GAVI Alliance

Annual Progress Report 2012

Submitted by

The Government of

Myanmar

Reporting on year: **2012**
Requesting for support year: **2014**
Date of submission: **5/22/2013 11:19:15 AM**

Deadline for submission: 9/24/2013

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

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

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

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

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

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

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

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

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

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

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

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

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

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

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

1. Application Specification

Reporting on year: **2012**

Requesting for support year: **2014**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	Measles second dose, 10 dose(s) per vial, LYOPHILISED	Measles second dose, 10 dose(s) per vial, LYOPHILISED	2016
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2016
INS			

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

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

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

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2011 is available here.

2. Signatures

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

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

For the Government of Myanmar

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

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Professor Dr. Pe Thet Khin	**Name**	U Kyaw Htay
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email

2.2. ICC signatures page

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

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

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

2.2.1. ICC report endorsement

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

Name/Title	Agency/Organization	Signature	Date

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), , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

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

Name/Title	Agency/Organization	Signature	Date

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

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

Myanmar is not reporting on CSO (Type A & B) fund utilisation in 2013

3. Table of Contents

This APR reports on Myanmar's activities between January – December 2012 and specifies the requests for the period of January – December 2014

Sections

4. Baseline & annual targets

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

Number	Achievements as per JRF		Targets (preferred presentation)							
	2012		2013		2014		2015		2016	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
Total births	1,510,745	1,602,657	1,519,321	1,519,321	1,527,254	1,527,254	1,521,058	1,521,058	1,513,433	1,513,433
Total infants' deaths	55,898	61,641	54,696	54,696	51,972	51,972	50,195	50,195	46,916	46,916
Total surviving infants	1454847	1,541,016	1,464,625	1,464,625	1,475,282	1,475,282	1,470,863	1,470,863	1,466,517	1,466,517
Total pregnant women	1,586,282	1,664,298	1,580,093	1,580,093	1,588,344	1,588,344	1,566,689	1,566,689	1,558,836	1,558,836
Number of infants vaccinated (to be vaccinated) with BCG	1,404,993	1,391,044	1,412,968	1,412,968	1,450,891	1,450,891	1,445,005	1,445,005	1,437,761	1,437,761
BCG coverage	93 %	87 %	93 %	93 %	95 %	95 %	95 %	95 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,353,008	1,332,137	1,362,101	1,362,101	1,386,808	1,386,808	1,382,611	1,382,611	1,393,190	1,393,190
OPV3 coverage	93 %	86 %	93 %	93 %	94 %	94 %	94 %	94 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,353,008	1,369,231	1,397,027	1,397,027	1,415,110	1,415,110	1,410,828	1,410,828	1,421,622	1,421,622
Number of infants vaccinated (to be vaccinated) with DTP3	1,323,911	1,303,246	1,362,101	1,362,101	1,386,808	1,386,808	1,382,611	1,382,611	1,393,190	1,393,190
DTP3 coverage	91 %	85 %	93 %	93 %	94 %	94 %	94 %	94 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	40	33	25	25	15	15	15	15	15	15
Wastage[1] factor in base-year and planned thereafter for DTP	1.67	1.49	1.33	1.33	1.18	1.18	1.18	1.18	1.18	1.18
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	669,070	218,935	1,392,037	1,397,027	1,417,287	1,417,287	1,412,998	1,412,998	1,423,810	1,423,810
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	669,070	0	1,392,037	1,362,101	1,386,101	1,386,101	1,386,611	1,386,611	1,393,190	1,393,190
DTP-HepB-Hib coverage	45 %	0 %	93 %	93 %	94 %	94 %	94 %	94 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%) [2]	0	25	0	25	20	20	15	15	15	15
Wastage[1] factor in base-year and planned thereafter (%)	1.33	1.33	1.25	1.33	1.25	1.25	1.18	1.18	1.18	1.18
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,163,878	1,287,153	1,142,407	1,397,027	1,357,301	1,357,301	1,367,902	1,367,902	1,378,525	1,378,525
Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles	1,163,878	1,169,681	1,142,407	1,397,027	1,180,262	1,180,262	1,206,107	1,206,107	1,246,539	1,246,539

Number	Achievements as per JRF		Targets (preferred presentation)							
	2012		2013		2014		2015		2016	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
Measles coverage	80 %	76 %	78 %	95 %	80 %	80 %	82 %	82 %	85 %	85 %
Wastage[1] rate in base-year and planned thereafter (%) {0}	0	50	0	45	0	0	0	0	0	0
Wastage[1] factor in base-year and planned thereafter (%)	1.67	2	1.67	1.82	1	1	1	1	1	1
Maximum wastage rate value for Measles second dose, 10 dose(s) per vial, LYOPHILISED	50.00 %	40.00 %	50.00 %	40.00 %	50.00 %	40.00 %	50.00 %	40.00 %	50.00 %	40.00 %
Pregnant women vaccinated with TT+	1,427,654	1,406,719	1,437,885	1,437,885	1,461,277	1,461,277	1,457,021	1,457,021	1,465,305	1,465,305
TT+ coverage	90 %	85 %	91 %	91 %	92 %	92 %	93 %	93 %	94 %	94 %
Vit A supplement to mothers within 6 weeks from delivery	1,087,941	989,220	1,106,980	1,106,980	1,126,352	1,126,352	1,146,064	1,146,064	1,166,120	1,166,120
Vit A supplement to infants after 6 months	652,765	526,567	664,183	664,183	675,811	675,811	687,638	687,638	699,672	699,672
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	2 %	5 %	3 %	3 %	2 %	2 %	2 %	2 %	2 %	2 %

** Number of infants vaccinated out of total surviving infants

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

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

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

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

5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2012 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2012.** The numbers for 2013 - 2016 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

- Justification for any changes in **births**

  The target children and Pregnant women to be vaccinated has been forecast using the national growth rate set by the health planning department.
  EPI modified the microplanning format for routine immunization programme and according to the new guideline , the growth rate of respective area/ health department has been used to estimate the target.
  The birth registration system has been strengthened by collaboration with the private sector and the birth data being changed after adhering the data from private hospitals. Myanmar will be doing a census in 2014 so a more reliable accurate data will be made avaliable soon

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

  Since there is change in birth registration data and the number for infants has been collected by head count that is significantly different from the estimation by available data from general administration and population department , the surviving infant number has been changed. Myanmar will be doing a census in 2014 so a more reliable accurate data will be made avaliable soon

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

  The change in birth and surviving infant has impact on the target for each vaccine .The country introduce Hib containing Penta Valent vaccine and the target for DTP and Penta vaccine has been changed once it has being introduced in 2012 November .

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

  The vaccine wastage has been monitored and according to new policy and strategy,multi-dose vial policy has been practice. The wastage for DPT has been reduced from 40% to 33% .However the wastage for Measles vaccine is increased following more outreach session in hard to reach areas in 2012.

5.2. Immunisation achievements in 2012

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

Generally, the immunization achievement in 2012 were lower than 2011 .The routine immunization could not be able to conduct in (14) townships out of total of 330 in the country. The total of 4 townships in Northern Shan State "WA" special administrative region where the routine immunization could not be covered in 2011 is still uncovered.However the polio campaign has been successfully conducted in those township in response to outbreak of Vaccine Derived Polio Virus. In the state of Rakhine there were ethcnic conflct and this resulted in distruption of services in many townships, Alos in areas of Kachin, Shan Another townships were in Kachin state where the basic health staff are not able to posted due to security reason .

The national immunization programme is planning to conduct advocacy meeting with regional governments to find ways to overcome the barrier to access to those hard to reach areas.
There is special achievement that EPI has expanded the routine performance areas in Special administrative areas near Myanmar Thailand border areas .
The returnees and the children in the region previously not accessible due to armed conflict has been conducted coordinated approach to reach more children in Kayin State.

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

The 25-40 percent of health centers in townships in Rakhine state , Kachin state and Kayin States are not covered by routine immunization in 2012.
The vaccinators has not visited to reach those areas due to lack of security and internal pressure between the local ethnic group this probelm has become more seroius in 2012 due to ethenic clases in Rakhine and break of seize fire in Kachin

5.3. Monitoring the Implementation of GAVI Gender Policy

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

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

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls

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

In Myanmar , there is no issue of gender discrimination for immunization as well as for other health care interventions.All children can get access for immunization for immunization .
EPI has been trying to record the achievement in sex disaggregated data in collaboration with health management information system implemented by department of health planning.
Also VPD Surveillance data does not show any major gender disease burden

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

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

The gender related barrier has not been identified for immunization in Myanmar.
Immunization in uiversally free activity, There is restriction of daily activities for women in some community especially in Bangali in Rakhine state where the families are more dominant in by male. The mothers in these community are not empowered for every family activities and social functions but not specifically for immunization.
There is more female proportion in health service providers for immunization and also for other health care activities.

