GAVI Alliance

Annual Progress Report 2012

Submitted by

The Government of

Ghana

Reporting on year: **2012**

Requesting for support year: **2014**

Date of submission: **5/15/2013 11:18:52 AM**

Deadline for submission: 9/24/2013

Please submit the APR 2012 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

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

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

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

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

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

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

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

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

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

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

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

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

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

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

1. Application Specification

Reporting on year: **2012**

Requesting for support year: **2014**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015
Routine New Vaccines Support	Yellow Fever, 5 dose(s) per vial, LYOPHILISED	Yellow Fever, 5 dose(s) per vial, LYOPHILISED	2015
Routine New Vaccines Support	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	2014
Routine New Vaccines Support	Rotavirus, 2 -dose schedule	Rotavirus, 2 -dose schedule	2014
Routine New Vaccines Support	Measles second dose, 10 dose(s) per vial, LYOPHILISED	Measles second dose, 10 dose(s) per vial, LYOPHILISED	2014
INS			
Preventive Campaign Support	Meningococcal type A, 10 dose(s) per vial, LYOPHILISED		2012
NVS Demo	HPV quadrivalent, 1 dose(s) per vial, LIQUID		2014

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

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2012	Request for Approval of	Eligible For 2012 ISS reward
VIG	Yes	N/A	N/A
COS	Yes	N/A	N/A
ISS	Yes	next tranche: N/A	N/A
HSS	Yes	next tranche of HSS Grant No	N/A
CSO Type A	No	Not applicable N/A	N/A
CSO Type B	Yes	CSO Type B extension per GAVI Board Decision in July 2012: N/A	N/A
HSFP	No	N/A	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2011 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 Ghana 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 Ghana

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

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Hon. Sherry AYITTEY	**Name**	Hon. Seth Emmanuel TEKPER
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
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Dr. Daniel YAYEMAIN	Child Health Specialist, UNICEF-Ghana	+233244606315	dyayemain@unicef.org

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. V. M. ADABAYERI/Paediatrician	Paediatric Society of Ghana		

Dr Frank NYONATOR/Chairman of ICC	Ministry of Health		
Dr Afisah ZAKARIAH/Director Policy Planning Monitoring and Evaluation	Ministry of Health		
Dr. Iyabode OLUSANMI/UNICEF Representative	UNICEF Country Office, Ghana		
Dr. Idrissa SOW/WHO Representative	WHO Country Office, Ghana		
Dr. Joseph AMANKWA/Director - Public Health Division	Public Health Division, Ghana Health Service		
Mr. Sam Worentetu, Chairman - Ghana National Polio Plus Committee of Rotary International	Rotary INternational		
Mrs. Cecilia LODONU-SENOO, Vice Chairman	Coalition of NGOs in Health		

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

All comments will be treated confidentially

Comments from Partners:

Partners endorsed the APR and hope for its approval by the IRC. They also commended the task team for the good work

Comments from the Regional Working Group:

The RWG urged Ghana to keep the good work and ensure all sections are completed before the deadline

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), Ghana Health Sector Coordinating Committee , 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

A. M. Van Ommen	Embassy of the Netherlands		

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

All comments will be treated confidentially

Comments from Partners:

2013 APR approved for submission

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
Patricia POREKUU / National Coordinator	Ghana Coalition of NGOs in Health		
Michael Boadi/ Program and Advocacy Officer	Ghana Coalition of NGOs in Health		
Cecilia LODONU-SENOO / Vice Chairman	Ghana Coalition of NGOs in Health		

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

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4. Baseline & annual targets

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

Number	Achievements as per JRF		Targets (preferred presentation)					
	2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
Total births	1,016,004	1,037,287	1,040,388	1,063,767	1,065,358	1,090,949	1,090,926	1,118,850
Total infants' deaths	50,800	51,865	52,019	53,188	53,268	54,547	54,546	55,943
Total surviving infants	965204	985,422	988,369	1,010,579	1,012,090	1,036,402	1,036,380	1,062,907
Total pregnant women	1,016,004	1,037,287	1,040,388	1,063,767	1,065,358	1,090,949	1,090,926	1,118,850
Number of infants vaccinated (to be vaccinated) with BCG	1,016,004	1,082,408	1,040,388	1,063,767	1,065,358	1,090,949	1,090,926	1,118,850
BCG coverage	100 %	104 %	100 %	100 %	100 %	100 %	100 %	100 %
Number of infants vaccinated (to be vaccinated) with OPV3	907,292	906,363	929,067	949,944	951,364	974,217	974,197	999,133
OPV3 coverage	94 %	92 %	94 %	94 %	94 %	94 %	94 %	94 %
Number of infants vaccinated (to be vaccinated) with DTP1	0	0	0	0	0	0	0	0
Number of infants vaccinated (to be vaccinated) with DTP3	0	0	0	0	0	0	0	0
DTP3 coverage	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	0	0	0	0	0	0	0
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	926,596	953,052	948,834	970,156	971,606	994,945	994,925	1,020,391
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	926,596	908,821	948,834	949,944	951,364	974,217	974,197	999,133
DTP-HepB-Hib coverage	94 %	92 %	94 %	94 %	94 %	94 %	94 %	94 %
Wastage[1] rate in base-year and planned thereafter (%) [2]	0	5	0	10	25	10	25	10
Wastage[1] factor in base-year and planned thereafter (%)	1.33	1.05	1.33	1.11	1.33	1.11	1.33	1.11
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with Yellow Fever	907,292	910,272	929,067	949,944	951,364	974,217	974,197	999,133
Yellow Fever coverage	94 %	92 %	94 %	94 %	94 %	94 %	94 %	94 %
Wastage[1] rate in base-year and planned thereafter (%)	0	19	0	25	25	25	25	25

Number	Achievements as per JRF		Targets (preferred presentation)					
	2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
Wastage[1] factor in base-year and planned thereafter (%)	1.33	1.23	1.33	1.33	1.33	1.33	1.33	1.33
Maximum wastage rate value for Yellow Fever, 5 dose(s) per vial, LYOPHILISED	50 %	10 %	50 %	10 %	50 %	10 %	50 %	10 %
Number of infants vaccinated (to be vaccinated) with 1 dose of Pneumococcal (PCV13)	926,596	667,237	711,626	970,156	971,606	994,945		
Number of infants vaccinated (to be vaccinated) with 3 dose of Pneumococcal (PCV13)	926,596	419,715	711,626	949,944	951,364	974,217		
Pneumococcal (PCV13) coverage	94 %	43 %	94 %	94 %	94 %	94 %	0 %	0 %
Wastage[1] rate in base-year and planned thereafter (%)	0	1	0	5	5	5		
Wastage[1] factor in base-year and planned thereafter (%)	1.05	1.01	1.05	1.05	1.05	1.05	1	1
Maximum wastage rate value for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	5 %	5 %	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1 dose of Rotavirus	685,681	613,983	948,834	970,156	971,606	994,945		
Number of infants vaccinated (to be vaccinated) with 2 dose of Rotavirus	685,681	483,105	948,834	949,944	951,364	974,217		
Rotavirus coverage	94 %	49 %	94 %	94 %	94 %	94 %	0 %	0 %
Wastage[1] rate in base-year and planned thereafter (%)	0	1	0	5	5	5		
Wastage[1] factor in base-year and planned thereafter (%)	1.05	1.01	1.05	1.05	1.05	1.05	1	1
Maximum wastage rate value for Rotavirus, 2-dose schedule	5 %	5 %	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles		919,825	929,067	949,944	951,364	974,217		
Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles		523,891	929,067	858,992	951,364	880,941		
Measles coverage	94 %	53 %	94 %	85 %	94 %	85 %	0 %	0 %
Wastage[1] rate in base-year and planned thereafter (%) {0}		21	0	25	25	25		
Wastage[1] factor in base-year and planned thereafter (%)		1.27	1.33	1.33	1.33	1.33	1	1
Maximum wastage rate value for Measles second dose, 10 dose(s) per vial, LYOPHILISED	50.00 %	40.00 %	50.00 %	40.00 %	50.00 %	40.00 %	50.00 %	40.00 %

Number	Achievements as per JRF		Targets (preferred presentation)					
	2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
Pregnant women vaccinated with TT+	863,604	763,182	884,330	904,202	905,554	927,307	927,287	951,023
TT+ coverage	85 %	74 %	85 %	85 %	85 %	85 %	85 %	85 %
Vit A supplement to mothers within 6 weeks from delivery	501,906	508,521	513,952	858,992	526,287	880,941	538,918	903,472
Vit A supplement to infants after 6 months	453,646	1,578,489	464,533	858,992	475,682	880,941	487,099	903,472
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	0 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %

** Number of infants vaccinated out of total surviving infants

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

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

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

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

5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2012 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2012.** The numbers for 2013 - 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 figures for annual births is not consistent with the figures Ghana provided to GAVI in the 2011 APR. This is because, though, Ghana conducted Population and Housing Census (PHC) in 2010, the final figures including the population structure (age breakdown) became available only in 2012. Ghana therefore reported with projected figures for the 2000 PHC in the 2011 APR and the new figures (2010 PHC) in the 2012 APR. This has resulted in a change in the figures for annual births for the respective periods.

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

  The figures for surviving infants is not consistent with the figures Ghana provided to GAVI in the 2011 APR. This is because, though, Ghana conducted Population and Housing Census (PHC) in 2010, the final figures including the population structure (age breakdown) became available only in 2012. Ghana therefore reported with projected figures for the 2000 PHC in the 2011 APR and the new figures (2010 PHC) in the 2012 APR. This has resulted in a change in the figures for surviving infants for the respective periods.

- 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.**

  The coverage target quoted in the 2011 APR has been maintained in 2012 APR. However the target for the 2nd dose of measles was changed from 94% to 85% based on the performance in 2012.

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

  The wastage rates quoted in the 2011 APR has been maintained in the 2012 APR. The wastage rate for DPT-HepB-Hib was changed from 25% to 10% based on the 2012 achievement.

5.2. Immunisation achievements in 2012

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2012 and how these were addressed:

Key Major Activities Conducted

- Routine immunization in all health facilities and outreach points
- Conducted one round of Polio NIDs
- Introduced 2nd dose of measles vaccination
- Conducted review of the EPI Programme in Ghana
- Commemorated African Vaccination Week
- Commemorated Child Health Promotion Week
- Introduced vaccines for pneumonia and diarrhoea
- Conducted the 2nd Phase of Yellow Fever Preventive Campaign
- Conducted Meningitis Preventive Campaign

Highlights of 2012 Performance

- The country has not recorded any documented death from measles
- Since November 2008 there has not been any report of wild polio virus
- No region, district or health facility in the country reported of vaccine shortage within the year
- The number of children vaccinated with the 3rd dose of DPT-HepB-Hib increased from 887,086 in 2011 to 908,821 in 2012.
- About 21,735 more children were reached in 2012 than in 2011
- First GAVI eligible country to introduce two new vaccines concurrently
- Ghana won 2 out of 8 awards at the GAVI Partners meeting

Challenges Faced

- Weak engagement of communities in routine immunization
- Inadequate funds at the operational level
- Poor documentation
- Weak/broken down motorbikes for outreach services

These Challenges were addressed through the following;

- Strengthening linkages at the community level with opinion leaders and political heads
- 'Thinking outside the box' to solicit for funds from other partners
- Target data management supportive supervision
- Implementation of Planned Preventive Maintenance

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

Targets for all antigens were not reached because of the following;

- Poor documentation (Tallying and recording)
- Lack of infrastructure in some districts
- Irregular/late release of funds for operations
- Low card retention/failure to tally appropriate status of pregnant women

5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **yes, 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

Demographic and Health Survey, Ghana	2008	88.8%	88.8%

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

NA

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

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

No such barriers exist in Ghana

5.4. Data assessments

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

There was no discrepancy between Ghana's data and the WHO/UNICEF Estimate of National Coverage data for 2011. We hope there will be no discrepancy in the 2012 data.

* Please note that the WHO UNICEF estimates for 2012 will only be available in July 2013 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2011 to the present? **Yes**

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

EPI Coverage Surveys were conducted in the 1st Quarter of 2011, 2012 and 2013. This is part of the strategies to identify strengths for replication and weaknesses that have to be addressed in subsequent years.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2010 to the present.

In 2011, data management training was organize for Regional Level EPI Data Managers to improve data management and mapping.

The Ghana Health Service has instituted monthly data validation meeting at the national level (GHS/EPI, WHO, National Public Health and Reference Laboratory, Noguchi Memorial Institute for Medical Research) to reconcile immunization, laboratory and surveillance data.

The National EPI Office has instituted monthly feedback of routine immunization data to regions highlighting key areas/districts for support. Regions have also instituted monthly data validation with districts and also send monthly feedback on immunization performance to districts.

To improve data accuracy and consistency, the Ghana Health Service has deployed Districts Health Information Management System (DHIMS). With this system, data entry is only done at the districts level. Key actors at the regional and national level have access to the database. This not withstanding, the Programme still uses an Excel-based District Vaccination Data Management Tool (DVDMT) to validate data in the DHIMS.

As part of the activities for the introduction of pneumococcal and rotavirus vaccines staff at all levels were trained in data management (Tallying, recording, filling and reporting).

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

The are plans to organize training of all EPI Coordinators and Data Managers in DHIMS and DVDMT.

The EPI Sub-Techical Committee comprising the EPI Programme, WHO and WHO will continue to discuss data management issues and regular monitoring and support visit at all levels to identify deficiencies and strengths in the management of data.

EPI Coverage Survey will also be conducted every year to validate the administrative data.

5.5. Overall Expenditures and Financing for Immunisation

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

Exchange rate used	1 US$ = 1.7	Enter the rate only; Please do not enter local currency name

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

Expenditure by category	Expenditure Year 2012	Source of funding						
		Country	GAVI	UNICEF	WHO	Rotary	NA	NA
Traditional Vaccines*	1,404,737	1,404,737	0	0	0	0	0	0
New and underused Vaccines**	37,610,403	2,150,914	35,459,489	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	9,246,723	415,437	8,831,286	0	0	0	0	0

Cold Chain equipment	489,299	489,299	0	0	0	0	0	0
Personnel	77,598	77,598	0	0	0	0	0	0
Other routine recurrent costs	0	0	0	0	0	0	0	0
Other Capital Costs	250,866	250,866	0	0	0	0	0	0
Campaigns costs	3,911,977	0	1,950,000	0	1,943,977	18,000	0	0
NA		0	0	0	0	0	0	0
Total Expenditures for Immunisation	52,991,603							
Total Government Health		4,788,851	46,240,775	0	1,943,977	18,000	0	0

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

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2013 and 2014

NA

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Not selected**

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

Action plan from Aide Mémoire	Implemented?

