GAVI Alliance

Annual Progress Report2013

Submitted by

The Government of

Honduras

Reporting on year: **2013**
Requesting for support year: **2015**
Date of submission: **5/20/2014**

Deadline for submissions: 5/22/2014

Please submit the APR 2013 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI partner agency. The documents can be shared with GAVI 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 for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this 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 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 this 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 this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

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

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

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

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

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

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

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

1. Application Specification

Reporting on year: **2013**

Requesting for support year: **2015**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	Pneumococcal (PCV13), 1 doses/vial, Liquid	Pneumococcal (PCV13), 1 doses/vial, Liquid	2015
Routine New Vaccines Support	Rotavirus 2-dose schedule	Rotavirus 2-dose schedule	2015

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

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in {2013}	Request for Approval of	Eligible For 2013 ISS reward
ISS	No	next tranche: N/A	N/A
Health Systems Strengthening (HSS)	Yes	next tranche of HSS Grant	N/A
CSO Type A	No	Not applicable	N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July {2013}: N/A	N/A
HSFP	No	Next tranche of HSFP Grant N/A	N/A
VIG	No	Not applicable	N/A
COS	No	Not applicable	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2012 is available here.

2. Signatures

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

By signing this page, the Government of Honduras 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).

The Government of Honduras

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	Edna Yolani Batres	**Name**	Wilfredo Cerrato
Date		**Date**	
Signature		**Signature**	

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

Full Name	Position	Telephone	Email
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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
Ana Emilia Solis-Ortega Treasurer/Representative	PAHO/WHO		
Cristian Munduati/Representative	UNICEF		
Gustavo Avila/Health Officer	USAID		
Marco Antonio Suazo / Director	Project HOPE		
Renato Valenzuela, Chairman	National Immunisations Advisory Committee (CCNI)		
Nery Cerrato/Chairman	Honduran Municipalities Association (AMHON)		
Gerardo Valladares/Director of Public Affairs	The Church of Jesus Christ of Latter-Day Saints		
Fernando Tomé Abarca, Chairman	Instituto Interamericano del Niño		

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

All comments will be treated confidentially

Comments from Partners:

National Immunisations Advisory Committee (CCNI)

We worry about the fate of the Expanded Programme on Immunisations (EPI) since, as per the new organizational structure of SESAK published in the Official Bulletin "La gaceta", programmes, and hence the EPI, will disappear, despite their success in contributing to the control, elimination and eradication of vaccine-preventable diseases through immunisation. We have begun to advocate the analysis of this situation to the political authorities so as not to put programme achievements at risk.

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), Honduras 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 (TAP) 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
Edna Yolani Batres/State Secretary of the Department of Health	Secretariat for Health		
Jeanethe Aguilar/UPEG Director	Secretariat for Health		
Ana Emilia Solis-Ortega Treasurer/Representative	PAHO/WHO		
Selim Nazar/Medical Officer	Honduran Secretariat for Labour		
Yanira B Gómez/Representative	Honduran College of Physicians		
Eduardo Villars A./General Secretariat	Honduran College of Dental Surgeons		
Narda Maradiaga de Nazar/Chairman	College of Chemists and Pharmacists		
Hugo Rodríguez M/National Medical Director	Honduran Social Security Institute		
Nery Cerrato/Chairman	Honduran Municipalities Association (AMHON)		

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

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

Honduras is not reporting on CSO (Type A & B) fund utilisation in 2014.

3. Table of contents

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

Sections

4. Baseline & annual targets

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

Number	Achievements as per JRF		Targets (preferred presentation)			
	2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2013	Current estimation
Total births	220,983	220,983	221,718	221,718	222,256	22,256
Total infants' deaths	5,082	5,082	5,099	5,099	5,111	5,111
Total surviving infants	215,901	215,901	216,619	216,619	217,145	17,145
Total pregnant women	259,980	259,980	260,845	260,845	261,478	261,478
Number of infants vaccinated/to be vaccinated	214,354	192,191	215,066	215,066	215,588	215,588
BCG coverage	97 %	87 %	97 %	97 %	97 %	969 %
Number of infants vaccinated/to be vaccinated	205,106	191,846	205,788	205,788	206,288	206,288
OPV3 coverage	95 %	89 %	95 %	95 %	95 %	1203 %
Number of infants vaccinated/to be vaccinated with 1st dose	211,583	193,947	212,287	212,287	212,802	212,802
Number of infants vaccinated/to be vaccinated with 3rd dose	205,106	191,691	205,788	205,788	206,288	206,288
DTP3 coverage	95 %	89 %	95 %	95 %	95 %	1203 %
Wastage *[1]* rate in base-year and planned thereafter (%) for DTP	5	0	5	5	5	5
Wastage *[1]* factor in base year and planned thereafter for DTP	1.05	1.00	1.05	1.05	1.05	1.05
Infants vaccinated (to be vaccinated) with 1st dose of Pneumococcal (PCV-13)	211,583	193,812	212,287	212,287	212,802	212,802
Infants vaccinated (to be vaccinated) with 3rd dose of Pneumococcal (PCV-13)	211,583	192,095	212,287	205,788	206,288	206,288
Pneumococcal (PCV13) coverage	98 %	89 %	98 %	95 %	95 %	1203 %
Wastage *[1]* rate in base-year and planned thereafter (%)	5	4	5	5	5	5
Wastage*[1]* factor in base-year and planned thereafter (%)	1.05	1.04	1.05	1.05	1.05	1.05
Maximum wastage rate value for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Rotavirus	211,583	192,190	212,287	212,287	212,802	212,802
Number of infants vaccinated (to be vaccinated) with 2nd dose of Rotavirus	211,583	191,745	212,287	205,788	206,288	206,288
Rotavirus coverage	98 %	89 %	98 %	95 %	95 %	1203 %

Wastage *[1]* rate in base-year and planned thereafter (%)	5	5	5	5	5	5
Wastage*[1]* factor in base-year and planned thereafter (%)	1.05	1.05	1.05	1.05	1.05	1.05
Maximum wastage rate value for Rotavirus, 2-dose schedule	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	205,106	191,482	205,788	205,788	206,288	206,288
Measles coverage	95 %	89 %	95 %	95 %	95 %	1203 %
Pregnant women vaccinated with TT+	38,997	65,822	39,127	39,127	39,222	39,222
TT+ coverage	15 %	25 %	15 %	15 %	15 %	15 %
Vit A supplement to mothers within 6 weeks from delivery	154,688	136,232	166,289	166,289	177,804	177,804
Vit A supplement to infants after 6 months	176,786	182,705	177,374	177,374	177,805	177,805
Annual DTP Drop out rate [(DTP1 - DTP3) / DTP1] x 100	3 %	1 %	3 %	3 %	3 %	3 %

** 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.

5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2013 must be consistent with those that the country reported in the WHO/UNICEF Joint Reporting Form (JRF) for 2013. The numbers for 2014 - 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**

  Number of births has not changed since we are still awaiting the population projections from the Honduran National Census of Population and Housing for 2013. The National Statistics Institute (INE) has been consulted and we hope to avail of the projections in the first quarter of 2015.

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

  Number of surviving infants has not changed since we are still awaiting the infant mortality rate to be reported by the Honduran National Census of Population and Housing for 2013.

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

  No changes have been made in the targets for each vaccine.

  The original targets approved by GAVI per decision letter for 2013 on third doses of pnuemococcal and second doses of rotavirus should be revised and adjusted, since they set the same target for first doses. A similar situation was reported in APR 2012.

  The column on estimates for 2015 in Table 4 for baseline and targets for the different vaccines should be corrected since they generate numbers in three digits.

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

  No changes have been made to the wastage rate for any of the vaccines. In keeping with national EPI standards, the wastage percentage established for single-dose vaccines is 5%. Wastage for both vaccines has been kept below 5%.

5.2. Immunisation achievements in 2013

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2013 and how these were addressed:

Immunisation programme achievements against targets:

In 2013, coverage levels of 87% in children under one year of age were attained for BCG, OPV, Rotavirus, DPT-HepB-Hib and pneumococcal, with 89% for MMR in the 12-23 month-old population, failing to achieve the target set for the different vaccines in APR 2012 for the second consecutive year. This was associated to several factors, among which it is relevant to mention the overestimation of the official population denominator for children under one provided by the INE.

Key activities conducted:

- Monthly monitoring and analysis of immunisation coverage on all planes: local, municipal, regional and national, for timely decision-making.

- The conduct of national immunisation days from April 22 to May 3, 2013, addressing the search for subjects pending initiation or completion of the immunisation schedule, with emphasis on children under five from

municipalities at risk due to coverage rates inferior to 95%.

- The intervention of 41 municipalities at risk in 16 priority health regions: 29 municipalities for coverage levels inferior to 95% in DPT-HepB-Hib and 12 municipalities of high population concentration, with the financial support of PAHO/WHO/CIDA. The choice of municipalities is based on DPT-HepB-Hib and SRP coverage indicators, epidemiological silence in reporting probable acute flaccid paralysis (AFP) and suspect M/R cases, and the concentration of a population under one year of age. Outstanding among the key activities conducted are municipality profiling, situation analyses, the formulation of plans for each municipality to be intervened by local or municipal teams with regional support, and the execution of programmed activities: operations, rapid coverage monitoring, and supervision, among other examples. This approach made it possible to maintain or improve coverage in 85% of the municipalities at risk (35/41).

- Delivery of basic health service package (BHSP) in places with coverage lower than 95% for DPT-HepB-Hib by the health units of municipalities at risk and closed health units in 46 municipalities distributed throughout 9 health regions, thanks to the support of GAVI-HSS funds.

- Vaccine Supplies Stock Management (VSSM) program monitoring as regards inventories of vaccines, syringes and sharps boxes, implemented in 19/20 health regions.

- Immunisation data quality control in the 20 health regions, with DQS used to supervise and evaluate data quality in 4 health regions under the guidance of the Department of Statistics.

- EPI monitoring in all programme components, with emphasis on health regions, municipalities and places at risk in the 20 health regions, with the participation of the central, regional and municipal levels.

- Conduct of two EPI evaluation meetings with programme managers and regional epidemiologists to analyse immunisation coverage, epidemiological surveillance status for vaccine-preventable diseases, and cold chain status, emphasizing strengths, weaknesses, opportunities and threats (SWOT) and proposals for intervention.

Difficulties encountered and routes taken:

Failure to achieve the set targets is associated to difficulties that represent obstacles, some of them being institutional while others are not. Following are the main barriers. It is important to underscore that the majority do not differ from those mentioned in the APRs for 2011 and 2012.

- Overestimation of the denominator for children under one year of age in 16/20 health regions, resulting in the classification of more than 80% of the municipalities as being at risk due to coverage levels inferior to 95% for DPT-HepB-Hib. Thus, to establish priority for intervention, the conduct of rapid coverage monitoring to verify coverage rates in the routine programme was established in addition to the criteria already defined.

- Limited institutional funding for fuel for field immunisation in the routine programme and in areas of difficult geographic access: through coordination with municipal governments and NGOs, areas of difficult access were prioritised for immunisation, and HSS funds were used to support intervention in 46 municipalities, delivering the basic health service package.

- Security problems limiting population access to immunisation services and health workers' access to neighbourhoods and districts, particularly towns for routine programme field immunisation targeting those families who, for different reasons, do not request immunisation services. Every health unit has identified the neighbourhoods and districts of highest security risk, called "hot zones", and formulated specific strategies to protect their population by negotiating with the leaders of bands and organizations (*patronatos)*, since it is impossible to enter these areas with military escorts, as before.

- Limited supervision from the regional to the municipal levels and from the municipal to the local levels due to lack of funding, transport logistics and fuel: PAHO/WHO/CIDA funds were used to finance central to regional and regional to municipal supervision, and GAVI-HSS funds to finance supervision from the municipal to the local level.

- Health units closed for prolonged periods due to regular and preventive staff holidays, causing rural health units to remain closed for an average of three months each year, with no personnel to cover this period: Vaccination operations were performed by staff from nearby health units, to provide the population with disease protection. Moreover, 40 nursing aides were hired with GAVI-HSS funds to support 58 health establishments that had been closed in 56% (26/46) of the priority municipalities, for terms ranging from 15 days to 4 months, on average.

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

In general, in accordance with analyses conducted on immunisation coverage achieved during the 2012-2013 period, several reasons have been identified for not attaining coverage rates superior to 95%, the principal among which were:

- ✓ Overestimation of the population denominator for children under one year and aged 1 to 4,
- ✓ Decrease in the enrolment of target population for 2012. 194,289 first doses of DPT-HepB-Hib were applied, which decreased by 2,706 doses in comparison with the doses applied in 2011 (196,995 first doses). For 2013, 193,947 first doses of DPT-HepB-Hib were applied, decreasing by 373 doses in comparison with 2012. This was associated to the decrease in field activities for the routine programme due to civil insecurity risks for health workers in certain districts, neighborhoods, new settlements, villages and farmhouses; limited transport logistics; lack of fuel, and lack of human resources in immunisation.
- ✓ Lack of financing for the implementation of the routine programme communication strategy, since financing is only available for informing and educating the population during immunisation days or campaigns.

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
National Survey on Demography and Health (ENDESA)	2011-2012	95.5	95

5.3.2. How have you been using the above data to address gender-related barrier to immunisation access?

The data given in the National Survey on Demography and Health 2011-2012 show that, in Honduras, access to immunisation services is universal, with no existing gender-related barriers.

