Annual Progress Report 2008

Submitted by

The Government of

[Liberia]

Reporting on year: __2008__

Requesting for support year: _2009/2010_

Date of submission: 15, May, 2009

Deadline for submission: 15 May 2009

Please send an electronic copy of the Annual Progress Report and attachments to the following e-mail address: **apr@gavialliance.org**

and any hard copy could be sent to :

GAVI Alliance Secrétariat,
Chemin de Mines 2.
CH 1202 Geneva,
Switzerland

Enquiries to: **apr@gavialliance.org** or representatives of a GAVI partner agency. The documents can be shared with GAVI partners, collaborators and general public.

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

Please note that Annual Progress reports will not be reviewed or approved by the Independent Review Committee without the signatures of both the Minister of Health & Finance and their delegated authority.

By signing this page, the whole report is endorsed, and the Government confirms that funding was used in accordance with the GAVI Alliance Terms and Conditions as stated in Section 9 of the Application Form.

For the Government of [**Liberia]**……..……

Minister of Health:

Dr. Walter T. Gwenigale

Title: *Minister of Health and Social Welfare*

Signature: ……

Date:……

Minister of Finance:

Mr. Augustine K. Ngafuan

Title: *Minister of Finance*

Signature: ……

Date: ……

This report has been compiled by:

Full name: **Thomas K. Nagbe**

Position: **Acting EPI Manager**

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ICC Signatures Page

If the country is reporting on ISS, INS, NVS support

We, the undersigned members of the Inter-Agency Co-ordinating Committee 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.

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The ICC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date
Dr. Walter T. Gwenigale, Minister of Health and Social Welfare	*Ministry of Health and Social Welfare*		*May13, 2009*
Mr. Augustine K. Ngafuan , Minister of Finance	*Ministry of Finance*		*May13, 2009*
Mr. Amara Konneh, Minister of Planning and Economic Affairs	*Ministry of Planning and Economic Affairs*		*May13, 2009*
Mr. Ambulai Johnson, Minister of Internal Affairs	*Ministry of Internal Affairs*		*May13, 2009*
Dr. Nester Ndayimirje , WHO Representative	*World Health Organization*		*May13, 2009*
Ms. Rozanne Chorlton, UNICEF Representative	*United Nations Children's Fund*		*May13, 2009*
Dr. Christopher McDermott, Health Team Leader, Director	*United States Agency for International Development*		*May13, 2009*
Mr. David K. Vinton, National Chairman Polio plus, Rotary International Coordinator	*Rotary International*		*May13, 2009*

Comments from partners:
You may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

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As this report been reviewed by the GAVI core RWG: y/n

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HSCC Signatures Page

If the country is reporting on HSS, CSO support

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

Financial accountability forms an integral part of GAVI Alliance monitoring of reporting of country performance. It is based on the regular government audit requirements as detailed in the Banking form.

The HSCC Members confirm that the funds received from the GAVI Funding Entity have been audited and accounted for according to standard government or partner requirements.

Name/Title	Agency/Organisation	Signature	Date
Dr. Walter T. Gwenigale, Minister of Health and Social Welfare	*Ministry of Health and Social Welfare*		*May13, 2009*
Mr. Augustine K. Ngafuan , Minister of Finance	*Ministry of Finance*		*May13, 2009*
Mr. Amara Konneh, Minister of Planning and Economic Affairs	*Ministry of Planning and Economic Affairs*		*May13, 2009*
Mr. Ambulai Johnson, Minister of Internal Affairs	*Ministry of Internal Affairs*		*May13, 2009*
Dr. Nester Ndayimirje , WHO Representative	*World Health Organization*		*May13, 2009*
Ms. Rozanne Chorlton, UNICEF Representative	*United Nations Children's Fund*		*May13, 2009*
Dr. Christopher McDermott, Health Team Leader, Director	*United States Agency for International Development*		*May13, 2009*
Mr. David K. Vinton, National Chairman Polio plus, Rotary International Coordinator	*Rotary International*		*May13, 2009*

Comments from partners:
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All comments will be treated confidentially

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

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

Name: ……

Post: ……

Organisation:……...

Date: ……

Signature: ……

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

The consultation process has been approved by the Chair of the National Health Sector Coordinating Committee, HSCC (or equivalent) on behalf of the members of the HSCC:

Name: ……

Post: ……

Organisation:……...

Date: ……

Signature: ……

We, the undersigned members of the National Health Sector Coordinating Committee, …… (insert name) endorse this report on the GAVI Alliance CSO Support. The HSCC certifies that the named CSOs are bona fide organisations with the expertise and management capacity to complete the work described successfully.

Name/Title	Agency/Organisation	Signature	Date

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

Annual Progress Report 2008: Table of Contents

This APR reports on activities between January - December 2008 and specifies requests for the period January - December 2010.

Text boxes supplied in this report are meant only to be used as guides. Please feel free to add text beyond the space provided

Table A: Latest baseline and annual targets (*From the most recent submissions to GAVI)*

Number	Achievements as per JRF	Targets						
	2008	2009	2010	2011	2012	2013	2014	2015
Births	195,698[1]	178,117	181,858	185,677	189,576	193,557	197,622	201,772
Infants' deaths	39,139	35,623	36,372	37,135	37,915	38,711	39,524	40,354
Surviving infants	156,559	142,494	145,486	148,541	151,661	154,846	158,097	161,417
Pregnant women	195,698	178,117	181,858	185,677	189,576	193,557	197,622	201,772
Target population vaccinated with BCG	179,663	163,868	167,309	170,823	174,410	178,072	181,812	185,630
BCG coverage*	92%	92%	92%	92%	92%	92%	92%	92%
Target population vaccinated with OPV3	144,714	131,094	133,847	136,658	139,528	142,458	145,450	148,504
OPV3 coverage**	92%	92%	92%	92%	92%	92%	92%	92%
Target population vaccinated with DTP (DTP3)***	144,469	131,094	133,847	136,658	139,528	142,458	145,449	148,504
DTP3 coverages**	92%	92%	92%	92%	92%	92%	92%	92%
Target population vaccinated with DTP (DTP1)***	165,598	139,644	142,576	145,570	148,627	151,749	154,935	158,189
Wastage[2] rate in base-year and planned thereafter	5%	5%	5%	5%	5%	5%	5%	5%
Duplicate these rows as many times as the number of new vaccines requested								
Target population vaccinated with **3rd dose** of ……..								
……. Coverage**	93%	93%	93%	93%	93%	93%	93%	93%
Target population vaccinated with **1st dose** of Yellow Fever …….	146,295	132,519	135,302	138,143	141,044	144,006	147,031	150,118
Wastage[1] rate in base-year and planned thereafter	25%	25%	20%	20%	20%	20%	15%	15%
Target population vaccinated with **1st dose** of Measles	148,186	135,369	138,212	141,114	144,078	147,103	150,193	153,347
Target population vaccinated with **2nd dose** of Measles								
Measles coverage**	95%	95%	95%	95%	95%	95%	95%	95%
Pregnant women vaccinated with TT+	176,129	160,306	163,672	167,109	170,618	174,201	177,860	181,595
TT+ coverage****	90%	90%	90%	90%	90%	90%	90%	90%
Vit A supplement 86,763	106,870	109,115	111,406	113,746	116,134	118,573	121,063	
Vit A supplement 114,719	113,995	116,389	118,833	121,329	123,876	126,478	129,134	
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100	13%	10%	10%	10%	10%	10%	10%	10%
Annual Measles Drop out rate (for countries applying for YF)	18%	10%	10%	10%	10%	10%	10%	10%

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants

[1] The drop in immunization target in 2009 compared to 2008 is as result of the release of the official census report
[2] 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. For new vaccines check table α after Table 7.1.

*** Indicate total number of children vaccinated with either DTP alone or combined
**** Number of pregnant women vaccinated with TT+ out of total pregnant women

Table B: Updated baseline and annual targets

Number	Achievements as per JRF	Targets						
	2008	2009	2010	2011	2012	2013	2014	2015
Births	195,698	178,117	181,858	185,677	189,576	193,557	197,622	201,772
Infants' deaths	39,139	35,623	36,372	37,135	37,915	38,711	39,524	40,354
Surviving infants	156,559	142,494	145,486	148,541	151,661	154,846	158,097	161,417
Pregnant women	195,698	178,117	181,858	185,677	189,576	193,557	197,622	201,772
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BCG coverage*	92%	92%	92%	92%	92%	92%	92%	92%
Target population vaccinated with OPV3	144,714	131,094	133,847	136,658	139,528	142,458	145,450	148,504
OPV3 coverage**	92%	92%	92%	92%	92%	92%	92%	92%
Target population vaccinated with DTP (DTP3)***	144,469	131,094	133,847	136,658	139,528	142,458	145,449	148,504
DTP3 coverage**	92%	92%	92%	92%	92%	92%	92%	92%
Target population vaccinated with DTP (DTP1)***	165,598	139,644	142,576	145,570	148,627	151,749	154,935	158,189
Wastage[3] rate in base-year and planned thereafter	5%	5%	5%	5%	5%	5%	5%	5%
Target population vaccinated with **3rd dose** of ……..								
……. Coverage**	93%	93%	93%	93%	93%	93%	93%	93%
Target population vaccinated with **1st dose** of Yellow Fever……..	146,295	132,519	135,302	138,143	141,044	144,006	147,031	150,118
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Annual Measles Drop out rate (for countries applying for YF)	18%	10%	10%	10%	10%	10%	10%	10%

* Number of infants vaccinated out of total births
** Number of infants vaccinated out of surviving infants

[3] 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. For new vaccines check table α after Table 7.1.