5.4. Data assessments

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

The immunization performance indicator from multiple indicator cluster survey (by UNICEF) has been conducted in 2011 -2012 and the survey showed the EPI coverage are around 97-98% but reported EPI coverage is only around 80%. MOH estimation

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

5.4.2. Have any assessments of administrative data systems been conducted from 2011 to the present? **No**

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

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

The EPI is planning to get more accurate coverage and other EPI related data.The immunization system is in close collaboration the health management information system tried to get reliable denominator for calculation of EPI coverage, As aprt of intensification of RI , Microplans were revised and their is more relevent / correct data in the Progrma

. The country is planning to conduct the census in 2014 and the activity will facilitate to get accurate baseline for immunization.
Meanwhile the coverage data has been calculated using the head count data of the children and the training to forecast the target has been conducted in all the State and Region.

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.

EPI is planing to upgrade the data management to electronic based system using IT technology from paper based system.Monthly data would be reported from state and region thereby compiling the data at central EPI.

The data quality audit has to be conducted in 2013-2014 and national-wide EPI coverage survey has been planning to take place in 2014.

5.5. Overall Expenditures and Financing for Immunisation

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

Exchange rate used	1 US$ = 850	Enter the rate only; Please do not enter local currency name

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

Expenditure by category	Expenditure Year 2012	Source of funding						
		Country	GAVI	UNICEF	WHO	Thematic/JCV	AusAid	UNF
Traditional Vaccines*	2,431,378	0	0	1,984,402	0	0	446,976	0
New and underused Vaccines**	7,047,438	512,848	6,534,590	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	87,599	0	0	30,876	0	0	56,723	0
Cold Chain equipment	326,965	0	0	251,500	0	75,465	0	0
Personnel	2,142,992	2,089,242	49,481	0	0	0	4,269	0
Other routine recurrent costs	209,602	31,732	111,208	32,451	21,873	0	4,269	8,069
Other Capital Costs	769,776	0	768,684	1,092	0	0	0	0
Campaigns costs	2,526,148	0	216,423	225,403	1,568,317	29,795	0	486,210
Procurement of IT equpment and Immunization card(UNICEF) Support towards Surveillance for VPD		0	137,856	69,978	727,517	0	0	0
Total Expenditures for Immunisation	15,541,898							
Total Government Health		2,633,822	7,818,242	2,595,702	2,317,707	105,260	512,237	494,279

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

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

The government has started to co-finance the cost of new vaccine pentavalent . EPI has proposed to allocate the government fund for immunization programme as well as the cost of new vaccine.Currently the traditional vaccines has been supported by UNICEF.

5.6. Financial Management

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

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

Action plan from Aide Mémoire	Implemented?

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

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

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2012? **2**

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

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

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

If Yes, which ones?

List CSO member organisations:
Chairman of Myanmar Maternal and Child Welfare Association
Chairman of Myanmar Red Cross Society

5.8. Priority actions in 2013 to 2014

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

5.9. Progress of transition plan for injection safety

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

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

Vaccine	Types of syringe used in 2012 routine EPI	Funding sources of 2012
BCG		
Measles		
TT		
DTP-containing vaccine		

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

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

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

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

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2012

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	297,000	252,450,000
Remaining funds (carry over) from 2011 *(B)*	2,812,000	2,390,200,000
Total funds available in 2012 *(C=A+B)*	3,109,000	2,642,650,000
Total Expenditures in 2012 *(D)*	1,349,188	1,146,809,800
Balance carried over to 2013 *(E=C-D)*	1,759,812	1,495,840,200

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

The ISS fund has transferred to DoH upon proposal received for the immunization service strengthening activities from Department of Health , EPI unit and office being approved by ICC .
The funding for procurement of supplies are being managed by concerned unit of WHO country office .
ISS fund has put in national health sector plan , the yearly costed plan of immunization programme has developed in collaboration with partners and being financed from government, WHO, UNICEF and GAVI ISS fund.
Once the programme has developed the proposal, it has to take 2-3 weeks to release fund from WHO to EPI unit and all payments are by A/C payee checque to MOH account

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

WHO use the bank account in Private bank and EPI unit use the account of department of health ,that is government account of Ministry of health.
The budget are approved once the proposed amount has been endorsed from Ministry of Health. The fund received from WHO has to be transected to department of health account and the fund are managed by budget management committee.The fund are allocated to State and Regional (sub-national level) and also to township level ,the basic health care management unit in the country.

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

EPI has been conducted in depth analysis of weak performing health center in 2011 . Low coverage areas were identified and support was provided to increase DPT3 coverage in these areas, The intensification of routine immunization has been planned and conducted in 2012 . The ISS fund has used for that strengthening activities.Microplannig , training,s ooperational cost etc were some of the major support provided to low coverage townships. High level advocacy workshop with mnister was done and Intensficatin was launched by HE Health mnister and also by state level officals

ISS funds were also used to conduct annual EPI evalaution meetings ,

The vehicles has procured to strengthen the supervision of regional supervisors and also the vehicles has been planning to purchase for central level supervisors.(in process)
The workshop to review and revise EPI and surveillance policy wwas under taken, as a out come of this workshop now Myanmar has adapted Multi dose open vial policy and made EPI sehedule more felxible from 6,10, 14 weeks to 2, 4 ,6 months

As a step for strengthening EPI , before New vaccine Introduction Myanmar conducted a AEFI workshop inviting SEARO/ HQ and internationsal consultants to strengthen the AEFI Sueveillance , AEFI committe was revised , AEFI guidlies awere also updates, Similarly MOH Myanmar conducted a 5 day Mid Level Manger trainings using standard WHO HQ tools, International experts were invited to train nationla and subnational level EPI managers as part of strengthening EPI specfically before. AEFI and NCIP members were provided with reference material and standard book like NVI

.Also the National Committee for Immunization practice (NCIP) meeting has been supported using ISS fund, THe NCIP charter has been updated and membership revised, this is very useful to provide independent Technical advice to govt

ISS funds were also used to support Cold chsain engeniors who are delpoyed at sub national level to help in maintaince of cold chain equipment and vaccine managment. This has helped program as vaccine wastage rates have reduced and cold chain break dwon rates are also less.

ISS funds were also used for Polio eradication activites, Myanmar has been free from Wild poliocvirus since 2007, how ever in May 2012 there was a Vaccine derived polio virus reported from Northen Shan state, the case was reported by China, This part of Myanmar is very diffuclt ISS funds were used for operational cost to conduct a Mop up House to house polio SIA, support was provided for vaccinatros to acess population in Hard to reach areas also volunters were supported to reach remote communities,

ISS funds were also used to strengthen AFP Surveillance and operational cost provided for case reporting anf investigation , as Myanmar and SEARO is progressing for regional certification , AFP surveillance was boosted

ISS funds were also used for Technica suppoertv and supervision by MOH staff to travel to state/ township level for monitoring of EPI activites

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

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

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

6.2.2. Has an external audit been conducted? **Yes**

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

6.3. Request for ISS reward

Calculations of ISS rewards will be carried out by the GAVI Secretariat, based on country eligibility, based on JRF data reported to WHO/UNICEF, taking into account current GAVI policy.

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

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

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

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

	[A]	[B]		
Vaccine type	**Total doses for 2012 in Decision Letter**	**Total doses received by 31 December 2012**	**Total doses of postponed deliveries in 2012**	**Did the country experience any stockouts at any level in 2012?**
Measles	2,429,600	2,429,600	0	No
DTP-HepB-Hib	3,336,988	3,080,500	256,488	No

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

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

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

The difference in Penta doses planned in decision letter and actual quantity received is difference due to difference in assumption of calender year . Myanmar count the fiscal year from April to next March . The planned introduced date has been postponed due to some delay in preparation process .
The vaccine shipments were well received and EPI had distributed all the required doses to sub-depot and to township level stores.

