GAVI Alliance

Annual Progress Report 2013

submitted by

the Government of

Togo

Reporting year: **2013**

Requesting for support for the year: **2015**

Submitted on: **15/05/2014**

Deadline for submission: 16/05/2014

Please submit the 2013 annual status report via the online platform
https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or to the representatives of a GAVI Alliance partner. Documents may be provided to GAVI partners, their staff and the public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *We invite you to use previous annual status reports and approved requests for support from GAVI as reference documents. The electronic copy of previous annual status reports and GAVI support requests are available from the following address*: http://www.gavialliance.org/country/

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

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMS

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 program(s) described in the Country's application. Any significant change from the approved program(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 THIS PROPOSAL

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

REIMBURSEMENT OF FUNDS

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

SUSPENSION/ CANCELLATION

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 programs described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programs described in this 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 accept any gifts, payments or benefits 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 assessments 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 this support application is accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programs described in this application.

CONFIRMATION REGARDING COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARENCY 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 the 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, 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 UNCITRAL Arbitration Rules in force. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The arbitration will be conducted in Geneva, Switzerland. The arbitration languages 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 programs described in this 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 programs described in this application.

By preparing 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. Features of the Support

Reporting year: **2013**

Requesting for support year: **2015**

1.1. NVS AND INS SUPPORT

Type of Support	Current vaccine	Preferred presentation	Active until
New Vaccines Support (routine immunization)	DTP-HepB-Hib, 10 dose (s) per vial, LIQUID	DTP-HepB-Hib, 10 dose (s) per vial, LIQUID	2015
New Vaccines Support (routine immunization)	Pneumococcal (PCV13), 1 dose (s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose (s) per vial, LIQUID	2015
New Vaccines Support (routine immunization)	Rotavirus, 2 schedule -doses	Rotavirus, 2 schedule -doses	2015
New Vaccines Support (routine immunization)	Yellow fever, 10 dose (s) per vial, LYOPHILIZED	Yellow fever, 10 dose (s) per vial, LYOPHILIZED	2015

DTP-HepB-Hib (pentavalent) vaccine: based on the current preferences of your country, the vaccine is available through UNICEF in liquid form in vials of one or ten doses and in liquid/lyophilized form in two-dose vials to be used with a schedule of three injections. The other presentations have already been pre-selected by WHO and the complete list can be viewed on WHO website, but the availability of each product should be confirmed specifically.

1.2. Extension of the Program

No NVS is eligible for an extension of this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilization in 2013	Request for Approval of	Eligible For 2013 ISS reward
ISS	Yes	next installment: N/C	Yes
HSS	Yes	HSS grant next installment Yes	N/C
Type A CSO	Yes	Not applicable	N/C
B type CSO	No	Extension of support for B type CSO by the Board in July 2013: N/C	N/C
HSFP	No	Next installment of HSFP Grant N/C	N/C
VIG	No	Not applicable	N/C
COS	No	Not applicable	N/C

AVI: Allocation of vaccine introduction; CSO: Operational support for a campaign

1.4. Previous IRC Report

The annual progress report (APR) of IRC for the year 2012 is available here. French version is also 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 Togo 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 funds 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 Togo

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

Minister of Health (or delegated authority):		**Minister of Finance (or delegated authority):**	
Name	Pr NAPO-KOURA Gado Agarassi	**Name**	Badawasso GNARO
Date		**Date**	
Signature		**Signature**	

This report has been complied by (these persons can be contacted in case GAVI Secretariat has any queries on this document):

Full name	Position	Telephone	E-mail
Dr NASSOURY I. Danladi Head of the Epidemiological Division +228 22 21 41 94/90 22 34 97 dinassoury@yahoo.fr	Head of the Epidemiological Division	+228 22 21 41 94/90 22 34 97	dinassoury@yahoo.fr
Mr. Anani LACLE	Head - Immunization division	+228 22 21 41 94/90 12 95 23	lacleae@yahoo.fr
Dr Kodjovi E. ADJEODA	WHO EPI In-charge	+228 2221 33 60/ 91 64 56 01	adjeodak@tg.afro.who.int
Mr. Wadagni SOSSAH	HSS Focal Point for the Ministry of Health	+228 24 45 78 62/90 94 48 62	sossahremi@yahoo.fr
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Dr. Minzah PEKELE	MPN, FP WHO HSS program in-charge	+228 2221 33 60/ 99 13 22 54	pekelem@tg.afro.who.int
Mr. Abeyeta DJENDA	union of NGOs in Togo (UNGOTO)	+228 90 14 68 27	aristidedjenda@yahoo.fr

2.2. ICC Signatures Page

If the country presents a report on the Immunization Services Support (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 is an integral part of GAVI Alliance monitoring of country's 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.

2.2.1. ICC report endorsement

We, the undersigned members of the immunization 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
Kwési Séléagbodji AHOUMEY-ZUNU	Ministry of Health		
Dr. IMBOUA-NAVA Lucile	Resident Representative of WHO in Togo		
Dr. Viviane Van STEIRTEGHEM	Resident Representative of UNICEF-Togo		
Pr NAPO-KOURA Gado Agarassi	Secretary General of the Ministry of Health		
Dr. DOGBE Koku	Director General of Health		
Mr. Gbehomilo - Nyelolo TOMEGAH Rotary International/President of the National Plus Polio Commission	Mr. Gbehomilo - Nyelolo TOMEGAH Rotary International/President of the National Plus Polio Commission		
Mr. Hervé ASSAH	Representative of the World Bank		
Mr. Philippe COLLIGNON	Cooperation Mission		
Mrs. Khardiata Lo NDIAYE	Resident representatives/United Nations Development Program		
Dr. Aristide APLOGAN	Department of Preventive Medicine (DPM)		
Dr. Kuami Guy BATTAH	Health Coordination/Togolese Red Cross		
Mr. Hokameto EDORH	Director of Planning, Training, and Research		

Dr. Sylvain Atayi KOMLANGAN	Director of Primary Health Care		
Dr. Afefa Amivi BABA Director	Directorate of Healthcare Facilities		
Dr. Atany NYANSA	Director of Pharmacies, Laboratories and Technical Equipment Mr. DJENDA Abeyeta Executive Director of UNGOTO		
Mr. Issaka LAGUEBANDE	Executive Assistant/Ministry of Development and Planning		

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), SECTORAL COMMITTEE endorse this report on the Health Systems Strengthening Program. 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's 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
Kwési Séléagbodji AHOUMEY-ZUNU	Minister of Health		
Mr. Adji Oteth AYASSOR	Ministry of Economy and Finances		
Mrs. ANATE Kouméalo	Minister for Communication and Culture		
Dr. Kodjo ABALO	Defence Minister (Representing the Minister)		

Mr. Mawussi Djossou SEMONDJI	Ministry for Planning, Development and Regional Planning		
Dr. IMBOUA-NAVA Lucile	Resident Representative of WHO in Togo		
Dr. Viviane Van STEIRTEGHEM	Resident Representative of UNICEF-Togo		
Dédé Ahouefa EKUE	Social Affairs Minister (Ministry of Social Action and National Solidarity)		
Mrs. Khardiata Lo NDIAYE	Resident representatives/United Nations Development Program		
Mrs. Cécile MUKARUDUGA	Representative of UNFPA		
Mr. Tamsir FALL	Representative of UNOAIDS		
Mr. Hervé ASSAH	Representative of the World Bank		
Mrs. Béatrice N'DARUGIRIRE	Representative of the European Union		
Pr PITCHE Vincent	Coordinator of the permanent Secretary of the National Council for Fight against AIDS/STI		
Dr. Assetina SIMGO-TOKOFAI	Coordinator of the National Council for Fight against AIDS/STI		
Dr. Kokou Mawulé DAVI	Coordinator of the National Council for Fight against AIDS/STI Dr. Kokou Mawulé DAVI Coordinator for the National Program for Fight against Tuberculosis Dr. AWOKOU Fantche Coordon		
Dr. Fantchè AWOKOU	Coordinator for the National Program for Fight against Malaria		

Mr. Philippe COLLIGNON	Representative of the French Cooperation Mission		
Mrs. Angélika KOBILE	Representative of PSI		
Sister Véronique MEDENDZI	Representative of CODI		
Pr ATTIPOU	Dean of the Joint Faculty of Medicine and Pharmacy (JFMP)		
Mr. DJENDA Abeyeta	Representative of UNGOTO		
Mr. Raven EDU	Representative of FNGOTO		
Mr. DOKLA Kokou Augustin	Representative of the National PVHIV network (APR+)		

If HSCC wishes it may 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)

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

2.4.1. Responsible for the preparation of the Quarterly monitoring Report on the support to CSOs

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

Name/Title	Agency/Organization	Signature	Date
Mr. DJENDA Abeyeta Executive Director of UNGOTO	Union of NGOs in Togo (UNGOTO)		

2.4.2. Hierarchy of the report on CSO support

We, the undersigned members of the National Health Sector Coordinating Committee, (or equivalent committee) endorse this report on the GAVI Alliance CSO Support.

Name/Title	Agency/Organization	Signature	Date

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

3. Table of Contents

This APR reports on activities carried out by Togo between January - December 2013 and specifies requests for the period January – December 2015

Sections

4. Baseline and annual targets

Countries are requested to make a realistic evaluation of vaccine wastages, clarified by an analysis of data collected at the national level. In the absence of specific data, the country can use the maximum wastage rates given for illustrative purposes in the Wastage rate table appendix of the support request guidelines. Please note the reference wastage rate for Pentavalent vaccine available in ten dose vials.

Number	Achievements in line with WHO/UNICEF Joint Report		Targets (Preferred presentation)			
	2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2013	Current estimation
Total number of births	297,640	297,640	304,124	306,405	310,749	310,749
Total infants' deaths	23,216	23,151	23,722	23,831	24,239	24,239
Total number of surviving infants	274,424	274,489	280,402	282,574	286,510	286,510
Total pregnant women	297,640	297,640	304,124	304,124	310,749	310,749
Number of infants who have received (yet to receive) BCG vaccine	282,758	249,816	291,959	291,959	298,319	298,319
BCG coverage	95%	84%	96%	95%	96%	96%
Number of infants who received (yet to receive) OPV3 vaccine	257,959	208,746	266,382	266,382	272,185	272,185
OPV3 coverage	94%	76 %	95%	94%	95%	95%
Number of infants who have received (yet to receive) DTP1 vaccine	266,192	245,587	274,794	274,794	280,780	280,780
Number of infants who received (yet to receive) DTP3 vaccine	257,959	237,467	266,382	266,382	272,185	272,185
DTP3 coverage	94%	87%	95%	94%	95%	95%
Wastage[1] rate during the reference year and anticipated thereafter (%) for DTP vaccine	19	5	18	18	16	16
Wastage [1] factor during the reference year and anticipated thereafter for DTP vaccine	1.23	1.05	1.22	1.22	1.19	1.19
Number of infants who received (yet to receive) 1 dose(s) of DTP-HepB-Hib vaccine	267,985	245,587	274,794	274,794	280,780	280,780
Number of infants who received (yet to receive) 3 dose(s) of DTP-HepB-Hib vaccine	267,985	237,467	274,794	274,794	272,185	272,185
DTP-HepB+Hib coverage	98 %	87%	98 %	97 %	95%	95%
Wastage [1] rate in base-year and planned thereafter (%) [2]	19	5	10	10	10	10
Wastage [1] factor in base-year and planned thereafter (%)	1.23	1.05	1.11	1.11	1.11	1.11
Maximum loss rate for DTP-HepB-Hib vaccine, 10 dose (s) per vial, LIQUID	25 %	0%	25 %	25 %	25 %	25 %
Number of infants who received (yet to receive) Yellow fever vaccine	241,461	227,259	260,774	260,774	272,185	272,185

Yellow fever coverage:	88%	83%	93%	92%	95%	95%
Wastage [1] rate in base-year and planned thereafter (%)	19	17	18	18	16	16
Wastage [1] factor in base-year and planned thereafter (%)	1.23	1.2	1.22	1.22	1.19	1.19
Maximum loss rate for Yellow fever, 10 dose (s) per vial, LYOPHILIZED	40%	40%	40%	40%	50%	40%
Number of infants who received (yet to receive) 1 dose(s) of Pneumococcal (PCV13) vaccine		0	272,048	0		0
Number of infants who received (yet to receive) 3 dose(s) of Pneumococcal (PCV13) vaccine		0	272,048	0		0
Pneumococcal (PCV13) coverage		0%	97 %	0%		0%
Wastage [1] rate in base-year and planned thereafter (%)		0	5	0		0
Wastage [1] factor in base-year and planned thereafter (%)		1	1.05	1		1
Maximum loss rate for Pneumococcal (PCV13) vaccine, 1 dose (s) per vial, LIQUID	0%	5%	5%	5%	0%	5%
Number of infants who received (yet to receive) 1 dose(s) of Rotavirus vaccine		0	272,048	0		0
Number of infants who received (yet to receive) 2 dose(s) of Rotavirus vaccine		0	272,048	0		0
Rotavirus coverage		0%	97 %	0%		0%
Wastage [1] rate in base-year and planned thereafter (%)		0	5	0		0
Wastage [1] factor in base-year and planned thereafter (%)		1	1.05	1		1
Maximum wastage rate for Rotavirus vaccine, 2-dose schedule	0%	5%	5%	5%	0%	5%
Number of infants who received (yet to receive) 1st dose(s) of measles vaccine	249,726	224,948	260,774	260,774	272,185	272,185
Measles coverage	91%	82%	93%	92%	95%	95%
Pregnant women immunized with TT+	270,853	235,707	282,836	282,836	295,212	295,212
TT+ coverage	91%	79%	93%	93%	95%	95%
Vit A supplement to mothers within 6 weeks from delivery	227,092	219,995	232,373	232,373	237,654	237,654
Vit A supplement to infants after 6 months	249,726	223,330	260,774	260,774	260,774	260,774
Annual DTP Drop-out rate [(DTP1–DTP3)/DTP1] x100	3%	3%	3%	3%	3%	3%

** Number of infants vaccinated out of total surviving infants

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

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

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

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

5. General Program Management Component

5.1. Updated Baseline and Annual Targets

Note: Please fill in the table in section 4 “Baseline and Annual Targets” before you continue

The figures for 2013 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) of immunization activities for 2013.** The figures for 2014 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in CMYP.

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

- Justification for any changes in **births**:

  The figures for APR 2013 correspond to those from JRF 2013. On the other hand, the APR 2014 figures are slightly higher than the previous projections sent by the country to GAVI: In 2010, Togo organized a General Census on Population and Housing whose final official results were published in 2011. A new projection of population was prepared by the Ministry of Health based on the official results until the projections from the Ministry of Statistics were received. These are the projections of the Ministry of Health from the global census data which was previously sent to GAVI. In 2014, the total population displayed by the national statistical directorate (6,809,000) is slightly higher than those estimated by the Ministry of Health (6758311). By applying the birth ratio of 4.50% to this population, there are 306,405 live births instead of 304124 live births.

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

  The slight increase in the total population compared to the previous projections from the Ministry of Health explains the increase in surviving infants

- Provide justification for any changes in Targets by vaccine: **Please note that for targets more than 10%, the results from previous years must be justified.**

  For the vaccination coverage targets, there are no differences with the cMYP data mentioned in APR 2010. This is explained by the fact that differences in the national plan, between 2010 census data and those which were previously used, are not huge.

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

  No differences

5.2. Immunization achievements in 2013

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

The immunization results in 2013 were not satisfactory. The objectives set for 2013 were not achieved. After a significant increase from 2002 to 2010, stagnation in coverage was observed since 2011, partly due to the difficulty in obtaining good denominators for 0-11 months old children ever since the general population census of 2010 was conducted.

Ag:

2011

2012

2013

BCG

243,939

266,600

249,816

Penta3

236,205

243,181

237,567

Measles vaccine

219,367

232,199

224,948

In terms of number of children immunized, the absolute figures for 2013 remained lower than the ones for 2012 for all the antigens (249816 children immunized with BCG in 2013 as against 266600 children in 2012; 237567 children are immunized with DTP-HepB-Bib3 in 2013 as against 243,181 in 2012; 224948 children immunized with MV in 2013 as against 232,199 in 2012.

The immunization coverage obtained in 2013, is lower compared to 2012:

BCG (84% in 2013 as against 92% in 2012 and 90% in 2011),

DTP-HepB-Hib1 at 89% in 2013 as against 95% for 2011 and 2012,

DTP-HepB-Hib3 at 87% as against 91% in 2012 and 92% in 2011,

MV-AAV (82% in 2013 as against 87% in 2012 and 85% in 2011).

The following are the reasons for this counter-performance:

1. Inadequate funding for the reach every district approach (especially funds from the Government and other national Partners), since 2011, had adverse effects on:

- Organization of advanced strategies This will help immunizing a significant number of children in remote villages and hamlets, this number can exceed 30% of the target.
- The motivation of Community Health Worker involved with the health facilities in planning advanced strategies, negotiations for immunization schedules in communities and search for the ignorant

2. The targets which are calculated and communicated to districts for 2013 are derived from the 2010 General census results. These results indicate that the children under one year represent 3.26% as against 4.50% used till then. These targets broken down at the district and health facilities level became very low. Hence, this had an impact on the number of children immunized. For example, the below table describes the targets which were used since 2010. It is observed that the application of 2010 census data (which were lower compared to the actual targets) negatively influenced the immunization coverage in 2013. That is why, in the monitoring conducted in September 2013, the program decided to re-adjust the targets for the rest of the year by using the general population from the 2010 census and the ratio of 4.50% as the ratio of live births. This gives the ratio of surviving infants at 4.15%, if we use the infant mortality rate at 7.8% according to MICS 4 data. Hence, we could catch-up with a few children but did not achieve the desired results. This readjustment continued in 2014 and for the next years.

