GAVI Alliance

Annual Progress Report 2011

Submitted by

The Government of

Democratic People's Republic of Korea

Reporting on year: **2011**
Requesting for support year: **2013**
Date of submission: **5/29/2012**

Deadline for submission: 5/22/2012

Please submit the APR 2011 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

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

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

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

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

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

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

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

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

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

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

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

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

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

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

1. Application Specification

Reporting on year: **2011**

Requesting for support year: **2013**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	2015
Routine New Vaccines Support	Measles, 10 dose(s) per vial, LYOPHILISED	Measles, 10 dose(s) per vial, LYOPHILISED	2012

1.2. Programme extension

Type of Support	Vaccine	Start year	End year
Routine New Vaccines Support	Measles, 10 dose(s) per vial, LYOPHILISED	2013	

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2011	Request for Approval of
ISS	Yes	ISS reward for 2011 achievement: Yes
HSS	Yes	next tranche of HSS Grant Yes
CSO Type A	No	Not applicable N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2011: N/A

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2010 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 Democratic People's Republic of Korea hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of Democratic People's Republic of Korea

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	CHOE Chang Sik	**Name**	SIN Pong Ryul
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
Dr. Kim Jong Hwan	National EPI manager	(850-2)-3814077	Bogon.moph@star.co.net.kp
Dr. Tuya Mungun	Health Specialist, UNICEF	850)-191-250-0553 (mobile)	tmungun@unicef.org
Dr. Zobaidul Haque Khan	Medical Officer, WHO	(850)-191-250-0734(mobile)	Khanzo@searo.who.int
Dr. Kamrul Islam	Chief of Health	(850-2)-191-250-0495	kislam@unicef.org

2.2. ICC signatures page

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

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

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

2.2.1. ICC report endorsement

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

Name/Title	Agency/Organization	Signature	Date
RI Pong Hun , Vice-Minister	Ministry of Public Health		
PAK Myong Su, Director, State Hygienic Control Board,	Ministry of Public Health		

PAK Jong Min, Director, External Affairs Department	Ministry of Public Health		
KIM Pok Sil, Director, Department of Finance,	Ministry of Public Health		
PAK Tong Chol, Focal Point, GAVI Programme,	Ministry of Public Health		
KIM Jong Hwan, National EPI manager,	Ministry of Public Health		
JANG Jun Sang, Director of Medical Service,	Ministry of Public Health		
CHOE Gum Song, Director, Department of External Finance	Ministry of Finance		
KIM Su Gil, Vice Director, Department of Cooperation	Stae Planning Committee		
Dr. TEGEGN Yonas, WHO Representative	WHO, DPR Korea		
Mr. Bijaya RAJBHANDARI , UNICEF Representative	UNICEF, DPR Korea		

ICC 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:

2.3. HSCC signatures page

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

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

Name/Title	Agency/Organization	Signature	Date
RI Pong Hun, Vice-Minister	Ministry of Public Health		
PAK Myong Su, Director, State Hygienic Control Board	Ministry of Public Health		
PAK Jong Min, Director, External Affairs Department,	Ministry of Public Health		
KIM Pok Sil, Director, Department of Finance,	Ministry of Public Health		
PAK Tong Chol, Focal Point, GAVI Programme,	Ministry of Public Health		
KIM Jong Hwan, National EPI manager,	Ministry of Public Health		
JANG Jun Sang, Director of Medical Service,	Ministry of Public Health		
CHOE Gum Song, Director, Department of External Finance	Ministry of Finance		
KIM Su Gil, Vice Director, Department of Cooperation	State Planning Committee		
Dr. TEGEGN Yonas, WHO Representative	WHO, DPR Korea		
Mr. Bijaya RAJBHANDARI , UNICEF Representative	UNICEF, DPR Korea		

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)

Democratic People's Republic of Korea is not reporting on CSO (Type A & B) fund utilisation in 2012

3. Table of Contents

This APR reports on Democratic People's Republic of Korea's activities between January – December 2011 and specifies the requests for the period of January – December 2013

Sections

4. Baseline & annual targets

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Total births	354,438	350,568	356,352	356,352	358,276	358,276	360,211	360,211	362,156	362,156
Total infants' deaths	6,841	5,925	6,878	6,878	6,915	6,915	6,952	6,952	6,990	6,990
Total surviving infants	347597	344,643	349,474	349,474	351,361	351,361	353,259	353,259	355,166	355,166
Total pregnant women	359,045	356,917	360,984	360,984	362,934	362,934	364,893	364,893	366,864	366,864
Number of infants vaccinated (to be vaccinated) with BCG	347,349	342,329	349,225	349,225	351,110	351,110	353,007	353,007	354,913	354,913
BCG coverage	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %
Number of infants vaccinated (to be vaccinated) with OPV3	343,773	342,505	345,979	345,979	347,847	347,847	349,726	349,726	351,970	351,614
OPV3 coverage	99 %	99 %	99 %	99 %	99 %	99 %	99 %	99 %	99 %	99 %
Number of infants vaccinated (to be vaccinated) with DTP1	328,479	327,133	333,748	335,495	339,063	339,063	342,661	342,661	344,511	344,511
Number of infants vaccinated (to be vaccinated) with DTP3	326,741	322,729	332,000	332,000	337,306	337,306	339,129	339,129	340,959	344,511
DTP3 coverage	94 %	94 %	95 %	95 %	96 %	96 %	96 %	96 %	96 %	97 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	30	0	5	0	3	0	1	0	1
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.43	1.00	1.05	1.00	1.03	1.00	1.01	1.00	1.01
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	347,349	327,410	349,225	335,495	351,110	339,063	353,007	349,726	354,913	344,511
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	326,741	323,964	332,000	332,000	337,306	337,306	339,129	339,129	344,511	344,511
DTP-HepB-Hib coverage	94 %	94 %	95 %	95 %	96 %	96 %	96 %	96 %	97 %	97 %
Wastage[1] rate in base-year and planned thereafter (%)	25	5	25	5	30	3	30	1	30	1
Wastage[1] factor in base-year and planned thereafter (%)	1.33	1.05	1.33	1.05	1.43	1.03	1.43	1.01	1.43	1.01
Maximum wastage rate value for DTP-HepB-Hib, 1 dose/vial, Liquid	5 %	5 %	5 %	5 %	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	336,073	339,535	342,484	345,280	344,334		346,194		348,063	
Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles	336,073	339,014	342,484	344,581	344,334		346,194		348,063	
Measles coverage	97 %	98 %	98 %	99 %	98 %	0 %	98 %	0 %	98 %	0 %
Wastage[1] rate in base-year and planned thereafter (%)	30	30	30	30	30		30		30	

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Wastage[1] factor in base-year and planned thereafter (%)	1.43	1.43	1.43	1.43	1.43	1	1.43	1	1.43	1
Maximum wastage rate value for Measles, 10 dose (s) per vial, LYOPHILISED	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %	50.00 %
Pregnant women vaccinated with TT+	351,146	352,482	353,764	353,264	355,675	355,675	358,325	358,325	360,260	360,260
TT+ coverage	98 %	99 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %
Vit A supplement to mothers within 6 weeks from delivery	354,438	350,568	356,352	353,264	358,276	355,675	360,211	358,325	362,156	360,260
Vit A supplement to infants after 6 months	340,645	171,255	342,484	174,039	344,334	175,505	346,194	176,276	348,063	177,405
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	1 %	1 %	1 %	1 %	1 %	1 %	1 %	1 %	1 %	0 %

*

** Number of infants vaccinated out of total surviving infants

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

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

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

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 2011 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2011.** The numbers for 2012 - 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**

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

  The figure used for APR in 2011 is consistent with WHO/UNICEF Joint Reporting Form for 2011 and the updated cMYP for 2011-2015 for DPRK.

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

  The figure used for APR in 2011 is consistent with WHO/UNICEF Joint Reporting Form for 2011 and the updated cMYP for 2011-2015 for DPRK.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

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

  The figure used for APR in 2011 is consistent with WHO/UNICEF Joint Reporting Form for 2011 and the updated cMYP for 2011-2015 for DPRK.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

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

  NO.

5.2. Immunisation achievements in 2011

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 2011 and how these were addressed:

Immunization is one of the most sustainable public health programs in DPR Korea. The year of 2011 was a great year for EPI in the country because the program achieved following results:<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

1. Due to effective partnership among GAVI, WHO and UNICEF high vaccination coverage (>97%) for all the antigens except DTP-HepB3 which is 93.6% is achieved in 2011. 322,729 under one children and 352,482 pregnant women were vaccinated in 2011.
2. Effective Vaccine Management Assessment using WHO tool was done for the first time in the country that has covered quality and sufficiency of seven of the seven component elements of an effective supply chain: buildings, storage and transport capacity, cold chain equipment, vehicles, repairs and maintenance, training and management systems needed for different level of service. Based on the EVM assessment report a detailed 'Improvement Plan" was developed and will be implemented to improve vaccine management capacity throughout the country.
3. One of the major achievements in 2011 is the approval of pentavalent vaccine by GAVI Board for the period of July 2012 to December 2015.
4. DPRK government has made its co-financing contribution amounting to 200,000USD that has been used for the procurement of 250,000 doses of DTP-HepB vaccine through UNICEF Supply Division.
5. Multi-dose vial policy was introduced at the village level.
6. National immunization schedule was also revised in 2011 in relation with the introduction of Penta vaccine.
7. All cold chain managers working in different levels were trained in vaccine cold chain and logistic management. As a result, cold chain management and its maintenance were much improved at all levels particularly at county/district level.
8. Study tour was organised to learn from the experience of introduction of Penta vaccine in Vietnam. National program managers had opportunity to learn on all activities including the implementation of preparation plan, actual vaccine introduction and program results as well as challenges faced during introduction.
9. The major challenges was to get the disaggregated data by age, sex and geographical location. WHO and UNICEF have been working with the MoPH to revise the reporting format in the coming years.
10. Supportive supervision and regular monitoring were also a major constraint due to transport issue. UNICEF procured some motor cycles to address this issue.

