs, level of efforts and skills required to achieve the targets (EPI, MDG 4 & 5), the problems at grass root levels.

Initially 19 CSOs submitted the proposal and out of which 15 CSOs were selected to become the recipient of GAVI fund Type B.

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

Delay in disbursement of funds (18 months from the time of submission of proposals) has made it difficult for CSO to complete their activities within the budget primarily because of inflationary rise.

Please give the names of the CSOs that have been supported so far with GAVI Alliance Type B CSO support and the type of organisation. Please state if were previously involved in immunisation and / or health systems strengthening activities, and their relationship with the Ministry of Health.

For each CSO, please indicate the major activities that have been undertaken, and the outcomes that have been achieved as a result. Please refer to the expected outcomes listed in the proposal.

Table 18: Outcomes of CSOs activities

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

Aga Khan Health Services, Pakistan (AKHSP) AKHSP is a Not for Profit Public Company, limited by guarantee, incorporated under the Companies Ordinance, 1984.	AKHSP's primary health care programs reach vulnerable groups in providing health and survival interventions like prenatal care, aseptic deliveries, Integrated Management of Childhood Illnesses (IMCI), immunization, growth monitoring oral etc. AKHSP has remained in close coordination with the government through TB DOTS strategy and GFATM, EPI and FP services are examples of joint partnership initiative with GoP.	Major tasks initiated or completed include project staff hiring and orientation, launching of project among various stakeholders, data collection from district authorities, Community Based Organization (CBOs) and First Level Care Facilities (FLCF) assessments including initiating Knowledge, Attitude Practice (KAP) survey. AKHSP ensured district government's participation by signing Memorandum of Understanding. Further to this a District Advisory Committee has been formed comprising members from AKHSP, local CBOs and district officials.	AKHSP strengthens its team to expand its coverage as technical resource in the area. Conducted baseline survey of the project district. Secured government cooperation and active participation for the project for health system strengthening.
Aga Khan University (AKU) It is a private, non-profit international university established in 1983.		Frequent visits to the district health officials, sharing with them the ongoing progress reports of the project; Community mobilization and awareness sessions for the community members, and follow-up on the tasks/activities underway; The data collection for measles component is completed, thus the data entry and interim analysis will start; Requisition for procurement of refrigerator and generators as back-up supplies; and Hands-on refresher training session on-site for laboratory technicians at the THQ hospitals.	

All Pakistan's Women Association (APWA) APWA is a non-Government and voluntary organization.	APWA's activities in the areas of women health is focused on addressing maternal neonate infant and child mortality, promote through immunization of mother, children and reproductive health (RH) services in collaboration with Government department and other stakeholders.	Project coordinator including site supervisors for three different project locations have been recruited and trained. Data collected from selected villages about their knowledge attitude practice on MNCH.	Survey of 2000 households of 3 union councils Awareness of women about danger signs of pregnancy
Basic Development Need (BDN)	BDN through government fund, WHO fund, fund by the community and BDN revolving fund have been working in health sector in areas of mother and child health, children immunization, TT coverage of pregnant women, etc.	Project staff has been recruited and oriented about the project goal and objectives. Cluster representatives (one covering 30-50 households) have been selected. And VDCs formation in is process in the selected districts	Better management in BDN at District level through enhancement in existing capacities by recruiting additional staff. Availability of suitable social environment for better mother-child health care and improved EPI Services through broadening the existing setup of volunteers/Village Development Committees (VDCs).