Ratio of surviving infants

Surviving infants population used

2010

4.28%

251,438

2011

4.28%

257,480

2012

4.28%

263,650

2013

3.07%

203,717

2013 adjusted from October

4.15%

274,489

2014

4.15%

282,574

3. Lack of CC equipment and logistics. This does not enable all health facilities to vaccinate everyday

4. Lack of qualified human resources especially at the operational level (USP

However: 10 districts maintained an IC > 90% during the last 4 years, they are: district 5 (Lome), districts of Ave and Yoto in Maritime; districts of Amou and Eastern-Mono (Plateaux), district of Blitta (Central), those of Dankpen and Keran (Kara) and finally the districts of Kpendjal and Oti (Savannahs)

The main activities carried out in 2013 were:

1. Implementation of activities under the RED approach, in districts
2. Submission for GAVI support for the introduction of new vaccines with the following results: approval with clarifications (December 2013) followed by a final approval in January 2014, they are:

- anti-HPV vaccines: demonstration projects (Golfe and Tchamba)
- MenAfriVac: immunization campaign against Meningitis A (regions of Plateaux, Central, Kara and Savannahs)

3. Celebration of the third edition of the African Immunization Week (AIW) (Advocacy meeting with Partners, EPI visibility, Strengthening advanced strategies and social mobilization in the districts)
4. Implementation of a national anti-polio immunization campaign in two cycles (May and October 2013);
5. Implementation of an anti-Measles immunization campaign (November 2013);
6. Support to district monitoring meetings;

7. Finalizing the use of DVD-MT in the new monthly immunization report format;
8. Organization of two national monitoring workshops integrated with EPI/SIMR/Nutrition (April and October 2013)
9. Revision of supports (Registers and immunization cards)
10. Supplying regions with vaccines, syringes and safety boxes
11. Repairs of faulty CC material in the districts (region of Plateaux): 33 refrigerators and freezers;
12. National inventory of CC equipment and mobile logistics
13. Evaluation of CC requirements by considering the new vaccines
14. Training 25 CSOs and red cross on EPI management in partnership with UONGTO

Obstacles

• Lack of funding for RED especially at the national level (State and other national funds), resulting in the reduction of vaccination coverage in certain districts due to the reduction of advanced strategies: community funding enabled to overcome these obstacles to a certain extent but the districts encountered severe funding problems for RED, sometimes resulting in the demotivation of certain personnel
• Lack of qualified human resources especially at the operational level (PHU): the vaccination campaigns against polio helped strengthen the existing human resource capabilities. There is an improvement in collaborating with private health facilities. However, a capability strengthening plan is planned for.
• Lack of CC equipment and logistics: continued advocacy in the institutions (JICA, Rotary, UNICEF etc.) for implementing the CC and logistics strengthening plan

Challenges to be addressed in 2014

1. Introduction of new vaccines: vaccine against pneumococcal and vaccine against rotavirus and anti-HPV vaccine (demonstration project) and immunization campaign against Meningitis (MenAfriVac)
2. Financing advanced strategies by mobilizing local resources
3. Submission to GAVI/HSS for strengthening the health system
4. Strengthening the cold chain
5. Strengthening capabilities: Training EPI managers and training in CC maintenance
6. Scaling up DQS to ensure reliability of data and quality of the monitoring system

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

The following are the reasons for this counter-performance:

1. 1. Inadequate funding for the reach every district approach (especially funds from the Government and other national Partners), since 2011, had adverse effects on:

    - Organization of advanced strategies. This will help immunizing a significant number of children in remote villages and hamlets, this number can exceed 30% of the target.
    - The motivation of Community Health Worker involved with the health facilities in planning advanced

strategies, negotiations for immunization schedules in communities and search for the ignorant

2. Lack of CC equipment and logistics. This does not enable all health facilities to vaccinate everyday

3. Lack of qualified human resources especially at the operational level (USP)

4. The targets which are calculated and communicated to districts for 2013 are derived from the 2010 General census results. These results indicate that the children under one year represent 3.26% as against 4.50% used till then. These targets broken down at the district and health facilities level became very low. Hence, this had an impact on the number of children immunized. For example, the below table describes the targets which were used since 2010. It is observed that the application of 2010 census data (which were lower compared to the actual targets) negatively influenced the immunization coverage in 2013. That is why, in the monitoring conducted in September 2013, the program decided to re-adjust the targets for the rest of the year by using the general population from the 2010 census and the ratio of 4.15% as the ratio of live births. Hence, we could catch-up with a few children but the desired results were not achieved. This readjustment continued in 2014 and for the next years.

Ratio of surviving infants

Surviving infants population used

2010

4.28%

251,438

2011

4.28%

257,480

2012

4.28%

263,650

2013

3.07%

203,717

2013 adjusted from October

4.15%

274,489

2014

4.15%

282,574

5.3. Monitoring the implementation of GAVI gender policy

5.3.1. In the past five years, were the sex-disaggregated data on the coverage of DTP3, through administrative sources and/or surveys, available in your country? **Yes, available**

If yes, please provide us with the latest data available and indicate the year in which this data was collected.

Data Source	Year of reference for estimation	DTP3 coverage estimation	
		Boys	Girls
MICS 4	2010	42.5%	44.9%
ADMINISTRATIVE DATA 2012/	NUMBER OF CHILDREN IMMUNIZED FROM OCTOBER TO DECEMBER 2012	40,159 (50.23%)	39,794(49, 77%)
ADMINISTRATIVE DATA 2013/	NUMBER OF CHILDREN IMMUNIZED FROM JANUARY TO DECEMBER 2013	119,002 (50.09%)	118,565 (49.91%)

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

Gender-based data collection began in mid-2012 and will be available from 2014.
There are no gender-specific barriers related to immunization There is no gender-discrimination in Togo. Right to healthcare including immunization is ensured by the constitution to all Togolese citizens without gender or religious discrimination. Everybody, men and women, girls and boys, have the same rights and duties in all socio-economic activities of Togo. When the data from MICS 2010 survey in Togo is examined, note that the girls and boys have equal access to various services. The below table explains this exclusive right to all services.
In 2012, from October to December 2012, of the 79,953 immunized children under one year, 40,159 (50.23%) are Boys and 39,794 (49.77%) are Girls. These results correspond to the distribution of less than one year by gender (2010 census). Hence, there is no gender-based discrimination in the accessibility to immunization services in Togo.

TOGO

SEX

Male

Female

Infant mortality rate (%)

78.0

84.0

72.0

Infant and child mortality rate (%)

124.0

131.0

117.0

Under weight or height/age%

16.6

18.5

14.5

Growth retardation or height/weight ratio (%)

29.7

31.5

27.9

Emaciation or height/ratio (%)

4.8

5.9

3.6

Children under 6 months who are exclusively breastfed (%)

62.4

62.6

62.2

Vitamin supplements for children under 5 years (%)

88.1

87.6

88.6

Vaccine Coverage against Measles (%)

68.3

68.6

97.9

Children aged 12-23 months completely immunized (%)

43.7

42.5

44.9

Children aged 12-23 months who did not receive any vaccine (%)

3.8

2.5

5.2

Children under five years who sleep under an insecticide treated mosquito net in households with a mosquito net (%)

74.7

74.9

74.4

Children under 5 years who had diarrhea and received treatment by oral rehydration with further food supply (%)

23.6

22.6

24.8

Net attendance rate in primary schools (%)

88.7

90.7

86.6

Gender parity index (GPI) in primary schools (ratio)

1.0

Children under 5 years whose birth was registered in the civil status (%)

77.9

77.7

78.2

Children involved in child labor

46.6

44.2

49.1

Sources: MICS 2010 in Togo

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

5.3.4. How the gender-related barriers at the access and at the implementation of immunization services (for example, mothers having no access to the services, the gender of service provider of services, etc.) were resolved from the programs point of view? (For more information on these gender-related barriers, refer to the GAVI “Gender and immunization” sheet at http://www.gavialliance.org/fr/librairie/)

Not applicable

5.4. Data assessments

5.4.1. Please comment on any discrepancies between immunization 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 Immunization Coverage and the official country estimate are different)

There is no difference between the administrative data and WHO estimates. The WHO-UNICEF estimates considered the preliminary results from EPI review with vaccine coverage survey conducted in November - December 2012.

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

5.4.2. Have any assessments of administrative data systems been conducted from 2012 to the present? **No**

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

N/A

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

- Continue the implementation of DQS at district level in 2013,
- Revision of management tools (Registers, time sheets, monthly report sheets...) to include the introduction of new vaccines,
- Harmonization with DVD-MT and SMT data
- Use of EPI review results in 2012.
- Analysis of General Census on Population and Housing 2010 data

Training EPI and ISDR focal points in computerized EPI management (DVD-SMT) in September 2011

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.

- Monthly trainings for data harmonization at national level
- Continue monthly and bi-annual meetings to monitor EPI ISDR data at the national, regional and district level.

Set-up an incentive mechanism and monitoring districts in the implementation of DQS at their level.

5.5. Overall Expenditure and Financing for Immunization

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

Exchange rate used	1 US$ = 493.672	Enter just the exchange rate and not the name of local currency

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

Expenditures by Category	Year of Expenditure 2013	Sources of Finance						
		Country	GAVI	UNICEF	WHO	Rotary International	TOGO PLAN	UNFPA
Traditional vaccines*	324,309	324,309	0	0	0	0	0	0
New and Under-used Vaccines (NVS)**	1,372,312	169,000	1,203,312	0	0	0	0	0
Injection material (AD syringes and others)	3,545	0	3,545	0	0	0	0	0
Cold Chain equipment	105,057	0	3,778	0	0	101,279	0	0
Staff	68,893	0	21,892	6,919	40,082	0	0	0
Other routine recurrent costs	146,614	11,749	80,154	4,613	50,098	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	2,132,921	0	0	1,092,106	1,040,815	0	0	0
APR		0	0	0	0	0	0	0
Total Expenditures for Immunization	4,153,651							

Total Government Health expenditures		505,058	1,312,681	1,103,638	1,130,995	101,279	0	0

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

5.5.1. If no government funds are allocated to traditional vaccines, please find why and provide plans for expected sources of funding for 2014 and 2015

NOT APPLICABLE

5.6 Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Yes, partially implemented**

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

Action plan from Aide-Mémoire	Implementation?
Inclusion of HSS funds in the State Budget	Yes
Easing the management of recipient accounts of HSS funds	Yes
More support in custom clearance procedures	No
Final implementation of the new regulatory procedures of procurement procedures in MS.	Yes
Bi-annual audit of recipient accounts of HSS funds for the first 2 years of the program and annual audit for the 3rd and 4th year	No

If the above table shows that the plan from Aide-Mémoire was completely or partially implemented, briefly describe what was exactly executed.

Inclusion of HSS funds in the State Budget: the HSS funds are included in the 2013 State budget
• Easing the management of recipient accounts of HSS funds: a sub-account from the ISS account was created to receive HSS funds. At the regional level, accounts existing in these regions and districts were used to receive HSS fund transfers.
• More support in custom clearance procedures: a letter was sent to the Finance Minister for complete exemption for purchase of vaccines and supplies under HSS.
• Final implementation of the new regulatory procedures of procurement procedures in MS: as a part of restructuring public finance management, procedures were implemented at the Presidency and all Ministries.
• Bi-annual audit of recipient accounts of HSS funds for the first 2 years of the program and annual audit for the 3rd and 4th year: audit being prepared for end of June 2014

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

NOT APPLICABLE

5.7 Inter-Agency Coordination Committee (ICC)

How many times did the ICC meet in 2013? **3**

Please attach the minutes **(Document N°4)** from all the ICC meetings held in 2014, including those of the meeting endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Baseline data and current annual targets to Overall Expenditure and Financing for Immunization

Consider the 2012 EPI review results for training participants especially in adhering to the immunization schedule, creating awareness to parents/guardians to keep vaccination cards.

Take actions to improve vaccine coverage in districts with a high number of non or under immunized children with a specific emphasis for DTP-HepB-Hib3, MV and YFV as well as TT2

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

If yes, which ones?

List CSO members of ICC:
Federation of NGOs in Togo (FNGOTO)
Union of NGOs in Togo (UNGOTO)

5.8. Priority actions in 2014 to 2015

What are the country's main objectives and priority actions for its EPI program for2014to2015?

The main targets are:
1. Increase vaccine coverage at the national level in children
aged 0-11 months and in pregnant women from:
o 91% to 93% for Penta3 and OPV3,
o 86% to 89% for MV,
o 86% to 89% for YFV
o 81% to 89% for TT2+
2. Increase vaccine coverage to at least 80% in each district;
3. Achieve world/regional targets in performance indicators for national level eradication and elimination of avoidable diseases through immunization
o Polio: maintain the number of wild polio cases at zero
o Measles: maintain reduction in measles mortality at more than 98%
o MNT: maintain morbidity rate due to MNT (Maternal and Neonatal Tetanus) at less than 1 case per 1000 live births,
o Yellow fever: foresee and detect the yellow fever epidemic well in advance
throughout the country

The main activities for 2014 - 2015 are:

- Implementation of activities under the RED approach, in districts
- Celebration of the AIW (Advocacy meeting with partners, EPI visibility, HA Strengthening, and social mobility in districts)
- introduction of an IPV dose with the third dose of OPV

Conducting a National Polio Immunization Campaign based on epidemiological profile

- Supply of vaccines, syringes and BS to regions
- Introduction of new vaccines: vaccine against pneumococcal and vaccine against rotavirus and anti-HPV vaccine (demonstration project) and immunization campaign against Meningitis (MenAfriVac)

Financing advanced strategies by mobilizing local resources

Submission to GAVI/HSS for strengthening the health system

Strengthening the Cold chain

Strengthening capabilities: Training EPI managers and training in CC maintenance

Scaling up DQS to ensure reliability of data and quality of the monitoring system

organization of two national-level integrated workshops on monitoring EPI-ISDR-Nutrition and Reproductive Health every year

- Mobilization of partners for funding the RED approach in 2014 in the 6 regions to help strengthen advanced strategies, monitoring, and supervision
- Continuing to strengthen the search system for ignorant people (bill books, cards, monitoring tools)
- Integrating DQS in supervision to help improve the quality of data and strengthen the monitoring system
- Publishing the new immunization card
- Training local staff in CC management
- Introduction of the Rotavirus vaccine and pneumococcal vaccine in routine EPI (2013 end - 2014 beginning)

5.9. Progress of transition plan for injection safety

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

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

Vaccine	Types of syringe used in 2013 routine EPI	Funding sources of 2013
FR BCG	AD syringes	State
FR Measles	AD syringes	State
FR TT	AD syringes	State
FR DTP-containing vaccine	AD syringes	State/GAVI
	AD syringes	State/GAVI

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

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

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

Yes, the country has an injection safety policy based on the systematic use of AD syringes for injections, safety boxes to collect used AD syringes and incineration to destroy sharp wastes.
The main problems related to the mal-functioning, break-down of incinerators, lack of and obsolete equipment provided to the incineration staff on the sites.
The country also has a national waste management plan 2010 - 2014. This plan includes management of wastes from immunization services.

Please explain how in 2013 sharps have been eliminated, what were the problems, etc...

Systematic use of safety boxes for collection of used syringes is effective in all immunization centers.
- Every district has at least 2 Montfort type incinerators for destroying sharp wastes from immunization activities.
- A plan for collection and elimination of wastes is drafted at the beginning of every year by every district and implemented during the year to ensure the collection and elimination of wastes in all health facilities organized around the incineration site networks Apart from the stockouts of safety boxes, no other problem was encountered.

6. Immunization Services Support (ISS)

6.1. Report on the use of ISS funds in 2013

	Amount in USD	Amount in local currency
Funds received in2013 *(A)*	0	0
Remaining funds (carry over) from 2012 *(B)*	138,323	69,157,958
Total Available Funds in 2013 (C=A+B)	138,323	69,157,958
Total expenditures in 2013*(D)*	113,847	51,982,348
Balance carried over to 2014 *(E=C-D)*	24,476	17,175,610

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 program use.

The balance of funds transferred is made up of notional balance kept in the bank on January 1, 2013 (54,157,958 CFA Francs) and repayment of a loan of 15,000,000 CFA Francs as part of the implementation of EPI review in November 2012. This explains the amount of 69157958.