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

Not Applicable.

5.3. Monitoring the Implementation of GAVI Gender Policy

In the past three years, were the sex-disaggregated data on immunisation services access available in your country? Choose one of the three: **no, not available**

If yes, please report all the data available from 2009 to 2011

Data Source	Timeframe of the data	Coverage estimate

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

As DPRK is a socialist country where every body has the equal access to all health services. Both males and females have the equal access to immunization service for the entire country.

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**

What action have you taken to achieve this goal?

The primary data is available with MoPH; however, there is a need for analyzing the available data. WHO and UNICEF have proposed to support data management system development by MoPH to get age/sex/location-wise disaggregated data.

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)

2008 CES shows that the administrative data is very close to covergae survey data.

* Please note that the WHO UNICEF estimates for 2011 will only be available in July 2012 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2010 to the present? **No**

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

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2009 to the present.

Information system of EPI in the country is planned to be computerized at all levels. In this connection, administrative data system at provincial and some urban district in the capital
city was upgraded through provision of computer utilizing ISS award money and training of the satff by government funds in 2011. Moreover in relation to forthcoming introduction of Penta valent vaccine in routine EPI from July 2012, reporting, recording forms and Child Immunization card have been revised during the reporting year. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

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.

There is a plan for printing of revised reporting books, form and child immunization card that have been reflected in the 2012 annual workplan of UNICEF to support this activity. So all required support including financial and logistic resources for this activity is committed by UNICEF. Computerization of EPI information system will be continued in a phased manner for the entire country till 2015 and beyond.

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** and **Table 5.5b** 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$ = 99.25	Enter the rate only; Please do not enter local currency name

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

Expenditure by category	Expenditure Year 2011	Source of funding						
		Country	GAVI	UNICEF	WHO	0	0	0
Traditional Vaccines*	820,000	0	0	820,000	0	0	0	0
New and underused Vaccines**	825,500	183,000	642,500	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	375,300	17,000	85,500	272,800	0	0	0	0
Cold Chain equipment	35,000	0	0	35,000	0	0	0	0
Personnel	1,701,167	1,701,167	0	0	0	0	0	0
Other routine recurrent costs	600,000	0	0	0	600,000	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	200,000	0	0	0	200,000	0	0	0
Activities Prevention and control of H1N1 pandemic in Dec, 2010-Jan, 2011)		0	0	0	0	0	0	0
Total Expenditures for Immunisation	4,556,967							
Total Government Health		1,901,167	728,000	1,127,800	800,000	0	0	0

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

Please state if an Annual Action Plan for the year 2011, based on the cMYP, was developed and costed.

5.5.1. If there are differences between available funding and expenditures for the reporting year, please clarify what are the reasons for it.

The DPRK remains under UN sanctions. The country has limited financial resources for running key public health programs including EPI. The government contribution is very limited. Mainly for co-financing for tetra valent vaccine, distribution of supply within the country and monitoring. UNICEF, WHO and GAVI have been providing technical as well as financial support for the provision of routine vaccines and vaccination devices, cold chain equipment, capacity building and surveillance system for vaccine preventable disease as indicated in cMYP for EPI. UNICEF spent more funds for provision of BCG and Hep B mono in 2011 compared to the planned amount due to increased wastage rate for both the vaccines.

5.5.2. If less funding was received and spent than originally budgeted, please clarify the reasons and specify which areas were underfunded.

Not applicable.

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5.5.3. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2012 and 2013

DPRK continues to require support to life saving health interventions and is heavily dependent on international aid assistance. Due to limited resources available for the health program in the government budget, all routine vaccines and devices will be procured with financial support from UNICEF for 2012 and 2013. WHO is providing support for efforts of the government for local vaccine production in 2012-13.

Table 5.5b: Overall Budgeted Expenditures for Immunisation from all sources (Government and donors) in US$.

Expenditure by category	Budgeted Year 2012	Budgeted Year 2013
Traditional Vaccines*	980,000	1,000,000
New and underused Vaccines**	5,668,368	3,076,972
Injection supplies (both AD syringes and syringes other than ADs)	354,229	349,466
Injection supply with syringes other than ADs	32,000	30,000
Cold Chain equipment	287,000	174,000
Personnel	1,735,190	1,769,894
Other routine recurrent costs	45,000	50,000
Supplemental Immunisation Activities	0	0
Total Expenditures for Immunisation	9,101,787	6,450,332

* 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.

If there are major differences between the cMYP projections and the budgeted figures above, please clarify the main reasons for it.

5.5.4. Are you expecting to receive all funds that were budgeted for 2012 ? If not, please explain the reasons for the shortfall and which expenditure categories will be affected.

DPRK is expecting to get all planned budget for EPI from UNICEF,WHO and GAVI in 2012 based on their commitment made.

5.5.5. Are you expecting any financing gaps for 2013 ? If yes, please explain the reasons for the gaps and strategies being pursued to address those gaps.

Major financing gaps for 2013 are not expected. UNICEF and WHO Country Offices are committed to support key intervetions of EPI for 2013.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2011 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

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

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2011? **3**

Please attach the minutes **(Document N°)** from all the ICC meetings held in 2011, including those of the meeting 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

During the reporting year, there were 5 ICC/HSCC meetings taken place and following key issues discussed and recommendations made for future implementation:<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

- Focus was given to those counties where highest number of un-immunised children with low coverage.
- Co-financing issue was discussed many times in the ICC meeting resulting timely transfer of funds to UNICEF by MOPH.
- Review and discussion on HSS funds utilization and implementation status of planned activities.

Are any Civil Society Organisations members of the ICC? **No**

If Yes, which ones?

List CSO member organisations:

5.8. Priority actions in 2012 to 2013

What are the country's main objectives and priority actions for its EPI programme for 2012 to 2013?

1. Prioritize/focus on those counties with the highest numbers of unimmunized children and lowest covergae.

2. Introduction of Penta vaccine through successfully implementation of preparation plan. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

3. Train national trainer, House hold doctors on EPI MLM at national provincial level.

4. To promote and support all families and communities for EPI through distribution of IEC materials.

5. To improve the mobility of health managers and staff in support of improved delivery and supervision of immunization services (provision of moto-cycles for county and bicycles for Ri).

6. Implement Improvement plan of EVM for primary and subnational levels.

7. Phased introduction of electronic reporting system county to national level.

8. To maintain polio free and maternal and neonatal elimination status.

9. To achieve measles control status by 2013.

10. To assure immunization safety by strengthening a monitoring system of AEFI.

Are they linked with cMYP? **Yes**

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 2011

Vaccine	Types of syringe used in 2011 routine EPI	Funding sources of 2011
BCG	0.05 ml AD syringe for BCG and 2ml reconstitution	UNICEF
Measles	0.5 ml AD syringes for measles 5ml reconstitution	UNICEF and GAVI (measles II dose)
TT	0.5 ml AD syringe	UNICEF
DTP-containing vaccine	0.5 ml AD syringe	GAVI and MOPH

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)

Please explain in 2011 how sharps waste is being disposed of, problems encountered, etc.

Sharps waste has being dsiposed through burial and open burning methods at subdistrict and incineration at provincial and national levels. No problem encountered in the reporting year.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2011

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	0	0
Remaining funds (carry over) from 2010 *(B)*	118,484	0
Total funds available in 2011 *(C=A+B)*	118,484	0
Total Expenditures in 2011 *(D)*	118,484	0
Balance carried over to 2012 *(E=C-D)*	0	0

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

APR for 2010 reported 101,870$ available as a balance from ISS for 2006-08 to be carried out in 2011. During the reporting year, after completion of the procurement service the program was informed that available balance is increased up to 118,483.80 USD for 2011 due to addition of some buffer stock funds by Copenhagen. MOPH has ordered 20 desktop computers along with supporting stuff and 810 large cold boxes to UNICEF procurement service to use this balance in 2011. However, due to introduction of VISION, new financial and program management software for entire UNICEF globally, procurement transaction was delayed in the reporting year and actual expenditure was made in early 2012 as stated by UNICEF Supply Division.

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

All ISS funds directly transferred to UNICEF Supply Division account and any balance also kept there. Based on government request, all procurement done through "Procurement Services" of UNICEF.

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2011

As mentioned in 6.1.1 the process of procurement started in 2011 but actual implemnetatiion will be done in 2012.

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

6.2. Detailed expenditure of ISS funds during the 2011 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2011 calendar year (Document Number 13) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **Not selected**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number 19).

6.3. Request for ISS reward

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

a) if the number of children vaccinated with DTP3 is higher than the previous year's achievement (or the original target set in the approved ISS proposal), and

b) if the reported administrative coverage of DTP3 (reported in the JRF) is in line with the WHO/UNICEF coverage estimate for the same year, which will be published at http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tscoveragedtp3.htm

If you may be eligible for ISS reward based on DTP3 achievements in 2011 immunisation programme, estimate the $ amount by filling **Table 6.3** below

The estimated ISS reward based on 2011 DTP3 achievement is shown in Table 6.3

Table 6.3: Calculation of expected ISS reward

				Base Year**	2011
				A	B***
1	Number of infants vaccinated with DTP3* (from JRF) **specify**			391485	322729
2	Number of **additional** infants that are reported to be vaccinated with DTP3				-68756
3	Calculating	$20	per additional child vaccinated with DTP3		0
4	**Rounded-up estimate of expected reward**				0

* Number of DTP3: total number of infants vaccinated with DTP3 alone plus the number of those vaccinated with combined DTP-HepB3, DTP-HepB-Hib3.

** Base-year is the previous year with the highest DTP3 achievement or the original target set in the approved ISS proposal, whichever is higher. Please specify the year and the number of infants vaccinated with DTP3 and reported in JRF.