*** 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. Immunization Programme Support (ISS, NVS, INS)

1.1 Immunization Services Support (ISS)

Were the funds received for ISS on-budget in 2008? (Reflected in Ministry of Health and/or Ministry of Finance budget): Yes/No
If yes, please explain in detail how the GAVI Alliance ISS funding was reflected in the MoH/MoF budget in the box below.
If not, please explain why the GAVI Alliance ISS funding was not reflected in the MoH/MoF budget and whether there is an intention to get the ISS funding on-budget in the near future?

Though 2007 ISS support has not been received up to the time of preparation of this report, GAVI ISS funding has been part of the MOHSW plan and budget since 2007.

1.1.1 Management of ISS Funds

Please describe the mechanism for management of ISS funds, including the role of the Inter-Agency Co-ordinating Committee (ICC).
Please report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

GAVI ISS funds are deposited in the MOHSW accounts and monitored by the Ministry's Office of Financial Management (OFM). The Inter-Agency Coordination Committee approves proposals originating from the EPI programme following the review of the Technical Coordinating Committee (TCC) decision. Upon approval, funds are requested and released by the MOH&SW based on time line of activities. Funds are released for implementation through the signatures of the Comptroller of the Ministry of Health and the Hon. Minister who is the Chairman of ICC.

There has been problem in receiving GAVI ISS support following the lancet article of December 2008 and subsequent suspension of fund release by GAVI secretariat. .

1.1.2 Use of Immunization Services Support

In 2008, the following major areas of activities have been funded with the GAVI Alliance ***Immunization Services Support*** *contribution.*

Funds received during 2008: **0.00**
Remaining funds (carry over) from 2007: **309,180.00**
Balance to be carried over to 2009: **0.00**

Table 1.1: Use of funds during 2008*

Area of Immunization Services Support	Total amount in US $	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines	0.00	0.00		0.00	
Injection supplies	0.00	0.00		0.00	
Personnel	119,000.64	32,100.00		86,900.64	
Transportation	49,583.60	19,583.60		30,000.00	
Maintenance and overheads	29,750.16	29,750.16		0.00	
Training	0.00	0.00		0.00	
IEC / social mobilization	75,545.00	0.00		75,545.00	
Outreach	0.00	0.00		0.00	
Supervision	0.00	0.00		0.00	
Monitoring and evaluation	22,191.25	0.00		22,191.25	
Epidemiological surveillance	0.00	0.00		0.00	
Vehicles	0.00	0.00		0.00	
Cold chain equipment	12,750.00	12,750.00		0.00	
Other...*(Bank Service charge)*	360.00	360.00		0.00	
Total:	**309,180.65**	**94,543.76**		**214,636.89**	
Remaining funds for next year:	**0.00**				

1.1.3 ICC meetings

How many times did the ICC meet in 2008? ***(2[4])***
Please attach the minutes (DOCUMENT N°.....) from all the ICC meetings held in 2008 specially the ICC minutes when the allocation and utilization of funds were discussed.

Are any Civil Society Organizations members of the ICC: ***[Yes]***
if yes, which ones?

Save the Children UKl
Rotary International Polio plus

Please report on major activities conducted to strengthen immunization, as well as problems encountered in relation to implementing your multi-year plan.

- *In 2008, 95 additional health reactivated facilities, an increase of 21% started providing immunization services. Bringing to 450 the total number of routine immunization fixed sites in Liberia.*
- *Pentavalent vaccine single dose presentation was introduced into the routine immunization schedule and a national Penta 3 coverage of 92% was achieved. This was partly attributable to regular vaccine supply, 2 rounds of nation-wide outreach services conducted in five poor performing counties and monthly district multi-antigen outreach services to underserved communities.*
- *In addition to the routine immunization services, the programme also immunized 545,859 (92%) women of child bearing ages against maternal and neonatal tetanus in the 3rd round of the MNTE campaign covering ten counties[5]. It was integrated with Measles vaccine, Vitamin A supplementation and Mebendazole targeting children < 5 years of age. Administrative coverages attained were above 90% in all antigens. No case of Adverse Events Following Immunization (AEFI) was reported.*
- *Yellow Fever response campaign was conducted in seven districts within four counties: Compound number 3 (Grand Bassa County), Jowein, Dodian (Rivercess County), Putu, Tchien,(Grand Gedeh County) Tappitta, and Saclepea-Mah (Nimba County). 328,832 (99%) persons 9 months and older excluding pregnant women were immunized.*
- *Improved the skills of 176 community mobilizers in basic routine EPI messages in five poor performing counties (River Gee, Maryland, GrandKru, Sinoe and Grand Gedeh) aimed at improving immunization coverage and intensifying disease surveillance.*
- *Conducted Post Introductory Evaluation of the new vaccine after 10 months of implementation. Findings include;*

indicator	*%*
Report satisfaction with training	*100*
Report availability of new vaccine introduction guidelines	*94*
Report smooth transition	*100*

Other findings include

- *NGOs actively involved in training*
- *Only 1/18 HFs visited had a gap between introduction of pentavalent and return of DPT*
- *Good knowledge of HCWs at county level on the new vaccine*
- *Good knowledge of HCWs at HF level on general immunization issues*
- *High profile launches at all levels including use of local media - evidence of political will and*

[4] One of the meetings was postponed because attendants did not form a forum to take decision.
[5] Liberia's County is equivalent to WHO district.

commitment

- *HCWs are well prepared to provide information to caregivers*
- *100% of HFs have staff who are aware of adequate information to provide to caregivers during immunization*
- *Vaccine well received by community - no refusals*
- *Good knowledge of AEFI at all levels – including mothers*
- *Zero reporting of (AEFI) in some facilities*
- *No expired Pentavalent or other vaccine was observed*
- *83% of HFs reported **no stock-outs** in last 6 months*

Areas that need improvement for future introduction and programming:

- *No county-specific plans*
- *No **written** policy on how to handle remaining DPT stocks*
- *Weak inter-personal communication skills*
- *General lack of awareness by mothers regarding diseases prevented by the vaccines*
- *In 50% of HFs visited, Immunization Monitoring Charts do not reflect coverage correctly*
- *Process for managing and reporting of AEFIs is over-reliant on county officials*

- *Increase vaccine storage capacity by 14.4 % with solar refrigerators in 15 counties bringing the total 298.*
- *Conducted 3 integrated quarterly health services review meetings. More than 150 participants were in attendance in each meeting including 15 County Health Teams and their respective Health Board Chairs, WHO, UNICEF, UNDP, USAID, DFID, UNFPA and NGO representatives. This meeting reviewed the status of implementation of the national and county specific health plans with focus on BPHS, infrastructure, support system, Health Information System, etc.*
- *3 Quarterly BPHS supportive supervision was also conducted from national to county and health facility levels to validate data and encourage good practises, conduct on the job training and make paradigm shift in implementation strategy if necessary.*
- *Provided 22 Yamaha Motorbikes for 15 counties to strengthen district integrated outreach services in under serve communities.100% of the district have at least one motorbike. However, there is need to cover the health facilities especially those in the hard to reach communities to assist with outreach services.*
- *Developed, pre-tested and aired surveillance spot Messages and drama on 20 community radio stations in fifteen counties. This was an effort to intensify disease surveillance through local languages for early detection and reporting of diseases under active surveillance in the country.*
- *Conducted national cold chain and transport assessment in fifteen counties to identify the condition of cold chain equipment and other EPI logistics available at the various levels of service delivery and ascertain the future needs. Key findings include;*
    - *More than 70% of the health facilities providing immunization services are without electricity. 37% (173) of the health facility of these facilities are without solar refrigerators. These are potential sites for installation of solar refrigerators because more than 50% of them are support with fast cold chain.*
    - *Different equipment is being used to maintain the desire temperature of vaccine at various: work in cold room at central level, Electric refrigerators and Freezers at county level and solar refrigerators, cold boxes, vaccine carriers at facility level.*
    - *More than 90% (out of 118) of the EPI Motorbike distributed in 2004 are beyond repairs.*
- *2 National staff attended an International capacity building workshops and meetings on Vaccine Management and vaccine Security, Injection Safety and Waste management, Monitoring and Evaluation in the Republics of Senegal and Burkina Faso. As measures from these trainings, the District Vaccine Data Management Tool (DVD-MT) training was conducted for 15 Child Survival Service supervisors and 15 Cold Chain Officers from the in the fifteen counties. This tool was introduced to improve vaccine management. (state what they have done with the training)*
- *Attained certification level of non-polio AFP rate at the national level. Thirteen counties out of the fifteen districts also achieved the African target of non-polio AFP rate of above 2/100,000*

- *Percentage of stools collected within 14 days of onset of paralysis was 91% at the national level. All counties except one achieved 100% for this indicator. Results from the Lab indicated that all specimen (100%) from Liberia arrived in the lab in good condition.*
- *The African Regional Certification Commission (ARCC) accepted Liberia documentation for polio free status.*

Problems:

- *The decline in the amount of GAVI ISS support brings to cessation the monthly operational support to health facility and district for vaccine delivery. This could only be funded up to July, 2008. However the gap was temporarily covered by GOL through the Basic Health Package Services (BPHS) allotment to the counties.*

Attachments:

Three (additional) documents are required as a prerequisite for continued GAVI ISS support in 2010:

a) Signed minutes (DOCUMENT N°……) of the ICC meeting that endorses this section of the Annual Progress Report for 2008. This should also include the minutes of the ICC meeting when the financial statement was presented to the ICC.
b) Most recent external audit report (DOCUMENT N°……) (e.g. Auditor General's Report or equivalent) of **account(s)** to which the GAVI ISS funds are transferred.
c) Detailed Financial Statement of funds (DOCUMENT N°……) spent during the reporting year (2008).
d) The detailed Financial Statement must be signed by the Financial Controller in the Ministry of Health and/or Ministry of Finance and the chair of the ICC, as indicated below:

1.1.4 Immunization Data Quality Audit (DQA)

If a DQA was implemented in 2007 or 2008 please list the recommendations below:

No DQA was conducted in the year under review.