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

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

The country has conducted the cold chain logistic management workshop in April 2013 with the aim to improve the vaccine and other logistic management in the country.
The EVM improvement plan has developed after EVM assessment and GAVI HSS reprogramming fund has being planned to utilized for some of the activities such as procurement of vaccine cold van, upgrading information system along with existing Health Management Information System.
The ares need to strengthen are issue for cost estimates , forecasting the vaccine need and other logistics and those issue have to manage in close collaboration with UNICEF supply division , country office and EPI unit since lack of experience and expert in concerned unit in EPI unit of MOH and also in partners agencies.
In 2012 Myanmar has revised its Vaccine vial policy , now Health workers have been directed to use Multi dose Open vial policy for Penta, OPV, TT . With the change in the policy and revised of cold chain management, Multi dose vial policy being instructed to be in practice for multi dose vial presented vaccine such as Pentavalent vaccine. This will help to reduce wastage rates

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

no

7.2. Introduction of a New Vaccine in 2012

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

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Phased introduction	No	
Nationwide introduction	Yes	06/11/2012
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	The country has been planned to introduced DTB-HepB-Hib in 2012 , June but the programme has competing priority to respond the outbreak of Vaccine Derived Virus in 2012 June.and other disaster managment, There was some delays in prepartion , The preparation on advocacy and training has been deferred due to mentioned outbreak and other competiing priority

Measles second dose, 10 dose(s) per vial, LYOPHILISED		
Phased introduction	No	
Nationwide introduction	Yes	06/11/2012
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	Measles 2nd dose same reason as Penta valent vaccine. as both the vaccine were launched together on 6th Nov 2012

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

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

PIE is planned for both the vaccines by SEARO and partners in September 2013. this will be submitted in next APR

7.2.3. Adverse Event Following Immunization (AEFI)

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

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

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

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

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

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

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

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

Does your country conduct special studies around:

a. rotavirus diarrhea? **Yes**

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

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

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

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

Rota surveillance is being carried out in Yangon Children in three wards results from 2012 data show   P8 is the most comomn type of geno type followed by P6 . These study also show that most casoes of Rota virus occured in the mnoths of Nov-March Typhoid sential surveillance is laso being carried out in Two hospitals, Mandalay and Nay Pyi Taw, in first 3 months of 2013 , a total of 57 suspected typhoid cases were tested and two were pound positive Country plans to conduct a sero survey for Polio, Measles and Rubella in 6 high risk township to study the immunity levels Myanmar plans to start JE and CRS Surveillance soon Sero survey is being planned to look into immunity for Polio , Measles, Rubella in identified High risk areas

7.3. New Vaccine Introduction Grant lump sums 2012

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2012 (A)	2,418,000	2,055,300,000
Remaining funds (carry over) from 2011 (B)	0	0
Total funds available in 2012 (C=A+B)	2,418,000	2,055,300,000
Total Expenditures in 2012 (D)	296,010	251,608,500
Balance carried over to 2013 (E=C-D)	2,121,990	1,803,691,500

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

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2012 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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

The transportation cost for new vaccine, IEC materials production for social mobilization activities, medial workshop and central and regional training has been utilized by New vaccine introduction grant in 2012.
26,208- New vaccine ltransportation cost to state/ regional store
8,657: New vaccine launching activites
6,037 Central level training activites
36,453 : Sub national , regional level training activites 2215 : media workshop on New vaccines
58,268 :prinint of guidelines, forms etc for NVI

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

The is no major problem encountered in 2012 using new vaccine introduction grant., how ever some of the other planned activites including procurments of goods such as vaccine vans, generators etc were delayed.

In some parts of Myanmar specfically in Rakhine state, ethenic disturbances took place and a mumber of people were displacesd. Routine Immunization services were hampered in there areas and NVI counld not be rolled out to these areas, effrots are onn way to normalise and re start routine Immunization services in this areas, so that childrencould recieve penta , measles 2nd dose and other EPI vaccine at the earliest. Back log fighting / mopping up will have to under taken to ensure tat all missed children are reached and protected.

Similarly in some townships of Shan state , Kachin and Chin state , some hard to reach areas and some insecure areas were not covered by EPI and there for NVI benifits could not reach these populations, all effeorts are being made to reach these populations. in 2013. Because of Rakhine crisis some of the NV implemenation plans were not done in time, hpefully these will be done in 2013-14

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

A number of activities are being planned such as ,

Surveillance of vaccine preventable diseases, cold chain system strengthening at all level has been planned as priority activities in 2013-2014.Upgrading the facilities for the information system and expansion of cold chain capacity would be the major activities to be implemented.
There are also plans for procurmnt of genratros, for cold chan vaccine sbu depots and vaccine vans for transportation, transportation cost for vaccines to sub deports and HRA, Socail mobilization to increase awarness and demand for EPI .

HMIS strengthening, EPI coverage survey, coordination with private sectors and support to Measles rubella surveillance . labs and procurment of cold chain itens vaccine carrier, cold boxes are some of the identified activites.

7.4. Report on country co-financing in 2012

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2012?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	464,358	256,500
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED	0	0
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2012 from the following sources?	
Government	1292781.87	
Donor	0	
Other	0	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	48,489	770,000
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED	0	0

	Q.4: When do you intend to transfer funds for co-financing in 2014 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2014	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	February	Goverment
Awarded Vaccine #2: Measles second dose, 10 dose(s) per vial, LYOPHILISED		
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	The country need to develop financial sustainability plan(FSP) . The exercise has been conducted in 2006-2007 for the development of cMYP(2007-2011) however EPI need to develop the FSP with the changing government health care expenditure and opening up of the country.	

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

NA

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

7.5. Vaccine Management (EVSM/VMA/EVM)

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

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

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

Please attach:

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

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

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

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

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

If yes, provide details

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

7.6. Monitoring GAVI Support for Preventive Campaigns in 2012

Myanmar does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

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

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2013

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

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

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

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

If you don't confirm, please explain

The quantity of vaccine need to be adjusted that Penta price has been reduced and the quantity for 2014 has to be revised. The quantity procured by co-financed budget is less then the fund transferred to UNICEF supply division and the quantity has to be adjusted accordingly.

7.11. Calculation of requirements

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

ID		Source		2012	2013	2014	2015	2016	TOTAL
	Number of surviving infants	Table 4	#	1,541,016	1,464,625	1,475,282	1,470,863	1,466,517	7,418,303
	Number of children to be vaccinated with the first dose	Table 4	#	218,935	1,397,027	1,417,287	1,412,998	1,423,810	5,870,057
	Number of children to be vaccinated with the third dose	Table 4	#	0	1,362,101	1,386,101	1,386,611	1,393,190	5,528,003
	Immunisation coverage with the third dose	Table 4	%	0.00 %	93.00 %	93.95 %	94.27 %	95.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.33	1.33	1.25	1.18	1.18	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	2,469,260					
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	2,469,260					
	Number of doses per vial	Parameter	#		10	10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.04	2.04	1.99	1.93	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	0.00 %	0.00 %	

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

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

There is no stock difference between 31st December 2012 and 1st January 2013.

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

Co-financing group	Low

	2012	2013	2014	2015	2016
Minimum co-financing	0.20	0.20	0.20	0.20	0.20
Recommended co-financing as per APR 2011			0.20	0.20	0.20
Your co-financing	0.20	0.20	0.20	0.20	0.20

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

		2013	2014	2015	2016
Number of vaccine doses	#	6,126,700	4,824,600	4,529,100	4,557,800
Number of AD syringes	#	5,956,600	4,719,600	4,705,300	4,752,000
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	66,125	52,400	52,250	52,750
Total value to be co-financed by GAVI	$	13,587,500	10,701,500	9,819,500	9,596,500

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

		2013	2014	2015	2016
Number of vaccine doses	#	623,200	490,800	473,500	492,700
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country ^[1]	$	1,350,000	1,063,500	1,001,000	1,010,500

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

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	9.23 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	218,935	1,397,027	128,978	1,268,049
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B X C*	656,805	4,191,081	386,934	3,804,147
E	Estimated vaccine wastage factor	*Table 4*	1.33	1.33		
F	Number of doses needed including wastage	*D X E*	873,551	5,574,138	514,622	5,059,516
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		1,175,147	108,494	1,066,653
H	Stock on 1 January 2013	*Table 7.11.1*	2,469,260			
I	Total vaccine doses needed	*F + G – H*		6,749,785	623,162	6,126,623
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		5,956,514	0	5,956,514
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		66,118	0	66,118
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		13,742,563	1,268,757	12,473,806
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		276,978	0	276,978
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		38,349	0	38,349
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		879,525	81,201	798,324
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*		14,937,415	1,349,957	13,587,458
U	Total country co-financing	*I x country co-financing per dose (cc)*		1,349,957		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		9.23 %		

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

		Formula	2014			2015		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.23 %			9.46 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,417,287	130,849	1,286,438	1,412,998	133,737	1,279,261
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	4,251,861	392,546	3,859,315	4,238,994	401,211	3,837,783
E	Estimated vaccine wastage factor	*Table 4*	1.25			1.18		
F	Number of doses needed including wastage	*D X E*	5,314,827	490,682	4,824,145	5,002,013	473,429	4,528,584
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	0	0	0	0	0	0
H	Stock on 1 January 2013	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	5,315,327	490,728	4,824,599	5,002,513	473,476	4,529,037
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	4,719,566	0	4,719,566	4,705,284	0	4,705,284
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	52,388	0	52,388	52,229	0	52,229
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	10,822,006	999,123	9,822,883	9,934,991	940,323	8,994,668
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	10,822,006	0	219,460	9,934,991	0	218,796
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	30,386	0	30,386	30,293	0	30,293
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	692,609	63,944	628,665	635,840	60,181	575,659
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	11,764,461	1,063,066	10,701,395	10,819,920	1,000,503	9,819,417
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,063,066			1,000,503		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.23 %			9.46 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 3)

