GAVI Alliance

Annual Progress Report 2014

Submitted by

The Government of

Pakistan

Reporting on year: **2014**
Requesting for support year: **2016**
Date of submission: **11/06/2015**

Deadline for submission: 27/05/2015

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

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

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

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

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

Important problems that were encountered and how the country has tried to overcome them

Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners

Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released

How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.

1. Application Specification

Reporting on year: **2014**

Requesting for support year: **2016**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2015
Routine New Vaccines Support	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	2015

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

1.2. Programme extension

Type of Support	Vaccine	Start year	End year
Routine New Vaccines Support	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2016	2018
Routine New Vaccines Support	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	2016	2018

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2014	Request for Approval of	Eligible For 2014 ISS reward
CSO Type B	Yes	CSO Type B extension per GAVI Board Decision in July 2014: N/A	No
COS	Yes	Not applicable	No
HSS	Yes	next tranche of HSS Grant No	No

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2013 is available here.

2. Signatures

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

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

For the Government of Pakistan

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

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Mrs. Saira Afzal Tarar	**Name**	Mr. Arshad Ahmad
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
Dr. Aijaz AHMED KHAN	Director Surveillance & Training, Federal EPI	05192555605	aijazahmadkhan@gmail.com
Dr. Quamrul HASAN	Medical Officer /WHO	03218038643	hasanq@who.int
Dr. Sadia FARRUKH	HEALTH SPECIALIST (EPI), UNICEF	0300 9546516	sfarrukh@unicef.org
Dr. Sabeen AFZAL	Deputy Director (programs),Ministry of NHSR&C	051-9245734	drsabeenafzal@gmail.com
Dr. Farah SABIH	Program Officer , WHO	03444277777	farahsabih95@gmail.com
Ms. Nosheen KHAWAR	Donor Coordination Officer, Federal EPI Cell	03238853069, 051 9255101	nosheenkhawar@hotmail.com

2.2. ICC signatures page

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

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

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Name/Title	Agency/Organization	Signature	Date

Dr. Syed Saqlain Ahmed GILANI	National Programme Manager Federal EPI		

ICC may wish to send informal comments to: apr@gavi.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.3. HSCC signatures page

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

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

Name/Title	Agency/Organization	Signature	Date
Not Applicable	Not Applicable		

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

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

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).

2.4.1. CSO report editors

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

Name/Title	Agency/Organization	Signature	Date

2.4.2. CSO report endorsement

We, the undersigned members of the National Health Sector Coordinating Committee (or equivallent

committees)- , endorse this report on the GAVI Alliance CSO Support.

Name/Title	Agency/Organization	Signature	Date
Dr. Syed Saqlain Ahmed GILANI	National Programme Manager , Federal EPI		

Signature of endorsement does not imply any financial (or legal) commitment on the part of the partner agency or individual.

3. Table of Contents

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

Sections

4. Baseline & annual targets

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

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

Number	Achievements as per JRF		Targets (preferred presentation)							
	2014		2015		2016		2017		2018	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation	Previous estimates in 2014	Current estimation	Previous estimates in 2014	Current estimation
Total births	6,422,105	6,411,268	6,547,664	6,547,664		6,675,758		6,806,441		6,939,767
Total infants' deaths	456,795	493,668	463,612	463,612		470,493		477,440		484,450
Total surviving infants	5965310	5,917,600	6,084,052	6,084,052		6,205,265		6,329,001		6,455,317
Total pregnant women	6,550,547	6,539,493	6,678,617	6,678,617		6,809,273		6,942,570		7,078,562
Number of infants vaccinated (to be vaccinated) with BCG	5,035,557	6,103,509	5,374,925	5,374,925		5,741,152		6,057,732		6,384,586
BCG coverage*[1]*	78 %	95 %	82 %	82 %	0 %	86 %	0 %	89 %	0 %	92 %
Number of infants vaccinated (to be vaccinated) with OPV3	4,055,752	5,349,683	4,410,005	4,410,005		4,778,054		5,126,491		5,487,019
OPV3 coverage*[2]*	68 %	90 %	72 %	72 %	0 %	77 %	0 %	81 %	0 %	85 %
Number of infants vaccinated (to be vaccinated) with DTP1*[3]*	4,831,901	5,818,867	5,049,763	5,049,763		4,778,054		5,126,491		5,487,019
Number of infants vaccinated (to be vaccinated) with DTP3*[3][4]*	4,049,372	5,347,973	4,406,903	4,406,903		4,529,841		5,026,262		5,274,474
DTP3 coverage*[2]*	68 %	90 %	72 %	72 %	0 %	73 %	0 %	79 %	0 %	82 %
Wastage*[5]* rate in base-year and planned thereafter (%) for DTP	5	8	5	5		5		5		5
Wastage*[5]* factor in base-year and planned thereafter for DTP	1.05	1.09	1.05	1.05	1.00	1.05	1.00	1.05	1.00	1.05
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	5,610,149	5,818,867	5,049,763	5,049,763		4,778,054		5,126,491		5,487,019
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	4,701,582	5,347,973	4,406,903	4,406,903		4,529,841		5,026,262		5,274,474
DTP-HepB-Hib coverage*[2]*	79 %	90 %	72 %	72 %	0 %	73 %	0 %	79 %	0 %	82 %
Wastage*[5]* rate in base-year and planned thereafter (%)	5	5	5	5		5		5		5
Wastage*[5]* factor in base-year and planned thereafter (%)	1.05	1.05	1.05	1.05	1	1.05	1	1.05	1	1.05
Maximum wastage rate value for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	0 %	5 %	0 %	5 %	0 %	5 %	0 %	5 %	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Pneumococcal (PCV10)	5,610,149	5,526,253	5,049,763	5,049,763		6,205,265		6,329,001		6,455,317

Number of infants vaccinated (to be vaccinated) with 3rd dose of Pneumococcal (PCV10)	4,708,592	5,072,363	4,406,903	4,406,903		4,529,841		5,026,262		5,274,474
Pneumococcal (PCV10) coverage*[2]*	79 %	86 %	72 %	72 %	0 %	73 %	0 %	79 %	0 %	82 %
Wastage*[5]* rate in base-year and planned thereafter (%)	10	10	10	10		10		10		10
Wastage*[5]* factor in base-year and planned thereafter (%)	1.11	1.11	1.11	1.11	1	1.11	1	1.11	1	1.11
Maximum wastage rate value for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	0 %	10 %	0 %	10 %	0 %	10 %	0 %	10 %	0 %	10 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	3,738,007	5,370,777	4,096,700	4,096,700		4,716,001		5,063,201		5,274,474
Measles coverage*[2]*	63 %	91 %	67 %	67 %	0 %	76 %	0 %	80 %	0 %	82 %
Pregnant women vaccinated with TT+	4,005,343	4,085,014	4,406,903	4,406,903		4,766,491		5,137,502		5,450,493
TT+ coverage*[7]*	61 %	62 %	66 %	66 %	0 %	70 %	0 %	74 %	0 %	77 %
Vit A supplement to mothers within 6 weeks from delivery	0	3,971,122	0	0		0		0		0
Vit A supplement to infants after 6 months	0	0	0	0	N/A	0	N/A	0	N/A	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	16 %	8 %	13 %	13 %	0 %	5 %	0 %	2 %	0 %	4 %

[1] Number of infants vaccinated out of total births

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

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

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

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

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

5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2014 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2014.** The numbers for 2015 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

- Justification for any changes in **births**

  The number of births in 2014 is consistent with JRF 2014 and for the period of 2015 is consistent with cMYP. There is no change.

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

  The number of surviving infants in 2014 is consistent with JRF 2014 and for the period of 2015 is consistent with cMYP. There is no change.

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.** For IPV, supporting documentation must also be provided as an attachment(s) to the APR to justify ANY changes in target population.

  There is no change in target by vaccines except for Pneumococcal (PCV10) vaccine.

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

  Wastage rate of PCV10 is changed from 5% to10% considering the 2 dose/vial without preservative presentation.

5.2. Monitoring the Implementation of GAVI Gender Policy

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

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

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls

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

There are no significant discrepancies in reaching boys versus girls with robust evidence to support data.

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

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

No evidence of Gender related barriers is available .

5.3. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.3a** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 100	Enter the rate only; Please do not enter local currency name

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

Expenditure by category	Expenditure Year 2014	Source of funding						
		Country	GAVI	UNICEF	WHO	JICA	USAID	0
Traditional Vaccines*	14,581,448	12,481,448	0	0	0	2,100,000	0	0
New and underused Vaccines**	8,567,140	7,113,973	51,767	0	0	1,401,400	0	0
Injection supplies (both AD syringes and syringes other than ADs)	1,335,491	1,335,491	0	0	0	0	0	0
Cold Chain equipment	1,027,077	0	0	128,911	0	898,166	0	0
Personnel	1,648,097	342,910	748,912	78,205	355,670	122,400	0	0
Other routine recurrent costs	1,758,900	646,290	588,490	470,773	53,347	0	0	0
Other Capital Costs	277,658	0	254,658	23,000	0	0	0	0
Campaigns costs	2,330,672	0	2,218,377	3,771	108,524	0	0	0
ACSM Activities, Capacity Building (UNICEF)		0	2,590,837	382,002	0	168,696	6,680,483	0
Total Expenditures for Immunisation	31,526,483							
Total Government Health		21,920,112	6,453,041	1,086,662	517,541	4,690,662	6,680,483	0

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

5.4. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2014? **1**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2015 endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.3 Overall Expenditures and Financing for Immunisation

None

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

If Yes, which ones?

List CSO member organisations:
Representative of CSO

5.5. Priority actions in 2015 to 2016

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

Country's main objectives and Priority Actions in 2015

Completion of SIA Measles in 2015 in the remaining provinces and areas.

Completion of introduction of PCV 10 in the remaining provinces and areas.

Introduction of IPV in Routine Immunization.

Endorsement of Effective Vaccine Management -Improvement plans.

Endorsement of Routine Immunization Communication Strategy.

To meet the co-financing obligation for 2014 for releasing Pakistan from default.

To apply for new HSS funding worth of potential USD 100 M for five years.

Development and subsequent approval of Federal and Provincial PC-1s based on cMYP.

Finalizations of financing mechanism and fund flow under NISP.

Post Introduction Evaluation of PCV10 (Completed)

Development of Management Information System for EPI.

End of Project Evaluation of GAVI CSO Grant

Country's main objectives and Priority Actions in 2016

Transition from tOPV to bOPV (tOPV-bOPV switch)

Legacy Planning for Polio assets.

Address inequities in immunization coverage through Reaching Every District, Reaching Every Community approach.c

Completion of successful Implementation of HSS work plan.

Introduction of Rota Virus

Implementation of Effective Vaccine Management -Improvement plans starting from 2016.

Implementation of Communication Strategy starting from 2016.

5.6. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety
Please report what types of syringes are used and the funding sources of Injection Safety material in 2014

Vaccine	Types of syringe used in 2014 routine EPI	Funding sources of 2014
BCG	AD Syringes 0.05ml	Government of Pakistan
Measles	Auto Disable 0.5ml	Government of Pakistan
TT	Auto Disable 0.5ml	Government of Pakistan
DTP-containing vaccine	Auto Disable 0.5ml	Governement of Pakistan and GAVI
IPV	Auto Disable 0.5ml	Government of Pakistan
PCV10	Auto Diable 0.5ml	Government of Pakistan and GAVI

Does the country have an injection safety policy/plan? **Yes**
If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?

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

No obstacles found during the implementation of the injection safety policy.

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

- Sharp waste is collected in Safety Boxes which are later disposed off by burn and bury method.
- The main problem in sharp waste disposal is non adherence to the waste disposal guidance by some of the vaccinators.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2014

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

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

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

6.3. Request for ISS reward

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

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

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

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

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

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

	[A]	[B]	[C]	
Vaccine type	**Total doses for 2014 in Decision Letter**	**Total doses received by 31 December 2014**	**Total doses postponed from previous years and received in 2014**	**Did the country experience any stockouts at any level in 2014?**
Pneumococcal (PCV10)	20,254,700	18,772,200	0	No
DTP-HepB-Hib	13,648,900	13,655,596	2,595,696	No

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

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

  As per the decision letter attached for NVS, dated 15 October 2013 the Total doses for PCV 10 are 18,772,200 which are wrongly reflected in column A. Similarly the total doses for Penta for 2014 were approved as 11,059,900 again wrongly reflected in column A.

  Thus there is no difference between the allocated number of doses as per decision letter and the Total Doses actually received during 2014.

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

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

  Improvement plan based on EVM Assessment 2014 is being developed.

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

There was one month stock out of BCG and stock out between Sept. and Dec. 2014 of TT vaccines at both the central and regional level due to the complicated tendering process of Government. Though there was no major impact of the stock out faced.