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

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

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2012? **11**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2013 endorsing this report.

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

With regards to section 5.1, the ICC was concerned about the target population with regards to the change from the projected 2000 Population and Housing Census (PHC) data to the 2010 PHC data. The ICC noted that the district breakdown of the 2010 PHC was yet to be released coupled with the fact that new districts were being created. The ICC advised the Monitoring and Evaluation Department of the Ghana Health Service to expedite actions in getting the district breakdown of the 2010 PHC. With regards to the overall expenditures and financing, the ICC approved the budget for implementation and advised that the EPI Programme solicits for funds from other sources to support routine immunization.

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

If Yes, which ones?

List CSO member organisations:
Coalition of NGOs in Health
Rotary International, Ghana National Polio Plus Committee
Paediatric Society of Ghana

Ghana Registered Midwives Association
Church of Jesus Christ of Latter Day Saints (LDS)

5.8. Priority actions in 2013 to 2014

What are the country's main objectives and priority actions for its EPI programme for 2013 to 2014

Main Objectives with Priority Actions

- Update the programme's cMYP with new policies and innovations
  - Update the EPI logistics forecasting tool by 20th April
  - Update the cMYP costing tool by 20th April
- Monitor and evaluate programme implementation at all levels
  - Monitoring and supervision of new vaccine introduction in all regions at all levels by end of the year
  - Conduct Post Introduction Evaluation on the new vaccines by July 2013
  - Conduct Vaccine Wastage Sentinel Project from May - Sept 2013
  - Conduct National EPI Cluster Survey in by March 2013
- Foster solid partnership towards the control of vaccine preventable diseases
  - Meeting of National Polio Certification Committee (NCC) at least once in every quarter
  - Meeting of National Polio Experts Committee (NPEC) at least once in every quarter
  - Meeting of Inter-Agency Coordinating Committee (ICC) at least once in every quarter
- Ensure effective management of data and use of data for action at all levels
  - Conduct Data Quality Audit by end of the year
  - Build capacity in Data Management at all levels during supportive supervision
  - Hold Review Meetings regularly
- Improve Access to New Vaccines and Innovative Technologies for vaccine preventable diseases
  - Pilot the introduction of HPV Vaccine in selected districts in September
  - Replace TT vaccine with Td vaccine in the last quarter
  - Replace measles vaccine with measles-rubella vaccine in the last quarter
- Heighten awareness on available child health interventions, particularly, immunization
  - Commemorate African Vaccination Week in April 2013
  - Commemorate Child Health Promotion Week in May 2013
- Accelerate the control and prevention of vaccine preventable diseases
  - Conduct Sub-National Meningitis (A&C) Preventive Campaign in Ashanti Region in February 2013
  - Conduct two rounds of Polio Vaccination Campaigns in May and September
  - Conduct Measles-Rubella Vaccination Campaign in August 2013
- Increase and maintain routine immunization coverage for all childhood antigens to 90% and above
  - Improve Communication for Routine Immunization
- Promote and ensure injection safety
  - Construct incinerators in new districts and old districts without standard incinerators

5.9. Progress of transition plan for injection safety

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

Please report what types of syringes are used and the funding sources of Injection Safety material in 2012

Vaccine	Types of syringe used in 2012 routine EPI	Funding sources of 2012
BCG	Auto-Disable Syringe 0.05ml	Government of Ghana
Measles	Auto-Disable Syringe 0.5ml	Government of Ghana and GAVI
TT	Auto-Disable Syringe 0.5ml	Government of Ghana
DTP-containing vaccine	Auto-Disable Syringe 0.5ml	Government of Ghana and GAVI
Yellow Fever	Auto-Disable Syringe 0.5ml	Government of Ghana and GAVI
PCV-13	Auto-Disable Syringe 0.5ml	Government of Ghana and GAVI

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

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

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

The Government of Ghana has been paying for injection safety supplies since 2006. Though, issues relating to injection safety has been adequately addressed in the revised Policy on Immunizations in Ghana (2011), there is need to review the country's injection safety policy. The problems we encountered during implementation of the plan are as follows:

- Inadequate fundingremains a major problem
- Creation of newdistricts - 32 districts were created in 2007 (all provided with incinerator), 46 new districts were created in 2011 which will need incinerators. All these are outside the original Injection Safety Plan
- Some of the oldincinerators (which are more than 7 years old) need major rehabilitation at thetime cash flow is problematic
- Lack of ownership by some districts in terms of maintenance

Please explain in 2012 how sharps waste is being disposed of, problems encountered, etc.

Incinerators have been constructed for all the older districts as well as the 32 districts that were created in 2007. Plans are underway for the construction of incinerators for the 45 new districts that were created in 2011. The Government has procured 20 mobile incinerator which could easily be transported to problematic areas in times of emergency.

Sharps waste are destroyed by incineration and for areas where there are noincinerators they are burnt in pits. Complete incineration of the needles hasbeen problematic because high temperatures are not achieved during burning.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2012

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	0	0
Remaining funds (carry over) from 2011 *(B)*	690,415	1,132,281
Total funds available in 2012 *(C=A+B)*	690,415	1,132,281
Total Expenditures in 2012 *(D)*	370,742	608,017
Balance carried over to 2013 *(E=C-D)*	319,673	524,264

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

The GAVI ISS funds is included in the National Health Sector Plans and Budgets as part of the GAVI support. Budget relating to ISS are prepared and submitted to the ICC for approval. During implementation, budget for specific activities are prepared and approved by the Director General of the Ghana Health Service. The delays in ISS funds affects programme implementation as a number of activities are made to wait till funds are received.

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

Accounts Holder: GhanaHealth Service
Currency: US Dollars
Bank Account's Title: GHS Earmarked USD Accounts
Bank's Name: Ecobank Ghana Limited
Bank Type: Commercial
Account Auditors: Ghana Audit Service and Ernst and Young
Account Number: 1101-530640-226

ISS Funds are approved by the ICC. Specific activity budgets areprepared and submitted to the Director General of the Ghana Health Service forapproval. Budget allocations to lower levels are also approved by the ICC andthe Director General before cheques are written. Upon completion of anactivity, the technical report together with the financial report are submittedto the Director General.

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2012

Procurement of spare parts for refrigerators

Servicing and maintenance of vehicles

Rehabilitation of the Sub-National Cold Room in Tamale

Procured one hyundai Refrigerated Van

Procured two double cabin Toyota Hilux

Procured one True Energy Solar Powered Refrigerator

Procured Hub-cutter to improve injection safety

Immunization Data Validation and Reconciliation

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

6.2. Detailed expenditure of ISS funds during the 2012 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2012 calendar year (Document Number 7) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

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

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number 8).

6.3. Request for ISS reward

Request for ISS reward achievement in Ghana is not applicable for 2012

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

7.1. Receipt of new & under-used vaccines for 2012 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2012 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2012 vaccinations against approvals for 2012

	[A]	[B]		
Vaccine type	**Total doses for 2012 in Decision Letter**	**Total doses received by 31 December 2012**	**Total doses of postponed deliveries in 2012**	**Did the country experience any stockouts at any level in 2012?**
DTP-HepB-Hib	3,709,054	2,284,100	1,425,100	No
Yellow Fever	1,206,800	1,106,800	0	No
Pneumococcal (PCV13)	3,648,473	3,649,100	0	No
Rotavirus	1,799,914	1,968,100	0	No
Measles		2,285,300	0	No

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

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

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

  The delivery of 1,560,900 doses of DTP-HepB-Hib vaccines for 2011 was rescheduled for 2012 to avoid overstocking

- 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.

  Postponement of shipment deliveries to avoid over-stocking

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.

NA

7.2. Introduction of a New Vaccine in 2012

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2012, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

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

Measles second dose, 10 dose(s) per vial, LYOPHILISED		
Phased introduction	No	
Nationwide introduction	Yes	01/02/2012
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Ghana planned to introduce Measles Second Dose in April 2012 as part of the activities for the 2012 African Vaccination Week. However, GAVI needed some clarifications on Ghana's application for pneumococcal and rotavirus vaccines. The approval to introduce the new vaccines was finally given in July 2011. In addition, the funds for the introduction of the new vaccines arrived in the country in the last quarter of 2011. In view of the numerous activities that had to be undertaken before the introduction of the new vaccines, the country decided to introduce Measles Second Dose in February 2012 and the new vaccines in the middle of 2012.

Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
Phased introduction	No	
Nationwide introduction	Yes	02/05/2012
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Ghana planned to introduce pneumococcal vaccine together with rotavirus vaccine in January 2012 and Measles Second Dose in April 2012 as part of the activities for the 2012 African Vaccination Week. However, GAVI needed some clarifications on Ghana's application. The approval to introduce the new vaccines was finally given in July 2011. In addition, the funds for the introduction of the new vaccines arrived in the country in the last quarter of 2011. In view of the numerous activities that had to be undertaken before the introduction of the new vaccines, the country decided to introduce Measles Second Dose in February 2012 and the new vaccines in the middle of 2012.

Rotavirus, 1 dose(s) per vial, ORAL		
Phased introduction	No	
Nationwide introduction	Yes	02/05/2012
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Ghana planned to introduce rotavirus vaccine together with pneumococcal vaccine in January 2012 and Measles Second Dose in April 2012 as part of the activities for the 2012 African Vaccination Week. However, GAVI needed some clarifications on Ghana's application. The approval to introduce the new vaccines was finally given in July 2011. In addition, the funds for the introduction of the new vaccines arrived in the country in the last quarter of 2011. In view of the numerous activities that had to be undertaken before the introduction of the new vaccines, the country decided to introduce Measles Second Dose in February 2012 and the new vaccines in the middle of 2012.

Yellow Fever, 5 dose(s) per vial, LYOPHILISED		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	NA

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

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

NA

7.2.3. Adverse Event Following Immunization (AEFI)

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

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

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

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

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

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

Does your country conduct special studies around:

a. rotavirus diarrhea? **Yes**

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:

The Coordinators of the sentinel sties are yet to present their findings to the ICC

7.3. New Vaccine Introduction Grant lump sums 2012

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2012 (A)	0	0
Remaining funds (carry over) from 2011 (B)	914,992	1,555,486
Total funds available in 2012 (C=A+B)	914,992	1,555,486
Total Expenditures in 2012 (D)	883,946	1,502,709
Balance carried over to 2013 (E=C-D)	31,046	52,777

Detailed expenditure of New Vaccines Introduction Grant funds during the 2012 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2012 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

- Advocacy, Communication and Social Mobilization
- Support to regions and districts
- Material development and Training
- Knowledge, Attitude, Beliefs and Practices (KABP) Study
- Piloting of New Vaccine Introduction in two districts
- Advertising and Event Organization
- National Launching
- Adverse Events Following Immunization (AEFI) Monitoring System
- Monitoring and Evaluation of New Vaccine Introduction

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

The major problem encountered was the delay in the delivery of the rotavirus vaccine. This affected the new vaccines introduction training as the actual vaccine was not available for demonstration. The late arrival of the vaccine also affected the timing of the piloting. The piloting was done barely one week to the national introduction and as such not much lessons were learnt. The implementation was also affected by the delay in the printing of data collection tools especially the child health record and tally sheet books. We improvised by designing inserts/addendum to the old recording tools for use.

Please describe the activities that will be undertaken with any remaining balance of funds for 2013 onwards

NA

7.4. Report on country co-financing in 2012

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2012?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	536,462	284,100
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED	0	0
Awarded Vaccine #3: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	818,454	194,400
Awarded Vaccine #4: Rotavirus, 1 dose(s) per vial, ORAL	462,048	168,000
Awarded Vaccine #5: Yellow Fever, 5 dose(s) per vial, LYOPHILISED	249,303	342,800
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2012 from the following sources?	
Government	1604219	
Donor	0	
Other	0	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	

Co-Financed Payments	Total Amount in US$	Total Amount in Doses
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	40,273	284,100
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED	0	0
Awarded Vaccine #3: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	48,149	194,400
Awarded Vaccine #4: Rotavirus, 1 dose(s) per vial, ORAL	24,452	168,000
Awarded Vaccine #5: Yellow Fever, 5 dose(s) per vial, LYOPHILISED	69,063	342,800
	Q.4: When do you intend to transfer funds for co-financing in 2014 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2014	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	April	Government of Ghana
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED	April	Government of Ghana
Awarded Vaccine #3: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	April	Government of Ghana
Awarded Vaccine #4: Rotavirus, 1 dose(s) per vial, ORAL	April	Government of Ghana
Awarded Vaccine #5: Yellow Fever, 5 dose(s) per vial, LYOPHILISED	April	Government of Ghana
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	Ghana will require assistance in the area of high level advocacy (Parliament, Cabinet, traditional leaders and Private organization) to mobilize funds to support immunization activities	

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

NA

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

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

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

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **September 2010**

Please attach:

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

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

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

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

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

If yes, provide details

The only region out of the ten regions which was yet to construct and install their walk-in-cold room has almost finish with the superstructure. The walk-in-cold room will be installed latest by the third quarter of 2013. Fridge tags, vaccine refrigerators and vaccine carriers have all been delivered. The procurement process for continuous temperature monitor has also been initiated.

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

7.6. Monitoring GAVI Support for Preventive Campaigns in 2012

7.6.1. Vaccine Delivery

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

[A]	[B]	[C]
Total doses approved in DL	**Campaign start date**	**Total doses received (Please enter the arrival dates of each shipment and the number of doses of each shipment)**
3539200	10/9/2012	3,329,000 (28th September 2012)

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

Though the quantity received was less than what was stated in the decision letter, we adjusted the wastage factor from 1.18 to 1.10. The campaign was conducted without any shortage of vaccine

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

NA

7.6.2. Programmatic Results of Meningococcal type A preventive campaigns

Geographical Area covered	Time period of the campaign	Total number of Target population	Achievement, i.e., vaccinated population	Administrative Coverage (%)	Survey Coverage (%)	Wastage rates	Total number of AEFI	Number of AEFI attributed to MenA vaccine
Northern Sector (3 regions)	9 - 18 October	3098348	3038393	98	90	3	621	0

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

Has the campaign been conducted according to the plans in the approved proposal?" **Yes**

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

According to the plan that was submitted to GAVI, the campaign was scheduled for November 2011 and targeted about 2,999,293 persons. The campaign was rescheduled to October 2012 and the target population was adjusted to reflect the current population of the targeted geographical area.