		Formula	2016		
			Total	Government	GAVI
A	Country co-finance	*V*	9.75 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,423,810	138,887	1,284,923
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B X C*	4,271,430	416,659	3,854,771
E	Estimated vaccine wastage factor	*Table 4*	1.18		
F	Number of doses needed including wastage	*D X E*	5,040,288	491,658	4,548,630
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	9,569	934	8,635
H	Stock on 1 January 2013	*Table 7.11.1*			
I	Total vaccine doses needed	*F + G – H*	5,050,357	492,640	4,557,717
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	4,751,909	0	4,751,909
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	52,747	0	52,747
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	9,732,038	949,316	8,782,722
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	220,964	0	220,964
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	30,594	0	30,594
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	622,851	60,757	562,094
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	10,606,447	1,010,072	9,596,375
U	Total country co-financing	*I x country co-financing per dose (cc)*	1,010,072		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.75 %		

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

ID		Source		2012	2013	2014	2015	2016	TOTAL
	Number of surviving infants	Table 4	#	1,541,016	1,464,625	1,475,282	1,470,863	1,466,517	7,418,303
	Number of children to be vaccinated with the first dose	Table 4	#	1,287,153	1,397,027	1,357,301	1,367,902	1,378,525	6,787,908
	Number of children to be vaccinated with the second dose	Table 4	#	1,169,681	1,397,027	1,180,262	1,206,107	1,246,539	6,199,616
	Immunisation coverage with the second dose	Table 4	%	75.90 %	95.38 %	80.00 %	82.00 %	85.00 %	
	Number of doses per child	Parameter	#	1	1	1	1	1	
	Estimated vaccine wastage factor	Table 4	#	2.00	1.82	1.00	1.00	1.00	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	4,576,800					
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	4,576,800					
	Number of doses per vial	Parameter	#		10	10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		0.27	0.29	0.30	0.32	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.00	0.00	0.00	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		14.00 %	14.00 %	14.00 %	14.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	10.00 %	10.00 %	

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

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

There is no stock difference between 31st December 2012 and 1st January 2013.

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

Co-financing group	Low

	2012	2013	2014	2015	2016
Minimum co-financing	0.00	0.00	0.00	0.00	0.00
Recommended co-financing as per APR 2011			0.00	0.00	0.00
Your co-financing	0.00	0.00	0.00	0.00	0.00

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

		2013	2014	2015	2016
Number of vaccine doses	#	2,593,500	1,180,400	1,212,700	1,256,800
Number of AD syringes	#	1,607,100	1,310,100	1,346,000	1,394,900
Number of re-constitution syringes	#	287,900	131,100	134,700	139,500
Number of safety boxes	#	21,050	16,000	16,450	17,050
Total value to be co-financed by GAVI	$	914,500	467,500	494,500	549,500

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

		2013	2014	2015	2016
Number of vaccine doses	#	0	0	0	0
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country ^[1]	$	0	0	0	0

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

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	1,169,681	1,397,027	0	1,397,027
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1	1		
D	**Number of doses needed**	*B X C*	1,169,681	1,397,027	0	1,397,027
E	**Estimated vaccine wastage factor**	*Table 4*	2.00	1.82		
F	**Number of doses needed including wastage**	*D X E*	2,339,362	2,542,590	0	2,542,590
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*		50,807	0	50,807
H	**Stock on 1 January 2013**	*Table 7.11.1*	4,576,800			
I	**Total vaccine doses needed**	*F + G – H*		2,593,497	0	2,593,497
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*		1,607,096	0	1,607,096
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*		287,879	0	287,879
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*		21,035	0	21,035
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		708,025	0	708,025
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		74,730	0	74,730
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		10,652	0	10,652
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		12,201	0	12,201
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		99,124	0	99,124
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		9,759	0	9,759
T	**Total fund needed**	*(N+O+P+Q+R+S)*		914,491	0	914,491
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*		0.00 %		

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

		Formula	2014			2015		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %			0.00 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,180,262	0	1,180,262	1,206,107	0	1,206,107
C	Number of doses per child	*Vaccine parameter (schedule)*	1			1		
D	Number of doses needed	*B X C*	1,180,262	0	1,180,262	1,206,107	0	1,206,107
E	Estimated vaccine wastage factor	*Table 4*	1.00			1.00		
F	Number of doses needed including wastage	*D X E*	1,180,262	0	1,180,262	1,206,107	0	1,206,107
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	0	0	0	6,462	0	6,462
H	Stock on 1 January 2013	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	1,180,362	0	1,180,362	1,212,669	0	1,212,669
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,310,091	0	1,310,091	1,345,952	0	1,345,952
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	131,021	0	131,021	134,607	0	134,607
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	15,997	0	15,997	16,435	0	16,435
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	337,584	0	337,584	358,951	0	358,951
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	337,584	0	60,920	358,951	0	62,587
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	4,848	0	4,848	4,981	0	4,981
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	9,279	0	9,279	9,533	0	9,533
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	47,262	0	47,262	50,254	0	50,254
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	7,505	0	7,505	7,711	0	7,711
T	Total fund needed	*(N+O+P+Q+R+S)*	467,398	0	467,398	494,017	0	494,017
U	Total country co-financing	*I x country co-financing per dose (cc)*	0			0		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	0.00 %			0.00 %		

Table 7.11.4: Calculation of requirements for Measles second dose, 10 dose(s) per vial, LYOPHILISED (part 3)

		Formula	2016		
			Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	1,246,539	0	1,246,539
C	**Number of doses per child**	*Vaccine parameter (schedule)*	1		
D	**Number of doses needed**	*B X C*	1,246,539	0	1,246,539
E	**Estimated vaccine wastage factor**	*Table 4*	1.00		
F	**Number of doses needed including wastage**	*D X E*	1,246,539	0	1,246,539
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*	10,108	0	10,108
H	**Stock on 1 January 2013**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*F + G – H*	1,256,747	0	1,256,747
J	**Number of doses per vial**	*Vaccine Parameter*	10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*	1,394,879	0	1,394,879
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*	139,499	0	139,499
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*	17,032	0	17,032
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	404,673	0	404,673
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	64,862	0	64,862
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	5,162	0	5,162
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	9,879	0	9,879
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	56,655	0	56,655
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	7,991	0	7,991
T	**Total fund needed**	*(N+O+P+Q+R+S)*	549,222	0	549,222
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	0.00 %		

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

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

   a. Progress achieved in 2012

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

   c. Plans for 2014

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

For countries that received HSS funds within the last 3 months of 2012, or experienced other delays that limited implementation in 2012, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2012 fiscal year starts in January 2012 and ends in December 2012, HSS reports should be received by the GAVI Alliance before **15th May 2013**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2013, the HSS reports are expected by GAVI Alliance by September 2013.

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

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

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

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

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

   a. Minutes of all the HSCC meetings held in 2012

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

   c. Latest Health Sector Review Report

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

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

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

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

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

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

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

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

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

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

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

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

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

If yes, please indicate the amount of funding requested: **8353249** US$

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

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

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

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)					3649218	6653686
Revised annual budgets (*if revised by previous Annual Progress Reviews*)					3649218	5061666
Total funds received from GAVI during the calendar year (*A*)					2807506	5061666
Remaining funds (carry over) from previous year (*B*)					0	1950586
Total Funds available during the calendar year (*C=A+B*)					2807506	7012252
Total expenditure during the calendar year (*D*)					856920	768106
Balance carried forward to next calendar year (*E=C-D*)					1950586	6244146
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	3649218	7459586	8353249

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)	9883249	12594749		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	8353249	14124749		
Total funds received from GAVI during the calendar year (*A*)	0			
Remaining funds (carry over) from previous year (*B*)	6244146			
Total Funds available during the calendar year (*C=A+B*)	6244146			
Total expenditure during the calendar year (*D*)	2068942			
Balance carried forward to next calendar year (*E=C-D*)	4175204			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	14124749	0	0	0

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)					2819020905	5656963837
Revised annual budgets (*if revised by previous Annual Progress Reviews*)					2819020905	4303428433
Total funds received from GAVI during the calendar year (*A*)					2168798848	4303428433
Remaining funds (carry over) from previous year (*B*)					0	1658388217
Total Funds available during the calendar year (*C=A+B*)					2168798848	5961816650
Total expenditure during the calendar year (*D*)					661970924	653043721
Balance carried forward to next calendar year (*E=C-D*)					1506827924	5308772929
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	2819020905	5762530185	7101932300

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)	8402738300	1070805560		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	7101932300	1200886160		
Total funds received from GAVI during the calendar year (*A*)	0			
Remaining funds (carry over) from previous year (*B*)	5308772929			
Total Funds available during the calendar year (*C=A+B*)	5308772929			
Total expenditure during the calendar year (*D*)	1759014488			
Balance carried forward to next calendar year (*E=C-D*)	3549758441			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	1200886160	0	0	0

Report of Exchange Rate Fluctuation

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

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January					851	807.5
Closing on 31 December					791	850

Detailed expenditure of HSS funds during the 2012 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2012 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2013 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

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

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

Financial Management of GAVI HSS funds are done as per the Aide Memoire signed between CEO GAVI on 26/1/2011 and Minister of Health, <?xml:namespace prefix = st1 />Myanmar on 4/2/2011 . <?xml:namespace prefix = o />

HSS support approved by the GAVI Board is disbursed to and managed by MoH-Myanmar's principle development partners namely WHO and UNICEF. Since It is mandatory to record all the external funding(grants) coming into the country in the national health sector budget, GAVI HSS funds are then reflected in our National Health Sector Budget.

