GAVI Alliance

Annual Progress Report 2011

Submitted by
The Government of
Myanmar

Reporting on year: 2011
Requesting for support year: 2013
Date of submission: 5/28/2012

Deadline for submission: 5/22/2012

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

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

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

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

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

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country. The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

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

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

By filling this APR the country will inform GAVI about:
- Accomplishments using GAVI resources in the past year
- Important problems that were encountered and how the country has tried to overcome them
- Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners
- Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released
- How GAVI can make the APR more user-friendly while meeting GAVI’s principles to be accountable and transparent.
1. Application Specification

Reporting on year: 2011

Requesting for support year: 2013

1.1. NVS & INS support

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Current Vaccine</th>
<th>Preferred presentation</th>
<th>Active until</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine New Vaccines Support</td>
<td>Measles, 10 dose(s) per vial, LYOPHILISED</td>
<td>Measles, 10 dose(s) per vial, LYOPHILISED</td>
<td>2016</td>
</tr>
<tr>
<td>Routine New Vaccines Support</td>
<td>DTP-HepB-Hib, 10 dose(s) per vial, LIQUID</td>
<td>DTP-HepB-Hib, 10 dose(s) per vial, LIQUID</td>
<td>2016</td>
</tr>
</tbody>
</table>

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

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

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2010 is available [here](#).
2. Signatures

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

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

For the Government of Myanmar

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

<table>
<thead>
<tr>
<th>Minister of Health (or delegated authority)</th>
<th>Minister of Finance (or delegated authority)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name</td>
</tr>
<tr>
<td>Professor Dr. Pe Thet Khin</td>
<td>U Kyaw Htay</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
<tr>
<td>Signature</td>
<td>Signature</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Full name</th>
<th>Position</th>
<th>Telephone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Kyaw Kan Kaung</td>
<td>Project Manager/Assistant Director</td>
<td>0095-9-8702267</td>
<td><a href="mailto:kyawkankaungmo@gmail.com">kyawkankaungmo@gmail.com</a></td>
</tr>
</tbody>
</table>

2.2. ICC signatures page

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

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

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

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.
ICC may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.3. HSCC signatures page

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

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

<table>
<thead>
<tr>
<th>Name/Title</th>
<th>Agency/Organization</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

HSCC may wish to send informal comments to: apr@gavialliance.org
All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

Myanmar is not reporting on CSO (Type A & B) fund utilisation in 2012
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This APR reports on *Myanmar’s* activities between January – December 2011 and specifies the requests for the period of January – December 2013

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   1.3. ISS, HSS, CSO support
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13. Attachments
## 4. Baseline & annual targets

<table>
<thead>
<tr>
<th>Number</th>
<th>Achievements as per JRF</th>
<th>Targets (preferred presentation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Total births</td>
<td>1,508,265</td>
<td>1,586,789</td>
</tr>
<tr>
<td>Total infants’ deaths</td>
<td>58,822</td>
<td>61,030</td>
</tr>
<tr>
<td>Total surviving infants</td>
<td>1,449,443</td>
<td>1,525,759</td>
</tr>
<tr>
<td>Total pregnant women</td>
<td>1,598,761</td>
<td>1,647,819</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with BCG</td>
<td>1,402,687</td>
<td>1,411,894</td>
</tr>
<tr>
<td>BCG coverage</td>
<td>93 %</td>
<td>89 %</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with OPV3</td>
<td>1,318,993</td>
<td>1,366,303</td>
</tr>
<tr>
<td>OPV3 coverage</td>
<td>91 %</td>
<td>90 %</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with DTP1</td>
<td>1,347,982</td>
<td>1,350,134</td>
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<tr>
<td>Number of infants vaccinated (to be vaccinated) with DTP3</td>
<td>1,318,993</td>
<td>1,318,388</td>
</tr>
<tr>
<td>DTP3 coverage</td>
<td>91 %</td>
<td>86 %</td>
</tr>
<tr>
<td>Wastage[1] rate in base-year and planned thereafter (%) for DTP</td>
<td>0</td>
<td>44</td>
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<tr>
<td>Wastage[1] factor in base-year and planned thereafter for DTP</td>
<td>1.00</td>
<td>1.79</td>
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<tr>
<td>Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib</td>
<td>0</td>
<td>669,070</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib</td>
<td>0</td>
<td>654,681</td>
</tr>
<tr>
<td>DTP-HepB-Hib coverage</td>
<td>0 %</td>
<td>45 %</td>
</tr>
<tr>
<td>Wastage[1] rate in base-year and planned thereafter (%)</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Wastage[1] factor in base-year and planned thereafter (%)</td>
<td>1</td>
<td>1.33</td>
</tr>
<tr>
<td>Maximum wastage rate value for DTP-HepB-Hib, 10 doses/vial, Liquid</td>
<td>25 %</td>
<td>25 %</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with 1st dose of Measles</td>
<td>1,304,499</td>
<td>1,344,922</td>
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<tr>
<td>Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles</td>
<td>0</td>
<td>1,163,878</td>
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<tr>
<td>Measles coverage</td>
<td>90 %</td>
<td>0 %</td>
</tr>
<tr>
<td>Wastage[1] rate in base-year and planned thereafter (%)</td>
<td>0</td>
<td>45</td>
</tr>
</tbody>
</table>

