Annual Progress Report 2008

Submitted by

The Government of

[*Sri Lanka*]

Reporting on year: __2008__

Requesting for support year: Jan-Dec 2010_

Date of submission: _____

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 :

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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 or 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 [*Name of Country*]……..……

Minister of Health:	**Minister of Finance:**
Title: ……	Title: ……
Signature: ……	Signature: ……
Date: ……	Date: ……

This report has been compiled by:

Full name: .....

Position: .....

Telephone: .....

E-mail: .....

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

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, …… (insert name) endorse this report on the Health Systems Strengthening Programme and the Civil Society Organisation 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

Comments from partners:
You may wish to send informal comment to: apr@gavialliance.org
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		379,912	380,000	385,000	390,000	395,000	400,000	405,000	410,000
Infants' deaths		4,179	4,180	4,196	4,212	4,226	4,240	4,252	4,305
Surviving infants		375,733	375,820	380,804	385,788	390,774	395,760	400,748	405,695
Pregnant women		379,912	380,000	385,000	390,000	395,000	400,000	405,000	410,000
Target population vaccinated with BCG		361,136	376200	381150	386100	391050	396000	400950	405900
BCG coverage*		95%	99%	99%	99%	99%	99%	99%	99%
Target population vaccinated with OPV3		347,951	376200	381150	386100	391050	396000	400950	405900
OPV3 coverage**		92.6%	99%	99%	99%	99%	99%	99%	99%
Target population vaccinated with DTP (DTP3)***		341,061	376200	381150	386100	391050	396000	400950	405900
DTP3 coverage**		90.7%	99%	99%	99%	99%	99%	99%	99%
Target population vaccinated with DTP (DTP1)***		365,151	376200	381150	386100	391050	396000	400950	405900
Wastage[1] 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 DPT-HBV-HIB		4488	364545	369380	374214	379051	383887	388726	393524
…….. Coverage**		1.2%	97%	97%	97%	97%	97%	97%	97%
Target population vaccinated with **1st dose** of DPT-HBV-HIB		123,170	372062	376996	381930	386866	391802	396741	401638
Wastage[1] rate in base-year and planned thereafter		5%	5%	5%	5%	5%	5%	5%	5%
Target population vaccinated with **1st dose** of Measles		371,618	372062	376996	381930	386866	391802	396741	401638
Target population vaccinated with **2nd dose** of Measles		342,683	349513	354148	358783	363420	368057	372696	377296
Measles coverage** MCV1		98.9%	99 %	99 %	99 %	99 %	99 %	99 %	99 %
Pregnant women vaccinated with TT+		344,223	345800	350350	354900	359450	364000	368550	373100
TT+ coverage****		90.6%	91 %	91 %	91 %	91 %	91 %	91 %	91 %
Vit A supplement	Mothers (<6 weeks from delivery)								
	Infants (>6 months) same as 9 months measles coverage	95.7%	97%	98%	99%	99%	99%	99%	99%
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100		6.6%	2%	2%	2%	2%	2%	2%	2%
Annual Measles Drop out rate (for countries applying for YF)									

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

[1] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. 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: *No Difference. Same as Table A*

Number		Achievements as per JRF	Targets						
		2008	2009	2010	2011	2012	2013	2014	2015
Births									
Infants' deaths									
Surviving infants									
Pregnant women									
Target population vaccinated with BCG									
BCG coverage*									
Target population vaccinated with OPV3									
OPV3 coverage**									
Target population vaccinated with DTP (DTP3)***									
DTP3 coverage**									
Target population vaccinated with DTP (DTP1)***									
Wastage[2] rate in base-year and planned thereafter									
Duplicate these rows as many times as the number of new vaccines requested									
Target population vaccinated with **3rd dose** of ……..									
……. Coverage**									
Target population vaccinated with **1st dose** of ……..									
Wastage[1] rate in base-year and planned thereafter									
Target population vaccinated with **1st dose** of Measles									
Target population vaccinated with **2nd dose** of Measles									
Measles coverage**									
Pregnant women vaccinated with TT+									
TT+ coverage****									
Vit A supplement	Mothers (<6 weeks from delivery)								
	Infants (>6 months)								
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100									
Annual Measles Drop out rate (for countries applying for YF)									

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

[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

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?

No ISS support received in 2008

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.