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7.2. Introduction of a New Vaccine in 2014

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

DTP-HepB-Hib, 1 dose(s) per vial, LIQUID		
Nationwide introduction	No	
Phased introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	

When is the Post Introduction Evaluation (PIE) planned? **March 2015**

Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID		
Nationwide introduction	No	
Phased introduction	Yes	
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	Punjab: Launched in Oct '12 AJK: Launched in Feb '13 Sindh: Launched in May '13 Islamabad: Launched in May '13 KP: Launched in Oct '13 Balochistan: Launched in May '14 GB: Launched in November '14 FATA: Planned to launch in May '15

When is the Post Introduction Evaluation (PIE) planned? **March 2015**

7.2.2. If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9))

PIE for PCV 10 has been conducted in March 2015, report shall be furnished when available.

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **No**

Is there a national AEFI expert review committee? **No**

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

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

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

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

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

Does your country conduct special studies around:

a. rotavirus diarrhea? **No**

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

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **No**

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

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

N/A

7.3. New Vaccine Introduction Grant lump sums 2014

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2014 (A)	0	0
Remaining funds (carry over) from 2013 (B)	559,321	55,932,100
Total funds available in 2014 (C=A+B)	559,321	55,932,100
Total Expenditures in 2014 (D)	51,767	5,176,700
Balance carried over to 2015 (E=C-D)	507,554	50,755,400

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

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2014 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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

Trainings were conducted at Regional ,Provincial and District level

Vaccination cards were modified were including PC10 in the list of the vaccines.

Reporting forms and guidelines on PCV10 introduction were disseminated.

Communication and social mobilization activities were conducted

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

N/A

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

PIE for PCV10
Printing and distribution of vaccination cards
Training of health workers

7.4. Report on country co-financing in 2014

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2014?

Co-Financed Payments	Total Amount in US$	Total Amount in Doses
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	8,369,799	2,589,000
Awarded Vaccine #2: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	5,920,428	1,482,500
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2014 from the following sources?	
Government	Government (Pending payments under process)	
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	158,744	2,672,200
Awarded Vaccine #2: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	75,384	1,482,000
	Q.4: When do you intend to transfer funds for co-financing in 2016 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2016	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	September	
Awarded Vaccine #2: Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	September	
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	No there are no such needs.	

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

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **No**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at
http://www.who.int/immunization/programmes_systems/supply_chain/evm/en/index3.html

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

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **April 2014**

Please attach:

(a) EVM assessment **(Document No 12)**

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

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

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

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

If yes, provide details

EVM Improvement Plan being developed in April 2015 and is being finalized .

When is the next Effective Vaccine Management (EVM) assessment planned? **July 2017**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2014

Pakistan does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

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

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2015

If 2015 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 2016 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby requests an extension of GAVI support for the years 2016 to 2018 for the following vaccines:

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**
* **Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID**

At the same time it commits itself to co-finance the procurement of the following vaccines in accordance with the minimum Gavi co-financing levels as summarised in section 7.11 Calculation of requirements.

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**
* **Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID**

The multi-year support extension is in line with the new cMYP for the years 2016 to 2018, which is attached to this APR (Document N°**16**). The new costing tool is also attached (Document N°**17**) for the following vaccines:

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**
* **Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID**

The country ICC has endorsed this request for extended support of the following vaccines at the ICC meeting whose minutes are attached to this APR. (Document N°**18**)

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**
* **Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID**

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

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

Confirm here below that your request for 2016 vaccines support is as per 7.11 Calculation of requirements

Yes

If you don't confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigen	Vaccine Type	2011	2012	2013	2014	2015	2016	2017
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID				3.40 %	3.50 %	3.60 %	4.40 %
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID				4.40 %	4.50 %	4.40 %	4.50 %

Vaccine Antigen	Vaccine Type	2018
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	4.40 %
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	4.60 %

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID

ID		Source		2014	2015	2016	2017	2018	TOTAL
	Number of surviving infants	Parameter	#	5,965,310	6,084,052	6,205,265	6,329,001	6,455,317	31,038,945
	Number of children to be vaccinated with the first dose	Parameter	#	5,610,149	5,049,763	4,778,054	5,126,491	5,487,019	26,051,476
	Number of children to be vaccinated with the third dose	Parameter	#	4,701,582	4,406,903	4,529,841	5,026,262	5,274,474	23,939,062
	Immunisation coverage with the third dose	Parameter	%	78.82 %	72.43 %	73.00 %	79.42 %	81.71 %	
	Number of doses per child	Parameter	#	3	3	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.05	1.05	1.05	1.05	1.05	
	Stock in Central Store Dec 31, 2014		#	11,155,291					
	Stock across second level Dec 31, 2014 (if available)*		#	0					
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#	0					
	Number of doses per vial	Parameter	#		1	1	1	1	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.46	0.52	0.60	0.69	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	0	0	

cs	Safety box price per unit	Parameter	$		0.0054	0.0054	0.0054	0.0054	
fv	Freight cost as % of vaccines value	Parameter	%		3.50 %	3.60 %	4.40 %	4.40 %	

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

There is no Difference.

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

Not defined

Co-financing tables for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID

Co-financing group	Intermediate

	2014	2015	2016	2017	2018
Minimum co-financing	0.40	0.46	0.52	0.60	0.69
Recommended co-financing as per			0.52	0.60	0.69
Your co-financing	0.40	0.46	0.52	0.60	0.69

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

		2014	2015	2016	2017	2018
Number of vaccine doses	#	11,059,900	8,843,400	9,144,000	13,718,000	13,231,500
Number of AD syringes	#	11,415,800	9,121,400	9,498,800	14,567,200	14,050,600
Number of re-constitution syringes	#	0	0	0	0	0
Number of safety boxes	#	126,750	100,375	100,600	150,900	145,550
Total value to be co-financed by GAVI	$	23,323,500	18,002,000	17,449,500	21,864,000	21,088,500

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

		2014	2015	2016	2017	2018
Number of vaccine doses	#	2,589,000	2,581,900	3,425,000	8,282,200	10,101,600
Number of AD syringes	#	2,672,200	2,663,000	3,557,900	8,794,900	10,726,900
Number of re-constitution syringes	#	0	0	0	0	0
Number of safety boxes	#	29,675	29,300	37,675	91,125	111,125
Total value to be co-financed by the Country *[1]*	$	5,460,000	5,256,000	6,536,000	13,200,500	16,100,000

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

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-finance**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	5,610,149	5,049,763		
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	4,701,582	5,049,763		

C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	15,549,368	14,242,857		
E	**Estimated vaccine wastage factor**	*Table 4*	1.05	1.05		
F	**Number of doses needed including wastage**	*D x E*		14,955,000		
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*				
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*				
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	7,639,415	11,155,291		
H3	**Shipment plan**	*Approved volume*		11,425,300		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		11,425,300		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*				
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*				
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*				
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*				
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*				
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*				
T	**Total fund needed**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / T*				

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

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 2)

		Formula	2014		
			Total	**Government**	**GAVI**
A	**Country co-finance**	*V*			
B	**Number of children to be vaccinated with the first dose**	*Table 4*	4,778,054	1,301,997	3,476,057
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	4,529,841	1,234,360	3,295,481
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		

D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	13,984,182	3,810,623	10,173,559
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D X E*	14,683,391	4,001,154	10,682,237
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*	- 97,002	- 26,432	- 70,570
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*	2,017,468	549,751	1,467,717
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*	7,625,592	2,077,938	5,547,654
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*Approved volume*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	12,568,950	3,424,979	9,143,971
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	13,056,684	3,557,884	9,498,800
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	138,259	37,675	100,584
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	22,586,404	6,154,687	16,431,717
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	584,940	159,394	425,546
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	753	206	547
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	813,111	221,569	591,542
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	23,985,208	6,535,854	17,449,354
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	6,535,854		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	27.25 %		

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

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 3)

		Formula	2017		
			Total	**Government**	**GAVI**
A	**Country co-finance**	*V*	37.65 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	5,126,491	1,929,916	3,196,575
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	5,026,262	1,892,184	3,134,078
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	15,238,151	5,736,546	9,501,605
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D X E*	16,000,058	6,023,373	9,976,685
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted***	6,000,022	2,258,765	3,741,257

		Buffer on doses needed *= (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*			
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*			
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*			
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*Approved volume*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	22,000,100	8,282,146	13,717,954
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	23,361,991	8,794,842	14,567,149
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	242,002	91,104	150,898
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	32,582,149	12,265,858	20,316,291
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	1,046,618	394,010	652,608
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	1,317	496	821
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	1,433,615	539,698	893,917
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	35,063,699	13,200,060	21,863,639
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	13,200,060		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	37.65 %		

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

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 4)

		Formula	2018		
			Total	**Government**	**GAVI**
A	**Country co-finance**	*V*	43.29 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	5,487,019	2,375,487	3,111,532
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	5,274,474	2,283,470	2,991,004
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	16,161,369	6,996,715	9,164,654
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D X E*	16,969,437	7,346,551	9,622,886
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted*** *=* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375*	6,363,540	2,754,957	3,608,583

		• *<u>else:</u> (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*			
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*			
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*			
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*Approved volume*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	23,333,000	10,101,518	13,231,482
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	24,777,400	10,726,840	14,050,560
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	256,664	111,118	145,546
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	34,556,173	14,960,348	19,595,825
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	1,110,028	480,563	629,465
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	1,397	605	792
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	1,520,472	658,256	862,216
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	37,188,070	16,099,770	21,088,300
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	16,099,770		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	43.29 %		

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

Table 7.11.1: Specifications for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID

ID		Source		2014	2015	2016	2017	2018	TOTAL
	Number of surviving infants	Parameter	#	5,965,310	6,084,052	6,205,265	6,329,001	6,455,317	31,038,945
	Number of children to be vaccinated with the first dose	Parameter	#	5,610,149	5,049,763	6,205,265	6,329,001	6,455,317	29,649,495
	Number of children to be vaccinated with the third dose	Parameter	#	4,708,592	4,406,903	4,529,841	5,026,262	5,274,474	23,946,072
	Immunisation coverage with the third dose	Parameter	%	78.93 %	72.43 %	73.00 %	79.42 %	81.71 %	
	Number of doses per child	Parameter	#	3	3	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.11	1.11	1.11	1.11	1.11	
	Stock in Central Store Dec 31, 2014		#	8,273,390					
	Stock across second level Dec 31, 2014 (if available)*		#	0					
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#	0					
	Number of doses per vial	Parameter	#		2	2	2	2	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.35	0.35	0.40	0.46	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	0	0	
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	0.0054	0.0054	
fv	**Freight cost as % of vaccines value**	Parameter	%		4.50 %	4.40 %	4.50 %	4.60 %	

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

There is no difference.

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

Co-financing group	Intermediate

	2014	2015	2016	2017	2018
Minimum co-financing	0.26	0.30	0.35	0.40	0.46
Recommended co-financing as per			0.35	0.40	0.46
Your co-financing	0.26	0.35	0.35	0.40	0.46

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID (part 1)

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-finance**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	5,610,149	5,049,763		
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B x C*	16,830,447	15,149,289		
E	**Estimated vaccine wastage factor**	*Table 4*	1.11	1.11		
F	**Number of doses needed including wastage**	*D x E*		16,815,711		
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*				
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	3,097,600	8,273,390		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		12,091,600		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*				
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*				
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*				
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*				
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*				
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*				
T	**Total fund needed**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / T*				

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID (part 2)

		Formula	2016		
			Total	Government	GAVI
A	**Country co-finance**	*V*	9.80 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	6,205,265	608,322	5,596,943
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B x C*	18,615,795	1,824,964	16,790,831
E	**Estimated vaccine wastage factor**	*Table 4*	1.11		
F	**Number of doses needed including wastage**	*D x E*	20,663,533	2,025,711	18,637,822
G	**Vaccines buffer stock**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*	961,956	94,304	867,652
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*	4,069,463	398,943	3,670,520
H2	**Reported stock on January 1st**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	17,556,400	1,721,109	15,835,291
J	**Number of doses per vial**	*Vaccine Parameter*	2		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	17,059,117	1,672,358	15,386,759
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	193,121	18,933	174,188
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	59,305,520	5,813,904	53,491,616
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	764,249	74,922	689,327
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	1,051	104	947
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	2,609,443	255,812	2,353,631
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	62,680,263	6,144,740	56,535,523
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	6,144,740		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	9.80 %		

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID (part 3)

		Formula	2017		
			Total	Government	GAVI
A	**Country co-finance**	*V*	11.37 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	6,329,001	719,423	5,609,578
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B x C*	18,987,003	2,158,267	16,828,736
E	**Estimated vaccine wastage factor**	*Table 4*	1.11		
F	**Number of doses needed including wastage**	*D x E*	21,075,574	2,395,677	18,679,897
G	**Vaccines buffer stock**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** = *(F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*	4,756,959	540,728	4,216,231
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*			
H2	**Reported stock on January 1st**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	25,832,800	2,936,434	22,896,366
J	**Number of doses per vial**	*Vaccine Parameter*	2		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	26,118,359	2,968,894	23,149,465
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	284,161	32,301	251,860
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	85,868,228	9,760,706	76,107,522
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	1,170,103	133,007	1,037,096
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	1,546	176	1,370
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	3,864,071	439,232	3,424,839
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	90,903,948	10,333,120	80,570,828
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	10,333,120		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	11.37 %		

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID (part 4)

		Formula	2018		
			Total	Government	GAVI
A	**Country co-finance**	*V*	13.27 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	6,455,317	856,792	5,598,525
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B x C*	19,365,951	2,570,374	16,795,577
E	**Estimated vaccine wastage factor**	*Table 4*	1.11		
F	**Number of doses needed including wastage**	*D x E*	21,496,206	2,853,115	18,643,091
G	**Vaccines buffer stock**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** = *(F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*	4,851,909	643,977	4,207,932
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*			
H2	**Reported stock on January 1st**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	26,348,400	3,497,130	22,851,270
J	**Number of doses per vial**	*Vaccine Parameter*	2		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	26,639,647	3,535,786	23,103,861
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	289,833	38,469	251,364
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	86,159,268	11,435,614	74,723,654
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	1,193,457	158,404	1,035,053
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	1,577	210	1,367
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	3,963,327	526,039	3,437,288
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	91,317,629	12,120,264	79,197,365
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	12,120,264		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	13.27 %		

8. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2014**. All countries are expected to report on:

   a. Progress achieved in 2014

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

   c. Plans for 2016

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

For countries that received HSS funds within the last 3 months of 2014, or experienced other delays that limited implementation in 2014, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2014 fiscal year starts in January 2014 and ends in December 2014, HSS reports should be received by the GAVI Alliance before **15th May 2015**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2015, the HSS reports are expected by GAVI Alliance by September 2015.