In addition, a third agency will be engaged by MOH-Myanmar to implement "renovation and construction works."

Funds are managed as follows:

a. UNICEF received a total of USD 1,188,000 for year two, and it has been used for the procurement of life saving drugs and supplies in the implementation of the strategy of reaching every community;

b. WHO received a total of USD 3,873,666 for the second year of the HSS programme. WHO is responsible for the overall management and administration of the GAVI HSS programme and activities; provision of technical assistance to all aspects of the programme including cross cutting support in capacity building, research, planning and monitoring and evaluation; and, recruitment of technical staff and international consultants;

C. Infrastructure: This component was pending till date. Myanmar Red Cross Society (MRCS) was identified as the third party to implement this by Ministry of Health . As an outcome of GAVI mission in February 2013, Ministry of Health was informed by the GAVI secretariat to submit the proposal from MRcs to GAVI throgh NHSC (Annexure I).. The proosal was endorsed by the 4th NHSC on 1st April 2013 and subsequently submitted to GAVI.

Funds managed by UNICEF

UNICEF is responsible for procurement of supplies for the GAVI-supported townships. A Letter of Agreement covering the 4 year period dated April 2009 between MOH-Myanmar and UNICEF has been signed for UNICEF's role in procurement of supplies.

UNICEF Country Office has procured the supplies through UNICEF Supply Division at Copenhagen. The MoH-Myanmar receives at the port of entry, gets customs clearance and distributes all supplies to township level. UNICEF has also supported the MOH Myanmar at CMSD level in supervision and monitoring of distribution of these supplies. UNICEF provides utilization of funds reports annually to the Focal Point for GAVI-HSS in the MoH-Myanmar.

Funds managed by WHO

A significant portion of the HSS programme in Myanmar is implemented jointly by WHO and the MoH-Myanmar. This has been agreed in a Letter of Agreement, dated 4 June 2009 between MoH-Myanmar and the WHO Country Office, which outlines in detail WHO's role in the administration and management of the HSS GAVI funds and the different contractual mechanisms that will be used by WHO in the implementation of the HSS programme.

GAVI mission visited Myanmar in February 2013 to review the funding mechanism for year 3 and year 4 . As an outcome of the visit, it was unanimously agreed by GAVI, WHO and MOH to continue the current fund management mechanism(reference letter from GAVI and MoH , Annexure II). To endorse this officialy a new grant agreemnt will be signed soon. Inorder to continue the current implementtaion mechanism with WHO, some adjustment to budget was required . The adjustment was made from the following budgteline as follows:

For year 3:

1) Renovation of RHC in year 3 = $ 720,000

2)Installation of solar in year 3= $ 86,000

For year 4:

1) Renovation of RHC in year 4= $ 720,00O

2) Insrallation of solar in year 4 = $ 43,000

3) from construction of Sub RHCs = $ 176,142

Abovementioned program change was proposed to and approved by the 5th NHSC on 7th May 2013.

The bulk of the activities is implemented by MoH-Myanmar with technical support from WHO. Funds are therefore disbursed to MoH-Myanmar using one of the modalities, subject to the following conditions:

a. Each contract signed between WHO and the MoH-Myanmar has a clear time frame for implementation. Monitoring of implementation are undertaken through generation of regular reports in WHO's GSM system as well as through monitoring officers in WHO. Quarterly statements of expenditure/progress reports of WHO are compiled and consolidated by MoH-Myanmar and WHO respectively and presented to the National Health Sector Coordinating Body for Health System Strengthening (NHSC), sometimes referred to as Health Sector Coordination Committee (HSCC). Contractual arrangements for Agreements for the Performance of Work (APWs) and

Has an external audit been conducted? Yes

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

9.2. Progress on HSS activities in the 2012 fiscal year

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

Please provide the following information for each planned activity:

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

Table 9.2: HSS activities in the 2012 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Procurement and distribution of essential medicine and equipment to 20 townships up till sub-RHC level.	Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	100	UNICEF (list of medicines and equipments procured/ disbursed to CMSD- CMSD (Distribution breakdown of medicine and equipments to 20 townships- Annexure III) UNICEF progress Report. Annexure IV)
Infrastructure, Identification of third party	Activity 1.3: INFRASTRUCTURE 540 RHCs and 324 sub-RHCs in 180 HSS-targeted Townships will be renovated/ constructed including construction of sanitary latrines and improve access to safe water source by 2015, based on needs identified in coordinated township health plans. Installation of solar at the RHC at HTR areas	30	- 4TH NHSC Minutes. - MRCS proposal.
Supply of Motorcycles to the BHS of 20 townships	Activity 1.4.2: Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan	70	WHO: email communications
Explore strategic Health Financing Options	Activity 2.2: HEALTH FINANCING RESEARCH Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships by 2012.	80	Guideline on MCH Voucher. Annexure V)
Hospital Equity Fund	2.5.1 Management Support (from Township Coordinated Plans) Includes supervision and planning activities $10,000 per Township per annum scaling up to 180 Townships by 2011)	90	Quarterly report on HEF to WHO SEARO. Annexure VI) Minutes from Annual Progess Review. Annexure VII).
Annual Program Review and NHSCs	2.6.1 Annual Program Review Central Level	100	1st -4th NHSC minutes & Annual Program Review Minutes. Annexure VIII)

Health System Research	2.6.4 Establish Health Systems Research Fund	100	Reserach findings. Annexure IX)
Research on motivation and retention of midwives	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010, motivational factors of rural health workforce)	100	Report. Annexure X)
Development of HR strategic plan	Activity 3.2: HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1 (complementary Funding through AAAH, but with National HR Conference funded through GAVI)	100	HR Strategic Plan (Annexure XI)
Policy brief for retention scheme options for Health Workforce including financial incentive	Activity 3.3: HR PROPOSAL Development of Proposal to MOH recommending appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives. (complementary Funding through AAAH)	70	Research proposal. Annexure XII. List of AMW kits procured. Annexure XIII.
Technical skill upgradation for Basic Health Staffs	3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines	80	Training Proposals.
Experience sharing among HSS countries	3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems	100	Travel Reports. Annexure IV).
Logistic Support (2 cars)	Transport/Vehicles for DOH and local transport costs	50	WHO: email communications
External Consultant (Financial Management)	Financial Management Consultancies	100	Report MCH voucher (Annexture XV).

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

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
Objective 1:	By the end of 2015, 20 selected townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%
Procurement and distribution of essential drugs	Progress: Essential medicine and equipment procured and distributed to 20 townships up till sub-RHC level.
Infrastructure	Progress: GAVI Mission in Feb 2013. MRCS proposal endorsed by 4th NHSC and submitted to GAVI secretariat.
Increase access to hard to reach areas	Progress: Access to essential components of EPI, MCH, Nutrition and Environmental health for the hard to reach communities in 20 townships through coordinated efforts and package of service delivery.

Procurement and supply of Motorcycles	Progess: Now Procurement process reached a advanced level following WHO procurement rules. even year two goods will be procured along with this. Constraints: limited budget only allowed procurement of local products. whereas, WHO has specific procurment rules for procuring non-catalogue products. This took long time .
Objective 3:	By the end of 2015, 20 selected townships with identified hard to reach areas will be staffed by midwives and PHSII according to the national HR standards
Research on motivation and retention of midwives	Progress: - Research on Movitation factors for rural retention of midwives conducted- - Findings disseminated at national level in July, 2012.
Development of HR strategic plan	Progress: - National Health workforce Strategic Plan (2012-2017) drafted and disseminated. - Document Publication under process.
Policy brief for retention scheme options	Progress: - Research under process.
Technical skill upgradation for Basic Health Staff	Progress: All Basic Health Staffs in 20 townships trained on maintaining service quality for provision of MCH, EPI, Nutrition and envt health during package tour.
Experience sharing among HSS countries	Progress: 10 health professionals from central, state and township level visited Cambodia and Laos.
Objective 2:	By the end of 2015, 180 selected townships with identified hard to reach areas will have developed and implemented coordinated township micro-plan.
Explore strategic Health Financing Options	Progress: MCH voucher scheme launched with high level advocacy in one township. Constraints: Planned budget for year one was not enough and had to reprogram additonal funds from other areas (consultancies).
Hospital Equity Fund	Progess: Funds implemented in all 20 townships. Constraints: High varience in hospital capacities in 20 townships shows different fund utility rates across hospitals. Fund distribution mechanism for year two will be revised.
Annual Program Review and NHSCs	Progress: - Annual Programme Review meeting for year one plan held on 1st April 2013. - 5 NHSCs conducted till date.