Civil Society Human and Institutional Development Programme (CHIP) During 1993 CHIP registered as an independent, not-for-profit national support organization registered under Section 42 of the Companies ordinance 1984.	CHIP was engaged with Federal Ministry of Health EPI section for conducting training of key personnel of health departments all over Pakistan. The overall objectives of these trainings were to introduce a new way of designing training materials, training trainers at the department level and introducing social mobilization, interpersonal communication and conflict management.	Project staff hired and extensively trained for project implementation. First phase of data collection is already completed where village profiles and maps were formed and community influential and local government individuals were identified. 15 Village Health Committees (VHC), has been formed and a training manual for these VHCs is in process. MoU signed with District Health offices of Skardu and Swabi for possible cooperation between CHIP and District Health Office (DHO). District Health forum organized in Skardu which was participated by health committees and health department. Training Manual for training of skilled birth attendant finalized. 54 women theatre performers mobilized in 20 villages to perform theatre performances.	Hired and trained project staff. Conducted baseline survey. Secures cooperation from district authorities.
Health and Nutrition Development Society (HANDS) Registered as Not-for Profit social organization in 1979.	HANDS is benefiting more than 8 million population of 14,586 villages in 18 districts of Sindh working in close coordination with district governments with focus on women and children health.	HANDS team conducted survey of 28 health care facilities with the support of in charge facility; Conducted KAP survey with the scientific selection of 30 villages of district Matiari and total 210 forms were filled from mothers. HANDS team is working in mutual understanding with district health department for effective mobilization and implementation of the project activities. With the coordination from district health department Matiari and total of 10 vaccinators were selected in 4 UCs.	Baseline survey completed. Cooperation from the district government secured.

Health Education and Literacy Program (HELP) It is a non-government organization registered in 1991.	The organization's focus is on health care of women and children, including reproductive health, family planning and nutrition by forming a link between the Community and the Government Hospitals. Not involved in immunization.	Hiring of project coordinator at field level. Establishment of office at Taluka Nagarparkar with the help of its partner Thardeep Rural Development Program (TRDP). A series of meetings has been conducted with TRDP, EDO Health, in charge BHU Danu Dandhal, BHU Vira Wah, etc; 12 enumerators have been trained for data collection and a baseline of 8,000 household has been completed. Trainings for LHWs and Lady Health Supervisor (LHS) were organized to cover the different topics like counselling skills, antenatal and postnatal care, safe delivery, breast feeding, etc. A three days training of BHU and THQ staff was successfully organized on facility based management of severely malnourished children. Health facilities were equipped with growth and nutrition status assessment tools.	Strengthening of Government health facilities. Capacity Building of 100% health personnel working in Govt. health facilities & community and providing primary preventive & curative healthcare to women & children under 5 years. Increase coverage of population in providing Ante Natal and post Natal Service of the Population by skilled health care providers at health facilities. Reduce maternal mortality.
[7]**Literacy, Information, Family health and Environment (LIFE)** It is a non-government organization.	LIFE works in the areas of general health, nutrition and with specialized focus, in reproductive health, immunization, safe injection safety and HIV/AIDS awareness, through a multifaceted approach.	Project staff has been hired and trained. Meetings with district authorities have been successfully organized to endure participation. Rapid Situational Analysis has been initiated for setting baseline for the project.	Coordination and involvement of district government is secured.
National Rural Support Program (NRSP) NRSP was established in 1991 as a not for profit organization registered under section 42 of companies ordinance 1984.	NRSP has been working under various thematic areas in almost 49 districts of the countries. It works with a philosophy of establishing linkages between communities, government departments, district and union councils for sustainable impact.	NRSP has completed the mapping exercise in all the four districts. IEC material has also been prepared for the awareness sessions. Organized community awareness session on EPI and TT vaccination.	Increase in knowledge about MNH among the communities. Community members organized into groups and have emergency funds with them.

[7] Agreement was signed in the month of November and funds were transferred during December 2009.

Pakistan Voluntary Health and Nutrition Association (PAVHNA) Established in 1979 and registered at federal and provincial level.	Since 1994, PAVHNA has been working in Larkana district on community based reproductive health project for creating awareness. PAVHNA is also running a surgical center at Larkana providing MCH services.	PAVHNA completed rapid situational analysis of both the districts and a report is prepared and ready for printing, the four community based clinics have been established and were fully equipped and made operational for the services to the community, field staff was recruited and trained on this project and six days training of community workers and community mobilizers were organized. The purpose of the workshop was to orient and build capacity of the project and community field staff on MNCH.	Increased demand for RH and MNCH services in the targeted population. Quality RH and MNCH services delivered by PAVHNA community based clinics and surgical centre. Strengthened capacity of community based workers and TBAs. Effective advocacy for RH and MNCH services and referral linkages.
Punjab Rural Support Program (PRSP) PRSP is registered as a company limited by guarantee under Section 42 of the Companies Ordinance 1984.	One of the projects operated by PRSP is The Chief Minister's Initiative for Primary Healthcare (CMIPHC) which is managing 1044 Health Facilities in 12 districts of the Punjab. The CMIPHC is also implementing a project on Reproductive Health and Family Planning in our 12 districts.	Staff nominated and trained on the project goals and objectives. Ensuring cooperation by district governments through meetings with them. Selection of 4 UCs each from the 6 districts.	Coordination, Mobilization and Motivation of District Authorities