Funds received from ISS are included in the planning document from the Ministry of Health by the Directorate of Financial Affairs. This funding is communicated to the Ministry of Economy and Finances to be integrated in the external funding line (budgetary support).
Once the EPI action plans of districts, regions and central level are validated by ICC, the partners (WHO, UNICEF and Rotary) will decide on the funding of activities by considering the GAVI ISS funds. The Epidemiological Division prepares funding requests, which are submitted to the Director General of Health and Health Minister for approval. These requests are then sent to funding partners (GAVI, WHO, UNICEF and Rotary). Once these requests are approved, the funds are sent to the operational level by bank transfer to bank accounts of health regions.
After the execution of activities, every region sends the supporting documents and the technical report to the Epidemiological Division who verifies them and in turn sends them to the concerned partners. For using GAVI ISS and HSS funds, the same procedures are applicable.
No problem is encountered in the use of ISS funds: there is no delay in the availability of funds.

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 channeled 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

Government accounts managed by the Ministry of Health (for the receipt of funds) and by regions and districts (for routing) are used to manage GAVI funds
Once the EPI action plans for the districts, regions and central level are validated by ICC, the partners (WHO, UNICEF and Rotary) will decide on the funding of activities by considering the GAVI ISS funds. The Epidemiological Division prepares funding requests, which are submitted to the Director General of Health and Health Minister for approval. These requests are then sent to the funding partners (GAVI, WHO, UNICEF and Rotary). Once these requests are approved, the funds are sent to the operational level by bank transfer to bank accounts of the health regions.
After the execution of activities, every region sends the supporting documents and the technical report to the Epidemiological Division who verifies them and in turn sends them to concerned partners. For using GAVI ISS and HSS funds, the same procedures are applicable.

6.1.3. Please report on major activities conducted to strengthen immunization using ISS funds in 2013

The major activities executed with ISS funds in 2013 are:
- Implementation of RED approach
- Supervision of districts and regions by the central level
- Conduct EPI review (co-financing from WHO, UNICEF and GAVI ISS)
- Planning and management
- Maintenance of cold chamber

- Equipment and maintenance of computer hardware and mobile logistics
- Participation in operational expenses of the Epidemiological Division

6.1.4. Indicate whether ISS funds have been included in national health sector plans and budgets. **Yes**

6.2. Detailed expenditure of ISS funds during the calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2013 calendar year (Document No. 7). (Terms of reference for this financial statement are attached in Annex 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

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

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

6.3. Request for ISS reward

Request for ISS reward achievement in 2013 is applicable for Togo

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

7.1. Receipt of new & under-used vaccines for 2013 immunization program

7.1.1. Did you receive the approved amount of vaccine doses for the vaccination program in 2013 that GAVI communicated to you in its decision letter (DL)? Please fill the table below

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

	[A]	[B]		
Vaccine Type	**Total doses for 2013 in DL**	**Total doses received by 31 December 2013**	**Total doses of postponed deliveries in 2013**	**Has the country experienced a stock out at any level in 2013?**
DTP-HepB-Hib	600,000	543,500	56,500	No
Pneumococcal (PCV13)		0	0	No
Rotavirus		0	0	No
Yellow Fever	245,000	194,400	50,600	No

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

If the figures [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilization 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 color or because of the expiry date?...)

  The difference is explained by the fact thin Togo received the vaccine stocks financed by GAVI; the difference is for the stocks co-financed by Togo. These stocks are received in the first half of 2014.
  No problem was encountered in 2013 for the use of vaccines: DTP-HepB-Hib and Yellow fever

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

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

  N/A

If **Yes**, for any vaccine in **Table 7.1,** indicate the duration, reason and the impact of stock-out even if the stock-out occurred at central, regional, district or a lower level.

N/A

7.2. Introduction of a New Vaccine in 2013

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

Yellow fever, 10 dose (s) per vial, LYOPHILIZED		
PHASED INTRODUCTION	No	
Nationwide introduction [YES / NO]	No	
The time and scale of introduction was as planned in the proposal? If No, Why?	No	NOT APPLICABLE

Pneumococcal (PCV13), 1 dose (s) per vial, LIQUID		
PHASED INTRODUCTION	No	
Nationwide introduction [YES / NO]	No	
The time and scale of introduction was as planned in the proposal? If No, Why?	No	NOT APPLICABLE

Rotavirus, 1 dose (s) per vial, ORAL		
PHASED INTRODUCTION	No	
Nationwide introduction [YES / NO]	No	
The time and scale of introduction was as planned in the proposal? If No, Why?	No	NOT APPLICABLE

DTP-HepB-Hib, 10 dose (s) per vial, LIQUID		
PHASED INTRODUCTION	No	
Nationwide introduction [YES / NO]	No	
The time and scale of introduction was as planned in the proposal? If No, Why?	No	NOT APPLICABLE

7.2.2. When is the Post introduction evaluation (PIE) planned? **December 2015**

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 No.9))

NOT APPLICABLE

7.2.3. Post Immunization Adverse Events (PIAE)

Is there a national dedicated vaccine pharmaco-vigilance capacity? **Yes**

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

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

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

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

Has your country implemented a risk communication strategy along with national preparedness plans to deal with possible immunization issues? **Yes**

7.2.4. Supervision

Has your country set up a sentinel monitoring system for:

a. Rotavirus diarrhea? **Yes**

b. Bacterial meningitis or pneumococcal or meningococcal disease in children? **Yes**

Has your country conducted special studies on:

a. Rotavirus diarrhea? **Yes**

c. Bacterial meningitis or pneumococcal or meningococcal disease in children? **Yes**

If yes, the National Technical Advisory Group on Immunization (ITAG) or the Interagency Coordinating Committee (ICC), does it regularly examine the data from sentinel surveillance and special studies to make recommendations on the quality of data produced and on how to further improve the quality of data? **Yes**

Are you planning to use the data of national sentinel surveillance and / or special studies to monitor and assess the impact of the introduction and use of vaccines? **Yes**

Please describe the results of monitoring / special studies and NITAG / ICC contributions:

Monitoring of rotavirus diarrhea is effective on the sentinel site of CHU-Sylvanus Olympio since 2008. These data are shared with the regional WHO offices every month. Currently, it is observed that more than 50% of diarrheal stool samples of children aged less than 5 years at CHU-SO are due to rotavirus. Togo is keen on introducing the vaccine against Rotavirus to reduce the cases of serious diarrhea due to Rotavirus.

This recommendation was considered and Togo is preparing to introduce the vaccine against Rotavirus (Rotarix) before the end of the first half of 2014.

With regards to pediatric bacterial meningitis, this monitoring began in 2005 and the country shares this data also with the regional WHO offices on a monthly basis. This monitoring, for example, enabled to observe the disappearance of Haemophilus influenza, in children aged less than 5 years, since the introduction of DTP-HepB-Hib vaccine in 2008. However, there is an increase in cases of Pneumococcal Meningitis. By introducing this vaccine in routine EPI, Togo hopes to bring the cases of pneumococcal meningitis in children aged less than 5 years to zero. This recommendation was also considered and Togo is preparing to introduce the vaccine against Pneumococcal (PCV13) before the end of the first half of 2014.

7.3. Lump sum allocation for the introduction of a new vaccine in 2013

7.3.1. Financial Management Reporting

	Amount in USD	Amount in local currency
Funds received in 2013 (A)	0	0
Balance of funds carried forward from 2012	0	0
Total Available Funds in 2013 (C=A+B)	0	0
Total expenditures in 2013(D)	0	0
Balance carried over to 2014 (E=C-D)	0	0

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

Please attach a detailed financial statement for the use of ISS funds during the 2013 calendar year (Document No. 10, 11). (Terms of reference for this financial statement are attached in **Annex 1.)** Financial statements should be signed by the Finance Manager of the EPI Program and the EPI Manager, or by the Permanent Secretary of Ministry of Health.

7.3.2. Programmatic Reporting

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

NOT APPLICABLE

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

NOT APPLICABLE

Please describe the activities that will be undertaken with the balance of funds carried forward to 2014

NOT APPLICABLE

7.4. Report on country co-financing in 2013

Table 7.4: 5 questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2013?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Vaccine selected # 1: Yellow fever, 10 dose (s) per vial, LYOPHILIZED	49,000	50,600
Vaccine selected # 2: Pneumococcal (PCV13), 1 dose (s) per vial, LIQUID	0	0
Vaccine selected # 3: Rotavirus, 1 dose (s) per vial, ORAL	0	0
Vaccine selected # 4: DTP-HepB-Hib, 10 dose (s) per vial, LIQUID	120,000	56,500
	Q.2: What were the shares of country co-financing during the reporting year 2013 from the following sources?	
Government	169,000	
Donor	0	
Other	0	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Vaccine selected # 1: Yellow fever, 10 dose (s) per vial, LYOPHILIZED	0	0
Vaccine selected # 2: Pneumococcal (PCV13), 1 dose (s) per vial, LIQUID	0	0
Vaccine selected # 3: Rotavirus, 1 dose (s) per vial, ORAL	0	0
Vaccine selected # 4: DTP-HepB-Hib, 10 dose (s) per vial, LIQUID	0	0
	Q.4: When do you intend to transfer funds for co-financing in 2015 and what is the expected source of this funding?	
Schedule of Co-Financing Payments	Proposed Payment Date for 2015	Funding source

Vaccine selected # 1: Yellow fever, 10 dose (s) per vial, LYOPHILIZED	October	STATE
Vaccine selected # 2: Pneumococcal (PCV13), 1 dose (s) per vial, LIQUID	June	STATE
Vaccine selected # 3: Rotavirus, 1 dose (s) per vial, ORAL	September	STATE
Vaccine selected # 4: DTP-HepB-Hib, 10 dose (s) per vial, LIQUID	March	STATE
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilizing funding for immunization, including for co-financing.	
	This year also, Togo will request GAVI for a technical support for high level Advocacy for mobilizing State funds for funding immunization activities and health system strengthening. In 2013, the health funding from the government was less than 6% of the total state budget as against 15% as per the declaration of Abuja to which Togo had subscribed.	

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

NOT APPLICABLE

Is GAVI's new or under-used vaccines and injection supply support reported in national health sector budget? **Yes**

7.5 Vaccine Management (EVSM/EVM/VMA)

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. The progress of the implementation of this plan is reported in annual progress report. The EVM assessment is valid for a period of three years.

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

Please attach the following documents:

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

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

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

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

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

If yes, provide details

NOT APPLICABLE

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

7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

Togo does not provide a report on NVS as part of the prevention campaign

7.7. Change of vaccine presentation

Togo does not require changes in the vaccine presentation in the coming years.

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

The renewal of multi-year support for Togo is not available in 2014

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

In order to request NVS support for 2015 vaccination do the following:

Confirm here below that your request for2015 vaccines support is as per table 7.11 Calculation of requirements **Yes**

If you don't confirm, please explain:

NOT APPLICABLE

7.10. Weighted average prices of supplies and related freight costs

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight cost

Vaccine Antigens	Vaccine Type	No threshold	200,000$		250,000$	
			<=	>	<=	>
Yellow fever	YF	7.80%				
Type A meningococcal	MENINACONJUGATE	10.20%				
Pneumococcal (PCV10)	PNEUMO	3.00%				
Pneumococcal (PCV13)	PNEUMO	6.00%				
Rotavirus	ROTA	5.00%				
Measles second dose	MEASLES	14.00%				
DTP-HepB	HEPBHIB	2.00%				
HPV bivalent	HPV2	3.50%				
HPV quadrivalent	HPV2	3.50%				
RR	OR	13.20%				

Vaccine Antigens	Vaccine Type	500,000$		2,000,000$	
		<=	>	<=	>
Yellow fever	YF				
Type A meningococcal	MENINACONJUGATE				
Pneumococcal (PCV10)	PNEUMO				
Pneumococcal (PCV13)	PNEUMO				
Rotavirus	ROTA				
Measles second dose	MEASLES				
DTP-HepB	HEPBHIB				
DTP-HepB-Hib	HEPBHIB	25.50%	6.40%		
HPV bivalent	HPV2				
HPV quadrivalent	HPV2				
RR	OR				

7.11. Calculation of requirements

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

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	274,424	280,402	286,510	841,336
	Number of children to be vaccinated with the first dose	Table 4	#	267,985	274,794	280,780	823,559
	Number of children to be vaccinated with the third dose	Table 4	#	267,985	274,794	272,185	814,964
	Immunization coverage with	Table 4	%	97.65 %	98.00 %	95.00%	

	the third dose						
	Number of doses per child	Parameter:	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.23	1.11	1.11	
	Vaccine stock as at December 31, 2013 *(see explanatory note)		#	712,920			
	Vaccine stock as of January 1, 2014 *(see explanatory note)		#	712,920			
	Number of doses per vial	Parameter:	#		10	10	
	AD syringes required	Parameter:	#		Yes	Yes	
	Reconstitution syringes required	Parameter:	#		No	No	
	Safety boxes required	Parameter:	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40%	6.40%	
fd	**Freight cost as % of material value**	Parameter:	%		0.00%	0.00%	

* Stocks of vaccines on 31 December 2012: the country is requested to indicate the total closing stock on December 31 of the reporting year.

** The country is requested to indicate its opening stock on 1 January 2014, if there is a discrepancy between the stock on 31 December 2013 and 1 January 2014, please explain the reason in the box below.

NOT APPLICABLE

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

Not defined

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

Co-financing group	Low

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

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

		2014	2015
Number of vaccine doses	#	832,900	971,400
Number of AD syringes	#	915,300	1,082,100

Number of re-constitution syringes	#	0	0
Number of safety boxes	#	10,075	11,925
Total value to be co-financed by GAVI	$	1,747,500	2,063,500

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

		2014	2015
Number of vaccine doses	#	90,200	103,700
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value of country co-financing[1]	$	185,000	215,000

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

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-financing	*V*	0.00%	9.76 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	267,985	274,794	26,833	247,961
B1	Number of children to be vaccinated with the third dose	*Table 4*	267,985	274,794	26,833	247,961
C	Number of doses per child	*The immunization schedule*	3	3		
D	Number of doses required	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	803,955	824,382	80,499	743,883
E	Estimated vaccine wastage factor	*Table 4*	1.23	1.11		
F	Number of doses required including wastage	*D X E*		915,065	89,354	825,711
G	Buffer stock of vaccines	*((D - D of previous year) x 0.375) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.375)*		7,661	749	6,912
H	Stock to be deducted	*H1 - F of previous year x 0.375*				
H1	Calculated opening stock	*H2 (2014) + H3 (2014) - F (2014)*				
H2	Stock on 1st January	*Table 7.11.1*	0	712,920		
H3	Shipment plan	*UNICEF shipment report*		394,300		
I	Total vaccine doses required	*Round up((F + G - H) / vaccine package size) x vaccine package size*		923,000	90,128	832,872
J	Number of doses per vial	*Vaccine parameter*		10		
K	Number of Auto-disable syringes (AD syringes) required (+10% wastage)	*(D + G – H) x 1.10*		915,248	0	915,248
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*		0	0	0
M	Total number of safety boxes required (10% extra)	*(K + L) / 100 x 1.10*		10,068	0	10,068
N	Cost of the required vaccines	*1* price of vaccine per dose(g)*		1,776,775	173,497	1,603,278
O	Cost of AD syringes required	*K x AD syringe price per unit (ca)*		41,187	0	41,187
P	Cost of required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*		0	0	0
Q	Cost of the required safety boxes	*M X unit price of safety boxes (cs)*		51	0	51
R	Freight cost of required vaccines	*N x Freight cost as % of vaccines value (fv)*		113,714	11,104	102,610
S	Freight cost of required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*		0	0	0
T	Total funds required	*(N+O+P+Q+R+S)*		1,931,727	184,600	1,747,127
U	Total country co-financing	*I x Country co-financing per dose (cc)*		184,600		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		9.76 %		

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

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

		Formula	2015		
			Total	Government	GAVI
A	Country co-financing	*V*	9.64 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	280,780	27,080	253,700
B1	Number of children to be vaccinated with the third dose	*Table 4*	272,185	26,251	245,934
C	Number of doses per child	*The immunization schedule*	3		
D	Number of doses required	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	830,222	80,071	750,151
E	Estimated vaccine wastage factor	*Table 4*	1.11		
F	Number of doses required including wastage	*D X E*	921,547	88,878	832,669
G	Buffer stock of vaccines	*((D - D of previous year) x 0.375) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.375)*	2,431	235	2,196
H	Stock to be deducted	*H1 - F of previous year x 0.375*	-150,993	-14,562	-136,431
H1	Calculated opening stock	*H2 (2014) + H3 (2014) - F (2014)*	192,156	18,533	173,623
H2	Stock on 1st January	*Table 7.11.1*			
H3	Shipment plan	*UNICEF shipment report*			
I	Total vaccine doses required	*Round up((F + G - H) / vaccine package size) x vaccine package size*	1,075,000	103,678	971,322
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of Auto-disable syringes (AD syringes) required (+10% wastage)	*(D + G – H) x 1.10*	1,082,011	0	1,082,011
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*	0	0	0
M	Total number of safety boxes required (10% extra)	*(K + L) / 100 x 1.10*	11,903	0	11,903
N	Cost of the required vaccines	*1* price of vaccine per dose(g)*	2,095,175	202,068	1,893,107
O	Cost of AD syringes required	*K x AD syringe price per unit (ca)*	48,691	0	48,691
P	Cost of required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	Cost of the required safety boxes	*M X unit price of safety boxes (cs)*	60	0	60
R	Freight cost of required vaccines	*N x Freight cost as % of vaccines value (fv)*	134,092	12,933	121,159
S	Freight cost of required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	Total funds required	*(N+O+P+Q+R+S)*	2,278,018	215,000	2,063,018
U	Total country co-financing	*I x Country co-financing per dose (cc)*	215,000		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.64 %		

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

The calculated stock which is the stock level estimated by the end of year is negative. A negative calculated stock means that the consumption of the buffer stock would be needed to reach your planned target. Please explain the main reason(s) for replenishment of buffer stocks, such as higher than expected coverage, open vial wastage, other.