*** Please note that value B1 is 0 (zero) until **Number of infants vaccinated (to be vaccinated) with DTP3** in section 4. Baseline & annual targets is filled-in

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

7.1. Receipt of new & under-used vaccines for 2011 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2011 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below **Table 7.1**

Table 7.1: Vaccines received for 2011 vaccinations against approvals for 2011

	[A]	[B]	
Vaccine type	**Total doses for 2011 in Decision Letter**	**Total doses received by 31 December 2011**	**Total doses of postponed deliveries in 2012**
DTP-HepB		764,400	0
Measles		855,000	125,600
DTP-HepB-Hib		0	0

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

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

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

  In 2011, Country was provided 125,600 doses of measles vaccine less than the original decision letter (25 August 2010).
- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  Regular communication between UNICEF Supply Division and UNICEF country office has taken place for the timely shipments of vaccines.

7.1.2. For the vaccines in the **Table 7.1**, has your country faced stock-out situation in 2011? **No**

If **Yes**, how long did the stock-out last?

0

Please describe the reason and impact of stock-out, including if the stock-out was at the central level only or at lower levels.

0

7.2. Introduction of a New Vaccine in 2011

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2011, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

Vaccine introduced	0	
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	0

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **January 0**

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° 20))

0

7.2.3. Adverse Event Following Immunization (AEFI)

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

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

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

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

7.3. New Vaccine Introduction Grant lump sums 2011

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2011 (A)	0	0
Remaining funds (carry over) from 2010 (B)	0	0
Total funds available in 2011 (C=A+B)	0	0
Total Expenditures in 2011 (D)	0	0
Balance carried over to 2012 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2011 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2011 calendar year (Document No 14) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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

0

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

0

Please describe the activities that will be undertaken with any remaining balance of funds for 2012 onwards

0

7.4. Report on country co-financing in 2011

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2011?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
1st Awarded Vaccine DTP-HepB, 10 dose(s) per vial, LIQUID	200,000	250,000
1st Awarded Vaccine DTP-HepB-Hib, 1 dose(s) per vial, LIQUID		
1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED		
	Q.2: Which were the sources of funding for co-financing in reporting year 2011?	
Government	Ministry of Public Health, DPR Korea.	
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	

1st Awarded Vaccine DTP-HepB, 10 dose(s) per vial, LIQUID		17,000
	Q.4: When do you intend to transfer funds for co-financing in 2013 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2013	Source of funding
1st Awarded Vaccine DTP-HepB, 10 dose(s) per vial, LIQUID		
1st Awarded Vaccine DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	June	MOPH, DPR Korea
1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED		
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	UNICEF and WHO have been continuously advocating with relevant donors to mobilize funds for EPI in DPR Korea.	

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 GAVI's new vaccine support reported on the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

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

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

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **July 2011**

Please attach:

(a) EVM assessment **(Document No 15)**

(b) Improvement plan after EVM **(Document No 16)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 17)**

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

Kindly provide a summary of actions taken in the following table:

Deficiency noted in EVM assessment	Action recommended in the Improvement plan	Implementation status and reasons for for delay, if any
Improvement plan is well developed and was appreci	Recommended actions are in document-16	Implementation are on-going as per plan.

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

If yes, provide details

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

7.6. Monitoring GAVI Support for Preventive Campaigns in 2011

Democratic People's Republic of Korea does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

Due to the high demand in the early years of introduction, and in order to ensure safe introductions of this new vaccine, countries' requests for switch of PCV presentation (PCV10 or PCV13) will not be considered until 2015.

Countries wishing to apply for switch from one PCV to another may apply in 2014 Annual Progress Report for consideration by the IRC

For vaccines other than PCV, if you would prefer, during 2011, to receive a vaccine presentation which differs from what you are currently being supplied (for instance the number of doses per vial, from one form (liquid/lyophilised) to the other, …), please provide the vaccine specifications and refer to the minutes of the ICC meeting recommending the change of vaccine presentation. The reasons for requesting a change in vaccine presentation should be provided (e.g. cost of administration, epidemiologic data, number of children per session). Requests for change in presentation will be noted and considered based on the supply availability and GAVI's overall objective to shape vaccine markets, including existing contractual commitments. Country will be notified in the If supplied through UNICEF, planning for a switch in presentation should be initiated following the issuance of Decision Letter (DL) for next year, about the ability to meet the requirement including timelines for supply availability, if applicable. Countries should inform about the time required to undertake necessary activities for preparing such a taking into account country activities needed in order to switch as well as supply availability.

You have requested switch of presentation(s); Below is (are) the new presentation(s) :

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

Please attach the minutes of the ICC and NITAG (if available) meeting (Document N° **10**) that has endorsed the requested change.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2012

If 2012 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support starting from 2013 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

Please enter current cMYP End Year:

The country hereby request for an extension of GAVI support for

* **Measles, 10 dose(s) per vial, LYOPHILISED**

vaccines: for the years 2013 to .At the same time it commits itself to co-finance the procurement of

* **Measles, 10 dose(s) per vial, LYOPHILISED**

vaccine in accordance with the minimum GAVI co-financing levels as summarised in section 7.11 Calculation of requirements.

The multi-year extension of

* **Measles, 10 dose(s) per vial, LYOPHILISED**

vaccine support is in line with the new cMYP for the years 2013 to which is attached to this APR (Document N °**11**). The new costing tool is also attached.(Document N°**18**)

The country ICC has endorsed this request for extended support of

* **Measles, 10 dose(s) per vial, LYOPHILISED**

vaccine at the ICC meeting whose minutes are attached to this APR. (Document N°**21**)

7.9. Request for continued support for vaccines for 2013 vaccination programme

In order to request NVS support for 2013 vaccination do the following

Confirm here below that your request for 2013 vaccines support is as per 7.11 Calculation of requirements **Yes**

If you don’t confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2011	2012	2013	2014	2015
DTP-HepB, 10 dose(s) per vial, LIQUID	10					
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1		2.182	2.017	1.986	1.933
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10		2.182	2.017	1.986	1.933
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2		2.182	2.017	1.986	1.933
HPV bivalent, 2 dose(s) per vial, LIQUID	2		5.000	5.000	5.000	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1		5.000	5.000	5.000	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10		0.242	0.242	0.242	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10		0.520	0.520	0.520	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10		0.494	0.494	0.494	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2		3.500	3.500	3.500	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1		3.500	3.500	3.500	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10		0.900	0.900	0.900	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5		0.900	0.900	0.900	0.900
Rotavirus, 2-dose schedule	1		2.550	2.550	2.550	2.550
Rotavirus, 3-dose schedule	1		5.000	3.500	3.500	3.500
AD-SYRINGE	0		0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-PENTAVAL	0		0.047	0.047	0.047	0.047
RECONSTIT-SYRINGE-YF	0		0.004	0.004	0.004	0.004
SAFETY-BOX	0		0.006	0.006	0.006	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2016
DTP-HepB, 10 dose(s) per vial, LIQUID	10	
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1	1.927
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10	1.927
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2	1.927
HPV bivalent, 2 dose(s) per vial, LIQUID	2	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	0.900
Rotavirus, 2-dose schedule	1	2.550
Rotavirus, 3-dose schedule	1	3.500
AD-SYRINGE	0	0.047
RECONSTIT-SYRINGE-PENTAVAL	0	0.047
RECONSTIT-SYRINGE-YF	0	0.004
SAFETY-BOX	0	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	500,000$	
			<=	>
DTP-HepB	HEPBHIB	2.00 %		
DTP-HepB-Hib	HEPBHIB		23.80 %	6.00 %
Measles	MEASLES	14.00 %		
Meningogoccal	MENINACONJUGATE	10.20 %		
Pneumococcal (PCV10)	PNEUMO	3.00 %		
Pneumococcal (PCV13)	PNEUMO	6.00 %		
Rotavirus	ROTA	5.00 %		
Yellow Fever	YF	7.80 %		

7.11. Calculation of requirements

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

ID		Source		2011	2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	344,643	349,474	351,361	353,259	355,166	1,753,903
	Number of children to be vaccinated with the first dose	Table 4	#	327,410	335,495	339,063	349,726	344,511	1,696,205
	Number of children to be vaccinated with the third dose	Table 4	#	323,964	332,000	337,306	339,129	344,511	1,676,910
	Immunisation coverage with the third dose	Table 4	%	94.00 %	95.00 %	96.00 %	96.00 %	97.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.05	1.05	1.03	1.01	1.01	
	Vaccine stock on 1 January 2012		#	0					
	Number of doses per vial	Parameter	#		1	1	1	1	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.18	2.02	1.99	1.93	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0058	0.0058	0.0058	0.0058	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.00 %	6.00 %	6.00 %	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	10.00 %	10.00 %	

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

Co-financing group	Low

	2011	2012	2013	2014	2015
Minimum co-financing	0.30	0.20	0.20	0.20	0.20
Recommended co-financing as per APR 2010			0.20	0.20	0.20
Your co-financing	0.30	0.20	0.20	0.20	0.20

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

		2012	2013	2014	2015
Number of vaccine doses	#	971,300	949,700	961,800	942,000
Number of AD syringes	#	1,124,300	1,129,100	1,168,000	1,147,300
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	12,500	12,550	12,975	12,750
Total value to be co-financed by GAVI	$	2,304,000	2,088,500	2,084,500	1,989,000

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

		2012	2013	2014	2015
Number of vaccine doses	#	92,000	98,100	101,000	101,900
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0

Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country	$	213,000	210,000	213,000	209,000

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

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	8.65 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	327,410	335,495	29,011	306,484
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B X C*	982,230	1,006,485	87,032	919,453
E	**Estimated vaccine wastage factor**	*Table 4*	1.05	1.05		
F	**Number of doses needed including wastage**	*D X E*	1,031,342	1,056,810	91,384	965,426
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*		6,367	551	5,816
H	**Stock on 1 January 2012**	*Table 7.11.1*	0			
I	**Total vaccine doses needed**	*F + G – H*		1,063,177	91,934	971,243
J	**Number of doses per vial**	*Vaccine Parameter*		1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*		1,124,266	0	1,124,266
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*		12,480	0	12,480
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		2,319,853	200,600	2,119,253
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		52,279	0	52,279
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		73	0	73
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		139,192	12,037	127,155
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		5,236	0	5,236
T	**Total fund needed**	*(N+O+P+Q+R+S)*		2,516,633	212,636	2,303,997
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		212,636		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*		8.65 %		