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

The campaign aimed at reaching 95% of the targeted population. We were able to reach 98.1% of the target. This target was achieved through the following;

- High political commitment
- Advocacy and social mobilization for effective partnership, collaboration and public support
- Improved microplans at lower level
- Improved data and logistics management
- Good level of collaboration with GES, Assemblies and communities
- Improved communication between teams and supervisors
- Adequate media coverage of the campaign

What lessons have you learned from the campaign?

- Marking of finger nails of children less than 5 years to avoid double vaccination
- High level of awareness on the risk of the disease made those outside the target desire for the vaccine
- Early involvement of the education sector in planning was a plus since school-based vaccination was a major strategy
- Good social mobilization was key to the success of the programme
- Early involvement of stakeholders is paramount

7.6.3. Fund utilsation of operational cost of Meningococcal type A preventive campaigns

Category	Expenditure in Local currency	Expenditure in USD
Supervision and Monitoring	102000	60000
AEFI Surveillance	170000	100000
Construction of incinerators	544000	320000
Compilational of Reports	11025	6485
Independent monitoring	68000	40000
Vaccination card	268600	158000
Training	284872	167572
Social Mobilisation, IEC and Advocacy	413003	242943
Vehicles and Transportation	306000	180000
Human Resources	1147500	675000
Total	**3315000**	**1950000**

7.7. Change of vaccine presentation

Ghana 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 2013

Renewal of multi-year vaccines support for Ghana is not available in 2013

7.9. Request for continued support for vaccines for 2014 vaccination programme

In order to request NVS support for 2014 vaccination do the following

Confirm here below that your request for 2014 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don’t confirm, please explain

NA

7.11. Calculation of requirements

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

ID		Source		2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	985,422	1,010,579	1,036,402	1,062,907	4,095,310
	Number of children to be vaccinated with the first dose	Table 4	#	953,052	970,156	994,945	1,020,391	3,938,544
	Number of children to be vaccinated with the third dose	Table 4	#	908,821	949,944	974,217	999,133	3,832,115
	Immunisation coverage with the third dose	Table 4	%	92.23 %	94.00 %	94.00 %	94.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.05	1.11	1.11	1.11	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	2,586,000				
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	2,586,000				
	Number of doses per vial	Parameter	#		10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.04	2.04	1.99	
cc	**Country co-financing per dose**	Co-financing table	$		0.23	0.26	0.30	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	0.00 %	

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

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

NA

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

Co-financing group	Intermediate

	2012	2013	2014	2015
Minimum co-financing	0.20	0.23	0.26	0.30
Recommended co-financing as per APR 2011			0.26	0.30
Your co-financing	0.20	0.23	0.26	0.30

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

		2013	2014	2015
Number of vaccine doses	#	2,947,500	2,943,700	2,946,000
Number of AD syringes	#	2,952,700	2,945,300	2,947,600

Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	32,775	32,700	32,725
Total value to be co-financed by GAVI	$	6,541,500	6,533,000	6,381,500

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

		2013	2014	2015
Number of vaccine doses	#	340,800	390,700	473,700
Number of AD syringes	#	341,400	390,900	473,900
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	3,800	4,350	5,275
Total value to be co-financed by the Country ^[1]	$	756,500	867,000	1,026,000

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

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	10.36 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	953,052	970,156	100,542	869,614
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B X C*	2,859,156	2,910,468	301,626	2,608,842
E	Estimated vaccine wastage factor	*Table 4*	1.05	1.11		
F	Number of doses needed including wastage	*D X E*	3,002,114	3,230,620	334,805	2,895,815
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		57,127	5,921	51,206
H	Stock on 1 January 2013	*Table 7.11.1*	2,586,000			
I	Total vaccine doses needed	*F + G – H*		3,288,247	340,777	2,947,470
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		3,294,031	341,376	2,952,655
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		36,564	3,790	32,774
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		6,694,871	693,821	6,001,050
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		153,173	15,875	137,298
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)*		21,208	2,198	19,010
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		428,472	44,405	384,067
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)*		7,297,724	756,297	6,541,427
U	Total country co-financing	*I x country co-financing per dose (cc)*		756,297		
V	Country co-financing % of GAVI supported proportion	*U / T*		10.36 %		

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

		Formula	2014			2015		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	11.72 %			13.85 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	994,945	116,564	878,381	1,020,391	141,324	879,067
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	2,984,835	349,691	2,635,144	3,061,173	423,972	2,637,201
E	Estimated vaccine wastage factor	*Table 4*	1.11			1.11		
F	Number of doses needed including wastage	*D X E*	3,313,167	388,157	2,925,010	3,397,903	470,609	2,927,294
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	20,637	2,418	18,219	21,184	2,934	18,250
H	Stock on 1 January 2013	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	3,334,304	390,633	2,943,671	3,419,587	473,612	2,945,975
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	3,336,074	390,841	2,945,233	3,421,417	473,866	2,947,551
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	37,031	4,339	32,692	37,978	5,260	32,718
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	6,788,643	795,329	5,993,314	6,791,300	940,594	5,850,706
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	6,788,643	18,175	136,953	6,791,300	22,035	137,061
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	21,478	2,517	18,961	22,028	3,051	18,977
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	434,474	50,902	383,572	434,644	60,199	374,445
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	7,399,723	866,920	6,532,803	7,407,068	1,025,878	6,381,190
U	Total country co-financing	*I x country co-financing per dose (cc)*	866,920			1,025,877		
V	Country co-financing % of GAVI supported proportion	*U / T*	11.72 %			13.85 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
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 7.11.1: Specifications for Measles second dose, 10 dose(s) per vial, LYOPHILISED

ID		Source		2012	2013	2014	TOTAL
	Number of surviving infants	Table 4	#	985,422	1,010,579	1,036,402	3,032,403
	Number of children to be vaccinated with the first dose	Table 4	#	919,825	949,944	974,217	2,843,986
	Number of children to be vaccinated with the second dose	Table 4	#	523,891	858,992	880,941	2,263,824
	Immunisation coverage with the second dose	Table 4	%	53.16 %	85.00 %	85.00 %	
	Number of doses per child	Parameter	#	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	1.27	1.33	1.33	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	1,836,500			
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	1,836,500			
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		0.27	0.29	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.00	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		14.00 %	14.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	

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

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

NA

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

Co-financing group	Intermediate

	2012	2013	2014
Minimum co-financing	0.00	0.00	0.00
Recommended co-financing as per APR 2011			0.00
Your co-financing			0.00

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

		2013	2014
Number of vaccine doses	#	1,261,900	1,179,100
Number of AD syringes	#	1,085,900	986,000
Number of re-constitution syringes	#	140,100	130,900
Number of safety boxes	#	13,625	12,400
Total value to be co-financed by GAVI	$	463,000	448,500

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

		2013	2014
Number of vaccine doses	#	0	0
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by the Country ^[1]	$	0	0

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

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	523,891	858,992	0	858,992
C	Number of doses per child	*Vaccine parameter (schedule)*	1	1		
D	Number of doses needed	*B X C*	523,891	858,992	0	858,992
E	Estimated vaccine wastage factor	*Table 4*	1.27	1.33		
F	Number of doses needed including wastage	*D X E*	665,342	1,142,460	0	1,142,460
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		119,280	0	119,280
H	Stock on 1 January 2013	*Table 7.11.1*	1,836,500			
I	Total vaccine doses needed	*F + G – H*		1,261,840	0	1,261,840
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		1,085,882	0	1,085,882
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		140,065	0	140,065
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		13,609	0	13,609
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		344,483	0	344,483
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		50,494	0	50,494
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		5,183	0	5,183
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		7,894	0	7,894
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		48,228	0	48,228
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		6,358	0	6,358
T	Total fund needed	*(N+O+P+Q+R+S)*		462,640	0	462,640
U	Total country co-financing	*I x country co-financing per dose (cc)*		0		
V	Country co-financing % of GAVI supported proportion	*U / T*		0.00 %		

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

		Formula	2014		
			Total	Government	GAVI
A	Country co-finance	*V*	0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	880,941	0	880,941
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B X C*	880,941	0	880,941
E	Estimated vaccine wastage factor	*Table 4*	1.33		
F	Number of doses needed including wastage	*D X E*	1,171,652	0	1,171,652
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	7,298	0	7,298
H	Stock on 1 January 2013	*Table 7.11.1*			
I	Total vaccine doses needed	*F + G – H*	1,179,050	0	1,179,050
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	985,946	0	985,946
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	130,875	0	130,875
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	12,397	0	12,397
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	337,209	0	337,209
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	337,209	0	45,847
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	4,843	0	4,843
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	7,191	0	7,191
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	47,210	0	47,210
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	5,789	0	5,789
T	Total fund needed	*(N+O+P+Q+R+S)*	448,089	0	448,089
U	Total country co-financing	*I x country co-financing per dose (cc)*	0		
V	Country co-financing % of GAVI supported proportion	*U / T*	0.00 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
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 7.11.1: Specifications for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

ID		Source		2012	2013	2014	TOTAL
	Number of surviving infants	Table 4	#	985,422	1,010,579	1,036,402	3,032,403
	Number of children to be vaccinated with the first dose	Table 4	#	667,237	970,156	994,945	2,632,338
	Number of children to be vaccinated with the third dose	Table 4	#	419,715	949,944	974,217	2,343,876
	Immunisation coverage with the third dose	Table 4	%	42.59 %	94.00 %	94.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.01	1.05	1.05	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	1,667,800			
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	1,667,800			
	Number of doses per vial	Parameter	#		1	1	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		3.50	3.50	
cc	**Country co-financing per dose**	Co-financing table	$		0.23	0.26	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.00 %	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	

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

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

NA

Co-financing tables for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

Co-financing group	Intermediate

	2012	2013	2014
Minimum co-financing	0.20	0.23	0.26
Recommended co-financing as per APR 2011			0.26
Your co-financing	0.20	0.23	0.26

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

		2013	2014
Number of vaccine doses	#	3,113,900	2,937,600
Number of AD syringes	#	3,302,900	3,104,600
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	36,675	34,475
Total value to be co-financed by GAVI	$	11,727,500	11,063,000

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

		2013	2014
Number of vaccine doses	#	202,600	217,900
Number of AD syringes	#	214,900	230,300
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	2,400	2,575
Total value to be co-financed by the Country ^[1]	$	763,000	820,500

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 1)

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	6.11 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	667,237	970,156	59,248	910,908
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B X C*	2,001,711	2,910,468	177,744	2,732,724
E	Estimated vaccine wastage factor	*Table 4*	1.01	1.05		
F	Number of doses needed including wastage	*D X E*	2,021,729	3,055,992	186,631	2,869,361
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		258,566	15,791	242,775
H	Stock on 1 January 2013	*Table 7.11.1*	1,667,800			
I	Total vaccine doses needed	*F + G – H*		3,316,358	202,532	3,113,826
J	Number of doses per vial	*Vaccine Parameter*		1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		3,517,628	214,823	3,302,805
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		39,046	2,385	36,661
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		11,607,253	708,860	10,898,393
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		163,570	9,990	153,580
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)*		22,647	1,384	21,263
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		696,436	42,532	653,904
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)*		12,489,906	762,763	11,727,143
U	Total country co-financing	*I x country co-financing per dose (cc)*		762,763		
V	Country co-financing % of GAVI supported proportion	*U / T*		6.11 %		

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 2)

		Formula	2014		
			Total	Government	GAVI
A	Country co-finance	*V*	6.90 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	994,945	68,691	926,254
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B X C*	2,984,835	206,073	2,778,762
E	Estimated vaccine wastage factor	*Table 4*	1.05		
F	Number of doses needed including wastage	*D X E*	3,134,077	216,376	2,917,701
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	19,522	1,348	18,174
H	Stock on 1 January 2013	*Table 7.11.1*			
I	Total vaccine doses needed	*F + G – H*	3,155,399	217,848	2,937,551
J	Number of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	3,334,837	230,237	3,104,600
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	37,017	2,556	34,461
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	11,043,897	762,468	10,281,429
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	11,043,897	10,706	144,364
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)*	21,470	1,483	19,987
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	662,634	45,749	616,885
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	11,883,071	820,405	11,062,666
U	Total country co-financing	*I x country co-financing per dose (cc)*	820,404		
V	Country co-financing % of GAVI supported proportion	*U / T*	6.90 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
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 7.11.1: Specifications for Rotavirus, 1 dose(s) per vial, ORAL

ID		Source		2012	2013	2014	TOTAL
	Number of surviving infants	Table 4	#	985,422	1,010,579	1,036,402	3,032,403
	Number of children to be vaccinated with the first dose	Table 4	#	613,983	970,156	994,945	2,579,084
	Number of children to be vaccinated with the second dose	Table 4	#	483,105	949,944	974,217	2,407,266
	Immunisation coverage with the second dose	Table 4	%	49.03 %	94.00 %	94.00 %	
	Number of doses per child	Parameter	#	2	2	2	
	Estimated vaccine wastage factor	Table 4	#	1.01	1.05	1.05	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	779,650			
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	779,650			
	Number of doses per vial	Parameter	#		1	1	
	AD syringes required	Parameter	#		No	No	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		No	No	
g	Vaccine price per dose	Table 7.10.1	$		2.55	2.55	
cc	Country co-financing per dose	Co-financing table	$		0.23	0.26	
ca	AD syringe price per unit	Table 7.10.1	$		0.0465	0.0465	
cr	Reconstitution syringe price per unit	Table 7.10.1	$		0	0	
cs	Safety box price per unit	Table 7.10.1	$		0.5800	0.5800	
fv	Freight cost as % of vaccines value	Table 7.10.2	%		5.00 %	5.00 %	
fd	Freight cost as % of devices value	Parameter	%		0.00 %	0.00 %	