APR

The calculated stock which is the stock level estimated by the end of year is negative. A negative calculated stock means that the consumption of the buffer stock would be needed to reach your planned target. Please explain the main reason(s) for replenishment of buffer stocks, such as higher than expected coverage, open vial wastage, other.

APR

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

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	274,424	280,402	286,510	841,336
	Number of children to be vaccinated with the first dose	Table 4	#	0	272,048	0	272,048
	Number of children to be vaccinated with the third dose	Table 4	#		272,048	0	272,048
	Immunization coverage with the third dose	Table 4	%	0.00%	97.02 %	0.00%	
	Number of doses per child	Parameter:	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.00	1.05	1.00	
	Vaccine stock as at December 31, 2013 *(see explanatory note)		#	0			
	Vaccine stock as of January 1, 2014 *(see explanatory note)		#	0			
	Number of doses per vial	Parameter:	#		1	1	
	AD syringes required	Parameter:	#		Yes	Yes	
	Reconstitution syringes required	Parameter:	#		No	No	
	Safety boxes required	Parameter:	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.00%	6.00%	
fd	**Freight cost as % of material value**	Parameter:	%		0.00%	0.00%	

* Stocks of vaccines on 31 December 2012: the country is requested to indicate the total closing stock on December 31 of the reporting year.

** The country is requested to indicate its opening stock on 1 January 2014, if there is a discrepancy between the stock on 31 December 2013 and 1 January 2014, please explain the reason in the box below.

NOT APPLICABLE

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

Co-financing group	Low

	2013	2014	2015
Minimum co-financing	0.00	0.20	0.20
Your co-financing		0.20	0.20

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

		2014	2015
Number of vaccine doses	#	1,013,200	- 192,000
Number of AD syringes	#	1,133,500	- 224,400
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	12,475	- 2,450
Total value to be co-financed by GAVI	$	3,693,000	- 736,500

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

		2014	2015
Number of vaccine doses	#	59,700	- 11,300
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value of country co-financing[1]	$	215,000	0

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

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-financing	*V*	0.00%	5.56 %		
B	Number of children to be vaccinated with the first dose	*Table 4*	0	272,048	15,138	256,910
C	Number of doses per child	*The immunization schedule*	3	3		
D	Number of doses required	*B x C*	0	816,144	45,412	770,732
E	Estimated vaccine wastage factor	*Table 4*	1.00	1.05		
F	Number of doses required including wastage	*D X E*		856,952	47,682	809,270
G	Buffer stock of vaccines	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		214,238	11,921	202,317
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Stock on 1st January	*Table 7.11.1*	0			
I	Total vaccine doses required	*Round up((F + G - H) / vaccine package size) x vaccine package size*		1,072,800	59,692	1,013,108
J	Number of doses per vial	*Vaccine parameter*		1		
K	Number of Auto-disable syringes (AD syringes) required (+10% wastage)	*(D + G – H) x 1.10*		1,133,421	0	1,133,421
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*		0	0	0
M	Total number of safety boxes required (10% extra)	*(K + L) / 100 x 1.10*		12,468	0	12,468
N	Cost of the required vaccines	*1* price of vaccine per dose(g)*		3,637,865	202,416	3,435,449
O	Cost of AD syringes required	*K x AD syringe price per unit (ca)*		51,004	0	51,004
P	Cost of required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*		0	0	0
Q	Cost of the required safety boxes	*M X unit price of safety boxes (cs)*		63	0	63
R	Freight cost of required vaccines	*N x Freight cost as % of vaccines value (fv)*		218,272	12,145	206,127
S	Freight cost of required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*		0	0	0
T	Total funds required	*(N+O+P+Q+R+S)*		3,907,204	214,560	3,692,644
U	Total country co-financing	*I x Country co-financing per dose (cc)*		214,560		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		5.56 %		

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

		Formula	2015		
			Total	Government	GAVI
A	Country co-financing	*V*	5.60%		
B	Number of children to be vaccinated with the first dose	*Table 4*	0	0	0
C	Number of doses per child	*The immunization schedule*	3		
D	Number of doses required	*B x C*	0	0	0
E	Estimated vaccine wastage factor	*Table 4*	1.00		
F	Number of doses required including wastage	*D X E*	0	0	0
G	Buffer stock of vaccines	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	- 204,036	- 11,423	- 192,613
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	Stock on 1st January	*Table 7.11.1*			
I	Total vaccine doses required	*Round up((F + G - H) / vaccine package size) x vaccine package size*	- 203,400	- 11,387	- 192,013
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of Auto-disable syringes (AD syringes) required (+10% wastage)	*(D + G – H) x 1.10*	- 224,439	0	- 224,439
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*	0	0	0
M	Total number of safety boxes required (10% extra)	*(K + L) / 100 x 1.10*	- 2,468	0	- 2,468
N	Cost of the required vaccines	*1* price of vaccine per dose(g)*	- 685,458	- 38,377	- 647,081
O	Cost of AD syringes required	*K x AD syringe price per unit (ca)*	- 10,099	0	- 10,099
P	Cost of required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	Cost of the required safety boxes	*M X unit price of safety boxes (cs)*	- 12	0	- 12
R	Freight cost of required vaccines	*N x Freight cost as % of vaccines value (fv)*	- 41,127	- 2,302	- 38,825
S	Freight cost of required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	Total funds required	*(N+O+P+Q+R+S)*	- 736,696	0	- 736,696
U	Total country co-financing	*I x Country co-financing per dose (cc)*	- 40,680		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	5.60%		

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

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	274,424	280,402	286,510	841,336
	Number of children to be vaccinated with the first dose	Table 4	#	0	272,048	0	272,048
	Number of children to be vaccinated with the second dose	Table 4	#		272,048	0	272,048
	Immunization coverage with the second dose	Table 4	%	0.00%	97.02%	0.00%	
	Number of doses per child	Parameter:	#	2	2	2	
	Estimated vaccine wastage factor	Table 4	#	1.00	1.05	1.00	
	Vaccine stock as at December 31, 2013 *(see explanatory note)		#	0			
	Vaccine stock as of January 1, 2014 *(see explanatory note)		#	0			
	Number of doses per vial	Parameter:	#		1	1	
	AD syringes required	Parameter:	#		No	No	
	Reconstitution syringes required	Parameter:	#		No	No	
	Safety boxes required	Parameter:	#		No	No	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		5.00%	5.00%	
fd	**Freight cost as % of material value**	Parameter:	%		0.00%	0.00%	

* Stocks of vaccines on 31 December 2012: the country is requested to indicate the total closing stock on December 31 of the reporting year.

** The country is requested to indicate its opening stock on 1 January 2014, if there is a discrepancy between the stock on 31 December 2013 and 1 January 2014, please explain the reason in the box below.

NOT APPLICABLE

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

Co-financing group	Low

	2013	2014	2015
Minimum co-financing	0.00	0.20	0.20
Your co-financing		0.20	0.20

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

		2014	2015
Number of vaccine doses	#	662,300	- 124,900
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by GAVI	$	1,781,000	- 361,500

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

		2014	2015
Number of vaccine doses	#	53,300	- 10,000
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value of country co-financing[1]	$	143,500	0

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

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-financing	*V*	0.00%	7.44%		
B	Number of children to be vaccinated with the first dose	*Table 4*	0	272,048	20,234	251,814
C	Number of doses per child	*The immunization schedule*	2	2		
D	Number of doses required	*B x C*	0	544,096	40,468	503,628
E	Estimated vaccine wastage factor	*Table 4*	1.00	1.05		
F	Number of doses required including wastage	*D X E*		571,301	42,491	528,810
G	Buffer stock of vaccines	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		142,826	10,623	132,203
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Stock on 1st January	*Table 7.11.1*	0			
I	Total vaccine doses required	*Round up((F + G - H) / vaccine package size) x vaccine package size*		715,500	53,216	662,284
J	Number of doses per vial	*Vaccine parameter*		1		
K	Number of Auto-disable syringes (AD syringes) required (+10% wastage)	*(D + G – H) x 1.10*		0	0	0
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*		0	0	0
M	Total number of safety boxes required (10% extra)	*(I / 100) x 1.10*		0	0	0
N	Cost of the required vaccines	*1* price of vaccine per dose(g)*		1,832,396	136,286	1,696,110
O	Cost of AD syringes required	*K x AD syringe price per unit (ca)*		0	0	0
P	Cost of required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*		0	0	0
Q	Cost of the required safety boxes	*M X unit price of safety boxes (cs)*		0	0	0
R	Freight cost of required vaccines	*N x Freight cost as % of vaccines value (fv)*		91,620	6,815	84,805
S	Freight cost of required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*		0	0	0
T	Total funds required	*(N+O+P+Q+R+S)*		1,924,016	143,100	1,780,916
U	Total country co-financing	*I x Country co-financing per dose (cc)*		143,100		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		7.44%		

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

		Formula	2015		
			Total	Government	GAVI
A	Country co-financing	*V*	7.46%		
B	Number of children to be vaccinated with the first dose	*Table 4*	0	0	0
C	Number of doses per child	*The immunization schedule*	2		
D	Number of doses required	*B x C*	0	0	0
E	Estimated vaccine wastage factor	*Table 4*	1.00		
F	Number of doses required including wastage	*D X E*	0	0	0
G	Buffer stock of vaccines	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	- 136,024	- 10,148	- 125,876
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	Stock on 1st January	*Table 7.11.1*			
I	Total vaccine doses required	*Round up((F + G - H) / vaccine package size) x vaccine package size*	- 135,000	- 10,072	- 124,928
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of Auto-disable syringes (AD syringes) required (+10% wastage)	*(D + G – H) x 1.10*	0	0	0
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*	0	0	0
M	Total number of safety boxes required (10% extra)	*(I / 100) x 1.10*	0	0	0
N	Cost of the required vaccines	*1* price of vaccine per dose(g)*	- 344,655	- 25,714	- 318,941
O	Cost of AD syringes required	*K x AD syringe price per unit (ca)*	0	0	0
P	Cost of required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	Cost of the required safety boxes	*M X unit price of safety boxes (cs)*	0	0	0
R	Freight cost of required vaccines	*N x Freight cost as % of vaccines value (fv)*	- 17,232	- 1,285	- 15,947
S	Freight cost of required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	Total funds required	*(N+O+P+Q+R+S)*	- 361,887	0	- 361,887
U	Total country co-financing	*I x Country co-financing per dose (cc)*	- 27,000		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	7.46%		

Table 7.11.1: Characteristics for Yellow fever, 10 dose (s) per vial, LYOPHILIZED

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	274,424	280,402	286,510	841,336
	Number of children to be vaccinated with the first dose	Table 4	#	241,461	260,774	272,185	774,420
	Number of doses per child	Parameter:	#	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	1.23	1.22	1.19	
	Vaccine stock as at December 31, 2013 *(see explanatory note)		#	44,740			
	Vaccine stock as of January 1, 2014 *(see explanatory note)		#	44,740			
	Number of doses per vial	Parameter:	#		10	10	
	AD syringes required	Parameter:	#		Yes	Yes	
	Reconstitution syringes required	Parameter:	#		Yes	Yes	
	Safety boxes required	Parameter:	#		Yes	Yes	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0450	0.0450	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0050	0.0050	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		7.80%	7.80%	
fd	**Freight cost as % of material value**	Parameter:	%		10.00%	10.00%	

* Stocks of vaccines on 31 December 2012: the country is requested to indicate the total closing stock on December 31 of the reporting year.

** The country is requested to indicate its opening stock on 1 January 2014, if there is a discrepancy between the stock on 31 December 2013 and 1 January 2014, please explain the reason in the box below.

APR

Co-financing table for Yellow fever, 10 dose (s) per vial, LYOPHILIZED

Co-financing group	Low

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

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

		2014	2015
Number of vaccine doses	#	231,500	267,700
Number of AD syringes	#	243,500	302,600
Number of re-constitution syringes	#	30,700	36,000
Number of safety boxes	#	3,025	3,725
Total value to be co-financed by GAVI	$	285,500	311,000

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

2014	2015

Number of vaccine doses	#	47,300	59,200
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value of country co-financing[1]	$	56,000	65,500

Table 7.11.4: Calculation of requirements for Yellow fever, 10 dose (s) per vial, LYOPHILIZED (section 1)

		Formula	2013	2014		
				Total	Government	GAVI
A	Country co-financing	*V*	0.00%	16.96%		
B	Number of children to be vaccinated with the first dose	*Table 4*	241,461	260,774	44,224	216,550
C	Number of doses per child	*The immunization schedule*	1	1		
D	Number of doses required	*B x C*	241,461	260,774	44,224	216,550
E	Estimated vaccine wastage factor	*Table 4*	1.23	1.22		
F	Number of doses required including wastage	*D X E*		318,145	53,954	264,191
G	Buffer stock of vaccines	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*		5,287	897	4,390
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Stock on 1st January	*Table 7.11.1*	0			
I	Total vaccine doses required	*Round up((F + G - H) / vaccine package size) x vaccine package size*		278,700	47,264	231,436
J	Number of doses per vial	*Vaccine parameter*		10		
K	Number of Auto-disable syringes (AD syringes) required (+10% wastage)	*(D + G – H) x 1.10*		243,454	0	243,454
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*		30,658	0	30,658
M	Total number of safety boxes required (10% extra)	*(K + L) / 100 x 1.10*		3,016	0	3,016
N	Cost of the required vaccines	*1* price of vaccine per dose(g)*		304,898	51,707	253,191
O	Cost of AD syringes required	*K x AD syringe price per unit (ca)*		10,956	0	10,956
P	Cost of required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*		123	0	123
Q	Cost of the required safety boxes	*M X unit price of safety boxes (cs)*		16	0	16
R	Freight cost of required vaccines	*N x Freight cost as % of vaccines value (fv)*		23,783	4,034	19,749
S	Freight cost of required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*		1,110	0	1,110
T	Total funds required	*(N+O+P+Q+R+S)*		340,886	55,741	285,145
U	Total country co-financing	*I x Country co-financing per dose (cc)*		55,740		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		16.96%		

Table 7.11.4: Calculation of requirements for Yellow fever, 10 dose (s) per vial, LYOPHILIZED (section 2)

		Formula	2015		
			Total	Government	GAVI
A	Country co-financing	*V*	18.10%		
B	Number of children to be vaccinated with the first dose	*Table 4*	272,185	49,267	222,918
C	Number of doses per child	*The immunization schedule*	1		
D	Number of doses required	*B x C*	272,185	49,267	222,918
E	Estimated vaccine wastage factor	*Table 4*	1.19		
F	Number of doses required including wastage	*D X E*	323,901	58,628	265,273
G	Buffer stock of vaccines	*((D - D of previous year) x 0.25) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.25)*	2,853	517	2,336
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	Stock on 1st January	*Table 7.11.1*			
I	Total vaccine doses required	*Round up((F + G - H) / vaccine package size) x vaccine package size*	326,800	59,152	267,648
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of Auto-disable syringes (AD syringes) required (+10% wastage)	*(D + G – H) x 1.10*	302,542	0	302,542
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*	35,948	0	35,948
M	Total number of safety boxes required (10% extra)	*(K + L) / 100 x 1.10*	3,724	0	3,724
N	Cost of the required vaccines	*1* price of vaccine per dose(g)*	334,970	60,631	274,339
O	Cost of AD syringes required	*K x AD syringe price per unit (ca)*	13,615	0	13,615
P	Cost of required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*	144	0	144
Q	Cost of the required safety boxes	*M X unit price of safety boxes (cs)*	19	0	19
R	Freight cost of required vaccines	*N x Freight cost as % of vaccines value (fv)*	26,128	4,730	21,398
S	Freight cost of required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	1,378	0	1,378
T	Total funds required	*(N+O+P+Q+R+S)*	376,254	65,360	310,894
U	Total country co-financing	*I x Country co-financing per dose (cc)*	65,360		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	18.10%		

8. Injection Safety Support (INS)

This type of support is no longer available

9. Health System Strengthening Support (HSS)

Instructions for reporting on HSS funds received

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

   a. The progress achieved in 2013

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

   c. Plans for 2015

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

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

2. In order to better align HSS support reporting to country processes, for countries of which the 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **15th May 2014**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2014, the HSS reports are expected by GAVI Alliance by September2014.

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

4. If you would like to modify the objectives, activities and pre-approved budgets (reprogramming), please ask the person in charge of your country at the GAVI Secretariat for guidelines on reprogramming or send an email at gavihss@gavialliance.org.

5. If you are requesting additional funds, 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 the HSCC meetings held in 2013

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

   c. Latest Health Sector Review Report

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

   e. External audit report of 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 installments of HSS funding:

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

   b. Demonstrating (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 monitor 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 installment of HSS funds.