Not Applicable

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 ___Nil_____
Remaining funds (carry over) from 2007 ___- Nil_____
Balance to be carried over to 2009 _____- Nil_____

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					
Injection supplies					
Personnel					
Transportation					
Maintenance and overheads					
Training					
IEC / social mobilization					
Outreach					
Supervision					
Monitoring and evaluation					
Epidemiological surveillance					
Vehicles					
Cold chain equipment					
Other …… *(specify)*					
Total:					
Remaining funds for next year:					

1.1.3 ICC meetings

How many times did the ICC meet in 2008?
Because of the suspension of Pentavalent vaccine in late April 2008 and frequent convenience National AEFI causality assessment committees, National Advisory Committee on Communicable Diseases (NACCD) to discuss the Pentavalent vaccine AEFI issue and Frequent consultation with WHO Sri Lanka, WHO SEARO and WHO HQ experts to discuss same, the convening of ICC did not arise in 2008 because majority of the members (Secretary Health, Director General of Health Services, Deputy Director general of Public Health Services, WHO representatives, Representatives of the Collage of Peadiatrics, Representatives of the Collage of Medicine, Representatives of Collage of Community Physicians ect. Only persons not represented were CBO representatives) of ICC also were members of the above committees.

The minutes of the AEFI, NACCD (Annexure 1) and different WHO committees (Annexure 2) conducted in 2008 are attached for easy perusal

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?

List CSO member organisations
1. Sarvodaya Sramadana Sangamaya
2. Rotary Club, Sri Lanka

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

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 endorse 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:

DQA was not conducted in 2007 or 2008 and the next DQA is scheduled for 2009

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

YES ☐ *NO* ☐

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

Not applicable

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:

1. EPI Coverage survey Ampara District 2008 (Annexure 3)

- Report attached

2. DHS Survey 2006/2007

- Respective data tables from the DHS survey report are attached (Annexure 3)

List challenges in collecting and reporting administrative data:

In Sri lanka routine reporting of data starts at the divisional level where primary healthcare implementation is centered and children and mothers get services. Epidemiology Unit is the national focal point for the monitoring and evaluation of the Epi programme. All divisional level staff called Medical Officers of Health in all districts in Sri Lanka send reports of the EPI programme for each quarter of the year to the Epidemiology Unit. Reporting system is very good and the Epidemiology Unit gets quarterly returns from all MOH areas in all districts. In addition to the divisional level reporting, 26 district managers also quarterly send EPI consolidated returns to the Epidemiology Unit after consolidating the returns sent by the divisional level staff.

With the withdrawal of Pentavalent vaccine from the national programme a fair proportion of children in urban areas turned to private sector for Hib containing combined vaccines and some for aceluler pertussis containing vaccines. Presently there is no system in place to capture the number immunized in the private sector into the national data base. This has resulted in the low coverage of DPT and Hepatitis B in comparison to BCG and measles vaccine.

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]

DPT-HBV-Hib (Quinvaxem)

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

Only single dose vials

Dates shipments were received in 2008.

Vaccine	Vials size	Total number of Doses	Date of Introduction	Date shipments received (2008)
DPT-HBV-Hib	Single Dose	489,600	01 – 01 - 2008	08 – 04 – 2008
		870,800 doses were received in December 2007		

Please report on any problems encountered.

No.

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.

Epidemiology Unit of the Ministry of Health has done all necessary ground work including staff training, improving regional and divisional level cold chain facilities, distribution of vaccines and other logistics, AEFI surveillance and public propaganda activities in view of introducing DTP-HepB-Hib vaccine into the national EPI programme during the 4th Quarter of 2007.

On 1st January 2008, introduction of Pentavalent vaccine was commenced ceremonially by the Hon. Minister of Health. On the same day newly commissioned central cold room complex was also declared open by the Hon Minister of Health.

Being a new vaccine, all providers were requested to closely monitor AEFI due to this vaccine. Around 135,000 pentavalent immunizations have been carried out during the first four months of 2008.

During the first two months of 2008, One hundred and twenty four (124) cases of AEFI following pentavalent immunization have been reported through the national AEFI surveillance system. Majority were expected AEFI following Pertussis containing vaccine such as high fever (47 cases) and allergic reactions (25 cases). Ten cases of persistent screaming and 7 cases of seizures were

also among the reported AEFI.