Has a plan of action to improve the reporting system based on the recommendations from the last DQA been prepared?

YES [X] *NO* [ ]

If yes, what is the status of recommendations and the progress of implementation and attach the plan.

Reported in the APR for 2007.

Please highlight in which ICC meeting the plan of action for the last DQA was discussed and endorsed by the ICC. *[mm/yyyy]*

Please report on any studies conducted and challenges encountered regarding EPI issues and administrative data reporting during 2008 (for example, coverage surveys, DHS, house hold surveys, etc).

List studies conducted:
The MOHSW did not conduct any study on EPI in 2008

1.2. GAVI Alliance New & Under-used Vaccines Support (NVS)

1.2.1. Receipt of new and under-used vaccines during 2008

When was the new and under-used vaccine introduced? Please include change in doses per vial and change in presentation, (e.g. DTP + HepB mono to DTP-HepB)

[List new and under-used vaccine introduced in 2008]

Pentavalent Vaccine (DTP + HepB +Hib) was introduced on the 1st January, 2008.

[List any change in doses per vial and change in presentation in 2008]

The *Pentavalent* (*DTP + HepB +Hib)* is in single dose wholly liquid presentation.

Dates shipments were received in 2008.

Vaccine	Vials size	Total number of Doses	Date of Introduction	Date shipments received (2008)
Pentavalent	1	266,400	1 January, 2008	November 15 2007
Pentavalent	1	243,527		April 9, 2008
Pentavalent	1	22, 500		September 17, 2008

Please report on any problems encountered.

[List problems encountered]
The Post Introductory Evaluation identified:

- *No county-specific plans*
- *No written policy on how to handle remaining DPT stocks*
- *Weak inter-personal communication skills*
- *General lack of awareness by mothers regarding diseases prevented by the vaccines*
- *In 50% of HFs visited, Immunization Monitoring Charts do not reflect coverage correctly*
- *Process for managing and reporting of AEFIs is over-reliant on county officials*
- Quality of supervision from the county level is weak
    - Only 29% of HFs receiving supervisory visits received written reports of the visit
    - Recommendations of supervisory visits are not implemented
    - Visits not used as opportunities for on-the-job training
- Capacity of HCWs is not currently sufficient to absorb the transition of HF management from NGOs
- Regular meetings held used to review data

1.2.2. Major activities

Please outline major activities that have been or will be undertaken, in relation to, introduction, phasing-in, service strengthening, etc. and report on problems encountered.

[*List activities*]
In January 2007, Liberia submitted an application to GAVI for the introduction of Pentavalent Vaccine (DTP-HepB-Hib) in January 2008. The application was approved and training for the introduction of the Pentavalent vaccine was conducted in December 2007 in all 15 Counties.

- *A plan of action was developed which was harmonized with the training plan of action for*

injections safety & immunization waste disposal plan of action for 2007. The plan of action was implemented in 2007. Some major activities that were undertaken were as follows:

- ***Capacity building:*** *Review and update EPI training manuals and reference materials; Training of Trainers and training of lower level staff*
- ***Logistics, Injections Safety, Waste and Procurement Management****: Installation and maintenance of cold chain equipments. Installation of 160 solar fridges in 2007 and 43 in 2008; Vaccine management assessment and development and implementation of comprehensive logistics and vaccine management information system; Training on cold chain, logistics and vaccine management;*
- ***Increase access to EPI services****: Conducted out outreach immunization activities in poorly performing districts and underserved communities; Support districts in micro-planning and implementation of RED approach; Conduct integrated planning and integrate EPI with other maternal and child survival programmes (e.g. Child Health, RH, malaria*
- ***Monitoring and Supervision:*** *Conducted quarterly EPI reviews at national level; quarterly supportive supervision from national to districts and monthly from districts to health facilities;*
- ***Communication and Advocacy:*** *Conducted KAP study; Develop IEC materials; Training health workers on IPC; Sensitized community mobilizers; Improved collaboration and coordination*
- ***Surveillance:*** *Strengthened active surveillance with laboratory support. for EPI priority diseases*
- *Strengthen and introduce early warning system for epidemics of YF and Meningitis in conjunction with the EPR unit at the MOH&SW*

Conducted surveillance sensitization for all priority diseases.

In 2008, the above activities were similarly conducted but integrated to cover all BPHS interventions including infrastructure, support system, etc.
Eg.

- ***Logistics, Injections Safety, Waste and Procurement Management****: Installation of additional 43 solar refrigerators and installation of 3 incinerators. Cold chain and transport assessment was conducted in the fifteen counties.*
- ***Increase access to EPI services****: with support from WHO through USAID and UNICEF Conducted integrated medical out outreach activities in five poorly performing counties and underserved communities(This outreach include Antenatal care, immunization, ITN and condom distribution, etc);*
- ***Monitoring and Supervision:*** *Conducted quarterly integrated supportive supervision and health services reviews; this reviews have now been institutionalize to be held in counties on a quarterly basis before the national reviews.*
- ***Communication and Advocacy:*** *developed a national strategic document for BCC/IEC*
- ***Surveillance:*** *Strengthened active surveillance with adequate transportation and laboratory support. for EPI priority diseases*

1.2.3. Use of GAVI funding entity support for the introduction of the new vaccine

Funds was received on 8/8/2007 for the introduction of the Pentavalent vaccine

Please report on the proportion of introduction grant used, activities undertaken, and problems encountered such as delay in availability of funds for programme use.

Year	Amount in US$	Date received	Balance remaining in US$	Activities	List of problems
2007	100,000.00	8/8/2007	0.00	*Development and production of training*	The Fund was inadequate. Therefore, Some of

				materials 1,151 service providers in preparation for the introduction of Pentavalent vaccines	Injection fund was used to conduct the nation-wide training for health workers.

1.2.4. Effective Vaccine Store Management/Vaccine Management Assessment

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? *[28 April-9 May 2007]*

If conducted in 2007/2008, please summarize the major recommendations from the EVSM/VMA.

Vaccine Management Assessment and Training on Computerized Vaccine Management Tool:
Bullet key recommendations:

- *Conduct computerized vaccine Stock Management training for the national EPI technical staff at MOHSW, UNICEF and WHO*
- *Introduce the Stock management Tool (SMT) at national level and District Data Management Tool (DVD-MT) at county level to enhance accurate reporting and sufficient monitoring of wastage rate*
- *National level needs a Logistics officer with a good level of knowledge on VM, with good management and good technical skills (including computerized skills)*
- *National level needs a storekeeper with a good knowledge on vaccines and consummables and good skills on items arrangement in store and recording*
- *WHO & UNICEF to pursue the support to EPI UNIT (MoH SW) to reach the standards of WHO and UNICEF in Vaccine Management (Cold chain equipment, capacity building….)*
- *WHO & UNICEF to support EPI to conduct an EVSM assessment of the primary cold store in 2010 (2 years after the introduction of the pentavalent)*

Was an action plan prepared following the EVSM/VMA? Yes

If yes, please summarize main activities under the EVSM plan and the activities to address the recommendations and their implementation status.

[List main activities]

- *Conducted three days training session for 11 national staff, 2 WHO data Officers and 1 UNICEF staff on computerized vaccine management tool: the training was conducted by the IST West Africa WHO logistics technical Officer. The first day session was on theoretical orientation and updating of knowledge on vaccine management and followed by a two day practical session on the utilization of the computerized tool, focusing particularly on estimation of needs, ordering and reception, stock control & recording, and wastage monitoring. As a result, Liberia started implementing the new tool by the end of July 2007 and is officially communicating to WHO country office and IST West Africa on monthly basis.*
- *A national logistics officer recruited and trained both locally and internationally to improve EVSM*
- *Vaccine storage capacity was strengthen at facility level with solar refrigerators covering about 250 health facilities in 2007*
- *Weekly Joint monitoring and supervision of the national depot by UNICEF and MOHSW and dissemination of weekly and monthly vaccine utilization updates from both county and national levels*

When will the next EVSM/VMA* be conducted? *[August 2010]*
All countries will need to conduct an EVSM/VMA in the second year of new vaccines supported under GAVI Phase 2.

Table 1.2

Vaccine 1: Pentavalent	
Anticipated stock on 1 January 2010	**35,644**
Vaccine 2: Yellow Fever	
Anticipated stock on 1 January 2010	**33,826**
Vaccine 3:	
Anticipated stock on 1 January 2010	**.....**

1.3 Injection Safety

1.3.1 Receipt of injection safety support (for relevant countries)

Are you receiving Injection Safety support in cash or supplies? Yes

If yes, please report on receipt of injection safety support provided by the GAVI Alliance during 2008 (add rows as applicable).

Injection Safety Material	Quantity	Date received
AD syringes	*386,800*	*[6]January 15 2008*
AD syringes	*1,080,000*	*May,1, 2008*
Mixing syringes and needles	*402000*	*January 15, 2008*
Mixing syringes and needles	*96, 000*	*April29, 2008*
Safety boxes	*2, 175*	*April 28, 2008*
Safety boxes	*38275*	*May 1, 2008*

Please report on any problems encountered.

- *No problems encountered.*

1.3.2. Even if you have not received injection safety support in 2008 please report on progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report how injection safety supplies are funded.