9.1. Report on the use of ISS funds in 2013 and request for additional funds

Countries that have already received the final disbursement of GAVI approved funds under HSS grant and require no further financing: Is the implementation of HSS grant completed? YES/NO If NO, please indicate the anticipated date for completion of the HSS grant. **No**

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

December 2015

Please attach all studies and evaluations related to GAVI HSS grant or financed by it.

Please attach the gender disaggregated data, if any, by rural/urban areas, district/state, especially for immunization coverage indicators. This is mainly important if the GAVI HSS grants are used to target populations and/or specific geographic locations in the country.

If the CSOs are involved in HSS implementation, please attach a list of those involved in implementing the grant, financing received by CSOs for GAVI HSS grant and activities that are conducted. If the CSO involvement was already planned in the initial proposal approved by GAVI, but no financing was provided to CSOs, please explain why. Go to http://www.gavialliance.org/support/cso/, for the GAVI CSO implementation framework.

The involvement of the civil society in Togo in the health system strengthening is expressed from the beginning of the preparation of HSS support. This civil society (UONGTO) benefitted from the GAVI Alliance support in two steps; for mapping the NGOs involved in immunization and for institutional strengthening of these organizations. Some on-going HSS support activities relates to the installation of NGOs. For example, for executing Activity 1.2: “Establish performance contracts with 420 community health workers (CHW) in the intervention zones concerning IMCI activities at the community level”, the NGOs and associations are already working with these CHWs that will help them monitor their activities.

Further, the civil society participates in deciding the guidelines to be given to various support implementation bodies.

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

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

Please attach the latest report of national/monitoring and evaluation framework results of the health sector (with actual data reported for the latest year available in the country).

9.1.1. Report on the use of HSS funds in **2013**

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 program 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: US$ **1273507**

These funds will be sufficient to ensure the HSS allocation until December 2015.

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

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

Table 9.1.3a $(US)

	2008	2009	2010	2011	2012	2013

Original annual budgets (*as per the originally approved HSS proposal*)				1,200,492	1,224,500	1,249,000
Revised annual budget (*if revised during a review of the previous years' annual reports*)				0	0	0
Total funds received from GAVI during the calendar year (A)				1,200,492	0	1,224,500
Remaining funds (carry over) from previous year (*A*)				0	1,200,492	234,073
Total Funds available during the calendar year (C=A+B)				1,200,492	1,200,492	1,458,573
Total expenditure during the calendar year (*D*)				0	966,419	179,628
Balance carried forward to the next calendar year (E=C-D)				1,200,492	234,073	1,278,945
Amount of funding requested for future calendar year(s) [please ensure that you complete this row if you are requesting additional funds]	0	0	0	0	1,224,500	1,249,000

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	1,273,507			
Revised annual budget (*if revised during a review of the previous years' annual reports*)	0			
Total funds received from GAVI during the calendar year (A)	1,249,000			
Remaining funds (carry over) from previous year (*A*)	1,278,945			
Total Funds available during the calendar year (C=A+B)	2,527,945			
Total expenditure during the calendar year (*D*)				
Balance carried forward to the next calendar year (E=C-D)				
Amount of funding requested for future calendar year(s) [please ensure that you complete this row if you are requesting additional funds]	1,273,507	0	0	0

Table 9.1.3b (Local currency)

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)				533,018,670	614,258,180	626,548,360
Revised annual budget (*if revised during a review of the previous years' annual reports*)				0	0	0
Total funds received from GAVI during the calendar year (A)				533,018,670	0	614,258,180
Remaining funds (carry over) from previous year (*A*)				0	533,018,670	103,928,590
Total Funds available during the calendar year (C=A+B)				533,018,670	533,018,670	718,186,770
Total expenditure during the calendar year (*D*)				0	429,090,080	89,454,583
Balance carried forward to the next calendar year (E=C-D)					103,928,590	628,732,187
Amount of funding requested for future calendar year(s) [please ensure that you complete this row if you are requesting additional funds]	0	0	0	0	614,258,180	626,548,360

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	638,842,051			
Revised annual budget (*if revised during a review of the previous years' annual reports*)				
Total funds received from GAVI during the calendar year (A)				
Remaining funds (carry over) from previous year (*A*)				
Total Funds available during the calendar year (C=A+B)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to the next calendar year (E=C-D)				
Amount of funding requested for future calendar year(s) [please ensure that you complete this row if you are requesting additional funds]	638,842,051	0	0	0

Report of Exchange Rate Fluctuation

Please indicate in Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2008	2009	2010	2011	2012	2013
Opening on 1st January				444	500.495	494.592
Closing on 31st December					501.64	482.889

Detailed expenditure of HSS funds during the 2013 calendar year

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

If any expenditures for the January April 2014 period are reported in Tables14, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

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

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

The HSS funds are deposited in a commercial bank (Eco bank). The budget proposed by the coordination unit, validated by the support implementation group, is adopted by HSCC, now converted to the Health Coordination Committee - HIV/AIDS.
Funds received under HSS are included in the planning document of the Ministry of Health by the Directorate of Financial Affairs. This funding is communicated to the Ministry of Economy and Finances to be integrated in the external funding line (budgetary support).

Once the HSS action plans for districts, regions and central level are validated by HSCC, the coordination unit prepares the funding requests, which are submitted to the Implementation Group for approval. Once these requests are approved, the funds are sent to the operational level by bank transfer to bank accounts of health regions.
After the execution of activities, every region sends the supporting documents and the technical report to the coordination unit which, in turn, verifies them and sends them to the implementation group before their archival.
No problem is encountered in the use of HSS funds: there is no delay in the availability of funds.

Note: Togo received funds for the 1st year at the end of 2011 and these funds helped implementing the activities in 2012. Togo did not receive funds in 2012, but in 2013, it received funds in 2013.

The process of recruiting a firm followed the intellectual procurement process. This majorly delayed the execution of external audit. However, the process is about to end and the audit for the last two years (2012-2013) will be conducted in April 2014

Has an external audit been conducted? No

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

9.2. Progress on HSS activities in the 2013 fiscal year

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

Please provide the following information for each planned activity:

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

Table 9.2: HSS activities in the 2013 reporting year

Major Activities (insert as many rows as necessary)	**Activity planned for 2013**	**Percentage of Activity completed** (annual) (where applicable)	**Source of information/data** (if relevant)
Objective 1: Increase the coverage in integrated and rationalized basic services, to at least 80%, in the 21 health districts showing a poor vaccine coverage and Minimum Activities Package by 2015.	Activity 1.1: Recruitment of 3 surgeons or obstetricians/gynecologists, 10 midwives, 42 registered nurses, 20 registered assistant midwives, all based on performance agreements	80	EPI Annual Report REPORT FROM THE DIRECTORATE OF HUMAN RESOURCES
	Activity 1.2: Establish performance contracts with 420 community health workers in the intervention zones concerning IMCI activities at the community level	30	EPI Annual Report REPORT FROM THE DIRECTORATE OF HUMAN RESOURCES
	Activity 1.3: Construct 8 staff quarters for head nurses and registered midwives	70	EPI Annual Report INFRASTRUCTURE AND EQUIPMENT SERVICES

			REPORT Districts report
	Activity 1.6 : Rehabilitate 6 PHUs (not covered under the state project and other partners) in the intervention zone	70	EPI Annual Report INFRASTRUCTURE AND EQUIPMENT SERVICES REPORT Districts report
	Activity 1.7 : Equip 36 PHUs with medico-technical equipment (14 PHUs rehabilitated and 22 new constructed by the State)	70	EPI Annual Report INFRASTRUCTURE AND EQUIPMENT SERVICES REPORT
	Activity 1.8 : Provide motorcycles to 25 PHUs for advanced strategy	100	EPI Annual Report INFRASTRUCTURE AND EQUIPMENT SERVICES REPORT Districts report
	Activity 1.9 : Equip 5 rehabilitated and isolated PHUs with solar power devices for continuous power supply to the cold chain	90	EPI Annual Report INFRASTRUCTURE AND EQUIPMENT SERVICES REPORT
	Activity 1.10: Provide 420 bicycles to CHWs involved in search for the ignorant and in monitoring potential epidemic diseases in support zone communities.	50	EPI Annual Report INFRASTRUCTURE AND EQUIPMENT SERVICES REPORT
Objective 2: Increase the access of women and children aged less than 5 years, to quality health care services, in 21 districts with a low vaccine coverage, to at least 90%, by 2013.	Activity 2.2: Train 6 regional and 21 district teams in managing the district health system	100	EPI Annual Report TRAINING REPORT TRAINING DEPARTMENT REPORT
	Activity 2.3: Train 2 senior members in CESAG	100	EPI Annual Report EPI Annual Report TRAINING REPORT TRAINING DEPARTMENT REPORT
	Activity 2.8: Organize 2 integrated supervision missions at district level, 1 integrated supervision mission at regional level and 1 supervision mission at national level	100	EPI Annual Report Districts report
	Activity 2.9 : Conduct internal and external audits in financial management in 21 districts and 05 regions	60	EPI Annual Report
	Activity 2.11a: Support the experience-sharing and information-sharing meetings once a year for 21 districts	0	EPI Annual Report Districts report

	Activity 2.12: Organize integrated priority intervention monitoring twice a year (PMA)	100	EPI Annual Report Districts report
	Activity 2.13: Finance the gap for updating district health standards in line with RED support.	100	EPI Annual Report
	Activity 2.11b Organize annual national review to measure progress at the end of 2013 (for 3 days for 70 people) with the participation from regional and district focal points in addition to the district and regional Directors and CSOs involved.	25	EPI Annual Report
REPOSITIONING ACTIVITIES FOR THE REMAINING FROM 2012	1. Conduct preparatory activities before the operational action plan 2013	100	EPI Annual Report
	2. Providing the Ministry of Health with a straight block truck for transporting inputs to regions and districts under the health programs.	80	EPI Annual Report
	3. Providing the central level with a 4x4 vehicle for integrated monitoring.	80	EPI Annual Report

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

Major Activities (insert as many rows as necessary)	**Explain progress achieved and constraints**
Activity 1.1 : Recruit on a contract-basis	The activity was 80% completed The tenders were completed. More than 400 candidates were short-listed and evaluated. 50 candidates were selected and retained. The contract signing process for allocating their post is in progress. This process coincided with the recruitment assessments for health workers by the State, and the results are awaited.
Activity 1.2: Preparation of performance contracts	The activity was 30% completed The performance contracts were drafted and validated. The identification of CHWs was delayed for concerns of having an integrated activities package harmonizing all CHWs including those already on site.
Activity 1.3: Construct 8 staff quarters	In response to the tenders, two (2) companies were selected and the work began in November 2013. Currently, the activity is evaluated at 80% and will soon be completed. In view of the current market costs, the funds planned could cover the construction of only seven of the eight staff quarters planned.
Activity 1.6: Rehabilitate 6 PHUs (not covered)	In response to the tenders, three (03) companies were selected and the work began in November 2013. Currently, the activity is evaluated at 80% and will soon be completed. The budget could cover the rehabilitation of only 5 of the 6 PHUs planned.
Activity 1.7 : Equip with medico-technical materials	The activity was 70% completed In response to the tenders, a company was selected for the supply of this material. The contract is signed. The material is yet to be supplied.
Activity 1.8 : Provide motorcycles to 25 PHUs for the advanced strategy	The activity was 100% completed No major obstacles in executing this activity.
Activity 1.9 : Equip 5 rehabilitated and isolated PHUs	The activity is 90% complete. The entire process is about to finish.

Activity 1.10: Equip health zone communities	The tender is completed; the evaluation of tenders was unsuccessful as none of the bidders qualified. The process will be repeated with the support from Partners like UNICEF, WHO and Rotary.
Activity 2.2: Train 6 regional and 21 district teams	52 management teams were trained in leadership, management and health management system. These health system managers at all levels use skills acquired to improve district management.
Activity 2.3: Train 2 senior members in CESAG	The activity is 100% completed. 3 teams are trained in risk management. These teams, in turn, prepared a training plan for all health system managers at all levels, in project/program risk management. A team from the planning department was trained in result-based planning and management.
Activity 2.8: Organize 2 supervision missions	A supervision mission was organized by the national level. This mission evaluated the material use level (computers, vehicles, photocopiers, procedure documents, description of posts) and the medicine recovery level.
Activity 2.9: Organize an internal and an external audit	The tender is completed, procurement completed, audit will be finalized in April.
Activity 2.11a: Support the experience-sharing and information-sharing meetings once a year	Activity not executed, organization of this sharing meetings is planned for 2014.
Activity 2.12: Organize twice a year	Support was provided to the district of plateaux region for implementing the “reach every district” approach (RED). This helped improving the immunization coverage in this region.
Activity 2.13: Finance the financial gap for activities	The activity was 100% completed The standards document is available
Activity 2.11b Organize annual national review	Activity in progress at the national level
REPOSITIONING ACTIVITIES FOR THE REMAINING PROGRMS FROM 2012	
1. Conduct preparatory activities as a prelude	100% completed
2. Equip the ministry of health with a truck	Tender documents for procurement of goods and services are prepared, procurement completed, acquisition of the vehicle is in progress
3. Providing the central level with a 4x4 vehicle	Tender documents for procurement of goods and services are prepared, procurement completed, acquisition of the vehicle is in progress

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

Activities 1.1 and 1.2 were not completed as the process of recruiting technical staff coincided with the recruitment drive for the health workers by the State, and the results are awaited.

Activities 13; 1.3; 1.7; 1.9 and 1.10 were not completed as the procurement processes were delayed or even cancelled for a few (1.10)

9.2.3 If the GAVI HSS grant has been utilized 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 funds helped in implementing the policy or national guidelines on human resources:
Strengthening capabilities of onsite participants was a motivating factor: training, leadership and management of the system enabled these workers to better execute their activity. This is a motivating factor. Provision of motorcycles and vehicles for advanced strategy and supervision of health facilities is another motivating factor for the human resources.
Construction of staff quarters, rehabilitation of a few health facilities, and provision of medico-technical

equipment and provision of solar energy to certain PHUs are some incentives provided for workers to retain them in their position.

9.3. General overview of targets achieved

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

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2013 target						Data Source	Explanation if any targets were not achieved
	Baseline Value	Baseline source/date			2009	2010	2011	2012	2013		
1. National Coverage for DTP3 (%)	76%	EPI review 2006	90%					84%			
	88%(2007)	EPI administrative data	90%	94%	89%	92%	92%	91%	87%	Administrative data 2013	RED funding deficit
2. Number / % of districts achieving ≥ 80% of coverage for DTP3	50%(3/6)	EPI review 2006	100%								
	80%(2008)	EPI administrative data	95		83%	89%	86	94%	90%	Administrative data 2013	RED funding deficit
3. Vaccine coverage in MV (Measles)	63.1%	MICS3	> OR = 66%					71.7%		REVIEW 2012	
	80% (2008)	EPI administrative data	95	91%	84%	85%	85	87	82%	EPI administrative data 2013	RED funding deficit
4. Children completely immunized	49.2%	MICS 3	> OR = 55%					70			
5. Maternal mortality rate (for 100,000 live births) Rate of assisted childbirth by qualified personnel.	478 for 100000 live births	EDSTII	120 for 100,000 live births					300			
6. Mortality Rate for children less than five years of age (for 1,000 live births)	123 for 1000	MICS3	118 for 1000					123			
7. Rate of assisted childbirth by qualified personnel.	62%	MICS3	> 80%					60			
8. Coverage in prenatal consultation PNC4	53.5%	AS-SR	> 70%					55			
9. Ratio of districts in the intervention zone having guides and maintenance	0	Activity Reports	> Or = 90%					100	100%		

procedures developed											
10. Percentage of health facilities who received regular supervision visits per year	50	Annual report of health activities from the Ministry of Health	> Or = 75%					50	50%		Interferences from other health system activities did not enable completing the supervision activities.
11. Percentage of districts using self-copying register for data management	0	Annual report of health activities from the Ministry of Health	> Or = 80%					2.77%	0		Process of implementing carbonless registers was stopped for lack of funding for the purchase of registers and for recruiting data entry operators.

9.4 Program implementation in 2013

9.4.1. Please provide a narrative on major accomplishments in 2013, especially impacts on health service programs, and how the HSS funds have proved useful to the immunization system.

- Construction of staff quarters enables staff working in these facilities to be more motivated to stay and be more available.
- Rehabilitation of seven health facilities and their equipment will make these facilities more attractive and increases their usage rate.

- Provision of rolling logistics to 25 health facilities (25 motorbikes to PHUs for advanced strategy) helped the health facilities to carry out their advanced strategy activities including immunizations, pre-natal consultations, monitoring and promoting the growth of young children...

- The contribution of GAVI HSS funds enabled funding the reach every district approach in a region that did not have funding for this activity for three years.

- These funds will also help implementing the health system review at national level.

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

This year also, the main problems were programmatic in nature. There were constraints in coordinating various funding sources and sharing real-time information. To address these constraints, we strengthened the information sharing (all documents related to operational action plans, TDR of activities and periodic reports) by using various available channels (presentations at coordination meetings, sharing printed documents and through e-mails.)

The national public procurement procedures, even though they are in the third year of implementation, are long and cumbersome, and may extend the deadline for completing certain activities. Based on the lessons learnt from the first year of implementing the support, this aspect was considered while preparing the action plans and activity schedules in order not to underestimate the time required for completing the activities subject to public procurements. However, disputes of tender evaluation results by unsuccessful bidders delayed the time for signing contracts. Some contracts were cancelled and processes repeated.