However, six cases of acute onset of pallor, cyanosis, reduced responsiveness and convulsions (Hypotonic Hyporesponsive Episode (HHE) like syndrome) were also reported within few minutes to several hours of administration of pentavalent vaccine. Majority of these cases fully recovered without sequelae. Further, four deaths also have been reported following pentavalent vaccination during the first three months.

However, it should be noted that no HHE like events have been reported through the routine AEFI surveillance system in previous years against DPT or any other vaccine.

Hence, a meeting of the National Expert Committee on Adverse Events Following Immunization (NECAEFI) was convened on 10th April 2008 to discuss this issue and to determine the causality of the pentavalent vaccine related AEFI and deaths.

Even though HHE is a known adverse event following pertussis containing vaccine and no clear evidence to conclude that the deaths reported following pentavalent vaccine are causally associated with the vaccine, as a precautionary measure experts decided to suspend the DPT-HBV-HIB (Pentavalent) vaccine bearing batch number 0451111 from use until further notice and all concerned were requested to use the next batch of pentavalent vaccine bearing batch number 0451112 for immunization with immediate effect. Further, we informed all providers and clinical staff to further strengthen the surveillance of AEFI with emphasis on HHE like illnesses following pentavalent vaccination.

After the meeting of the National Expert Committee on Adverse Event Following Immunization which was convened on 10th April 2008, another 10 cases of HHE like cases have been reported after the administration of 1st batch and on 26th April 2008 occurrence of another three episodes of Hypotonic–Hyporesponsive Episode HHE like cases was reported in one immunization season with the administration of vaccines from the 2nd batch.

Following this episode the National Expert Committee on Adverse Events Following Immunization was convened to determine further the course of action to be taken with regard to the continued occurrence of pentavalent vaccine related HHE like cases.

Opinion of the experts were, as a further precautionary measure to temporary withdraw the DPT-HBV-HIB (Pentavalent) vaccine from the national immunization schedule and revert back to the previous immunization schedule by providing DPT and Hepatitis B vaccine at 2, 4 and 6 months until investigations are concluded.

Accordingly newly introduced Pentavalent vaccine was withdrawn from the programme on 29th April 2008 and reverted back to the DPT and HBV vaccine. Since there were sufficient buffer stocks of DPT and Hep B vaccines available at all levels without much issues transition took place smoothly.

With this decision the Ministry of Health requested the support of WHO to investigate this situation and report on safety of Quinvaxim and suitability of same for reintroduction. A team of experts' from WHO SEARO and WHO HQ visited Sri Lanka and had a series of consultations with the national EPI team and with the members of the National Expert Committee on Adverse Events Following Immunization to ascertain the causality of the HHE cases and post Quinvaxim deaths. Since there were some disagreements/unclear status of the causality of some deaths, WHO in concurrence with MoH, Sri Lanka, decided to appoint an independent global panel of experts to review these deaths and give their opinion on causality of the above AEFI deaths following Quinvaxim. The report of the WHO experts is annexed (Annexure 2) hereto for your easy perusal.

The report of the independent panel of experts was made available to Sri Lanka on 23rd December 2008 (report is annexed) and their view was that there was no evidence to conclude causal relationship between Quinvaxim and the five deaths.

The NEC/AEFI which met on 29th January 2009 reviewed the findings, recommendations and other new evidence emerged and agreed with the findings of the WHO and the independent panel of experts and recommended the reintroduction of Pentavalent vaccine into the national immunization programme.

Findings of the two WHO expert committees and findings and recommendations of the NEC/AEFI was brought before the National Advisory Committee on Communicable Diseases held on 2nd March 2008 and a decision was taken to reintroduce the pentavalent vaccine commencing from 1st April 2009.

However, unfortunately on 20th March 2009 a 13 year old child died from severe anaphylaxis within a few hours of administration of rubella vaccine during a school immunization programme. At this stage an issue of quality of vaccines used in the EPI programme came under heavy media scrutiny and the EPI programme came almost to a standstill during the months of April and early May.

At this stage it was the opinion of the senior health administrators, including Hon. Minister of Health that Sri Lanka should resolve this situation by addressing one issue at a time and it is just coming out of the rubella crisis. Hence another non-straightforward coincidental death following pentavalent vaccine on its reintroduction may cause havoc and it could lead to a complete derailment of its reintroduction resulting in further delay to the reintroduction of pantavalent vaccine.

The issue was further complicated due to the colour status of VVM attached to the Quinvaxem stocks in the periphery, changing to Stage II and III.