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[1] Wastage
<table>
<thead>
<tr>
<th>Number</th>
<th>Achievements as per JRF</th>
<th>Targets (preferred presentation)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Original approved target according to Decision Letter</td>
<td>Reported</td>
</tr>
<tr>
<td>Wastage[1] factor in base-year and planned thereafter (%)</td>
<td>1</td>
<td>1.82</td>
</tr>
<tr>
<td>Maximum wastage rate value for Measles, 10 dose(s) per vial, LYOPHILISED</td>
<td>50.00 %</td>
<td>50.00 %</td>
</tr>
<tr>
<td>Pregnant women vaccinated with TT+</td>
<td>1,406,910</td>
<td>1,413,659</td>
</tr>
<tr>
<td>TT+ coverage</td>
<td>88 %</td>
<td>86 %</td>
</tr>
<tr>
<td>Vit A supplement to mothers within 6 weeks from delivery</td>
<td>0</td>
<td>1,069,230</td>
</tr>
<tr>
<td>Vit A supplement to infants after 6 months</td>
<td>N/A</td>
<td>641,538</td>
</tr>
<tr>
<td>Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100</td>
<td>2 %</td>
<td>2 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Targets (preferred presentation)</th>
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<tbody>
<tr>
<td></td>
<td>Previous estimates in 2011</td>
</tr>
<tr>
<td>2016</td>
<td></td>
</tr>
<tr>
<td>Total births</td>
<td>1,513,433</td>
</tr>
<tr>
<td>Total infants' deaths</td>
<td>46,916</td>
</tr>
<tr>
<td>Total surviving infants</td>
<td>1,466,517</td>
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<tr>
<td>Total pregnant women</td>
<td>1,558,836</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with BCG</td>
<td>1,437,761</td>
</tr>
<tr>
<td>BCG coverage</td>
<td>95 %</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with OPV3</td>
<td>1,393,190</td>
</tr>
<tr>
<td>OPV3 coverage</td>
<td>95 %</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with DTP1</td>
<td>0</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with DTP3</td>
<td>1,393,190</td>
</tr>
<tr>
<td>DTP3 coverage</td>
<td>0 %</td>
</tr>
<tr>
<td>Wastage[1] rate in base-year and planned thereafter (%) for DTP</td>
<td>0</td>
</tr>
<tr>
<td>Wastage[1] factor in base-year and planned thereafter for DTP</td>
<td>1.00</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib</td>
<td>1,423,810</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib</td>
<td>1,393,190</td>
</tr>
<tr>
<td>Number</td>
<td>Targets (preferred presentation)</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>DTP-HepB-Hib coverage</td>
<td>95 %</td>
</tr>
<tr>
<td>Wastage[1] rate in base-year and planned thereafter (%)</td>
<td>15 %</td>
</tr>
<tr>
<td>Wastage[1] factor in base-year and planned thereafter (%)</td>
<td>1.18 %</td>
</tr>
<tr>
<td>Maximum wastage rate value for DTP-HepB-Hib, 10 doses/vial, Liquid</td>
<td>25 %</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with 1st dose of Measles</td>
<td>1,378,525</td>
</tr>
<tr>
<td>Number of infants vaccinated (to be vaccinated) with 2nd dose of Measles</td>
<td>1,246,539</td>
</tr>
<tr>
<td>Measles coverage</td>
<td>94 %</td>
</tr>
<tr>
<td>Wastage[1] rate in base-year and planned thereafter (%)</td>
<td>0 %</td>
</tr>
<tr>
<td>Wastage[1] factor in base-year and planned thereafter (%)</td>
<td>1 %</td>
</tr>
<tr>
<td>Maximum wastage rate value for Measles, 10 doses (s) per vial, LYOPHILISED</td>
<td>50.00 %</td>
</tr>
<tr>
<td>Pregnant women vaccinated with TT+</td>
<td>1,465,305</td>
</tr>
<tr>
<td>TT+ coverage</td>
<td>94 %</td>
</tr>
<tr>
<td>Vit A supplement to mothers within 6 weeks from delivery</td>
<td>0 %</td>
</tr>
<tr>
<td>Vit A supplement to infants after 6 months</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual DTP Drop out rate [ (DTP1 – DTP3) / DTP1 ] x 100</td>
<td>2 %</td>
</tr>
</tbody>
</table>

** Number of infants vaccinated out of total surviving infants

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

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

1 The formula to calculate a vaccine wastage rate (in percentage): \( \left( \frac{A - B}{A} \right) \times 100 \). Whereby: \( A \) = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; \( B \) = the number of vaccinations with the same vaccine in the same period.
5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2011 must be consistent with those that the country reported in the WHO/UNICEF Joint Reporting Form (JRF) for 2011. The numbers for 2012 - 2016 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

- Justification for any changes in births
  
  There is change of birth as the 2011 data reported in annual evaluation. Other base line data for 2012 onwards remain unchanged as mentioned in cMYP(2012-2016).

- Justification for any changes in surviving infants
  
  The data compiled from annual evaluation shows that there is change of surviving infants. Other base line data for 2012 onwards remain unchanged as mentioned in cMYP(2012-2016).

- Justification for any changes in targets by vaccine
  
  The target children for each antigen has been changed due to change of reported figure in the annual evaluation. Other base line data for 2012 onwards remain unchanged as mentioned in cMYP(2012-2016).

- Justification for any changes in wastage by vaccine
  
  The wastage rate for every antigen remain unchanged.

5.2. Immunisation achievements in 2011

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2011 and how these were addressed:

Routine immunization coverage for 2011 is as follows; BCG- 93 %, DTP1 88 %, DTP3 86 %, OPV3 90 % and Measles 1st dose 88 %. The immunization activities of Mobile session in physically hard to reach areas where the session were planned in 3 months in open season could not be conducted due to inadequate supply of DTP vaccine and Hep B and delay in receiving the operational costs from partners (UNICEF/WHO).

<table>
<thead>
<tr>
<th>Antigen</th>
<th>Achievement in 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>93% Challenges: Hep B vaccine for new born is very difficult as only 8-10 % of deliveries are in hospitals</td>
</tr>
<tr>
<td>DPT 1</td>
<td>88%</td>
</tr>
<tr>
<td>DPT3</td>
<td>86%</td>
</tr>
<tr>
<td>OPV3</td>
<td></td>
</tr>
</tbody>
</table>
Challenges faced:-

- No operational cost from government budget, donor dependent activities, including supply of all vaccines,
- A single case of VPDP was reported in Dec 2010 in Mandalay region, with support from UNICEF and WHO govt conducted a Sub national Polio immunization campaign in 129 townships targeting around 2.9 million children 0-5 years with two doses of OPV.
- With the new government in place there are changes in the administrative set up, Regional Health departments are being strengthened, however still there are unclear areas and roles and responsibilities.
- In parts of the country the security situation is still not very good, specifically in areas of Kachin state and Shan state. There are pockets where EPI services were conducted. A total of 17 townships had no routine immunization services conducted in 2011 approx (20,000) children under 1 missed in these townships. There are very hard to reach and remote very sparse population and poor infra-structure, road communication is limited and also health man power is limited.
- Correct estimation of target population is not known,
- Shortage of Midwives / HW specifically in rural hard to reach areas.
- Cold chain capacity is limited, electricity supply is poor in most part of country and hence vaccines are kept only at sub depots (state level). Vaccine transportation cost is very high as it has to be delivered by special trucks and Air (with an operational cost its again donor depended). Maintenance cost for generators / IEC is not available.
- Vaccines are not stored at township level or at Rural Health center level there by Health workers get vaccine once a month and they have to rush to complete immunization in 3-4 days, first week of every month. Missed opportunities are high, sessions are short timed and hurriedly conducted as cold chain is a major concern.
- In 2011 24% of townships had less than 80% coverages and around 100,000 missed children in these areas.
- Large measles outbreak were seen in 2011, a total of 32 measles lab confirmed outbreaks were reported. Where 890 cases were reported some 7 children also died because of measles complication.
- Case based measles surveillance has also reported more than 1857 cases last year. Subsequently in early 2012 a nation wide mass measles campaign has been conducted to protect all under 9-5 years children from measles.