5.3.3. If no sex-disaggregated data is available at the moment, do you plan in the future to collect sex-disaggregated data on routine immunisation reporting? **Yes**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (e.g., 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/)

Not applicable to the case of Honduras. Nonetheless, a national health promotion plan has been drawn up in EPI 2013-2016 to maintain this national achievement, the principal purpose of which is to strengthen the routine programme by stimulating demand in the 298 municipalities of the country. One constraint in its advance has been financial. Hence, resources are being mobilised for its implementation.

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).*

The administrative immunisation coverage of the Secretariat for Health has been compared with

WHO/UNICEF estimates, which have coincided with the administrative data up to 2010. For 2011, the WHO/UNICEF estimate for DPT third doses in children under one is 98%, lower than the official country data, which exceeded 100% (105%). For 2012, there are no discrepancies between administrative coverage rates and the WHO/UNICEF estimates. For 2013, comparison can be drawn in July 2014, since these estimates are still not available.

On comparing administrative immunisation coverage rates with surveys conducted in the country, as per the data of the National Survey on Demography and Health (ENDESA) 2011-2012, which measured immunisation coverage levels in the population aged 12-59 months, a coverage rate of 95.2% for DPT3 was found, superior to the administrative coverage rate.

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

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

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

Since 2007, the assessment of immunisation data quality has been conducted systematically. In 2007, coinciding with the international assessment of the EPI conducted by the Pan-American Health Organization (PAHO), data quality assessment DQS) was also conducted. The country has continued to perform internal data quality assessments under the guidance of the Department of Statistics of the Secretariat for Health, except for 2012, when this was not done due to financial problems.

In 2013, internal assessment of immunisation data quality was conducted in four health regions from August to October, with the financial support of PAHO/WHO. These were Copán, Choluteca, Ocotepeque and Santa Bárbara, using DQS, and evaluating 3 municipalities in each region, for a total of 28 health establishments. Outstanding among the principal findings were:

- The average quality index for the 28 health units was 78%, varying from 55% to 97%. On the regional level, this was 92%, varying from 83% to 100%.

- The accuracy of the data for Penta1 between local and regional level for the months of March, June and July 2013 was 99%. For Penta3 it was 91%.

- Integrity and timeliness in the reports were verified on all levels. The information system is operating properly as per predefined flow.

Based on the findings, an information system quality improvement plan was formulated, which was reflected in the EPI action plan for 2014.

(Document No.28)

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

Following are the main activities conducted since 2011 to improve the immunisation data system of the Secretariat for Health:
- Monthly central level monitoring as to timeliness and consistency of data.

- Monitoring of all EPI components, using a national monitoring guide that covers immunisation data quality control and enables comparison between different local sources: List of children for integrated surveillance (LINVI), daily immunisation record form (VAC1) and monthly immunisation form (VAC2).

- Monitoring the operation of the Vaccine Information System (SIVAC) from the central (statistics department) level to the priority regions.

- In 2012, a training workshop on the information system was held for statisticians from the 20 health regions, using GAVI-HSS funds.

- During the 2012-2013 period, health staff from 12 health regions was trained in EPI standards, including the module on the information system.

- Providing the statistics departments of the 20 health regions with computer equipment with GAVI-HSS

financial support in 2011.

- Implementing the pilot project of the Nominal System of Immunisation (SINOVA) in the two health regions of Comayagua and Francisco Morazán in 2013.

- Annual internal immunisation data quality assessment using the WHO method in priority regions, with negative desertion rates as principal criterion..

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

In the framework of the EPI five-year action plan 2011-2015 and the annual action plan, a project for the design and implementation of the nominal system of immunisation (SINOVA) in three phases was formulated in 2011, for execution during the 2011-2014 period, mobilising resources in technical and financial assistance from the Spanish International Development Cooperation Agency (AECID), PAHO/WHO and the CDC. The plan has been adjusted up to the year 2016. Below are its principal advances:

- In 2011, requirements for the design of the system were defined with PAHO support.

- In 2012, the nominal system of immunisation was designed and validated with AECID support.

- In November 2012, the first phase of the project was implemented on the central level (Department of Statistics) and in the two pilot health regions (Francisco Morazán and Comayagua), which were provided with equipment, office supplies, and regional, municipal and local human resources training.

- Weekly/monthly monitoring of system operation under the responsibility of the Department of Statistics.

- Monthly meetings on system monitoring with the participation of the central department of statistics, EPI and PAHO/WHO.

- Two pilot project assessments have been conducted with municipal, regional, central (Department of Statistics and EPI), country PAHO and regional PAHO participation, establishing a programme of commitments.

- Health units in the municipalities of the pilot regions have been identified for expansion in 2014, along with project expansion to two new regions (La Paz and Olancho).

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$ = 20.02	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$

Expenditures by Category	Expenditure Year	Funding source						
		Country	GAVI	UNICEF	WHO	Project HOPE	CMMB/IPPF	Others
Traditional Vaccines*	9,004,840	9,004,840	0	0	0	0	0	0
New and underused Vaccines**	7,148,724	1,327,776	3,706,348	0	0	1,755,600	359,000	0
Injection supplies (both AD syringes and syringes other than ADs)	682,366	502,214	180,152	0	0	0	0	0
Cold chain equipment	561,700	555,600	0	0	0	6,100	0	0
Personnel	641,000	604,500	36,500	0	0	0	0	0
Other routine recurrent costs	1,225,192	751,938	130,300	10,000	284,494	14,000	34,460	0
Other Capital Costs	8,000	3,900	0	0	2,900	1,200	0	0

Campaigns costs	596,678	487,132	0	0	66,436	0	43,110	0
None		0	0	0	0	0	0	0
Total Expenditures for Immunisation	19,868,500							
Total Government Health		13,237,900	4,053,300	10,000	353,830	1,776,900	436,570	0

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

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

In line with the Vaccine Act, the Secretariat for Health signs an annual agreement on vaccine, syringe and sharps box supplies and cold chain equipment for the PAHO to acquire through its Rotating Fund, making it possible to ensure the annual allocation of funds from the country's income and expenditure budget for the purchase of traditional vaccines and the pertinent co-payment on the new rotavirus and pneumococcal conjugate vaccines, in keeping with the country commitment made to GAVI.

For the 2013-2015 period and henceforward, the Government of the Republic will continue to allocate the funds required from the national budget of the Secretariat for Health to ensure the purchase of traditional and new vaccines.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **No, not implemented at all**

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

Not applicable

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

Not applicable

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2013 **2**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2014 endorsing this report.

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

Dr Alma Morales, Coordinator for Health, Family, Gender and Life Course of the Pan-American Health Organization (PAHO/WHO:

Congratulates both speakers first of all, and explains that her comments focus on the technical aspects. With regard to the EPI, she says she worries about low immunisation coverage in the past 2 years and she does not know whether it will always be attributed to an overestimated population, since this problem has become chronic. This is the right time to call and consult whether coverage was crossed with the incidence of VPDs, for example whooping cough in those health regions where coverage is low, such as Choluteca, Lempira and Intibucá. Hence, she wants to know the SESAL position in the context of the organizational structure being

developed as regards low coverage rates and what else can be done to resolve the problems formulated.

As to Health Service Strengthening, it is observed that the regions were empowered by the decentralization of resources. It would have been ideal to select municipalities with 100% of their communities. She considers this a lesson learned. There are some problems. For example, infant mortality has decreased but neonatal mortality has increased. This makes it vital to focus strategies. She repeats her congratulations.

Dr. Nery Artega, Chairman of the Honduran Municipalities' Association (AMHON), says:

- On behalf of the mayors of the entire country, he reiterates his commitment to the people and mentions that in the budget items of municipalities, there is a percentage earmarked for health. However, regardless of the budget allocated, this will always be insufficient, making strategic alliances important. <?xml:namespace prefix = "o" />

- He is worried about the statistical data on immunisation coverage rates and believes that the problem will not be solved by the new census of 2013, since there are many complaints about it. He expresses his agreement with Dr. Cleves' statement to the effect that greater organization is needed of SESAL.

- AMHON is interested in the topic of Primary Healthcare and will be presenting a proposal to promote it nationwide. There are currently 1,200 medical students ready to perform their mandatory medical service, which will be considered in the proposal. Such teams will not only be composed of doctors, but also by nurses and social workers for an integrated approach; not, as is done at present, by hiring outsourced services and conducting activities that are not integrated.

Dr. Gustavo Ávila/USAID states:

- That the immunisation coverage of 77% for the health region of Lempirade does not reflect reality, considering that it has a high percentage of decentralized municipalities. He believes that coverage in this department is greater than the administrative coverage rates presented.

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

If Yes, which ones?

List CSO member organisations:
Honduran College of Physicians
Honduran Municipalities Association (AMHON)
Honduran Association of Paediatricians
College of Chemists and Pharmacists
The American Red Cross
National Immunisations Advisory Committee (Consejo Consultivo Nacional de Inmunizaciones)
Honduran College of Nurses
College of Dentists
Federation of Private Development Organizations (Federación de Organizaciones Privadas de Desarrollo – FOPRIDE)
The Church of Jesus Christ of Latter-Day Saints

5.8. Priority actions in 2014 to 2015

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

Based on the multi-year action plan 2011-2015 and the action plan for 2014, following are the priority objectives and actions by component for the 2014-2015 period:

General Objective <?xml:namespace prefix = "o" />

To decrease disease and mortality due to VPDs in the general population, with emphasis on the age group under five and groups at risk through immunisation; to maintain the poliomyelitis eradication certificate, eliminate measles, rubella, congenital rubella syndrome and neonatal tetanus; to control the severe forms of infant tuberculosis, whooping cough, diphtheria, mumps, hepatitis B, invasive diseases due to Hib, diarrhoea due to rotavirus, invasive diseases provoked by pneumococci (meningitis, pneumonia and septicaemias, among others) and influenza.

Specific Objectives

1. To consciously promote the spontaneous supply and demand for immunisation services among the health workers and beneficiary population in the context of the healthy municipalities and communities strategy through the EPI health promotion process.
2. To provide the service networks of the 20 health regions with vaccines, syringes, materials, sharps boxes, office supplies and equipment for the conduct of immunisation and epidemiological surveillance activities and safe injections.
3. To achieve national immunisation coverage superior to 90% in the target population in terms of all vaccines.
4. To intervene on 20% (53) of the municipalities at risk with greater population densities based on characterization until coverage rates superior to 95% are achieved for third doses of DPT-HepB-Hib in children under one old.
5. To maintain seamless operation in over 90% of the cold chain equipment on all the levels of the network in the 20 health regions to guarantee the safe storage and conservation of vaccines as per EPI standards.
6. To guarantee the safe administration of injectable vaccines to the EPI target population, implementing biosafety standards to protect health workers, the population and the environment.
7. To implement the nominal system of immunisation in its second phase in two priority health regions.
8. To maintain active epidemiological surveillance of VPDs in the process of their eradication, elimination and control through efficient and timely response based on the disease concerned, in fulfilment of international surveillance indicators and EPI standards of epidemiological surveillance.
9. To maintain systematic EPI monitoring, supervision and evaluation of all components on all levels, to ensure fulfilment of the targets and objectives established.

Priority activities by component:

1. Political Priority and Basic Legal Principles

- Compliance with the law in the acquisition of vaccines through the PAHO Rotating Fund to guarantee the annual budget allocation in the Republic's general budget of income and expenditure, through fulfilment of the agreement on vaccines between the Secretariat for Health and the PAHO as regards payment for the timely supply of vaccines, syringes and cold chain equipment.
- To formulate the regulations to govern “The Vaccine Act of the Republic of Honduras”, approved by the Sovereign National Congress through Decree 288 – 2013 on January 13, 2014.
- To disseminate the law and its regulations nationwide with the help of key agents, so as to ensure fulfilment.
- Maintaining the EPI topic on the agenda of the political authorities so as to ensure the fulfilment of regional and sub-regional agreements and commitments.

- Monitoring fulfilment of the basic functions of the National Regulating Authority (ARN) as regards the vaccines.

2. Planning and Coordination

Planning

- Formulation of the EPI Annual Action Plan on the national and regional scale and on the level of financial management.
- Incorporation of the main activities of the EPI regional action plan into municipal and local health plans.
- Formulation of plans for intervention in 53 municipalities at risk due to pentavalent coverage levels under 95%, high population concentrations and epidemiological silence in case reporting.
- Formulation and handling of project profiles for management and the search for additional funds from international cooperation, NGOs/PAHO and private companies on the national and international scale to strengthen critical EPI components.
- Presentation of the national plan to introduce the Human Papilloma Vaccine (HPV) to political authorities and cooperation partners.
- Formulation of contingency plans on vaccine storage and distribution.
- Programming of the EPI target population in accordance with the national schedule
- Programming of vaccine, syringe and supply requirements for 2014 on the local, municipal and regional levels using programming logs and national consolidation

Coordination

- Transferring the different units of the EPI to new hierarchic structures in the context of the new organization implemented by the Secretariat for Health.
- EPI coordination on all intra-institutional, inter-programme and inter-institutional levels.
- Operation, expansion and revision of the National Immunisations Advisory Committee (CCNI) regulations.
- Operation of the national committees on the classification of cases: the National Committees on the eradication of poliomyelitis (CONEPO), on the documentation and verification of the measles elimination, on the classification of special cases of measles, rubella and congenital rubella syndrome, and the HPV technical committee.
- Establishment of vaccine storage agreements with public and private institutions.
- Strengthening of the coordination between the IHSS and the private sector for immunisation and epidemiological surveillance activities.
- Establishment of a bilateral Secretariat for Health (SESAL)/IHSS agreement for financial support in the component of social communication.
- Maintenance of the coordination with health resource training schools and the College of Medical Sciences (FCM) as regards the EPI on the national and regional scale.
- Strengthening local coordination with municipal governments through the Honduran Municipalities Association (AMHON) in support of priority EPI activities in municipal development plans, with emphasis on municipalities at risk and health units with decentralized health models.