Liberia introduced the recommended safe injection equipments years' back and all immunization activities are offered with auto disable syringes and needles. In 2008 UNICEF procured and delivered adequate AD syringes, Reconstitution Syringes & needles and Safety Boxes. UNICEF also provided procurement services to GOL to facilitate its Co-financing obligations with GAVI.

Please report how sharps waste is being disposed of.

All used syringes and needles are collected directly in to safety boxes which are burnt and buried. The purchase of waste disposal units is in line with the EPI injection safety and waste disposal plan of action 2006-2010. According to the plan, at least 90 WDU would be purchased and installed at strategic locations in the country.
However, with the help of UNICEF, 47 Waste Disposal Units (WDU) were purchased in 2006/2007. The training was conducted with external technical support through UNICEF in April-May 2007. WHO also provided external consultant to advice on the quality of installation. The installation of 16 is on-going and will be completed by end of 2009. The ministry is making effort to mobilize resources to install the remaining 31.

Please report problems encountered during the implementation of the transitional plan for safe injection and sharps waste.

- *.Funding shortfall for the installation of the procured 47 WDUs*
- *Some components (Chimneys, Glue, etc) of the WDUs have been degraded because of harsh conditions meted as a result of the long stay and need to be replaced*

1.3.3. Statement on use of GAVI Alliance injection safety support in 2008 (if received in the form of a cash contribution)

The following major areas of activities have been funded (specify the amount) with the GAVI Alliance injection safety support in the past year:

- *$ 90,000.00 used on the training of 1,151 service providers on new vaccine introduction including injection safety and waste management.*
- *$ 4,000.00 used to facilitate the training of 4 local engineers and 2 national staff on the installation of WDUs.*

2. Vaccine Immunization Financing, Co-financing, and Financial Sustainability

Table 2.1: Overall Expenditures and Financing for Immunization

The purpose of Table 2.1 is to guide GAVI understanding of the broad trends in immunization programme expenditures and financial flows.
Please the following table should be filled in using US $.

	Reporting Year 2008	**Reporting Year + 1**	**Reporting Year + 2**
	Expenditures	Budgeted	Budgeted
Expenditures by Category			
Traditional Vaccines (Bundle)	*274,884.16*		
New Vaccines(Bundle)	*177,125.00*[7]	*1,817,161*	*1,738,145*
Injection supplies	*0.00*	*152,100*	*156,148*
Cold Chain equipment	*186,176.10*	*18,293*	*94,841*
Operational costs	*2,249,816.00*	*2,248,415*	*1,406,793*
Other (please specify)Transportation (motorbikes)	1,200,000.00		
Total EPI	3,772,028.90		
Total Government Health	*15,128,880.00*	*80,000.000*	*91,000.000*

Exchange rate used	

Please describe trends in immunization expenditures and financing for the reporting year, such as differences between planned versus actual expenditures, financing and gaps. Give details on the reasons for the reported trends and describe the financial sustainability prospects for the immunization program over the next three years; whether the funding gaps are manageable, challenge, or alarming. If either of the latter two is applicable, please explain the strategies being pursued to address the gaps and indicate the sources/causes of the gaps.

GAVI support accounts for more than 60% of the operational burden of the EPI programme. It covers personnel incentives, training, reproduction of data tools, supervision, monitoring and evaluation, etc. With the drop in GAVI support coupled with the temporary suspension of ISS, the actual expenditure dropped grossly from the plan budget in 2008.

With the continuing withdrawal of some International Health NGOs, the limited support from GOL to the programme annual budget and the expected end of GAVI support to Pentavalent and Yellow Fever vaccines by 2015 amidst the global financial crisis, is a major and growing challenge to consider in the coming years.

However, we endeavour to increase advocacy with political leaders to increase budgetary allocation for immunization; possible inclusion for immunization support from the pool fund established by the MoH&SW; continual negotiation for USAID support to the RED approach and local resource mobilization

[7] New vaccine expenditure does not reflect GAVI supplies. Monetary details was not available

Future Country Co-Financing (in US$)

Please refer to the excel spreadsheet Annex 1 and proceed as follows:

- Please complete the excel sheet's "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.

- Then please copy the data from Annex 1 (Tab "Support Requested" Table 2) into Tables 2.2.1 (below) to summarize the support requested, and co-financed by GAVI and by the country.

Please submit the electronic version of the excel spreadsheets Annex 1 (one Annex for each vaccine requested) together with the application.

Table 2.2.1 is designed to help understand future country level co-financing of GAVI awarded vaccines. If your country has been awarded more than one new vaccine please complete as many tables as per each new vaccine being co-financed (Table 2.2.2; Table 2.2.3; ….)

Table 2.2.1: Portion of supply to be co-financed by the country (and cost estimate, US$)>

1st vaccine: Yellow Fever		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose		$0.10	$0.15	$0.15	$0.15	$0.15	$0.15
Number of vaccine doses	#	19,200	27,300	27,300	27,400	27,700	27,200
Number of AD syringes	#	16,400	22,900	22,900	22,900	23,100	22,700
Number of re-constitution syringes	#	2,200	3,100	3,100	3,100	3,100	3,100
Number of safety boxes	#	225	300	300	300	300	300
Total value to be co-financed by country	**$**	$19,500	$28,000	$28,500	$29,000	$29,500	$30,500

Table 2.2.2: Portion of supply to be co-financed by the country (and cost estimate, US$)

2nd vaccine: Pentavalent		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose		$0.15	$0.20	$0.20	$0.20	$0.20	$0.20
Number of vaccine doses	#	23,800	29,600	32,300	41,600	46,500	50,700
Number of AD syringes	#	25,300	31,300	34,100	44,000	49,200	53,600
Number of re-constitution syringes	#	0	0	0	0	0	0
Number of safety boxes	#	300	350	400	500	550	600
Total value to be co-financed by country	**$**	$79,000	$92,500	$94,500	$96,500	$98,500	$100,500

Table 2.2.3: Portion of supply to be co-financed by the country (and cost estimate, US$)

3rd vaccine:……		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose							
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by country	**$**						

Table 2.3: Country Co-Financing in the Reporting Year (2008)

Q.1: How have the proposed payment schedules and actual schedules differed in the reporting year?			
Schedule of Co-Financing Payments	Planned Payment Schedule in Reporting Year	Actual Payments Date in Reporting Year	Proposed Payment Date for Next Year
	(month/year)	(day/month)	
1st Awarded Vaccine (Yellow Fever)	August 2008	April 2009	August 2009
2nd Awarded Vaccine (Pentavalent)	August 2008	April 2009	August 2009
3rd Awarded Vaccine (specify)			

Q. 2: How Much did you co-finance?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (Yellow fever)	29,656.00	33,700
2nd Awarded Vaccine (Pentavalent)	115,312.50	30,750
3rd Awarded Vaccine (specify)		

Q. 3: What factors have slowed or hindered or accelerated mobilization of resources for vaccine co-financing?
1. *The national fiscal year runs from July – June. (1st July 2008 to the 30th June, 2009 for the 2008 budget year). The passage of budget for the fiscal year goes two or more months beyond July and the released from finance ministry is very slow. Funds are usually released in the second half of the following year.*
2. *The establishment of the Office of Financial Management (OFM) and the new regulation on the release of funds*

If the country is in default please describe and explain the steps the country is planning to come out of default.

The country is not in default.

3. Request for new and under-used vaccines for year 2010

*Section 3 is to the request new and under-used vaccines and related injection safety supplies for **2010**.*

3.1. Up-dated immunization targets

*Please provide justification and reasons for changes to baseline, targets, wastage rate, vaccine presentation, etc. from the previously approved plan, and on reported figures which differ from those reported in the **WHO/UNICEF Joint Reporting Form** in the space provided below.*

Are there changes between table A and B? Yes

If there are changes, please describe the reasons and justification for those changes below:

Provide justification for any changes ***in births**:*

Liberia conducted national population census in 2008 that gave population of 3.4 Million with a growth rate of 2.1% against the estimated projections provided by Planning Ministry in previous years

*Provide justification for any changes **in surviving infants**:*

The surviving infants remain five percent but the figure change because of the change in population

*Provide justification for any changes **in Targets by vaccine**:*

The change in target per vaccine is as a result of the change in population and annual growth rate

*Provide justification for any changes **in Wastage by vaccine**:*

No change in vaccine wastage

Vaccine 1: .....

Please refer to the excel spreadsheet Annex 1 and proceed as follows:

- Please complete the "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.

- Please summarise the list of specifications of the vaccines and the related vaccination programme in Table 3.1 below, using the population data (from Table B of this APR) and the price list and co-financing levels (in Tables B, C, and D of Annex 1).

- Then please copy the data from Annex 1 (Tab "Support Requested" Table 1) into Table 3.2 (below) to summarize the support requested, and co-financed by GAVI and by the country.

Please submit the electronic version of the excel spreadsheets Annex 1 together with the application.

(Repeat the same procedure for all other vaccines requested and fill in tables 3.3; 3.4; .....)

Table 3.1: Specifications of vaccinations with new vaccine

Yellow Fever	*Use data in:*		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#						
Target immunization coverage with the third dose	*Table B*	#	93%	93%	93%	93%	93%	93%
Number of children to be vaccinated with the first dose	*Table B*	#	135,302	138,143	141,044	144,006	147,031	150,118
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#	1.33	1.33	1.33	1.33	1.33	1.33
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$	$0.10	$0.15	$0.15	$0.15	$0.15	$0.15

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.2: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

Yellow fever		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#	172,000	157,400	161,300	165,200	169,000	173,600
Number of AD syringes	#	146,300	131,600	134,900	138,200	141,300	145,100
Number of re-constitution syringes	#	19,100	17,500	18,000	18,400	18,800	19,300
Number of safety boxes	#	1,850	1,675	1,700	1,750	1,800	1,825
Total value to be co-financed by GAVI	**$**	$171,500	$160,000	$167,500	$175,000	$180,500	$192,500

Vaccine 2: .....