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

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

NA

Co-financing tables for Rotavirus, 1 dose(s) per vial, ORAL

Co-financing group	Intermediate

	2012	2013	2014
Minimum co-financing	0.20	0.23	0.26
Recommended co-financing as per APR 2011			0.26
Your co-financing	0.20	0.23	0.26

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

		2013	2014
Number of vaccine doses	#	2,045,900	1,899,600
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Total value to be co-financed by GAVI	$	5,478,000	5,086,500

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

		2013	2014
Number of vaccine doses	#	192,300	204,400
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Total value to be co-financed by the Country ^[1]	$	515,000	547,500

Table 7.11.4: Calculation of requirements for Rotavirus, 1 dose(s) per vial, ORAL (part 1)

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	8.59 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	613,983	970,156	83,338	886,818
C	Number of doses per child	*Vaccine parameter (schedule)*	2	2		
D	Number of doses needed	*B X C*	1,227,966	1,940,312	166,675	1,773,637
E	Estimated vaccine wastage factor	*Table 4*	1.01	1.05		
F	Number of doses needed including wastage	*D X E*	1,240,246	2,037,328	175,009	1,862,319
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		199,271	17,118	182,153
H	Stock on 1 January 2013	*Table 7.11.1*	779,650			
I	Total vaccine doses needed	*F + G – H*		2,238,099	192,256	2,045,843
J	Number of doses per vial	*Vaccine Parameter*		1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		0	0	0
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*				
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		5,707,153	490,251	5,216,902
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		0	0	0
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)*		0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		285,358	24,513	260,845
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)*		5,992,511	514,763	5,477,748
U	Total country co-financing	*I x country co-financing per dose (cc)*		514,763		
V	Country co-financing % of GAVI supported proportion	*U / T*		8.59 %		

Table 7.11.4: Calculation of requirements for Rotavirus, 1 dose(s) per vial, ORAL (part 2)

		Formula	2014		
			Total	Government	GAVI
A	**Country co-finance**	*V*	9.71 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	994,945	96,615	898,330
C	**Number of doses per child**	*Vaccine parameter (schedule)*	2		
D	**Number of doses needed**	*B X C*	1,989,890	193,230	1,796,660
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D X E*	2,089,385	202,891	1,886,494
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*	13,015	1,264	11,751
H	**Stock on 1 January 2013**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*F + G – H*	2,103,900	204,301	1,899,599
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*	0	0	0
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*			
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	5,364,945	520,966	4,843,979
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	5,364,945	0	0
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)*	0	0	0
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	268,248	26,049	242,199
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)*	5,633,193	547,014	5,086,179
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	547,014		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	9.71 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	Country co-finance	*V*
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*
C	Number of doses per child	*Vaccine parameter (schedule)*
D	Number of doses needed	*B X C*
E	Estimated vaccine wastage factor	*Table 4*
F	Number of doses needed including wastage	*D X E*
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*
H	Stock on 1 January 2013	*Table 7.11.1*
I	Total vaccine doses needed	*F + G – H*
J	Number of doses per vial	*Vaccine Parameter*
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*
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 7.11.1: Specifications for Yellow Fever, 5 dose(s) per vial, LYOPHILISED

ID		Source		2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	985,422	1,010,579	1,036,402	1,062,907	4,095,310
	Number of children to be vaccinated with the first dose	Table 4	#	910,272	949,944	94.00 %	999,133	3,833,566
	Number of doses per child	Parameter	#	1	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	1.23	1.33	1.33	1.33	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	1,001,100				
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	1,001,100				
	Number of doses per vial	Parameter	#		5	5	5	
	AD syringes required	Parameter	#		Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		0.90	0.91	0.92	
cc	**Country co-financing per dose**	Co-financing table	$		0.34	0.39	0.45	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		7.80 %	7.80 %	7.80 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	10.00 %	

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

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

NA

Co-financing tables for Yellow Fever, 5 dose(s) per vial, LYOPHILISED

Co-financing group	Intermediate

	2012	2013	2014	2015
Minimum co-financing	0.20	0.23	0.26	0.30
Recommended co-financing as per APR 2011			0.40	0.46
Your co-financing	0.30	0.34	0.39	0.45

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

		2013	2014	2015
Number of vaccine doses	#	870,500	813,600	766,500
Number of AD syringes	#	733,100	680,300	641,000
Number of re-constitution syringes	#	193,300	180,600	170,200
Number of safety boxes	#	10,300	9,575	9,025
Total value to be co-financed by GAVI	$	896,500	844,000	808,500

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

		2013	2014	2015
Number of vaccine doses	#	429,000	490,400	570,800

Number of AD syringes	#	361,300	410,100	477,300
Number of re-constitution syringes	#	95,300	108,900	126,800
Number of safety boxes	#	5,075	5,775	6,725
Total value to be co-financed by the Country ^[1]	$	442,000	508,500	602,000

Table 7.11.4: Calculation of requirements for Yellow Fever, 5 dose(s) per vial, LYOPHILISED (part 1)

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	33.01 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	910,272	949,944	313,620	636,324
C	Number of doses per child	*Vaccine parameter (schedule)*	1	1		
D	Number of doses needed	*B X C*	910,272	949,944	313,620	636,324
E	Estimated vaccine wastage factor	*Table 4*	1.23	1.33		
F	Number of doses needed including wastage	*D X E*	1,119,635	1,263,426	417,115	846,311
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		35,948	11,869	24,079
H	Stock on 1 January 2013	*Table 7.11.1*	1,001,100			
I	Total vaccine doses needed	*F + G – H*		1,299,424	428,999	870,425
J	Number of doses per vial	*Vaccine Parameter*		5		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		1,094,341	361,292	733,049
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		288,473	95,239	193,234
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		15,350	5,068	10,282
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		1,169,482	386,100	783,382
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		50,887	16,801	34,086
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		10,674	3,524	7,150
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		8,903	2,940	5,963
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		91,220	30,116	61,104
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		7,047	2,327	4,720
T	Total fund needed	*(N+O+P+Q+R+S)*		1,338,213	441,805	896,408
U	Total country co-financing	*I x country co-financing per dose (cc)*		441,805		
V	Country co-financing % of GAVI supported proportion	*U / T*		33.01 %		

Table 7.11.4: Calculation of requirements for Yellow Fever, 5 dose(s) per vial, LYOPHILISED (part 2)

		Formula	2014			2015		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	37.61 %			42.68 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	974,217	366,370	607,847	999,133	426,454	572,679
C	Number of doses per child	*Vaccine parameter (schedule)*	1			1		
D	Number of doses needed	*B X C*	974,217	366,370	607,847	999,133	426,454	572,679
E	Estimated vaccine wastage factor	*Table 4*	1.33			1.33		
F	Number of doses needed including wastage	*D X E*	1,295,709	487,273	808,436	1,328,847	567,183	761,664
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	8,071	3,036	5,035	8,285	3,537	4,748
H	Stock on 1 January 2013	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	1,303,830	490,327	813,503	1,337,182	570,741	766,441
J	Number of doses per vial	*Vaccine Parameter*	5			5		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,090,340	410,040	680,300	1,118,234	477,289	640,945
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	289,451	108,853	180,598	296,855	126,705	170,150
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	15,316	5,760	9,556	15,708	6,705	9,003
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	1,182,574	444,726	737,848	1,234,219	526,794	707,425
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	1,182,574	19,067	31,634	1,234,219	22,194	29,804
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	10,710	4,028	6,682	10,984	4,689	6,295
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	8,884	3,341	5,543	9,111	3,889	5,222
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	92,241	34,689	57,552	96,270	41,091	55,179
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	7,030	2,644	4,386	7,210	3,078	4,132
T	Total fund needed	*(N+O+P+Q+R+S)*	1,352,140	508,495	843,645	1,409,792	601,732	808,060
U	Total country co-financing	*I x country co-financing per dose (cc)*	508,494			601,732		
V	Country co-financing % of GAVI supported proportion	*U / T*	37.61 %			42.68 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
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*

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2012**. All countries are expected to report on:

    a. Progress achieved in 2012

    b. HSS implementation during January – April 2013 (interim reporting)

    c. Plans for 2014

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

For countries that received HSS funds within the last 3 months of 2012, or experienced other delays that limited implementation in 2012, 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 2012 fiscal year starts in January 2012 and ends in December 2012, HSS reports should be received by the GAVI Alliance before **15th May 2013**. 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 2013, the HSS reports are expected by GAVI Alliance by September 2013.

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

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

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

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

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

    a. Minutes of all the HSCC meetings held in 2012

    b. Minutes of the HSCC meeting in 2013 that endorses the submission of this report

    c. Latest Health Sector Review Report

    d. Financial statement for the use of HSS funds in the 2012 calendar year

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

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

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

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

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

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

9.1. Report on the use of HSS funds in 2012 and request of a new tranche

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

9.1.1. Report on the use of HSS funds in **2012**

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

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

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

If yes, please indicate the amount of funding requested: **0** US$

These funds should be sufficient to carry out HSS grant implementation through December 2014.

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

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

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)		1035500	7230500	767000	637000	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)		1035500		3615250	2509625	2509625
Total funds received from GAVI during the calendar year (*A*)		1035500		3615250	2509625	
Remaining funds (carry over) from previous year (*B*)			762236	407449	2463160	3860055
Total Funds available during the calendar year (*C=A+B*)		1035500	762236	4022699	4972785	3860055
Total expenditure during the calendar year (*D*)		273264	354787	1559539	1112730	2312828
Balance carried forward to next calendar year (*E=C-D*)		762236	407449	2463160	3860055	1547227
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2013	2014	2015	2016
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*)	2509625			
Remaining funds (carry over) from previous year (*B*)	1547227			
Total Funds available during the calendar year (*C=A+B*)	4056852			
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)		1006506	9023664	1092208	943397	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)		1006506		5148116	3716754	4050534
Total funds received from GAVI during the calendar year (*A*)		1006506		5148116	3716754	
Remaining funds (carry over) from previous year (*B*)			678862	582244	3576508	5572982
Total Funds available during the calendar year (*C=A+B*)		1006506	678862	5728323	7293262	5572982
Total expenditure during the calendar year (*D*)		327643	506990	2264450	1720280	3732904
Balance carried forward to next calendar year (*E=C-D*)		913920	582244	3576508	5572982	1840078
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2013	2014	2015	2016
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*)	4050534			
Remaining funds (carry over) from previous year (*B*)	1840078			
Total Funds available during the calendar year (*C=A+B*)	5890612			
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
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 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January	0.912	0.972	1.248	1.424	1.481	1.614
Closing on 31 December	0.968	1.199	1.429	1.452	1.546	1.98

Detailed expenditure of HSS funds during the 2012 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2012 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 2013 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

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

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

Consistent with the Government of Ghana financial managementprocedures, the sector continues to maintain two accounts with the ECOBANKGHANA (cedi and dollar accounts respectively). The operation of these twoaccounts took cognizance of the recommendations from the Ministry of Health 2011Aide Memoire. In terms of funds disbursements for carrying out activities, allfunds are channeled through the Ministry of Health to the Ghana Health Serviceheadquarters and subsequently transferred to the various service implementationlevels (Regional Health Service, District Health Service and Sub Districts).There is a bottom-up approach to financial reporting from the lower levels ofservice delivery (Community, Sub Districts and Districts) through to theMinistry of Health. In this system, the Districts collate financial expenditureoutlays from the lower levels and submit to the Regional level for onwardsubmission to headquarters.

The GHS headquartersquarterly collates and analysis all the financial reports from the variouslevels and then report to the Ministry of Health. At the Ministry headquarterslevel, the financial statements are discussed together with other keyperformance indicators during the quarterly business meeting of the HSCC.

As per agreement by theMinistry of health with its Partners, it was decided that the external auditreport should be ready in nine months after the end of the year. The 2011 auditreport will be submitted for this APR. It is worth noting that the HSS budget is included in the annual health sectorplan and annual work plan of the implementing agencies.

After the 2012 FMA, a lot of work has been done on logistics and improvementof the financial system at the Regional and District levels. Electronically thesystem is being modified to make available electronic financial statementswhich will resolve most of the challenges involved in the current financialsystem.

Has an external audit been conducted? Yes

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

9.2. Progress on HSS activities in the 2012 fiscal year

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

Please provide the following information for each planned activity:

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

Table 9.2: HSS activities in the 2012 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Objective 1	Strengthening District and Sub-districts		N/A
Objective 1.1	Strengthen management capacity in leadership		N/A
Activity 1.1	Equip national and Regional in-service training centres	100	GHS PPMED 2012 Annual report
Activity 1.2	Train District directors and Senior managers in leadership and management	80	GHS HRDD 2012 Annual report
Activity 1.3	Train selected NGOs, RHMT and DDHS in teambuilding	80	GHS HRDD 2012 Annual report
Activity 1.4	Develop simplified financial management and procurement operational manual for sub districts, CHOs and NGOs	100	GHS PPMED 2011 Annual report

Activity 1.5	Train sub district managers and CHOs in procurement and financial management	50	GHS PPMED 2012 Annual report
Objective 1.2	Strengthen District Health planning, prioritization and resource allocation		N/A
Activity 1.2.1	Technical assistance to update DHA tools to support DSS sites	100	GHS PPMED 2011 Report
Activity 1.2.2	Train Senior managers including national, regional and district directors in the use of DHIP and DHA for priority setting and decision-making.	100	GHS PPMED 2012 Report
Objective 1.3	Strengthen Support & Supervision Systems		N/A
Activity 1.3.1	Train district, sub districts and NGOs in supportive supervision		N/A
Activity 1.3.2	Provide fuel and stationery to districts, sub districts and NGOs to undertake supportive supervision	100	GHS PPMED 2012 Annual Report
Objective 2	Expand functional CHPS coverage to deliver essential services especially for MDG 4 and 5	0	N/A
Activity 2.1	Procure vehicles for sub districts	100	GHS HASS 2012 Report
Activity 2.2	Procurement of Service delivery kits for CHOs	100	PPMED Annual Report 2012
Objective 3	Strengthening sub-district Health Information Systems especially at the CHPS zone level using District Wide Information Management System (DWIMS)	0	N/A
Activity 3.1	Procure PDA (Smart phones) for CHOs	50	GHS PPMED 2012 Annual report
Activity 3.2	Train CHOs in the use of PDA (Smart phone) equipment	50	GHS PPMED 2012 Annual report
Activity 3.3	Customise and Integrate PDA data into existing health management information system	80	GHS PPMED 2012 Annual report
Objective 4	Strengthening Information management, M&E and operational and implementation research	0	N/A
Activity 4.1	Undertake operational and implementation research	50	PPMED 2010 Annual Report
Activity 4.2	Support national & regional level M&E	100	GHS 2012 Annual report
Activity 4.3	Review and Evaluation of HSS support	100	GHS PPMED 2011 Annual Report