3. Biological Products and Supplies

- Acquisition, supply and distribution of vaccines, syringes and sharps boxes nationwide.
- Strengthening of virology and bacteriology laboratories through supplies of reagents, materials and laboratory consumables.

4. Cold Chain

- Annual implementation of the national/regional plans for technical, logistic, preventive and corrective cold chain operation maintenance.
- Annual cold chain inventory update.
- Acquisition of spare parts and fuel for cold chain operation on all levels.
- Improving the operation of regional cold rooms.
- Basic cold chain equipment for 30% of municipal centres (at least 2 refrigerators, 1 freezer and 1 icebox).

5. Training

- Formulation of a national and regional training plan.
- Training in updated EPI standards to health staff from backlogged health regions and primary care teams (PCTs) using different modalities.
- Preparation and implementation of standard operating procedures (SOPs) for effective vaccine management.
- Training of the regional, municipal and local teams of 2 selected health regions in the nominal immunisation system.
- Dissemination of the guidelines for National Immunisation Days and the Seasonal Flu Campaign 2014.
- Preparation and implementation of a generic guideline or protocol on the production and use of press articles for communication and promotion.

6. Social Mobilisation

- Implementation of the national health promotion plan in EPI 2013-2016 on the regional and municipal levels, including organized civil society and community leaders in the management of their own resources within the political framework of the health sector, documenting and systematizing activities.
- Design and implementation of a national promotional campaign on the EPI routine programme to stimulate demand.

7. Operating Expenses

- Ensuring EPI operation on the national scale with regard to the salaries of permanent staff, infrastructure maintenance, cold chain equipment, transport logistics, communication and the customs clearance of vaccines, syringes, sharps boxes and cold chain equipment.
- Strengthening the regular immunisation programme through the promotion of a quality immunisation service offer on the public service and social security network, to generate spontaneous demand in the target population.
- Execution of National Immunisation Days from April 28 to May 9 to search for vulnerable populations as part of the Americas immunisation week (SVA), with the inclusion of other health promotion and disease prevention activities.
- Execution of the immunisation campaign against seasonal flu from November 10 to 21.

8. Supervision and Monitoring

- Formulation and implementation of the EPI national and regional supervision plan.
- EPI monitoring in terms of all components, including the NID and the Influenza Campaign in all levels, ensuring at least one supervision visit for each health region and municipality.

- Monthly monitoring and analysis of tracking indicators (immunisation coverage, abandonment, cold chain on all levels and weekly monitoring of AFP, MMR and CRS epidemiological surveillance indicators) in the regional and central levels.
- Monitoring of the quarterly fulfilment of the EPI action plan on the central and regional levels.

9. Epidemiological and Laboratory Surveillance

- Strengthening active VPD epidemiological surveillance in terms of control, elimination and eradication on the out-patient and hospital levels through the training and implementation of Analysis Units on all levels.
- Maintaining nationwide epidemiological surveillance on VPDs under national surveillance.
- Supporting sentinel hospital surveillance operations regarding gastroenteritis due to rotavirus, meningitis and bacterial pneumonia in children under five, and influenza.
- Expanding the network of notification units for AFP and MR in the private sector (including military hospitals).
- Systematizing the active institutional search for VPDs on the municipal plane.
- Strengthening laboratory diagnoses of VPDs on the central and regional levels.
- Analysis of the seasonal character of seasonal influenza to define vaccine type to be used.

10. Information System

- Monitoring of the vaccine information system (SIVAC) software operation, to improve data record quality on all levels.
- Assessment of immunisation data quality in selected regions.
- Expanded implementation of the EPI nominal system of immunisation (SINOVA) in two pilot regions and two new priority regions for the second phase.
- Equipment for SINOVA operation in priority regions.
- Conduct of immunisation data quality audits in five priority health regions.
- Implementation of computerized vaccine and syringe inventory control in the region of Gracias a Dios.
- Upkeep of computerized Vaccine Stock Supplies Management (VSSM) operation.

11. Research

- Preparation of a bank of scientific and operational research profiles of national interest in EPI.
- Promotion of the conduct of EPI-related operational research in coordination with undergraduate and postgraduate health resource training schools and schools of other disciplines.
- Dissemination of research work conducted: Economic Study of the EPI, Cost-effectiveness Study of HPV Vaccine Introduction and Evaluation of Seasonal Influenza Vaccine Effectiveness.
- Participation in research on influenza immunisation impact and in global vaccine safety research.

12. Evaluation

- Six-monthly EPI evaluation in terms of all components on all levels.
- Assessment of SINOVA pilot project.

- Assessment of HVP immunisation in pilot projects.
- Annual evaluation of the effectiveness of the influenza vaccine (REVELAC-i).

5.9. Progress of transition plan for injection safety

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

Please report what types of syringes are used and the funding sources of Injection Safety material in 2013

Vaccine	Types of syringe used in 2013 routine EPI	Funding Sources of 2013
BCG	Disposable 1cc with 26 x 3/8 needle	Government
Measles	AD 0.5cc with 25 X5/8 needle	Government
TT	AD 0.5cc with 1 X5/2 needle	Government
DTP-containing vaccine	AD 0.5cc with 23 X5/1 needle	Government
Pneumococcus	AD 0.5cc with 23 X5/1 needle	Government and GAVI
Paediatric HepB	AD 0.5cc with 23 X 1 needle	Government
Adult HepB	Disposable 1cc with 22 x 1 1/2 needle	Government
YF	AD 0.5cc with 25 X5/8 needle	Government
Influenza	AD 0.5cc with 1 X5/2 needle	Government

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)

In 2003, a national EPI injection safety plan was formulated in the context of INS policy. In 2008, a legal framework was established through Resolution No. 07 dated February 28, 2008 on regulations for handling hazardous waste generated in health establishments.

Among the main obstacles are some that were mentioned in APR 2012:

1. Breach of regulations in the network of public health services, social security and the private sector as regards final sharps disposal.

2. Limited dissemination of the regulations.

In the context of health sector reform and reorganization, the governing role of the Secretariat for Health will be strengthened and is expected to overcome the obstacles previously pointed out.

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

In 2013, the sharps generated by the vaccination services were disposed of following EPI guidelines, as follows:

1. Used syringes and their needles disposed of in sharps boxes in 100% of health units.

2. Used needles destroyed in portable electrical syringe needle destroyers in urban health centres and disposal of syringes in sharps boxes.

3. Sharps boxes finally disposed of in safety pits or buried, in the case of rural health centres.

Principal problems encountered:

1. Because of the shortage of safe incinerators and sanitary landfill, in urban areas, sharps boxes are dumped in municipal tips. However, progress has been made in one of the most densely-populated health regions (department of Cortés), where boxes are incinerated safely.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2013

Honduras is not reporting on Immunisation Services Support (ISS) fund utilisation in 2013

6.2. Detailed expenditure of ISS funds during the 2013 calendar year

Honduras is not reporting on Immunisation Services Support (ISS) fund utilisation in 2013

6.3. Request for ISS reward

Request for ISS reward is not applicable to Honduras in 2013

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

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

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

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

	(A)	[B]		
Vaccine type	**Total doses for 2013 in Decision Letter**	**Total doses received by 31 December 2013**	**Total doses of postponed deliveries in 2013**	**Did the country experience any stockouts at any level in 2013?**
Pneumococcal (PCV13)	673,200	673,200	0	No
Rotavirus	448,500	448,500	0	No

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

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? ...)

  In 2013, the rotavirus and pneumococcal conjugate vaccines were received as per Decision Letter (GAVI/12/252/lm/dlc) of November 29, 2012.

  In the case of the rotavirus vaccine, 116,280 doses were received in December 2012, corresponding to the request for 2013 as needed by the country to ensure supply for the first quarter of that year.

- 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.

  Several measures have been undertaken to improve vaccine management:

  - Implementation of vaccine supplies stock management (VSSM) on the central level and in 19/20 health regions with the technical and financial support of the

  PAHO/WHO;

  - Adjusting the proposed UNICEF and PAHO Rotating Fund dispatch plan in the course of the year to secure quarterly national distribution.

  - Quarterly adjustment of rotavirus and pneumococcal conjugate distribution to regional cold rooms in accordance with stocks.

  Problems identified

  - In XXX health regions, the staff assigned to handle the VSSM is contractual, giving rise to personnel rotation and new staff training.

  - Financial problems on the health region level in purchasing toner for printers, limiting the printing of invoices.

- The EPI has made sure that there is a reserve stock of traditional vaccines on the health region level. Nonetheless, this has not been possible for the new vaccines.

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.

In 2013, there was no shortage of rotavirus or pneumococcal conjugate vaccines on any of the levels.

7.2. Introduction of a New Vaccine in 2013

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

Pneumococcal (PCV13), 1 doses/vial, Liquid		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why?	No	No new vaccine was introduced with GAVI support in Honduras in 2013. The 13-valent pneumococcal conjugate vaccine was introduced in 2011. Hence, this section is not applicable.

Rotavirus, 1 dose(s) per vial, ORAL		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why?	No	The rotavirus vaccine was introduced in Honduras in 2009. Hence, this section is not applicable.

7.2.2. When is the Post introduction evaluation (PIE) planned? **September 2014**

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

The Honduran Secretariat for Health introduced the pneumococcal conjugate vaccine into the national immunisation schedule in April 2011. National evaluation was conducted in February 2012, with the participation of regional managers, epidemiologists and EPI health region coordinators. Document No. 9 presents the results of the meeting to evaluate the introduction of the pneumococcal conjugate vaccine, as well as the advances made in the fulfilment of the commitments established.

In 2013, the six-monthly EPI evaluation included as well evaluation of the use of the vaccine biologicals introduced with GAVI support, advances made in coverage and abandonment rates.

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 diarrhoea? **Yes**

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

Does your country conduct special studies around:

a. rotavirus diarrhoea? **No**

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

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

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

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

Below is a description of the results of rotavirus sentinel surveillance in 8 hospitals and meningitis and bacterial pneumonia sentinel surveillance in 3 hospitals among the under-five population for 2013:

Gastroenteritis due to Rotavirus

In 2013, total confinements of children under 5 in sentinel hospitals for all reasons amounted to 30,342 cases. Admissions due to diarrhoea numbered 3,903, spelling out 13% of the total number of hospital confinements. Of the total number of children admitted for diarrhoea, 3,305 met the criteria for suspect cases. Stool samples were collected in a timely manner and studied from 1,425 of the cases, spelling out 43.1% in surveillance efficiency. Of these samples, 294 were found positive for rotavirus (21%), inferior to the proportion reported in 2012. This means that in 7.5% of the children under 5 admitted for diarrhoea, the aetiology was rotavirus.

The greatest number of cases and highest positive percentage was observed during the first 7 months of the year, with February, March, April and May presenting the highest peaks.

The sentinel sites with the greatest number of admissions for diarrhoea were Hospital Escuela and Mario Catarino Rivas, but the highest positive rate for rotavirus was reported by the Hospital Regional del Sur (26%). Rates were: Hospital Escuela (25%), Mario C. Rivas (22%), Hospital Atlántida and Hospital de Occidente (20%), IHSS (15%) and Gabriela Alvarado (10%).

Samples were sent to the CDC for genotyping in 2013. However, the results of these are still pending. As regards efficiency percentage in complying with surveillance for 2013, Hospital Gabriela Alvarado achieved 100%, followed by the Hospital de Occidente, with 99%, Hospital Regional de Atlántida with 93%, Hospital Regional del Sur with 88%, Hospital San Francisco with 78%, the IHSS with 74.5%, Hospital Escuela with 29%, and lastly, Mario C. Rivas with 18%. Striking is the fact that the lower efficiency percentages occur in the more complex hospitals.

The most severely affected age group was that of 12 to 23 months, with 41% of the cases: the group under 12 months had 39% and that aged 24 to 59 months had 20%. As regards the immunisation status of positive cases, this was 48.6% in all the children under 5 years of age. In 15% of the cases, they were not immunised and in 37%, the information to such regard was not collected.

Pneumonia and bacterial meningitis

Pneumonia

In 2013, 16,530 children under five were confined in three sentinel hospitals. Of these, 1,644 (10%) were suspect for pneumonia. 1,185 (72%) of the 1,644 were studied by means of chest x-rays, expected range being 80-100%. The IHSS hospital of San Pedro Sula was the only one that reached the range.

Of the x-ray imaging cases suspect for bacterial pneumonia, 1,128 (69%) were reported probable. It must be mentioned that 9% of the probable cases exceeded the expected range (20-40%), with the IHSS of San Pedro Sula and Tegucigalpa having higher percentages.