Same procedure as above (table 3.1 and 3.2)

Table 3.3: Specifications of vaccinations with new vaccine

Pentavalent	*Use data in:*		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#	133,847	136,658	139,528	142,458	145,449	148,504
Target immunisation coverage with the third dose	*Table B*	#	92%	92%	92%	92%	92%	92%
Number of children to be vaccinated with the first dose	*Table B*	#	142,576	145,570	148,627	151,749	154,935	158,189
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#	1.05	1.05	1.05	1.05	1.05	1.05
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$	$0.15	$0.20	$0.20	$0.20	$0.20	$0.20

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.4: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

Pentavalent		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#	502,100	431,400	438,400	439,000	444,200	450,300
Number of AD syringes	#	534,600	456,200	463,600	464,200	469,700	476,200
Number of re-constitution syringes	#	0	0	0	0	0	0
Number of safety boxes	#	5,950	5,075	5,150	5,175	5,225	5,300
Total value to be co-financed by GAVI	**$**	$1,669,500	$1,347,000	$1,280,500	$1,016,000	$938,500	$891,500

Vaccine 3: .....

Same procedure as above (table 3.1 and 3.2)

Table 3.5: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#						
Target immunisation coverage with the third dose	*Table B*	#						
Number of children to be vaccinated with the first dose	*Table B*	#						
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#						
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$						

* Total price pre dose includes vaccine cost, plus freight, supplies, insurance, fees, etc

Table 3.6: Portion of supply to be procured by the GAVI Alliance (and cost estimate, US$)

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by GAVI	**$**						

4. Health Systems Strengthening (HSS)

Instructions for reporting on HSS funds received

1. As a Performance-based organisation the GAVI Alliance expects countries to report on their performance – this has been the principle behind the Annual Progress Reporting –APR- process since the launch of the GAVI Alliance. Recognising that reporting on the HSS component can be particularly challenging given the complex nature of some HSS interventions the GAVI Alliance has prepared these notes aimed at helping countries complete the HSS section of the APR report.
2. All countries are expected to report on HSS on the basis of the January to December calendar year. Reports should be received by 15th May of the year after the one being reported.
3. This section **only needs to be completed by those countries that have been approved and received funding for their HSS proposal before or during the last calendar year**. For countries that received HSS funds within the last 3 months of the reported year can use this as an inception report to discuss progress achieved and in order to enable release of HSS funds for the following year on time.
4. It is very important to fill in this reporting template thoroughly and accurately, and to ensure that **prior to its submission to the GAVI Alliance this report has been verified by the relevant country coordination mechanisms** (ICC, HSCC or equivalent) in terms of its accuracy and validity of facts, figures and sources used. Inaccurate, incomplete or unsubstantiated reporting may lead to the report not being accepted by the Independent Review Committee (IRC) that monitors all APR reports, in which case the report might be sent back to the country and this may cause delays in the release of further HSS funds. Incomplete, inaccurate or unsubstantiated reporting may also cause the IRC to recommend against the release of further HSS funds.
5. Please use additional space than that provided in this reporting template, as necessary.

4.1 Information relating to this report:

a) Fiscal year runs from **July 1** (month) to **June 30** (month).

b) This HSS report covers the period from **January 2008** (month/year) to **December 2008** (month year)

c) Duration of current National Health Plan is from **June 2007** (month/year) to **June 2011** (month/year).

d) Duration of the immunisation cMYP:

e) Who was responsible for putting together this HSS report who may be contacted by the GAVI secretariat or by the IRC for any possible clarifications?

It is important for the IRC to understand key stages and actors involved in the process of putting the report together. For example: '*This report was prepared by the Planning Directorate of the Ministry of Health. It was then submitted to UNICEF and the WHO country offices for necessary verification of sources and review. Once their feedback had been acted upon the report was finally sent to the Health Sector Coordination Committee (or ICC, or equivalent) for final review and approval. Approval was obtained at the meeting of the HSCC on 30th April 2009. Minutes of the said meeting have been included as annex XX to this report.'*

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any clarifications			
S. Tornorlah Varpilah/Deputy Minister for Planning Research & Statistics	Ministry of Health and Social Welfare	Coordinated the report writing team	+231-6519765 stvarpilah@yahoo.com
Other partners and contacts who took part in putting this report together			
Dr. Terkula Ben Alagh	UNICEF	Member of the report writing team	+231-6670489
Mr. Eric Johnson	WHO		+231-77513516

f) Please describe briefly the main sources of information used in this HSS report and how was information verified (validated) at country level prior to its submission to the GAVI Alliance. Were any issues of substance raised in terms of accuracy or validity of information and, if so, how were these dealt with or resolved?

This issue should be addressed in each section of the report, as different sections may use different sources. In this section however one might expect to find what the MAIN sources of information were and a mention to any IMPORTANT issues raised in terms of validity, reliability, etcetera of information presented. For example: *The main sources of information used have been the external Annual Health Sector Review undertaken on (such date) and the data from the Ministry of Health Planning Office. WHO questioned some of the service coverage figures used in section XX and these were tallied with WHO´s own data from the YY study. The relevant parts of these documents used for this report have been appended to this report as annexes X, Y and Z.*

Information quoted or referenced in this report can be verified in the following documents;

- Ministry of Health and Social Welfare 2008 Annual Report
- Basic Package of Health Services document
- 2008 National Health Conference Report
- 2008 National Health Fair Report
- 3rd and 4th Quarter Review Meetings Reports.

g) In putting together this report did you experience any difficulties that are worth sharing with the GAVI HSS Secretariat or with the IRC in order to improve future reporting? Please provide any suggestions for improving the HSS section of the APR report? Are there any ways for HSS reporting to be more harmonised with existing country reporting systems in your country?

There were few challenges encountered during the compilation of this report. Receiving status report from programs that are directly involved with implementing the project in a timely fashion was difficult.

4.2 Overall support breakdown financially

Period for which support approved and new requests. For this APR, these are measured in calendar years, but in future it is hoped this will be fiscal year reporting:

	Year								
	2007	2008	2009	2010	2011	2012	2013	2014	2015
Amount of funds approved	1,022,380.00	1,022,380.00							
Date the funds arrived	27/07/2007	**27/07/2008**							
Amount spent	27,171	1,286,704.62							
Balance	995,209	(264,324.62)							
Amount requested	1,022,380.00	1,022,380.00							

Amount spent in 2008: 1,286,704.62
Remaining balance from total: 562,836.68[8]

[8] This amount is the current balance for the total GAVI HSS grant (2,044,760) approved in 2007&2008.

Table 4.3 note: This section should report according to the original activities featuring in the HSS proposal. It is very important to be precise about the extent of progress, so please allocate a percentage to each activity line, from 0% to 100% completion. Use the right hand side of the table to provide an explanation about progress achieved as well as to bring to the attention of the reviewers any issues relating to changes that have taken place or that are being proposed in relation to the original activities.

Please do mention whenever relevant the **SOURCES** of information used to report on each activity. The section on **support functions** (management, M&E and Technical Support) is also very important to the GAVI Alliance. Is the management of HSS funds effective, and is action being taken on any salient issues? Have steps been taken to improve M&E of HSS funds, and to what extent is the M&E integrated with country systems (such as, for example, annual sector reviews)? Are there any issues to raise in relation to technical support needs or gaps that might improve the effectiveness of HSS funding?

Table 4.3 HSS Activities in reporting year (ie. 2008)						
Major Activities	**Planned Activity for reporting year**	**Report on progress [9] (% achievement)**	**Available GAVI HSS resources for the reporting year (2008)**	**Expenditure of GAVI HSS in reporting year (2008)**	**Carried forward (balance) into 2009)**	**Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements**
Objective 1:						
Activity 1.1:	Develop and disseminate an Integrated BPHS, which include maternal and newborn health; child health and immunizations; Nutrition; Communicable Diseases; and Health promotion and Behavioral Change Communications.	100%	0	13,100.00	497.50	The BPHS document was developed and disseminated at all levels. Staffing requirements at the clinic, health center and hospital levels were determined. The BPHS include maternal, newborn and child health including immunization and nutrition. A national BPHS communication strategy was developed to create awareness and social market the document. **See attached BPHS document.**
Objective 2:						

[9] For example, number of Village Health Workers trained, numbers of buildings constructed or vehicles distributed

Activity 2.1:	Define the role of the community in the delivery of nutrition, integrated management of childhood illnesses, treatments for diarrhea diseases, malaria, pneumonias and home based care for HIV/AIDS and other basic health services.	70%	17,000	17,000	0	The Ministry has set-up a community health unit to coordinate and supervise community health related activities. • An Operational Guidelines for Community Health Committees has been developed, with clear role and responsibilities of the community in the delivery of BPHS. • The reactivation of Community Health Committees in 35 districts is underway. **See attached Community Health Committees Operational Guidelines.**
Objective 3:		50%				
Activity 3.1:	Develop roles and responsibilities of identified community health workers, develop training materials and train community health workers based on integrated BPHS for community health workers.	60%	139,889	42,905.80	96,982.60*	Roles and responsibilities of Community Health Volunteers (CHVs) have been developed in the Community Health Services Policy and Strategy Document. • Training contents for community health volunteers have been developed. • The training materials for CHVs have been drafted. It includes: 1) The Training Manual 2) Facilitator's guides 3) Job aids among others. **See attached Community Health Volunteers Policy & Strategy**
Activity 3.2:	Establish a training unit and define roles and responsibilities of the unit which should be composed of representatives from each health unit of the MOHSW and relevant technical partners.	80%	15,000	13,027.50	1,972.50	Ministry of Health and Social Welfare Training Unit has been established with clear roles and responsibilities. Trainers have been identified from various health programs and departments. There are some relevant health partners that are actively involved with the Unit. Their involvement with the Unit includes; curriculum reviews, development of training manuals and serving on the scholarship committee.
Activity 3.3:	Develop or revise treatment protocols and guidelines, including those for health promotion and behavioral change.		10,000	11,422.73	(-1,422.73)	The Ministry organized a meeting to identify and review existing treatment protocols and guidelines.