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

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.35 %			9.50 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	339,063	31,718	307,345	349,726	33,226	316,500
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	1,017,189	95,153	922,036	1,049,178	99,678	949,500
E	Estimated vaccine wastage factor	*Table 4*	1.03			1.01		
F	Number of doses needed including wastage	*D X E*	1,047,705	98,008	949,697	1,059,670	100,674	958,996
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	0	0	0	2,992	285	2,707
H	Stock on 1 January 2012	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	1,047,705	98,008	949,697	1,062,662	100,959	961,703
J	Number of doses per vial	*Vaccine Parameter*	1			1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,129,080	0	1,129,080	1,167,909	0	1,167,909
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	12,533	0	12,533	12,964	0	12,964
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,113,221	197,681	1,915,540	2,110,447	200,503	1,909,944
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	2,113,221	0	52,503	2,110,447	0	54,308
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	73	0	73	76	0	76
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	126,794	11,861	114,933	126,627	12,031	114,596
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	5,258	0	5,258	5,439	0	5,439
T	Total fund needed	*(N+O+P+Q+R+S)*	2,297,849	209,541	2,088,308	2,296,897	212,533	2,084,364
U	Total country co-financing	*I x country co-financing per dose (cc)*	209,541			212,533		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.35 %			9.50 %		

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

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	9.76 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	344,511	33,628	310,883
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B X C*	1,033,533	100,883	932,650
E	Estimated vaccine wastage factor	*Table 4*	1.01		
F	Number of doses needed including wastage	*D X E*	1,043,869	101,892	941,977
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	0	0	0
H	Stock on 1 January 2012	*Table 7.11.1*			
I	Total vaccine doses needed	*F + G – H*	1,043,869	101,892	941,977
J	Number of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,147,222	0	1,147,222
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	12,735	0	12,735
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,017,799	196,957	1,820,842
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	53,346	0	53,346
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	74	0	74
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	121,068	11,818	109,250
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	5,342	0	5,342
T	Total fund needed	*(N+O+P+Q+R+S)*	2,197,629	208,774	1,988,855
U	Total country co-financing	*I x country co-financing per dose (cc)*	208,774		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.76 %		

Table 7.11.1: Specifications for Measles, 10 dose(s) per vial, LYOPHILISED

ID		Source		2011	2012	TOTAL
	Number of surviving infants	Table 4	#	344,643	349,474	694,117
	Number of children to be vaccinated with the first dose	Table 4	#	339,535	345,280	684,815
	Number of children to be vaccinated with the second dose	Table 4	#	339,014	344,581	683,595
	Immunisation coverage with the second dose	Table 4	%	98.37 %	98.60 %	
	Number of doses per child	Parameter	#	1	1	
	Estimated vaccine wastage factor	Table 4	#	1.43	1.43	
	Vaccine stock on 1 January 2012		#	0		
	Number of doses per vial	Parameter	#		10	
	AD syringes required	Parameter	#		Yes	
	Reconstitution syringes required	Parameter	#		Yes	
	Safety boxes required	Parameter	#		Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		0.24	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0058	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		14.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	

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

Co-financing group	Low

	2011	2012
Minimum co-financing	0.00	0.00
Recommended co-financing as per APR 2010		
Your co-financing		

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

		2012
Number of vaccine doses	#	494,800
Number of AD syringes	#	384,700
Number of re-constitution syringes	#	55,000
Number of safety boxes	#	4,900
Total value to be co-financed by GAVI	$	156,500

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

		2012
Number of vaccine doses	#	0
Number of AD syringes	#	0
Number of re-constitution syringes	#	0

Number of safety boxes	#	0
Total value to be co-financed by the Country	$	0

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

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	339,014	344,581	0	344,581
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1	1		
D	**Number of doses needed**	*B X C*	339,014	344,581	0	344,581
E	**Estimated vaccine wastage factor**	*Table 4*	1.43	1.43		
F	**Number of doses needed including wastage**	*D X E*	484,791	492,751	0	492,751
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*		1,990	0	1,990
H	**Stock on 1 January 2012**	*Table 7.11.1*	0			
I	**Total vaccine doses needed**	*F + G – H*		494,741	0	494,741
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*		384,694	0	384,694
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*		54,917	0	54,917
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*		4,880	0	4,880
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		119,728	0	119,728
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		17,889	0	17,889
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		204	0	204
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		29	0	29
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		16,762	0	16,762
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		1,813	0	1,813
T	**Total fund needed**	*(N+O+P+Q+R+S)*		156,425	0	156,425
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*		0.00 %		

Table 7.11.4: Calculation of requirements for (part 2)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2012**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2012**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*

8. Injection Safety Support (INS)

Democratic People's Republic of Korea is not reporting on Injection Safety Support (INS) in 2012

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 2011**. All countries are expected to report on:

   a. Progress achieved in 2011

   b. HSS implementation during January – April 2012 (interim reporting)

   c. Plans for 2013

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

For countries that received HSS funds within the last 3 months of 2011, or experienced other delays that limited implementation in 2011, 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 2011 fiscal year starts in January 2011 and ends in December 2011, HSS reports should be received by the GAVI Alliance before **15th May 2012**. 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 2012, the HSS reports are expected by GAVI Alliance by September 2012.

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 activities and budget (reprogramming) please explain these changes in this report (Table/Section 9.5, 9.6 and 9.7) and provide explanations for each change so that the IRC can approve 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. The changes must have been discussed and documented in the HSCC minutes (or equivalent).**

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 2011

   b. Minutes of the HSCC meeting in 2012 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2011 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 2011 and request of a new tranche

9.1.1. Report on the use of HSS funds in **2011**

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

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

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

If yes, please indicate the amount of funding requested: **1206000** US$

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

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

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	450450	1307650	1026900	1025850	549150	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)		450450	1307650	1026900	1025860	549150
Total funds received from GAVI during the calendar year (*A*)		1758500		402600		287000
Remaining funds (carry over) from previous year (*B*)			1758500	1539631	1350941	678615
Total Funds available during the calendar year (*C=A+B*)			1758500	1539631	1350941	965615
Total expenditure during the calendar year (*D*)		0	218369	591296	672326	
Balance carried forward to next calendar year (*E=C-D*)		1758500	1539631	1350941	678615	
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)						
Revised annual budgets (*if revised by previous Annual Progress Reviews*)						
Total funds received from GAVI during the calendar year (*A*)						

Remaining funds (carry over) from previous year (*B*)						
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 the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January						
Closing on 31 December						

Detailed expenditure of HSS funds during the 2011 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2011 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: 9)**

If any expenditures for the January April 2012 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 22)**

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 funds are managed by WHO and UNICEF <?xml:namespace prefix = o />

<!--[if !supportLists]-->• <!--[endif]-->For the WHO part of the project,activities are implemented by Ministry of Public Health using standard WHO implementation modalities per the agreement signed between WHO and the GAVI.

- UNICEF part of the HSS fundsdirectly transferred from GAVI to UNICEF Copenhagen for the procurement of coldchain equipment and transportation means for EPI programme . MoPH submit theirrequest (list of CC equipment and transport) through UNICEF-Pyongyang andallprocurement done by UNICEF-Copenhagen based on government request.

- No HSS funds are included in national health sector plan andbudget currently. However in recently developed 'Medium Term Plan forDevelopment of Health Sector in DPR Korea, 2010-2015',GAVI funds are consideredas finances available to the country.

<!--[if !supportLists]-->• <!--[endif]-->There have been delays ininitial approval of the HSS funds and then in mechanisms for transferring thefunds. Following these, the funds were made available to WHO Country Office atmuch later date which has adversely affected the implementation pace andaccordingly resulted in deferment of activities and timeline.

<!--[if !supportLists]-->• <!--[endif]-->The funds are utilized perstandard WHO norms and standards where by MOPH submits the proposal for each ofthe approved activity in the workplan. These proposals are reviewed technically and for compliance to agreed costs between WHO and MOPH and then approved at WHO country office and processed through WHO online Global Management Systemaccording to type of expenditure such as Agreement of Performance of Work(APW), Direct Financial Cooperation (DFC) or Procurement for S&E.

<!--[if !supportLists]-->• <!--[endif]-->The funds are transferredto Ministry of Public Health Bank account for both national and sub-nationalactivities. Internal transfer to sub-national level is managed by Ministryof Health's finance departments.

<!--[if !supportLists]-->• <!--[endif]-->MOPH submits an approvedfinancial SOE along with Technical Report of all the activities per WHOstandard reporting template which is scrutinized, reviewed and verified by WHOstaff and processed online for balance payment since payments are usually madein installments and linked to deliverables.

<!--[if !supportLists]-->• <!--[endif]-->Following the grantagreement between WHO and GAVI and subsequent establishment of award, the fundshave been provided to MOPH for activities without delays. Since WHO system initially allowed utilization of funds only until December 2010, some activities were put on hold and organized in first quarter of 2011 following amendment in award end date per clarifications from GAVI and WHO, internal clearances, following which the activities were implemented smoothly.

<!--[if !supportLists]-->• <!--[endif]-->WHO did not receive any funds after the initial tranche; the third, 4th and 5th Tranches are planned to be delivered after a new Grant agreement between GAVI and WHO, whichis being currently delayed for clarification of some issues

It may be noted that out of the carried over fund of USD 546,481 withWHO, USD 302,591 has already been spent by April 30 and USD 158,891 is in the final stage of process to been committed. As the new cycle starting on 1May 2012, only USD 89,999 will be brought forward.