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

- National Immunization programme could not provide the Hepatitis B vaccine since April 2011 and the expected delivery of DTP vaccine in August 2011 was not materialized. Consequently buffer stock has started to use since September 2011 and all stock was completed in December 2011.
- Consequently the coverage of these two antigens were significantly reduced all over the country.
- However the remaining antigens were available and Immunization sessions were continued as planned.
- On going armed insurgency and conflict in some border areas of country has resulted in interruption of EPI vaccination and a total of 17 townships could not implement EPI program in 2011.
- Lack of funds to support travel of health workers to session site, poor supervision of activities are also reasons for low coverages in some pockets.
- No NGO's in EPI, limited no of partners.

5.3. Monitoring the Implementation of GAVI Gender Policy

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

If yes, please report all the data available from 2009 to 2011.
How have you been using the above data to address gender-related barrier to immunisation access?

In Myanmar there are no gender related barriers for routine EPI. The immunization program is free service to population, however this issue is being seriously considered. At last ICC on 11th May Members have also raised this issue and urged to address this point at the earliest.

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

What action have you taken to achieve this goal?

The country is planning to conduct census on 2013-2014. EPI is planning to collect and analyze the immunization coverage data for sex-disaggregation in future. As part of NeV vaccine introduction and intensification of routine program

- Revision of EPI recording, reporting formats, charts
- Revision of micro-planning formats, registers
- Revision of EPI guidelines

In all these documents revision are being made in 2012, for future to capture and report EPI data sex disaggregated

5.4. Data assessments

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

Myanmar has not had a population census since last 30 years, all programs work on best estimates only. In 2011 there are discrepancies between reported data and collected data in some survey areas where the data collection was done for other purpose such as assessment of integrated household and livelihood survey and rapid assessment in disaster affected areas. Also due to rapidly changing political situation in country there is quite a lot internal migration of population, urbanization construction etc, this is resulting in denominator and reported coverages.

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

5.4.2. Have any assessments of administrative data systems been conducted from 2010 to the present? **Yes**

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

**UNICEF** in collaboration with Ministry of Health and National Planning and Economic Development Ministry conducted MICS survey in Myanmar. The report was released in 2011. This survey reported a very high level of EPI coverage, almost on line with reported coverages or even more. The methodology, quality of this coverage survey has been questioned by partners specifically WHO, since the survey results and data is misleading its not being used, reported

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

- Regular supportive supervision at field level supervisors by Central, Regional and Township level in high risk townships.
- Head counted activities were instructed to do at the end of every year to ensure denominator to reflect the field reality.
- In crease in no of EPI evaluation meeting at central and state level.
- Computerization of EPI data, (in progress)

5.4.4. Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.
The Government of Union of Myanmar is planning to conduct a national census in 2013-2014 and the stratified data will be available for better planning.

Sub national EPI reviews are being planned in two states for 2012-2013.

5.5. Overall Expenditures and Financing for Immunisation

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

Exchange rate used: 1 US$ = 825

Enter the rate only; Please do not enter local currency name.

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

<table>
<thead>
<tr>
<th>Expenditure by category</th>
<th>Expenditure Year 2011</th>
<th>Country</th>
<th>GAVI</th>
<th>UNICEF</th>
<th>WHO</th>
<th>JCV</th>
<th>EU&amp;Aus Aid</th>
<th>CERF/U NF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Vaccines*</td>
<td>2,250,198</td>
<td>0</td>
<td>0</td>
<td>1,722,313</td>
<td>0</td>
<td>527,885</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New and underused Vaccines**</td>
<td>89,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>89,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Injection supplies (both AD syringes and syringes other than ADs)</td>
<td>226,866</td>
<td>0</td>
<td>0</td>
<td>102,784</td>
<td>0</td>
<td>124,082</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cold Chain equipment</td>
<td>161,833</td>
<td>0</td>
<td>0</td>
<td>53,388</td>
<td>0</td>
<td>0</td>
<td>108,445</td>
<td>0</td>
</tr>
<tr>
<td>Personnel</td>
<td>1,368,280</td>
<td>1,242,780</td>
<td>0</td>
<td>0</td>
<td>60,500</td>
<td>65,000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other routine recurrent costs</td>
<td>92,720</td>
<td>0</td>
<td>0</td>
<td>42,720</td>
<td>50,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Capital Costs</td>
<td>50,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>50,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Campaigns costs</td>
<td>4,013,072</td>
<td>0</td>
<td>0</td>
<td>3,804</td>
<td>250,000</td>
<td>641,975</td>
<td>749,578</td>
<td>2,367,715</td>
</tr>
<tr>
<td>Procurement of IT equipment and Immunization Cards</td>
<td>0</td>
<td>0</td>
<td>75,002</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total Expenditures for Immunisation</td>
<td>8,251,969</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Government Health</td>
<td>1,242,780</td>
<td>0</td>
<td>0</td>
<td>2,060,511</td>
<td>504,000</td>
<td>1,293,942</td>
<td>2,858,023</td>
<td>2,367,715</td>
</tr>
</tbody>
</table>

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

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

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

There are difference between available funding and expenditures. GAVI ISS fund to strengthen routine immunization is available but the fund was received in last quarter of 2011. Please see the attachments for detail expenditures from UNICEF and WHO since the table 5.5 a allows to enter only 3 donors.

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

NA.