As regards number of probable pneumonia cases, blood samples for culture were only taken from 176 (16%), with expected range being 80-100%. The IHSS of Tegucigalpa was the only site that achieved 84%, complying with the range set.

Pleural liquid for culture was only taken from 0.1% of the total number of probable cases. 62 isolations were performed, in which the agent involved (Spn) was only specified in one case. The rest were reported as being for other bacteria.

The sentinel site confirming the highest number of cases by bacteriology was the San Pedro Sula IHSS (11.0%), followed by the Tegucigalpa IHSS (5.7%). The highest number of cases was confirmed in the age

group under 12 months, followed by that aged 12-23 months.

The increase in suspect and confirmed cases starts in the month of July, with confirmed cases reaching a maximum peak in August and suspect cases in October. 63 deaths were reported for a mortality of 5.6%, with the age group younger than 12 months being the most affected. The sentinel site reporting the highest number of deaths was Hospital [X, name not mentioned], in disregard of age group.

Meningitis

In 2013, 16,530 children under five were confined in three sentinel hospitals. Suspect meningitis cases were only reported by Hospital Escuela (27) and the Tegucigalpa IHSS (1), for a total of 28 (0.17%). Of these, only 22 cases (78%) were studied through cerebrospinal fluid (CSF) analysis, the expected range being greater than 80%. 4 cases (33%) were confirmed by CSF results, expected range being 80%. The bacteria involved were not specified in the isolations conducted.

Three deaths were reported for a fatality of 18.7%, which occurred in the Hospital Escuela.

Strengths Identified in Sentinel Site Surveillance

1. Sentinel sites equipped with the basic requirements to comply with surveillance activities.

2. Process performed by the sentinel site epidemiologist.

3. Participation of medical staff, with heads of units and nursing spearheading surveillance activities in some hospitals.

4. Availability of equipment and supplies for laboratory surveillance.

5. Technical capacity to process samples in all laboratories.

6. Information on the country indicators is generated and shared with all levels.

Weaknesses Identified in Sentinel Site Surveillance

1. The persons charged with epidemiology in the sentinel sites have multiple functions.

2. Lack of periodic training from the team conducting hospital surveillance to the medical staff providing healthcare.

3. Problems in the understanding of case definitions in certain sentinel sites.

4. Incomplete information provided on records.

5. No standard, updated or complete databases exist.

6. Coordinating team meetings to analyse surveillance results are not scheduled.

7. No feedback on results from the team conducting the surveillance to the staff providing healthcare to patients.

8. The majority of the sites do not keep the records in NVSN.

9. Lack of coordination as to EPI regional techniques for completing the information on file relating to patient immunisation status.

10. Entry of cases on the monthly template during the month that samples are processed in the laboratory and not the month of case enrolment.

11. Absence of mechanisms to prevent delays in the dispatch of samples to the virology laboratory on the central level.

12. No budget allocated for sentinel site consumables and materials.

Lines of Action

1. Conduct of periodic supervision to guarantee data quality.

2. Monthly reporting of data to the NVSN.

3. Continuous training for proper surveillance to new hires in the sentinel sites.

4. Training in EPI information for the coordinating teams of the sentinel sites to improve data analysis.

5. Periodic meetings for the technical group conducting surveillance: the DGVS, the virology laboratory, the Expanded Programme on Immunisation and PAHO.

6. Printing and supply of posters to promote surveillance in every sentinel site.

7. Permanent supply of consumables for surveillance.

8. Annual meeting to exchange experiences among sentinel sites, with the participation of the surveillance coordinators in each site.

9. Promoting the research on outbreaks due to rotavirus in other hospitals and health regions that are not sentinel sites.

10. Creation of EPI alerts and informative bulletins, with the information generated by sentinel site surveillance.

11. Design of a new electronic template and/or mask for the creation of files and the characterization of these diseases and the conduct of visits and in-service training for record implementation.

7.3. New Vaccine Introduction Grant lump sums 2013

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2013 (A)	0	0
Remaining funds (carry over) from 2012 (B)	0	0
Total funds available in 2013 (C=A+B)	0	0
Total Expenditures in 2013 (D)	0	0
Balance carried over to 2014 (E=C-D)	0	0

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

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2013 calendar year (Document No 10.11) . Terms of reference for this financial statement are available in **Annex 1**. Financial statements should be signed by the Finance Manager of the EPI Program and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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

Not applicable

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

Not applicable

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

Not applicable

7.4. Report on country co-financing in 2013

Table 7.4: Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2013?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: Pneumococcal (PCV13), 1 doses/vial, Liquid	872,215	387,000
Awarded Vaccine #2: Rotavirus, 1 dose(s) per vial, ORAL	455,079	171,000
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2013 from the following sources?	
Government	1,467,500	
Donor	0	
Other	0	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: Pneumococcal (PCV13), 1 doses/vial, Liquid	137,785	283,400
Awarded Vaccine #2: Rotavirus, 1 dose(s) per vial, ORAL	2,421	1,900
	Q.4: When do you intend to transfer funds for co-financing in 2015 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2015	Funding source
Awarded Vaccine #1: Pneumococcal (PCV13), 1 doses/vial, Liquid	April	Government
Awarded Vaccine #2: Rotavirus, 1 dose(s) per vial, ORAL	April	Government
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	- The law stating that vaccines must be procured through the PAHO Revolving Fund and the establishment of an annual agreement between the Ministry for Health and PAHO guarantee sustainability in the procurement of vaccines, syringes and sharps boxes. - The multi-year plan and annual action plans, adapted to targets, progress and national and international commitments, are fundamental tools for negotiation and resource management. - The work of the Interagency Cooperation Commission (ICC) continues to be an example of the mobilisation of additional resources for the Extended Immunisation Programme. - On January 13, 2014, the Sovereign National Congress passed the Vaccine Act of the Republic of Honduras, which deals with programme implementation financing in different components. This law was published in the official gazette "La Gaceta" on March 26, 2014 and its regulations are being developed (Document 30).	

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/

Not applicable

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

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_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? (effective vaccine storehouse management and vaccine management assessment) **November 2011**

Please attach:

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

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

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

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

Are there any change/s in the Improvement plan, with reasons? **Yes**

If yes, provide details

Honduras has not conducted effective vaccine management assessment. From November 20 to 25, 2011, the PAHO conducted an international assessment on the management and control of vaccine, syringe and supply inventories (VSSM) in 5 of the 20 health regions and in the national cold rooms, making it possible to identify strengths, provide recommendations and formulate an improvement plan. The first progress report on the improvement plan was prepared in 2012 and updated for 2013 (Document No14).

From October 14 to 19, 2013, an international workshop on Effective Vaccine Management (EVM) was held by the PAHO and WHO in Honduras, with the participation of GAVI country beneficiaries from the Americas region. In the specific case of Honduras as host country, the EPI and 10 selected health regions with regional cold rooms participated. Fieldwork was conducted on the different levels of the service network in one health region, facilitating findings in terms of strengths and weaknesses and making it possible to provide recommendations.

As an outcome of the workshop, the EPI team participating subsequently formulated an EVM improvement plan along nine criteria for implementation in 2014 (Document 29).

EVM assessment was initially programmed for August 2013, but the PAHO rescheduled it for 2014. Nonetheless, due to changes of state secretary for the health departments and the impending date of presidential elections, the country requested rescheduling for June 2015

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

7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

Honduras does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

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

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2014

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

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

In order to request NVS support for 2015 do the following:
Confirm here below that your request for 2015 vaccines support is as per 7.11 Calculation of requirements **Sí**
If you don't confirm, please explain

Not applicable

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1 Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2 Freight Cost

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

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

7.11. Calculation of requirements

Table 7.11.1: Specifications for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	215,901	216,619	17,145	449,665
	Number of children to be vaccinated with the first dose	Table 4	#	211,583	212,287	212,802	636,672
	Number of children to be vaccinated with the third dose	Table 4	#	211,583	212,287	206,288	630,158
	Immunisation coverage with	Table 4	%	98.00 %	98.00 %	1203.20 %	

	the third dose						
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.05	1.05	1.05	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	111,634			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	111,634			
	No. 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	
cc	**Country co-financing per dose**	Co-financing table	$		2.13	2.75	
ca	**AD syringe price per unit**	Table 7.10.1:	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1:	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1:	$		0.0050	0.0050	
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 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

As per the December 31 VSSM report, the year ended with a pneumococcal stock of 111,634 doses and January 1, 2013 opened with the same amount, with no difference.

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

Co-financing group	Graduating

	2013	**2014**	**2015**
Minimum co-financing	1.50	2.13	2.75
Recommended co-financing as per APR 2012			2.75
Your co-financing	1.50	2.13	2.75

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

		2014	**2015**
Number of vaccine doses	#	231,600	161,300
Number of AD syringes	#	240,100	168,800
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	2,650	1,875
Total value to be co-financed by GAVI	$	843,500	584,000

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

		2014	2015
Number of vaccine doses	#	326,500	510,200
Number of AD syringes	#	338,400	534,000
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	3,725	5,875
Total value to be co-financed by the Country [1]	$	1,189,000	1,846,500

Table 7.11.4 Calculation of requirements for Pneumococcal (PCV13), 1 doses/vial, LIQUID

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	58.50 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	211,583	212,287	124,184	88,103
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B x C*	634,749	636,861	372,550	264,311
E	Estimated vaccine wastage factor	*Table 4*	1.05	1.05		
F	Number of doses needed including wastage	*D X E*		668,705	391,178	277,527
G	Vaccines buffer stock	*((D - D of previous year) x 0,25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0,25)*		555	325	230
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Stock on January 1st	*Table 7.11.1:*	0			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		558,000	326,418	231,582
J	No. of doses per vial	*Vaccine Parameter*		1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*		578,361	338,329	240,032
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*		6,362	3,722	2,640
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		1,892,178	1,106,883	785,295
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		26,027	15,226	10,801
P	Cost of reconstitution syringes needed	*L * reconstitution price per unit*		0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		32	19	13
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		113,531	66,414	47,117
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)*		2,031,768	1,188,540	843,228
U	Total country co-financing	*I x country co-financing per dose (cc)*		1,188,540		
V	Country co-financing % of GAVI supported proportion	*U / T*		58.50 %		

Table 7.11.4 Calculation of requirements for Pneumococcal (PCV13), 1 doses/vial, LIQUID

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	75.98 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	212,802	161,688	51,114
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B x C*	638,406	485,063	153,343
E	Estimated vaccine wastage factor	*Table 4*	1.05		
F	Number of doses needed including wastage	*D X E*	670,327	509,317	161,010
G	Vaccines buffer stock	*((D - D of previous year) x 0,25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0,25)*	406	309	97
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	Stock on January 1st	*Table 7.11.1:*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	671,400	510,132	161,268
J	No. of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	702,694	533,910	168,784
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	7,730	5,874	1,856
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,262,618	1,719,145	543,473
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	31,622	24,027	7,595
P	Cost of reconstitution syringes needed	*L * reconstitution price per unit*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	39	30	9
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	135,758	103,150	32,608
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)*	2,430,037	1,846,350	583,687
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,846,350		
V	Country co-financing % of GAVI supported proportion	*U / T*	75.98 %		

Table 7.11.1: Specifications for Rotavirus, 1 dose(s) per vial, ORAL

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	215,901	216,619	17,145	449,665
	Number of children to be vaccinated with the first dose	Table 4	#	211,583	212,287	212,802	636,672
	Number of children to be vaccinated with the second dose	Table 4	#	211,583	212,287	206,288	630,158
	Immunisation coverage with the second dose	Table 4	%	98.00 %	98.00 %	1203.20 %	
	Number of doses per child	Parameter	#	2	2	2	
	Estimated vaccine wastage factor	Table 4	#	1.05	1.05	1.05	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	69,195			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	69,195			
	No. 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	
cc	**Country co-financing per dose**	Co-financing table	$		1.48	2.03	
ca	**AD syringe price per unit**	Table 7.10.1:	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1:	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1:	$		0.0050	0.0050	
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 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

As per the December 31, 2013 VSSM report, the year ended with a rotavirus stock of 69,195 doses and January 1, 2013 opened with the same amount, with no difference.