Health System Research	Progress: - Three health system researches on EPI, MCH and Environmental Sanitation conducted covering 11 townships. Constraints: - Research capacity still at infancy level and needs further strengthening.
Support costs	
Logistic Support (2 cars)	Progress: procurement process at advanced level. Constraints: Due to the sanctions, WHO and Ministry had to undergo various procedures in procuring the vehicles.
External Consultant (Financial Management)	Progress: consultants recruited through WHO funds and exsiting fund reprogramed to implement MCH voucher scheme.
HR consultant	Progress: Consultant recruited through WHO funds. Funds from GAVI reprogramed to support MCH Voucher scheme.

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

Piloting MCH voucher scheme planned under Objective 2 was delayed because there was not enough fund budgeted in year one. Hence, funds booked for Consultancies for financial management and HR are reprogrammed to support this activity. The consultancies were supported by WHO funds.

Procurement of motorbikes and vehicles were also delayed due to quality screening and regulation process by WHO. Now, procurement is at an advanced stage and even the products planned for year two will be procured upfront.

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

GAVI HSS funds supported various studies and research on rural retention of health workforce in Myanmar as it was identified as one of the key barriers in the system. HSS funds were also invested in provding per diem and transportation support for the basic health staffs in delivering PHC services to hard to reach areas in 20 townships. Funds were used to recruit and train the community health workers(CHWs and AMWs) to fill HR gap at the hard to reach areas in 20 townships.

GAVI HSS funds supplemented WHO's support to the Ministry in drafting the National Health Workforce plan (2012- 2017). This document is expected to guide future decision on HR in the country.

9.3. General overview of targets achieved

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

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2012 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2008	2009	2010	2011	2012		
Outcome and Impact Indicators											
1. National DPT3 coverage (%)	70%	2006	90%	90%	86%	90%	90%	86%	85%	EPI unit, MOH	

2. Number / % of districts achieving ≥80% DTP3 coverage (National)	75 Townships 23%	WHO UNICEF Joint Report Dept. of Health/ 2006	325 townships	330 townships	221	289	283	252	211	EPI evaluation , MOH	
3. Under five mortality rate (per 1000) (national	66.1/1000LB	HMIS: Dept of Health Planning. Survey DOH UNICEF / 2003	38.5 MDG target by 2015	NA	*40.73/1000LB		**46.1/1000LB	NA	NA	* CSO **MICS (2009-2010)	Next MICS will be able to give this data.
4. Delivery by Skilled Birth Attendants (HSS targeted Townships)	67.5%	Union of Myanmar MDG report 2006 Fertility Reproductive Health Survey/2003	80%	NA	67%	64.4%	64.8%	67.1%	NA	HMIS 2012	2012 data will be available only after few months.
5. Rate of ORS Use of < 5 children (National)	53%	Dept. of Health Planning Public Health Statistics Annual Report 2006	80%	NA	94.1%	95.6%	96.4%	97.1%	NA	HMIS 2012	2012 data will be available only after few months
6. % of 6-59 months children having Vitamin A during past 6 months (National)	80%	Bi Annual Report of Nutrition Dept/2007	90%	95.1%	94.9%	94.5%	94.0%	95.74 %	96.08 %	Bi annual report of Nutrition	
Output Indicators											
1. % of townships have developed and implemented coordinated plans according to national framework	0	Annual Program Review (Annual Evaluation Report)/2006	55%(180 townships out of 325)	20 townships					20 townships	DOH	
2. Number/% of RHC(in 180 HSS townships) visited at least 6 times in the last year using a quantified checklist	0	Base line survey	100%	115 RHCs in 2012					67 RHCs	HSS Assessment	115 includes all easy and hard to reach RHCs. However, the program budget could cover supervisory visits to only Hard to Reach RHCs.
3. Number of managers/ trainers / BHS trained for MEP at each level per year	300 BHS and 50 managers and trainers for MEP	Annual Program Review	9000 BHS and 100 Managers & trainees	1200 BHS including TMOs trained on CTHP					1137	HSS Assessment	almost achieved.
4. Proportion of RHCs with no stock out of essential supplies in the last 6 months (availability, service access, utilization, quality)	0	Base line survey	100% of RHCs in HSS investment area.	115 RHC				0	115 RHCs	DOH	
5. No of RHC and sub RHC renovated and/or constructed per year	30 RHCs (renovated) and 90 sub RHCs (constructed)	Dept. Health	540 RHC renovated and 324 Sub RHC constructed in HSS investment area(180 townships)	30 sub RHCs				0	0	DOH	Infrastructure component still under process

6. Percent of selected Townships with identified hard to reach areas staffed by midwives and PHS2 according to the National HR Standards.	0	Base line survey	50%	NA					NA		No computarised Personal Information System in place to help track this indicator. Minsitry is working on developing this system.

9.4. Programme implementation in 2012

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

- 20 townships implemnted coordinated township health plans and delivered package of Primary Health Care services(MCH, EPI, Nutrition and EH) to the hard to reach areas. Through the package of service delivery:

1. 14867 ANC Performed

2. 3163 PNC performed

3. 16289 children immunized (BCG, OPV, DPT, measles).

4. Nutritional status of 90064 under 5 children measured.

5. Health Education service enhanced the advocacy on immunisation especially for hard to reach areas.

- Hospital equity fund ($ 200, 0000 benifited the following vulnerable groups in 20 townships):

1. 722 mothers treated for Obstetric cases.

2. 325 under 5 children treated for life saving conditions.

3. 24 men treated for surgical and medical cases.

- Data quality and service quality assessment conducted in 20 townships facilitated in streamlining data recording system for DPT 3 and ANC and PNC and TT.

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

Problems encountered:

Findings from annual progress review conducted in March 2013, demonstrated data inconsistencies. Multiple data sources, data collection and calculation methods were applied, that demonstrates different output scenarios for DPT 3 coverage and SBA rates.

Solution:

Process is under way to hire team of External experts to assess the performance of HSS in 1st 20 townships and to design way forward. M&E tool will be designed to support continued data input and allow analysis of data from multiple sources and enable tracking of health-systems performance based on focused interventions. This tool is expected to generate quality data and information that is adequate enough to inform decision making at different levels and also to facilitate reporting to GAVI.

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

Different Monitoring and Evaluation Mechanisms are instituted at different levels as explained below:<? xml:namespace prefix = o />

Monthly supervision visits by TMOs to the RHCs and Sub RHCs to track progress status on delivering package of services (EPI, MCH, Nutrition and Environmental Health) to hard to reach areas.

18 Health System Strengthening Officers (HSSOs) are recruited and deployed by WHO: 14 at the townships level and 4 at central. HSSOs conducts field visit to monitor and supervise the delivery of package and submit monthly report to central. Since these HSSO's are recruited by WHO, they also submit their duty travel report to the WHO technical unit for every visit they make.

Further, random Monitoring visits are also made by the Planning Unit, under Department of Health to review the status of implementation at the townships; this will be also complemented by random auditing by the finance unit of DoH together with the HSSO designated for financial management.

Fund release for each activity to ministry is subject to receipt of proposal (APW and DFC) by WHO from Ministry. Proposal for every activity highlights the timeline and budget breakdown for implementation. GAVI HSS technical unit in WHO then tracks the implementation status referring to the timeline and budget breakdown highlighted in the proposal. WHO does not accept any delay in the activity implementation and deviation in budget use by MOH, unless proper technical justification is provided by the central team of the Ministry to WHO.

Monitoring of the services is done through Quarterly Review Meetings held at the townships and National Health Sector Coordination Committee at the central levels. As of now, three NHSC meetings are conducted at the central level and one Quarterly Review Meeting is held at each GAVI HSS township. (Minutes from these meetings are shared for reference).

Annual Auditing was conducted twice (2012 & 2013) for the GAVI HSS funds by the Auditor Generals Office, report. Further an external team will be hired to assess the performance of HSS in 1st 20 townships and specific M&E tool will be designed to update and track progress.