Activity 3.4:	Develop training manuals for the integrated BPHS, including training materials for training health institutions.	50%	20,899	11,536	9,353	An integrated BPHS training material has been developed. Trainings are ongoing with selected cadres of health workers. The training institutions component of the Integrated BPHS material has not been drafted.
Activity 3.5:	Plan and implement outreach sessions using the defined integrated BPHS for outreach activity, while ensuring quality of services and impact.	50%	187,000	128,856.80	58,143.20	A national health fare was conducted in November, 2008 during which the following outreach activities were carried out: 1. 240 (Males-127; Females- 113) persons were tested for HIV. 5 positive and 235 negative cases were identified. 2. 418 (children under five -47; adults -371) persons tested and treated for malaria. 3. 478 persons tested for Hepatitis B; 392 negative and 86 positive 4. 300 ITNs were distributed to pregnant women and under five, 1000 posters and 1000 fact sheets on malaria prevention and treatment distributed. 5. Nutrition education was provided along with the demonstration of the preparation of weaning foods. 6. 475 health facilities assessed nationwide for BPHS accreditation 7. Eye Examinations were provided for 1,500 persons 8. 1,085 pregnant women and under five were immunized **See attached 2008 National Health Fair Report**
Activity 3.6:	Conduct annual meetings with all relevant line ministries and health partners to assure that various policy elements within the integrated BPHS are addressed.	100%	30,000	13,438	16,562	The Ministry conducted a national health conference in July 2008 with all stakeholders. This led to the development of the health sector year 2 plan of action. There is a planned national conference for 2009, in July to review and assess year 2 implementation of the National Health Plan. **See attached year 1 National Health Conference Report.**
Activity 3.7:	Purchase two vehicles for smooth coordination and mobility of training unit and plan for maintenance system.	100%	50,000	50,000	0	Two Nissan pick-ups were procured and assigned at central level to facilitate the implementation of the BPHS by conducting central and county levels trainings, regular quarterly supervision and staff transport to work.

Activity 3.8:	Develop HR plan and initiate the establishment of an HR database with periodic HR assessments and use of data for decision making.	25%	44,000	43868.70	131.30	Three computers were procured to strengthen the HRH Unit and management HR records. Others activities carried out with funding from different sources include; • The Ministry developed a transitional human resource plan (2006 -2008) that recommended the operational staffing pattern and strategy of the BPHS. The transitional plan concentrated on redeployment, retention, and recruitment/hiring of health workers among others. • For the developmental phase, three major studies (HRH census, Labour Dynamic & Pre-investment) are underway that will inform the elaboration of the National Human Resources for Health (HRH) Policy and Plan. • Recruitment process for a consultant is ongoing. The World Bank is funding the National Health Workers Census and the Labour Market/Pre-investment studies including the consultancy cost.
Activity 3.9:	Provision of local technical Assistance (TA) to assist with developing an HR plan (and potentially organizing an HR unit) and strengthening of MOHSW HR management	100%	50,000	26,400	23,600	One local technical assistance was hired and is currently assisting in the organization of meetings, studies, recruitment processes of personnel and other human resource related tasks.
Activity 3.10:	Identification and selection of 800 community health workers, two for each health facility, by the communities using given criteria and provision of operational support funds to the CHWs.	50%	450,000	412,120.30	37,879.70	The identification and selection of 875 community health volunteers are currently taking place in 35 districts in 6 counties; River Cess, Bsssa, Margibi, Bomi, Gbarpolu and Cape Mount. • TOT workshop was conducted for 35 Districts Health Officers. Financial Support is being given to the counties for the selection and identification exercise. • 100 motor cycles have been purchased for monitoring and supervision community health workers.

Activity 3.11:	Standardize curricula of CHW, develop skill-competency testing train new CHWs and increase the skills of existing community health workers in implementing specific interventions within the BPHS.	50%	100,000	0	100,000*	• The training contents for CHVs on Malaria, Darrhea and ARI have been drafted but need s finalization, printing and nationwide distribution. The document is expected to be disseminated in June 2009.
Activity 3.12:	Purchase one vehicle for smooth coordination of HR activities.	100%	25,000	25,000	0	One vehicle was purchased to facilitate the implementation of the BPHS.
Activity 3.13:	Establish linkages between communities and formal health by defining and putting in place community based surveillance and information systems.	50%	60,000	2,150	57,850	There is an active surveillance system in place to report and notify relevant health workers on major diseases such as; Lassa Fever, Yellow Fever, Measles, Diarrhoea, Polio, Cholera among others. Surveillance officers are regularly trained in case detection, management and definition. In addition, the operational guidelines provide linkages between the communities and health facility focal persons. Reports from the communities through the CHVs are sent to the county health team through the OIC and DHO.
Activity 3.14:	Conduct district and county micro-plans of the integrated BPHS at the county level with all stakeholders and review plans regularly to enhance programme ownership at the local level.	100%	36,794.25	30,263.25	6,531	County micro-plans were developed based on national agenda (National Health Plan & PRS). Every county health plan was developed through a participatory process that involved all stakeholders in the county. There are regular quarterly BPHS review meetings were county plans are assessed and the next quarter plan developed. **See attached 4th quarter 2008 and 1st quarterly 2009 review meetings reports.**
Activity 3.15:	Plan and conduct operational research for community based services and BCC/IEC to enhance linkages of health facilities with the community for improved community participation and involvement.	25%	60,000	0	60,000	Very little has been done in this direction. In 2009, there are planned communities based health operational studies that are expected to absorb this fund. • One survey was conducted to inform the development of a national health BCC Community Strategy. • A national Communication Strategy has been drafted.

Activity 3.16:	Develop and implement quality HMIS and database for smooth management of health information and human and financial resources of the integrated BPHS.	60%	275,898	231,022.97	44,875.03*	• 30 computers with accessories have been procured for county health system to manage and process data. • Officers in charge of health facilities along with clinic registrars from every county were trained in data collection and management. • Basic computer trainings were organized and conducted for 30 county data managers and registrars. The HMIS Unit is functional and improving gradually. The Health Management Information System Policy and Plan have been finalized. Printing of the Policy and Plan is ongoing with support from USAID. Dissemination of the HMIS Policy and Plan is expected by July 2009.
Activity 3.17:	Provide data management tools and conduct regular training and refresher training of key health workers on data collection, analysis, management of information and resources.	80%	70,000	1,500	68,500*	• An Integrated data collection tool (NEIDS) has been developed. • Over 500 health workers have been trained in data collection using an integrated reporting tool and 75 County Health Team members have been trained in the District Health Information System software that process, manage and analyze routine health data.
Activity 3.18:	Plan and establish a computerized stock management and logistics system to support the forecasting and distribution of drugs and supplies and rehabilitation of equipments.	50%	50,000	19,379.55	30,620.45	• 15 Laptops were procured for county and central levels pharmacists. • 15 pharmacists were trained in basic computer operation and computerized stock management.
Activity 3.19:	Establish an M & E system to monitor and evaluate the regular and appropriate use of the National Health Information and management system.	60%	60,000	19,959	40,041*	• The MOHSW Monitoring and Evaluation Unit has been established with support from UNDP Global Fund Capacity Building funds. • A National M&E Policy and Plan has been elaborated and endorsed by the Program Coordination Team (PCT) at the Ministry. Printing and dissemination is plan for this quarter.

						• A technical working group on M&E and research has been formed. • There have been two major national M&E trainings for programs staff as a strategy for enhancing their skills, knowledge, competency and proficiency of work.
Activity 3.20:	Purchase one vehicle to ensure smooth coordination and monitoring of the health information and management system.	100%	25,000	25,000	0	One vehicle has been procured and assigned to the Unit to ensure smooth coordination, monitoring and supervision of HMIS activities and to facilitate HMIS trainings to counties.
Support Functions						
Management		75%	112,127.58	101,243.52	10,884.06	Management support through this grant has been helpful in the day to day running of the ministry. This component of the grant is use to repair and maintain project and program vehicles.
M&E		50%	0	0	0	
Technical Support		60%	50,760	47,509.90	3,250.10	Seven (7) staff were hired to provide technical support to the ministry that are paid from this grant. The BPHS TA, directors of the Training Unit, Family Health Division and Information Technology (IT) were contracted using GAVI HSS fund.
Total Expenditure & Carried Forward				1,286,704.62[10]	562,836.68	

[10] This figure has changed greatly because of expenditures made between January and May 2009. The current expenditure as of May 2009 equals US 1,382,579.90

* Figures reported as carry forward for 2008 that have been reduced considerable in the first 3 months of 2009. Actual amount carried forward equals 562,836.68

Table 4.4 note: This table should provide up to date information on work taking place in the first part of the year when this report is being submitted i.e. between January and April 2009 for reports submitted in May 2009.