5.5.3. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2012 and 2013.
There is no funding from the Government for the traditional vaccine. Government support for immunization programme is currently focused on human resource and basic salary for immunizers and supervisors and the facilities for immunization in term of health center. Government has agreed to start to co-finance for new vaccine introduction in 2012-2016 for Pentavalent vaccine targeting all eligible children.

There are no govt funds for supporting routine EPI services in Myanmar. Health workers have to pay out of pocket for IEC cost, transportation cost to visit session sites. Hence many a times HW do not conduct sessions in hard to reach areas, Similarly supervisors are not paid for any visit including

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

<table>
<thead>
<tr>
<th>Expenditure by category</th>
<th>Budgeted Year 2012</th>
<th>Budgeted Year 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional Vaccines*</td>
<td>2,787,216</td>
<td>2,236,124</td>
</tr>
<tr>
<td>New and underused Vaccines**</td>
<td>6,253,795</td>
<td>10,541,926</td>
</tr>
<tr>
<td>Injection supplies (both AD syringes and syringes other than ADs)</td>
<td>1,269,276</td>
<td>1,290,124</td>
</tr>
<tr>
<td>Injection supply with syringes other than ADs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cold Chain equipment</td>
<td>3,875,495</td>
<td>4,056,865</td>
</tr>
<tr>
<td>Personnel</td>
<td>4,796,757</td>
<td>4,892,692</td>
</tr>
<tr>
<td>Other routine recurrent costs</td>
<td>5,501,452</td>
<td>5,658,109</td>
</tr>
<tr>
<td>Supplemental Immunisation Activities</td>
<td>4,874,069</td>
<td>923,633</td>
</tr>
<tr>
<td>Total Expenditures for Immunisation</td>
<td>29,358,060</td>
<td>29,599,473</td>
</tr>
</tbody>
</table>

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

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

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

No.

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

Yes. The costing in cMYP are based on the optimal standard for the immunization programme and there are gaps for implementation of the addressed activities especially for operational costs and maintenance of building and equipments. Currently the programme has being planned for donor advocacy and fund raising activities.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2011 calendar year? Yes, fully implemented

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

<table>
<thead>
<tr>
<th>Action plan from Aide Mémoire</th>
<th>Implemented?</th>
</tr>
</thead>
<tbody>
<tr>
<td>As outlined in FMA, ISS fund management has been done as in last years.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented.
If none has been implemented, briefly state below why those requirements and conditions were not met.

### 5.7. Interagency Coordinating Committee (ICC)

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

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

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

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

If Yes, which ones?

<table>
<thead>
<tr>
<th>List CSO member organisations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar Women's Affairs Federation</td>
</tr>
<tr>
<td>Myanmar Maternal and Child Welfare Association</td>
</tr>
<tr>
<td>Myanmar Red Cross Society</td>
</tr>
<tr>
<td>Japan International Co-operation Agency</td>
</tr>
</tbody>
</table>

### 5.8. Priority actions in 2012 to 2013

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

- Intensification of Routine Immunization by identifying the gap coverage, using Reaching Every Community Strategy implementation
- Introduction of New Vaccine (Pentavalent ) in mid 2012 and Mid Level manager training at national level followed by comprehensive Immunization trainings for all Township medical officers, Health workers in entire country.
- Advocacy meeting with medical associations on NVI and RI intensification
- Support to field staff in by provision of two wheelers in HRA and jeeps for regional / state level supervisors to enhance supervision
- Sub national EPI review in two provinces
- Updating of EPI guidelines , new HW guidelines planning tools, microplanning formats, recording and reporting formats
- New communication strategy for reaching all areas of community, new posters, baners, branding
- Introduction of regular Measles second dose in routine immunization at 18 months
- Nationwide Mass Measles Campaign ( Conducted in March 2012)
- Improvement Activities of cold chain system based on EVM assessment report and identification of strategic options for cold chain and logistics
- Temperature monitoring study on vaccines
- Strengthening of AEFI management, revision of guidelines
- MNTE maintenance strategies life long TT cards, school plan & TT SIA in High risk areas
- Strengthening National Committiee on Immunizatin Practices ( NCIP)
- EPI coverage Survey ( 2013)
- Sero Survey for Polio and measles in slect identified high risk ares
- Strengthening of VPD surveillance specifically in silent areas
- Invasive Bacterial Disease surveillance and Rota surveillance initiation
- Typhoid surveillance in tow townships ( in collaboration with Medical research departments)

Are they linked with cMYP? **Yes**

### 5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety
Please report what types of syringes are used and the funding sources of Injection Safety material in 2011

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Types of syringe used in 2011 routine EPI</th>
<th>Funding sources of 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>BCG AD syringe</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Measles</td>
<td>AD syringe</td>
<td>UNICEF</td>
</tr>
<tr>
<td>TT</td>
<td>AD syringe</td>
<td>UNICEF</td>
</tr>
<tr>
<td>DTP-containing vaccine</td>
<td>AD syringe</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>AD syringe</td>
<td>GAVI</td>
</tr>
</tbody>
</table>

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

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

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

There is limitation of materials for safe disposal of injection devices such as incinerators and shortage of fund for transport of waste products to the sites for proper disposal. Limited incinitators at township level.

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

The sharp wastes are collected in the safety boxes and burnt i and buried in pit at Rural Health centers and disposed by incinerators in Urban areas where the facility is available. However in many townships incinersators are not available or non functional. This is a major concern.
6. Immunisation Services Support (ISS)


<table>
<thead>
<tr>
<th>Description</th>
<th>Amount US$</th>
<th>Amount local currency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds received during 2011 (A)</td>
<td>2,628,038</td>
<td>2,168,131,350</td>
</tr>
<tr>
<td>Remaining funds (carry over) from 2010 (B)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total funds available in 2011 (C=A+B)</td>
<td>2,628,038</td>
<td>2,168,131,350</td>
</tr>
<tr>
<td>Total Expenditures in 2011 (D)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balance carried over to 2012 (E=C-D)</td>
<td>2,628,038</td>
<td>2,168,131,350</td>
</tr>
</tbody>
</table>

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

The ISS programme is managed by the Inter Agency Coordinating Committee (ICC). After receipt, from GAVI, of notification of approval of GAVI ISS reward money to the country, the central EPI unit at the DoH will develop a plan of action with budget for immunization services strengthening in the country. The ICC, chaired by Director General DOH, MOH-M and with members drawn from the MoH-Myanmar, WHO and UNICEF and in-country development partners (tbc), will meet 3-4 times annually or more yearly to:

- Review and endorse plans and budgets to be submitted to WHO through Planning Division, DoH using Direct Financial Cooperation (DFCs) or Agreement for Programme of Work (APWs)
- Oversee, through receipt of progress reports and financial statements prepared by the MoH-Myanmar EPI Manager, programme implementation and approve financing arrangements of the programme;

6.1.2. Please include details on the type of bank account(s) used (commercial versus government accounts), how budgets are approved, how funds are channelled to the sub-national levels, financial reporting arrangements at both the sub-national and national levels, and the overall role of the ICC in this process.
a. ISS proposals will be reviewed by the MO-EPI in WHO and passed on to WHO Budget and Finance unit to release the funds (by cheque in local currency). The DoH will receive the funds and further release them to Central, State/ Region and township levels depending upon the activity implementation status.

b. ICC will oversee programme and financial implementation including the review of quarterly financial monitoring submitted by MOH, WHO, and UNICEF, containing the analysis of expenditure against budget.

c. ICC will receive and review end of year financial statements of ISS and provide comments and/or raise issues.

d. ICC will request when considered necessary that internal MOH audit of MOH managed funds of ISS funding mechanisms are undertaken at an appropriate time through-out the year.

e. ICC will ensure that the external audit of MOH of ISS programmes is conducted within agreed time frames and that external audit reports are submitted to the GAVI Secretariat no later than 6 months following the end of the financial year. The ICC will also ensure that any issues raised in the internal or external audit letters to management are addressed in a timely way;

f. ICC will request UNICEF to take responsibility for procurement of new vaccine, cold chain equipment and safe injection support and WHO to act as administrator and manager of ISS funds.

g. An MoH internal audit team will be formed with representatives from the MoH to undertake random, unannounced reviews of the townships which are part of the HSS and ISS programmes. Internal audit responsibility will be extended to the management arrangements established by the Township Health Committees, the TMO and his/her accounting staff. This audit plan will be risk-based and will set out which aspects of internal control will be tested, how many auditors will be deployed to do the work (audit man days) and the geographical areas to be covered. Subsequent audit findings and audit reports will be presented to the Director General and the ICC for information and follow-up.

h. The Office of Auditor General (Ministerial Level) will conduct an external audit of the MOH HSS and ISS programme financial statements. The Auditor General will be notified well in advance of the end of the financial year of the obligations to GAVI for external audit and the Terms of Reference for the external audit (to be provided by GAVI before the end of the first year of implementation). External Audit reports on HSS and ISS programmes will be provided to the NHSC and ICC respectively, and to the DG MoH. An independent 3rd party firm of accountants or auditors (preferably from within Myanmar) will be employed to undertake an enhanced external audit of the MOH ISS and HSS programmes if required.

• Internal audits are carried out by concerned government department and then final reports submitted to GAVI.

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

There were no activities undertaken using ISS fund in 2011. ISS funds were received only in later part of 2011, and the ICC has decided to use ISS rewards to strengthen supervision at all level by supporting transportation facilities in 2012 and this is in process.

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

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

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

6.2.2. Has an external audit been conducted? No

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

6.3. Request for ISS reward

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

a) if the number of children vaccinated with DTP3 is higher than the previous year’s achievement (or the original target set in the approved ISS proposal), and
b) if the reported administrative coverage of DTP3 (reported in the JRF) is in line with the WHO/UNICEF coverage estimate for the same year, which will be published at [http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tscoveragedtp3.htm](http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tscoveragedtp3.htm)

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

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

**Table 6.3: Calculation of expected ISS reward**

<table>
<thead>
<tr>
<th></th>
<th>Base Year**</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Number of infants vaccinated with DTP3* (from JRF) specify</td>
<td></td>
<td>1356921</td>
</tr>
<tr>
<td>2 Number of additional infants that are reported to be vaccinated with DTP3</td>
<td></td>
<td>-38533</td>
</tr>
<tr>
<td>3 Calculating</td>
<td>$20 per additional child vaccinated with DTP3</td>
<td></td>
</tr>
<tr>
<td>4 Rounded-up estimate of expected reward</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

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

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

*** Please note that value B1 is 0 (zero) until Number of infants vaccinated (to be vaccinated) with DTP3 in section 4. Baseline & annual targets is filled-in
7. New and Under-used Vaccines Support (NVS)

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

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

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

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

Note:
- Myanmar’s 2nd dose of Measles vaccine has been approved by GAVI in 2011, however the country is yet to receive the supply of Measles vaccine, The country recently completed its national wide mass measles campaign in March 2012 and plans to start the 2nd dose of routine measles vaccine at 18 months.
- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

EVM was conducted in August 2012, based on the findings an Cold chain and Vaccine improvement plan has been finalised. UNICEF is the lead agency supporting MOH on this. UNICEF is also hiring an consultant in July- Aug to conduct Temp study to look in to vaccine temperatures during storage, transportation at all level
- New monitoring tools Freeze tags (7800) and Fridge tags (730), log tag (255) have been procured and will be used in field. (after training)
- Data loggers 8/12 sensors for sub depots

It’s proposed to procure 3 Vaccine vans (by re-programning HSS) to give a VV to central cold room and two sub depots for transportation of vaccines and logistics. How ever need is quite high and all the 17 state and region need at least one vaccine van to ensure continuous, and timely supply of vaccines to all townships of country through out the year. Can HSS support this? It’s a major constraint

7.1.2. For the vaccines in the Table 7.1, has your country faced stock-out situation in 2011? No
If Yes, how long did the stock-out last?

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

7.2. Introduction of a New Vaccine in 2011

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2011, please refer to the vaccine introduction plan in the proposal approved and report on achievements:
<table>
<thead>
<tr>
<th>Vaccine introduced</th>
<th>Approved for Measles Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phased introduction</td>
<td>No</td>
</tr>
<tr>
<td>Nationwide introduction</td>
<td>Yes 15/07/2012</td>
</tr>
</tbody>
</table>

The Measles second dose introduction was approved by GAVI in 2011. However Myanmar is still awaiting Vaccine and Logistics from UNICEF SD, no confirmed date has been informed by SD. It is requested to please follow up with SD to get the vaccine according to vaccine arrival schedule.