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

Support from GAVI for health System strengthening is captured in the annual budget of the country and also in the National Plan (2011-2016) of the Country. <?xml:namespace prefix = o />

Much of the GAVI HSS activities are implemented in collaboration with WHO and is incorporated in the WHO detailed work plans. Accordingly the end of biennium review by WHO captures the progress status of HSS activities.

Some of the HSS activities that were implemented in 2010 were reflected (2010-2011biennium) and were reviewed during the end of biennium review for (2010-2011) in December 2011. The rest of the activities are planned in 2012-2013 biennium and it will be reviewed by end of 2013.

Since the procurement of essential medicines and equipments are done by UNICEF, the annual program review by UNICEF will tab the progress status on the distribution and utilization of medicines and equipment at the townships.

Further the impact of GAVI HSS interventions will be evaluated during the review of the National Health Plan by 2015.

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

Major organizations that were involved in the implementation of GAVI HSS in <?xml:namespace prefix = st1 />Myanmar are WHO and UNICEF. Further JICA, Save the Children and MERLIN, ACF, representative from Donor Consortium (CCM) are the NHSC members and contribute in M& E and decision making.

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

Myanmar Maternal and Child Welfare Association (MMCWA) & Myanmar Women's Affairs Federation: facilitates community mobilization to access package of services (EPI, MCH, Nutrition and environmental health), especially in hard to reach areas. Myanmar Medical Association and Myanmar Red Cross Association are members of NHSC and contribute in decision making and M&E of the GAVI HSS interventions. <?xml:namespace prefix = o />

These local NGOs actively participates in the quarterly review meetings held at the townships to review the package of service (EPI,MCH, Nutrition and Environmental Health) delivery for the hard to reach areas in the townships.

Myanmar Maternal and Child Welfare Association (MMCWA) contributed referral fees for the poor pregnant mothers with need of emergency care (that will be added to Hospital Equity Fund at townships), Clean Delivery Kits (CDK), weighing machines and labour beds and to all HSS 20 townships in year one.

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

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

With the involvement of WHO and UNICEF as the external partners and internal funds disbursement and management mechanism established at various levels (as per Financial Management Assessment), the HSS fund management has been effective so far.

9.5. Planned HSS activities for 2013

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

Table 9.5: Planned activities for 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2013 actual expenditure** (as at April 2013)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)

Objective 1:					Expenditure in column 5 is cumulative figures on expenses made from both sources(yr 1 & yr 2 budget) for the period 1st April 2012- 31st March 2013. *** detailed breakdown on expenses by source (yr 1 & yr 2 budget) for the above period by activityline is attached as annexure XVI, for reference.	
Health System Assessment and CTHP development	Activity 1.1: SURVEY Conduct survey to establish base line indicators & outcome, impact and research for operations	80000	61523		survey protocols were already developed and saving money will be used to train Auxillary Midwives. saving($ 15,000) will be moved to activity (1.5) under same objective.	65000
Procurement and distribution of essential drugs	Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans	1080000	1029654			1080000
INFRASTRUCTURE	Activity 1.3: INFRASTRUCTURE 540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source	1586000	0		fund for renovation of RHCs ($480,000) reprogramed to ISS.	1106000
Increase access to EPI/MCH	1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans	300000	0			300000
Procurement and supply of motorcycles	Activity 1.4.2 Supply of transportcapital to Townships based on needs identified in Township Coordinated Health Plan	100000	7022			100000

Social Mobilization activities:	Activity 1.5: SOCIAL MOBILIZATION: InvolvingNGOs, local authorities and Community Health Workers in developing and implementing coordinated township Health plans in 100% of HSS-targeted townships	400000	168433		more funds needed to train the Community health workers(AMWs). so reprogramed $15,000 from activity 1.1.	415000
Objective 2:						
	Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) & supervision at all levels (including checklists)	20000	51162			20000
	Activity 2.2: HEALTH FINANCING RESEARCH Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships	40000	43343			40000
Implemetation of MVS in piloted 2 townships	Activity 2.3: HR FINANCING Training and Piloting of health financing schemes, according to national guidelines in 50 townships by 2015	300000	0			300000

Leadership and management training based on HSS in HSS townships	Activity 2.4: TRAINING Implementthe training program on coordinated management through the modified MEP program in HSS targeted townships	60000	30017			60000
Hospital Equity Fund	2.5 Management Supp	600000	200000			600000
Annual Programe Review and NHSCs	2.6.1 Annual Program Review Central Level and NHSCs	20000	0			20000
Annual Program Review at townships	2.6.2 Annual Program Review State and Division Level	51000	0			51000
HSR	2.6.4 Established Health Systems Research Funds	72049	49991			72049
Objective 3:						
Supportive activity for creating HR unit	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity	10000	23748			10000
	Activity 3.2: HR Plan Deveop HR Plan recommendin g strategies for retension and deployment of staff in hard to reach areas.		0			
	Activity 3.3: HR PROPOSAL Development of Proposal to MOH recommendin g appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives.	10000	107558			10000

Provision of package of service to HTR areas	3.3.1 HR costs (HR Finance incentivescheme for health staff in remote areas - identified in Township Coordinated Plans)	346500	0			346500
Continuous training	3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines	60000	0			60000
	3.4.2 International short courses Health Financing		0			
Study tour	3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems	40000	45568			40000
Recruitment of Health System Strengthening Officers	3.4.4 Leadership Development Program	331200	438751			331200
Support costs						
	Office Equipment Central		554			
	Transport/ Vehicles for DOH and local transport costs		57340			
logistics for central	ComputersCentral	30000	20000			30000
logistics for townships	Computers Townships	80000	0			80000
Administration cost for WHO	Management costs Administration and Management Cost (WHO)	366500	129041			366500
Administration cost for MOH	Administration Costs Central Level (DOH)	30000	20284	fund for planning consultant will be reprogramed to this activity.Planning consultant already recruited in year one.		45000
International technical assistance	International Technical Assistance Health Systems Advisor (WHO)	198000	177776			198000
External consultant (Financial Management)	Financial Management Consultancies	15000	0			15000

External consultant (Health System Analyst)	Health System Analyst	15000	0			15000
External consultant (HSR)	Operational Health Systems Research	15000	0			15000
External consultant (Drug Supply)	Drugs Supply System	15000	0			15000
External consultant (planning)	Planning consultant	15000	0	planning consultant already recruited in year one. fund reprogrammed to suport monitoring and supervision.		0
		6286249	2661765			5806249

9.6. Planned HSS activities for 2014

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

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

Table 9.6: Planned HSS Activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
Objective 1:	By 2015, selected townships with identified hard to reach areas will have increased access to essential components of MCH-EPI and EH and Nutrition as measured by increased DPT from 70% to 90% and SBA from 67.5% to 80%				
Health System Assessment and CTHP development	Activity 1.1: SURVEY Conduct survey to establish base line indicators & outcome, impact and research for operations	120000			120,000

Procurement and distribution of essential drugs	Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinatedTownship health plans	2160000			2,160,000
	Activity 1.3: INFRASTRUCTURE 540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source by 2011, based on needs identified in coordinated township health plans. 1.3.1 Renovation of 540 RHCs	720000	PSC and Technical Assistance from WHO	Inorder to continue the current implementation method with WHO for year 3 and year 4, a budget adjustment of $ 829,487 was needed to cover PCS and Technical Assistance for WHO in year 3.	720,000
	1.3.3. Installation of Solar for (63) RHCs at hard to reach townships	86000	PSC and Technical Assistance from WHO.	Inorder to continue the current implementation method with WHO for year 3 and year 4, a budget adjustment of $ 829,487 was needed to cover PCS and Technical Assistance for WHO in year 3.	86,000
Social Mobilization activities:	Activity 1.5: SOCIAL MOBILIZATION: Involving NGOs, local authoritiesand Community Health Workers in developing and implementing coordinatedtownship Health plans in 100% of HSS-targeted townships by 2015)	600000			600,000
Procurement and supply of motorcycles	1.4.2 Supply of transport capital to Townships based on needs identified in Township CoordinatedHealth Plan	150000			150,000

Social Mobilization activities:	Activity 1.5: SOCIAL MOBILIZATIO N: Involving NGOs, local authoritiesand Community Health Workers in developing and implementing coordinatedto wnship Health plans in 100% of HSS-targeted townships by 2015)	600000			600,000
Objective 2:	By the end of 2015, 180 selected townships with identified hard to reach areas will have developed and implementedc oordinatedtow nship micro-plans				
Production of guidelines	Activity 2.1: GUIDELINES DEVELOPME NT Develop national guidelines for coordinatedto wnship health planning (including financial management and health financing) & supervision at all levels (including checklists)	20000			20,000
Maternal Voucher Scheme	Activity 2.3: HR FINANCING Training and Piloting of health financing schemes, according to national guidelines in 50 townships	600000			600,000
Management Training	Activity 2.4: TRAINING Implement the training program on coordinatedm anagement through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2015	90000			90,000