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

Co-financing group	Graduating

	2013	2014	2015
Minimum co-financing	1.02	1.48	2.03
Recommended co-financing as per APR 2012			2.03
Your co-financing	1.02	1.48	2.03

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

		2014	2015
Number of vaccine doses	#	170,000	108,900
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 GAVI	$	457,500	292,000

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

		2014	2015
Number of vaccine doses	#	208,100	339,700
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]	$	559,500	910,500

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

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	55.04 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	211,583	212,287	116,839	95,448
C	Number of doses per child	*Vaccine parameter (schedule)*	2	2		
D	Number of doses needed	*B x C*	423,166	424,574	233,678	190,896
E	Estimated vaccine wastage factor	*Table 4*	1.05	1.05		
F	Number of doses needed including wastage	*D X E*		445,803	245,362	200,441
G	Vaccines buffer stock	*((D - D of previous year) x 0,25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0,25)*		370	204	166
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Stock on January 1st	*Table 7.11.1:*	0			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		378,000	208,044	169,956
J	No. of doses per vial	*Vaccine Parameter*		1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*		0	0	0
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(I / 100) x 1.10*		0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		968,058	532,800	435,258
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		0	0	0
P	Cost of reconstitution syringes needed	*L * reconstitution price per unit*		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)*		48,403	26,641	21,762
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)*		1,016,461	559,440	457,021
U	Total country co-financing	*I x country co-financing per dose (cc)*		559,440		
V	Country co-financing % of GAVI supported proportion	*U / T*		55.04 %		

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

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	75.73 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	212,802	161,151	51,651
C	Number of doses per child	*Vaccine parameter (schedule)*	2		
D	Number of doses needed	*B x C*	425,604	322,301	103,303
E	Estimated vaccine wastage factor	*Table 4*	1.05		
F	Number of doses needed including wastage	*D X E*	446,885	338,417	108,468
G	Vaccines buffer stock	*((D - D of previous year) x 0,25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0,25)*	271	206	65
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	Stock on January 1st	*Table 7.11.1:*			
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*	448,500	339,640	108,860
J	No. of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*	0	0	0
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(I / 100) x 1.10*	0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	1,145,021	867,100	277,921
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	0	0	0
P	Cost of reconstitution syringes needed	*L * reconstitution price per unit*	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)*	57,252	43,356	13,896
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)*	1,202,273	910,455	291,818
U	Total country co-financing	*I x country co-financing per dose (cc)*	910,455		
V	Country co-financing % of GAVI supported proportion	*U / T*	75.73 %		

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2013**. All countries are expected to report on:

   a. Progress achieved in 2013

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

   c. Plans for 2015

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

For countries that received HSS funds within the last 3 months of 2013, or experienced other delays that limited implementation in 2013, this section can be used as an inception report to comment on start-up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **15th May 2014**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2014, the HSS reports are expected by GAVI Alliance by September 2014.

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

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

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

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

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

   a. Minutes of all the HSCC meetings held in 2013

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

   c. Latest Health Sector Review Report.

   d. Financial statement for the use of HSS funds in the 2013 calendar year.

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

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

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

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

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

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

9.1. Report on the use of HSS funds in 2013 and request of a new tranche

For countries that have already received the last disbursement of all GAVI HSS funds approved and no longer have funds to apply for: has implementation of the HSS grant been completed? (YES/NO). If NO, please indicate the anticipated date for completion of the HSS grant. **No**

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

The anticipated date for complete implementation of all the funds is the second half of 2014, since the process of purchasing primary care equipment for maternal and child care has still not been concluded by the PAHO/WHO. Moreover, a transfer of funds will be made to the region of Islas de la Bahía to finish activities from the operating plan that are pending due to a bank account inconvenience, explained in the section on HSS Financial Management.

Please attach the studies or assessments related to or financed with the HSS grant.

Please attach data broken down by sex, rural or urban area, district or state whenever this information is available, particularly as regards immunisation coverage indicators. These data are of special importance in cases where GAVI HSS grants are addressed to specific populations or geographical areas of the country.

Where CSOs collaborate in the implementation of the HSS grant, please attach a list of participating CSOs, the funding they received in the context of the HSS grant, and the activities in which they participated. If CSO participation was included in the original proposal approved by GAVI but these were not provided with funds, please explain the reasons. For more information on GAVI's CSO implementation framework, please consult http://www.gavialliance.org/support/cso/.

The funds from the grant were used for the assessment meeting of 2013, where each Health Region presented its established indicators and achievements. The results of this are described in this report, and more specifically in Tables 9.2, 9.2.1 and 9.3.<?xml:namespace prefix = "o" />

The assessment meeting had the technical support of the units involved: the Directorate General of Health Networks and Services (DGRSS), the Expanded Programme on Immunisation (EPI), the Children's Integrated Healthcare Programme (PAIN) and the Women's Integrated Healthcare Programme (PAIM), allowing for the validation of data and discussion and analysis of facilitating factors and constraints.

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

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

Please attach the most recent national results reported/M&E framework of the health sector (with real reported figures for the most recent year available in the country).

9.1.1. Financial statement for the use of HSS funds in the **2013** calendar year

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.1.3.a and Table 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: US$

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

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

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

Table 9.1.3a (US)$

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	607000	1004639	574000	349000		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)		452807	1086792	1126089	762234	538231
*Total funds received from GAVI during the calendar year (*A)	607000		1004500	574000	349000	
Remaining funds (carry over) from the previous year (*B*)		452807	82292	858343	662372	538231
Total Funds available during the calendar year (*C=A+B*)	607000	452807	1086792	1432343	1011372	538231
Total expenditure during the calendar year (*D*).	154193	370515	228450	769971	473141	381532
Balance carried forward to next calendar year (*E=C-D*)	452807	82292	858343	662372	538231	156698
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from the previous year (*B*)				
Total Funds available during the calendar year (*C=A+B*)				
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)

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)	11545140	19108234	10917480	6637980		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)		8612398	20670788	21418222	14497688	10119221
Total funds received from GAVI during the calendar year (*A*)	11545140		19105590	10917480	6969530	
Remaining funds (carry over) from the previous year (*B*)		8612398	1565198	16325675	12598312	10119221
Total Funds available during the calendar year (*C=A+B*)	1154514	8612398	20670788	27243155	19567842	10119221
Total expenditure during the calendar year (*D*).	2932742	7047200	4345113	14644843	9448621	7844308
Balance carried forward to next calendar year (*E=C-D*)	8612398	1565198	16325675	12598312	10119221	3221721
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from the previous year (*B*)				
Total Funds available during the calendar year (*C=A+B*)				
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 Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2008	2009	2010	2011	2012	2013
Opening on 1 January		1890	1890	1890	1890	1994
Closing on 31 December		1890	1890	1890	1902	2056

Detailed expenditure of HSS funds during the 2013 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2013 calendar year. *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January — April 2014 period are reported in Table 14, 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.

HSS/GAVI Financial Management:<?xml:namespace prefix = "o" />

Funds from donations are channelled through Honduras PAHO/WHO to the different HSS/GAVI implementing units, among them the Health Regions, the Expanded Programme on Immunisation (EPI) and the Central Coordinating Unit.

Mechanisms for fund allocation:

- Each implementing unit presents an operations plan to the Central Coordinating Unit/UPEG for review and approval. This is approved if it meets HSS/GAVI objectives. Afterwards, the request is sent to the PAHO/WHO for fund allocation

- Fund allocation takes two administrative forms: Letters of Agreement and requests for Courses and Seminars, specifying activities, budget and implementation timeline. Where the amounts requested are less than $25,000.00, they are directly allocated in Honduras. Amounts exceeding that limit require authorization from the PAHO/WHO in Washington.

- The funds are disbursed directly by the PAHO/WHO to each implementing unit, which administers these through private banking sector current accounts. Two persons are charged by each unit to sign its cheques. In the majority of cases, these are the Regional Head and the Unit Administrator.

- The Health Regions, in their case, channel the funds to the health teams in priority municipalities for the conduct of planned activities, subject to prior submission of work plans and the issuance of cheques.

Mechanisms of accountability:

- Once funds are implemented according to plan, each implementing unit presents the liquidation of the funds allocated by means of supporting documents (invoices, receipts, attendance lists, etc.) as provided for by the “HSS/GAVI Fund Implementation and Accountability Manual”, including the technical and financial reports for the period concerned.

- This report is sent with an official letter to the Central Coordinating Unit (UCC)/UPEG for review and approval.

- Once the liquidation of the funds has been reviewed by the UCC/UPEG, it is sent to the Special Accounts Unit of SESAL Administrative Management, which in turn reviews and approves it.

- Once this has been reviewed and approved by both authorities, UPEG/SESAL management sends the original documents of accountability to the PAHO/WHO administration for official receipt and approval. This represents an auditing sequence for liquidation in both a technical and financial sense.

- No new funds are allocated if the liquidation submitted does not comply with the requirements established in the plan, the objectives of the HSS/GAVI initiative, the transparent handling of funds and the administrative standards of the Manual and of PAHO/WHO.

- No internal audit report is being presented for SESAL for 2013, since this unit underwent a special intervention that impeded the conduct of a funding audit. Nonetheless, the PAHO/WHO acts as an external auditor, since it revises the liquidation of expenses for the funds awarded in order to close the letters of agreement. Likewise, PAHO/WHO is also subject to external audits every year, when HSS funds are also audited. The external audit report for 2013 was requested from PAHO/WHO, but SESAL was informed that this could not be provided, since it contained general treasury information about the Organization's funds.

Donated HSS funds are not reported in the national budget, since these are directly administered by PAHO/WHO. An annual official notice on financial and technical implementation is sent to the Secretariat for Health by means of reports.

National counterpart funding, however, has been included in the national budget since 2010 up to 2014, but this is transferred to PAHO/WHO and is administered in the same way as the funds from donations, under administration agreement.

The National Health Council (CONSALUD) does not participate in the financial monitoring of the HSS-GAVI initiative; only PAHO/WHO does this as general fund administrator. Nonetheless, on May 13, 2014, the members of CONSALUD

attended the presentation and approval of the Annual Progress Report for 2013 submitted by the EPI and UPEG.

Problems identified in the use of funds:

1. In August 2013, the Secretariat for Health became the subject of attachment as a result of failure to fulfil an obligation assumed between Administrative Management and a supplier of goods and services. This affected the HSS donations bank account for Islas de la Bahía health region, for an amount of $ 9,411.99. This situation had nothing to do with the administrative liability of the HSS-GAVI Central Coordinating Unit and the Islas de la Bahía health region.

To return the funds seized from the Islas de la Bahía region, in November 2013, the Health Secretary decided to transfer the national counterpart funds for HSS-GAVI to the item on funds donated for the Initiative by making an amendment to the "*Technical Cooperation Agreement between SESAL and PAHO/WHO for the administration of HSS-GAVI counterpart funding".*

The amendment to the Agreement is in the process of being approved by the PAHO/WHO Head Office. Once the funds are effectively transferred to the Islas de la Bahía region, the activities that remained pending because of this situation will be implemented.

1. The allocation of the funds to the implementing units (Health Regions) by PAHO/WHO was delayed three months due to a deficit reported in one of the expenditure categories arising from PAHO/WHO administrative errors on committing the funds corresponding to SESAL cooperation applications, affecting the calendar for the execution of activities by the health regions.

To remedy the situation, the HSS-GAVI-UPEG administration gave support to the PAHO/WHO administration in March 2013 in reconciling and organizing the budget balances and ceilings in the four expenditure categories of the item on funds from donations, so as to unify the criteria on obligations for future cooperation requests.

3. In the financial report at the close of December 2013, a new deficit was reported in expenditure category 03 "Contracts" for an amount of $ 12,730.58, due to new PAHO/WHO administrative errors regarding obligation in cooperation requests. The responsibility for correcting the negative balances in the financial report on the grant falls upon the PAHO/WHO, based on this being an internal administrative process of its organization.

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 government's fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

9.2. Progress on HSS activities in the 2013 fiscal year

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

Please provide the following information for each planned activity:

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

Table 9.2: HSS activities in the 2013 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
A. Training of teams in management development			
A.1 Team management training	A.1 Training of department and municipal teams in technical and managerial aspects	100	Technical Reports on the workshops and attendance lists

A.2 Integration of mother and child plans	A.2 Technical and financial support in the drawing up of mother and child health plans at local level and for their incorporation into Municipal Development Plans, in order to ensure their implementation	85	Reports from health region and municipal health teams
A.3. Training in the use of data	A.3 Contribution to the updating of the Mother and Child Health subsystem and training in data processing, analysis and application	100	EPI Technical Reports
B. Delivery of basic health services package			
B.2 Health staff recruitment	B.2 Hiring of personnel to attend health units that had been closed for a range of causes, to be scheduled	100	Reports from health region and municipal health teams
B.3 Scheduling delivery of basic package	B.3 Prioritising, planning and scheduling of health units at municipal level for the delivery of the basic package, with support from the community and municipal corporations	100	Reports from health region and municipal health teams
B.4 Implementation of monitoring tools	B.4 Resumption of implementation and monitoring of the application and use of LINVI, LISEM and LISMEF as local infant health monitoring tools	100	Reports from health region and municipal health teams
B.5 Delivery of basic services package	B.5 Delivery of basic packages to 281 priority locations, in accordance with local scheduling	81	Reports from health region and municipal health teams
B. Municipal health workshops	B.6 Annual mother and child health workshops, to identify target population (pregnant women, newborns, growth, development and vaccination), involving local governments	88	Reports from health region and municipal health teams
C. Extension of C-ICCP AIN-C strategy			
C.2 Leadership training in C-ICCP AIN-C	C.2 Recruitment, selection and training of leaders in priority communities.	88	Reports from health region and municipal health teams Note: The San Pedro Sula and Central District metropolitan regions implement IMCI instead of C-ICCP AIN-C.
C.3 Monitoring of C-ICCP AIN-C strategy	C.3 Monitoring of C-ICCP AIN-C implementation and operation.	93	Reports from health region and municipal health teams
D. Extension of IMCI strategy			
D.2 IMCI training	D.2 IMCI training for priority health units	100	Reports from health region and municipal health teams
D.3 Monitoring of IMCI strategy	D.3 Monitoring of IMCI strategy and its operation in the metropolitan health regions	100	Reports from health region and municipal health teams
E. Provision of basic healthcare equipment			
E.1 Provision of basic healthcare equipment	E.1 Procurement, distribution and installation of basic mother and child PHC equipment in health units in	75	PAHO/WHO progress reports

	priority municipalities		
E.3 Strengthening of the cold chain network	E.3 Support for the strengthening of the cold chain network at national level, for the introduction of new vaccines	100	EPI Technical Reports
E.4 Maintenance and equipment of basic equipment and vehicles	E.4 Drafting and implementation of maintenance plan for basic equipment and mobile mother and child units	100	Reports from health region and municipal health teams
F. Reinforcement of monitoring, supervision and evaluation processes			
F.2 Annual supervision plan	F.2 Drafting of annual department and municipal plans for the monitoring, supervision and evaluation of institutional and community mother and child care.	100	Reports from health region and municipal health teams
F.3 Supervision and monitoring visits	F.3 Supervision and monitoring of municipalities by the department and of health units and the community by the municipalities, every three months	75	Reports from health region and municipal health teams
F.4. Evaluation of targets at department and municipal level	F.4 Evaluation at department and municipal level of mother and child targets in priority municipalities, with the support of technicians and municipal corporations	100	Reports from health region and municipal health teams
G. Support costs			
G.1 Administrative costs	G.1 Administrative costs	100	Work contracts with HSS-GAVI Central Coordination Unit
G.2 Monitoring and evaluation costs	G.2 Support, follow-up and evaluation costs	100	Work contracts with HSS-GAVI Central Coordination Unit
G.3 Technical support	G.3 Technical support	100	Work contracts with HSS-GAVI Central Coordination Unit