Further, VVM status in remaining batches, which were still in central cold rooms with very strict cold chain conditions, also indicated the change of VVM status to stage II even well before its date of expiry.

This issue was brought to the notice of the vaccine manufacturer and the WHO and according to the replies received it was implied that due to lack of stability data at the time of prequalification, VVM 7 was put on the Quinvaxem instead of VVM 14. Hence the type of VVM colour change observed could occur even with 1° C change even within 2 -8 °C storage temperatures with the VVM 7.

Hence under the circumstances of quality and safety of Quinvaxem already under scrutiny by the medical community and the public in Sri Lanka due to HHE and AEFI deaths following Quinvaxem, it became a tedious task to convince both above categories regarding the potency and efficacy of Quinvaxem as well as to build confidence in them on this product. Further this issue has been raised in public by the media.

Because of the above reasons reintroduction process was further delayed and it was decided to solicit advice from WHO and GAVI to resolve this issue.

Accordingly a meeting was organized at the margins of the World Health Assembly between Hon. Minister of Health Sri Lanka and CEO GAVI to resolve this issue. During this meeting and therafter in writing, Government of Sri Lanka made representations to GAVI for the following.

1. Write off and replace the stock of Pentavalent vaccine expired in May and June 2009.
2. Write off the co-financing amount to be paid for 2008.

3. Consider writing off the stock due to expire in December 2009 with VVM colour change.

On 23rd July 2009 Hon. Minister of Health received the reply from CEO GAVI agreeing to all above three requests and accordingly, the Ministry of Health decided to reintroduce prentavalent vaccine to the EPI programme as soon as possible, preferably from 1st September 2009 if logistics permit. (Relevant documents are in Annexure 4)

This was the reason for the delay in submitting 2008 APR because without making the decision on reintroduction, date of reintroduction and resolving above issues it was not possible to complete APR 2008 and request vaccines for 2009 and 2010.

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

Even though US $ 100,000/= has been earmarked for this purpose no funds have been received for this purpose.

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

1.2.4. Effective Vaccine Store Management/Vaccine Management Assessment

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? *2007*

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

Pre shipment & Arrival procedures

1. Standard VAR to be introduced for all vaccines.
2. WHO/V&B/05.23 version of the WHO Guidelines on international packaging and shipping of vaccines is to be referred[3].
3. Procure all vaccines with VVMs.

Maintaining correct storage temperatures

1. A multi channel electronic PC based temperature monitoring system is installed for the new cold storage facility equipment.
2. All thermo-sensors of cold and freezer rooms should be tested for accuracy using TinyTalk devices.
3. Recommend transfer of guidelines available for power cuts into a proper contingency plan and this plan to be rehearsed at least once a year.

Building, equipment and transport

1. Adequate shelving to be provided along the walls of the primary store for consumables and diluents.

[3] *It should also be noted that this document is currently under revision and will be replaced with an updated version*

Effective stock management

1. A computerized stock control system should be adopted.
2. All vaccines should be arranged in a way to promote EEFO principle.

Reliable delivery to intermediate stores minimizing damage during distribution

1. Taking into consideration that the longest journey for vaccine distribution in Sri Lanka takes not more than 6 hours, it is strongly recommended that the programme stops using frozen icepacks for vaccine distribution and introduces use of cool water packs (+2^{o}C to +8^{o}C).
2. Monitor vaccine temperature during transport using Tiny - Talk

Standard Operating Procedures

1. In order to ensure correct practices and BEP sustain quality it is highly recommended that routine procedures be translated into SOP format.
2. The new version of the Immunization Manual should be in line with recent WHO recommendations on vaccine management and store management training course.

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.

1. Filling of standard VAR for all vaccines is implemented
2. WHO/V&B/05.23 version of the WHO Guidelines on international packaging and shipping of vaccines is always referred now in preparation of procurement specifications
3. The guidelines for vaccine management on interruption of power supply has been revised and it tested once in every three months.
4. A multi channel electronic PC based temperature monitoring system is yet to be installed.
5. All thermo-sensors of cold and freezer rooms have been tested for accuracy using TinyTalk devices.
6. Cool water packs (+2^{o}C to +8^{o}C) instead of freeze packs yet to be introduced
7. The regular monitoring of temperatures during vaccine distribution using standard WHO study protocol is underway.
8. A computerized stock control system is under development.
9. Storekeeper has attended the GTN/VM vaccine store management training course.
10. The new version of the Immunization Manual has been revised in line with the recent WHO recommendations on vaccine management.
11. Periodical physical verification of stocks is implemented.