Has an external audit been conducted? No

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 26)

9.2. Progress on HSS activities in the 2011 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 2011 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2011**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Development of micro-plan on immunization services	Translation of guideline of preparation of county micro-plan	100	Translated guideline on Micro-planning
Development of micro-plan on health service delive	Evaluate the impact of the implementation of the introduction of micro-planning	0	To be implemented in 2012
Development of Health Sector Plan	National Conference on the Health Sector Plan	100	Activity report
Capacity Building of Health Managers through train	Capacity Building of Health Managers through training on Management of immunization and other health services (the cascaded training programme is intended to provide appropriate technical background to health managers at different levels for practical usage of management principles in planning, implementing and supervising immunization and other health services), ACTIVITIES: Consensus workshop on finalization of health management training module and planning; Translation for health management training module; Printing of health management training module; ToT on health management at central level, provincial level after TOT;	100	Activity reports
Household doctor training on EPI and HS	Provincial level training of trainers (ToT) for household doctor training; Household doctor training in the county level with emphasis on vaccine preventable and communicable diseases and immunization	75	TOT done, county level training on going

Supporting IMCI	Supporting and strengthening Integrated Management of Childhood illness (IMCI) with the objective to strengthen immunization and disease surveillance (IMCI implementation deals with management and control of childhood respiratory diseases and diarrhea and so the support here is linked strongly with data generation for decision making for introduction of new vaccines like PCV or Rota); Printing IMCI training material; Training for pediatrician/HHDs of ri level in IMCI including immunization in Hyangsan and Tongchon county hospitals; Local training in IMCI at 5 counties; Support to regional training center on immunization and IMCI with training materials and IT equipment	100	Activity reports
Supporting VPD surveillance and IDSP	Supporting Vaccine Preventable Diseases surveillance and management within the Integrated Disease Surveillance Programme (IDSP), (It is expected that data generated through VPD surveillance will be valuable in planning control response including that of new vaccine introduction, especially as advocacy for obtaining high level approval); Strengthen the disease surveillance activities at provincial and county levels in the pilot area for developing a backbone for the VPDs; Interim assessment of pilot programme to establish IDSP; Refresher training on VPD surveillance and integrated disease surveillance system for health workers at central level; Updating manuals and guidelines on communicable disease surveillance and immunization services	100	Assessment report on IDSP, VPD Surveillance guidelines; many activities supported from other WHO sources
Strengthening Newborn Care including immunization	Strengthening Newborn Care with immunization during neonatal period as the main focus ; training at provincial level in North Hwanghae, province; at county and Ri levels in South Hwanghae province; and at on managing immunization and newborn care; Duplication of CD on immunization and newborn care; Printing of Algorithm for neonatal resuscitation; Printing of Poster on Hepatitis B vaccination	100	Activity report

Capacity building for nurses/ midwifes	Capacity building for nurses/ midwifes, the principal providers of Immunization Services through; Procurement of Practical mannequins kit for nursing and midwifery school; Printing of guideline on evaluation of nurse and midwifery standard skill; Printing of flip charts on newborn care for nurse education	100	Activity report
Strengthen transport means for EPI	Procurement of 60 Moto-tricycles for EPI team working at county level	100	Arrival and distribution reports
Improving Cold Chain System based on EVM	Provision of cold chain equipment (23,720 icepacks with different capacities)	100	Arrival and distribution reports

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**
Development of micro-plan for immunization & HS	1.With assistance of WHO consultant, the guidelines and templates for micro-planning, and manuals for health managers at provincial, county and ri level in 2010 were developed and translated into local language under APW contract with National Institute of Public Health. Back-translation of selected pages proved consistency with original version. Improved micro-planning will have long lasting impact on immunization service delivery plan, implementation, supervision and monitoring. 2. Since the completion of translation has taken long time for quality check, printing/distribution of the guideline on micro-planning is planned in 2012. 3. A pilot training conducted in 10 counties across the country with participation of 20 health staffs from each county, from 18th – 22nd July 2011. Based on the assessment of this pilot training, the decision was to continue the planned training on micro-planning along with the training on health and immunization management. 4. Evaluation of impact of introducing micro-planning is planned for 2012 and 2013, with focus on the counties which received training on micro-planning in 2011 and onwards.
Development of Health Sector Plan	Development of Health Sector Plan 1. National conference on the formulation of Medium Term Strategic plan for development of health sector was held in Pyongyang with participation of other health partner agencies and the draft plan was presented. The plan was finalized taking into consideration of comments, suggestions and recommendations of all the stake-holders participating in the conference. 2. The completed version of the Plan was printed in Korean and English languages: 250 copies of each and distributed. 3. The HSP has been used internally for linking achievements in immunization with long term vision of strong health system. It is also used for resource mobilization purpose as an advocacy tool

Capacity Building of EPI & Health Managers	Capacity Building of EPI & Health Managers through training on Health Management including that of immunization services management through: 1. A consensus workshop on finalization of health management training module was held in the second quarter of 2011 among health staffs from MoPH and National Institute of Public Health Administration (NIPHA) and health mangers from provincial level and county level, before translation. 2. The training module was translated and printed for distribution to the trainees as reference. With expansion of training to further counties and ris (sub-counties), the need for printing of more copies is expected. 3. ToT on health management of EPI and other health services, from central level was undertaken from 20-30 June 2011, followed by provincial level training from 11-15 July 2011. Through the ToTs, 30 trainers were made available at central level and 120 at provincial level (12 trainers for each province). The activity laid the foundation for expansion of training further down to the implementing level. 4. First phase training on health management was facilitated by national trainers for 30 health staffs including EPI managers, directors, administrative and planning staffs and finance staffs of hospitals, anti-epidemic and hygienic center, medical logistic management agency of central level during 26 September – 6 October 2011. 5. Provincial level training on health management was also conducted by national training team from 12 October – 17 November 2011, in four sites covering 100 health staffs from all 10 provinces. 10-day training module was used and Medical officer and National program officer of WHO country office participated in the training of South Hamgyong Province as resource persons. Pre/post evaluation of training showed that the training was effective in raising the awareness level of the participants. 6. Training for health staffs working for immunization, TB/malaria control, and other health programs at county level was organized in two phases after due consideration of training capacity: the 1st phase of training was conducted in 10 counties with participation of 240 health staffs from 20 counties from 28 November – 7 December 2012. The 2nd phase of training was undertaken in another 10 counties for 240 health staffs from 20 counties from 9-20 December 2011. Pre& post training evaluation was made to measure immediate effect of the training, the result of which showed satisfactory improvement in the level of understanding by trainees at the end of the training. A National Professional Officer from WHO country office to DPRK participated in the 2nd phase in Hyangsan County as technical resource person. 7. Upon success in training of county level in 2011, MoPH proposed to undertake the health management training at county level in three regions of the country: west, north and south regions with coverage of 28 counties in each region. Due to limited fund, the proposal for training in south region was suspended to be supported with fund of year four. APW contract was made with National Institute of Public Health & Administration (NIPHA) to carry out the county level training plan in two regions (west and north regions) for 56 counties which were not covered by the training of 2011. 336 health staffs of county level are planned to be trained in 10-day trainings from 15th March to 30 July 2012 and pre/post training evaluation are given as package of training. 8. NIPHA has also been contracted to organize and guide ri-level training on health management for immunization, utilizing trainers of central and provincial level from 12 March – 15 May 2012. The ris covered by the current APW are selected from counties which were covered by health management training of 2011. 3-day training module was prepared for ri-level health staffs with focus on such areas as □Basic epidemiology and statistics, □planning and management of health activities including immunization, □management for human resources for health program, logistic and finance □Communication. The training targeted for directors of ri level people's hospitals and polyclinics and leading household doctors from 40 counties. Altogether 1440 health staffs of ri level are to be trained in 48 batches during the grace period. MO and NPO of WHO country office to DPRK participated in one training session in Kangso district of Nampho city as trainers.

Household doctor training on immunization & HS	1. With the objective to improve quality of health program implementation immunization services and surveillance of vaccine preventable and other priority diseases, by Household doctors, Provincial level training of trainers (ToT) for household doctors was organized in 5 cities for all provinces of the country (2 provinces per venue). The training objectives were to develop a set of trainers at the provinces to organize training on regular basis according to their need to relay training down to peripheral level. 2. Following provincial ToT, Household doctor training for county level was organized in 8 counties of 2 provinces from 25 Oct-18 Dec, 2011 for 720 house-hold doctors The counties for training were selected by provincial level in the order of priority for immunization coverage
Supporting IMCI	Supporting and strengthening Integrated Management of Childhood illness (IMCI) with the objective to strengthen disease surveillance and immunization implemented through 1. IMCI training material was printed (1000 copies) and distributed to two medical universities (names of provinces) at provincial level which were left out of IMCI introduction in pre-service curriculum in 2011. With distribution of training materials, these universities were able to include IMCI into its curriculum.(activity 3.4) 2. Training for pediatrician/HHDs of ri level in IMCI including immunization in Hyangsan and Tongchon county hospitals 3. Local trainings in IMCI in 5 counties were participated by 548 pediatricians and household doctors of hospitals and polyclinics of county and ri level from September to November 2011 4. The training centers in the north region were supported with training equipment such as 25 desktop and 14 laptop computers and 3 sets of training materials in 2011, to support these provinces with geographically hard-to-reach areas. The north region comprises three provinces (Chagang, Ryanggang and North Hamgyong). It is believed that proper training of the health service providers in the counties of these provinces will enhance improved access and coverage for immunization and other health services.
	Supporting Vaccine Preventable Diseases surveillance and Integrated Disease Surveillance Programme (IDSP) through strengthening disease surveillance activities at provincial and county levels: (It should be noted that currently 7 major vaccine preventable diseases are included in IDSP) 1. Technical support for developing and field testing of standardized tools for data collection and reporting of vaccine preventable diseases. The developed tools are as follows o VPD monthly reporting form o Weekly reporting form o Daily reporting form o Register of patients with communicable disease o Laboratory specimen registering form o Laboratory result recording form o Laboratory result reporting form o Case investigation forms for 7 kinds of VPDs 2. The standardized forms for recording and reporting of VPDs have been produced in sufficient quantities, distributed and utilized at 2,000 reporting sites in IDSs piloting areas (Pyongyang City and South Pyongan Province) in 2010 and 2011. 3. Reports on VPDs flow from peripheral ri/dong level up to the central level on regular basis. 3.2.2.Interim assessment of pilot programme to establish IDSS 1. Interim assessment on piloting of IDSS was conducted during 21 February – 15 March 2011 by an expert from WHO Regional office for South East Asia (SEARO) 2. The assessment highlighted key areas that should be improved for consolidating piloting and further expansion of IDSs in the country including following interventions. o Updating and standardization of surveillance guidelines and training manuals on integrated disease surveillance o Training of public health workers and epidemiologists on filed epidemiology and disease surveillance o Strengthening laboratory surveillance from collection of specimens in the field to confirmation at national reference laboratories. 3.2.3. Refresher training on integrated disease surveillance system for health workers at central level