The column on Planned expenditure in coming year should be as per the estimates provided in the APR report of last year (Table 4.6 of last year´s report) or –in the case of first time HSS reporters- as shown in the original HSS proposal.
Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right.

Table 4.4 Planned HSS Activities for current year (ie. January – December 2009) and emphasise which have been carried out between January and April 2009

Major Activities	Planned Activity for current year (ie.2009)	Planned expenditure in coming year	Balance available (To be automatically filled in from previous table)	Request for 2009	Explanation of differences in activities and expenditures from original application or previously approved adjustments**
Objective 1:					
Activity 1.1:	Completed	0	497.50	0	
Objective 2:					
Activity 2.1:	Define the role of the community in the delivery of home based care for HIV/AIDS and other basic health services.	0	0	0	There is balance and appropriation for this activity in 2009-2010. Other funding source will be explored to achieve this activity.
Objective 3:					
Activity 3.1:	Finalized, print and distribute CHV training Manual and train CHVs based on the BPHS/ CHS Policy Guidelines	146,982.60	96,982.60	50,000	
Activity 3.2:	Train central and county levels BPHS master/core trainers to rollout the integrated BPHS county level trainings.	1,972.50	0	0	

Activity 3.3:	Develop or revise treatment protocols and guidelines, xx programs.	0	0	0	
Activity 3.4:	Review and revise health training institutions curriculum to reflect BPHS.	9,353	9,353	0	
Activity 3.5:	Plan and implement outreach sessions using the defined integrated BPHS for outreach activity, while ensuring quality of services and impact.	170,143.20	58,143.20	112,000	
Activity 3.6:	Conduct annual health conference in July 2009 with all relevant line ministries and health partners to assure that various policy elements within the integrated BPHS are implemented based on timeline.	31,562	16,562	15,000	This amount cannot fully cover the 3 days National Health Conference cost. Additional funds will be sourced from government and partners.
Activity 3.7:	Completed	0	0	0	
Activity 3.8:	Develop a National HRH Policy and Plan and initiate the establishment of an HR database.	15,131.30	131.30	15,000	World Bank to provide additional fund for these activities
Activity 3.9:	Recruit local technical Assistance (TA) to assist with developing an HR Policy and Plan (and potentially organizing an HR unit) and strengthening of MOHSW HR management	38,600	23,600	15,000	
Activity 3.10:	Identify and train 2,500 community health workers, 23 per district, using CHS criteria and provide operational support	287,879.70	37,879.70	250,000	

	funds to the CHWs.				
Activity 3.11:	Increase the skills of existing and new community health workers in implementing specific interventions within the BPHS.	150,000	100,000	50,000	
Activity 3.12:	Completed	0	0	0	
Activity 3.13:	Strengthen community based surveillance and information systems.	87,850	57,850	30,000	
Activity 3.14:	Conduct regular integrated BPHS quarterly review meetings to assess counties plans and performance to enhance programme ownership at the county level.	36,531	6,531	30,000	Available fund cannot finance one review meeting. Additional fund will be sourced from Government and partners.
Activity 3.15:	Plan and conduct operational research for community based services and BCC/IEC to enhance linkages of health facilities with the community for improved community participation and involvement.	90,000	60,000	30,000	
Activity 3.16:	Develop In-patient reporting system. Distribute & disseminate HMIS Policy and Plan nationwide. Conduct quarterly monitoring and supervision. Develop other components of HMIS (HRH, FMIS, etc)	234,875.03	44,875.03	190,000	

Activity 3.17:	Provide data management tools and conduct regular training and refresher training of key health workers on data collection, analysis, management of information and resources.	118,500	68,500	50,000	
Activity 3.18:	Establish computerized stock management and logistics system to support the forecasting and distribution of drugs and supplies. Conduct stock management trainings for health facilities staff.	60,620.45	30,620.45	30,000	
Activity 3.19:	Print, distribute and disseminate the National Monitoring and Evaluation Policy and Plan nationwide. Conduct regular integrated BPHS monitoring and supervision and M&E trainings for CHT members	80,041	40,041	40,000	
Activity 3.20:	Completed	0	0	0	
Support costs					
Management costs				90,000	
M&E support costs				0	
Technical support				25,380	

TOTAL COSTS			562,836.68	(This figure should correspond to the figure shown for 2009 in table 4.2)	

Table 4.5 Planned HSS Activities for next year (ie. 2010 FY) This information will help GAVI's financial planning commitments					
Major Activities	**Planned Activity for current year (ie.2010)**	**Planned expenditure in coming year**	**Balance available (To be automatically filled in from previous table)**	**Request for 2010**	**Explanation of differences in activities and expenditures from original application or previously approved adjustments****
Objective 1:					
Activity 1.1:		0	0	0	
Activity 1.2:		0	0	0	
Objective 2:					
Activity 2.1:		0	0	0	
Activity 2.2:		0	0	0	
Objective 3:					
Activity 3.1:	Train community health workers based on integrated BPHS and conduct community supportive supervision and monitoring	0	0	50,000	
Activity 3.3:	Print and disseminate revised treatment protocols and guidelines. Train health workers in revised treatment protocols and guidelines.	0	0	10,000	
Activity 3.5:	Plan and implement outreach sessions using the defined	0	0	112,000	

	integrated BPHS for outreach activity, while ensuring quality of services and impact.				
Activity 3.6:	Conduct annual meetings with all relevant line ministries and health partners to assure that various policy elements within the integrated BPHS are addressed.	0	0	15,000	
Activity 3.8:	Print and widely disseminate HRH Policy and Plan	0	0	15,000	
Activity 3.9:	Recruit local technical Assistance (TA) to assist with developing an HR plan (and potentially organizing an HR unit) and strengthening of MOHSW HR management	0	0	15,000	
Activity 3.10:	Identify and train community health workers and provide operational support funds and logistics to the CHWs.	0	0	250,000	
Activity 3.11:	Enhance the knowledge and skills of community health workers nationwide to implement specific interventions within the BPHS.	0	0	50,000	
Activity 3.13:	Improve community based surveillance and information systems. Train community surveillance officers in case detection, management & reporting.	0	0	30,000	
Activity 3.14:	Conduct regular integrated BPHS quarterly review			30,000	Available fund cannot finance one review meeting. Additional fund will be

	meetings to assess counties plans and performance to enhance programme ownership at the county level.				sourced from Government and partners.
Activity 3.15:	Plan and conduct operational research for community based services.			30,000	
Activity 3.16:	Develop and improve other components of the HMIS. Conduct regular supportive supervision, repair and maintenance of hardware equipment. Produce and disseminate Statistical Bulletins			190,000	
Activity 3.17:	Conduct trainings and refresher trainings for key health workers on data collection, analysis, management of information and resources.			50,000	
Activity 3.18:	Conduct stock management and forecasting trainings for health facilities staff.			30,000	
Activity 3.19:	Conduct regular integrated BPHS monitoring and supervision and M&E refresher trainings for MOHSW program staff			30,000	
Support costs					
Management costs				90,000	
M&E support costs				0	

Technical support				25,380	
TOTAL COSTS				1,022,380	

4.6 Programme implementation for reporting year:

a) Please provide a narrative on major accomplishments (especially impacts on health service programs, notably the immunization program), problems encountered and solutions found or proposed, and any other salient information that the country would like GAVI to know about. Any reprogramming should be highlighted here as well.

This section should act as an executive summary of performance, problems and issues linked to the use of the HSS funds. This is the section where the reporters point the attention of reviewers to **key facts**, what these mean and, if necessary, what can be done to improve future performance of HSS funds.

The GAVI HSS support has helped the Ministry of Health and Social Welfare in many ways. Major achievements include the establishment of Community Health Services, Training, Human Resource and Health Management Information System Units. These units contribute to the entire health sector development including improving and strengthening expanded program on immunization.

Other accomplishments include the following;

- Development of a draft National M&E Policy and Strategy
- Development of Community Health Services Strategy
- Development of Operational Guidelines for Community Health Committees
- Defining Roles and Responsibilities for Community Health Volunteers
- Development of an integrated BPHS Training Manual
- Development of HMIS Policy and Plan
- Procurement of computers and accessories for central and county levels data management
- Procurement of motorcycles for all (100) district surveillance offices to strengthen surveillance system between the health facilities and communities

The Community Health Services Unit since its establishment has been involved with developing the health facility links with the community by setting standards and policy that will drive the BPHS community component. It envisaged that the community health services when fully operational will strengthen links between health facilities and communities that will impact on immunization services.

The Training has developed an integrated BPHS training material that reflects immunization training needs. Full implementation of this document along with the training of relevant clinical staff will improve not only immunization coverage but the entire health care delivery system.

b) Are any Civil Society Organizations involved in the implementation of the HSS proposal? If so, describe their participation? For those pilot countries that have received CSO funding there is a separate questionnaire focusing exclusively on the CSO support after this HSS section.

There is no civil society organization involved with the implementation of this project.

4.7 Financial overview during reporting year:

4.7 note: In general, HSS funds are expected to be visible in the MOH budget and add value to it, rather than HSS being seen or shown as separate “project” funds. These are the kind of issues to be discussed in this section

a) Are funds on-budget (reflected in the Ministry of Health and Ministry of Finance budget): Yes/No

If not, why not and how will it be ensured that funds will be on-budget? Please provide details.