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

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavi.org.

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

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

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

   a. Minutes of all the HSCC meetings held in 2014

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

   c. Latest Health Sector Review Report

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

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

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

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

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

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

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

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

For countries that have previously received the final disbursement of all GAVI approved funds for the HSS grant and have no further funds to request: Is the implementation of the HSS grant completed ? **Not selected**

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

There are two HSS grants currently under implementation;<?xml:namespace prefix = "o" />

The balance of approximately US$3.48 m (PKR 3.48 m) of the first tranche, which was awaiting approval of PC 1.The Ministry of National Health Services & Regulations with concurrence ofthe Ministry of P, D& R and the provincial governments had proposed resolution of the issue and utilization through WHO on 2nd & 11th Feb, 2015respectively which was formally approved by the Gavi secretariat on 5th March,2015 for utilization by 30th June 2016 (Annex 1).

The second tranche of US$ 6.626 m is under implementation through Gavi Alliance partners, WHO & UNICEF (Partners' Work plan) with different timelines as follows:

WHO activities will end by 31st March 2016 (US$ 3.281)

UNICEF activities will end by 31st July, 2015 (US$ 3.34)

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

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

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

Under GAVI Business Plan 2013-14, Gavi is contributing towards the Strategic Goal 2 of GAVI aims to ensure that health system strengthening efforts lead to improved immunization outcomes, specially reduce inequities in coverage. Under the Programme Objective 2.2.1 of GAVI Business Plan, Pakistan is one of the ten countries where UNICEF aims to enhance the equity in routine immunization hence contributing to health system strengthening efforts with improved immunization outcomes. GAVI provided funds for the technical support to introduce and support methodologies to identify main drivers of inequities shifting the focus beyond national level planning for 'Reaching Every District / Reaching Every Community' (RED/ REC) approach. <?xml:namespace prefix = "o" />

The main objective was to identify the key drivers of inequities in immunization for which desk review was undertaken using the latest available survey data including the Pakistan Demographic Health Survey (PDHS 2012-13), Pakistan Social Living Standard Measurement Survey (PSLM 2010-11), System indicators, Child well-being indicators, EPI reviews, annual progress reports, plan of actions for EPI for the previous years and the reported data to look at the national and subnational level of inequities in immunization. Furthermore, Polio high risk districts were also taken into account as a proxy indicator for weak Routine Immunization (RI).

Based on the analysis, the Country Office undertook the situation analysis of the key drivers of immunization inequities and selected ten districts of Pakistan (two from each of the four provinces in addition to the Azad Jammu Kashmir (AJK). Out of ten pilot districts, six are overlapped with Polio high risk districts where PEI-EPI convergence has taken place. Equity Improvement plan was developed and implementation of EIP using RED approach was kicked off initially in two districts of Punjab followed by expansion into three more districts of Punjab during last quarter of 2014. In last quarter of 2014, following the completion of assessment of RED districts, UNICEF carried out three days desk review of RED approach and based on the findings of the review and assessment of RED districts; it was decided to start afresh by taking Reaching Every Community approach that puts the focus on the Health Centre and community working together to improve the immunization services for children in the most disadvantaged communities.

The report of the ten districts is attached as annex

Please refer to the PDHS 2012-13 and PSLM 2010-11 for access to the requisite information on the following

link:

http://www.nips.org.pk/abstract_files/PDHS%20Final%20Report%20as%20of%20Jan%2022-2014.pdf

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

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

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

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

Please complete Table 8.1.3.a and 8.1.3.b (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 8.1.3.a and 8.1.3.b.

8.1.2. Please indicate if you are requesting a new tranche of funding **No**

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

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

Table 8.1.3a (US)$

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	6626000	0
Remaining funds (carry over) from previous year (*B*)	12579621	4162591	4063838	3869686	3869686	10486194
Total Funds available during the calendar year (*C=A+B*)	12579621	4162591	4063838	3869686	10495686	10486194
Total expenditure during the calendar year (*D*)	8417030	98753	194152	0	9492	140272
Balance carried forward to next calendar year (*E=C-D*)	4162591	4063838	3869686	3869686	10486194	10345922
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	6626000	6626000	6626000	6626000	0	0

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	0			

Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0			
Total funds received from GAVI during the calendar year (*A*)	0			
Remaining funds (carry over) from previous year (*B*)	10345922			
Total Funds available during the calendar year (*C=A+B*)	10345922			
Total expenditure during the calendar year (*D*)	2608010			
Balance carried forward to next calendar year (*E=C-D*)	7737912			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Table 8.1.3b (Local currency)

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	646697600	0
Remaining funds (carry over) from previous year (*B*)	995362512	349797507	348909346	348252779	377681354	1104720538
Total Funds available during the calendar year (*C=A+B*)	995362512	349797507	348909346	348252779	1024378954	1104720538
Total expenditure during the calendar year (*D*)	665997499	8298570	16669328	0	926419	14777655
Balance carried forward to next calendar year (*E=C-D*)	329365013	341498937	332240018	348252779	1023452534	1089942883
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)	1039972079			
Total Funds available during the calendar year (*C=A+B*)	1039972079			
Total expenditure during the calendar year (*D*)	262157165			
Balance carried forward to next calendar year (*E=C-D*)	777814914			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Report of Exchange Rate Fluctuation

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

Table 8.1.3.c

Exchange Rate	2009	2010	2011	2012	2013	2014
Opening on 1 January	79.125	84.0336	85.8571	89.9951	97.6	105.35
Closing on 31 December	84.0336	85.8571	89.9951	90.8822	105.65	101.09

Detailed expenditure of HSS funds during the 2014 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2014 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2015 period are reported in Tables 8.1.3a and 8.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Has an external audit been conducted? Yes

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

8.2. Progress on HSS activities in the 2014 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 8.2. It is very important to be precise about the extent of progress and use the M&E framework in your original

application and approval letter.

Please provide the following information for each planned activity:

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

Table 8.2: HSS activities in the 2014 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Activity1.1: Improved Monitoring & Evaluation of Immunization Data (Validation, Consistency, Accuracy & Capacity Building)	Workshops in Statistical Analysis and Use of Information for EPI Program Management	100	WHO and UNICEF Updates
	Identification & Defining New Data and integration Needs for DHIS	40	WHO and UNICEF Updates
	Feasibility & Development of IT based Software for Integrated MIS for all Diseases	50	WHO and UNICEF Updates
	Comprehensive Review of EPI Data Collection, Consolidation and Use including Quality Audit, Consistency and Integration with DHIS	30	WHO and UNICEF Updates
	Computer Hardware and IT Network for District Data Managers	70	WHO and UNICEF Updates
Activity1.2: Support for improving effective use of vaccines	Conduct Effective Vaccine Management (EVM) Assessment to Improve Vaccine Management Practices	100	WHO and UNICEF Updates
Activity1.3: Technical Support For HSRUs/ PSPU (Digitalization of EPI data and pay for performance)	Piloting of vaccine registry and pay for performance in District Hafizabad (Punjab)	50	WHO and UNICEF Updates
Activity1.6: Standard System for Vaccine Management (Strengthening of VLMIS & Implementation of Integrated Logistic Support System LSS/ LMIS)	Upscaling VLMIS/LSS	20	WHO and UNICEF Updates
	Software and Hard Ware Support for Vaccine and Logistics Management for PHC Level	80	WHO and UNICEF Updates
M& E Capacity Building & Training on Integrated MIS Software	Capacity Building of Health Care Providers on IT based Software for Integrated MIS for all Diseases	10	WHO and UNICEF Updates
Activity1.6: Strengthening/ Establishment of Warehouses & Cold Storage	Repeated consultative meeting with UNICEF came up with the final need of establishing new warehouses and strengthening existing ones. UNICEF CO with the support of the supply section has initiated the process of implementation and so far	60	WHO and UNICEF Updates

	received the request for 22 warehouses combination of new construction and renovations. A total of 08 warehouses for Baluchistan, 08 for KPK (mostly renovations), 02 in GB (Gilgit and Skardu), 01 in AJK Muzzafarabad and 02 state of art warehouses for Punjab in Lahore and Multan and 01 in Sindh province. The construction and renovations of the requested warehouses is at variable stages.		
Activity2.1: Introduction of Hepatitis B Birth Dose for Immunization	Of the four provinces, only KP has introduced the birth dose of Hepatitis B in September 2013 and has a clear strategy in place to implement this activity. Introduction of birth dose of Hepatitis B was endorsed by NITAG on 1 February 2011 and is part of the draft EPI policy developed in 2011 and updated in 2013. UNICEF is in close consultation with the federal and provincial counterparts and WHO finalized the planning of the introduction of birth dose of Hepatitis B in a total of nine secondary health care facilities (02 in Punjab, 04 in Sindh, 03 in KPK) on pilot basis. Based on the number of births occurring in these health facilities in one year; requisite quantity of Hepatitis B birth dose procured by UNICEF. Furthermore the NNCUs were strengthened across three provinces. The training of HCP on the introduction of birth dose of Hepatitis B and initiation of vaccination planned for Q-1 of 2015..	65	UNICEF progress report and Inception meetings
Activity2.2: Up-scaling Training of LHWs in Routine EPI	District Level Trainings (DSAs Facilitator and Participants, Stationery)	50	WHO and UNICEF Updates
	Facility Level Trainings (DSAs Facilitator and Participants, Stationery)	20	WHO and UNICEF Updates
Activity2.3: Development of Modalities between LHWs/CMWs and Vaccinators for Integrated MNCH and EPI Service Delivery at the Community Level	Development of Modalities between LHWs/CMWs and Vaccinators for Integrated MNCH and EPI Service Delivery at the Community Level	30	WHO and UNICEF Updates
Activity2.4: Capacity Assessment for MCH Service Delivery including EPI	Capacity Assessment for MCH Service Delivery including EPI	30	WHO and UNICEF Updates
Activity2.5: Operational Cost Monitoring & Evaluation	Hiring for Work plan Implementation (Program Support Staff at Federal and Provincial level)	90	WHO and UNICEF Updates

	External audit of cash based GAVI grants (ISS and HSS)	70	WHO and UNICEF Updates
	Printing of Training Materials & Guidelines	100	WHO and UNICEF Updates
	Periodic Planning, Coordination & Review Meetings	70	WHO and UNICEF Updates
	Operational Cost (M&E, Per-diem and Travel Cost of Staff)		WHO and UNICEF Updates
Demand Generation and Creating Awareness for Routine EPI Activities through CSOs/ and Community involvement	A CSO named JSCD is working in hard-to-reach 12 Union Councils of district Rajanpur, a district of South Punjab with one of the poorest indicators of maternal and child health portraying a grim picture of inadequate and inaccessible healthcare system and poor health indicators along with high level of in equities in access and coverage of immunization and weak demand for the services. This work was completed in 2014 and was reported in last year's APR as well.	100	UNICEF quarterly report