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**
A. Management training for health teams	A Strategic Plan 2013-2016 aligned with the Institutional Strategic Plan 2013-2016 (ISP) was obtained for each implementing unit of the Secretariat for Health. The ISP focuses on eight strategic objectives: 1. To bring the National Health System closer to integration and plurality in all its processes. 2. To improve safety and quality in the products and services obtained by the population to reduce their risk of disease and death. 3. To decrease collective risk and damage to the health of the population. 4. To improve health conditions in pregnancy. 5. To improve health conditions in children under five. 6. To improve control of priority vector-transmitted diseases. 7. To improve control of priority infectious diseases. 8. To implement life cycle-based interventions to mitigate disease and death risks in the population. Under the fifth strategic objective of improving health in children under five, children with complete immunisation schedules are considered an intermediate product

	Implementing units were assisted technically in the conceptual and analytical development of strategic planning stages based on the regulatory institutional framework of SESAL, the Institutional Strategic Plan, the organizational structure of the institution, the structure of the budget and the budget reprogramming guidelines of the preliminary AOP/budget for 2014, essential elements for shaping the process of preparing strategic plans for every unit. A total number of 135 persons comprising the planning teams and coordinating implementation in the country's health regions and hospitals were trained. Implementation of this activity made use of $ 42,037 in national counterpart funding as budget complement.
B. Incorporation of the health plan into the municipal plan	In 2013, 39/46 priority municipalities managed to integrate their health plan into the municipal development plan, whereby following activities were promoted: 1. Conduct of immunisation days 2. Purchase of drugs for the basic package. 3. Hiring of health staff for direct healthcare or as auxiliary human resources. 4. Transport of staff for basic health service package delivery and health fair support. 6. Patient transfers. 7. Preventive activities for vector disease control. Periodic meetings are held to monitor municipal development plans. These are also evaluated jointly by both parties. Municipalities managing to integrate their health plans into municipal development plans still experience difficulties and challenges to overcome, among them the absence of an established budget allocation for health in the Municipalities Act and the involvement of municipal corporations in their processes, not only as mere support in sporadic activities. The municipalities that have not managed to integrate their plans into municipal plans are: La Ceiba, Tela, Puerto Cortés, Villanueva, the Central District, Ojos de Agua and Minas de Oro. This is due to constraints such as: a) Disinterest of the authorities in coordinating activities with the health sector, above all in big cities. b) Municipal corporations in financial crises. c) Weakness of some health teams in negotiating with municipal authorities.
C. Training in data use and analysis	In implementing the Nominal System of Immunisation (SINOVA), the EPI was supported in the regions of Comayagua and Francisco Morazán through financed monitoring visits by the staff from the Information Systems Area to train personnel and supervise implementation.
E. Recruitment of personnel to staff closed health units	40 nursing aides were hired to keep 58 health establishments open and offering services on a continuous basis. Contracts ranged from 15 days to 4 months. 56%(26/46) of the prioritised municipalities were able to benefit. This activity made it possible to give continuous community services such as sustained immunisation, prenatal care, treatment of patients with chronic diseases and others. Among the constraints identified were the decrease of donated funds for this item in the budget, since 6/9 health regions had no funds for it during the first quarter of 2013. Above all, the national budget cannot cover 100% of the demand from the health units of the priority municipalities.
F. Scheduling delivery of basic package	The health regions (9/9) scheduled visits for Basic Health Service Package delivery in 281 selected areas, coordinating with the key agents such as: municipal governments, foundations and health volunteers

	291 areas were scheduled in 2012. In 2013, donated funds managed to finance BHSP delivery in 281 areas. The remaining 10 areas in the Metropolitan Region of San Pedro Sula, more geographically accessible than other municipalities, were visited by the health teams without funding.
G. Implementation of monitoring tools	Local surveillance and monitoring tools have been resumed in prioritised health establishments and subjected to continuous updating. Local surveillance is also implemented via LINVI and LISEM, checking children pending immunisation and pregnant women who have not come to their prenatal check-ups by name, allowing for the active search of these populations. Constraints identified include: 1. Insufficient human resources, impeding daily data recording. 2. Low supply of monitoring tools 3. Difficulty with LISMEF lists of women in childbearing age, since this deals with a bigger population. 4. High population density and mobility. The strategy that has enabled sustained updating of tools is continuous training supervision in the health units, in addition to the commitment of health staff.
H. Delivery of basic package in communities	1172 visits to priority communities were scheduled and 909 carried out – a compliance rate of 81% with respect to the annual target. Breakdown as per target 4 visits/community: a) 50% (141/281) received basic packages 4 times in the year. b) 29% (82) received three visits in the year. c) 15% (43) received two visits in the year. d) 5% (13) received the package once in the year. Progress achieved through Basic Package delivery: 1. Immunisation of children, adolescents, pregnant women and seniors pending start and completion of the immunisation schedule. 2. Increased enrolment of pregnant and post-natal women and women of childbearing age. 3 .Increased coverage in family planning methods. 4. Improved access to diagnostic tests such as rapid tests for HIV-AIDS detection in pregnant women and cytologies in women of childbearing age. 5. Actions to promote health and prevent and control vector-transmitted and communicable diseases, such as malaria, dengue fever, TB, STDs and HIV. 6. Healthcare to families at risk in selected communities. 7. Organization of health volunteers. 8. Increased proximity to the communities through knowledge of their needs. Constraints on achieving 100% delivery of the basic package include: a) Weak logistics capacity to transport supplies and staff to locations. b) Delayed allocation of funds. Approximately three months a year, health regions do not have funds due to the time taken for submitting accounts and the time it takes PAHO/WHO to allocate new funds. c) Insufficient supply of drugs in municipalities to guarantee Basic Package delivery. d) Community road access. Rainy seasons make access difficult to the priority locations. e) Some municipalities have a reduced number of personnel for direct healthcare, limiting field activities for these human resources so as not to close down the health centre. f) Labour strikes by health personnel. g) Delinquency and security problems. h) Reduction of the donation fund budget for basic health service package delivery; since the national funds cannot cover all field activities.

	Another constraint to achieving the target was the seizure of the funds for the Islas de la Bahía region, which did not allow for the total delivery of the scheduled Basic Package.
I. Municipal health workshops	93 municipal health workshops were conducted, benefiting 91% (43/46) of the priority municipalities. The workshop focus strengthens health promotion and disease prevention services among the population. These health workshops were conducted in coordination with local governments, NGOs and health volunteers to improve integrated family and environmental healthcare, strengthening services and processes based on health promotion and disease prevention. Maternal and child health were promoted through birth control, post-natal check-ups, family planning, nutrition, hygiene, sexual and reproductive health, growth monitoring in children under five, immunisation to the pending population and vector control.
J. Leadership training in C-ICCP AIN-C implementation	160 leaders from 78 priority communities were trained to promote the AIN-C Strategy. Constraints encountered in carrying out this activity included: 1. Lack of equipment such as scales and chronometers. 2. Abandonment of the volunteer monitors due to lack of incentives. 3. Insufficient teaching material to train new groups or give training in new modules. 4. Reduced funds for continued reinforcement and the opening of new groups. 5. Security problems and violence. Another constraint to achieving the target was the seizure of the funds for the Islas de la Bahía region, which did not allow for the training of 30 monitors as per schedule; hence, only 88% (8/9) of the regions managed to complete this activity.
K. Monitoring of C-ICCP AIN-C strategy	224 communities were given priority in the implementation of the C-ICCP AIN-C strategy. Of these, 208 (93%) are currently implementing the strategy. This strategy improves the healthcare access of children under two years of age, more specifically: 1. To sustained immunisation, since monitors and nursing aides provide continuous monitoring of immunisation schedule completion. 2. To integrated child growth and development. 3. To the timely referral of sick children to health establishments. The strategy used to keep monitor groups active in implementing C-ICCP AIN-C consists of periodic visits by the health establishment personnel, particularly nursing aides. Constraints identified include: difficulties encountered by health staff in making monthly community visits, delinquency and violence.
L. Personnel training in IMCI	As per the plan, the metropolitan regions of the Central District and San Pedro Sula are priority regions for promoting IMCI via donation funds. 141 persons were trained, among them doctors and nurses. Constraints in implementing this activity included: 1. Decreased funding for conducting reinforcement workshops. 2. Insufficient teaching materials for periodic personnel training. 3. Personnel rotation. 4. Medical schools do not include IMCI dissemination in their curricula.
M. Monitoring of IMCI strategy	This strategy is subject to quarterly monitoring by the Accelerated Reduction of Maternal and Child Mortality project (RAMNI)

	implemented by intermediate-level staff and targeting the health establishments. Constraints of IMCI implementation: 1.Attitude of medical personnel in applying IMCI standards. 2. Rotation of untrained doctors in social services and mobility of already-trained human resources. 4. Insufficient budgets in the health regions to keep health establishments stocked with office supplies for records. 5. Management weakness in tracking responsibilities among staff who do not comply with the strategy and healthcare standards.
N. Procurement and distribution of basic equipment	This activity is underway in PAHO/WHO and will finish in July. The equipment purchased will be delivered to the Health Regions in August this year. The constraints identified are: 1. Reduced personnel in the PAHO/WHO Purchasing Unit. 2. The PAHO/WHO WDC policy of authorizing delegations when purchases exceed US$ 50,000, which entails 2 to 3 months of waiting for the signal to process purchases. 3. The unavailability of all the equipment among the suppliers, who have a policy of delivering from 60 to 90 days.
P. Strengthening of the national cold chain network	The proper installation of the Ocotepeque regional cold room was completed, improving vaccine access and conservation. Spare parts to meet the needs of the country's cold chain were acquired for the EPI stocks. EPI technicians conducted monitoring visits to improve the operation of the cold chain at national level. $ 40,173.73 were implemented from national counterpart funds to finance EPI cold chain network and biologicals transport monitoring visits.
Q. Implementation of the equipment maintenance plan	Only six of the nine health regions availed of donation funds for this activity during the year. Hence, the national budget covered the costs of those health regions that were not allocated funding. The health regions used these funds to maintain the cold chain of prioritised health units and the vehicle fleet to cover activities in the municipalities.
S. Drawing up of the monitoring and supervision plan	The regional teams prepared a monitoring plan for execution in coordination with the health service network to meet health staff compliance with maternal and child healthcare standards. Monthly supervision visits, quarterly monitoring and six-monthly assessment meetings are held to follow through with the plans. Local level plans are disseminated among health staff and their monitoring falls upon the sector supervisors and municipal managers. These orient their visits to the health establishments presenting problems.
T. Quarterly supervisory and monitoring visits	75% of scheduled visits (483/648) to the health establishments (HUs) were conducted and 91% of the scheduled HEs were monitored more than twice for the year The monitoring visits have improved the implementation of immunisation and maternal and child healthcare standards in the HUs and activities such as local surveillance, inventory monitoring and others have been promoted. Constrains encountered in completing this activity include: a) Weak logistic capacity to deploy teams to health establishments. b) Insufficient human resources available for visits due to overlap with other activities, central level workshops, holidays, etc.

	c) Security problems and delinquency. d) Labour strikes by health personnel. The Islas de la Bahía region was unable to complete total number of scheduled visits due to the seizure of its funds.
U. Department and municipal evaluation of targets	100% (46/46) of the priority municipalities conducted the six-monthly evaluation. This activity makes it possible to identify constraints as well as timely interventions that can facilitate achieving the targets set in terms of maternal care, child care and other programmes. The M&E activities on Central Coordinating Unit HSS implementation were financed from the national counterpart funds for an amount of $ 1,530.70.
V. Administrative costs	The scheduled funds supported the hiring of HSS-GAVI technical and administrative personnel for six months. Afterwards, these salaries were cancelled and replaced by national counterpart funds.
W. Support, follow-up and evaluation costs	Funding for this activity was used to hire two administrative assistants to monitor the financial implementation of HSS-GAVI in the ten implementing units from January to June 2013.
X. Technical support	Funding for this activity was used to hire a technical assistant to monitor the technical implementation of HSS-GAVI from January to June 2013.