Supporting VPD Surveillance & IDSP	1. The 1st training on integrated disease surveillance for health workers at central and provincial level was conducted by WHO SEARO team in September 2009 for implementing IDSS in 2 pilot provinces. 2. 3 day refresher training on integrated disease surveillance was conducted during 20 – 22 September 2011 participated by 55 trainers from health facilities at central and provincial level. 3. Training materials were updated; a group of facilitators were trained to conduct cascaded trainings at lower levels for further expansion of IDSS to other parts of the country. 4. Cascaded trainings at provincial and county level are planned in 2012. 3.2.4. Updating manuals and guidelines on disease surveillance and immunization services 1. 5 Guidelines and manuals on integrated disease surveillance and immunization services updated/ developed in at the end of 2011 o Manual on immunization services for household doctors, o Manual on surveillance of vaccine preventable diseases, o Guideline on control of communicable diseases, o Manual on surveillance of communicable diseases for household doctors, o Guideline on surveillance of adverse effects following immunization (AEFI)) 2. Manuals and guidelines specifically designed for household doctors who are responsible for disease surveillance and immunization services at community level were developed to ensure the timely detection of disease outbreak, quality and safety of immunization services. 3. Technical review by WHO, production and distribution of the manuals and guidelines are planned in 2012. 3.2.5. Purchase necessary supplies and equipments for the pilot project. WHO SEARO is planning to organize a review of the needs of the laboratories soon to streamline further plans for supporting lab networks needed to strengthen VPD surveillance and IDSP. There is difficulties in supporting infrastructure and system development for surveillance, the pace of implementation of IDSP outside pilot areas is slow; however, with support available from GAVI, WHO and other donors, this will be soon over come.
Strengthening Newborn Care including immunization	1. TOT on newborn care in North Hwanghae province 2. Training for newborn care at county level in South Hwanghae province 3. Immunization focused training for ri-level health staffs on managing newborn care in South Hwanghae Province 4. 5,000 CD on newborn care and 50,000 copies of algorithm for neonatal resuscitation were produced and distributed to pediatric and obstetrics& gynecology departments of provincial and county level hospitals. 5. 10,000 posters on Hepatitis B vaccination was printed and distributed to hospitals of central and provincial level.
Capacity building for nurses/ midwifes	Capacity building for nurses/ midwifes, the principal providers of Immunization Services through 1. Three sets of practical mannequins were procured and distributed to three nursing and midwifery schools 2. 6,000 copies of guidelines on evaluation of nurse and midwifery standard skill were made available for use in 6 nurse/midwife schools. 3. 1500 copies of flip charts on newborn care were printed for nurse education of all nurse/midwifery schools. It is expected that with continued support the graduates from nursing schools will be able to provide quality immunization services.
Transport means and cold chain equipment for EPI	Provision of 60 moto-tricycles and 23,720 icepacks with different capacity; Supply request submitted in June 2011 to UNICEF SD was delayed due to introduction of VISION (new financial & program management software) for entire UNICEF globally. Cost estimation for supply items was done and actual expenditure will be made in 2012.

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

Contents of the training activities modified to provide better linkage of immunization services delivery with HSS. The essence has been that immunization strengthening contributes to HSS and vice-versa.
Procurement of lab supplies for supporting surveillance under VPDS and IDSP strengthening was postponed for clarifying actual needs through lab support assessment to be carried out through WHO-SEARO support.
Activities related to impact assessment of key HSS activities like immunization and health management training immunization and HSS; and of Micro-planning implementation have been carried forward to 2012, so as to give adequate time for the impact to be measurable.

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?

GAVI-HSS grant has not been used for national human resources.

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 2010 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	2011 Target					Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2007	2008	2009	2010	2011	
Numbers of staff trained in integrated health mana	0	HMIS	3850	3850	0	0	0	0	2736	Report by MoPH	Trainings started only in 2011, and could not be finished all over the country.
Guidelines developed for micro-planning	0	HMIS	YES	YES	0	0	0	YES	YES	Report by MoPH	
Guidelines developed for financial management	0	HMIS	YES	YES				YES	YES	Report by MoPH	
Guidelines developed/updated for VPD Surveillance	0	HMIS	YES	YES				YES	YES	Report by MoPH	
Co-ordination Mechanism established for HSS	0	MoPH Report	YES	YES				YES	YES	Report by MoPH	
% counties identify service packages by microplan	0	Planning department of MoPH	100%	100%				100%	100%	Survey by health management training team	
% counties implement supportive supervision	0	Planning department of MoPH	100%	NA		0%	25%	30%	60%	Survey by health management training team	No set target for 2011, with strengthening of supportive supervision, this target is achievable by project end
% counties utilizing integrated VPD surveillance	0	National EPI	100%	100%		30%	60%	90%	100%	Survey by EPI team	
No of Provinces with VPD Focal points trained_Dat	0	National EPI	100%	100%		30%	60%	100%	100%	Annual Provincial Report	

% counties routinely integrate VitA with RI	99.7%	MoPHReport	100%	100%		100%	100%	100%	100%	Report by MoPH	
% counties able to show tracked budget vs expended	NA		100%	!00%					NA	Report by MoPH	Owing to incomplete information, the trends and achievement can't be reported as yet. With improvement in health management at province and county level, it may be possible for health managers to report on this.
% Counties managed by trained health managers	0%	MoPH report	100%	100%					100%	Planning departme nt MoPH	
% counties implementing IMCI	25%	Annual Provincial Report	100%	100%					100%	Annual Provincial Report	
% counties with 90% functioning cold chain	NA		100%	100%				NA	100%	EVM Report	
DPT- HepB 3 coverage	82.3%	JRF 2007	90%	90%	83%	85%	90%	93%	93.6%	JRF 2011	
MCV1 Coverage	80%	JRF 2007	90%	90%	80%	85%	90%	99%	98.1%	JrF 2011	
% of counties achieving >80% DPT3 coverage	100%	Ministry of Public Health Annual Report,2007	100%				100%	100%	100%	Ministry of Public Health Annual Report	

9.4. Programme implementation in 2011

9.4.1. Please provide a narrative on major accomplishments in 2011, especially impacts on health service programs, notably the organization program

In 2011 the activities on health system strengtheningsupported by GAVI were enhanced. There was visible progress in theimplementation of planned activities. In the field of capacity building, majorprogress has been made in training health managers on micro-planning and EPIand health management. The technical content of both the training packages werereviewed to emphasize the linkage with improved immunization services. So the practicalimmunization micro-plan process was included in the training. As most of the healthmanagers are from clinical background the basic knowledge about epidemiology,bio-statistics, operational research methodologies and their practical usage isrelatively low. So this package of training was need based and should becontinued.

A huge benefit of theactivities in 2010-11is the creation of pool of health management trainers atthe national and provincial level, which will be available in future forsimilar trainings with appropriate materials and minimal guidance. This groupof trainers can be used in near future for specific immunization relatedtrainings like AEFI Surveillance, Training on Measles Case Based surveillancein relation to measles elimination goal or for new vaccine introduction. Withsimilar effectiveness the trainers can be used in health services management orplanning training or for training of field researches or coverage surveyors.

Another majoraccomplishment is progress towards establishing country wide VPDS and integrateddisease surveillance programme(IDSP), into which all major vaccine preventabledisease surveillance is included. IDSP is currently functional in two provincesin the pilot phase; an interim assessment was done by WHO and way forward hasbeen outlined. Considering lab network is an integral part of surveillance WHOSEARO is going to assist preparation of a master plan for provision of specificsupport for labs at different levels based on thorough needs-assessment verysoon. IDSP is another area where support from different partners including GAVIand WHO is being utilized. Government is also considering how IDSP and routineimmunization reporting system can benefit from existing mechanism successfullyutilized by Telemedicine Project, a very successful project of the governmentaided by WHO.

Other activities taken up by MoPH with GAVI support like training ofHousehold doctors, who are the major providers/managers of immunizationservices and surveillance focal points for all diseases including VPDs, onhealth management, IMCI training, training on Neonatal Care and support fortraining and education at nursing schools for future nurses and midwives, whoare the providers of vaccination services all contributed to health systemstrengthening in general and more specifically to immunization systemstrengthening. For example, coverage of Hepatitis-B birth-dose hasreached 99.2% in 2011 (Data source: WHO-UNICEF JRF 2011).

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

The major problems were associated with deficiency in knowledge of the health managers and service providers on basic epidemiologyand its application in health management; so rightly importance has beenprovided to train them in these fields. Also, there are deficiency in thesupervisory capacity and for monitoring and evaluation. The activities in2012and 2013 are directed to address these issues.

The following factorsmay also be noted as **risks and challenges**

- In absence of verifiable external resources and support, the internal resources alone are not enough to sustain the gains in HSS and inimmunization; the dip in immunization coverage in mid nineties with resultant outbreaks of vaccine preventable diseases, especially of countrywide severe outbreak of measles in 2006-07, are the examples in past.

- The available donors for this country are very few in numbers, and for some of the available donors, often the aid flow is affected by geo-politicalsituation or other issues beyond the control of the program

For **mitigation of these risks,** MoPH DPRKand partners would like to appeal to GAVI Alliance and other donors to continue their valuable support while MoPH will ensure the most rational use of the availableresources.