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

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
Improved Monitoring & Evaluation of Immunization	
1. Workshops in Statistical Analysis and Use of In	Three Workshops conducted for Punjab & KPK, Sindh & Balochsitan and AJK
2. Identification & Defining New Data and Integrat	Study on 'Review of Current IT Structures in Health for an Integrated Platform' completed (Annex 2)
3. Feasibility & Development of IT based Software	1. Consultative Workshop on 'Integration of Health Information & Disease Surveillance Systems' held on 14-15 Oct, 2014 in Lahore with specific recommendation made for the following areas: i. Integrated MIS ii. Inclusion of New Indicators i.e. NCD, Hepatitis, Health Education etc. iii. Integration of Dashboard on Disease Surveillance; and Integrated e Monitoring (Annex 3) 2. Provincial core committee on integration of HIS and Disease surveillance system notified with specific TORs (Annex 4) 3. Work plan for development of Integrated Health information and Disease Surveillance system finalized in consensus with relevant stakeholders (PSPU, DoH, TRF +) (Annex5) 4. TORs for "Context Analysis for Development of integrated Health Information & Disease Surveillance System" developed.(Annex 6) and submitted to the regional office for approval.
4. Computer Hardware and IT Network for District D	Procurement completed with supply of IT equipment to support timely data reporting from the districts.
Review and Finalization of Strategy for Appropriat	
1. Conduct Effective Vaccine Management (EVM) Asse	Consultations have been concluded for development of an improvement plan based on the evidence generated through EVM Assessment last year.
Technical Support For HSRUs/ PSPU (Digitalization	APW for Piloting of vaccine registry and pay for performance in District Hafizabad (Punjab) approved.(annex7)
Standard System for Vaccine Management (Strengthen	
1. Upscaling VLMIS/LSS	Negotiations are going on with Federal EPI for identification of specific support for VLMIS in terms of strengthening and refresher

	trainings in the districts where VLMIS has already been implemented
2. Software and Hard Ware Support for Vaccine and	Procurement completed with provision of IT equipment (38 Desktop Monitor & Printers, 14 Laptops, 6 UPS, 2) to the Provincial Departments of Health.
Strengthening/ Establishment of Warehouses & Cold	The construction /renovation of the warehouse is underway. One of the major achievement is that all the steps mentioned below are undertaken to ensure cost efficiency, transparency and quality of the work committed under this project. 1) Need assessments undertaken jointly by UNICEF and the Department of Health (DoH) at the federal and provincial levels. 2) Design and layout contracted to a construction consultancy firm. 3) Joint site inspection by UNICEF and consultancy firm. 4) Finalization of the design and approval by DoH. 5) Preparation of Bills of Quantities (BoQs). 6) Open bidding process for the construction activities. 7) Quality assurance and risk mitigation by undertaking site supervision and monitoring payment process which is then submitted to the Construction Unit of UNICEF's Supply Division in Copenhagen for their review, advice and authorization for local construction. Tender is initiated by the UNICEF Pakistan Supply section, it is evaluated by the consultant, a qualified civil engineer based in the Country Office and award of contract granted subject to the vetting and approval of the UNICEF Contract Review Committee (CRC). 8) Monitoring of the entire construction process by the Civil Engineer hired by the construction consultancy firm. This is a time taking activity that needs higher level of monitoring and quality assurance. Major challenge was the delayed concurrence of the Health department of KPK. Although the consensus to go with the construction of new and renovation of the existing warehouses was given in q-1 2014 yet after the death of 04 children due to AEFI during Measles SIA in May 2014; the entire management of EPI was changed and the entire EPI work plan came to a halt. It was only in March 2015, that after persistent advocacy missions to Peshawar that Government requested UNICEF for the construction/ renovation of the 08 warehouses. Second challenge was to predict the exact cost of the warehouse and funds utilization as for all the warehouses open bidding process was undertaken following UNICEF's procedure which is again a time taking process. Third challenge is that all the warehouses are at different stages of construction and since the grant is concluding by the end of July 2015; the remaining funds will be committed as the construction is expected to complete in August 2015.
Introduction of Hepatitis B Birth Dose for Improve	This activity is a pilot introduction of birth dose of Hepatitis B in 10% of the referral facilities (THQ & DHQ hospitals). UNICEF has selected a total of 11 first level referral facilities in four provinces (05 in Sindh, 02 in Punjab, 03 in KPK and 01 in Baluchistan). A total of 410,00 USD have been allocated under this activity and three key activities include the strengthening of the NNCU, training of the Health Care Providers and introduction of birth dose of Hepatitis B. There is a potential chance of under spending in this activity which is less than 10% of the total funds. Verbal discussion has already been undertaken with Senior Country Manager (SCM) for Pakistan with the possibility of a request for the reallocation of the remaining balance under this head to activity 1.6 related to the warehouse construction/renovation. Pakistan CO shall review the budget utilization by the end of May 2015 and if reallocation is required shall write to Gavi for formal approval.
Up-scaling Training of LHWs in Routine EPI	Refresher training of 1960 LHWs in routine EPI has been completed in Baluchistan

	Trainings of LHWs in routine are under process approved in 12 districts of Punjab (13003 LHWs), 6 districts of KP (1607 LHWs), 10 in AJK (3044) . Trainings have been finalized and approval is in process for trainings in 4 districts of Sindh (2796 LHWs) and ICT (322 LHWs). Third phase of training in the new work plan(annex8) has been approved by the Ministry of National Health Services, Regulation and Coordination and will include approximately another 22000 LHWs in Punjab (12025), Sindh (2500), Baluchistan (4500), Gilgat Balitstan (1366) and FATA (1500).
Development of Modalities between LHWs/CMWs and Va	As some of the provinces (Punjab, KP) have already developed integrated Service Delivery Package the activity was reviewed and considered to be duplication hence the funds will be diverted to fill in the gaps in any other ongoing activity like strengthening VLMIS.
Capacity Assessment for MCH Service Delivery inclu	The activity was reviewed and considered to be a duplication as Health Facility Assessment have already been completed in some provinces, hence the funds will be diverted to fill in the gaps in any other ongoing activity.
Strengthening Management and Accountability in Imm	The work plan has been developed and has been approved by the Ministry of National Health Services, Regulation and Coordination (Annex 9)
1. Accountability assessment of the role of distri	
2. Third party monitoring of 10% Training of LHWs	
3. Upscaling of accountability and pay for perform	
4. Support to HSPU and HSRUs/ PSPU for strengtheni	
Operational Cost Monitoring & Evaluation	
1. Hiring for Work plan Implementation (Program Su	Technical Officer M&E inducted in June, 2014 Provincial HSS Balochistan in place since July, 2014 Provincial Officers Sindh, KP, and Punjab in place since Nov, 2014
2. Printing of Training Materials & Guidelines	Procurement of printed material (50, 000 copies of EPI recording and reporting material for LHWs Program) for Punjab, KP and AJK is complete and delivered in March, 2015. Order for additional 32000 copies for Sindh and ICT has been placed.
3. Periodic Planning, Coordination & Review Meetin	
Demand Generation and Creating Awareness for Routi	

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

<!--[if !supportLists]-->1. <!--[endif]-->Not Implemented: <?xml:namespace prefix = "o" />

- HSS PC 1 of Ministry of National Health Services Regulations & Coordination: Activities in the work plan of draft HSS PC 1 worth US$ 3. 48 m were not implemented owing to different perspectives of Mo NHSR&C and the Ministry of Planning, Development & Reform (PD&R). However, the issue of utilization of balance HSS grant has now been resolved. The Ministry of National Health Services & Regulations with concurrence of the Ministry of PD&R and the provincial governments proposed utilization through WHO (Consultative meetings held on 2nd & 11th Feb, 2015; which was formally approved by the Gavi secretariat on 5th March, 2015. Consequently, the under implementation Gavi HSS work plan has been revised to include proposed activities for utilization of balance grant (Annex: 1&9).

- Additionally, two activities namely “Development of modalities between LHWs/CHW and vaccinators for integrated MNCH service delivery at community Level” and Capacity assessment of MNCH service delivery including EPI’ have not been implemented to avoid duplication with similar activities currently undergoing implementation by the Departments of Health.

<!--[if !supportLists]-->2. <!--[endif]-->Modifications:

- Reference for previous modifications in some activities may please be seen in APR 2013.
- Activity for “defining new data needs’ has been modified to include “review of current IT structures in health for integrated platform” (Reference Annex 2)

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

Please refer to the previous APR2012 for an overview of GAVI HSS support utilized for contributing to HRHstrategy and policy formulation and other aspects. Further updates for buildingon the contribution towards implementation of National Human Resource policyand guidelines are as under:<?xml:namespace prefix = "o" />

Implementation<!--[if !supportAnnotations]-->[SDF1]<!--[endif]--> of Human Resource InformationSystem (HRIS) through systematic phasing of activities. The aim is to developand implement a well functioning, standardized Human Resource InformationSystem (HRIS) to enable extension of comprehensive HR information to decisionmakers in areas of HR management, personal details, chronological history,position data, payroll records, training history, employee benefits andperformance analysis; which is also compatible to the existing InformationSystems in Health.

In the first phase situation analysis would be undertaken byreview of existing data sources, collection & analysis of existing HRMpractices and data use. The second phase of Human Resource for HealthInformation System (HRHIS) software development will include consensus buildingworkshops on development of tools/data collection procedure and instructionmanual for finalization of tools and data collection procedures; which willthen be pilot tested prior to wide scale implementation. An initial activityfor implementation will include organizing trainings of Master Trainers on thenewly designed system and computer staff on HRIS in the six pilotdistricts. The last phase of consolidation will comprise of developmentof reports and publications, implementation reviews and data sharing meetings.

Almost all the provinces have either drafted HR strategies or are in theprocess of development. Recently, a meeting was held in Islamabad on 31st March, 2014involving all stakeholders on Developing Human Resource for Health Strategy forPakistan. Each province presented the development of their HRH plan detailingSWOT analysis, challenges and way forward.
<!--[if !supportAnnotations]--><!--[endif]-->
<!--[if !supportAnnotations]-->
<!--[endif]--><!--[if !supportAnnotations]--><!--[endif]-->

<!--[if !supportAnnotations]-->[SDF1]<!--[endif]-->Tobe updated by provinces

<!--[if !supportAnnotations]-->
<!--[endif]-->

8.3. General overview of targets achieved

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

Table 8.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2014 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2010	2011	2012	2013	2014		
Trainings of LHWs as vaccinators	15%	Ex-MoH/DOH	30%	45%	15%	15%	15%	15%	15%	Third party evaluation of LHW program	do
Vaccine wastage	30%	MoIPC/UNICEF	5%	5%	30%	30%	30%	30%	30%	UNICEF Report, 2012	do
Fully immunized children aged 12-23 months	53%	PSLM, 2011	80%			53%	53%	53%		PDHS 2012-13	do
Poorly functioning system for	Quarterly monitoring	MoIPC/Federal EPI	functioning system for monitoring and	Functional M&E					33%	Mo NHSR&C/ Federal	do

monitoring and evaluation			evaluation							EPI	
Refresher and on job trainings for existing vaccinators on SOPs of appropriate use of vaccine	30%	MoIPC/Federal EPI	60%	60%	20%	30%	30%	30%		Mo NHSR&C/ Federal EPI	do
Trainings for EPI data managers on data entry for EPI, vaccines and logistic	0%	MoIPC/Federal EPI	70%	70%	0	0	0	38%		Mo NHSR&C/ Federal EPI	do
Establishment of web based EPI data management system at provincial and district level	0	MoIPC/Federal EPI	100%	100%	0	0	0	38%		Mo NHSR&C/ Federal EPI	do
appropriate use of vaccine and health technology	60%	MoIPC/Federal EPI	80%	80%	60%	60%	60%	65%		Mo NHSR&C/ Federal EPI	do
Establishment/ strengthening of 22 warehouses with cold rooms	1	MoIPC/Federal EPI	70, however based on the need given by the provinces the total number of ware houses will be less because of changing needs and escalating cost of construction, labour and POL.	70, however based on the need given by the provinces the total number of ware houses will be less because of changing needs and escalating cost of construction, labour and POL.	1	1	1	1	60%	UNICEF Report	do
Establishment of neonatal units with provision of Hepatitis B birth dose in selected 10% districts (DHQs/THQs	0	MoIPC/Federal EPI	10%	10%	0	0	0	0		Mo NHSR&C/ Federal EPI	do

8.4. Programme implementation in 2014

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

Referencefor pervious achievements of under implementation Gavi HSS work plan may pleasemade from APR 2013. The additional achievements of the same work plans in 2014are as under:<?xml:namespace prefix = "o" />

<!--[if !supportLists]-->1. <!--[endif]-->Inphase-I 14910 LHWs had been trained in 32 districts across different provincesof Pakistan.

Inthe second phase in 2014, training of LHWs in Routine EPI was successfullyup-scaled to an additional 28 districts of Punjab (12 districts, KP (6districts) & AJ&K (10 districts). Intense planning, consultation withseveral stakeholders in the DoH and HDPs (UNICEF) and coordination withdifferent provincial & regional departments of health/ managers of bothLHWs & EPI programs were undertaken in this regard.