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

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**

Activity 1.1 Equip national and Regional in-servic	As far as equipping the 10 Regional training centers with conferencing facilities, all the training centres have been resourced and equipped with modern conferencing facilities. As a follow up to this activity, plans were initiated to also resource the offices of the Regional Directors of Health Services to facilitate cross Regional and headquarters communication among managers. At the moment, 3 offices of the Regional Directors in CR, WR and ER have been equipped. The remaining 7 are yet to be resourced.
Activity 1.2 Train District directors and Senior m	As part of GHS support towards the Leadership Development Programme (LDP), in 2012 a number of training programmes were undertaken in six Regions with support from GAVI HSS funds. This includes 111 regional staff made up of Volta Region (41), Greater Accra (35), and Western Region (35) completed. The programme was further rolled out in the three Northern Regions (150). (Northern region 46, Upper East 60 and Upper West 44) GHS was able to mobilize funding aside GAVI for these training programmes. It is envisaged that with the increased number of Districts, GAVI funds would be applied for downstream training in 2013.
Activity 1.3 Train selected NGOs, RHMT and DDHS in	This activity was modified in 2010 (without any change in the intent and contribution to objective one) during the reprogramme. It was implemented together with the support and supervision activity (Activity 1.3.1), capacity building and Sub Districts certification process to address gaps that would be identified. The training programmes would be carried out in the 2nd half of 2013. The sub district when certified will provide better information about the areas of strengthening for which the supportive supervisory visits will tackle. The number and quantum of the supportive supervision will not change. However the two activities have been linked to provide better outcome. The intent within the original plan was not to isolate NGO activities but to make it a part of the implementation of the activities. For example, the CSO were supported to finalize their strategic plan and it is intended that some activities within the strategic plan will be supported within these activity lines. In 2013, CSO/NGOs will be supported to conduct monitoring visits as part of the integrated visits to the sub district and community level.
Activity 1.3.2 Provide fuel and stationery to dist	In 2011, funds were disbursed to all 170 districts and sub-districts to support the provision of fuel and other logistics for supportive supervision. This activity will be continued in 2013 thus funds will be provided for the purchase of fuel for immunisation and outreach activities in the various Districts, Sub districts and CHPS Zone and to improve data capture (Community Health Information Systems). The funds that will be allocated to the Districts will also be used for the servicing of motorbikes in the sub districts to facilitate immunisation activities. In 2012 Support was provided to the districts and subdistricts to districts for service delivery
Activity 1.4 Develop simplified financial manageme	The development of the manual was completed in 2010 The manual was printed in 2011. Its being used for the training in Activity 1.5
Activity 1.5 Train sub district managers and CHOs	Since 2011 to date, a total of 1673 staff in five Regions have been trained namely Greater Accra (157) Central (380 managers), Western (160 managers), Eastern (573 managers) and Ashanti (403 managers) have been trained. There are plans to train the remaining 5 Regions in 2013. Two regions have completed their training as at the the time of submitting this APR. The delays are due to time constraints in scheduling the programme at the sub districts considering their routine and other programme activities, which leaves the sub district with little or no time for other activities. The sub district trainings is aimed at building capacity in management including service delivery at the sub district level with the focus of scaling up interventions in which immunisation and outreach services to the communities are key.

Activity 1.2.1 Technical assistance to update DHA	The Service continues to use the DHIP software developed since 2010 to guide its planning and budgeting for 2012 – 2015 MTEF plans and budget. More tools for planning (situational analysis) are being deveveloped. In 2013, the DHIP together with other existing planning tools would be redefined to take on board the Bottleneck Analysis tool (BNA) which would be used to guide the strategic planning for 2013 – 2018.
Activity 1.2.2 Train Senior managers including nat	Training was carried out in 2012 as part of the overall GHS medium term (MTEF) planning and budgeting process. In 2013, the training would further be complimented with the BNA tools.
Activity 1.3.1 Train district, sub districts and N	National and regional levels were supported to conduct supportive supervisory visits. In 2013 District and subdistrict level supportive supervision visits will be supported from the budget and the national/regional visits evaluated.
Activity 1.3.2 Provide fuel and stationery to dist	In 2011, funds were disbursed to the sub districts to be used to procure fuel to support the sub district staff in their routine activities including immunisation and outreach services. Plans are in place to disburse funds to the District and sub districts in the second quarter of 2013 for outreach and immunisation activities.
Activity 2.1 Procure vehicles for sub districts	A number of vehicles have been purchased to strengthen National, Regional and District capacity to go on routine monitoring visits in the quest to improve the GHS service delivery mandate. The vehicles including 11 Toyota 4WDs and 30 Pickups were received and distributed to the districts and Regions.
Activity 2.2 Procurement of Service delivery kits	The procurement process for the 1,500 service delivery kits was initiated in 2012. The tender and evaluation have been carried out. 1,500 CHOs will receive the service delivery kits in 2013.
Activity 3.1 Procure PDA (Smart phones) for CHOs	The procurement of the PDA was delayed due to modifications for the purchase of an enhanced Smart phone to be able to capture and transfer electric data integrated with the eRegister system. So far 50% of the Smart phones have been procured. The strategy for mobile phones has been expanded to include laptops for the subdistricts which is the supervisory level for the CHPS (who are receiving the phones) In the first quarter of 2013,
Activity 3.2 Train CHOs in the use of PDA (Smart p	Training has been organized for five regions (Regional and district) and the remaining 5 regions will be completed in 2013. The number of staff trained included; Central (180), Volta (190), UER (100), NR (220) and UWR (110).
Activity 3.3 Customise and Integrate PDA data into	Innovatively the PDA system has been upgraded to the use of Smart phones for capturing data. This has been linked to the eRegister system. The eRegister system is also to be expanded and integrated into the DHIMS2.
Activity 4.1 Undertake operational and implementat	The finding from the operational research that was conducted in 2011 has been incorporated into the recommendations for capacity building in sub district management manual. In 2013 further operational research will be conducted in the areas of assessing the impact of the Smart phone, eRegister system and DHIMS2 in strengthening health information management.
Activity 4.2 Support national & regional level M&E	The integrated monitoring and evaluation framework has been disseminated and operationalized at the various levels. A number of trainings has been carried out for senior managers on the DHIMS2 to facilitate data entry, analysis and reporting on all indicators. Specialized trainings are organized weekly (every Monday afternoon) for managers on the DHIMS2. Desk officers at the headquarters (CHIM) have been assigned to each Region to look at the Regional data and provide weekly reports and feedback on the progress of all indicators to the Regions and Districts. The Desk officers also address challenges that are associated with the implementation of DHIMS2 at their respective assigned Regions. GAVI HSS funds are also used to support the routine monitoring and evaluation of the Service including the National, Regional and District performance reviews and senior managers meetings organized annually and biannually respectively.

Activity 4.3 Review and Evaluation of HSS support	In 2012, monitoring of GAVI HSS funds formed part of the routine monitoring of the whole health sector during the District, Regional and Headquarters performance reviews and the Senior Managers meetings. In 2013, there are plans in place to conduct monitoring of GAVI HSS funds at the Regional and Districts levels.

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

The Service has started the process of certifying sub districts as managing BMCs to enable them receive and utilize their own funding in their service delivery operations. As part of the process, plans are in place to build the capacity of sub district managers in management (Finance, procurement and administration). The training in team building (Ref, Activity 1.3) and the training in support supervision (Ref Activity 1.3.1) have been tied to this training.

Five Regions are still outstanding for the sub district management training to be conducted in their Regions. A detailed programme of work has been outlined for these Regions to be trained in 2013. The trainings would be completed by the 3rd Quarter of 2013. The key challenges have been scheduling the trainings so as not to interrupt the routine service delivery activities by the sub district managers. For instance in 2012, two new vaccines were introduced and managers at the subdistrict had to be trained in the proper administration of these vaccines. Aside that, there was need for planning, organization and collaborating with all stakeholders of the service delivery process to ensure effective administration of the vaccines. This brought a lot of pressure on the sub districts managersin ensuring that all the children in the immunization age were fully immunized.This took a lot of time on the part of the sub district managers, hence the rescheduling of the sub district management trainings.

The Review and Evaluation of HSS support has still not been implemented due to the changes in the service leadership. The processfor the assumption of their office and orientation for them to be familiar withall the head quarter's activities takes a while before key service activitiesare carried out.

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

The HSS support has not been used to provide national health human resources incentives but has rather been used for health system strengthening activities in the Service. A key component of these health system activity is the training of the desk officers and key GHS staff in the DHIMS2 software which has improved data capture monitoring and evaluation in the health information system in the service. It is now easier for the head of the Information Monitoring and Evaluation Department at the headquarter level to check data and report on district and regions who are not performing well in their operational activities. The funds were also used to build capacity in leadership and develop through the Leadership and Development (LDP) trainings. Sub district managers were also trained in management in the areas of procurement, financial management, administration and service delivery.

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2011 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2012 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2008	2009	2010	2011	2012		

1.2: Proportion of Regional and District Directors trained leadership and management	6.7	Training reports/2005	100	100	0%	0	100%	100%	90%	Training report	The 2012 elections made provision for the creation of new constituencies which has led to the increase in the number of districts. (45 new districts) necessitating further downstream training of leaders and managers. The new managers appointed to the new districts are scheduled to be trained in 2013.
1.2.1: Number of Health teams trained in team building	0	2007	138	100%	0	0	43%	100%	100%	Training report	GHS is reprogramming this activity to integrate it with training in supportive supervision, which will be an important component of the sub district certification process. This is supposed to compliment the capacity building in relation to gaps identified in the certification process.
1.2.2: Proportion of Districts using DHAP and MBB	12%	2007	100%	100%	0	100%	100%	100%	100%	M&E Report	As at the mid term of 2012 most the activities had not been implemented hence the review/monitoring process has been scheduled for the last quarter of 2013.
2.2 Proportion of functional CHPS zones with full compliment of service delivery kits	11%		72%	72%	0%	0%	0%	100%	100%	CHPS M&E	The 1,500 Service Delivery kits (Midwifery kits) procured will be delivered to the CHPS zones in 2013. The number of functional CHPS zones as at the end of 2012 was 2118 and additional is expected to be created as a result of the new districts created. . Thus only 71% of functional CHPS zones will receive the kits. This has necessitated the need to procure additional service delivery kits to cater for the outstanding numbers (29%).

3.3 Number of CHOs using PDAs	7%	2007	500	100%	3	10	30	82	48	Training & Monitoring Report	The PDAs have been enhanced to the use of the application of Smart phones in collecting immunisation and maternal health data at the community level. Five Regions namely Central, Volta, Upper East, Northern and Upper West have been trained. The five remaining Regions will be trained in 2013. It is important to note that the procurement of Smart phones (PDAs) have been modified to procure 520 lab tops for each of the sub districts in the five Regions namely Western, Ashanti, Greater Accra, Brong Ahafo and Eastern Regions when trained. There has also been a nation wide deployment of District Health Information Management System (DHIMS2) at the sub district to support the eregister, which has been developed to capture immunisation and growth monitoring data. These laptops also provide a central point for the community health officers to transfer the immunisation data from the SMART phones unto these lap tops.

9.4. Programme implementation in 2012

9.4.1. Please provide a narrative on major accomplishments in 2012, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

In relation to objective 3, the Ghana Health service innovatively introduced Smart phones as an enhancement of the proposed PDAs for data collection at the community level. The Smart phone (PDA) system has been integrated into the community electronic register (eRegister) to capture growth promotion, immunization and maternal health service data at the community level. Five Regions have been trained at the regional and district level. As at the end of 2012 Smart phones were provided for 3 District (Sene, Kintampo North and Asuogyaman) under the Sene GAVI Smart Phone initiative that tracks immunization of children. The health workers who capture these data use smart phones or mini laptops. Working with the Nutrition and Malaria Control for Child Survival Project (NMCCSP), sub districts were provided with laptops and CHOs with phones because there was the need for subdistricts who supervise the CHOs to also have access to the central system. The eRegister system would be expanded and integrated into the DHIM2, which is the sole data repository of the Ghana Health Service for data collection, analysis and reporting.

As an improvement in data management DHIMS1 was upgraded to DHIMS2 with enhanced features for management decisions at the various levels. The Service was able to migrate all data from DHIMS 1 to DHIMS2 and all Districts were able to complete their data transfer with success. Additionally new EPI reporting templates with newly introduced vaccines were incorporated into DHIMS2 for r

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

There has been considerable improvement in financial management tobe able to incorporate the modifications introduced in the health systems interms of disbursement and reporting of funds used for GAVI implementation aswell as other funds. This stems from taking account of the recommendations fromthe FMA. In terms of the overall financial management system, improvement canbe seen from the upgrading of the ACCPAC software license from 5.4 to 6.0 atthe headquarters level with enhanced features to enhance consolidation offinancial reports from the various levels of the Service whiles at the sametime capturing all known sources of funds for service implementation. Thesoftware is able to generate the basic financial statement reports (trialbalance, income statement and balance sheet). Notwithstanding these, there aredelays in the procurement process for the purchase of goods and services suchas the service delivery kits and Smart phones, which are critical forstrengthening community level interventions with regards to immunization, childand maternal health.

Work was also done toimprove the logistics and information system to capture transactions at theRegional and District levels to address challenges faced at these levels. Thesystem has an accounting module so the Regions and Districts can do theirfinancial transactions electronically and prepare their incomestatements.

Internet connectivity invery remote area is a challenge. To address this, an integrated triplicateregister were developed so that areas that have difficulty in network will sendthe duplicate to the sub district level for the entries to be done for thefacilities. The Service is currently working on how to address networkchallenges at the remote communities.