- However the country was engaged to conduct Mass Measles Campaign in first quarter of 2012 and the vaccine has not arrived to the country.
- It is planed to start regular routine second dose of Measles in mid of 2012 tentatively 15th July 2012.
- Preparation for Measles Second dose introduction is on track along with Penta introduction. Hopefully in coming months, both vaccines will be part of EPI vaccines.

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

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document No 20)

No new vaccine had been introduced last 2 years.

7.2.3. Adverse Event Following Immunization (AEFI)

- Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**
- Is there a national AEFI expert review committee? **Yes**
- Does the country have an institutional development plan for vaccine safety? **No**
- Is the country sharing its vaccine safety data with other countries? **No**

7.3. New Vaccine Introduction Grant lump sums 2011

7.3.1. Financial Management Reporting

<table>
<thead>
<tr>
<th></th>
<th>Amount US$</th>
<th>Amount local currency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds received during 2011 (A)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Remaining funds (carry over) from 2010 (B)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total funds available in 2011 (C=A+B)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Expenditures in 2011 (D)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balance carried over to 2012 (E=C-D)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

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

7.3.2. Programmatic Reporting

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

Myanmar did not receive new vaccine introduction grant from GAVI in 2011.

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

Myanmar did not receive new vaccine introduction grant from GAVI in 2011.
Please describe the activities that will be undertaken with any remaining balance of funds for 2012 onwards
Myanmar did not receive new vaccine introduction grant from GAVI in 2011.

7.4. Report on country co-financing in 2011

Table 7.4 : Five questions on country co-financing

<table>
<thead>
<tr>
<th>Co-Financed Payments</th>
<th>Q.1: What were the actual co-financed amounts and doses in 2011?</th>
<th>Total Amount in US$</th>
<th>Total Amount in Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Q.2: Which were the sources of funding for co-financing in reporting year 2011?

<table>
<thead>
<tr>
<th>Source</th>
<th>NA</th>
<th>NA</th>
<th>NA</th>
</tr>
</thead>
</table>

Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?

<table>
<thead>
<tr>
<th>1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED</th>
<th>0</th>
</tr>
</thead>
</table>

Q.4: When do you intend to transfer funds for co-financing in 2013 and what is the expected source of this funding

<table>
<thead>
<tr>
<th>Schedule of Co-Financing Payments</th>
<th>Proposed Payment Date for 2013</th>
<th>Source of funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Awarded Vaccine Measles, 10 dose(s) per vial, LYOPHILISED</td>
<td></td>
<td>GAVI has approved 5 yrs of Measles Second Dose</td>
</tr>
</tbody>
</table>

Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing

- Myanmar would like to conduct cost effectiveness study for selected vaccine such as Hepatitis B and Pentavalent in near future to advocate the health policy makers and health authority.
- Study tours of senior officials from MoH and Ministry of Finance to have some experience to developing countries (ASEAN and others) where EPI programme has developed good financial sustainability strategies.
- High level advocacy visit to Myanmar to sensitize senior policy makers on investment in EPI.
- Donors sensitization in the needs for Myanmar EPI programme.

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

**NA**

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

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

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

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

Please attach:

(a) EVM assessment (Document No 15)

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

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

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

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

<table>
<thead>
<tr>
<th>Deficiency noted in EVM assessment</th>
<th>Action recommended in the Improvement plan</th>
<th>Implementation status and reasons for delay, if any</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central store-Temperature &amp; Stock Management + MIS</td>
<td>Temperature Mapping &amp; Temp. monitoring Study</td>
<td>Recruitment of Consultant is in process</td>
</tr>
<tr>
<td>Central store-Temperature &amp; Stock Management + MIS</td>
<td>Computerized stock management system</td>
<td>Computers has been procured &amp; installed</td>
</tr>
<tr>
<td>Central store-Temperature &amp; Stock Management + MIS</td>
<td>Vaccine Management Training at all Levels</td>
<td>In preparation process</td>
</tr>
<tr>
<td>Sub- National stores-Vaccine Management</td>
<td>Install continuous temp. traces</td>
<td>Procured and installed</td>
</tr>
</tbody>
</table>

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

If yes, provide details

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

7.6. Monitoring GAVI Support for Preventive Campaigns in 2011

Myanmar does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

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

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

Renewal of multi-year vaccines support for Myanmar is not available in 2012

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

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

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

**Yes**

If you don’t confirm, please explain

Myanmar requests GAVI to continue supporting for both vaccines Measles 2nd dose and Penta for 2013 as outlined in table 7.11.
### Table 7.10.1: Commodities Cost

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

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

**Note:** WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)
Table 7.10.1: Commodities Cost
Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Presentation</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP-HepB, 10 dose(s) per vial, LIQUID</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>DTP-HepB-Hib, 1 dose(s) per vial, LIQUID</td>
<td>1</td>
<td>1.927</td>
</tr>
<tr>
<td>DTP-HepB-Hib, 10 dose(s) per vial, LIQUID</td>
<td>10</td>
<td>1.927</td>
</tr>
<tr>
<td>DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED</td>
<td>2</td>
<td>1.927</td>
</tr>
<tr>
<td>HPV bivalent, 2 dose(s) per vial, LIQUID</td>
<td>2</td>
<td>5.000</td>
</tr>
<tr>
<td>HPV quadriental, 1 dose(s) per vial, LIQUID</td>
<td>1</td>
<td>5.000</td>
</tr>
<tr>
<td>Measles, 10 dose(s) per vial, LYOPHILISED</td>
<td>10</td>
<td>0.242</td>
</tr>
<tr>
<td>Meningococcal, 10 dose(s) per vial, LIQUID</td>
<td>10</td>
<td>0.520</td>
</tr>
<tr>
<td>MR, 10 dose(s) per vial, LYOPHILISED</td>
<td>10</td>
<td>0.494</td>
</tr>
<tr>
<td>Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID</td>
<td>2</td>
<td>3.500</td>
</tr>
<tr>
<td>Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID</td>
<td>1</td>
<td>3.500</td>
</tr>
<tr>
<td>Yellow Fever, 10 dose(s) per vial, LYOPHILISED</td>
<td>10</td>
<td>0.900</td>
</tr>
<tr>
<td>Yellow Fever, 5 dose(s) per vial, LYOPHILISED</td>
<td>5</td>
<td>0.900</td>
</tr>
<tr>
<td>Rotavirus, 2-dose schedule</td>
<td>1</td>
<td>2.550</td>
</tr>
<tr>
<td>Rotavirus, 3-dose schedule</td>
<td>1</td>
<td>3.500</td>
</tr>
<tr>
<td>AD-SYRINGE</td>
<td>0</td>
<td>0.047</td>
</tr>
<tr>
<td>RECONSTIT-SYRINGE-PENTAVAL</td>
<td>0</td>
<td>0.047</td>
</tr>
<tr>
<td>RECONSTIT-SYRINGE-YF</td>
<td>0</td>
<td>0.004</td>
</tr>
<tr>
<td>SAFETY-BOX</td>
<td>0</td>
<td>0.006</td>
</tr>
</tbody>
</table>