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

The guide for operational action plans (OAP) at each level of the health pyramid designed a uniform format with details of funding sources and activity in-charges. This facilitates the traceability of GAVI-HSS support interventions at all the levels (districts, regions and central level) During coordination and monthly monitoring meetings at district level and quarterly meetings at the national level (Sectorial Committee), the agenda will include the activities supported by GAVI-HSS. The annual reports presented and discussed during annual reviews at each level of the health pyramid specifies funding sources and achievements made in compliance with the Results based Management model adopted by the National Development Plan 2012-2015.

9.4.4. Please outline to what extent the M&E is integrated with the country systems (such as, for example,

annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more harmonized 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.

After the preparation of NPMD 2012-2015 and signing of the compact (IHP+ partnership), all the stakeholders prepared a single results framework. In fact, it has been included in “the elements of the programmatic framework of the national compact” (3.4) as the NPMD results will be completely monitored by analyzing all indicators of effect and impact defined for each of the five programs. To facilitate the political discussion around the NPMD results, the monitoring bodies established at all levels focus on a list of indicators, especially “tracers”, that provides a common framework for monitoring the Compact (performance framework for NPMD monitoring/evaluation given in the annex). This framework has 33 indicators including EPI indicators and contractual indicators of HSS support.

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

Under the sectorial approach, the sectorial health committee for HIV/AIDS was created at the end of 2011. This sectorial committee which replaced the Health Sector Coordination Committee (HSCC) is a high-level coordination organization which has its branches at intermediate and operational level. This committee has all the stakeholders: Civil Society Organizations (UNGOTO), technical and financial partners (WHO, UNICEF, UNFPA, AFD) and ministries of finance and economy, primary and secondary education... This committee approves the annual operational plans of the HSS proposal and other health sector plans.

The steering committee, group responsible for implementation, is a body made up of members from the ministry of health and partners from WHO and UNICEF. These are:

- Management and officers from the Ministry of Health: Chief of Staff, Director General, Director for Planning, Director of Public Affairs, Head of the Family Health Division, Head of Epidemiological Division, HSS Focal point at the Ministry of Health.

- A representative from the Ministry of Economy and Finances: Division Head responsible for Studies at the Ministry of Finance; representatives from civil society organizations mainly the Federation of NGOs in Togo - FNGOTO- and the Union of NGOs in Togo - UNGOTO, Executive Director,

-Representatives of technical and financial partners mainly WHO (HSS focal point and advisor for health systems and policies) and UNICEF (Health Specialist and HSS Focal Point) as well as the representatives from other national institutions such as Permanent Secretary of CCM-Togo (Permanent Secretary) and resources. They are all members of the group responsible for implementing GAVI-HSS support.

The steering committee ensures leadership and coordination of all activities of the proposal by providing directions and guidelines on their implementation. The key participants who actively participate in implementing GAVI_HSS proposal are:

.

The HSS support management unit who coordinates the administrative, financial, monitoring/evaluation interventions prescribed in the proposal framework and

Prepare periodic reports related to project implementation to be submitted to the Group responsible for implementing GAVI-HSS support.

9.4.6. Please describe the participation of Civil Society Organizations in the implementation of the HSS application. Please provide names of organizations, type of activities and funding provided to these organizations from the HSS funding.

The civil society (UNGOTO) participates in deciding the guidelines to be given to various support implementation bodies.

For completing Activity 1.2: “Establish performance contracts with 420 community health workers (CHW) in the intervention zones concerning IMCI activities at the community level”, the NGOs and associations are already working with these CHWs that will help them monitor their activities. Payments to CHWs will be made after the reports from NGOs and Associations who monitor them.

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

- Whether the management of HSS funds has been effective?
- Where there any constraints in disbursing internal funds?

- Actions taken to address any issues and to improve the management
- Any changes to management processes in the coming year?

The management of HSS funds was efficient and there were no obstacles in internal disbursement of funds.

9.5. HSS Activities planned for 2014

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

Table 9.4: Activities planned for 2014

Major Activities (insert as many rows as necessary)	**Activities planned for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	**2014 actual expenditure** (as at April 2014)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
Objective 1: Increase the coverage in integrated and rationalized basic services, to at least 80%, in the 21 health districts showing a poor vaccine coverage and Minimum Activities Package by 2013.	Yes		0	No		
1.1 Recruitment of 5 surgeons or obstetricians/gynecologists, 10 midwives, 42 registered nurses and 20 registered assistant midwives on the basis of performance contracts	Yes	327,840	0	No		
1.2 Establish performance contracts with 420 community health workers in the intervention zones concerning IMCI activities at the community level	Yes	30,240	0	No		
1.3 Construct staff quarters for 8 ICPs and SFs	Yes	192,000	0	No		
1.6 Rehabilitate 6 PHUs (not covered under the state project and other partners) in the intervention zone (Kéran,Bassar,Dankpen,Blitta,Sotouboua,Avé,Yoto, Tone, oti,wawa,moyen-mono,Agou) 1.7. Equip 36 PHUs with medico-technical equipment (14 PHUs rehabilitated and 22 new constructed by the State)	Yes	150,000	0	No		
1.7. Equip 36 PHUs with medico-technical equipment (14 PHUs rehabilitated and 22 new constructed by the State)	Yes	100,000	0	No		
1.8 Prepare and distribute guides for mutual health insurances	Yes	20,000	0	YES		
1.19 Establish initiative committees and organize a constituent meeting	Yes	30,000	0	YES		
A Activity 1.20 Conduct 10 consultation sessions with the committees and health care providers for the first two years	Yes	20,000	0			
Activity 1.21 : Train 10 committees and 30 in-charges in mutual management within 2 years	Yes	20,000	0			
Activity 1.22: Support mutual initiatives in 2 districts	Yes	15,000	0			
Increase the access of women and children aged less than 5 years, to quality health care services, in 21 districts with a low vaccine coverage, to at least 90%, by 2013.	Yes					
Train 6 regional and 21 district teams in managing the district health system	Yes	67,498	0	No		
Train 2 senior members at DAKAR in CESAG	Yes	36,000	0	YES		
1.17 Study the ability of households to pay for health care to revise the prices.	Yes	64,270	0	YES		
2.1 Prepare a national framework for management expertise, in collaboration with the stakeholders, and distribute it.	Yes	15,000	0	No		
2.8 Organize 2 integrated supervision missions at district level, 1 integrated supervision mission at regional level and an integrated supervision mission at national level	Yes	32,102	0	No		

2.9 Organize an external audit for financial management in 21 districts, 5 HRD and central level by recruiting an audit firm and an internal audit by the audit department of DAC of the Ministry of Health in 21 districts and 05 regions and the implementation unit.	Yes	10,000	0	No		
2.11 Support the experience-sharing and information-sharing meetings, once a year and for 3 years, for 21 districts	Yes	3,000	0	No		
2.12. Organize integrated priority intervention monitoring twice a year (PMA)	Yes	21,000	0	No		
Travel abroad to study, share and experience the health system strengthening in three performing countries	Yes	10,000	0	No		
2.11. Organize annual national review to measure progress at the end of 2013 with the participation from regional and district focal points in addition to the district and regional Directors and CSOs involved.	Yes	26,050	0	No		
2.16 Support the evaluation (mid-term) of NHDP 2009-2013 and preparation of the extension of the current cMYP: NHDP evaluation: 20,000; preparation of the extension of cMYP: 15,000	Yes	35,000	0	No		
Supervising management team and meeting of the support implementation group	Yes	24,000	0	No		
		1,249,000	0			0

9.6. HSS Activities planned for 2015

Please use **Table 9.6** to outline planned activities for 2015. 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 the change in the budget is over 15% of the approved allocation for the specific activity during the current financial year, these proposed changes must be submitted to IRC for approval with the required proof.

Table 9.6: Planned HSS Activities for 2015

Major Activities (insert as many rows as necessary)	**Activity planned for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2015** (if relevant)
Objective 1: Increase the coverage in integrated and rationalized basic services, to at least 80%, in the 21 health districts showing a poor vaccine coverage and Minimum Activities Package by 2013.	YES				
Activity 1.1 : Recruitment of 5 surgeons or obstetricians/gynecologists, 10 midwives, 42 registered nurses, 20 registered assistant midwives, all based on performance agreements;	YES	327,840			
Activity 1.2 : Establish performance contracts with 420 community health workers in the intervention zones concerning IMCI activities at the community level	YES	30,240			
Activity 1.3 : Construct staff quarters for 21 ICPs and 10 SFs	YES	360,000			
Activity 1.6: Rehabilitation of 14 PHUs (not covered	YES	90,000			

under the state project and other partners) in the intervention zone (Kéran, Bassar, Dankpen, Blitta, Sotouboua, Avé, Yoto, Tône, Oti, Wawa, Moyen Mono, Agou,)					
1.7. Equip 36 PHUs with medico-technical equipment (14 PHUs rehabilitated and 22 new constructed by the State)	YES	100,000			
1.8 Prepare and distribute guides for mutual health insurances	YES	20,000			
1.19 Establish initiative committees and organize a constituent meeting	YES	30,000			
Activity 1.20 Conduct 10 consultation sessions with the committees and health care providers for the first two years	YES	10,000			
Activity 1.21 : Train 10 committees and 30 in-charges in mutual management within 2 years	YES	20,000			
Activity 1.22: Support mutualistic initiatives in 2 districts	YES	10,000			
Travel abroad to study, share and experience the health system strengthening in three performing countries	YES	10,000			
Objective 2: Ensure that at least 90% of women and infants in 21 districts with a low immunization coverage have access to quality health care services by 2013.					
Activity 2.2: Train 220 members of 6 regions and 21 districts in managing the district health system, in 3 years	YES	58,498			
Activity 2.3: Train 6 senior members in CESAG between 2010 and 2013	YES	36,000			
Contribute to operational expenses of the management team	YES	12,070			
Support the preparation of NHDP 2014-2018		30,000			
Activity 2.8: Organize integrated supervision of 5 RMTs by central level, 21 DMT by regional level and 260 PHUs by DMTs based on PMA, once per quarter and for 3 years.		42,000			
2.11. Organize annual national review to measure progress at the end of 2014 with the participation from regional and district focal points in addition to the district and regional Directors and CSOs involved.		32,000			
2.9 Organize an external audit at the end of the year		10,000			
Organize coaching and mentoring of 11 low performing Chief Medical		6,000			

Officers by their high performing counterparts for 3 years, for 1 month					
Organize integrated priority intervention monitoring twice a year (PMA)		17,800			
2.15 Establish a performance bonus system for workers		3,000			
2.17 Supervising management team		11,874			
		1,267,322			

9.7. Revised indicators in case of reprogramming

Countries planning to request a reprogramming can do it at any time of year. Please ask the person in charge of your country at the GAVI Secretariat for guidelines on reprogramming or send an email at gavihss@gavialliance.org.

9.8. Other sources of funding for HSS

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

Table 9.8: Sources of funds for HSS in your country

Donor	Amount in USD	Duration of support	Type of activities funded
No donor will finance the implementation of objectives appearing in the support proposal. However, the French Cooperation is currently working on a project in which some activities will help strengthening the human resources and medical capabilities. The HSS acted in tandem with this project.			

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

9.9. Reporting on the HSS grant

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

- How information was validated at country level prior to its submission to the GAVI Alliance.

-Any substantive issue as to the accuracy or validity of the information (especially financial data and indicator values) and how these issues were addressed and resolved.

Table 9.9: Data Sources

Data sources used in this report	How the information was validated?	Problems experienced, if any
Activity report	ICC/HSCC	APR
Activity report Directorate of Human Resources	ICC/HSCC	APR
EPI Review 2006	ICC/HSCC	APR
EPI Review 2012	ICC/HSCC	APR

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.

APR

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

Please attach:

1. The minutes from all the HSCC meetings held in 2014, endorsing this report **(Document Number: 6)**
2. Latest health sector review report **(Document number: 22)**

10. Strengthen the involvement of Civil Society Organizations (CSO): type A and type B

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

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

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

ABBREVIATIONS AND ACRONYMS
HSCC: Health Sector Coordinating Committee
SSC : Support Steering Committee
GAVI : Global Alliance for Vaccine and Immunization
WHO World Health Organization
CSO: Civil Society Organizations
APR: Annual Progress Report
SMC: Support Management Cell
UNICEF United Nations Children's Fund
HSS; Health System Strengthening
IDSR: Integrated Disease Surveillance and Response
HR: Human Resources
FHD: Family Health Division
EPI: Expanded Program on Immunization
DHISR: Division of Health Information, Studies and Research
RHD: Regional Health Directorate
RMT: Regional Management Team
PHD : Prefectural Health Directorate
DMT : District Management Team
HF: Health Facilities
MC: Management Committee
CHW: Community Health Worker

10.1.1. **Mapping exercise**

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunization.

Please describe the mapping exercise; the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed **(Document No. 23)**

INTRODUCTION

In the context of implementing the project for strengthening Togolese CSO participation in immunization services, maternal and child health and health system strengthening, financed by GAVI-Alliance for extending the type A support, five activities were carried out, namely:

- monitoring radio broadcasts;
- training CSOs on operational planning techniques and tools; and
- training CSOs in immunization, maternal and child health and health system strengthening on "know immunization better to commit better";
- Polio campaign;
- Updating CSO database

This report addresses four activities.

I. RADIO BROADCASTS

1.1 Overview on broadcasts

On the whole seventeen (17) radio programs were broadcasted in 16 local radio stations in five regions of Togo. They focused on the following topics:

- Importance of immunization;
- EPI diseases and importance of immunization;
- Save life, notify disabilities, immunize;
- Importance of immunization for expectant mothers and children;
- Importance of immunization for the mother and child
- Importance of immunization in preventing diseases in children;
- Importance of immunization for children from 0 to 11 months;
- Importance of immunization, immunization schedule and target groups;
- EPI vaccines: roles and importance;
- Importance of immunization, target groups and immunization schedule;
- African Immunization Week;
- Fight against polio under AIW;
- Save life, notify disabilities, immunize;
- Immunization schedule for children aged 0 - 11 months and expectant mothers.

1.2 Detailed presentation on broadcasts

No.

Organizational structures

Dates

Partner radio stations

Topics prepared

Resources involved

1

CRIPS TOGO

23/05/2013

Radio Maranatha Assahoun

Importance of immunization

- Mr. ADAM Kade, EPI DPS Focal point, Avé
- Mr. ZOMENI Kader, AM, CRIPS NGO

2

ATBEF

04/07/2013

Radio Victoire FM

Importance of immunization

- Mr. KOETING Inoussa, EPI D5 Focal point
- Mr. KOMBATE Edem, ATBEF immunization in-charge

3

CREDI

23/04/2013

Radio Citadelle de Vogan

EPI diseases and importance of immunization

- Mrs. SEDJRO Sophie, Mid-wife at HP Vogan
- Mr. SAMATY Tchakeé, AHE DPS Vo
- AYISSOU Kodjovi Honoré, AM CREDI NGO

4

ATPDC

25/04/2013

Peace Radio of Atakpame

Save lives, notify disabilities, immunize

- Health Assistant at a PHU in Agbonou
- Mr. TCHAGNAO Agoro, DE ATPDC

5

NOUVELLE ELITE

29/04/2013

Sports FM at Elavagnon

Importance of immunization for expectant mothers and children

- Mr. KPELE Aklesso, IEC DPS Focal point East Mono
- Mr. KASSIME Moutawakilou, EPI DPS Focal point East Mono
- Mr. ANAYO Mignouna, In-charge of the NE NGO branch at Elavagnon

6

APEB

06/06/2013

RTDS

Importance of immunization for the mother and child

- Mr. ANA Amansa, EPI DPS Focal Point Lacs

- Mrs. ATISSO E. Djidoula, SF, APEB NGO

7

AFAD

26/04/2013

Radio Peace/Kpalimé

Importance of immunization

- Mr. TITOME, EPI Focal point
- Mr. MAGNI, IDE, AFAD NGO
- Mr. TOMETY Mawuli, AFAD NGO Coordinator

8

ADESCO

24/04/2013

Radio Tchaoudjo

Importance of immunization in preventing diseases in children;

- Mr. ALI Mohamed, Central DRS EPI Focal Point
- Mr. PAKOU Mawa, Central DRS IEC Focal Point

9

ASMENE

18/05/2013

Radio Ephata

Importance of immunization for children from 0 to 11 months

- Mr. KOETING, EPI D5 Focal point
- Mr. AKUTSE Luc, In-charge of monitoring-evaluation at ASMENE

10

2APSCO

25/04/2013

Rural local radio of Savannah

Importance of immunization, immunization schedule and target groups

- Mr. ATCHALE Magnango, TGS Tone
- Mr. AMADOU Zakari
- DATIE Pakindame, In-charge of health center at 2 APSCO

11

OSV TOGO

11/06/2013

“Voice of Grand Kloto” Radio station

EPI vaccines: roles and importance

- Mr. KALIPE Séwonou, EPI DPS Focal point Kloto
- Mrs. DODJI Nicole, SF CMS Solidarity
- Mr. LOGOVI David, AM CMS Solidarity

12

3ASC

31/05/2013

Rural local radio of Savannah

Importance of immunization, target groups and immunization schedule

- DJAGBA Arsène, TGS 3 ASC
- KOLANI Labla, Facilitator 3 ASC Kpendjal

07/06/2013

Radio Maria at Dapaong

African Immunization Week

- ATCHALE Magnango, TGS Tone
- DJAGBA Arsène, TGS 3 ASC

13

CODE UTILE

29/04/2013

Rural local radio of Savannah

Fight against polio under AIW

- Mr. BOYODI Adonglisso, IEC DPS Focal point at Tandjoaré
- Mr. LAMBONI Lakpamame, CODE Utile Facilitator

14

RADAR

28/05/2013

Radio Etincelle

Save lives, notify disabilities, immunize

- Mr. LAMINE Adame, IEC DPS Focal point at Blitta
- Mr. POTCHENESSA Georges, RADAR NGO Facilitator

15

Amis du Bien Etre (ABE)

21/05/2013

Radio Fraternity at Notse

Importance of immunization

- Mr. DENAGNON Kodjo, EPI Focal Point at Haho

- Mrs. FETSU Elyse

- Mr. GBOLOGAN Emanuel, Medical assistant at ABE health center

16

SAG

10/05/2013

Radio Frequency 1

Immunization schedule for children aged 0 - 11 months and expectant mothers.