There are still disjointed monitoring and evaluationactivities at the various levels. In order to address this, in the year 2013 anintegrated monitoring and evaluation framework including a checklist has beendeveloped to harmonize all M&E activities of the Service. This willforestall duplication of M&E activities and further provide timely andevidence based reports for management decisions. There will therefore bescheduled integrated Regional visits to monitor and evaluate performance at theRegional level and below. This would be integrated into the Regional Parentconcept whereby each Region is assigned to a Senior Manager at the Headquarterslevel for purposes of communicating and reporting on the Regionsperformance.

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

Financial monitoring and evaluation of GAVI funds is undertaken as an integral part of the overall health sector donor coordinated earmarked funds process. In this regard, the existing GHS financial monitoring and evaluation system architecture and software are used to capture and report on financial outlay with regards to the use of GAVI funds. Specifically financial reporting is done through the use of the ACCPAC software.

In terms of activities and performance indicators reporting at the various levels, the Ghana Health Service is currently using the DHIMS 2 as the official data repository for reporting on all health service aggregated data. All GHS staff at the National,Regional, District and Sub districts levels can access this. The DHIM2 generates the Sector wide indicators aligned to health systems strengthening. Aside that there is an annual performance review where each level of service delivery organised mid year review and annual reviews. GAVI HSS funds are used to support the national level review and the observer teams that visit the district and regional performance reviews. These reviews provides an opportunity for all activities implemented with GAVI HSS funds to reviewed as part of the other service delivery activities of the GHS.

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

An integrated M&E framework has been developed and disseminated to all levels (Regions and Districts) to guide these levels in their monitoring and evaluation activities.

The Ministry of health is now implementingits 3rd Common Management Arrangement to guide the implementation of its current sector medium term development plan (2010 – 2013). This stipulates the needed coordination and collaboration between the Ministry of Health, its Agencies,Partners and other stakeholders in the health sector for the implementation of health programmes. In terms of systemic monitoring and evaluation of performance, the CMA outlines various arrangements for it's undertaken to which reporting on GAVI HSS funds are embodied. The following structures are specifically employed:

1. The inter-agency leadership committee set up to ensure the institutionalization of key leadership structures across MoH and Agencies. Members of this committee meet quarterly to deliberate on strategic direction relating to health policies.
2. Sector Working Groups (SWG) deals with crosscutting sectoral issues, share information and agree on sectoral operational directions. This group meets monthly and is chaired by the Chief Director of the Ministry.
3. Quarterly Business Meetings held in April/May to review sector performance appraisal, October/November to discuss key performance indicators and August to review performance from the beginning of the year.
4. Since 2012, Annual Health Summits (Sector Reviews) are organized to discuss annual performance reviews and development of sector programmes for the coming year. These summits include participation by all stakeholders including CSOs and the self-financing private sectors.
5. Decentralized level dialogue; a sector dialogue that take place at the decentralized levels and coordinated by the Ghana Health Service and the Ministry of Health aimed at planning effectively for the delivery of district health interventions.
6. At the Ghana Health Service level, 3 Senior Managers Meetings are organized within the year. The first which is organized in April is used to appraise the performance of the previous year, the second SMM is organised in July to detail out policies and priorities for planning and the third SMM which is held in November discusses the budget for the next year and the outlook. These meetings also provide a forum for the services to discuss issues of concern relating to service delivery. In all these various levels of performance appraisal are conducted with all stakeholders in the health sector including CSOs. Currently the 2012 annual performance review is being held from the 25th-26th of April to review the performance of all the various BMC in the GHS.

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

As part of promoting stakeholder (especially Civil Society Organisations), participation and support for healthservice delivery, GHS has taken key interest in building capacity of CSO managers in health by providing training in health activities. In 2012, GHS organized training in health management for selected CSO managers across the country. The CSO have been involved in various reviews of the health sector such as the Regional and District review and the annual health summits of the Ministry of Health. In the Health Summits, some of the CSOs work as facilitators of the summit and also contribute to innovative strategies for improving the health service delivery.

The CSOs on their part organises quarterly review meetings which is attended by Expanded Programme on Immunisation (EPI) team, members of the Policy Planning Monitoring and Evaluation (PPMED team, WHO and the Coalition of NGOs in Health. The meeting serves as a platform to discuss activities of the CSOs and update stakeholders on what they have been doing on the field. In the meeting members discuss the joint monitoring activities of the CSOs and all the other health stakeholders.

In 2012 the sub district financial management training gained interest from FOCUS Regional Health Project which also partly supported the training of the Greater Accra Regional sub district managers. In all over140 managers drawn from the sub districts were trained in the areas of financial management, service delivery, procurement, planning and budgeting and auditing.

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

CSOs have been much involved in the various health sector policy engagement processes such as the annual performance reviews, senior managers meetings, health summits, health sector working coordinating groups and Inter agency coordinating committee meetings.

The intent within the original plan was not to isolate NGO activities but to make it a part of the implementation of the activities. For example, the CSO (Ghana Coalition of NGOs in Health) were supported to finalize their strategic plan and its intended that some activities within the strategic plan will be supported within these activity lines. In 2013, CSO/NGOs will be supported to conduct monitoring visits as part of the integrated visits to the sub district and community level.

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

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

The HSS budget is included in the annual health sector plan and annual work plan of theimplementing agencies. Financial management for the HSS funds has greatly improved in terms of disbursement and reporting of funds for the HSS activities. The improvement involves improvement in the accounting reporting system through the use of electronic system for reporting (ACCPAC and the introduction of GIFMIS). However procurement procedures still remains a problem due to delays as a result of evaluations and change in management of the GHS leadership, which necessitated the review of various contracts that have been awarded.

In terms of structure, the GHS Headquarters PPMED still continuous to have oversight and coordinating responsibilities for the management of HSS funds and ensuring that activities outlined in the proposal are carried out to achieve the mandate of the Service as well as the outlined objectives in the HSS proposal.

There have not been any constraints in internal funds disbursement of the HSS funds for the implementation of activities. There are no unforeseen changes in the management processes in the coming year.

Although there will not be any significant change in the structural and managerial processes of the HSS funds, it is envisaged that the introduction of GIFMIS, which is the government accounting software for public sector in Ghana will also improve the overall reporting of the funds as an integral part of financial reports to the MoH and MoFEP.

It is important to note that the grant is being extended to another year due to the erratic disbursement and this has affected the cycle of activities since the Service also has its routine planned programme. Any delay in the disbursement of the funds on the part of GAVI affects the delivery of scheduled plans in the proposal. However, activities have been accelerated such that all the funds will be utilized in 2013. Two key activities that will require huge payments include the payment of the service delivery kits for CHPS zones and implementation budget for sub districts training.

9.5. Planned HSS activities for 2013

Please use **Table 9.5** to provide information on progress on activities in 2013. If you are proposing changes to your activities and budget in 2013 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2013 actual expenditure** (as at April 2013)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)
Activity 1.1	Activity 1 : Equip national and regional in-service training units	0	0	Resourcing of offices of regional directors	The activity has been scaled up to include the resourcing of offices of all the ten regional directors with conferencing facilities. This is to facilitate improved communication between the headquarters and regions	75758
Activity 1.2	Train District Directors and Senior managers in leadership and management	0	0	New districts have been created in the country	The activity has to be carried out in the remaining districts, including taking on board the newly created districts, hence need to increase the budgetary allocation	608812
Activity 1.3	Train Selected NGOs, RHMT and DDHS in team building	0	0		N/A	70707
Activity 1.5	Train District, sub districts managers and CHO in procurement and financial management	0	0		N/A	81818

Activity 1.2.1	Technical Assistance to update the DHA tools support DSS sites	0	0		N/A	40404
Activity 1.2.2	Train senior managers including National, Regional and District Directors in the use of DHIP and DHA in for priority setting and decision-making	0	0		N/A	80808
Activity 1.3.1	Train district, sub districts and NGOs in supportive supervision	0	0		The sub district when certified will provide better information about the areas of strengthening for which the supportive supervisory visits will tackle. The number and quantum of the supportive supervision will not change. However the two activites have been linked to provide better outcome.	244444
Activity 1.3.2	Provide fuel and stationery to districts, sub districts and NGOs to undertake supportive supervision	0	0		N/A	594000
Activity 2.1	Procure Vehicles for National/Regional/Districts and Sub Districts	0	0		N/A	
Activity 2.2	Procurement of Service delivery kits for CHOs	0	0		N/A	1717172
Activity 3.2	Train CHOs in the use of PDA equipment	0	0		N/A	65657
Activity 3.3	Customize and Integrate PDA data into existing health management information system	0	0		The procurement of PDA has been upgraded to the use of smart phone with enhanced features for gathering and transmitting data which is linked to the electronic register system and the DHIMS	126263
Activity 4.1	Undertake operational and implementation research	0	0		N/A	145455
Activity 4.2	Support National and Regional level M&E	0	0		N/A	104544
Activity 4.3	Review and Evaluation of HSS support	0	0		N/A	101010
		0	0			4056852

9.6. Planned HSS activities for 2014

Please use **Table 9.6** to outline planned activities for 2014. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

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

Table 9.6: Planned HSS Activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
N/A					
		0			

9.7. Revised indicators in case of reprogramming

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

9.8. Other sources of funding for HSS

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

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
N/A	0	N/A	N/A

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

9.9. Reporting on the HSS grant

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

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

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
2011 GHS Annual Reports	In validating this report, various Regional reports were reviewed.	N/A
2012 Annual Reports	In validating this report, various Regional reports were reviewed.	N/A
PPMED Divisional Report	Validated with meeting reports of various activities carried out by the Division	N/A
Regional Reports	It was validated with information from the DHIMS2 and also with the Regional presentations at the various Regional Performance review meetings.	N/A
Statement of Accounts from GHS Finance Division	Validated with various internal audit reports	N/A

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

N/A

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2012?5

Please attach:

1. The minutes from the HSCC meetings in 2013 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

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

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

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

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

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

This section is to be completed by countries that have received GAVI TYPE B CSO support1

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

Adaklu Anyigbe District	AAD
Civil Society Organization	NGO
Community-based Health Planning and Services	CHPS
Community Volunteers	CVs
District Health Management Team	DHMT
Expanded Programme on Immunization	EPI
Family Planning	FP
Future Generations International	FUGI
Ghana Coalition of NGOs in Health	GCNH
Ghana Health Service	GHS
Global Alliance for Vaccines and Immunizations	GAVI
Hope for Future Generations	HFFG
Health Systems Strengthening	HSS
Health Systems Funding Platform	HSFP
Ministry of Health	MOH
Non Governmental Organization	NGO
Reproductive and Child Health	RCH
Traditional Authorities	TAs
Twifo Hemang LowerDenkyira	THLD
World Health Organization	WHO

10.2.1. **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.

The progress made are presented under the key objectives (related to the goals) that were outlined in the proposal;

1. To identify and map 100hard-to-reach communities in 3 months;

Adaklu Anyigbe District (AAD) and Twifo Hemang Lower Denkyira (THLD) Districts were selected in Central and Volta Regions respectively through a baseline survey. The selection of these districts was based on reported low immunization coverage of these districts in the two (2)regions and 40 and 60 hard to reach communities were selected in THLD and AAD respectively jointly by the DHMT and the District Assembly. Hope for Future Generations (HFFG) is implementing the project in THLD, whiles Future Generations International (FUGI) and Seek to Save are implementing in AAD

The 40 hard-to-reach communities mapped in THLD include: Ateaso, Bimpong Forest, Kona, Lomnava, Mfantifuom, Nyamebekyere,Onomakwa, Atiganu Nyamebekyere, Ayedwe, Ayigbe, Bonsaho, Bronikrom, Camp,Esukeseakyi, Goslow, Gyamanfuom, Gyaware, Kojokrom, Mpaabaw, Nyameadom,Pataase, Pra-Agave, Tsimtsimhwe, Twifo Manfi, Tema, Simtsimhwe, Apokwaa,Gyaware, Nkroso/Kyirayewa, Asumdwee, Osamkwa, Asensoho Agave, Domeabra, Amuza,Antwikwaa, Bekawpa, Denyase, kyekyewere, mediamono and Old Darmang.

The 60 hard-to-reach communities mapped in AAD are: Adokpakope, Agorhokpo, Anatikope, Mangoase 1,2 and 3, Tumor, Trigorni,Silandre, Fulanikope, Kesenyemito, Wudzagla, Wudesi, Nornyikpo, Adzorvi,Shiavi, Ativorkope, Agortime Agordeke, Kpexor, Exakope, Yevi, Dohia, Wuvi,Wudesi, Vedomi, Gaenakope, Alorkpi, Wudorkpo, Adidove, Akakpokorpe, Kpota. Therest are: Boso, Kpodzi, Ablornu, Terikpo, Hinekofe, Hlihave, Sofa, Kpatove,Torda, ahunda Kpodzi, Waya, Anfoe, Kpetsu, Dawanu, Amuzudeve, Blidokofe,Segbale, Wumenu, Wavanu, Kodzobi, Vodze, Have, Goefa, Tsrefa, Takor, Kadiabe,Abuadi, Helekpe, Adaklu Kpetoe, Sikama, Dzokpo

2. To establish working relationship with existingcommunity groups, development partners and volunteer in 2 to 18

months

A 13-member National Steering committee has been established which has been providing technical support to implementing organizations to facilitate smooth implementation of the project. The committee has also been providing best recommendations for effective engagement of duty bearers for increased resources towards improvement of immunization coverage.This committee is made up of members from WHO, MOH, GHS, EPI, Red Cross Society, CSOs and the media who meets quarterly to take decisions affecting the project.

At the district levels, meetings have been organized with key stakeholders such as the Regional and District Health Directorate, Ghana Education Service, District Assemblies, Chiefs, Queen mothers, Opinion leaders, organized community groups such as youth groups, NGOs, CSOs and the media. In these meetings, stakeholders identified the key role each would play to ensure the success of this project. Regional and district health directorate pledged their support by ensuring the availability of Community Health Officers for outreached programs and the community leaders also assured members of their continuous role of monitoring the works of the volunteers.

To ensure community ownership and sustainability, oversight committees have been established in each community to ensure active participation of community traditional leadership, community members and also monitor the works of the volunteers. For effective grassroot participation, community volunteers were identified and trained in all the 100 hard to reach communities to serveas agents of immunization to promote community health and data collection suchas referrals and community registers.