In this context it may be important to underline that government isinvesting from national budget a significant amount of money to maintain the highEPI coverage in the form of infrastructure, human resources and the direct andindirect system costs (e.g., running the household doctor system, managementand supervision of the programme).

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

At the highest level GAVI HSS implementation is monitored by Health Sector Coordination Committee which oversees, monitors, guides and approves the implementation plan.<?xml:namespace prefix = o />

- On a routine basis the concerned national program managers with sub national counterpartsare responsible for implementation, monitoring and reporting the activities

- Organizationally WHO works closely with Department of External Affairs, MOPH and WHO Desk Officer and National program managers (EPI, Health System and Child Health) to facilitate development of quality proposals per activities in the work plan.

- The proposals are processed within WHO Country office using the standard checklist androuting chart and per identified expenditure type for each activity (Agreement for Performance of Work, Direct Financial Cooperation, Purchase Order) the transactions take place in GSM with built in quality checks

- The implementation of activities at different levels are monitored by WHO/UNICEF andMOPH both jointly and exclusively for example:

o Participating in training at different levels with national program manager

o Supportive supervision of routine activities (eg immunization services, surveillance, etc) or of special activities like Child Health Days

o Verification of arrival of supplies at Central Medical and Non Medical Warehouse

o End user and facility visit for utilizationof equipment and supplies

Each activity implementation technical and financial report is submitted to WHO, which is reviewed and processed per WHO procedures and feedback provided to NPM, MOPH for revisions and refinement if needed. Generally the payment to MOPH is done in installments and last installment is affected with final deliverable.

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.

GAVI HSS activities are integrated in MOPH own plan and are accordingly implemented, monitored and reported in their annual report. There is a special cell within MoPH, which plan, implement and monitor activities supported through GAVI HSS.

Since the funds used for in-country level activities are channeled through WHO and UNICEF, therefore, are subjected to additional monitoring and reporting. Both WHO and UNICEF have their own M&E Internal Audit and Oversight system of monitoring the GAVI HSS activities for monitoring both technical and financial aspects.

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

WHO and UNICEF support Ministry of Public Health (MOPH) in the implementation of GAVI HSS activities.<?xml:namespace prefix = o />

Representatives of WHO, UNICEF, MOPH and Ministry of Finance(MOF) are the members of HSCC

Provincial and county level health bureau and People's Health Committee are involved in the implementation of sub-national activities.

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.

In DPRK there is no Civil Society Organization as such, and this point is not relevant

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

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

The mechanism of channeling funds through WHO and UNICEF has been working effectively though there have been some procedural delays which were resolved.<?xml:namespace prefix = o />

Channeling of funds through WHO necessitate following the procedures including proposal development for each activity, monitoring and technical and financial reporting which is an additional requirement but ensure quality implementation and reporting.

In the process of signing of new Grant Agreement between GAVI and WHO for the 3rd-5thyear allocations, some errors have been found, the clarifications are underway; however, it took a considerable time to sort that out.

There are no changes proposed in the management processes.

9.5. Planned HSS activities for 2012

Please use **Table 9.5** to provide information on progress on activities in 2012. If you are proposing changes to your activities and budget in 2012 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2012

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Original budget for 2012** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2012 actual expenditure** (as at April 2012)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2012** (if relevant)
Health Management System Review and Development	Recruit TIPs to assist MoPH to review selected component of the health management system including impact evaluation of implementation of micro-planning.	30000	0			30000
Health Management System Review and Development		0	0	Sharing of the findings of the evaluation/refresher training	Newly proposed activity. Based on results of impact evaluation, the findings of it with recommendations will be shared with stakeholders and refresher training done, if needed among selected managers	20000

Capacity Building Health Management Systems	International public health short courses/linkages	30000	0	International training for strengthening the capacity of master trainers	Health management training gathers greater interest among immunization program managers/implementers of each level. The requirement for higher training skill among trainers is increasing with respect to gaining expertise through practical cases at regional and global contexts during the training. However the trainers are not enough experienced in this regard. In order to build up the skill in mixing up the theory and practice in the preparation of training module and in conducting trainings, it has been advised to organize one international training in an appropriate WHO Collaborative Centre . The recipients of the training upon their return will contribute in developing/revising training modules, conducting training and building up of new sets of trainers in country.	30000

Health management training program	Health management training program central/provincial levels	20000			Hospitals are the major player of health programs and co-working agency with anti-epidemic hygienic institute. Hospitals (both in county & ri levels) are the basic unit of data collection on immunization and other health programs implemented in community level. However, these data are not properly utilized by the directors of the hospitals for planning and management due to lack of analytical capacity because most of the directors are of medical background rather than public health management. One of the feedbacks from trainees following health management training at county/ri level in 2011 suggested extension of training period as the content of training needs to be also practiced under the supervision of trainers. In view of the need for provision of intensive training course to directors of hospitals about health management, MoPH agreed to avail of the training center in National Institute of Public health and administration with consideration of already established training capacity in the institute. This activity is to provide tools and materials to the institute to prepare for 6-month training course for Directors of health facilities which	20000
Health management training program		0		Procurement of equipments for facilitating immunization trainings	The above proposed training module will be mainly practical with emphasis on local level immunization data management of both RI and surveillance; this will require that the training centre has desk top computers to provide hands-on training to the participants.	50000
Health management training program	Health management training programs county level	132000			This training is the continuation from past year for the counties not covered; emphasis has been given for more focused training on immunization management issues. The reduction in cost is related to less area to be covered in 2012, only in southern area	80000

Health management training program	Health management training programs Ri level	200000			This is not a new activity; however, the technical content of the training has been revised to emphasis on practical immunization related issues, as per GAVI Alliance requirements.	200000
Evaluation of Capacity Building activities	Development of assessment tool, Field survey for evaluation and data analysis	5000			MoPH has already invested a lot of resources on capacity building; evaluation was a need foreseen from the beginning. However, it is evident that for this an appropriate assessment tool needs to be developed with external technical assistance. For actual assessment with data management component there is the proposed raise in the budget.	20000
Capacity Building	Printing cost	5000			Cost reduction was proposed as most activities has printing budget	2000
Service delivery support	Transport (through UNICEF)	100000			1 truck for central medical warehouse for EPI programme; 1 Land ceuiser for farthest province for vaccine delivery	100000
Surveillance and supervision	Study tour on vaccine preventable disease surveillance planning and management for health managers of central level	50000			The planning capacity should be sensitive to local area needs and ready for rapid response to any emergence of health challenges. There is limited opportunity for peer exchange internationally. The planning and management capacities of central level for planning and management of health programs including immunization requires to be upgraded with new development of planning and management skills(of international standard) so this capacity can be utilized to upgrade further lower level health planners and managers.	50000

Surveillance and supervision	Study tour on epidemiolgy	40000		Field epidemiology training program	Field epidemiology training program is available in south east Asia region of WHO with view to assist countries to build up its capacity of forecasting epidemiological trend and planning appropriate interventions to protect general population from preventable communicable diseases. Skilled epidemiologists with knowledge of skills of field investigation, risk analysis, and early detection and control of communicable disease including VPDs are needed for the country, Three public health professionals will be selected for this course so that they could substantially contribute to building up of capacity for epidemiological analysis at field through leading any outbreak investigation, if that would occur and also through providing training to other public health experts in the country. They could also contribute to in-country FETP courses in future.	40000
Surveillance and supervision	Training on epidemiologic methods and surveillance on VPDs and other diseases in IDSP for health workers	25000			To expand IDSP it is necessary to provide training on usage of epidemiology in practice with emphasis on diseases surveillance including disease detection, reporting, outbreak detection and investigation, risk assessment and principles of initiating control measures. This is the purpose of this proposed activity. All the major VPDs are included in present list of reportable diseases under IDSP. The fellows trained under FETP will be used as resource persons.	25000

Surveillance and supervision	Training on IDSP and routine immunization data management for health managers	20000			Data management, especially at lower levels, is a major constraint in building strong surveillance system in the country. There is little or no capacity for local level data analysis and interpreting, so that decisions may be data driven. The proposed activity will train health managers on data collection, compilation, analysis and interpretation for usage of data available on routine immunization and disease surveillance.	20000
Surveillance and supervision	Training of county level laboratory doctors on disease surveillance	15000			The role of lab networks in the disease surveillance programme is not well understood and the capacity of the labs to detect the reportable diseases under IDSP is also not up to the minimum level required. The proposed activity will address this issue regarding the lab diagnosis of vaccine preventable diseases and priority communicable diseases with explanation of specific roles of labs at different levels and answer the issues regarding specimen collection, handling and transportation, referral system, and clear division of responsibilities among labs depending upon its level, in disease surveillance.	15000
Cold chain (through UNICEF)	Batteries for solar refrigerators , solar refrigerators, tool box for maintenance	287000			As per cold chain replacement plan	167000

IMCI capacity building	Development of documentary scientific film on IMCI training, and Training on IMCI for health staff at county and Ri levels (remaining areas)	50000			IMCI implementation has been proving to be very effective for strengthening health system and reducing under 5 mortality, At the same time it is the base for strengthening immunization system as well. Most of the diseases in IMCI are now considered as vaccine-preventable. The data generated from IMCI clinics will be useful in estimating disease burden for such vaccine preventable diseases like pneumococcal pneumonia and meningitis, rotavirus, and even influenza. It will be an important basis for decision making for new vaccine introduction in future	50000
Communication	Communication materials	32000			Reduction is proposed as has been covered well by other programmes	2000
Technical Assistance	Technical Assistance	40000		Technical assistance and logistic support for GAVI technical team	For planning , implementing and supervising GAVI supported activities in the country a technical team in MOPH has been constituted which will be supported by MOPH in terms of salary and other facilities; but for smooth functioning this team will need some support for office logistics, for continued monitoring and supervisory visits to the field.	40000
		1081000	0			961000