When will the next EVSM/VMA* be conducted? Planned one in *2009*
**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: *DTP-hepB-Hib*	
Anticipated stock on 1 January 2010	**0**
Vaccine 2:	
Anticipated stock on 1 January 2010	**.....**
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? Supplies

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	**1,579,800**	**7th January 2008 & 25th March 2008**
Safety Boxes	**17,550**	**------ do -------**

Please report on any problems encountered.

Current WHO pre qualified AD syringes back side is covered with paper. During the investigation of AEFI deaths, syringes also became a prime suspect and during investigations in several instances it was found that some syringes were infested with fungus. On inquiry from the manufacturer it was revealed that because of the back side of the syringe wrapping has made out of paper, if proper storing standards are not adhered to possibility of such contamination. Based on this we were force to conduct an IEC campaign among PHC staff through out the country on safe handling of AD syringes.

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.

The Government of Sri Lanka has taken a policy decision to ensure continued supply of injection safety items with government funds for the entire EPI programme and since 2006, the MoH has purchased the balance Injection safety items, which were not covered by GAVI support.

The Government of Sri Lanka has already included a separate budget line for EPI expenses within the MoH budget from 2007 and this includes injection safety items.

The Medical Supplies Division (MSD) of the MoH is responsible for the procurement and distribution of injection safety items, whereas the Epidemiology Unit/MoH coordinates and monitors this activity to ensure the smooth functioning of the EPI programme in the country.

Please report how sharps waste is being disposed of.

One of the limitations in safe injection practice is the waste disposal. Still there is no advanced system of waste disposal following immunization. Burning of immunization waste (filled safety boxes) in open pits is the main practice. However, there is a rigorous method of monitoring this process at field level, and possibility of unsafe waste disposal is very low. MoH is in negotiation with a few plastic recyclers to explore the possibility of recycling plastic waste after disinfection.

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

No problems encountered

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:

Not applicable

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	644,326	643069	632164
New Vaccines (GAVI + Gov)	5,067,000	4,486,000	4,001,000
Injection supplies	586,788	600,266	610,861
Cold Chain equipment	65,545	58,897	103,372
Operational costs	9,526,003	10,353,675	10,556,849
Other (please specify) shared costs	5,215,092	5,319,394	5,425,782
Total EPI	21,104,754	21461301	21330028
Total Government Health			

Exchange rate used	SLR 114/=

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.

The Government of Sri Lanka has already included a separate budget line for EPI expenses within the MoH budget from 2007 and this includes injection safety items. Immunization is priority project of the government and hence government allocate required funds on priority basis for immunization. (Annexure 5)

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:……..		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose		$0.30	$0.35	$0.40	$0.46	$0.53	$0.61
Number of vaccine doses	#	132,200	125,500	145,300	169,200	197,400	227,900
Number of AD syringes	#	141,200	132,700	153,600	178,900	208,700	240,900
Number of re-constitution syringes	#						
Number of safety boxes	#	1,575	1,475	1,725	2,000	2,325	2,675
Total value to be co-financed by country	**$**	439,500	417,000	483,000	562,500	656,500	765,000

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

2nd 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 2.2.3: 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 (specify)	December 2007	Payment not done	Not available
2nd Awarded Vaccine (specify)			
3rd Awarded Vaccine (specify)			

Q. 2: How Much did you co-finance? Not applicable		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (specify)	Nil	
2nd Awarded Vaccine (specify)		
3rd Awarded Vaccine (specify)		

Q. 3: What factors have slowed or hindered or accelerated mobilization of resources for vaccine co-financing?
1. Please refer to the GAVI CEO's letter GAVI/09/201/rk dated 23 July 2009 (in annexure 4)
2.
3.
4.