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

The activity of procuring and distributing basic equipment was not fully executed since the purchase process was not completed by PAHO/WHO for the following reasons:<?xml:namespace prefix = "o" />

1. Reduced human resources in the Purchasing Unit to conduct quoting and awarding of purchased items, whereby this phase took almost 5 months.
2. The closure or blocking of the PAHO/WHO administrative system in December 2013 and January 2014 impeded purchases execution.
3. PAHO/WHO purchasing policies require a delegation of authority by the Head Office to proceed with purchases exceeding the amount of $50,000. This procedure takes approximately 2 to 3 months of waiting to proceed with purchase orders.
4. Suppliers do not have an immediate stock of the products requested in the purchase orders, and hence request 60 to 90 days to deliver the products following purchase order issue.

The operating plan for Islas de la Bahía was not completed due to the seizure of its funds, whereby following activities remained pending:

1. Two visits for BHSP delivery to the priority communities in each selected municipality.
2. Training of monitors in C-ICCP AIN-C.
3. Conduct of monitoring visits.

To resolve the problem of the seizure, request was sent to PAHO/WHO in November 2013 to transfer the amount seized from the national counterpart funding to the affected region so as to complete the activities pending as per plan. However, the administrative figure identified by PAHO/WHO as a solution was an amendment to the "*Technical Cooperation Agreement between SESAL and PAHO for the administration of HSS-GAVI counterpart funding"*, to return the funds to the country. This was initiated by PAHO/WHO for April 2014 and has an approximate duration of 3 months. Once the transfer has been made to SESAL, and from SESAL to the affected region, a 4-month operating plan will be implemented to complete pending activities and the HSS/UPEG Central Coordinating Unit will conduct technical and administrative monitoring.

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 grant funds have been made available for intermediate and local teams, which is an incentive to conduct the activities scheduled in the working plans. On another hand, the grant has contributed to human resource management development through training in strategic planning and in the creation of venues for negotiation with key municipal-level players, such as mayors' offices, NGOs and other agents, the integration of activities and the strengthening of the results expected by the population.<?xml:namespace prefix = "o" />

9.3. General overview of targets achieved

Please complete Table 9.3 for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2012 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2013 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2009	2010	2011	2012	2013		
A. Developing the management capacity of teams											
A.1 Percentage of municipalities having integrated plans	42%	Municipal reports from Health Regions (2010)	80% of municipalities have incorporated RAMNI activities into their integrated municipal development plans.	80%	NA	72%	87%	85%	85%	Reports from health region municipal health teams	Programmed target: 80% The target was achieved, since expectations were for 80% of the municipalities to achieve MI plan integration into the municipality. Only in 7/46 priority municipalities, since their local governments are reluctant to coordinate activities. Among constraining factors: -Indifference of municipal authorities. -Weak health personnel negotiation and leadership.
A.2 Number of persons receiving management training	Not established in proposal	Not applicable	300 persons trained in management development	300 persons	NA	132 persons	63 persons	161 persons	135 persons	HSS-GAVI/UPEG Central Coordination Unit technical reports	Programmed target: 300 persons To date the target has been exceeded, with 491 persons trained, since the needed budget was supplemented by national counterpart funds

A.3 % of persons receiving training in data use	Not established in proposal	Not applicable	100% (141 resources in statistics units in priority health regions)	100%	NA	45% (63/141)	88% (126/141)	Activity not scheduled	Activity not scheduled		
B.1 % of communities receiving four basic health packages	0%	Municipal and department reports 2007	100% of communities receiving four basic health service package visits in the year	100%	21%	49%	64%	60%	50%	Municipal and department reports	2013 target: 100% of communities. Only in 50%. 141/281 communities were visited 4 times, due to following constraints: - Management weakness - Reduced logistic capacity - Few personnel with multiple functions - Insufficient budget in 2013, with 3 scheduled visits in the majority of the Health Regions. - Geographic access to communities and climate conditions. - Lack of fuel. Breakdown as per target 4 visits/community in 2013: a) 50% (141/281) received basic packages 4 times in the year. b) 29% (82) received three visits in the year. c) 15% (43) received two visits in the year. d) 5% (13) received the package once in the year.
B.2 % of pregnant women attending 4 prenatal check-ups	0%	LISEM 2010	90% of pregnant women attending 4 prenatal check-ups	90%	48%	54%	55%	58%	66%	LISEM	2013 target: 90% Following are considered significant factors in not achieving the target: 1. Difficulty in enrolling women before 12

											weeks of pregnancy. 2. Frequency in coming to HUs due to geographic, economic or social barriers. 3. Under-reported healthcare in LISEM. 4. Mobility of pregnant women to come to different health centres for the last prenatal check-ups seeking delivery services or the closeness of family members. This data was also compared with ENDESA 2011-2012 results, and 89% of pregnant women (92% in the urban area and 86% in the rural area) received 4 prenatal check-ups or more.
B.3 % of health units offering service	0%	Reports from municipalities and regional offices 2010	80% of health units offering continuous year-round service	80%	87%	92%	90%	80%	84%	Reports from municipalities and regional offices	Programmed target:80% The target was achieved, but due to the shortage of contract hires paid from national funds and the reduction of funds for this item in the 2013 donation budget, this was reduced in comparison to levels achieved in 2010.
C. Extension of C-ICCP AIN-C strategy											
C.1 Percentage of	142 communities	Monthly monitors' reports	224 priority communities	224 communities	NA	63% (142/224 communities	82% (183/224 communities	97% (218/224 communities	93% (208/224 communities	Monthly summary of C-ICCP	Programmed target: 224 communities

communities implementing C-ICCP AIN-C		2010	es implementing the Integrated Community Child Care strategy (C-ICCP AIN-C)			s)	s)	s)	es)	AIN-C activities	16 of the scheduled communities did not manage to maintain C-ICCP AIN-C active, due to factors such as: 1. Lack of teaching materials. 2. Abandonment of volunteers in search of work, 3.Delinquency 4. Decrease in funding for regular visits to communities.
C.2 % of children whose growth is monitored	75%	AT-2R (ATA 2010)	80% of children's growth and development are being monitored	80%	59%	75%	87%	81%	82%	AT-2R (ATA)	Programmed target: 80%
C.3 Percentage of health units complying with IMCI	50%	Clinical files, IMCI record sheets for 2010	No target established in the HSS proposal.	80%	60%	63%	44%	59%	49%	RAMNI monitoring report and reports from municipalities and regional offices	Programmed target: 100% This target was not achieved because health personnel are not consistent in recording the care provided on file, and this is the primary sources of data. Another factor identified is medical personnel resistance in implementing the standard. Likewise, the indicator us drawn up through a checklist and if one item is missing, the indicator is zero.
C.4 % of health units with ORT spaces	60%	2010 checklist	No target established in the HSS proposal.	100%	60%	100%	92%	84%	98%	RAMNI monitoring report and reports from municipalities and departments offices	Programmed target:100% This target was not achieved because some health units do not

											have a specific place for ORT, their installations being small. Nonetheless, all units have the supplies necessary and, when indicated, health staff can provide patients everything required for ORT.
D. Provision of basic equipment for health services											
D.1 % of fully-equipped health units	Not established in proposal	Delivery certificates	112 health units provided with basic equipment for mother and child health services	112 Health Units	NA	NA	NA	128% (144/112 Health Units)	NA	Inventory of National Assets	This activity will [not] be completed until August 2014, when the purchasing process is finished and the equipment is delivered to the Health Regions.
E. Reinforcement of monitoring, supervision and evaluation processes											
E.1 % of health units supervised 4 times	0%	Municipal and department reports 2010	80% of health units supervised 4 times yearly	80%	39%	43%	53% (110/208)	46% (73/157)	40% (64/162)	Reports from municipalities and department offices	Programmed target: 80% The target was not achieved due to the weak logistic capacity to deploy staff on a quarterly basis to every health unit and reduced personnel. Likewise, visits to HUs are prioritised due to the problems arising or due to need and not to fulfil the four visits established by the standard. 91% (147/162 HUs) were visited twice

											during the year and 67% (109/162 HUs) were visited three times.
E.2 % of municipalities being evaluated twice yearly	72%	Municipal and department reports 2010	90% of municipalities performing 2 evaluations yearly	90%	34%	72%	90%	100%	100%	Reports from municipalities and department offices	Programmed target: 90%
F. National coverage with pentavalent 3rd dose	87%	SIVAC	95% national coverage with third dose of pentavalent	95%	98%	101%	105%	92%	91%	SIVAC	Programmed target: 95% This data relates to coverage in the 46 HSS-GAVI priority municipalities. National coverage is 87%. The programmed target was not achieved due to some factors such as overestimation of the population of children under 1 as per the projections of the National Statistics Institute (INE). According to the results of ENDESA 2011-2012, Pentavalent 3 coverage is 95%.
G. % of municipalities with > 80% coverage for pentavalent 3rd dose	32%	SIVAC	80% of municipalities with > 80% coverage for pentavalent 3rd dose	80%	96%	91%	100%	93% (43/46)	91% (42/46)	SIVAC	This data relates to coverage in the 46 HSS-GAVI priority municipalities.
H. MMR coverage in 12-23 month population	91%	SIVAC	95% coverage in population aged 12-23 months	95%	100%	101%	107%	91%	93%	SIVAC	Programmed target: 95% This data relates to coverage in the 46 HSS-GAVI priority municipalities. National coverage is 89%. Target was not achieved due to some factors such

											as overestimation of the population of children under 1 as per the projections of the National Statistics Institute (INE).
I. Mortality rate in children aged less than 5 years	26 X 1000LB	ENDESA	20 per 1000 live births	NA	1684 (total number of deaths in 104 priority municipalities)	566 (total number of deaths in 104 priority municipalities)	726 (total number of deaths in 104 priority municipalities)	1761 (total number of deaths in 104 priority municipalities)	29 X 1000LB	ENDESA 2011-2012	Post-infantile mortality rate for 2011-2012, 5 per 1000 live births
J. Infant mortality rate	23 X 1000LB	ENDESA	19 per 1000 live births	NA	2269 (total number of deaths in 104 priority municipalities)	516 (total number of deaths in 104 priority municipalities)	653 (total number of deaths in 104 priority municipalities)	1625 (total number of deaths in 104 priority municipalities)	24 X 1000LB	ENDESA 2011-2012	As per reference value, this was reduced by only 1 percentage point
K. Maternal mortality rate	108 per 100000LB	IMMER	82 X 100000 live births	NA	20 (total number of deaths in 104 priority municipalities)	21 (total number of deaths in 104 priority municipalities)	74 per 100000LB	74 per 100000LB	73 per 100000LB	RAMOS Study	Data resulting from the research on Maternal Mortality Ratio 2011-2012

9.4. Programme implementation in 2013

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

Major achievements:<?xml:namespace prefix = "o" />

- □□□□□□□□ Improvement in population access to health services, with emphasis on the maternal and child group in neglected communities, through the periodic delivery of the basic health service package, increasing enrolment in subjects pending immunisation, new pregnant and post-natal subjects, symptomatic respiratory patients, timely detection of uterine cervical cancer, HIV, etc.
- □□□□□□□□ Maintenance of immunisation coverage in priority municipalities through basic health service package delivery, health fairs and continuous monitoring.
- □□□□□□□□ Promotion of local surveillance through LINVI and LISEM lists making it possible to search for children under one year of age pending immunisation and pregnant women pending prenatal check-up.
- □□□□□□□□ Having kept 58 Health Units open, continuously providing services in communities and municipalities (particularly in HUs with only one nursing aide).
- □□□□□□□□ Support to family planning through the delivery of contraceptives and sexual and reproductive education, reducing (sic) pregnancy spacing in mothers and teenage pregnancies.
- □□□□□□□□ Strengthening the implementation of healthcare standards in health units through supervised and continuous training.
- □□□□□□□□ Timely detection of signs of risk, growth and development monitoring in children under 2 and promotion of oral rehydration therapy through the training of health staff and volunteers in the C-ICCP AIN-C and IMCI strategies.
- □□□□□□□□ Improvement of environmental health in communities through the inspection of water for human consumption, vector disease prevention and other activities.
- □□□□□□□□ Increased proximity between health personnel and the communities, identification of needs and

joint coordination to implement key activities.

•□□□□□□□□ Allocation of GAVI donation funds to conduct activities such as support visits to health regions for cold chain maintenance, purchase of spare parts, fuel supply and other needs.

•□□□□□□□□ Support for the strategy of guaranteed quality healthcare through monitoring, evaluation and supervision at the local levels.

Photographic report of the activities conducted by the Health Region teams in 2013 is attached (Document No 31).

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

Some negative factors that affected implementation of the HSS/GAVI Initiative at the different levels of the Secretariat for Health:<?xml:namespace prefix = "o" />

•□□□□□□□□ Reduced availability of national funds (national budget) for fieldwork activities, in items such as: per diem payments, fuel, and vehicle fleet maintenance.

•□□□□□□□□ Seizure of donated funds for the Islas de la Bahía region, due to default by the Secretariat for Health on supplies unrelated to the HSS-GAVI Initiative and the affected region. This situation hampered completion of the established operations plan.

•□□□□□□□□ Violence in municipalities caused by groups called “Maras” or illegal bands have not allowed for the implementation of health activities in some specific territories.

•□□□□□□□□ Cutback in health region contract hires.