- Mr. TENGUE Ayao, DPS EPI Focal point Golfe

- Mr. BANASSA ALOU Lanwi, Director of SAG NGO

II. TRAINING CSOs IN OPERTIONAL PLANNING TECHNIQUES AND TOOLS

2.1. Introduction

From June 17 to 19, 2013, a training for CSOs on operational planning techniques and tools was conducted at CESAL Tokoin Seminar.

This workshop was attended by around thirty participants from NGOs/Associations involved in immunization, maternal and child health and other related services. The sessions of the workshop were conducted in four (04) consecutive sequences, namely: (i) opening ceremony, (ii) presentation of papers, (iii) group activities and (iv) plenaries.

After the opening ceremony by Dr. BABA Amivi Afefa, representative from the Ministry of Health, the following papers were presented:

- 1st paper: Key interventions of CSOs in immunization;
- 2nd paper: Expanded Program of Immunization in Togo: successes, challenges and perspectives;
- 3rd paper: Planning techniques and tools;
- 4th paper: Data collection and analysis

After these papers, group activities were organized. These sessions focused on practical sessions on objective based planning (OBP) and result based management (RBM) under the supervision of group facilitators and a consultant.

All group activities were followed by plenaries who helped improve the work done by each group. After the workshop, the following roadmap was defined for next steps.

2.2. Papers

2.2.1. Key interventions of CSOs in immunization

This paper, presented by **Mr. Dominique YINA, In-charge of the UONGTO monitoring-evaluation Unit, focused on** 3 major points, namely, (i) overview on the involvement of CSOs in immunization, (ii) importance of CSOs in immunization and (iii) conditions for success of involvement of CSOs in immunization.

In terms of overview on the involvement of CSOs in immunization, the presenter stated that there are inadequacies in resources for health (RHS) at all levels (especially at operational level), outdated transport (cars and motorbikes) restricting the implementation of advanced strategies, low usage rate of immunization services by the community, high dropout rates, persistence of obstacles for immunization (taboos, rumors) in

certain localities.

Despite these shortcomings, the CSOs play a key role in terms of immunization. They offer several services including:

social mobilization;

education/training campaigns (IEC/CCC, broadcasts);

search for the ignorant

monitoring vaccinators;

contribution to planning and development of projects/programs at all levels;

Advocacy for the mobilization of resources.

Addressing the conditions for success, the speaker mentioned the following factors: professionalism (HR available and of quality, management tools, rolling stock available, financial resource mobilization capabilities, adequate framework, culture and excellence and transparency), collaboration / partnership and search for complementarity and not competition with the public sector.

2.2.2. Expanded Program of Immunization in Togo: successes, challenges and perspectives

The 2nd paper was presented by Mr. LACLE Anani, Head of the immunization division. His paper was based on the following points:

- EPI objectives
- Organizational aspects
- Intervention strategies
- Results
- Challenges and perspectives

2.2.2.1. EPI objectives

Although immunization is one of the most expensive interventions in public health, it plays a major role in achieving MDGs, especially OM4 and 5. Since 2005, the vision is to **immunize 90% of children across the country and achieve coverage of 80% in all the districts by 2015.** Started in Togo, in 1980, in the Savannah region, it scaled up in 1984 and involved all levels of the health pyramid. Today, EPI benefits from the support of several partners including WHO, UNICEF, Plan-Togo, Rotary, CSOs

The objective of EPI is to contribute to the reduction of morbidity and mortality caused due to vaccine-preventable diseases and mainly targets children between 0-11 months and pregnant women.

2.2.2.2. Organizational aspects

The organization of EPI is based on that of the health system. The central level is responsible for defining guidelines, preparing guides and guidelines, planning, preparing supervision, and monitoring and evaluation tools. The regional or intermediate level is responsible for planning, supporting peripheral level for implementing activities, supervision, monitoring and evaluation. And the district or peripheral level is responsible for planning, implementing activities, supervision, monitoring and evaluation.

2.2.2.3. **Intervention strategies**

EPI is based on 4 major strategies which are (i) systematic (routine) immunization of children between 0-11 months against 9 diseases, (ii) systematic (routine) immunization of pregnant women against tetanus, (iii) implementation of Reach Every District (RED) / Reach Every Child (REC) approach and monitoring and evaluation.

2.2.2.4. **Results**

The program recorded positive results from 2001 with a constant growth in immunization coverage and a

reduction of dropout rates. Some diseases are practically eliminated. They are poliomyelitis, tetanus and Measles.

2.2.2.5. Challenges and perspectives

The following challenges and perspectives are expected: introduction of new vaccines, increase or maintenance of current immunization coverage, improving immunization data quality through DQS, strengthening RED approach, a better integration with other interventions, reducing the number of ignorant or non-immunized and financial sustainability of EPI.

2.2.3. Planning techniques and tools

The paper on planning techniques and tools was presented by Mr. Dankom BAKUSA, Head of Programming Planning Division at the Ministry of Health, and Research professor at the University of Lome. Major aspects of this paper focused on the following points:

- Definition and characteristics of Planning
- Objective Based Planning (OBP): Which approach with which tool(s)?
- Result based Management (RBM): Performance chain?
- Analysis of bottlenecks (BN) based on the improved TANAHASHI model: How to identify and remove BN?

2.2.3.1. Definition and characteristics of Planning

Planning is defined as a continuous process of forecasting resources and services required to achieve the specific targets in an order of priority, to choose solution(s) among several alternatives; these selections considering the context of internal constraints, which are either known or predictable.

It is also a methodical process of defining an analytical problem, identify unmet needs and requirements that are a problem, determining the order of priority, fix realistic and achievable goals, list the resources required to achieve, project administrative activities by analyzing the various possible intervention strategies to resolve the problem.

It refers to 5 characteristics which are the future, the cause-effect relationship between actions and outcomes (between means and results (RBM), action or approach to be taken, the continuous and dynamic approach and multisectoral nature. There are 3 types of planning: plans, programs and projects.

2.2.3.2. Objective based planning (OBP): Which approach with which tool(s)?

There are 11 major steps:

1. Analysis of the health situation;
2. Identification of health problems;
3. Establishing the order of priority for problems;
4. Specifying the goals to be achieved;
5. Identifying implementation strategies;
6. Determining expected results;
7. Identifying activities to be conducted;
8. Identifying resources (including budgeting);
9. Identifying persons who are responsible and committed;
10. Establishing implementation plan or schedule;
11. Establishing an evaluation plan or logical framework.

2.2.3.3. Result based Management (RBM): Performance chain?

RBM is a foundation, a clear performance chain, accepted and endorsed by all, leading to expected results or desired changes by institutions (State, TFP, CSO, family, communities, woman, child, etc.) at a given context. It works on a logic (logic of interventions), a principle (if a problem has several causes, we should attack all the causes), and a resource/decision relationship. The different RBM steps are:

• Analysis of the health situation (AHS);

- Identification of BN (all negative aspects)
- Problem tree (balanced)
- Performance chain
- Performance measurement framework (see template)
- Schedule (see template)
- Action plans (AP)

2.2.4. **Data collection and analysis**

It was prepared by Mr. Dominique YINA, In-charge of the UONGTO monitoring-evaluation Unit. The trainer developed the following aspects:

Place data collection and analysis tool in a monitoring-evaluation system;

Use data collection and analysis tools;

Types of data collection and analysis tools;

Data collection;

Data analysis;

Data Quality assurance;

Data archival and distribution

He concluded this module by presenting a case study.

All the presentations were followed by discussions for a better understanding of the points addressed by the trainers.

2.3. Group activities

Group activities were organized during the workshop. These sessions focused on practical sessions on objective based planning (OBP) and result based management (RBM) under the supervision of group facilitators and a consultant.

Photos

2.4. Plenaries

All group activities were followed by plenaries who helped improve the work done by each group.

Photos

2.5. Roadmap for next steps

No.

Activities and tasks

Implementation period

Location

In-charge

1

Use of training outcomes in our facilities

From June 24 to 28, 2013

In each facility

Every participant

2

Send feedback to UONGTO

Latest by July 5th

Participants

3

Monitor activities from January to June 2013

July 2013

For facilities having a health center

In-charges

4

Participation in the drafting of PAO at the district level

July 2013

In each district

Participants

Recommendations

1

Organize training on archival

2

Organize a training on advocacy

3

Organize a training on supportive supervision and monitoring

III. TRAINING ON THE TOPIC: "KNOW IMMUNISATION BETTER TO COMMIT BETTER"

3.1. Introduction

From July 04 to 06, 2012, a training for CSOs on "**know immunization better to commit better**" topic was conducted at CESAL Tokoin Seminar.

This workshop was attended by twenty-three (23) CSOs and they participated in the first session. The participants were made up of: medical assistants, nurses, mid-wives and sociologists. The workshop was implemented in three phases, namely: (i) opening ceremony, (ii) development of training modules, and (iii) group activities.

The opening ceremony by the representative from the Minister of Health followed the speech from the Resident Representative of WHO and the welcome speech from PCA UONGTO and the development of training modules.

Five (05) modules were developed by the trainers. They focused on (i) components of RED and immunization schedule, (ii) EPI data collection tools: schedules and other tools, (iii) DQS: EPI monitoring system, (iv) Communication for EPI, and (v) EPI monitoring and evaluation: monitoring and EPI review.

To achieve the training objectives, two main approaches were used during the training, namely: plenary

sessions and group activities. Also, the trainers used participative approaches involving presentations, discussions, Q&A sessions and experience sharing among participants.

3.2. Training objectives

3.2.1. General objective

Is to contribute to the strengthening of operational capabilities of CSOs active in immunization and other related health services.

3.2.2. Specific objectives

Specifically, the second training session helped make beneficiary CSOs capable of presenting quality reports on their immunization activities and be familiar with the self-assessment of the quality of immunization data (DQS) tools.

3.3. Modules developed

3.3.1. Module 1 : “RED components/immunization schedule”

This presentation mainly focused on:

- planning and resource management;
- reaching the target populations
- establishing a link between services and communities;
- supportive supervision and
- monitoring for action.

3.3.2. Module 2 : “EPI data collection tools: schedules and other tools”

Totally ten(10) tools (immunization register, immunization card, follow-up card,

timesheet, reports, inventory sheet and stock management) were presented.

3.3.3. Module 3 : “DQS: EPI monitoring system”

This presentation summarized principles and methods, quality of the monitoring system, data accuracy, timeliness and completeness of data in EPI monitoring system.

3.3.4. Module 4 : “Communication”

This presentation helped participants to be capable of defining communication, explaining the elements of communication processes, identifying obstacles to communication, describing forms and types of communication, determine the importance of communication in EPI and list the specific aspects of EPI where communication is applicable, hone their knowledge of communication to EPI, foster their skills required for the preparation and execution of a communication activity for EPI.

3.3.5. Module 5 : EPI monitoring and evaluation: monitoring and EPI review”

It was to provide participants with a guidance on the minimum requirements for monitoring routine immunization activities, the procedure to monitor and use data and information generated for action. For this purpose, the development of this module mainly focused on:

- defining basic concepts such as: monitoring, evaluation, review, completeness of reports, promptness, indicator;
- timeline for circulating data from health facilities to Central level passing through the District and Regional level;
- monitoring and evaluation mechanisms;
- dropout rate, wastage rate, completeness rate, promptness rate, quality index (QI); and
- analyzing major problems related to low coverage.

After these presentations, two (02) group activities were organized during the workshop followed by feedback from plenaries.

3.4. Work groups

Two sessions were organized, namely:

- Session1: The activities of this session allowed participants to practice filling data quality self-assessment tool at PHU and District levels using immunization data, Excel tool for evaluating data accuracy and on calculating critical stocks.

- Session2: this session consisted of a mapping exercise on the development of a half-yearly work plan from June to December 2012.

3.5 Feedback from plenaries

3.5.1. Points of discussion

After various presentations and group activities, there were discussions on:

- accuracy of immunization data;

- completeness and promptness of reports;

- quality of immunization monitoring system;

- clarification questions to better understand DQS;

- different steps to prepare an advocacy plan.

3.5.2. Suggestions and recommendations

At the end of this second training session, recommendations were formulated by EPI, participants and UONGTO.

At EPI:

- Design a software for plotting the self-monitoring curve;

- Revise the immunization report;

- Organize continuous trainings at CSOs;

- Conduct an advocacy for a better collaboration between Districts and CSOs.

At CSOs, participants of this training:

- Ensure that the same people come back for the next sessions.

- At the end of each training session, deliver participation certificates;

- Provide a technical support for equipment to CSOs;

- Pay stipends from the second day of the workshop.

IV. POLIO CAMPAIGN

4.1.Major achievements

The strategies used were innovative both before and during the campaign.

➢ **Before the campaign:**

- Door to door awareness sessions (VAD);

- Awareness sessions for churches, mosques, markets and schools;

- Meetings with community leaders (Educational discussions);

- Radio broadcasts.

➢ **During the campaign:**

- Close monitoring of vaccinators during the campaign;

- Community monitoring (assigning focal points in the community to report inadequately covered areas (an inadequately covered area is an area where at least 10 households were not visited by vaccinators);

- Involvement of the police in case of resistance / refusal;

- Questioning DPS for covering reported inadequately covered areas;

- Monitoring-supervision.

4.2. Results:

- Awareness and mobilization of the population: 1202 VADs, 499 lectures and 14 discussion programs carried out; 712256 people affected;

- Good collaboration with ICP, CHW, district and community heads, religious heads and opinion leaders for reporting rejected cases and report on inadequately covered areas: 17 rejection cases, 5 inadequately covered areas (figures only from 3 NGOs);

- Recovering non-immunized children: 358 children were recovered and immunized through the involvement of NGOs in 16 covered districts (figures only from 5 of the 13 NGOs);

- Involve radio stations, town criers and gongonneurs in almost all the villages and localities to give information on the campaign before and during the campaign: 14 radio stations, 57 town criers/gongonneurs;

Monitoring-supervision: 1 monitoring-supervision mission organized by a coordination with UONGTO and 3 NGOs visited.

4.3. Main problems:

- Lack of financial resources to cover all expenses related to mobilization activities;

- Lack of human resources (number of supervisors) to cover few big districts

- Lack of equipment for mobility (megaphones, image boxes, raglan);

Delay in sending tools for conducting the activities.

4.4. Recommendations:

- Increase the budget for activities

- Equip facilities with megaphones, image boxes, rolling stock and others for mobile awareness campaigns;

- Consider the extent of the coverage area to determine the number of social mobilizers and resources to be allocated;

Provide resources to NGOs on time.

V. MONITORING MISSIONS

To provide a database of CSOs active in immunization, maternal and child health and health system strengthening, a monitoring mission was conducted. It was, on one hand, conducted by the Coordinator and Monitoring and evaluation head of the Project Management Unit for CSOs of the Savannah, Kara, Central and Plateaux regions, and by the President of the Administrative Council and Monitoring and evaluation head for CSOs for the regions of Maritime and Community Lome, on the other.

5.1. Objective of the mission

5.1.1. General objectives

This mission was to update the database of CSOs active in immunization, maternal and child health and health system strengthening.

5.1.2. Specific objectives

Specifically, the mission was to:

- conduct site visits from a sample of CSOs existing in the database;

- collect information required during site visits and through e-mails for the rest of CSOs to update the database;

- monitor implementation of action plans prepared in July 2012 by CSOs after the second training session on immunization;

- and propose the list of CSOs that are still active and eligible for computer equipment.

To achieve these objectives, the mission team adopted a very participative work method.

5.2. Work method

The work method used during the mission consisted of:

- design a data collection form for CSOs: this form was sent by e-mail to all the CSOs;

- organizing work sessions on site with executive teams (Executive Directors/Program heads, Accountants and monitoring-evaluation heads) from a sample of target CSOs;

- collecting information required for updating the database. This information is collected on site during site visits and through e-mails for other CSOs; and

- analyzing contents of collected forms and activity reports which gave the following results.

5.3. Findings

The following are the findings after the mission:

- a sample of 14 CSOs were visited;

- the forms collected at all the CSOs helped update the database of CSOs active in immunization, maternal and child health and health system strengthening.