The GAVI HSS fund is an integral part of the Ministry of Health budget but this is not reflected in the Ministry of Finance, national health budget. The Ministry has a National Health Plan that clearly articulates how the sector will be financed over the 5 years period. It identifies multi-sources of funding mechanism. The pool fund, GAVI and World Bank funds that are managed by the Ministry while the Global Fund (HIV, Malaria and TB) that is managed by UNDP. These mentioned grants support the health sector Plan but are not part of the Ministry of Finance budget.

b) Are there any issues relating to financial management and audit of HSS funds or of their linked bank accounts that have been raised by auditors or any other parties? Are there any issues in the audit report (to be attached to this report) that relate to the HSS funds? Please explain.

The national audit report did not bring out any issue about the implementation of this project. The current audit period is July 2006 to June 2007. This was the time the GAVI HSS fund was received by the Ministry. No money was used from the GAVI HSS project during this time.

The next fiscal audit (2007 July to 2008 June) that is expected soon will cover activities related to the implementation of GAVI HSS fund. The next GAVI HSS APR will include issues from this fiscal audit.

4.8 General overview of targets achieved

Table 4.8 Progress on Indicators included in application												
Strategy	**Objective**	**Indicator**	**Numerator**	**Denominator**	**Data Source**	**Baseline Value**	**Source**	**Date of Baseline**	**Target**	**Date for Target**	**Current status**	**Explanation of any reasons for non achievement of targets**
	1) To implement BPHS with child survival as an entry point	1. % of primary health facilities with functional community-based delivery of operationalized integrated BPHS.	N/A	N/A	Routine quarterly reports of County health teams and quarterly review and planning by the national planning department of the MOHSW	0%	N/A	2005	70%	2008	30%	The Community Health services Unit was organized during the last quarter of 2008. Major focus have been; a. Policy development b. Roles and Responsibilities of CHVs There are few health facilities that have community based delivery of BPHS, but

												this indicator will be achieved the next reporting period.
		2. % of counties with functional health information and resource management system.	N/A	N/A		0%	N/A	2005	70%	2008	50%	Every county has a functional health information system. The DHIS soft is currently used for capturing, processing and analysing data. What is a challenge is developme nt of other component of resource manageme nt.
		3. % of timely and complete reports received at national level from counties with functional information and resource management				0%	N/A	2005	80%	2008	60%	Assessing complete and timely data from few counties, especially from the South East

		system.										part of the country is a challenge because of very bad road and limited IT services and network.
		4. % of counties implementing BPHS, which include maternal and newborn health; child health and immunizations; Nutrition; Communicable Diseases; and Health promotion and Behavioural Change Communications in all primary health facilities within the given implementation time frame..	N/A	N/A	Routine quarterly reports of County health teams and quarterly review and planning by the national planning department of the MOHSW	0%	N/A	2005	70%	2008	70%	
	2) to link health services with the community by expanding community-	5. % of identified and recruited community health workers by the communities two for each	N/A	N/A		0%	N/A	2005	70%	2008	20%	Financial Support is has been provided to the counties for CHVs selection and

	based health workforce.	health facility and provision of operational support funds to CHW.										identification exercise. Delays has been due to late setting –up of the Community Health Services Unit
	3) to strengthen evidence-based management of primary health care service provision with emphasis on community-based health services.	6. % of counties implementing quality HMIS and database for smooth management of health information and human and financial resources of the BPHS.	N/A	N/A		0%	N/A	2005	70%	2008	70%	Every county is implementing quality HMIS but there are lot of improvement needed for the human, financial and other components.
		7. % of health facilities with delivery of improved quality of integrated primary health care services	N/A	N/A	Annual review and planning meetings	20%	N/A	2005	50%	2008	30%	The integration process for PHC is ongoing but has needs more commitment from all

		at the lower level.										stakeholders.
		8. Coverage of DTP3 (Pentavalent after 2008)			Routine Administrative coverage	87%	MOHSW 2006 Annual Report	2005	90%	2008	92%	
		9. Coverage of Routine Measles vaccination				94%	MOHSW 2006 Annual Report	2005	95%	2008	95%	
		10. Under 5 Mortality			Routine and Active surveillance and/or surveys	235	LDHS	2005	225	2008	110	

4.9 Attachments

Five pieces of further information are required for further disbursement or allocation of future vaccines.

a. Signed minutes of the HSCC meeting endorsing this reporting form
b. Latest Health Sector Review report
c. Audit report of account to which the GAVI HSS funds are transferred to
d. Financial statement of funds spent during the reporting year (2008)
e. This sheet needs to be signed by the government official in charge of the accounts HSS funds have been transferred to, as below.

Financial Comptroller Ministry of Health:

Name: Toagon Karzon

Title / Post: Comptroller

Signature:

Date: May ----2009

5. Strengthened Involvement of Civil Society Organisations (CSOs)

1.1 TYPE A: Support to strengthen coordination and representation of CSOs

This section is to be completed by countries that have received GAVI TYPE A CSO support[11]

Please fill text directly into the boxes below, which can be expanded to accommodate the text.

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

5.1.1 Mapping exercise

Please describe progress with any mapping exercise that has been undertaken to outline the key civil society stakeholders involved with health systems strengthening or immunisation. Please identify conducted any mapping exercise, the expected results and the timeline (please indicate if this has changed).

[11] Type A GAVI Alliance CSO support is available to all GAVI eligible countries.

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

5.1.2 Nomination process

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

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

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

5.1.3 Receipt of funds

Please indicate in the table below the total funds approved by GAVI (by activity), the amounts received and used in 2008, and the total funds due to be received in 2009 (if any).

ACTIVITIES	Total funds approved	2008 Funds US$			Total funds due in 2009
		Funds received	Funds used	Remaining balance	
Mapping exercise					
Nomination process					
Management costs					
TOTAL COSTS					

5.1.4 Management of funds

Please describe the mechanism for management of GAVI funds to strengthen the involvement and representation of CSOs, and indicate if and where this differs from the proposal. Please identify who has overall management responsibility for use of the funds, and report on any problems that have been encountered involving the use of those funds, such as delay in availability for programme use.

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

This section is to be completed by countries that have received GAVI TYPE B CSO support[12]

Please fill in text directly into the boxes below, which can be expanded to accommodate the text.

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

5.2.1 Programme implementation

Briefly describe progress with the implementation of the planned activities. Please specify how they have supported the implementation of the GAVI HSS proposal or cMYP (refer to your proposal). State the key successes that have been achieved in this period of GAVI Alliance support to CSOs.

Please indicate any major problems (including delays in implementation), and how these have been overcome. Please also identify the lead organisation responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

[12] Type B GAVI Alliance CSO Support is available to 10 pilot GAVI eligible countries only: Afghanistan, Burundi, Bolivia, DR Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan.

Please state whether the GAVI Alliance Type B support to CSOs has resulted in a change in the way that CSOs interact with the Ministry of Health, and or / how CSOs interact with each other.

Please outline whether the support has led to a greater involvement by CSOs in immunisation and health systems strengthening (give the current number of CSOs involved, and the initial number).

Please give the names of the CSOs that have been supported so far with GAVI Alliance Type B CSO support and the type of organisation. Please state if were previously involved in immunisation and / or health systems strengthening activities, and their relationship with the Ministry of Health.

For each CSO, please indicate the major activities that have been undertaken, and the outcomes that have been achieved as a result. Please refer to the expected outcomes listed in the proposal.

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2008	Outcomes achieved

Please list the CSOs that have not yet been funded, but are due to receive support in 2009/2010, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in immunisation and / or health systems strengthening.

Please also indicate the new activities to be undertaken by those CSOs already supported.

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2009 / 2010	Expected outcomes

5.2.2 Receipt of funds

Please indicate in the table below the total funds approved by GAVI, the amounts received and used in 2008, and the total funds due to be received in 2009 and 2010. Please put every CSO in a different line, and include all CSOs expected to be funded during the period of support. Please include all management costs and financial auditing costs, even if not yet incurred.

NAME OF CSO	Total funds approved	2008 Funds US$ (,000)			Total funds due in 2009	Total funds due in 2010
		Funds received	Funds used	Remaining balance		
Management costs (of all CSOs)						
Management costs (of HSCC / TWG)						
Financial auditing costs (of all CSOs)						
TOTAL COSTS						

5.2.3 Management of funds

Please describe the financial management arrangements for the GAVI Alliance funds, including who has overall management responsibility and indicate where this differs from the proposal. Describe the mechanism for budgeting and approving use of funds and disbursement to CSOs,

Please give details of the management and auditing costs listed above, and report any problems that have been experienced with management of funds, including delay in availability of funds.

5.2.4 Monitoring and Evaluation

Please give details of the indicators that are being used to monitor performance. Outline progress in the last year (baseline value and current status), and the targets (with dates for achievement).

These indicators will be in the CSO application and reflect the cMYP and / or GAVI HSS proposal.

Activity / outcome	Indicator	Data source	Baseline value	Date of baseline	Current status	Date recorded	Target	Date for target

Finally, please give details of the mechanisms that are being used to monitor these indicators, including the role of beneficiaries in monitoring the progress of activities, and how often this occurs. Indicate any problems experienced in measuring the indicators, and any changes proposed.

6. Checklist

Checklist of completed form:

Form Requirement:	Completed	Comments
Date of submission		
Reporting Period (consistent with previous calendar year)		
Government signatures		
ICC endorsed		
ISS reported on		
DQA reported on		
Reported on use of Vaccine introduction grant		
Injection Safety Reported on		
Immunisation Financing & Sustainability Reported on (progress against country IF&S indicators)		
New Vaccine Request including co-financing completed and Excel sheet attached		
Revised request for injection safety completed (where applicable)		
HSS reported on		
ICC minutes attached to the report		
HSCC minutes, audit report of account for HSS funds and annual health sector review report attached to Annual Progress Report		

7. Comments

ICC/HSCC comments:

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.

~ End ~