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

Table 7.10.2: Freight Cost

<table>
<thead>
<tr>
<th>Vaccine Antigens</th>
<th>VaccineTypes</th>
<th>No Threshold</th>
<th>500,000$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&lt;=</td>
<td>&gt;</td>
</tr>
<tr>
<td>DTP-HepB</td>
<td>HEPBHIB</td>
<td>2.00 %</td>
<td></td>
</tr>
<tr>
<td>DTP-HepB-Hib</td>
<td>HEPBHIB</td>
<td>23.80 %</td>
<td>6.00 %</td>
</tr>
<tr>
<td>Measles</td>
<td>MEASLES</td>
<td>14.00 %</td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>MENINACONGUATE</td>
<td>10.20 %</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (PCV10)</td>
<td>PNEUMO</td>
<td>3.00 %</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (PCV13)</td>
<td>PNEUMO</td>
<td>6.00 %</td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td>ROTA</td>
<td>5.00 %</td>
<td></td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>YF</td>
<td>7.80 %</td>
<td></td>
</tr>
</tbody>
</table>

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID
<table>
<thead>
<tr>
<th>ID</th>
<th>Source</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of surviving infants</td>
<td>Table 4</td>
<td># 1,525,759</td>
<td>1,454,847</td>
<td>1,464,625</td>
<td>1,475,282</td>
<td>1,470,863</td>
<td>8,857,893</td>
</tr>
<tr>
<td>Number of children to be vaccinated with the first dose</td>
<td>Table 4</td>
<td># 0</td>
<td>669,070</td>
<td>1,392,037</td>
<td>1,417,287</td>
<td>1,412,998</td>
<td>6,315,202</td>
</tr>
<tr>
<td>Number of children to be vaccinated with the third dose</td>
<td>Table 4</td>
<td># 0</td>
<td>654,681</td>
<td>1,362,101</td>
<td>1,386,101</td>
<td>1,386,611</td>
<td>6,182,684</td>
</tr>
<tr>
<td>Immunisation coverage with the third dose</td>
<td>Table 4</td>
<td>% 0.00 %</td>
<td>45.00 %</td>
<td>93.00 %</td>
<td>93.95 %</td>
<td>94.27 %</td>
<td></td>
</tr>
<tr>
<td>Number of doses per child</td>
<td>Parameter</td>
<td># 3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td># 1.00</td>
<td>1.33</td>
<td>1.25</td>
<td>1.25</td>
<td>1.18</td>
<td></td>
</tr>
<tr>
<td>Vaccine stock on 1 January 2012</td>
<td># 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of doses per vial</td>
<td>Parameter</td>
<td># 10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AD syringes required</td>
<td>Parameter</td>
<td># Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconstitution syringes required</td>
<td>Parameter</td>
<td># No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety boxes required</td>
<td>Parameter</td>
<td># Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g Vaccine price per dose</td>
<td>Table 7.10.1</td>
<td>$ 2.18</td>
<td>2.02</td>
<td>1.99</td>
<td>1.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cc Country co-financing per dose</td>
<td>Co-financing table</td>
<td>$ 0.00</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ca AD syringe price per unit</td>
<td>Table 7.10.1</td>
<td>$ 0.0465</td>
<td>0.0465</td>
<td>0.0465</td>
<td>0.0465</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cr Reconstitution syringe price per unit</td>
<td>Table 7.10.1</td>
<td>$ 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cs Safety box price per unit</td>
<td>Table 7.10.1</td>
<td>$ 0.0058</td>
<td>0.0058</td>
<td>0.0058</td>
<td>0.0058</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fv Freight cost as % of vaccines value</td>
<td>Table 7.10.2</td>
<td>% 6.00 %</td>
<td>6.00 %</td>
<td>6.00 %</td>
<td>6.00 %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fd Freight cost as % of devices value</td>
<td>Parameter</td>
<td>% 10.00 %</td>
<td>10.00 %</td>
<td>10.00 %</td>
<td>10.00 %</td>
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</tr>
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Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

<table>
<thead>
<tr>
<th>ID</th>
<th>Source</th>
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<tbody>
<tr>
<td>Number of surviving infants</td>
<td>Table 4</td>
<td># 1,466,517</td>
<td>8,857,893</td>
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<tr>
<td>Number of children to be vaccinated with the first dose</td>
<td>Table 4</td>
<td># 1,423,810</td>
<td>6,315,202</td>
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<tr>
<td>Number of children to be vaccinated with the third dose</td>
<td>Table 4</td>
<td># 1,393,190</td>
<td>6,182,684</td>
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<tr>
<td>Immunisation coverage with the third dose</td>
<td>Table 4</td>
<td>% 95.00 %</td>
<td></td>
</tr>
<tr>
<td>Number of doses per child</td>
<td>Parameter</td>
<td># 3</td>
<td></td>
</tr>
<tr>
<td>Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td># 1.18</td>
<td></td>
</tr>
<tr>
<td>Number of doses per vial</td>
<td>Parameter</td>
<td># 10</td>
<td></td>
</tr>
<tr>
<td>AD syringes required</td>
<td>Parameter</td>
<td># Yes</td>
<td></td>
</tr>
<tr>
<td>Reconstitution syringes required</td>
<td>Parameter</td>
<td># No</td>
<td></td>
</tr>
<tr>
<td>Safety boxes required</td>
<td>Parameter</td>
<td># Yes</td>
<td></td>
</tr>
<tr>
<td>g Vaccine price per dose</td>
<td>Table 7.10.1</td>
<td>$ 1.93</td>
<td></td>
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<tr>
<td>cc Country co-financing per dose</td>
<td>Co-financing table</td>
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<td>ca AD syringe price per unit</td>
<td>Table 7.10.1</td>
<td>$ 0.0465</td>
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</tr>
<tr>
<td>cr Reconstitution syringe price per unit</td>
<td>Table 7.10.1</td>
<td>$ 0</td>
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<tr>
<td>cs Safety box price per unit</td>
<td>Table 7.10.1</td>
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<td>fv Freight cost as % of vaccines value</td>
<td>Table 7.10.2</td>
<td>% 6.00 %</td>
<td></td>
</tr>
<tr>
<td>fd Freight cost as % of devices value</td>
<td>Parameter</td>
<td>% 10.00 %</td>
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Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group Low
<table>
<thead>
<tr>
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<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>Minimum co-financing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommended co-financing as per Proposal 2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Your co-financing</td>
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</tr>
<tr>
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</table>