3. To create demand for immunization and RCH services in 100 hard-to-reach communities in the selecteddistricts in 18 months

Considerable strides were made in reaching children under 5 years with EPI services in all the 40 communities in THLD. As a result of interventions provided in the 40 hard-to-reach communities, immunization coverage has increased. In THLD, community volunteers supported community health workers to administer 5,377 doses of EPI antigens to children from July, 2011 – December, 2012. This achievement was largely attributed to the mobile outreach services provided by the project in the communities and the continuous education on the importance of immunization and the schedule by the trained community volunteers and GHS. In AAD also, community volunteers supported community health workers to administer about 6,120 doses of EPI antigens to children within the period in the 60 hard to reach communities.

4. To facilitate the delivery of outreach services to the100 hard-to-reach communities in the selected districts from 3 to 18 months

In order to achieve practical results, the three (3) implementing NGOs in the AAD and THLD districts adopted different strategies. One of such strategies is the organization of community durbars and immunization football gala competitions which brought the communities together. Community Health Officers and NGOs use this platform to educate and sensitize community members on the importance of immunization and RCH services. In all, 4 community durbars were organised in each of the 100 hard to reach community reaching over 3500 community members. 4 outreached programs were organised in each community in churches, mosques and schools to sensitise a larger number of the populace about immunisation. 90 existing mother support groups were also reached through continuousengagement with service providers and other stakeholders. Also to facilitate delivery of outreached programs, NGOS were part of quarterly district Health management meetings tobrief members on the status of the project and ensure identified challengeshave been addressed.

5. To create awareness and buildthe capacity in advocacy, community monitoring of community stakeholders(chiefs, opinion leaders, queen mothers, Assembly men, etc) in 100 hard toreach communities in the AAD and THLD districts

In all selected communities, 308 chiefs, queen mothers and opinion leaders have been trained as community advocates and members of the oversight committees to monitor for improved health delivery at the community level. Out of this number, 90 community leaders formed the the Community Oversight Committees made up of 30 chiefs, 30 queen mothers and 30 community secretaries. As a result of this, chiefs and opinion leaders in four(4) communities in THLD officially wrote to the District Assembly and the District Health Directorate requesting for the construction of a CHPS compound in their communities. Likewise, some traditional authorities in the AAD are equally making demands for the improvement of CHPS compounds in (Kodiabe and Torda) and other communities such as Amuzudeve, Blidokofe and Segbale are also erecting structures to be used as CHIPS compunds for their communities.

6. To strengthen the capacity of100 community volunteers in advocacy, I.E&C and vital data collectionsystem in AAD and THLD districts

Although, the target was to train 100 community volunteers, 222 community volunteers were trained, an achievement in excess of the project target. These volunteers were trained to carry out community based education and promotion ofimmunization and RCH services in the 100 hard-to-reach communities and also tomonitor the health of communities by using standardized data management system.As a result of this training, community volunteers have been able to mobilize a considerable number of children in the 100 hard-to-reach community for immunization.

7. To set up a standardized systemto identify and document pregnancies, deliveries, neonatoa, infant and maternaldeaths

Community immunization registers have been developed to capture information on immunization and reproductive services in the communities. These registers are used to ensure that immunization schedulesare been followed and pregnant women are advised to attend anti natal. Theseregisters are verified and signed by established oversight committees andtraditional authorities.

8. To strengthen capacity of 3participating NGOs/CSOs to manage the project in areas of planning, financialmanagement, records management and monitoring and evaluation

The capacity of six (6) staff of the three (3) implementing NGOs were builtand skills impacted in project management, financial management, recordmanagement and M&E.

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).

The lead organization for managing thegrant implementation is GCNH and this has not changed.

Major problems encountered during thisperiod are:

- Limited number of functional CHPS compoundsand Community Health Officers
- Lack of accommodation for Community health Officers in the communities
- Inconsistent information of immunization by Community Health Officers
- Tracing of defaulting mothers
- Splitting of AAD district in two (2) inaccordance with Local Government Act 462, has created administrative challenges for the implementing NGOs
- Absence of a District Chief Executive ofthe Adaklu District continued to inhibit the functioning of the District Assembly and support for the project
- Inadequate and broken down fridges to keepvaccines and inadequate vaccine carriers
- Broken down child weighing scales in some sub-districts health facilities hinder monitoring of the growth of some children. This leads to frustrattion of some mothers which demotivates them from attending child welfare clinics and routine immunisation
- Poor and unmotorable road network during the raining season
- Inadequate motorbikes and broken down motorbikes
- Low patronage of Family Planning (FP)Services in the community, largely due to inadequate access to certain FPcommodities such as condoms and misconceptions about the service
- Low male involvement in mobilization and provision of child health services in the communities
- Inadequate RCH educational materials
- Low educational background of community volunteers hinders their performance
- High rate of volunteer turn over due topoor motivational package as a result of budgetary contraints

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.

GCNH has been working very closely with Ministry of Health, Ghana Health Service and other CSOs. The Ministry of Health has been very instrumental in the formation and strengthening of the Coalition of NGOsin health to play a key role as a CSO in the health sector and represent the mouthpiece of CSOs in the country. Due to this relationship, GCNH has participated in various health systems planning platforms such as Country Coordinating Mechanisms (CCM), Inter-Agency Coordinating Committee (ICC),monthly Health Partners meeting, Ministry of Health review meetings and thea nnual health summit which provided a great opportunity to move intentions and objectives to real deliverables that ultimately brings about real change atwhere the change most desired. UNICEF, WHO and Work Bank have also provided technical support to the GCNH through participation in the National Steering Committee meetings set up to support implementing organizations of GAVI CSO support project under type B funding to achieve the set goal and objectives. At the regional and district levels in AAD and THLD, collaboration between NGOs andGHS has increased tremendously through regular de-briefing sessions, joint monitoring and feedback which strengthened the commitment of parties to work together to expand immunization coverage in the districts. The GCNH has a strong coordinating mechanism through which it draws strong links with its membership at different locations and influence. This has given the GCNH the much needed edge to effectively undertake activities with national character through its membership. Apart from its membership, the Ghana Coalition of NGOsin Health has strong relationship with other platforms and networks such as the Stop TB partnership, Coalition of NGOs in Malaria, Essential Services Platform,GHANET, Alliance for Reproductive Health Services (ARHS) on matters of common interest for joint advocacy, information and lessons sharing and the sharing of best practices. For effective contribution in terms of collective responsibilities as well as promote synergy in activities to engender stronger health planning processes and delivery in the country, GCNH has worked effectively with these platforms and networks to ensure MOH and other policy makers involves CSO throughout the HSFP processes to address the constraints inimmunisation and other health areas. GCNH strengthened the capacity of its members in lobbying skills and network building to effectively participate in the various health systems planning platforms to move intentions and objectives to real deliverables that ultimately brings about real change at where the changes are most desired

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).

The support has led to a change in CSOs involvement inimmunization especially at the regional, district and community levels. Through the involvement of NGOs, joint monitoring visits have been organized with GHS both at the regional and districts levels to these hard-to-reach communities where communities interacted with leadership of GHS, this is a rare situation and seldom carried out. Community members appreciated these collaboration and were empowered toknow they also play a key role in monitoring the health of their communities.Also, as a result of these monitoring visits GHS has directed CHOs to provideoutreached services to these neglected communities. Although, 3 NGOs are playing a key role inthe implementation of the project, 7 NGOs have been brought on board, theseNGOs include (HERO Network, YGRO Ghana, Bethel Youth AID Foundation, Red Cross Society, Ghana, Volta Region, Divine Favour Agency, ROYAL Health Organisation

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

Late disbursement of funds delayed the start of the project however, there has not been anysignificant delays in project implementation. However, to prevent the interruptions in immunisation and RCH activities in these 100 hard to reach communities, GAVI Alliance has agreed to provide bridge funding for the 2013/2014 programme period until continuous funding for CSO support is made and approved through Ghana's HSS proposal submission to GAVI in September, 2013

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 10.2.1a: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2012	Outcomes achieved

FUTURE GENERATIONS INTERTIONAL (FUGI)	GAVI project in Adaklu District	Baseline Survey, Organise sensitization Workshop for GHS Staff & Community Stakeholders, Identify & train CBHVs to assist in immunization, Collaborate with GHS staff in Outreach activities to30 communities, Community Leadership Educated on "Community Ownership", and guided to form "Oversight Committees" to supervise and motivate Volunteers, Community "Oversight Committees" formed and trained on Project Goals and objectives and their roles and responsibilities, Facilitate and participate in Outreach activities and BCC/ IEC in 30 Project Communities, Develop uniform immunization data register for CBHVs & CSOs, Monitor immunization data collection by CBHVs, Community Immunization Data Entry Register sent to printer for printing, Undertake Supportive Participation in Monthly Outreach Activities and BCC/IEC in Communities, Design and discuss Composite Community Register with Key Stakeholders (WHO, GHS, Oversight Committee, Organize Refresher Training for CBHVs and Health Facilities Nurses.	One joint monitoring exercise held with the Ghana Health Service in 2012, Baseline conducted and report available, Successful Stakeholders Start-Up Meeting with all levels for technical support determined, Awareness of the importance of Child Immunization and attendance at ANCs by pregnant women increased in Project communities as a result of GAVI/GHS/FUGI Project. Compilation of child immunization data by CVs and Health Centre, Nurses indicate significant increases from 2011 to 2012. Population figures for 2012 compiled for Project Communities (in the absence of locality population data from the Ghana Statistical Service), Importance of community environmental sanitation and hygiene, to the welfare of children and well-being of community members being promoted by Project Staff, The literacy level, commitment of the Health Volunteers, and community ownership of the Immunization and RCH Services, should be highlighted for improvement,

HOPE FOR FUTURE GENERATIONS (HFFG)	GAVI project in the Twifo Hemang Lower Denkyira District	Baseline Survey, Sensitisation workshop for community stakeholders, Advocacy training for traditional leaders, Formation and Strengthening of organized groups, Training of community volunteers, Quarterly Community health durbars, Half-year meeting with community volunteers, Immunization Gala, Development and Distributed of BCC material, Facilitate Nurses to Child Welfare Clinic, Outreach education and data collection in communities by volunteers (House to house), Monthly community outreach activities (, video shows, drama, church and mosque outreaches, Monthly meetings with community immunization volunteers, Joint Monitoring of GAVI Project	Baseline conducted and all 40 hard-to-reach communities in THLD mapped, 80 community opinion (2 per community) sensitized on project goals and deliverables, 80 community leaders trained in advocacy (2 per community) to support community advocacy and mobilization for child immunization and other RCH service, 25 Mother Support Groups formed in 25 communities to lead education with women on the importance of immunization and other RCH services, 80 community Volunteers identified and trained (2 per community) to educate and mobilize communities for immunization and RCH services, 2 community durbars organized in 2012. A total of 510 people educated on the importance of reproductive and child health services, One Review meeting held with 80 Volunteers and selected Community Health Nurses to assess the project and strategize for the remaining implementing period, One immunization gala competition held among 4 project communities to advocate for utilization of immunization and other RCH services 400 people sensitized on the importance of immunization, 100 Immunization charts, 2 banners, 1 documentary, and 100 T-Shirts produced and distributed to volunteers and Community Health Nurses to promote awareness on immunization and RCH services, 40 communities provided with CWC in 2012. CWC revived in 23 out of the forty communities. A total of 987 children immunized from the 40 project communities in 2012. 10 nurses facilitated into communities on motorbikes every month, An average of 300 women and 180 men educated by Volunteers on the Immunization and RCH services every month, An average of 95 community level sensitization meetings (including education in churches, markets, mother support groups and CWC) held every month, An average of 30 communities visited every month by project staff to meet with volunteers to provide technical support and also collect completed data forms.

SEEK TO SAVE FOUNDATION	GAVI project in Agortime-Ziope District	Organised state- holders meeting, Train 60 community volunteers, Organised training workshop for 40 community Health Nurses and their in-charges, Organised quarterly training workshop for community volunteers, Organised quarterly training workshop for Queen- mothers and Chiefs, Organised 60 community durbars,	Awareness was created among Chiefs, Opinion-leaders, Queen- mothers and the populace on immunization, 60 community volunteers were trained on the importance of immunization and how to help the nurses to collect data, Awareness was created among 40 community Health nurses about the GAVI project. They were also trained on how to collect data on immunization and 32 Chiefs and 4 Queen- mothers help to promote immunization in the District

Please list the CSOs that have not yet been funded, but are due to receive support in 2012/2013, 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 10.2.1b: Planned activities and expected outcomes for 2012/2013

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2012/2013	Expected outcomes
FUTURE GENERATIONS INTERNATIONAL (FUGI)	Community mobilization and education on importance of Maternal and Child Health and Childhood Immunization, Community Ownership promotion for Community demand and support for Quality health services, Selective logistical support to GHS. e.g. Repair of weighing scale, Data collection Refresher Training to HS staff, Training & Capacity enhancement of volunteers & GHS staff in quality data collection, Support for data quality improvement/Design and provision of Community Childhood Immunization Register, Updating Community demographic data to verity Immunization & WIFA data outcomes, . Participation in GHS Review meetings, Consultative meeting with Regional and District Health Directorates, Consultative Meetings with Community Traditional Rulers, Consultation of FUGI on other development issues that affect health & well-being of community members by community leaders and some GHS Directors, Periodic meeting of community leadership on monthly (cabinet) meetings on Childhood Immunization and other health issues and Community education to promote Environmental Sanitation and Hygiene to ensure healthy community populations especially children	Obtain feed-back from CBHVs & GHS Nurses on revised Community Immunization Register, Monitor and Quality assure Community Childhood Immumnization Register administration, Organise Project Assessment Meeting of Stakeholders, Undertake Supportive participation in monthly outreach activities and BCC/IEC in 30 Project Communities, Distribute General Community Registers, Undertake education or Oversight Committee on General Community Register Administration, Undertake Preparations to conduct Project Evaluation and Engage Consultant, Write Monthly/Quarterly Report on Project update and Progress, Monitor and Quality assure Community Childhood Immunization and General Community Register administration in 30 Project Communities, Undertake Supportive participation in monthly outreach activities and BCC/IEC in the 30 Project Communities, Discuss & put in place Project Sustainability strategies, Organize End of Project Evaluation & Discuss Evaluation Report for Dissemination, Organize End of Project Stakeholders meeting and disseminate Project Evaluation Report and Write and Submit End of Project Report	Better understanding and completion of Community Register, Use of Community childhood Register by both Volunteers and GHS Staff to identify; (i).Children who have completed their immunization, (ii).Children due for Immunization, and organise them for the monthly session, (iii).Children who have dropped out/left Community, (iv).Newly born children for registering, Give and receive feedback on Project outcomes from GHS Staff, Community Leaders, Volunteers and other Stakeholders, Supportive supervision to volunteers, and participation at monthly outreach activities, Better informed and Pro-active Community leaders: (i).Demanding quality health service, (ii).Know the population of their Community, (iii).Know the number of new babies born in the year /given point in time, (iv).Know the number of pregnant women in the Community, (v).Number of children/pregnant women who are in a year, Under take project evaluation, Map-out Project sustainability strategies, Organise end of phase one (I) project meeting for Stakeholders and Write end of phase one (I) Project report.