Hospital Equity Fund	2.5.1 Management Support (from Township Coordinated Plans) Includes supervision and planning activities ($10,000 per Township per annum scaling up to 180 Townships by 2015)	1200000			1,200,000
Annual Program Review (Central) and NHSCs	2.6.1 Annual Program Review Central Level	20000			20,000
Annual Program Review at townships	2.6.2 Annual Program Review State and Division Level	51000			51,000
External Review of HSS	2.6.3 External Review of progress of HSS	50000			50,000
Health System Research	2.6.4 Establish Health Systems Research Fund	72049			72,049
Objective 3:	By the end of 2015, 20 selected townships with identified hard to reach areas will be staffed by midwives and PHS2 according to the National HR Standards.				
	Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing)	10000			10,000
Provision of package of service to HTR areas	3.3.1 HR costs (HR Finance incentive scheme for health staff in remote areas - identified in Township CoordinatedPlans)($5,500 per Township per Year)	693000			693,000

Continuing training	3.4.1 Continuing training and dissemination of CoordinatedTownship Planning and Programme Implementation Guidelines	120000			120,000
	3.4.2 International Short Courses Health Financing	50000			50,000
Experience sharing among HSS countries	3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems	40000			40000
Recruitment of Health System Strengthening Officers	3.4.4 Leadership Development Program	331200			331,200
Support cost					
Cars	Transport/Vehicles for DOH and local transport costs	60000			60,000
Computers (Central, States/Divisions)	Computers Central and States/Divisions	30000			30,000
Computers (Townships)	Computers Townships	120000			120,000
Management costs					
Management Support (WHO)	Administration and Management Cost (WHO)				
Management Support (DOH)	Administration Costs Central Level (DOH)	30000			30,000
M&E support costs	International Technical Assistance				
Health Systems Advisor (WHO)	Health Systems Advisor (WHO)	99000			99,000
External consultant (Operational Health System Research)	OperationalHealth Systems Research	15000			15,000
		8137249			

9.7. Revised indicators in case of reprogramming

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

9.8. Other sources of funding for HSS

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

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
Myanmar Maternal and Child Welfare Association(MMCWA)	11762	one year	Top up fund for Hospital Equity Fund in 20 HSS townships
World Health Organisation(WHO)	43000	Three Months	Consultancies for HR and Financial Management.

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

9.9. Reporting on the HSS grant

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

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

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Health System Assessment Reports and Results.	- Respective team leaders assigned for assessment at different townships	- Compilation of the information from different assessment teams and different townships.
MICS 2009-10 report and HMIS: indicators , Progam Data	- published reports	-discrepancies in data from different sources
Office of Auditor General of the Union, Myanmar: Audit report GAVI HSS funds	- Office of Auditor General of the Union, Myanmar	
UNICEF Country Office: Essential drugs and Equipments.	- Confirmation with UNICEF focal point	
WHO GSM, GAVI HSS Technical Unit (Financial statements and S &E). Budget and Finance section of DOH, MoH: Financial statements, S&E.	-Validated by WCO- GAVI HSS technical unit, Accounts and Finance section, followed by endorsement from Budget and Finance Office in WHO SEARO. - Validated by the Director of Planning and Finance, DOH, MoH.	- changes in Exchange rate

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.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2012?1

Please attach:

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

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

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

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

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

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

Myanmar **has NOT received GAVI TYPE B CSO support**

Myanmar is not reporting on GAVI TYPE B CSO support for 2012

11. Comments from ICC/HSCC Chairs

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

The ISS fund received and Government Audit amount are not the same. It is due to ONLY the ISS fund received during 2012 calender year has been examined by government audit and the fund received during 2013 has not been audited.

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

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

I. All countries that have received ISS /new vaccine introduction grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2012 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

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

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

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

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

I. All countries that have received HSS grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2012 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

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

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

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

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

I. All countries that have received CSO 'Type B' grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

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

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2012 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

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

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

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

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

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Health Minister and Finance Signature_Page.pdf.pdf File desc: Date/time: 5/14/2013 4:15:02 PM Size: 629907
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Health Minister and Finance Signature_Page.pdf.pdf File desc: Date/time: 5/14/2013 4:16:11 PM Size: 629907
3	Signatures of members of ICC	2.2	✓	ICC Signature.pdf File desc: Date/time: 5/14/2013 4:18:36 PM Size: 706391
4	Minutes of ICC meeting in 2013 endorsing the APR 2012	5.7	✓	ICC 2-5-2013.pdf File desc: Date/time: 5/21/2013 2:41:32 AM Size: 1214079
5	Signatures of members of HSCC	2.3	✗	Signatures of NHSC members.pdf File desc: Signatures of members of NHSC Date/time: 5/10/2013 4:38:04 AM Size: 269450
6	Minutes of HSCC meeting in 2013 endorsing the APR 2012	9.9.3	✓	Minutes of 5th NHSC meeting.docx.doc File desc: Minutes of NHSC meeting in 2013 endorsing the APR 2012 Date/time: 5/10/2013 12:00:38 AM Size: 44544
7	Financial statement for ISS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	SOE on ISS fund utilization.pdf File desc: Date/time: 5/20/2013 3:39:21 AM Size: 260778
8	External audit report for ISS grant (Fiscal Year 2012)	6.2.3	✗	Audit report (Eng).PDF File desc: Date/time: 5/20/2013 3:45:19 AM Size: 1779690
9	Post Introduction Evaluation Report	7.2.2	✓	PIE Myanmar.pdf File desc: Date/time: 5/1/2013 7:22:28 AM Size: 38458

10	Financial statement for NVS introduction grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	SOE on NVI Grant.pdf File desc: Date/time: 5/20/2013 3:38:40 AM Size: 103938
11	External audit report for NVS introduction grant (Fiscal year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.3.1	✓	Audit report explanation.pdf File desc: Date/time: 5/1/2013 7:58:27 AM Size: 43466
12	Latest EVSM/VMA/EVM report	7.5	✓	EVM_report-Myanmar+v6+3+October 2011.pdf File desc: Date/time: 5/1/2013 8:17:18 AM Size: 2388185
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	EVM-imp-plan-Myanmar 2011 v6.xlsx File desc: Date/time: 5/1/2013 8:28:54 AM Size: 135356
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	EVM Ipmrovement plan implementation Status.xlsx File desc: Date/time: 5/21/2013 3:41:29 AM Size: 12120
15	External audit report for operational costs of preventive campaigns (Fiscal Year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.6.3	✗	Preventative campaign Audit report.doc File desc: Date/time: 5/21/2013 3:41:58 AM Size: 26112
16	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	NV_Support_extension.pdf File desc: Date/time: 5/14/2013 4:28:04 PM Size: 11768
17	Valid cMYP if requesting extension of support	7.8	✗	cMYP_2012-2016 (12 Nov 11).pdf File desc: Date/time: 5/21/2013 2:42:37 AM Size: 1144343
18	Valid cMYP costing tool if requesting extension of support	7.8	✓	cMYP_Costing_Tool_Vs.2.5_EN_ 12 Nov 11.xlsx File desc: Date/time: 5/21/2013 3:42:43 AM

				Size: 1583601
19	Financial statement for HSS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✗	Financial statement for 2012 APR.pdf File desc: Date/time: 5/13/2013 2:02:30 PM Size: 764933
20	Financial statement for HSS grant for January-April 2013 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✗	Financial statement for 2012 APR.pdf File desc: Date/time: 5/13/2013 2:04:30 PM Size: 764933
21	External audit report for HSS grant (Fiscal Year 2012)	9.1.3	✗	External Audit report for 2012 pdf file.pdf File desc: Date/time: 5/15/2013 2:47:47 AM Size: 2711756
22	HSS Health Sector review report	9.9.3	✗	FINAL HSA UHC Myanmar Dec 12 2012.pdf File desc: National Health System Assessment Document for Myanmar. Date/time: 4/30/2013 11:42:44 PM Size: 1029616
23	Report for Mapping Exercise CSO Type A	10.1.1	✗	CSO_Mapping_Ex.pdf File desc: Date/time: 5/14/2013 4:41:07 PM Size: 10844
24	Financial statement for CSO Type B grant (Fiscal year 2012)	10.2.4	✗	expenditure statement CSO.pdf File desc: Date/time: 5/14/2013 4:47:17 PM Size: 10844
25	External audit report for CSO Type B (Fiscal Year 2012)	10.2.4	✗	Audit_report_for_CSO_Type_B.pdf File desc: Date/time: 5/14/2013 4:43:17 PM Size: 10844
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2012 on (i) 1st January 2012 and (ii) 31st December 2012	0	✓	Bank statement.doc File desc: Date/time: 5/21/2013 3:45:49 AM Size: 26112