9.6. Planned HSS activities for 2013

Please use **Table 9.6** to outline planned activities for 2013. If you are proposing changes to your activities and budget (reprogramming) please explain these changes in the table below and provide explanations for each change so that the IRC can approve 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 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)
Planning	Evaluate the impact of the implementation of the introduction of guidelines and manuals	30000			30,000

Capacity building	Arrange international training for central / provincial health managers on public health management	5000			5,000
Capacity building	Training programmes on health management for health managers of county (district) level	30000			30,000
Capacity building	Develop the capacity of RI level (PHC level) staff on managing RIs.	132000			132,000
Monitoring and evaluation	Evaluate the impact of the management training targeted at central, provincial and county level health managers	200000			200000
Service delivery	Duplicate training packages/training modules etc and purchase training material	5000			5000
Monittoring and evaluation	Recruit a STP to assess the country capacity and to provide technical assessment for the development of the health sector Master plan	5000			5000
Technical support	Technical support	88850			
		495850			

9.6.1. If you are reprogramming, please justify why you are doing so.

During the high level GAVI mission to DPRK in February 2012 it was explained that GAVI Alliance would appreciate that in the countries the HSS support provided, is used for health system strengthening that are linked with immunization strengthening. The current reprogramming of some of the activities are on this line, after careful consideration of the fact that DPRK has already attained remarkable progress in its immunization programme, while the health system itself is lagging behind in some of the important areas. The challenge of sustaining high immunization coverage with ensuring quality safe vaccines to its population is a real one if not supported appropriately. MOPH and its partners considered that some of the previously planned activities be reprogrammed to align more with immunization services strengthening. Some of the activities although were retained for the sake ofcontinuity, they were however, subject to change in their technical contents so that issues and problems related to immunization are addressed more while utilizing the GAAVI HSS support. <? xml:namespace prefix = o />

The issue of reprogramming of activities for 2013 was discussed at the HSCC, but was decided to keep the plan in line with original for the moment. It was also decided that reprogramming of 2013 activities could be done during the course of the year or prior to the APR 2012 drafting, if and when needed, which would be more practical.

9.6.2. If you are reprogramming, please outline the decision making process for any proposed changes

The programme changes reflected n the table 9.5 were produced after thorough and in depth discussions on each and every activity between MOPH, WHO and UNICEF. The decisions were brought forward to the meeting of the HSCC who made endorsement of the programme change on case by case basis. <? xml:namespace prefix = o />

Even if there was no change in activity, or budget HSCC was interested in rationale of most activities of 2012, which has been reflected in 2012 proposal

9.6.3. Did you propose changes to your planned activities and/or budget for 2013 in **Table 9.6** ? **No**

9.7. Revised indicators in case of reprogramming

If the proposed changes to your activities and budget for 2013 affect the indicators used to measure progress, please use **Table 9.7** to propose revised indicators for the remainder of your HSS grant for IRC approval.

Table 9.7: Revised indicators for HSS grant in case of reprogramming

Name of Objective or Indicator (Insert as many rows as necessary)	Numerator	Denominator	Data Source	Baseline value and date	Baseline Source	Agreed target till end of support in original HSS application	2013 Target

9.7.1. Please provide justification for proposed changes in the **definition, denominator and data source of the indicators** proposed in Table 9.6

Indicators were not revised

9.7.2. Please explain how the changes in indicators outlined in Table 9.7 will allow you to achieve your targets

9.8. Other sources of funding for HSS

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

Table 9.8: Sources of HSS funds in your country

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

Global Fund	14282013	2011-15	Capacity building, training, planning and implementation, infrastructure, technical assistance, monitoring and evaluation, supervision related to TB and Malaria control in the country.
ROK	3589092	2008-12	Capacity building, HMIS, Infra structure, IMCI, MCH, Blood Safety, Quality of pharmaceutical products, etc
WHO AC Budget	1511500	2010-13	Capacity building, Telemedicine, Medical education, Fellowships, Policy development, Planning, Management, Research, etc

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
Activity reports submitted to WHO	Ensuring names of participants of training Verification of arrival of goods at central medical and non-medical warehouse	The process is little tedious, but ensures quality of documentation of activities appropriately.
MDGs Progress and Annual Report on Health Status DPRK, 2011 Ministry of Public Health, DPRK		
MOPH annual report	Discussions with NPM and other focal points on specific issues needing clarification	
United Nations Strategic Framework (UNSF) Review 2012	Data were verified by different UN agencies	
WHO-UNICEF JRF on EPI Coverage	Cross-checked at different stages	

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.

- The reporting template is too long andcould be simplified.
- It was not possible to put the figures in table 9.1.3 (a) separately for WHO and UNICEF, in the present template.
- In some tables the number of characters in particular cells were limited, so there could be problem in matching with the previous report, and the original proposal and could create confusion
- The sequence of data entered into some tables was changed in MS-Word version; thatcould create confusion if not corrected. The sequence, however, were found to be maintained as intended, in the template itself. However, this problem was resolved after attention was drawn of GAVI Programme Manager

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2010?? 3

Please attach:

1. The minutes from all the HSCC meetings held in 2010, including those of the meeting which discussed/endorsed this report **(Document Number: 8)**
2. The latest Health Sector Review report **(Document Number: 23)**

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

Democratic People's Republic of Korea is not reporting on GAVI TYPE A CSO support for 2012

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

Democratic People's Republic of Korea is not reporting on GAVI TYPE B CSO support for 2012

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

2011 is the year of great achievement for DPR Korea with the approval of penta by GAVI. ICC is also very happy with the co-financing issue. DPR Korea has been fulfilling its obligation since 2009 and even Country has used the balance money from previous transactions for the procurement of 2012 penta vaccine. Another important event was the visit of high level delegation from GAVI from 5-9 March 2012. Following are the few remarks made by the GAVI delegation during their debriefing meeting:-<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

1. Consistently very high coverage >90% in all antigen - remarkable achievement for the country.
2. Well established cold chain system which is one of the models in the region.
3. They mentioned that Immunization programme in DPRK is the “Gold Standard”.
4. DPRK has the high potential to be the world leader/example in EPI in future if they sustain their high coverage above 95% in the years to come.
5. Finally, all these achievements were possible due an excellent relationship between UNICEF, WHO and the Ministry of Public Health-they added.

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 2011 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2011, 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 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 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 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	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 2011 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2011, 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 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	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 2011 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2011 (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 2011 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 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Signature_Minister Of Health.pdf File desc: File description... Date/time: 5/28/2012 3:40:10 AM Size: 229779
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature_Minister Of Finance.pdf File desc: File description... Date/time: 5/28/2012 3:40:33 AM Size: 229779
3	Signatures of members of ICC	2.2	✓	Signature_ICC members.pdf File desc: File description... Date/time: 5/28/2012 5:57:41 AM Size: 396693
4	Signatures of members of HSCC	2.3	✗	Signature_HSCC members.pdf File desc: File description... Date/time: 5/28/2012 5:58:04 AM Size: 384977
5	Minutes of ICC meetings in 2011	2.2	✓	ICC_HSCC Meeting Minutes for 2011.doc File desc: File description... Date/time: 5/28/2012 6:11:08 AM Size: 130048
6	Minutes of ICC meeting in 2012 endorsing APR 2011	2.2	✓	ICC_HSCC_Meeting Minutes_Endorsed APR-2011.docx File desc: File description... Date/time: 5/28/2012 6:13:56 AM Size: 28742
7	Minutes of HSCC meetings in 2011	2.3	✗	ICC_HSCC Meeting Minutes for 2011.doc File desc: File description... Date/time: 5/28/2012 6:14:21 AM Size: 130048
8	Minutes of HSCC meeting in 2012 endorsing APR 2011	9.9.3	✗	ICC_HSCC_Meeting Minutes_Endorsed APR-2011.docx File desc: File description... Date/time: 5/28/2012 6:14:40 AM Size: 28742
9	Financial Statement for HSS grant APR 2011	9.1.3	✗	Expenditure statement_Uncetified_SEARO.pdf File desc: File description...This is the statement of expenditure of HSS funds channeled through WHO up to 31 December 2011 Date/time: 5/17/2012 9:41:36 PM Size: 17274

10	new cMYP APR 2011	7.7	✓	cMYP__DPRK_Final Version_ 11 May 2011.docx File desc: File description... Date/time: 5/28/2012 3:45:36 AM Size: 343705
11	new cMYP costing tool APR 2011	7.8	✓	cMYP_Costing Tool_DPRK_Final Version_11 May 2011.xlsx File desc: File description... Date/time: 5/28/2012 3:46:15 AM Size: 1585595
13	Financial Statement for ISS grant APR 2011	6.2.1	✗	Annex-2 DPRK 2011 APR_ISS.NVS_Expend_05__May_12.docx File desc: File description... Date/time: 5/28/2012 4:38:11 AM Size: 24623
14	Financial Statement for NVS introduction grant in 2011 APR 2011	7.3.1	✓	Annex-2 DPRK 2011 APR_ISS.NVS_Expend_05__May_12.docx File desc: File description... Date/time: 5/28/2012 4:38:54 AM Size: 24623
15	EVSM/VMA/EVM report APR 2011	7.5	✓	EVM Assessment Report-Final_DPRK_10 October'11.doc File desc: File description... Date/time: 5/28/2012 3:54:03 AM Size: 1863168
16	EVSM/VMA/EVM improvement plan APR 2011	7.5	✓	EVM-Improvement Plan_final_DPRK_10 Oct'11.xls File desc: File description... Date/time: 5/28/2012 3:54:24 AM Size: 189440
17	EVSM/VMA/EVM improvement implementation status APR 2011	7.5	✓	EVM-Improvement Plan_final_DPRK_10 Oct'11.xls File desc: File description... Date/time: 5/28/2012 6:17:13 AM Size: 189440
23	HSS Health Sector review report	9.9.3	✗	MTPDHS in DPRK 2010-2015 FINAL 2011 April _2_.pdf File desc: As no Health Sector Review done till date, MTSP which describes some background on HS could be relevant Date/time: 5/18/2012 5:43:31 AM Size: 766219