Oneof the major outcomes was the agreement to update and revise the curriculum toinclude impending introduction of new vaccines, namely IPV and Hepatitis Bbirth dose in Pakistan. The curriculum has been revised accordingly andtraining is ongoing at different phases. After completion of the second phasean additional 20,772 LHWS will be trained to provide vaccination services tothe target population of mothers and

children less than two years.

Furthermore,on the explicit request of the Government of Balochistan refresher training of1960 LHWs initially trained in phase I (2009-2010) was also conducted andcompleted.

Availabilityof 45,682 LHWs as female vaccinators will not only be a tremendous boost forvaccination service delivery for improving EPI coverage in Pakistan; but willalso be culturally more acceptable to the community.

<!--[if !supportLists]-->2. <!--[endif]-->Printingand provision of 50, 000 EPI relevant reporting & recording tools for LHWstrained in Routine EPI were supplied in Punjab, KP and AJ&K. The process ofsupplying an additional 10, 000 printed material to Sindh and ICT has beeninitiated.

<!--[if !supportLists]-->3. <!--[endif]-->Procurement& provision of IT hardware and equipment to different departmentsof health for facilitating EPI data entry and timely sharing of information.

<!--[if !supportLists]-->4. <!--[endif]-->Thecurrent scenario of different health information and disease surveillancesystems operating in Pakistan has been a recognized challenge in terms ofduplication of efforts and resources. Moreover lack of integration of Verticaland perral fails to address the needs policy makers, programs and the utilizersof data on information. To address this challenge integration of healthinformation and disease surveillance system was included as a major area ofGavi HSS work plan.

Inthis regard following different activities were undertaken in 2014:

- Consultative Workshop on 'Integration of Health Information & Disease Surveillance Systems' held on 14-15 Oct, 2014 in Lahore
- Provincial core committee on integration of Health Information and Disease Surveillance System notified with specific TORs (Annex4)
- Work plan for development of Integrated Health Information and Disease Surveillance system finalized in consensus with relevant stakeholders (PSPU, DoH, TRF +) (Annex5)
- TORs for "Context Analysis for Development of Integrated Health Information & Disease Surveillance System" developed (Annex6) and submitted to the regional office for approval.

<!--[if !supportLists]-->5. <!--[endif]-->Deploymentof HSS HR in provincial departments of Health for coordination and oversight ofGavi HSS Work plan and technical support on HSS to the specifically toHSRU/PSPU and provincial departments of health in general.

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

The balance of approximately US$3.45 m (PKR 3.48 m) of the first tranche, which was awaiting approval of PC 1.The Ministry of National Health Services & Regulations with concurrence ofthe Ministry of P, D& R and the provincial governments had proposedresolution of the issue and utilization through WHO on 2nd & 11th Feb, 2015 respectively which was formallyapproved by the Gavi secretariat on 5th March, 2015 for utilization by 30th June2016.<?xml:namespace prefix = "o" />

Another challenge will be the post devolution obligation to engage simultaneously with several provincial/ regional DOH on an individual basis, which are essentially different entities in terms of status of development, needs and priorities,existing capacities and political inclinations.

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

Referenceto APR 2013 may please be made for monitoring and evaluation mechanismsoperating in the country. Additionally with reference to monitoring andevaluation of Gavi HSS grant the aspect strengthening of managementaccountability has been included the revise work plan for utilization ofbalanced HSS Grant. (for details please refer to 9.4.2 and Annex 16)<?xml:namespace prefix = "o" />

FurthermoreMinistry of National Health Services Regulation and Coordination has taken thedecision to reactivate Health System and Policy Unit (HSPU). The mainresponsibility of coordination of HSS activities and oversight will be carriedout by the HSPU, Mo NHSR&C in close collaboration with implementingpartners. The focus will be to ensure that the scope of monitoring is widerthan just assessing project deliverable and also include reviewingoverall performance, emerging gaps, partnerships, resource requirements, withparticular attention to achieving the targets and improvement in EPIindicators.

Monitoring would be multi functional so that information generatedor gathered at one level is useful at the next. Monitoring would also go beyondjust checking whether activities are taking place as planned. The quality andregularity of two-way information flow would be routinely checked and adjustedto meet specific needs.

Unitis proposed to have following TORs

<!--[if !supportLists]--> a <!--[endif]-->Function as coordination unit forHealth System Strengthening

<!--[if !supportLists]--> b <!--[endif]-->Develop and strengthen linkage andoversight mechanism with provincial Health Departments & will keepprovinces/region for grant/loan coordination and negotiations with GHI/healthdevelopment partners.

<!--[if !supportLists]--> c <!--[endif]-->Provide evidence based information to Provincial Health Departments that willsupport decision making and policy formulation and help in developing and transformingpolicy into strategic plans.

<!--[if !supportLists]--> d <!--[endif]-->Provide support to Provincial HealthDepartments to develop Monitoring, Evaluation and Surveillance framework totrack and monitor implementation of the health services.

<!--[if !supportLists]--> e <!--[endif]-->To monitor and report InternationalHealth commitments / Agreements like MDGs.

<!--[if !supportLists]--> f <!--[endif]-->Carry out research and evaluationand conduct Pilot innovative approaches/studies in Health Sector.

<!--[if !supportLists]--> g <!--[endif]-->Provide support for capacitybuilding, training, good governance initiatives / strategies in the healthsector and reform processes.

<!--[if !supportLists]--> h <!--[endif]-->Shall develop Health Observatory forHuman Resource for Health (HRH) and support development of provincial HRHprofile and strategy in health sector.

<!--[if !supportLists]--> i <!--[endif]-->To collect and collate healthstatistical data and results of health research both in public and privatesector.

j. Shall provide supportto Provincial Health Department to developing standardized SOPs, Manuals,Guidelines, etc.

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

The defined indicators of EPI in particular the percentage drop outbetween DTP1 and DTP3 coverage and percentage of surviving infants receiving 3doses of DTP-containing vaccine are common to all the health sector strategies such as the National EPI Policy and Provincial Health Sector strategies. Moreover, the systems defined for M&S are in line with the already existing set ups at all levels in the country, including Federal,Provincial and District. These indicators are also part of the District Health Information (DHIS), PSLM and PDHS which is the main source of healthinformation in Pakistan.

Provinces have organized EPI review atleast twice a year and annual EPI review of all the provinces and Areas is being planned in MAY 2015 by UNICEF support.

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

Previously EPI, HSS and CSOs were working as separate entities with different managementarrangements and lack of any meaningful collaboration for implementation ofactivities. However, now the GAVI HSS work plan and fund utilization is beingundertaken in coordination with all the key stakeholders including CSOs. Inthis context, both the revised HSS Work plan and PC-1 both have been developedin close coordination with Federal & Provincial EPI Programs, theProvincial Health Sector Reform Units (HRSU), CSOs and development partners(WHO and UNICEF). <?xml:namespace prefix = "o" />

All the partners worktogether in the preparation, planning and coordination for activityimplementation. Whenever applicable, joint preparatory meetings for review andstrategic planning and organization are held between the Mo NHSR&C, WHO& UNICEF.

The key stakeholdersin the coordination and implementation of GAVI HSS grant will include:

Ministry of NationalHealth Services, Regulation and Coordination

Federal EPI Cell andProvincial/ Regional EPI Programs

Provincial HealthSector Reform Units (HRSUs)

Provincial Lady HealthWorkers Programs (PPIUs)

WHO

UNICEF

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

A total of USD 60,000 were allocated to UNICEF under the strategic objective of strengthening Civil Society and Community Engagement in Health sector on demand generation andcreating awareness for routine EPI activities through CSOs/ and communityinvolvement. A CSO named JSCD is working in hard-to-reach 12 Union Councils ofdistrict Rajanpur, a district of South Punjab with one of the poorestindicators of maternal and child health portraying a grim picture of inadequateand inaccessible healthcare system and poor health indicators along with highlevel of inequities in access and coverage of immunization and weak demand forthe services. Through Community Action Plan (CAP), JSCD hasfostered co-operation among policy makers, local and state governmentofficials, religious leaders and local community members to advocateon issues related poor health situation of the district. It also facilitated outreach teams through the listing of mothers andchildren, refusal cases and missed cases as they are in close contact with the community. The funds have been fully utilized.

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

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

- The description of the effectiveness of the balance HSS (US$ 3.56m) funds management cannot be given due to lack of any activity or fundutilization being undertaken at any level in the reporting year, 2014. However,these funds will now be utilized through WHO as per decision of the MoNHSR&C and Gavi Alliance (Annex 1); for which a new MoU between Ministryand WHO is under Process of approval. <?xml:namespace prefix = "o" />

- Theprevious HSS funds management experience, disbursement constraints can bereferred to in APR 2013.

- Themanagement processes in aimed at improvement in the funds management throughAlliance Partners was effected through the following process:

Simultaneous and parallel GAVI HSS fund utilization of US$ 6.26million is currently under process through the partners work plan to insure facilitatecompletion of activities by July 2015 (UNICEF) & March 2016 (WHO).

Thefunds disbursement to Partners (WHO and UNICEF) has been effected throughseparate MoU between GAVI with WHO and UNICEF respectively. The organizationalmanagement mechanisms including the financial component applicable to the GAVIHSS work plan implementation has been defined in these MoUs.

8.5. Planned HSS activities for 2015

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

Table 8.5: Planned activities for 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2015 actual expenditure** (as at April 2015)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
Improved Monitoring & Evaluation of Immunization Data (Validation, Consistency, Accuracy & Capacity Building)						
	Identification & Defining New Data and integration Needs for DHIS	18000	6697			
	Feasibility & Development of IT based Software for Integrated MIS for all Diseases	50000	15265			
	Comprehensive Review of EPI Data Collection, Consolidation and Use including Quality Audit, Consistency and Integration with DHIS	50000	6449			
	Computer Hardware and IT Network for District Data Managers	100000	54073			
Technical Support For HSRUs/ PSPU (Digitalization of EPI data and pay for performance)	Piloting of vaccine registry and pay for performance in District Hafizabad (Punjab)	40000				
M& E Capacity Building & Training on Integrated MIS Software	Capacity Building of Health Care Providers on IT based Software for Integrated MIS for all Diseases	1200000				
M& E Capacity Building & Training on Integrated MIS Software	Capacity Building of Health Care Providers on IT based Software for Integrated MIS for all Diseases	1200000				
Standard System for Vaccine Management (Strengthening of VLMIS & Implementation of Integrated Logistic Support System LSS/ LMIS)	Upscaling VLMIS/LSS	80000				

Strengthening/ Establishment of Warehouses & Cold Storage	All four provinces after repeated consultative meeting with UNICEF have come up with the final need of establishing new warehouses and strengthening existing ones. UNICEF CO with the support of the supply section has initiated the process of implementation	2500000				
Introduction of Hepatitis B Birth Dose for Immunization	Introduction of Hepatitis B Birth Dose for Immunization	410000				
Up-scaling Training of LHWs in Routine EPI	Up-scaling Training of LHWs in Routine EPI	1600000			Additional Funds (US$ 1.5 M) will be utilized from the balance HSS Grant for further upscaling trainings of approximately 22000 LHWs in routine EPI Reference Annex 8 & 9	3100000
Development of Modalities between LHWs/CMWs and Vaccinators for Integrated MNCH and EPI Service Delivery at the Community Level	Development of Modalities between LHWs/CMWs and Vaccinators for Integrated MNCH and EPI Service Delivery at the Community Level	50000			This activity will not be implemented to avoid duplication with similar activities currently undergoing implementation by the Departments of Health.	
Capacity Assessment for MCH Service Delivery including EPI	Capacity Assessment for MCH Service Delivery including EPI	50000			This activity will not be implemented to avoid duplication with similar activities currently undergoing implementation by the Departments of Health.	
Strengthening Management and Accountability in Immunization						
	Accountability assessment of the role of district health management in involvement of trained LHWs in routine EPI	100000			New activity to be implanted from the Balance HSS Grant (US$ 3.56M) ref: annex 9	
	Third party monitoring of 10% Training of LHWs in EPI	200000			New activity to be implanted from the Balance HSS Grant (US$ 3.56M) ref: annex 9	
	Upscaling of accountability and pay for performance for vaccinator (one selected district each of	400000			New activity to be implanted from the Balance HSS Grant (US$ 3.56M) ref: annex 9	

	Sindh, KP and Baluchistan).					
	Support to HSPU and HSRUs/ PSPU for strengthening Accountability and management mechanisms.	383212			New activity to be implanted from the Balance HSS Grant (US$ 3.56M) ref: annex 9	
	Printing of MIS Tools	100000			New activity to be implanted from the Balance HSS Grant (US$ 3.56M) ref: annex 9	
		8531212	82484			3100000

8.6. Planned HSS activities for 2016

Please use **Table 8.6** to outline planned activities for 2016. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