- implementation level of action plans of CSOs is appreciated.

5.4. Major observations

The major general and specific observations were identified during the mission.

5.4.1. Major general observations

The following are the major general observations identified during the mission:

- most of the CSOs offering clinical care have their own locations or contracts for gifted places;

- although funding was not available, efforts were made by CSOs to implement activities planned in their action plans for immunization;

- need for computers were expressed by all the CSOs visited;

- one of the recommendations of the training workshops on immunization, especially the one related to merging the EPI timesheets and reports into a single document is implemented. The new documents designed for this purpose by DEPI were presented by the CSOs visited to the members of the team;

- all the CSOs are faced with challenges of contributing to the improvement of access to immunization and increase immunization coverage at community and national level: social mobilization, service provision, search for the ignorant, check immunization;

- poor public-CSO partnership.

5.4.2. Major specific observations

Major specific observations at a few CSOs were identified. The following are the observations:

- Association2APSCO does not have continuous power supply. The association uses solar panels and generators whose ability to provide electricity is not enough to power an entire computer;

- MEDESNGO is located in the buildings of the Bretelle Medical Office owned by a private operator. According to the MEDES head, the NGO uses the same staff as those recruited by the medical office. In this aspect, it is difficult to distinguish between the staff, equipment used and data generated by the NGO;

- IASP Association does not have its own office or staff; the physical offices of the association are “found” in the consultation room of a Medical Assistant of the Aneho Hospital, member of the association. In these circumstances, it will be difficult to provide physical equipment to this association.

5.5. Recommendations

Based on the general and specific observations, the team makes the following recommendations to the CSOs and UONGTO:

5.5.1. To CSOs

- To monitor the efforts in implementing the activities described in their action plans for immunization;

- Document the activities that they conduct in the areas of maternal and child health, immunization and health system strengthening and communicate the data to health district in-charges and to the UONGTO coordination;

- For2APSCO, speed up the process for providing power supply to its health center;

- For IASP and MEDES, provide them with offices and human resources.

5.5.2. At UONGTO

- Advocate with Tone DPS and Regional Director for Development and Regional Planning to facilitate the provision of power supply to 2APSCO;

- Send letters to MEDES and IASP officials for them to take necessary steps to make their facilities more operational.

CONCLUSION

With the support from GAVI Alliance, UONGTO and its members could improve their technical and operational capabilities in terms of advocacy, communication, knowledge in terms of immunization to better involve in this domain. The Togolese population benefitted from a large radio awareness campaign focusing on various topics related to maternal and child health and hygiene.

This support helped providing a database of CSOs active in immunization, maternal and child health and health system strengthening.

APPENDIX

If there is a balance of funds to support Type A CSO in the country, please describe how the funds will be used and will contribute to the objectives and results of vaccination included in the original proposal.

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

The difficulties encountered are:
- delay in the transmission of scripts by consultants;
- availability of members of the Support Steering Committee (SSC);

- delay in the implementation of GAVI-HSS project;
- and Malian conflict

10.1.2. **Nomination process**

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

NOT APPLICABLE

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

NOT APPLICABLE

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

- Activities Executed in 2013 1/3
- monitoring 17 radio broadcasts on various topics;
- training 23 CSOs on operational planning techniques and tools; and
- training 23 CSOs in immunization, maternal and child health and health system strengthening on the theme “know immunization better to commit better” ;
- Activities Executed in 2013 2/3
- Vaccinators During the campaign;
- Community monitoring (assigning focal points in the community to report inadequately covered areas (an inadequately covered area is an area where at least 10 households were not visited for the Polio campaign);
- **Before the campaign** :

- Door to door awareness sessions (VAD);
- Awareness sessions for churches, mosques, markets and schools;
- Meetings with community leaders (Educational discussions);
- Radio broadcasts

- **During the campaign :**
- Close monitoring of workers by the vaccinators);
- Involvement of the police in case of resistance / refusal;
- Questioning DPS for covering inadequately covered areas that were reported;
-

- Activities Executed in 2013 3/3
- Updating CSO database
-
-

38,332,103

28,284,562

9,047,541

Please provide the list of CSOs, names of representatives at HSCC or ICC and their contact details

Full name	Position	Telephone	E-mail

10.1.3. **Receipt and expenditure of CSO Type A funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type A funds for the 2013 year.

	Amount in US$	Amount in local currency
Funds received in 2013 *(A)*	0	0
Funds remaining (report) in2012 *(B)*	81,558	38,332,103
Total Available Funds in 2013 (C=A+B)	81,558	38,332,103
Total expenditures in 2013*(D)*	60,180	28,284,562
Balance carried forward to 2014(E=C-D)	21,378	10,047,541

Is GAVI's support to type A CSOs reported on the national health sector budget? **Yes**

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

Togo **has not received GAVI support for the Type B CSOs**

Togo has not presented report on GAVI support to the Type B CSOs in 2013

11. Comments from ICC/HSCC Chairs

You can submit observations that you may wish to bring to the attention of the monitoring IRC and any comments or information you may wish to share in relation to the challenges you have encountered during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

APR

12. Annexes

12.1. Annex 1: ISS instructions

INSTRUCTIONS:

FINANCIAL STATEMENTS **FOR THE ALLOCATION OF NEW VACCINE INTRODUCTION** UNDER **IMMUNIZATION SERVICES SUPPORT (ISS)**

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

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

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

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

b. Income received from GAVI during 2013

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis summarizes the total annual expenditure for the year by your Government's own system of economic classification, and relevant cost categories (for example: salaries and wages). Cost categories used shall be based on the economic classification of your Government. Please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2013 (referred to as the "variance").

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

V. Financial statements need not be 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 financial year 2013. Audits for ISS funds are to be submitted to the GAVI Secretariat 6 months following the close of the financial year in their respective countries.

12.2. Annex 2 - Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR ISS FINANCIAL STATEMENTSAND FOR THE ALLOCATION OF NEW VACCINE INTRODUCTION 1

An example of income & expenditure statement

Summary Table of income & expenditure – GAVI-ISS		
	Local Currency (CFA)	**Value in USD***
Closing balance for 2012 (*as of 31 December 2012*)	25,392,830	53,000
Summary of income received in 2013		
Income received from GAVI	57,493,200	120,000
Income from interests	7,665,760	16,000
Other incomes (charges)	179,666	375
Total Income	38,987,576	81,375
Total expenditure in 2013	30,592,132	63,852
Closing Balance on 31 December 2013 (Balance carried over to 2014)	60,139,325	125,523

* Enter the exchange rate at opening on 01.01.2013, the exchange rate at close on 31.12.2013 of the financial year and also indicate the exchange rate used to convert the local currency into USD in these financial statements.

Detailed Analysis of Expenses by economic classification – GAVI ISS**						
	Budget in CFA	**Budget in US$**	**Actual Expenses in CFA**	**Actual Expenses in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Payment of daily allowances	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 and general expenses	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenses						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

**The expense categories are indicative and included only as an example. Each Government will provide financial statements in compliance with their own economic classification system.

12.3. Annex 3 - Instructions for HSS support

INSTRUCTIONS:

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

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

II. Financial statements should be compiled based on the 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 activities carried out during the calendar year 2013, taking into account the points (a) through (f), below. A sample basic statement of income and expenditure is provided in the following page.

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

b. Income received from GAVI during 2013

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis should summarize 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: salaries and wages). Cost categories used shall be based on the economic classification of your Government. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2013(referred to as the "variance").

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

V. Financial statements need not be 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 2013financial year. Audits for ISS funds are to be submitted to the GAVI Secretariat 6 months following the close financial year in respective countries.

12.4. Annex 4 - Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR THE HSS-SUPPORT FINANCIAL STATEMENTS:

An example of income & expenditure statement

Summary Table of income & expenditure – GAVI-HSS		
	Local Currency (CFA)	**Value in USD***
Closing balance for 2012 (*as of 31 December 2012*)	25,392,830	53,000
Summary of income received in 2013		
Income received from GAVI	57,493,200	120,000
Income from interests	7,665,760	16,000
Other incomes (charges)	179,666	375
Total Income	38,987,576	81,375
Total expenditure in 2013	30,592,132	63,852
Closing Balance on 31 December 2013 (Balance carried over to 2014)	60,139,325	125,523

* Enter the exchange rate at opening on 01.01.2013, the exchange rate at close on 31.12.2013 of the financial year and also indicate the exchange rate used to convert the local currency into USD in these financial statements.

Detailed Analysis of Expenses by economic classification ** - GAVI-ISS						
	Budget in CFA	**Budget in US$**	**Actual Expenses in CFA**	**Actual Expenses in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Payment of daily allowances	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 and general expenses	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenses						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

**The expense categories are indicative and included only as an example. Each Government will provide financial statements in compliance with their own economic classification system.

12.5. Annex 5 - Instructions for CSO support

INSTRUCTIONS:

FINANCIAL STATEMENTS FOR **SUPPORT TO CIVIL SOCIETY ORGANIZATIONS (CSO)** TYPE B

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

II. Financial statements should be compiled based on the 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 activities carried out during the calendar year 2013, taking into account the points (a) through (f), below. A sample basic statement of income and expenditure is provided in the following page.

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

b. Income received from GAVI during 2013

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

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

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

V. Financial statements need not be 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 2013financial year. Audits for the CSO-Type B funds are to be submitted to the GAVI Secretariat 6 months following the close of the financial year in their respective countries.

12.6. Annex 6 - Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR FINANCIAL STATEMENTS ON TYPE- B CSO SUPPORT:

An example of income & expenditure statement

Summary Table of income & expenditure – GAVI-CSO		
	Local Currency (CFA)	**Value in USD***
Closing balance for 2012 (as of 31 December 2012)	25,392,830	53,000
Summary of income received in 2013		
Income received from GAVI	57,493,200	120,000
Income from interests	7,665,760	16,000
Other incomes (charges)	179,666	375
Total Income	38,987,576	81,375
Total expenditure in 2013	30,592,132	63,852
Closing Balance on 31 December 2013 (Balance carried over to 2014)	60,139,325	125,523

* Enter the exchange rate at opening on 01.01.2013, the exchange rate at close on 31.12.2013 of the financial year and also indicate the exchange rate used to convert the local currency into USD in these financial statements.

Detailed Analysis of Expenses by economic classification ** - GAVI-CSOs						
	Budget in CFA	**Budget in US$**	**Actual Expenses in CFA**	**Actual Expenses in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Payment of daily allowances	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 and general expenses	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenses						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR 2013	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

**The expense categories are indicative and included only as an example. Each Government will provide financial statements in compliance with their own economic classification system.

13. Attachments

Document Number	Document	Section	Mandatory	
1	Signature of the Health Minister (or delegated authority)	2.1	✓	SignatureMinistre de la santé.zip **File desc: ....** **Date/Time:** 15/05/2014 01:03:55 **Size:** 1 MB
2	Signature of the Finance Minister (or delegated authority)	2.1	✓	SignatureMinistre des finances.zip **File desc: ....** **Date/Time:** 15/05/2014 01:17:25 **Size:** 1 MB
3	Signatures of the ICC members	2.2	✓	Signnature CCIA_Réunion CCIA.zip **File desc: ....** **Date/Time:** 15/05/2014 01:23:38 **Size:** 1 MB
4	Minutes of the ICC meeting in 2014 endorsing the Annual Progress Report 2013.	5.7	✓	Rapport de la réunion CCIA Mai2014.docx **File desc:** ,, **Date/Time:** 15/05/2014 12:59:25 **Size:** 31 KB
5	Signature of the HSCC members	2.3	✓	Signnature CCSS.zip **File desc: ....** **Date/Time:** 15/05/2014 02:19:35 **Size:** 1 MB
6	Minutes of the HSCC meeting in 2014 endorsing the Annual Progress Report 2013	9.9.3	✓	Rapport de la réunion CCSS Mai2014.doc **File desc: ....** **Date/Time:** 15/05/2014 02:43:14 **Size:** 60 KB
7	Financial statements for ISS funds (fiscal year 2013) signed by the Chief Accountant or by the Permanent Secretary of the Ministry of Health	6.2.1.	✓	Etat financier SSV 2013.pdf **File desc: ....** **Date/Time:** 15/05/2014 06:19:40 **Size:** 1 MB Etat financier SSV 2013.pdf **File desc: ....** **Date/Time:** 15/05/2014 06:23:27 **Size:** 1 MB
8	External audit report on the allocation of ISS funds (fiscal year 2013)	6.2.3	✓	Rapport de l'audit externe SSV.docx **File desc: ....** **Date/Time:** 15/05/2014 04:45:52 **Size:** 18 KB

9	Post-introduction Evaluation Report	7.2.2.	✓	Rapport d'évaluation post introduction.doc **File desc:** .... **Date/Time:** 15/05/2014 07:00:32 **Size:** 27 KB
10	Financial statements for grants for introducing a new vaccine (fiscal year 2013) signed by the Chief Accountant or by the Permanent Secretary of the Ministry of Health	7.3.1	✓	Etat financier nvx vaccins.docx **File desc:** .... **Date/Time:** 15/05/2014 07:05:57 **Size:** 18 KB
11	External audit report on grants allocated for introducing a new vaccine (fiscal year 2013), if the total expenses in 2013 are greater than USD 250,000	7.3.1	✓	Rapport AUDIT FONDS NVX VACCINS.docx **File desc:** .... **Date/Time:** 15/05/2014 07:03:36 **Size:** 18 KB
12	EVSM/VMA/EVM report	7.5	✓	Rapport EVM Togo_Avril 2011_ 30 mai 2011 Definitif.doc **File desc:** ,, **Date/Time:** 03/05/2014 06:44:14 **Size:** 2 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	Plan d'amélioration de la gestion des vaccins.docx **File desc:** .... **Date/Time:** 03/05/2014 06:57:42 **Size:** 35 KB
14	Status of the implementation of EVSM/VMA/EVM improvement plan	7.5	✓	Evaluation de la mise en oeuvre du plan d'am_élioration de la **File desc:** .... **Date/Time:** 03/05/2014 06:59:26 **Size:** 38 KB
16	The cMYP valid if the country requests for extension of support	7.8	✗	PPAC_PEV Togo - 2011-2015_actualisé aout2013.doc **File desc:** .... **Date/Time:** 15/05/2014 07:25:14 **Size:** 1 MB
17	Costing tool for the cMYP is valid if the country requests for extension of support.	7.8	✗	cMYP_Costing_Tool_Vs 2 5_Fr Togo dernier actualisé aout2 **File desc:** .... **Date/Time:** 15/05/2014 07:42:39 **Size:** 3 MB
18	Minutes of the ICC meeting approving the extension of support to vaccines, if applicable	7.8	✗	Rapport de la réunion CCIA Mai2014.docx **File desc:** .... **Date/Time:** 15/05/2014 12:11:48 **Size:** 31 KB

19	Financial statements for the HSS funds (fiscal year 2013) signed by the Chief Accountant or by the Permanent Secretary of the Ministry of Health.	9.1.3	✓	etat financier RSS du 1er au 31 décembre 2013.pdf **File desc:** ,, ,, ,, ,, **Date/Time:** 15/05/2014 12:03:52 **Size:** 1 MB
20	Financial statements for the HSS funds for the period January-April 2014 signed by the Chief Accountant or by the Permanent Secretary of the Ministry of Health.	9.1.3	✓	Etat financier du 1er janvier au 31 mars 2014.pdf **File desc: ....** **Date/Time:** 15/05/2014 12:07:02 **Size:** 1 MB
21	External audit report on the allocation of HSS funds (fiscal year 2013)	9.1.3	✓	Rapport de l'audit externe RSS.docx **File desc: ....** **Date/Time:** 15/05/2014 12:15:25 **Size:** 18 KB
22	Review report on the health sector-HSS	9.9.3	✓	Rapport d'analyse sectorielle secteur santé_version finaliser **File desc:** ,,, **Date/Time:** 15/05/2014 12:51:56 **Size:** 4 MB
23	Listing Report - Type A - CSO support	10.1.1	✓	Rapport recensement OSC.doc **File desc:** ,,, **Date/Time:** 15/05/2014 01:06:08 **Size:** 68 KB
24	Financial statement for the allocation of type B CSO support (fiscal year 2013)	10.2.4	✓	Rapport financier GAVI.xlsx **File desc:** ,,, **Date/Time:** 15/05/2014 12:44:11 **Size:** 12 KB
25	External audit report on Type B CSO support (fiscal year 2013)	10.2.4	✓	Rapport recensement OSC.doc **File desc:** ,,, **Date/Time:** 15/05/2014 01:09:41 **Size:** 68 KB
26	Bank statements for each program funded in cash or a cumulative bank statement for all the programs funded in cash, if the funds are kept in the same bank account where the opening and closing balance for the year 2013i.e. i) January 1, 2013 and ii) closing balance as on December 31, 2013 appear.	0	✓	Relevé bancaireRSSV0001.pdf **File desc: ....** **Date/Time:** 15/05/2014 12:21:15 **Size:** 8 MB
27	compte_rendu_réunion_ccia_changement_présentation_vaccin	7.7	✗	No file downloaded

	Other documents		×	SSV.pdf **File desc:** ,,, **Date/Time:** 15/05/2014 12:37:41 **Size:** 4 MB