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

Not applicable

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? No

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

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

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

Vaccine 1: DTP-hepB-Hib

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

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#	364545	369380	374214	379051	383887	388726
Target immunisation coverage with the third dose	*Table B*	#	97%	97%	97%	97%	97%	97%
Number of children to be vaccinated with the first dose	*Table B*	#	372062	376996	381930	386866	391802	396741
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*	$	$0.30	$0.35	$0.40	$0.46	$0.53	$0.61

* 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$)

		2010	2011	2012	2013	2014	2015
Number of vaccine doses	#	1,058,700	1,066,000	1,061,800	1,053,400	1,040,700	1,025,800
Number of AD syringes	#	1,119,400	1,127,100	1,122,600	1,113,800	1,100,400	1,084,600
Number of re-constitution syringes	#						
Number of safety boxes	#	12,425	12,525	12,475	12,375	12,225	12,050
Total value to be co-financed by GAVI	**$**	4,432,500	3,544,000	3,530,000	3,502,000	3,460,000	3,443,000

Vaccine 2: .....

Same procedure as above (table 3.1 and 3.2)

Table 3.3: 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 3.4: 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	**$**						

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)

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 January 2008(month) to December 2008 (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 2007.(month/year) to 2016(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? Dr(Mrs.) S.C. Wickramasinghe, Director(Planning)

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 10th March 2008. Minutes of the said meeting have been included as annex XX to this report.'*

Name	Dr.S.C. Wickramasinghe, Director(Planning) Organisation	Role played in report submission prepared the reort. Implementing responsiility	Contact email and telephone number scwickrama@sltnet.lk, 0094(0)112674683

Government focal point to contact for any clarifications Dr. S.M. Samarage, Deputy Director General(Planning)

Other partners and contacts who took part in putting this report together

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.*

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?

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	$887500	$1012500
Date the funds arrived	May22	January 30
Amount spent	$171937.28	
Balance	$715562.72	
Amount requested	$1012500	

Amount spent in 2008: $171937.28 Remaining balance from total: $715562.72(31st December 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[3] (% 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 HR plan for underserved areas	0.96%	$20,000	$188.58	$19811.42	No

Activity 1.2:	Improve the facilities for PHC staff training at 6 training school	9%	$250000	$22667.47	$227332.53	Vavuniya Training center which is the most important training center for northern province was also provided with facilities.
Activity 1.4	Annual training of 300 PHC staff at 6 upgraded training schools	0%	$ 100000		$ 100000	Training schools were not upgraded. Also due to the conflict it was not feasible to recruite people. In 2009 arrangements are made to start training
Activity 1.5	Conduct in-service training programme for all PHC workers of underserved districts	11.6%	$100000	$11612.09	$88387.91	
Objective 2:						
Activity 2.1:	Improve the existing infrastructure facilities at MCH clinic centers in underserved	23.2%	$200000	$46476.93	$153523.07	

	districts					
Activity 2.2:	Supply basic MCH equipment to all MCH clinics in 10 underserved districts	0%	$20000		$20000	
Activity 2.4	Supply 500 Mopeds fo PHM in 10 underserved districts	162.4%	$30000	$ 48718.18	-$18718.18	80 Mopeds supplied The cost of a Moped was more than estimated
Activity 2.5	Supply of 20 scooters for supervisory staff covirng underserved districts	72.76%	$25000	$18190.91	$6809.09 ($ 2410.25)	Balance of activity 2.5 used for activity 2.4 Balance of activity 2.6 used for activity 2.4
Activity 2.6	Supply 100 moto bicycles for PHI	57.34%	$37500	$ 20994.3	16505.7	
Objective 3:						
Activity 3.1:	Quarterly district management review meetigs	0.16%	$20000	$31.23	19968.77	

3 For example, number of Village Health Workers trained, numbers of buildings constructed or vehicles distributed

Activity 3.2:

Support Functions

Management : Management is carried out by the Planning Unit of the Ministry of Healthcare & Nutrition. No additional staff is employed.

M&E: Master Plan Steering
Committee is managing and evaluating the progress at central level and district reviews are held every quarter to review the progress at district level.
Technical Support : DDG(Planning) is providing technical support for the plan.