Please list the CSOs that have not yet been funded, but are due to receive support in 2010/2011, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

Please also indicate the new activities to be undertaken by those CSOs already supported.

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

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2010 / 2011	Expected outcomes
AKHS - Aga Khan Health Services	Yes	Training/ skills to SBA, LHV and Volunteer and immunization teams and diversification of FLCF staff. Establish Health Committees and strengthen the existing ones to perform monitoring roles.	Increase in Immunization coverage (upto 23 months) Decrease in children with moderate / severe malnutrition (less than 5 yrs) Increase in delivery by Skilled Birth Attendants Increase in TT Coverage (pregnant mothers)

AKU - Aga Khan University	Yes	Establish surveillance capacity for Hib, pneumococcal and rotavirus gastroenteritis at district hospitals Immunization of EPI at the health centres in semi urban slums.	Increase in Immunization coverage (upto 23 months**)**
APWA-All Pakistan Women Association	Yes	Awareness raising and sensitization campaigns/ workshops at community level	Decrease in children with moderate / severe malnutrition (less than 5 yrs) Increase in delivery by Skilled Birth Attendants
BDN - Basic Development Need	Yes	Training of health care providers (doctors, LHVs, medical technicians) on integrated management of childhood illnesses. Strengthening public sector MCH centres through plugging gaps the equipment needed	Increase in Immunization coverage (upto 23 months) Decrease in children with moderate / severe malnutrition (less than 5 yrs) Decrease in low birth weight babies Increase in delivery by Skilled Birth Attendants Increase in TT Coverage (pregnant mothers)
CHIP - Civil Society Human and Institutional development Programme	Yes	Training of community volunteers on conducting awareness raising workshops. Development of IEC material on safe motherhood and child health to be disseminated in schools. Training of LHWs in reporting health related data.	Increase in Immunization coverage (upto 23 months) Increase in delivery by Skilled Birth Attendants Increase in TT Coverage (pregnant mothers)
HANDS – Health and Nutrition Development Society	Yes	Mobilization of community based institutions, capacity building and advocacy. Establishment of complaint centre at district.	Increase in Immunization coverage (upto 23 months) Decrease in children with moderate / severe malnutrition (less than 5 yrs) Decrease in low birth weight babies Increase in delivery by Skilled Birth Attendants Increase in TT Coverage (pregnant mothers)
HELP – Health Education and Literacy Programme	Yes	Increase awareness regarding birth spacing and nutrition amongst married couples.	Increase in Immunization coverage (upto 23 months**)** Decrease in children with moderate / severe malnutrition (less than 5 yrs) Decrease in low birth weight babies Increase in delivery by Skilled Birth Attendants Increase in TT Coverage (pregnant mothers)
LIFE – Literacy/Information in Family Health and Environment	Yes	Advocacy with policy makers on injection safety including its safe disposal.	Increase in Immunization coverage (upto 23 months) Increase in TT Coverage (pregnant mothers)

NRSP – National Rural Support Programme	Yes	Training of TBAs, community members and quakes. Street theatre and other BCC material. Set up free vaccination camps	Awareness sessions on MNCH with religious leaders & councillors. Increase in TT Coverage (pregnant mothers)
PAVHNA – Pakistan Voluntary Health and Nutrition Association	Yes	Establish out reach community based clinics. Provide door to door information on RH. Develop effective referral for safe deliveries and EmOC services.	Increase in Immunization coverage (upto 23 months) Decrease in children with moderate / severe malnutrition (less than 5 yrs) Decrease in low birth weight babies Increase in delivery by Skilled Birth Attendants Increase in TT Coverage (pregnant mothers)

ii. Receipt and expenditure of CSO Type B funds

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

Funds received during 2009:----------**US$: 2,839,314.80**.