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

Table 8.6: Planned HSS Activities for 2016

Major Activities (insert as many rows as necessary)	**Planned Activity for 2016**	**Original budget for 2016** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2016** (if relevant)
Training of LHWs in Routine EPI			NA	NA	NA
	Training of LHWs in Routine EPI	153231206			
Strengthening Management and Accountability in Immunization					
	Third party monitoring of 10% Training of LHWs in EPI	200000			
Strengthening Management and Accountability in Immunization					
	Training of LHWs in Routine EPI	153231206			
		306662412			

8.7. Revised indicators in case of reprogramming

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

8.8. Other sources of funding for HSS

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

Table 8.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
	70000000	April 2012-June 2015	Revitalizing Health Services in KP Health system performance70% • Percentage of people having access to basic package of health, nutrition or reproductive health services • Percentage of user satisfied with government health care services Population and reproductive health 20% • Percentage of birth by skilled birth attendants • Percentage increase in CPR (any modern method) Nutrition and food security 10% • Percentage of children with server acute malnutrition provided with nutritional adequate services The breakup of Total US$ 70 million is as under: Total: US$ 70.00 million GOP: US$ 54.00 million Grant : US$ 16.00 million (MDTF For Crisis Affected Areas of NWFP/ FATA/Balochistan)
One UN	752532	2014-15	Generate evidence and develop policies, strategies, standards & environment supportive for quality health service delivery; Health systems capacity improved for efficient health care delivery through strengthening human & financial capital to reduce OOP and enhance supply of medicine & equipment;
USAID /JSI		2013-18	Health Systems Strengthening Component of USAID's Maternal and Child Health (MCH) Program in Pakistan An initiative to systematize birth registration in 4 districts in Sindh to identify non-immunized children and pregnant women, resulting in • the immunization of 41,373 additional children under 2 years of age. • Introduced new budget codes as part of Mid-Term Budgetary Framework, which resulted in a 37% increase in the budget allocation for primary health care priorities identified in District Action Plans. • Supported Sindh's Department of Finance and Department of Health to prepare 23 District Action Plans (DAPs) for the 2015-16 budget cycle.
WHO JPRM	2400000	2014-15	All aspects of HSS will be addressed

			through four major work plans under the overall HSS category, namely 1. Policy Planning & HRH; 2. Health Care Delivery; 3. Health Information System; and 4. Essential Medicines & Technologies. Some of the main areas under the work plan include: Support for National Policy & Planning Processes and Capacity Building, UHC, HRH Accreditation & HRIS; Support for Improvement in Access and Utilization to Health Services, Quality & Accreditation of Health Care, Capacity Building of CHWs (LHWs), Strengthening of Hospital Management & Patient Safety; Promoting Health Information through Improvement in Data Quality, Analysis & Use of Information for Decision Making; Strengthening Civil Vital Registration & Statistics; Strengthen National Capacity to Ensure Availability, Access to & Rational Use of Quality Essential Medicines & Technologies; Support to National Regulatory Framework for Quality & Safety of Medicines & Medical Technologies.
World Bank	50000000	2015-20	The National Immunization Support Program (NISP) aims to achieve equitable increase in immunization coverage and quality through the following three components: 1. Building program capacity in the provinces and territories; 2. Support for a minimum set of competencies for coordination at the Federal level; and 3. A performance-based intervention to scale-up immunization services in districts
World Bank/ DFID	1116500000	May 2013-Dec 2017	Punjab Health Sector Reform Project Health system performance76% • Number of category-1 health care establishments issued provisional licensing • Percentage of user satisfied with government health care services Nutrition and food security 10% • Percentage of children -24 month of age receiving basic package of nutrition HIV/AIDS 6% Population and reproductive health 6% • Percentage of birth by skilled birth attendants • Percentage increase in CPR Child health 2% • Percentage of fully immunized children 12-23 month of age The breakup of Total US$ 1116.50 million is as under: GOP: US$ 830 million IDA: US$ 100.00 million DFID: US$ 165.00 million Health result based financing: US$ 21.5

			million

8.8.1. Is GAVI's HSS support reported on the national health sector budget? **No**

8.9. Reporting on the HSS grant

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

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

Table 8.9.1: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
1. PDHS 2012-13, NIPS, Mo NHSR&C 2. Federal EPI cell, Mo NHSR&C	1. The planning and implementation of the 2012-13 PDHS involved more then 30 national experts from the field of population, development and health including Technical Advisory Committee(TAC) members. PDHS used CAFE system in the field. the application was developed and fully tested before team deployment in the field. 2. Consultative meeting was held with all stakeholder to discuss the discrepancy between administrative data and data in survey report. it was decided that to mark average score for all the three available data sources for each VPD and benchmark a percent increase in coverage per year.	Immunization coverage in Pakistan has stayed steady over the last decade. Most of the popular surveys in Pakistan have given varying figures, yet have a consensus on a slow progress on immunization coverage. The current coverage, as estimated by different surveys, varies between 47 to 88 percent. The elements of over reporting in the routine data and of recall biases in the PDHS and PSLM cannot be ruled out.

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

1. There is some degree of repetition in most of the tables. It is sometimes not possible to indicate percentage of progress in some of the activities; or clarify the percentages in terms of physical completion ofactivity and actual funds utilization. Actual expenditures incurred is reported much later than completion of physical activity. <?xml:namespace prefix = "o" />

2. There should beflexibility in the reporting period to align with the country's fiscal year,for e.g. APR reporting for Pakistan should be in September to align with thefiscal year of June – July of next year.

3. The tables should be editable to allow for adjustment in some cases. On line formatting is not possible and creates problems.

4. On line system becomes frequently unresponsive; changes are not always saved in firstattempt.

5. Seeking and compiling information to update the APR particularlythe endorsement of relevant government counterpart usually takes longer thananticipated. Consideration maybe given to on line submission of completed report (withoutendorsement) within the deadline which could be simultaneously reviewed forGAVI feedback/ gaps while waiting for the official endorsement/ countryapproval.

6. Attachments; some documents are common to ISS, HSS and CSO section of APR and should not berequire separate uploading. It is difficult to up load all additional annexeswithout defined slots, into one folder for up loading at the end (Other).

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

Please attach:

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

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

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

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

Pakistan is not reporting on GAVI TYPE A CSO support for 2014

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

This section is to be completed by countries that have received GAVI TYPE B CSO support*1*

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

The Government of Pakistan recognizes improving the health and wellbeing of women and children is an essential precursor to achieving social sector goals for poverty reduction and overall development. To expand its efforts in reorganizing health services and tailoring them to the socioeconomic context in Pakistan and to the most vulnerable strata of the population, Government accepted Global Alliance for Vaccines and Immunization (GAVI) support to fund Civil Society Organizations (CSO) under a joint arrangement with the Expanded Programme on Immunization (EPI) and UNICEF in July 2009. <?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

The primary goal of this window of support is partnership building between government and CSOs for better health outcomes, to achieve Millennium Development Goals (MDGs) 4 and 5. The original Type B[1] support was provided for 18 months but the floods of 2010 and 2011, delays in funds disbursement, devolution of the Ministry of Health under the 18th Amendment to the Constitution (devolving key functions to the provinces) and other operational challenges caused delays in project implementation. As a result, the original Type B support was extended until February 2012. In 2011, the GAVI Alliance based on an external evaluation of Type B funding, approved bridge-funding support (for 2013) to enable 14 selected CSOs to continue their activities in selected Union Councils (UCs) of 19 districts across Pakistan. In 2012, GAVI again extended the funds for another 12 months to enable CSOs to continue their work; however there were delays in granting funds to CSOs in time due to operational challenges and UNICEF's shift to a new operating system, the Harmonized Approach to Cash Transfer (HACT). In March 2014, a no cost extension was requested until July 2015 (as the original project end date was July 2014) which was approved by GAVI.

During the reporting period, a total of 14 CSOs, ranging from grassroots organizations to highly academic institutions, implemented programme activities in the selected UCs of 19 districts across Pakistan. A baseline survey of these CSOs was conducted from May to June 2014. Generally the survey outlines that there were regional and rural/urban disparities among project districts where remote rural population is particularly disadvantaged. BCG coverage averaged at 80 per cent with the lowest (58 per cent) in Sanghar and the highest (96 per cent) in Jhelum and Skardu. PCV 10 coverage varied from 8 per cent in Sanghar to 88 per cent in Jhelum. Measles coverage ranged from 57 per cent in Tharparkar to 95 per cent in Jhelum. Children under 2 years, who never received any vaccination were the highest (30 per cent) in Muzaffarabad and lowest (2 per cent) in Skardu and Jhelum (4 per cent).

[1] Type B funding and support, intended for 10 countries, was aimed at including CSOs in the implementation of the GAVI health systems strengthening (HSS) proposals or comprehensive multi-year plans (cMYPs). The pilot countries for Type B support included Afghanistan, Bolivia, Burundi, the Democratic Republic of Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique, and Pakistan. Although initially introduced for the period 2007–2009, the GAVI Board subsequently extended support further.

9.2.1. **Programme implementation**

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

In 2013, two new objectives (for 2013 and 2014) were added to the existing three, with the aim to capitalize on the changing environment as a result of decentralization.<?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

The five objectives are as follows:

i. Improving the quality of Maternal, New-born and Child Health (MNCH) services by: (a) equipping and revitalizing First Level Care Facilities (FLCFs) through the provision of drugs and equipment; (b) enhancing the effectiveness of preventive and promotive MNCH outreach services through the provision of necessary equipment and supplies to Lady Health Workers (LHWs), Lady Health Visitors (LHVs) and Skilled Birth Attendants (SBAs);

ii. Broadening the range of MNCH services at various levels by improving, expanding and diversifying the skills of health workers in the private sector at FLCFs, as well as LHWs, LHVs and SBAs;

iii. Improving access to these services by: (a) improving referral systems and providing referral support to CSOs, EPI vaccinators, LHWs and LHVs for maternal and child health related activities; (b) empowering communities and village-based health committees (VHCs) to effectively participate in accessing and monitoring the quality of immunization and mother/child health care;

iv. Building partnerships with the provincial governments; and

v. Advocating for the involvement of CSOs at policy level.

Implementing Partners

AKHS-P – Aga Khan Health Services, Pakistan

AKU – Aga Khan University

BDN – Basic Development Needs Programme-Kasur

BDN – Basic Development Needs Programme-Muzaffarabad

BDN – Basic Development Needs Programme-Nowshera

CHIP – Civil Society Human and Institutional Development Programme

HANDS – Health and Nutrition Development Society

HELP – Health Education and Literacy Programme

LIFE – Literacy Information, Family Health and Environment

NRSP – National Rural Support Programme

PVDP – Participatory Village Development Programme

SABAWON – Social Action Bureau for Assistance in Welfare and Organizational Networking

THF – The Health Foundation

PAVHNA – Pakistan Voluntary Health and Nutrition Association

Strategic Partners

Ministry of National Health Services Regulation and Coordination

Federal Expanded Programme on Immunization (EPI)

World Health Organization (WHO)

Provincial Governments and District Health Departments.

United Nations Children's Fund (UNICEF)

1. Results

The reporting period covers the implementation of the agreed activities in approved Programme Cooperation Agreements (PCAs) of 14 CSOs across 19 districts. The pace of implementation was slow for most of the CSOs during the initial half of the year 2014 as they were in the planning phase of the project and engaged in the recruitment of staff and establishing offices. Furthermore because of the shift to the new UNICEF operating system, Harmonized Approach to Cash Transfer (HACT), some of the Implementing Partners (IPs) faced difficulties in managing their quarterly disbursements.

The GAVI CSO base line survey, carried out during the reporting period, findings are presented individually for each CSO in detail in the attached survey report (annex 1). Key recommendations put forth included development of common log frame for monitoring and evaluation and an end of project evaluation.

The survey results indicate regional and rural/urban disparities among project districts where remote rural population is particularly disadvantaged. BCG coverage averaged at 80 per cent with the lowest (58 per cent) in Sanghar and the highest (96 per cent) in Jhelum and Skardu. PCV 10 coverage varied from 8 per cent in Sanghar to 88 per cent in Jhelum. Measles coverage ranged from 57 per cent in Tharparkar to 95 per cent in Jhelum. Children under 2 years, who never received any vaccination were the highest (30 per cent) in Muzaffarabad and lowest (2 per cent) in Skardu and Jhelum (4 per cent).

Awareness levels regarding childhood immunization were generally high among community, however, there was misperception of communities with regards to facility based approach for routine immunization viz a viz special door-to-door campaign for Polio or Measles. Knowledge levels among community regarding vaccine preventable diseases were relatively higher in Matiari (80 per cent), Kasur (68 per cent) and Kech (62 per cent) and lower in Gawadar (14 per cent) and Skardu (24 per cent). Whereas, knowledge about vaccination schedule ranged from 1 per cent in Tando Allah Yar to

73 per cent in Rawalakot and Kotli.

Regarding the Knowledge, Attitude and Practice (KAP) towards injection safety was implemented in THF and LIFE districts only. Results show that community's awareness about hazards of unsafe injections and syringes was 60 per cent in Loralai, 71 per cent in Muzaffarabad and 80 per cent in Korangi (Karachi). Whereas, use of auto disable syringes was 57 per cent in Korangi (Karachi).