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:	Develop HR plan for underserved areas	$19811.42	$19811.42	No	The HR plan will e prepared in 2009
Activity 1.2:	Improve the facilities for PHC staff training in 6 training schools	$246433.64	$227332.53	$ 10000	

Activity 1.4	Annual training of 300 PHC staff at 6 upgraded training schools	$200000	$100000	$ 100000	$ 10000 was not adequate to conduct the training programmme. Therefore, it will e conducted today.
Activity 1.6	Conduct in-service training in all PHC workers of underserved districts	$96310.83	$ 86024.28	$ 50000	
Objective 2:					
Activity 2.1:	Improve the existing infrastructure facilities at MCH clinic centers in underserved districts	$307476.98	$144947.57	$ 200000	
Activity 2.2:	Supply basic MCH equipment packages to all MCH clinics in underserved districts. Supply 10 double cabs for MOH divisions in 10 underserved districts	$38576.36	$20,000	$20000	
Activity 2.3	Supply 500 Mopeds for PHM in 10 underserved districts Supply 100 motor biks for PHI in derserved districts	$163636.36	Nil	$200000	This amount was adequate only to purchase 3 double cabs.
Activity 2.4		$ 32410.25	$ 2410.25	$30000	
Activity 2.6		$37500	Nil	$ 37500	
Objective 3:					
Activity 3.1:	Quarterly district management review meetings	$18593.62	$19496	$10000	
Activity 3.2:	Conduct training programmes for supervising staff	$ 16703.71	$ 26627.84	$ 30000	

	on monitoring and supervision in a developed health system. Develop proposal appraisal tool to assess MCH skills & reporting by PHC staff				
Activity 3.3	Train district level managers and supervisors on PA tool Train PHC staff in 10 districts on best practice for AEFI surveilnace	$3013.92	$ 20000	$ 20000	Three tools developed. As there different stages it takes time to develop.
Activity 3.4	Review the quality & efficiency of existing management information system on MCH including EPI	$16232.00	Nil	$ 80000	
Activity 3.5	Staff performance appraisal will include assessing the completeness' and timely submission of monthly reports from PHC staff to divisions and quarterly reports from divisions to central level.	$ 29905.00	$14250.93	$ 15000	
Activity 3.6	Operational Research	$ 80,000		$ 80000	
Activity 3.7		$7529.78		$20000	
Acticity 4					
Activity 4.1		13090.91		$ 20000	
Support costs					

Management costs

M&E support costs

Technical support

TOTAL COSTS (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.2009)	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:	Develop HR plan for underserved areas	$19811.42	$19811.42	Nil	
Activity 1.2:	Improve the facilities for PHC staff training at 6 training schools	$246433.64	$237332.53	$200000	
Activity 1.4	Annual training of 300 PHC staff at 6 upgraded training schools	$200000	$200000	$100000	
Activity 1.6	Conduct inservice training programme for all PHC workers	$ 96310.83	$136024.28	$75000	

	of underserved districts			
Objective 2:				
Activity 2.1:	Improve the existing infrastructure facilities at MCH clinic centers in underserved districts	$ 307476.98	$344947.57	$200000
Activity 2.2:	Supply basic MCH equipment packages to all MCH clinics in underserved districts.	$38576.63	$ 40000	$20000
Activity 2.3	Supply 10 double cabs for MOH divisions in underserved districts	$ 163636.36	$200000	Nil
Activity 2.4	Supply 500 mopeds for PHM	$ 32410.25	$ 32410.25	$ 30000
Activity 2.6	Supply 100 motor bikes for PHI	$37500	$37500	$37500
Activity 2.7	Supply 2 double cabs to FHB and Epid Unit	Nil	Nil	$ 80000
Objective 3:				
Activity 3.1:	Quarterly district management review meetings	$18593.62	$48992	$10000
Activity 3.2:	Conduct training programmes for	$16703.71	$56627.84	$30000

	supervising staff on monitoring and supervision			
Activity 3.3	Develop performance appraisal tools to assess MCH skills of & reporting by PHC staff	$ 3013.92	$40000	Nil
Activity 3.4	Train district level managers and supervisors on PA tool	$16232	$80000	$80000
Activity 3.5	Train PHC staff in 10 districts on best practice for AEFI surveillance	$29905	$29250.93	$15000
Activity 3.6	Review the quality and efficiency of existing management information system on MCH including EPI	$ 80000	$ 80000	nil
Activity 3.7	Staff performance appraisal on timely submission of monthly reports from PHC staff	$ 7529.78	$ 20000	$ 20000

Support costs

Management costs			
M&E support costs			
Technical support			
Operational Reserach	$ 20000	$ 20000	Nil
TOTAL COSTS			

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. Almost 100% of mothers bring their children to clinic centers for immunization. Under this programme, we managed to repair 9 Clinic centers in the 10 underserved districts which help in improving the quality of services provided to the mothers.