Remaining funds (carried over) from 2008-------- US$: **NIL**.

Balance to be carried over to 2010----------**US$: 1,995,221.35.**

iii. Management of GAVI CSO Type B funds

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year ? **YES**

[IF YES] : please complete **Part A** below.
[IF NO] : please complete **Part B** below.

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

GAVI completed Financial Management Assessment (FMA) in 2009. The draft report has been shared with the Ministry of Health, GoP, which has sent feedback on the report. Ministry of Health has given its consent.

Aid Memoire will be sent to the GAVI after receiving the final signatures from the Ministry of Health, still awaited.

The overall management of the GAVI CSO support funds was through the Federal EPI Cell. Ministry of Health, the lead organization for the GAVI CSO Support requested UNICEF Pakistan to be the fund managers for this pilot initiative. Therefore, the GAVI CSO Support funds were channelled through UNICEF Headquarter through a Project Budget Allocation (PBA) to UNICEF country office.

On receipt of request by the National Programme Manager EPI, MoH, (focal person for GAVI CSO Support), funds are released by UNICEF for the activity through a bank to bank transfer from UNICEF to CSO account number given in the Agreement signed with MoH.

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

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

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

Please attach a detailed financial statement for the use of CSO Type B funds during the 2009 calendar year **(Document N° 13).** *(Terms of reference for this financial statement are attached in Annex 4).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

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

Since GAVI CSO Type B funds are not channelled through Ministry of Health, GoP, external audit is not applicable.

v. Monitoring and Evaluation

Please give details of the indicators that are being used to monitor performance; outline progress in the last year (baseline value and current status), and the targets (with dates for achievement).

These indicators will be in the CSO application and reflect the cMYP and / or GAVI HSS proposal.

Table 20: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target
Output level Indicators							
Improving The Quality of MNCH Services	Increase in FLC facilities in target areas equipped to deliver immunization and safe service delivery	**Data Source:** Most of the CSOs had budget of conducting the baselines against the indicators on which they are working. Whereas others CSOs are in the process of compiling baseline figures through other sources. However following are the sources of baseline: ▪ EPI MIS; ▪ Baselines (conducted by CSOs); ▪ Health Management Information System; ▪ CSOs own database; ▪ Community Information Management System; and ▪ Other NGO reports.					
	Increase in number of FLCF, LHVs, LHWs, and SBAs in project area who have equipment to provide basic health and immunization						
	Increase in number of safe deliveries conducted at FLCF/other community health care providers and through outreach services in project area						
	Increase in number of children vaccinated at FLCF/other community health care providers and through outreach services in project area						

Broadening the range of IMNCI and EmONC services	Increase in FLCF in project area that have trained staff	**Baseline Value and Date:** CSOs have collected data from field during the months of November/December 2009. However baseline reports and concrete figures against the indicators are still awaited from CSOs. **Targets:** Target against the indicators would be revised after having baseline figures against the indicators (expected to complete in the month of April 2010). **Date for Target:** All the CSOs will have to achieve the targets till December 2010.
	Increase in number of LHVs, LHWs and TBAs in project area who are trained in social mobilization	
	Increase in number of SBAs in project area who are trained in safe delivery practices	
	Increase in number of teams in project area that are trained for immunization	
Improving Access to Quality Services	Increase in number of mothers in project area with increased knowledge of preparation of ORS	
	Increase in number of mothers in project area who have increased awareness about danger signs of illness in a child under 5 years	
	Increase in number of delivered mothers in project area who have increased awareness about danger signs of pregnancy	
	Increase in number of decision makers related to delivered mothers in project area who have increased awareness about danger signs of pregnancy	
	Increase in number of referrals made for immunization to FLCF/other community health care providers in project area	
	Increase in number of referrals made at Comprehensive EmONC facilities in project area	
	Increase in number of health facilities in project area with functional health committees	
Outcome level Indicators		
	Percentage of fully immunized (up to 23 months)	
	Percentage of TT Coverage of pregnant mothers	
	Percentage of delivery by Skilled birth attendant	
	Percentage of low birth weight babies	
	Percentage of children with moderate and severe malnutrition (less than 5 yrs)	
	Increase in Hepatitis B vaccination of children (5-16 years)	
	Increase in number of mothers vaccinated for Hepatitis B	

Finally, please give details of the mechanisms that are being used to monitor these indicators, including the role of beneficiaries in monitoring the progress of activities, and how often this

occurs. Indicate any problems experienced in measuring the indicators, and any changes proposed.