Solutions encountered:

•□□□□□□□□ Some municipalities resolved some budget deficiencies by means of strategic alliances with municipal governments and NGOs.

•□□□□□□□□ Funds from the national HSS counterpart in the amount seized will be transferred to the Islas de la Bahía region to complete the pending activities of the operations plan. Likewise, deconcentration of funds was urged to facilitate financial implementation and direct implementation by PAHO/WHO for some activities.

•□□□□□□□□ Violence is a situation outside the competence of the Secretariat for Health and has been partly resolved by local teams resorting to strategic alliances with the Municipal Governments, local police authorities and leaders of the illegal groups.

•□□□□□□□□ Priority was given to the hiring of nursing aides using donated funds for those health establishments with only one staffer that have to close down when this person is absent.

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

Monitoring and evaluation is conducted as per page 43 of the document on the HSS/GAVI Initiative, setting forth M&E procedures on the three levels of the Secretariat for Health:<?xml:namespace prefix = "o" />

- **National level**: directly responsible for monitoring and evaluating the technical and financial implementation of the initiative through the HSS/GAVI UCC, housed in the UPEG/SESAL, in close contact with the EPI. This level evaluates and supervises execution of operating plans for each health region. Assessment is done annually, on the January of the following year, analysing the indicators proposed and monitoring the completion of objectives and activities. This evaluation is the basis for this report. It has the technical support of the Expanded Programme on Immunisations (EPI), the Department of Integrated Family Health (DSIF), and the technical areas of the UPEG: Information Systems and Planning, and M&E.
- **Intermediate level**, composed of the Health Regions, which are the implementing units of the HSS/GAVI Initiative, and which conducted M&E in shorter periods of time toward the local level (46 priority municipalities) by means of its technical teams.
- **Local level:** conducting monthly monitoring of activity implementation in prioritised locations. **This**

monitoring is done by the municipal health team accompanied by the regional team.

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.

HSS/GAVI objectives and targets are aligned with the Country Plan for Nation and Vision by 2038, with the Health Plan of the Secretariat for Health 2010-2014 — which aims at integrated quality maternal and infant healthcare, health promotion and disease prevention — and with Institutional Strategic Plan 2013-2016. Its indicators are also aligned with the tracking indicators of the aforementioned plans. <?xml:namespace prefix = "o" />

The technical regulating standards determined by the Expanded Programme on Immunisation, the Integrated Children's Health Progamme, the Integrated Women's Health Programme and the Directorate General of Health Service Networks have also been included in evaluating the targets of the HSS/GAVI Initiative. This allows for the combined analysis of data and weaknesses, the integrated validation of information and the coordination of interventions.

The HSS/GAVI Initiative submits implementation and official progress reports to the authorities of the Secretariat for Health every six months. These are included in the institutional report under the chapter on External Cooperation Funds. Likewise, a technical and financial implementation report is submitted to the Administrative Management of the Secretariat for Health and the Pan-American Health Organization (PAHO/WHO).

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.

Not applicable

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.

Not applicable

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

HSS/GAVI Financial Management:<?xml:namespace prefix = "o" />

Donated Funds:

•□□□□□□□□ These funds are managed by the PAHO/WHO, which directly channels them to each HSS/GAVI implementing unit, among them the nine Health Regions, the UPEG coordinating unit, and the EPI.

•□□□□□□□□ Fund allocation averages two to three months from the time SESAL submits the request to actual disbursement to the implementing units, through the agency of Letters of Agreement and the administrative procedures of PAHO/WHO/Honduras.

•□□□□□□□□ In seeking ways to improve funding management, meetings are held between the HSS/GAVI technical support team and its PAHO/WHO (Health Systems) counterpart, in addition to continuous meetings between the implementing units and the HSS/GAVI Central Coordination Unit.

•□□□□□□□□ Funds have been managed transparently, in keeping with the PAHO/WHO and country guidelines.

National Counterpart Funding

•□□□□□□□□ These funds are administered and allocated under the Secretariat for Health-PAHO/WHO Agreement, as per PAHO standards and procedures.

•□□□□□□□□ National counterpart funds are earmarked for implementation support and strengthening on the five HSS/GAVI Initiative objectives and for managing the Expanded Programme on Immunisation (EPI),

as per the original Honduras/GAVI Alliance agreement.

No management process changes are being considered for the remainder of 2014.

9.5. Planned HSS Activities for 2014

Please use **Table 9.4** to provide information on progress of activities in 2014. If you are proposing changes to your activities and budget in 2014 please explain these changes in the table below and provide explanations for these changes.

Table 9.4: Planned activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	**2014 actual expenditure** (as at April 2014)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
E.1 Provision of basic healthcare equipment	E.1 Procurement, distribution and installation of basic mother and child PHC equipment in health units in priority municipalities		23733	126653	Remaining balance from 2013, since basic equipment procurement is still being processed by PAHO/WHO. This is expected to conclude in August 2014.	126653
F.3 Supervision and monitoring visits	Supervision and monitoring of municipalities by the department every three months, and of communities by the municipalities every two months			12187	Remaining balance from 2013 due to reimbursement on supervision visits not made by the Health Regions. These funds are expected to meet needs for monitoring the completion of the operating plan for Islas de la Bahía region, once the counterpart funds are transferred from the national PAHO/WHO to SESAL and to support the EPI in the monitoring process.	12187
F.4. Evaluation of targets at department and municipal level	F.4 Evaluation at department and municipal level of mother and child targets in priority municipalities, with the support of technicians and municipal corporations	15858	15543	15858	Remaining balance from 2013	15,858
		15858	39276			154698

9.6. Planned HSS Activities for 2015

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

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

Table 9.6: Planned HSS Activities for 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
NOT APPLICABLE					
		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 US$	Duration of support	Type of activities funded
NOT APPLICABLE			

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

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
- Reports from the Health Regions, either detailed or through the liquidations of each Letter of Agreement. - Reports from the municipal health teams of prioritised municipalities. - Reports from the HSS-GAVI/UPEG Central Coordination Unit - Financial reports from PAHO/WHO. - Official report on the Updated Results of Maternal Mortality Ratio in Honduras, 2010-2012. - EPI 2013 coverage report. - National Survey on Demography and Health, 2011-2012.	- Evaluation meetings with HSS-GAVI coordinating teams in each of the nine Health Regions. - General evaluation for 2013 with all the teams from the health regions, accompanied by the Technical Support Team: Expanded Programme on Immunisation (EPI), Integrated Children's Health Programme (PAIN), Integrated Women's Health Programme (PAIM) and the Directorate General of Health Service Networks. - Immunisation data consistency check against EPI administrative coverage, SIVAC and ENDESA 2011-2012 - Finalised IPA submission to the International Health Cooperation Committee (IHCC) and the National Health Council (CONSALUD).	- Opportunity to deliver information from local level health teams to the intermediate and central levels. - Limited funds and human resources available for primary source data auditing in the health units of priority municipalities.

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.

There were no difficulties in filling up the report form, since it is the same form from previous years and the questions are clearly formulated.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2013?1

Please attach:

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

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

Honduras **has not received GAVI TYPE A CSO support**

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

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

Honduras **has not received GAVI TYPE B CSO support**

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

11. Comments from ICC/HSCC Chairs

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

The State Secretary for the Department of Health, who is by law IHCC and CONSALUD chairman, wishes to thank the GAVI Alliance for all the support provided along the different lines of cooperation and states that the Secretariat for Health acknowledges the existence of constraints. Nonetheless, there is a national political and technical commitment to surmount these barriers.

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

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

I. All countries that have received ISS /new vaccine introduction grants during the 2013 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2013, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on next page.

a. Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2013 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2013 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2012 (balance as of *31 December 2012*)	25,392,830	53,000
Summary of income received during 2013		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

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

I. All countries that have received HSS grants during the 2013 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2013, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on next page.

a. Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2013 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2013 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2012 (balance as of *31 December 2012*)	25,392,830	53,000
Summary of income received during 2013		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

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

I. All countries that have received CSO 'Type B' grants during the 2013 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2013, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages and salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2013 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2013 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2012 (balance as of *31 December 2012*)	25,392,830	53,000
Summary of income received during 2013		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	☑	Document 1 Signature of the Minister of Health.pdf **File desc:** **Date/Time:** 13/05/2014 05:05:22 **Size:** 547 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	☑	Document 2 Signature of the Minister of Finance.pdf **File desc:** **Date/Time:** 13/05/2014 05:07:51 **Size:** 547 KB
3	Signatures of members of HSCC	2.2	☑	Document No.3 IHCC Signatures.pdf **File desc:** **Date/Time:** 14/05/2014 04:53:01 **Size:** 454 KB
4	Minutes of ICC meeting in 2014 endorsing APR 2013	5.7	☑	Document No. 4 Minutes IHCC-CONSALUD 13 May (1).pdf **File desc:** , **Date/Time:** 14/05/2014 04:00:55 **Size:** 533 KB
5	HSCC signatures page	2.3	☑	Document 5 CONSALUD Signatures.pdf **File desc:** **Date/Time:** 14/05/2014 04:05:29 **Size:** 518 KB
6	Minutes of HSCC meeting in 2014 endorsing the APR 2013	9.9.3.	☑	Document No. 4 Minutes IHCC-CONSALUD 13 May (1).pdf **File desc:** **Date/Time:** 14/05/2014 04:04:35 **Size:** 533 KB
7	Financial statement for ISS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1.	☒	File not uploaded
8	External audit report for ISS grant (Fiscal Year 2013)	6.2.3.	☒	File not uploaded

9	Post Introduction Evaluation Report	7.2.2.	☑	Document 9.Evaluation Pneumococcal Introduction 2012.pdf **File desc:** ,,, **Date/Time:** 09/05/2014 12:15:52 **Size:** 569 KB
10	Financial statement for NVS introduction grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1.	☑	Document 10 Financial statement for NVS introduction grant 2013.pdf **File desc:** **Date/Time:** 14/05/2014 04:24:53 **Size:** 33 KB
11	External audit report for NVS introduction grant (Fiscal year 2013) if total expenditures in 2013 is greater than US$ 250,000	7.3.1.	☑	Document No 11 External audit report for NVS introduction grant.docx **File desc:** **Date/Time:** 14/05/2014 04:27:26 **Size:** 11 KB
12	Report on VSSM evaluation	7.5	☑	Document No 12 VSSM EVALUATION REPORT HND.pdf **File desc:** **Date/Time:** 09/05/2014 12:17:12 **Size:** 600 KB
13	Latest EVSM/VMA/EVM improvement plan	7.5	☑	Document No 13 VSSM and Cold Chain Improvement Plan 2012.pdf **File desc:** **Date/Time:** 09/05/2014 12:18:44 **Size:** 35 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	☑	Document No 14 Progress on VSSM and Cold Chain Improvement Plan 2012-2013.pdf **File desc:** **Date/Time:** 09/05/2014 12:20:06 **Size:** 29 KB
16	Valid cMYP if requesting extension of support	7.8	☒	File not uploaded
17	Valid cMYP costing tool if requesting extension of support	7.8	☒	File not uploaded
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	☒	File not uploaded

19	Financial statement for HSS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3.	☑	Document 19 HSS-GAVI Financial Statement January - December 2013.pdf **File desc:** **Date/Time:** 13/05/2014 07:07:39 **Size:** 514 KB
20	Financial statement for HSS grant for January-April 2014 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3.	☑	Document 20 HSS-GAVI Financial Statement January - April 2014.pdf **File desc:** **Date/Time:** 13/05/2014 07:09:05 **Size:** 239 KB
21	External audit report for HSS grant (Fiscal Year 2013)	9.1.3.	☑	Document No. 21 HSS Grant Audit Report.pdf **File desc:** Official letter from PAHO/WHO on implementation and accountability for HSS funds in 2013, as fund auditor. **Date/Time:** 15/05/2014 12:21:50 **Size:** 230 KB
22	HSS Health Sector review report	9.9.3.	☑	Document 22 Report of the Secretariat for Health.pdf **File desc:** **Date/Time:** 13/05/2014 06:08:33 **Size:** 3 MB
23	Report for Mapping Exercise CSO Type A	10.1.1.	☒	File not uploaded
24	Financial statement for CSO Type B grant (Fiscal year 2013)	10.2.4.	☒	File not uploaded
25	External audit report for CSO Type B (Fiscal Year 2013)	10.2.4.	☒	File not uploaded
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	0	☑	Document 26 PAHO-WHO Financial Statement.pdf **File desc:** **Date/Time:** 14/05/2014 02:07:06 **Size:** 565 KB

	2013 on (i) 1st January 2013 and (ii) 31st December 2013			
27	Minutes_ Meeting_ Inter-agency Coordinating Committee_ change_of_vaccine_presentation	7.7	☒	File not uploaded
	Other Document		☒	Document No. 31 Photoreportage HSS 2013.wmv **File desc:** **Date/Time:** 15/05/2014 11:59:04 **Size:** 4 MB Document No 28 DQS Evaluation Report Honduras 2013.pdf **File desc:** , **Date/Time:** 09/05/2014 12:22:10 **Size:** 719 KB Document No. 29 GEV Improvement Plan.pdf **File desc:** , **Date/Time:** 09/05/2014 12:23:16 **Size:** 207 KB Document No. 30 .Vaccine Act_Honduras_2014.pdf **File desc:** , **Date/Time:** 09/05/2014 12:24:32 **Size:** 4 MB