HOPE FOR FUTURE GENERATIONS (HFFG)	GAVI project in the Twifo Hemang Lower Denkyira District	Quarterly Community Durbar, Immunisation Football Gala, Facilitate Nurses to Child Welfare Clinic, Participate in GHS quarterly stakeholders meeting to discuss project outcome, Semi annual meeting with community volunteers (2 times), Review meeting with community leadership, women and men immunization support groups and volunteer leadership, Outreach education and data collection in communities by volunteers (House to house), An average of 250 women and 150 men educated by Volunteers on the Immunization and RCH services every month and Monitoring and support visits to volunteers.	4 community durbars organized. 1200 people sensitized on the importance of immunization and other RCH services, especially Family Planning, 3 football galas organized to promote immunization services. 600 people sensitized on the importance of immunization and other RCH services, especially Family Planning, CWC held in forty communities every month 900 children immunized at CWC every month. 10 nurses facilitated on motorbikes to project communities every month to provide EPI services, Stakeholders review meeting held. Project outcomes shared with stakeholders, Second semi annual review meeting held with 80 volunteers and selected Community Health Nurses. Project appraised and way forward discussed and agreed upon, 2 Review meetings held with community leadership from all four sub-districts -2 per community to assess project outcomes and impact. Close out meeting held with all stakeholders in June to share final project outcomes and agree on way forward, Posters and flyers on Family Planning, immunization and maternal health developed in collaboration with the health promotion unit of the Ghana Health service, Central Region, and distributed in all 40 project communities and All volunteers visited every month and provided with technical support in all 40 project communities.
SEEK TO SAVE FOUNDATION	Participated in the National Immunization at Penyi in Ketu North District for five consecutive times, Educated students on importance of immunization, Organized community durbars and educated the Chiefs and Queen mother's together with the populace on the importance of immunization as well as in Churches and Moques and Organised stakeholders meeting for Chiefs, Opinion- leaders, Queen- mothers, District Chief Executive.	Organize and Participate in quarterly review meetings with community leadership, women and men in immunization support groups and volunteers leaders, Organise stake- holders meeting to discuss the problems, challenges successes chopped and the progress or continuity of the project, Set up standardized data collection systems in the communities, collect and monitor data collection on monthly basis, Analyse data and generate monthly and quarterly report and Monitoring and Evaluation- monitor and evaluate the overall project and add reports	Increased awareness and commitment towards immunization

10.2.2. **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.

Ghana is planning for HSFP for 2014 and the process of proposal development will start from May, 2013, initial discussions have started with GHS and EPI. CSO engagement in related immunisation in the 100 hard to reach communities in the 2 regions have lead to a significant increase in immunisation coverage, demand for immunisation and relationship enhancement with the MOH/GHS, Development Partners and the community at large. Funding from GAVI support to CSOs through CRS to undertake Business Plan activities SG 2.1.1.2 for strenthening country level engagement of CSOs in policy level dialogue and in promoting immunisation ahd HSS has indeed strengthened the capacity of the Ghana Coalition of NGOs in health to fully participate in the HSFP processes. In the HSFP processes, CSOs would continue to use different strategies to stimulate demand for immunisation services in hard to reach communities and facilitate the provision of regular scheduled outreached services in at least 8 newly created districts (including island rural communities and urban slums) and depeened the already existing activities in the 3 districts. CSOs will educate and faciliate the establishement of functional CHPS compound through the use of traditional authorities and organised groups as immunisation advocates. CSOs will stimulate increased demand for immunisation through community level action that will foster networks of existing partnerships of community groups especially at the district levels and play a key role in district health review meetings. Capacities of community leaders, women groups and community volunteers using local systems will be institutionalised to monitor community health. The GCNH intend to provide immunisation and RCH services for hard to reach polupations especially in island communities, urban slums, marginalised populations and those in crisis situation where national infrastructure maybe less optimal and depeened the provision of immunisation services in the already 100 hard to reach communities to ensure the establishment of functional CHPS compounds for sustainability of services. GCNH will also ensure provision of services that would strengthen health systems, particularly at district and sub-district levels such as identifying innovative models, advocacy, management strengthening, monitoring and evaluation. The estimated budget is 1million USD

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

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10.2.4. **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 2012 year

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	0	0
Remaining funds (carry over) from 2011 *(B)*	392,492	612,287
Total funds available in 2012 *(C=A+B)*	392,492	612,287
Total Expenditures in 2012 *(D)*	296,787	462,988
Balance carried over to 2013 *(E=C-D)*	95,705	149,299

Is GAVI’s CSO Type B support reported on the national health sector budget? **Yes**

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.

Fund are transferred from the Ghana Health Service to the Coalition's accounts andsubsequently, specified amount will then be transferred to each CSO baseon quarterly plans and disbursement mechanism agreed by all parties. The threeCSOs are required to submit their quarterly plans with accompanying budgetaryneeds which has to be reviewed by the programme management team and finallyapproved by the Board of Trustees of the Coalition. Funds are then transferred into the respective accounts of the three CSOs. The three CSOs submit theirquarterly technical and financial reports which serve as the basis for thesubmission of financial request for the transfer of another tranche.

Detailed expenditure of CSO Type B funds during the 2012 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2012 calendar year **(Document Number)**. 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).

10.2.5. **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 10.2.5: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	Current status	Date recorded	Target	Date for target
Conduct a baseline survey	Baseline report	Baseline survey, 2012	April 2012	100%	April 2013	100	June 2013
EPI Outreach activities in 100 communities	100 communities served	CSO Proposal	April 2012	70%	April 2013	100	June 2013
Organise quarterly community health durbar	4 durbas in 100 communities	CSO Proposal	April 2012	80%	April 2013	100	June 2013
Organize quarterly community meetings	396 community meetings	CSO Proposal	April 2012	60%	April 2013	100	June 2013
Quarterly stakeholder meeting	4 quarterly meetings	CSO Proposal	April 2012	50%	April 2013	100	June 2013
Reach 100 Hard to reach communities	100 Communities	CNGH Report 2012	April 2012	100%	April 2013	100	June 2013
Set up standardized data collection system	Printed registers	Quarter meeting report	April 2012	90%	April 2013	100	June 2013
Train CVs to undertake BCC/IEC on EPI	200 CVs trained	CSO Proposal	April 2012	100%	April 2013	100	June 2013
Train TAs as advocate for immunization services	300 TAs trained	CSO Proposal	April 2012	100%	April 2013	100	June 2013

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.

Participatory monitoring has been a critical component in this project since its inception involving stakeholders ar the national, regional and communities members. At the national level, the National Steering committee members made up of MOH/GHS, WHO, UNICEF, NGOs and the media meet every quarter to plan and review the works of the NGOs at the community level. The committee provides the technical support, critiques and provides recommendations on the tools to be used to monitor indicators set by implementing NGOs. A joint monitoring by the committee has been planned for May, 2013 for members to visit some selected hard to reach coummunities to interview target groups in the community to ascertain the impact of the project on the lives of the community members

At the regional level, monitoring will be activity and performance based and will be guided by the project indicators and joint monitoring field visits will be organised with the implementing NGOs, regional health directors and EPI managers to the hard to reach communities. At the district levels, district health directors and disease control officers will continue joint monitoring which will be done through field visits and spot checks of the activities of the community volunteers. At the community levels, established oversight committees and trained traditional authorities will continue to monitor the works of the community volunteers and continue to play key roles in the district stakeholder meetings as strong advocates of immunisation

An end of project evaluation will be conducted to assess the key performance indicators as identified in the baseline to assess the impact of the project

11. Comments from ICC/HSCC Chairs

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

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

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

I. All countries that have received ISS /new vaccine introduction grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

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

I. All countries that have received HSS grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

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

I. All countries that have received CSO 'Type B' grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✔	Signature of Minister of Health.pdf File desc: Signature of Minister of Health Date/time: 5/13/2013 3:28:12 PM Size: 50362
2	Signature of Minister of Finance (or delegated authority)	2.1	✔	Signature of Minister of Finance (Ongoing).pdf File desc: MOF signature available below and downloaded under other Date/time: 5/13/2013 3:30:22 PM Size: 49660
3	Signatures of members of ICC	2.2	✔	Signature of ICC.pdf File desc: Signature of members of ICC Date/time: 5/13/2013 3:35:02 PM Size: 617470
4	Minutes of ICC meeting in 2013 endorsing the APR 2012	5.7	✔	Minutes ICC endorsing APR and extension of vaccine support.pdf File desc: Minutes of ICC meeting which endorsed the APR Date/time: 5/15/2013 9:40:36 AM Size: 267441
5	Signatures of members of HSCC	2.3	✘	HSCC signatures page SL Health.pdf File desc: Signature of Sector Lead of Health Sector Working Group/HSCC- Mr. Lander van Ommen Date/time: 5/14/2013 3:16:13 PM Size: 592534
6	Minutes of HSCC meeting in 2013 endorsing the APR 2012	9.9.3	✔	Minutes ICC endorsing APR and extension of vaccine support.pdf File desc: The ICC endorsed the 2013 APR-HSS as the HSCC could not meet Date/time: 5/15/2013 9:41:16 AM Size: 267441
7	Financial statement for ISS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✘	GAVI HSS_ISS FS.PDF File desc: Date/time: 5/15/2013 10:49:14 AM Size: 392701
8	External audit report for ISS grant (Fiscal Year 2012)	6.2.3	✘	Unavailable documents.docx File desc: No external audit has been conducted Date/time: 5/14/2013 2:18:15 PM Size: 12842
9	Post Introduction Evaluation Report	7.2.2	✔	PIE.docx File desc: Ghana will conduct Post Introduction Evaluation in July 2013

				Date/time: 4/15/2013 5:43:47 AM Size: 11405
10	Financial statement for NVS introduction grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✔	GAVI Vaccine Introduction grant_FS.PDF File desc: Date/time: 5/15/2013 10:51:37 AM Size: 352789
11	External audit report for NVS introduction grant (Fiscal year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.3.1	✔	Unavailable documents.docx File desc: No external audit conducted Date/time: 5/14/2013 2:19:23 PM Size: 12842
12	Latest EVSM/VMA/EVM report	7.5	✔	EVM Ghana report.pdf File desc: Report of Effective Vaccine Management conducted in September 2010 Date/time: 4/15/2013 5:37:26 AM Size: 982122
13	Latest EVSM/VMA/EVM improvement plan	7.5	✔	Cold Chain Management Improvement Plan.doc File desc: EVM improvement plan developed after the 2010 EVM Assessment Date/time: 4/15/2013 5:39:03 AM Size: 61952
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✔	Status of Implementation of EVM Improvement Plan.docx File desc: Status of Implementation of EVM Improvement Plan Date/time: 5/14/2013 1:31:27 PM Size: 13727
15	External audit report for operational costs of preventive campaigns (Fiscal Year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.6.3	✘	Unavailable documents.docx File desc: No external audit conducted Date/time: 5/14/2013 2:20:02 PM Size: 12842
16	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✘	Minutes ICC endorsing APR and extension of vaccine support.pdf File desc: ICC meeting minutes endorsing APR and extension of vaccine support Date/time: 5/15/2013 9:42:05 AM Size: 267441
17	Valid cMYP if requesting extension of support	7.8	✘	Revised cMYP 2010 - 2014_MS Word (2011) _Revised August 12.doc File desc: Revised cMYP Date/time: 4/15/2013 7:36:50 AM Size: 1139712

18	Valid cMYP costing tool if requesting extension of support	7.8	✔	Revised Ghana cMYP_Costing_Tool_Vs.2.5_ver1.0_MR_140513.xls File desc: Revised cMYP costing tool Date/time: 5/14/2013 8:12:43 AM Size: 3620864
19	Financial statement for HSS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✘	GAVI HSS_2012 FS.PDF File desc: Date/time: 5/15/2013 10:47:42 AM Size: 228373
20	Financial statement for HSS grant for January-April 2013 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✘	GAVI HSS_1st Quarter 2013.PDF File desc: Date/time: 5/15/2013 10:48:18 AM Size: 206969
21	External audit report for HSS grant (Fiscal Year 2012)	9.1.3	✘	MOH Audit 2011 (2) part 1.pdf File desc: External Audit report for 2011 Part 1. (see part 2, 3, & 4 in the other files below) Date/time: 5/14/2013 12:51:51 PM Size: 6318941
22	HSS Health Sector review report	9.9.3	✘	Review report 2011 POW.pdf File desc: Annual Health Sector Review Report for 2011. Date/time: 5/14/2013 11:44:42 AM Size: 2616283
23	Report for Mapping Exercise CSO Type A	10.1.1	✘	CSOs Mapping Report.pdf File desc: Report of CSOs mapping - 2009 Date/time: 5/13/2013 3:19:16 PM Size: 12478794
24	Financial statement for CSO Type B grant (Fiscal year 2012)	10.2.4	✘	Financial Statement - CSOs.pdf File desc: Financial statement for CSOs 2012 Date/time: 5/13/2013 3:19:54 PM Size: 193091
25	External audit report for CSO Type B (Fiscal Year 2012)	10.2.4	✘	CSOs Audited Report.pdf File desc: CSOs Audited Report for 2011. That of 2012 is not ready Date/time: 5/15/2013 7:19:58 AM Size: 1160894
				SCAN0070.PDF

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 2012 on (i) 1st January 2012 and (ii) 31st December 2012	0	✓	File desc: HSS Bank Statement (Opening and Closing Balance 2012) Date/time: 5/14/2013 11:00:41 AM Size: 103383