Following monitoring mechanism to be used by various partners involved in monitoring:

Level	Tools	Frequency
Federal	Reports	Six monthly
Provincial	Reports; Site Visits; FGDs with beneficiaries	Six monthly
District	Reports; Site Visits; Meetings/FGDs with beneficiaries	Six monthly
GAVI Unit	Quarterly reports, site visits, FGDs with beneficiaries	Quarterly
CSOs	Weekly reports, field visits, monitoring visits, through database	Continuous
Cluster	Reports; Site Visits; Meetings/FGDs with beneficiaries	Quarterly
TWG	Reports; Site Visits	Six monthly

The following partners are also responsible for monitoring:

- Ministry of Health, EPI Cell;
- HSS&PU;
- TWG;
- District and provincial governments; and
- Cluster coordinators.

The monitoring mechanism is designed keeping in view the fact that all CSOs are working in different geographical locations and under various thematic areas. Primarily monitoring is done at three different levels: i) Desk monitoring; ii) Field Monitoring; and iii) Telephony/Email Monitoring. The table in below presents the methodology of monitoring:

Table B: Monitoring Framework

Sr. No.	Objectives	Methodology	Level of Monitoring	Frequency
1.	To observe the project implementation strategy	Presentations from Project Coordinators (CSOs)	Field Monitoring	As and when required.
2.	To validate the project activities	Random checking and verification by physical visit	Field Monitoring (quarterly basis)	Quarterly basis
		Checking record keeping in both hard and soft form of project related activities		
		In-Depth interviews with field staff		
		Community visits (to interact with beneficiaries)		
3.	To measure the progress against planned activities	Quarterly report vs. PCA	Desk Monitoring (through quarterly progress reports)	Quarterly basis
4.	To assess the progress of weak performing CSOs (through pick and choose)	Monitoring of critical events	Desk Monitoring and Field Monitoring Telephony/Email Monitoring	As and when required

It has been a challenge for CSOs to acquire data from government sources to develop baseline for the project. In most of the cases the data from government sources is obsolete or is not readily available to the CSOs. Out of 15 CSOs, 9 have conducted baselines to develop value against the set indicators for the projects whereas other CSOs have not conducted any baselines and are heavily relying on other sources of data (government sources, its own database, community information system, other NGO reports, etc.). In cases where there is no set baseline value, measuring the results at outcome level may be difficult..

Another issue is measuring the quality of work as it greatly varies from region to region like in rural areas of Balochistan there is scarcity of human resources and the socio-economic conditions are very tough. Thus expecting high quality of work in Balochistan region may not be justified. On the other side CSOs working in the regions of AJK and Punjab enjoy the supportive environment in terms of highly skilled personnel, civic conditions and better socio-economic condition. As a result the CSOs working in these regions are performing well. Thus quality of work has been greatly varying from region to region and it is judgemental based.

3. Checklist

Table 21: Checklist of a completed APR form

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

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

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

4. Comments

Comments from ICC/HSCC Chairs:

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

~ End ~

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

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

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

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

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

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

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

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS:

An example statement of income & expenditure

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

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

[7] An average rate of CFA 479.11 = USD 1 applied.

[8] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own system for economic classification.

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

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

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

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

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

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

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

MINIMUM REQUIREMENTS FOR HSS FINANCIAL STATEMENTS:

An example statement of income & expenditure

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

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

[9] An average rate of CFA 479.11 = USD 1 applied.

[10] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own HSS proposal objectives/activities and system for economic classification.

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

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

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

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

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

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

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

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

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

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

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

[11] An average rate of CFA 479.11 = USD 1 applied.

[12] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own CSO 'Type B' proposal and system for economic classification.

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