TT vaccination of pregnant ladies varied from 22 per cent in Loralai to 79 per cent in Rawalakot; Antenatal care coverage from 22 per cent in Tharparkar to 92 per cent in Peshawar; and deliveries by skill birth attendants from 22 per cent in Tharparkar to 94 per cent in Kotli. Knowledge about proper timing of first antenatal care visit was the lowest (25 per cent) in Sanghar and the highest (81 per cent) in Rawalakot.

UNICEF Pakistan has several levels of monitoring mechanisms which ensure strengthened governance procedures, such as internal controls and compliance, risk assessment, monitoring and oversight, and capacity building of partners. In addition, third party field monitoring mechanism is also employed for identification of implementation gaps and immediate corrective measures.

The progress and achievement of all 14 CSOs against the output targets has already been shared in the UNICEF's progress update on December 2014

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).

IMPLEMENTATION CONSTRAINTS:<?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

A- Strategic

1. Fragile law and order conditions raised challenges and limitations in accessing communities, particularly in southern Peshawar (KP), Gwadar, Turbat and Loralai districts in Balochistan and the border areas of PAK;

2. Difficult geographic terrain has also been one of the bottlenecks to access the services;

3. Variable capacities of CSOs ranging from grassroots organizations to experienced organizations with academic expertise also affected the progress of activities.

4. Presence of CSOs at few UCs of a district cannot logically establish a measurable impact.

B- Programmatic and operational.

1. Non-functional CSO unit: The CSO unit was a coordinating unit to serve as an interface between the Government, CSOs and UNICEF and was relocated to the office of Federal EPI in the second quarter of 2013 to ensure that they are better positioned to fulfill their function to strengthen health systems.Since July 1, 2014, two key positions of the CSO unit including the CSOs unit coordinator and the M&E officer have been lying vacant while one admin/finance officer along with a consultant for reporting on advocacy and communication activities are still working. The two remaining positions being charged to the CSO grant are working with the Federal EPI and have not been able to provide any value addition to support the CSO coordination. This has led to shifting of the entire workload to UNICEF which has only two staff members at the country office level to deal with the entire EPI agenda ranging from procurement of vaccines, addressing in equities and improving immunization coverage, dealing with the vaccine management issues, introduction of new vaccines and managing the donor funded grants, mobilizing resources in addition to dealing with 14 CSOs under project Cooperation Agreement governed by HACT under this one single grant. It was a huge effort on part of UNICEF to efficiently manage this grant and took huge toll of UNICEF's staff's time and effort to do the work originally mandated for CSO unit.

2. Varying capacities of CSOs on the ground, coupled with the transition to UNICEF's new financial system, HACT, led to a slower pace of implementation during the initial period of the project implementation. UNICEF countered this challenge by building capacity of the weaker CSOs and extending supportive supervision to the IPs due to which the CSOs improved from high to medium risk on subsequent programmatic and financial assessments.

3. No Baseline was undertaken at the start of the project in 2009 which is one of the caveats in measuring the actual impact of the project activities. However, on the recommendation of GAVI Independent Review Committee (IRC), a survey was undertaken from May to June 2014 to set a baseline for the future work of GAVI funded CSOs.

4. Suboptimal understanding of payment processes led to delayed reporting by CSOs resulting in late disbursement of next quarter funds. To deal with the issue, continuous supportive supervision was imparted to the IPs.

5. Lack of interest of some of the well-established CSOs led to huge reporting delays hence leading them to move from advance to reimbursement modality of fund disbursement.

6. Quality of reporting is also variable and the link between the narrative report and financial spending is completing missing in all CSOs reporting thereby not capturing the burn rates Furthermore the interpretation of intended versus achieved targets is also a weak area of reporting. UNICEF Pakistan provided technical assistance in improving the quality of reporting.

1. **LESSONS LEARNED**

1. A window of opportunity exists in the engagement of CSOs in Pakistan in demand generation for better health service delivery, as well as community mobilisation through advocacy, communication for development and other social mobilization approaches.

2. CSOs by the virtue of their presence should augment the capacity and coverage of public sector community health workers by deploying additional workforce. This would be particularly suited to areas where people resist vaccination due to some myths and misconceptions.

3. Building linkages: Although CSOs are working in the selected UCs of a district and have close coordination with the District Health Department yet there is a strong need of building linkages not merely with the existing community based structures including other NGOs in the same and adjoining UCs in addition to developing mechanisms for stronger coordination with the provincial health department.Civil society has played a significant role in health systems strengthening in Pakistan, by extending support to government counterparts.

4. Regular monitoring and supervision is critical in order to identify key bottlenecks in a timely manner and to correct these in real time.

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.

Since the start of the project, CSOs have developed close coordination with the district health departments of target districts. In particular, CSOs have gained the confidence of district health departments to work jointly on immunization and maternal and child health services. Building on the efforts made under the GAVI CSO Initiative, CSOs have established a national coalition and have formulated a charter to govern the coalition. However, during the reporting period, efforts were made to strengthen the partnership with provincial Health Departments. In this respect, CHIP (one of the CSOs, working on CSO strengthening with CRS) worked in close coordination and had meetings with Sindh, Punjab and KP-K governments (EPI departments). As a result, formal Memorandum of Understanding (MoU) has also been signed with Sindh government and currently efforts are under way to sign similar MoUs with KP-K and Punjab governments.<?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

Gavi Type B collaborate with district health departments on occasions such as NIDs, SNIDs, health events, polio days, mother and child weeks and World Immunization week.

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 and names of CSOs involved, and the initial number and names of CSOs).

Two CSOs including CHIP and HELP are actively engaged in policy dialogue including feedback on EPI policy, cMYP 2014-18, development of communication strategy for RI and new vaccine introduction. In addition these two CSOs are representing CSOs in ICC, all government meetings and policy forums.

Name of the CSOFocal/Contact PersonNameContact NoE-mailAKHSPTahir Sheikh0300-2029274tahir.sheikh@akhsp.orgCHIPLubna Hashmat 0301-8547307lubna@chip-pk.org BDN Muzaffarabad Mr. Mukhtar P.M0300-6505438bdngfatm@hotmail.com HELPDr. Yasmeen0333-2096796help_ngo@hotmail.com BDN KasurDr. Zahid Chattah0336-8657475zachattah@hotmail.com NRSPDr. Irfana Asim0336-5562050irfana@nrsp.org.pk SABAWONMr. Iftikhar Hussain0301-8968274Iftikhar_sabawon@yahoo.comHANDsDr. Anjum Fatima0300-2370393anjum.fatma@hands.org.pk THFDr. Muhammad Kashif Riaz 0345-2172488kashifriaz1@yahoo.com BDN NowshehraMr. Tauheed Alam0313-953 3319tauheed.alam@yahoo.com LIFEAli Hasan0321-5122253life.mail786@gmail.com PVDPMr. Shehzad0334-3212561dspvdp97@gmail.com AKUDr. Ali Saleem0300-2245776ali.saleem@aku.edu PAVNAAtta u Baseer P.M0302-9735177pavhna@gmail.com

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

During the reporting period, the PCAs of six CSOs were approved while the PCAs of 08 CSOs were approved in December 2013. Under UNICEF's new financial system i.e., Harmonized Approach to Cash Transfer (HACT), all CSOs were assessed to become eligible for signing PCA with UNICEF. The three types of risk assessments included Programmatic, Financial and Supply were carried out. In case a CSO falls on high or significant risk, following the UNICEF's financial system, the working modality for cash support is changed from advance payments to reimbursement

mode.

The number of CSOs working previously under Gavi support dropped from 16 to 14 as the new PCAs(08) were signed with them in Dec 2013 and (06) February and June 2014.

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 9.2.1a: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2014	Outcomes achieved
AKHSP	YES	- 25, 555 vaccination doses facilitated to children less than 23 months;	YES
AKHS-P	YES	- 25, 555 vaccination doses facilitated to children less than 23 months;	YES
AKU	YES	Baseline Knowledge, Attitude and Practice (KAP) survey of 450 households in Karachi conducted from February to April 2014.	YES
BDN Kasur	YES	- 100 CRs trained on participatory development approach and importance of EPI & MCH care.	YES
BDN Muzaffarabad	YES	- - 90 community representatives trained so far;	YES
BDN Nowshera	YES	- One day refresher training given to 50 VDCs on EPI & MNCH.	YES
CHIP	YES	04 experience sharing meetings (2 each in Skardu and Jhelum) were held. In Skardu, 45 participants (25 health promoters, 20 VHC members) participated in quarterly meetings. In Jhelum, 28 health promoters and 14 VHC members participated.	YES
HANDS	YES	- Maternal health messages disseminated through 03 local cable operator channels one in each target Taluka i.e., Hala, Matiari and Saeedabad.	YES
HELP	YES	- Liaison established with Health department including National Program and EPI,	YES
LIFE Welfare Organization	YES	- 56 advocacy meetings with Provincial / District / Tehsil authorities on improving coordination with local communities held;	YES
National Rural Support Programme (NRSP)	YES	- 238 health awareness sessions held in which 5,256 people benefitted	YES
PVDP	YES	- 14 vaccination campaigns done reaching more than 80 per cent of the target age children and women in the intervention areas; 2,673 children received BCG, 2,206 received OPV1+PCV1+Penta1, 2,031 received OPV 2+PCV 2+Penta 2, 1,592 children received OPV3+ PCV3 + Penta3, 1,594 children vaccinated for Measles 1 530 for	YES

		Measles 2 while 3,066 pregnant women received TT vaccination;	
SABAWON	YES	Three alliance building workshops have been held successfully within stipulated timeframe. Two Alliance Building workshops held in Peshawar with total 84 participants (55 men; 29 women). One Alliance Building Workshop held in Mardan with 37 participants (23 men; 14 women). Participants were mostly from community as well as civil society organizations, EPI and local health facilities.	YES
THF	YES	- 24,415 children given all three doses of Hep-B vaccine (72%)	YES

Please list the CSOs that have not yet been funded, but are due to receive support in 2014/2015, 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 9.2.1b: Planned activities and expected outcomes for 2014/2015

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2014/2015	Expected outcomes
AKHSP	YES	- 7,700 vaccination doses to children less than 23 months	YES
BDN Muzaffarabad	YES	- Training of 90 office bearers of Village Development Committees (VDCs) on social mobilization and importance of vaccination and vaccination schedule;	YES
CHIP	YES	- Quarterly experience-sharing meetings of community based organizations (CBOs), VHCs and health promoters;	YES
HANDS	YES	- Dissemination of EPI and maternal health messages through local cable networks;	YES
HELP	YES	- Liaison with health department/ community / EPI/ national Programme;	YES
SABAWON	YES	- Organize three alliance-building workshops with stakeholders for smooth implementation of this initiative;	YES
THF	YES	- Vaccinate 168,869 children (5–15 years) against Hepatitis B in five years; Target under this project 33,774 children;	YES

9.2.2. **Future of CSO involvement to health systems, health sector planning and immunisation**

Please describe CSO involvement to future health systems planning and implementation as well as CSO involvement to immunisation related activities. Provide rationale and summary of plans of CSO engagement to such processes including funding options and figures if available.

If the country is planning for HSFP, please describe CSO engagement to the process.

During this phase, CSOs have been particularly focusing on strengthening routine immunization. CSOs (in their PCAs) have clearly agreed on concrete results in terms of number of children immunized/percentage increase in immunization (BCG, Penta 3 and Measles). Since the CSOs are good in social mobilization, arranging vaccination camps and vaccination points to ensure vaccination of children (missed and defaulter children). The CSOs have remained successful in uplifting immunization and addressing refusals. The district governments also truly appreciate and realize

CSOs contribution. At many occasions, district health offices, issued letter of appreciation in recognition of CSOs work for immunization.<?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

During the reporting period, CSOs provided input/feedback to federal EPI on policy documents such as the IPV Application and communication strategy for RI. Meetings with provincial governments of KP and Punjab were organized to sign formal MoU to ensure CSOs participation in different activities, while MoU with Sindh government was already signed by one of the CSOs, leading the Coalition..

After the devolution, with joint efforts of GAVI CSO Unit and CHIP (under CRS funding), the coalition has been planning to penetrate at provincial and federal level for CSOs role at policy and implementation level in a much formalized way.

It is envisioned that in future, the CSOs working on immunization and health (17CSOs working under GAVI funding since 2009 and 30 CSOs who have joined the coalition later (but are not recipient of GAVI funds) now organized into a coalition known as Pakistan Coalition for Health and Immunization (PCCHI) will engage with government at different levels for immunization and health system delivery and to become part of HSS.

The CSOs will be engaged in the development of new HSS application.

Pakistan is currently implementing the old HSS funding and it was only recently that the GoP has taken decision to apply new HSS application in September window. The roadmap for new HSS is yet to be drafted by the GoP and no consultation has been initiated with the CSOs on future health systems planning and implementation.