The public health staff involved in the immunization are the Public Health Midwives, Public Health Nursing Sisters, Supervising Public Health midwives and the Public Health Inspectors. Mobility is one of the most important factors for public health staff as they have to go to clinics and also make field visits. As the terrain they have to move is large it is important to have proper mode of transport. Because of this, mopeds were requested for PHM and SPHM and scooters for PHNS and motorcycles for PHII. During this period 50% of the target for mopeds was reached. Twenty scooters were planned for PHNS and it was achieved. This was so for Motor bikes also (25/25).

The human resource training is a very important area for these districts as there is very little opportunity for them to receive in-service training. As only a few people prefer to stay and work in these difficult areas, it is important for them to have a comprehensive training.

The training centers in these districts were not repaired and updated for a long time and it was affecting the quality of training of the health staff. Under the project major training centers for pulic health staff situated in Jaffna, Batticaloa, Kandy, Badulla, Galle and Ratnapura were repaired and upgraded. In addition the Regional Training Center Vavuniya was selected for repairs and upgrading as it was the main training center for northern province. After controlling the terrorism in this area Vavuniya Regional Training Center plays a major part in training he human resources. One very important training

center which was not included in the project was the National Institute of Health Sciences(NIHS) which carries out the bulk of the training. Although this training center was managed by the central government due to lack of funds the institute has lot of needs which need to e met. It is time to consider including NIHS into the GAVI HSS project. As the funds were received in June 2008, there was no sufficient time to forward proposals, approve them, transfer funds and to carry out repairs. Only 2 training centers in Galle and Ratnapura managed to completely utilize their allocation for 2008.

As there is no formal training programme for in-service training it is planned to develop a training manual for the public health staff and to carry out training afterwards. As there was not sufficient time it was not possible to prepare the manual. Therefore the in-service trainings had to e postponed. As there was a dire need to carry out in-service training in the northern province to improve their knowledge they have used an existing training guide and carried out 9 training programmes.

As there was in sufficient time to prepare AEFI guideline that training was also not conducted.

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.
No

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.*
yes

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.

no

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
	1to increase primary health care staff in correct skill mix in 10underserved districts	Under 5 mortality rate	Mortality of uder 5 children	1000 live births	MSU	16/1000	MSU	2005	8/1000			
		Infant mortality rate	Mortality under 1 yr	1000 live births	MSU	11/1000	HMIS	2005	7/1000			
	2 to ensure availability of	National DPT3 coverage	No DPT3 vaccinated	100 live births	HMIS	96%	Epid	2006	99%			

basic infrastructure and logistics to meet the national standards at 10 underserved districts for delivery of maternal and child health services by 2012. 3 to ensure regular monitoring and supervision of MCH services carried out at 10 underserved districts y the middle level facility managers. Y 2012	**No/% of districts achieving 80% DPT3 coverage**	**No of districts more than 80% coverage**	**Total no districts**	**HMIS**	**100%**	**Epid**	**2006**	**100%**
	Proportion of births attended by skilled 1ry health care staff in 10 underserved districts	**of births attended by skilled 1ry health care staff**	**Total births**	**HMIS**	**98%**	**FHB**	**2006**	**100 %**
	Percentage of children between 1 and 5 utilizing 1ry health care services at MCH centers in underserved districts	children aged 1 & 5 utilizing **1ry health care services at MCH centers**	**Total children 1 &5 living in underserved districts**	**HMIS**	**68%**	**FHB**	**2006**	**95 %**
	Percentage of mothers receiving post natal care of accepted level at home within first 10 days after delivery in the underserved areas.	**mothers receiving post natal care visit at home within first 10 days**	**Total mothers post partum**	**HMIS**	**<69%**	**FHB**	**2006**	**95 %**
	Staff trained	**No trained**	**Total staff available**	**Quarterly district reports**	**NA**	**RDHS**		

on MCH best practices in place in 10 districts based	**Districts with sufficient basic infrastructure**	**10**	**Quarterly district reports**	**NA**	**RDHS**	**2006**	**100**
All 10 districts will have sufficient basic infra-structure in place and functioning to provide the full range of MCH services							
Increase MCH coverage (which includes immunization) among all target groups living in underserved areas(aTd coverage used as proxy)	**Number of children who receive a single dose of aTd**	**Total children**	**HIMS**	**73%**	**EPID**	**2006**	

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:
Title / Post:
Signature:

Date:

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[4]

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).

[4] 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[5]

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).

[5] 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 ~