It is also important to highlight here that the Health Sector Funding Platform (HSFP) is currently in active.

9.2.3. Please provide names, representatives and contact information of the CSOs involved to the implementation.

Name of the CSOFocal/Contact PersonNameContact NoE-mailAKHSPTahir Sheikh0300-2029274tahir.sheikh@akhsp.orgCHIPLubna Hashmat 0301-8547307lubna@chip-pk.org BDN Muzaffarabad Mr. Mukhtar P.M0300-6505438bdngfatm@hotmail.com HELPDr. Yasmeen0333-2096796help_ngo@hotmail.com BDN KasurDr. Zahid Chattah0336-8657475zachattah@hotmail.com NRSPDr. Irfana Asim0336-5562050irfana@nrsp.org.pk SABAWONMr. Iftikhar Hussain0301-8968274Iftikhar_sabawon@yahoo.comHANDsDr. Anjum Fatima0300-2370393anjum.fatma@hands.org.pk THFDr. Muhammad Kashif Riaz 0345-2172488kashifriaz1@yahoo.com BDN NowshehraMr. Tauheed Alam0313-953 3319tauheed.alam@yahoo.com LIFEAli Hasan0321-5122253life.mail786@gmail.com PVDPMr. Shehzad0334-3212561dspvdp97@gmail.com AKUDr. Ali Saleem0300-2245776ali.saleem@aku.edu PAVNAAtta u Baseer P.M0302-9735177pavhna@gmail.com

9.2.4. **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 2014 year

	Amount US$	Amount local currency
Funds received during 2014 *(A)*	0	0
Remaining funds (carry over) from 2013 *(B)*	1,787,420	180,690,287
Total funds available in 2014 *(C=A+B)*	1,787,420	180,690,287
Total Expenditures in 2014 *(D)*	1,161,563	117,422,403
Balance carried over to 2015 *(E=C-D)*	625,857	63,267,884

Is GAVI's CSO Type B support reported on the national health sector budget? **No**

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.

The overall management of the GAVI CSO support funds is through the Federal EPI Cell/ Ministry of National Health Services Regulation and Coordination (MoNHSR&C). UNICEF Pakistan is the fund manager for this pilot initiative. Previously funds were transferred to CSO account from UNICEF upon a request letter from Federal EPI. But under the Harmonized Approach to Cash Transfer (HACT) and new Project Cooperation Agreements (PCAs) of CSOs, UNICEF does not need approval from EPI and the funds are directly transferred to CSOs account without the involvement of Federal EPI. It means that CSOs directly submits the reports and financial statements to UNICEF and UNICEF process

the CSOs payment on their own.

UNICEF contribution towards country programme includes provision of cash assistance to implement its programme activities. Cash assistance is the direct financial support to make the programmes operational in the short run and self sustaining in the long run. Working with partners means providing (technical, human, supply, and) financial assistance to them as and when required. The cash assistance (DCT-Direct Cash Transfer) is an important means of UNICEF's programme implementation strategy. Cash Assistance modalities can be categorized into three categories<?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

1. Reimbursement
2. Direct Payment
3. Advance (Director Cash Transfer – DCT)

Reimbursement (preferred)

Partners will utilize their funds to pay for the programme costs and obtain reimbursement from UNICEF;Reimbursement is the preferred method of cash assistance as it reduces dependency on UNICEF funds and facilitates UNICEF's programme procedures.

Direct Payment

- Payment by UNICEF upon partner's request to vendors, suppliers workshop participants or consultant etc;
- Partners need to submit duly certified original invoices, contracts, claims, service certificates etc for payment under this modality;
- Payment of hotel bills, TA/DA for workshop participants, consultant fees are examples of direct payment by UNICEF.

Advance (Direct Cash Transfer – DCT)

- When partners are unable to pre-finance the costs, UNICEF provides cash advance to carry out agreed upon activities on installments;
- Normally one installment covers three months' estimated programme costs.

Eligibility and changing risk level/modality

<?xml:namespace prefix = "v" ns = "urn:schemas-microsoft-com:vml" />• Risk Level can only be changed by doing another assessment;

- High or Significant Risk Partner's may be reassessed if partner has addressed recommendations from earlier Micro-Assessment;
- Evidence: Two consecutive Spot Checks of the Partner show 'strong controls';
- If risk level changes and UNICEF or Partner wants to change the cash transfer modality accordingly, a PCA Addendum needs to be done articulating the change;
- The reassessment could go vice versa also – 'medium' to 'significant'**.**

Aging and liquidation:

- Cash advance is provided for a period of three months;
- A partner must report expenses, or submit refund, once the three month period is over;
- As soon as the DCT-advance is processed for a partner, the clock in the UNICEF's financial system starts counting its age. The system stops further payments to a partner whose advance has touched 6-month aging (180 days);
- Once the FACE/accounting documents are received, an entry is made in UNICEF's accounting system, which converts the 'Advance' into 'expense', and closes the transaction. This process is called liquidation.

Detailed expenditure of CSO Type B funds during the 2014 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2014 calendar year **(Document Number 24)**. Financial statements should be signed by the principal officer in charge of the

management of CSO type B funds.

Has an external audit been conducted? No

External audit reports for CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number 25).

9.2.5. **Monitoring and Evaluation**

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

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

Table 9.2.5: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target
1	Percentage increase in immunization coverage	Baseline and Endline Surveys	Endline In Process	Work in progress	December / January 2013/14	20	Feb-April 2015

Planned activities :

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.

Every CSO has a set of predefined indicators which are part of their approved PCAs. There are three streams of monitoring the project activities; one by the head office team of the CSOs on a monthly basis followed by the district health departments of the districts of intervention and then review of the progress made in the monthly District Health Management Team (DHMT) meetings.

Some of the well established CSOs like National Rural Support Programme (NRSP) has a monitoring framework to monitor the core activities. Standard formats and other tools are used for monitoring of the programme activities. The Project Manager works and coordinate with the District Teams and is led by a District Coordinator (DC) who works closely with the existing field teams in the intervention districts to get maximum benefit from the existing social mobilization work. Some CSOs hired additional staff per district and the field staff of CSO's core operations helps the project staff in linking the existing COs with the project. Besides social mobilization staff finance person from region also work to make financial reports and to monitor finances. <?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

As already stated, head office level and District health department undertakes regular supervisory visits. Additionally, core staff of CSOs also makes field visits. Local communities are engaged with the program implementation and areas where CSOs are working with the grass root level organizations comprising of Local Support Organizations (LSOs). community are very much part of the bodies and plays a continuous role. Another important tool used by some of the well established CSOs for ensuring quality is using a strong Project Monitoring Plan (PMP) to track the progress and effective implementation process to deliver services to the targeted beneficiaries.

MONITORING ROLE OF UNICEF:

UNICEF undertakes the assessment of each CSO and based on the risk category in programme, finance and supply, assessment may be repeated from once in the life time of a PCA to more than once based on need. Furthermore programmatic monitoring is also undertaken by UNICEF focal points in the provinces.

10. Comments from ICC/HSCC Chairs

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

None

11. Annexes

11.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2014 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.2. Annex 2 – Example income & expenditure ISS

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

11.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

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

I. All countries that have received HSS grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2014 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

11.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

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

I. All countries that have received CSO 'Type B' grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2014, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2014 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2014 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2014 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.6. Annex 6 – Example income & expenditure CSO

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	APR Signature page.pdf **File desc:** MOH **Date/time :** 15/05/2015 07:55:15 **Size:** 331 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	APR Signature page.pdf **File desc:** MOF **Date/time :** 15/05/2015 07:55:26 **Size:** 331 KB
3	Signatures of members of ICC	2.2	✓	ICC Member Sig 2015.pdf **File desc:** **Date/time :** 12/05/2015 02:36:59 **Size:** 321 KB
4	Minutes of ICC meeting in 2015 endorsing the APR 2014	5.4	✓	ICC Minutes APR 2014 Final version 15th may 2015.docx **File desc:** **Date/time :** 15/05/2015 12:36:18 **Size:** 19 KB
5	Signatures of members of HSCC	2.3	✓	NOT APPLICABLE.docx **File desc:** **Date/time :** 15/05/2015 12:39:03 **Size:** 11 KB
6	Minutes of HSCC meeting in 2015 endorsing the APR 2014	8.9.3	✓	NOT APPLICABLE.docx **File desc:** **Date/time :** 15/05/2015 12:39:19 **Size:** 11 KB
7	Financial statement for ISS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	No file loaded
8	External audit report for ISS grant (Fiscal Year 2014)	6.2.3	✗	No file loaded
9	Post Introduction Evaluation Report	7.2.1	✗	No file loaded

10	Financial statement for NVS introduction grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	interim financial statement.pdf **File desc:** **Date/time :** 12/05/2015 03:38:41 **Size:** 87 KB
11	External audit report for NVS introduction grant (Fiscal year 2014) if total expenditures in 2014 is greater than US$ 250,000	7.3.1	✓	NOT APPLICABLE.docx **File desc:** **Date/time :** 15/05/2015 12:39:39 **Size:** 11 KB
12	Latest EVSM/VMA/EVM report	7.5	✓	EVM Assessment 2014.pdf **File desc:** **Date/time :** 12/05/2015 03:42:31 **Size:** 1 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	National EVMIP_2015.pdf **File desc:** **Date/time :** 12/05/2015 03:44:52 **Size:** 985 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	NOTE.docx **File desc:** **Date/time :** 15/05/2015 12:41:38 **Size:** 11 KB
16	Valid cMYP if requesting extension of support	7.8	✓	National cMYP.docx **File desc:** **Date/time :** 11/06/2015 07:14:38 **Size:** 4 MB
17	Valid cMYP costing tool if requesting extension of support	7.8	✓	_National cMYP.xlsx **File desc:** **Date/time :** 11/06/2015 07:15:31 **Size:** 3 MB
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✓	NOTE.docx **File desc:** **Date/time :** 11/06/2015 07:16:40 **Size:** 11 KB
19	Financial statement for HSS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	bank statement HSS 001.jpg **File desc:** **Date/time :** 15/05/2015 12:36:52 **Size:** 365 KB

20	Financial statement for HSS grant for January-April 2015 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	bank statement HSS 001.jpg **File desc:** **Date/time :** 15/05/2015 12:37:19 **Size:** 365 KB
21	External audit report for HSS grant (Fiscal Year 2014)	8.1.3	✓	Audit Status.pdf **File desc:** **Date/time :** 05/05/2015 07:46:49 **Size:** 31 KB
22	HSS Health Sector review report	8.9.3	✓	health sector review report _ESP_ 2013-14.pdf **File desc:** **Date/time :** 05/05/2015 07:47:30 **Size:** 91 KB
23	Report for Mapping Exercise CSO Type A	9.1.1	✓	NOT APPLICABLE.docx **File desc:** **Date/time :** 15/05/2015 12:50:27 **Size:** 11 KB
24	Financial statement for CSO Type B grant (Fiscal year 2014)	9.2.4	✓	SCANNED COPIES OF SOExpenditures UNICEF.pdf **File desc:** **Date/time :** 15/05/2015 12:52:12 **Size:** 1 MB
25	External audit report for CSO Type B (Fiscal Year 2014)	9.2.4	✓	NOTE.docx **File desc:** **Date/time :** 15/05/2015 08:06:49 **Size:** 11 KB
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2014 on (i) 1st January 2014 and (ii) 31st December 2014	0	✓	SCANNED COPIES OF SOExpenditures UNICEF.pdf **File desc:** **Date/time :** 15/05/2015 12:53:51 **Size:** 1 MB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✗	No file loaded
28	Justification for changes in target population	5.1	✗	No file loaded

	Other		✕	Annex 1.pdf **File desc:** **Date/time :** 05/05/2015 07:36:04 **Size:** 942 KB
				Annex 2.pdf **File desc:** **Date/time :** 05/05/2015 07:36:38 **Size:** 3 MB
				Annex 3.pdf **File desc:** **Date/time :** 05/05/2015 07:36:44 **Size:** 42 KB
				Annex 4.pdf **File desc:** **Date/time :** 05/05/2015 07:36:53 **Size:** 436 KB
				Annex 5.xlsx **File desc:** **Date/time :** 05/05/2015 07:37:22 **Size:** 20 KB
				Annex 6.pdf **File desc:** **Date/time :** 05/05/2015 07:37:35 **Size:** 152 KB
				Annex 7.pdf **File desc:** **Date/time :** 05/05/2015 07:37:47 **Size:** 65 KB
				Annex 8.pdf **File desc:** **Date/time :** 05/05/2015 07:37:54 **Size:** 111 KB
				Annex 9.pdf **File desc:** **Date/time :** 05/05/2015 07:38:03 **Size:** 395 KB
				KAPB 2014 NATL clean 291214.pdf **File desc:** **Date/time :** 15/05/2015 07:53:34 **Size:** 12 MB