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Minimum co-financing</td>
<td>0.20</td>
</tr>
<tr>
<td>Recommended co-financing as per Proposal 2011</td>
<td>0.20</td>
</tr>
<tr>
<td>Your co-financing</td>
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</table>
Table 7.11.2: Estimated GAVI support and country co-financing (GAVI support)

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of vaccine doses</td>
<td>#</td>
<td>3,337,000</td>
<td>5,309,900</td>
<td>4,831,400</td>
</tr>
<tr>
<td>Number of AD syringes</td>
<td>#</td>
<td>2,968,900</td>
<td>5,343,300</td>
<td>4,745,900</td>
</tr>
<tr>
<td>Number of re-constitution syringes</td>
<td>#</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of safety boxes</td>
<td>#</td>
<td>32,975</td>
<td>59,325</td>
<td>52,700</td>
</tr>
<tr>
<td>Total value to be co-financed by GAVI</td>
<td>$</td>
<td>7,870,500</td>
<td>11,626,500</td>
<td>10,414,000</td>
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Table 7.11.2: Estimated GAVI support and country co-financing (Country support)

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of vaccine doses</td>
<td>#</td>
<td>0</td>
<td>548,000</td>
<td>507,200</td>
</tr>
<tr>
<td>Number of AD syringes</td>
<td>#</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of re-constitution syringes</td>
<td>#</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of safety boxes</td>
<td>#</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total value to be co-financed by the Country</td>
<td>$</td>
<td>0</td>
<td>1,172,000</td>
<td>1,068,000</td>
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Table 7.11.3: Estimated GAVI support and country co-financing (Country support)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Number of vaccine doses</td>
<td>#</td>
</tr>
<tr>
<td>Number of AD syringes</td>
<td>#</td>
</tr>
<tr>
<td>Number of re-constitution syringes</td>
<td>#</td>
</tr>
<tr>
<td>Number of safety boxes</td>
<td>#</td>
</tr>
<tr>
<td>Total value to be co-financed by GAVI</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of vaccine doses</td>
<td>#</td>
</tr>
<tr>
<td>Number of AD syringes</td>
<td>#</td>
</tr>
<tr>
<td>Number of re-constitution syringes</td>
<td>#</td>
</tr>
<tr>
<td>Number of safety boxes</td>
<td>#</td>
</tr>
<tr>
<td>Total value to be co-financed by the Country</td>
<td>$</td>
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Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

<table>
<thead>
<tr>
<th>Formula</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Government</td>
</tr>
<tr>
<td>A Country co-finance</td>
<td>V</td>
<td>0.00 %</td>
</tr>
<tr>
<td>B Number of children to be vaccinated with the first dose</td>
<td>Table 5.2.1</td>
<td>669,070</td>
</tr>
<tr>
<td>C Number of doses per child</td>
<td>Vaccine parameter (schedule)</td>
<td>3</td>
</tr>
<tr>
<td>D Number of doses needed</td>
<td>B x C</td>
<td>2,007,210</td>
</tr>
<tr>
<td>E Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td>1.00</td>
</tr>
<tr>
<td>F Number of doses needed including wastage</td>
<td>D x E</td>
<td>2,669,590</td>
</tr>
<tr>
<td>G Vaccines buffer stock</td>
<td>(F – F of previous year) * 0.25</td>
<td>667,398</td>
</tr>
<tr>
<td>H Stock on 1 January 2012</td>
<td>Table 7.11.1</td>
<td>0</td>
</tr>
<tr>
<td>I Total vaccine doses needed</td>
<td>F + G – H</td>
<td>3,336,988</td>
</tr>
<tr>
<td>J Number of doses per vial</td>
<td>Vaccine Parameter</td>
<td>10</td>
</tr>
<tr>
<td>K Number of AD syringes (+ 10% wastage) needed</td>
<td>(D + G – H) * 1.11</td>
<td>2,968,815</td>
</tr>
<tr>
<td>L Reconstitution syringes (+ 10% wastage) needed</td>
<td>I / J * 1.11</td>
<td>0</td>
</tr>
<tr>
<td>M Total of safety boxes (+ 10% of extra need) needed</td>
<td>(K + L) / 100 * 1.11</td>
<td>32,954</td>
</tr>
<tr>
<td>N Cost of vaccines needed</td>
<td>I x vaccine price per dose (g)</td>
<td>7,281,308</td>
</tr>
<tr>
<td>O Cost of AD syringes needed</td>
<td>K x AD syringe price per unit (ca)</td>
<td>138,050</td>
</tr>
<tr>
<td>P Cost of reconstitution syringes needed</td>
<td>L x reconstitution price per unit (cr)</td>
<td>0</td>
</tr>
<tr>
<td>Q Cost of safety boxes needed</td>
<td>M x safety box price per unit (cs)</td>
<td>192</td>
</tr>
<tr>
<td>R Freight cost for vaccines needed</td>
<td>N x freight cost as of % of vaccines value (fv)</td>
<td>436,879</td>
</tr>
<tr>
<td>S Freight cost for devices needed</td>
<td>(O+P+Q) x freight cost as % of devices value (fd)</td>
<td>13,825</td>
</tr>
<tr>
<td>T Total fund needed</td>
<td>(N+O+P+Q+R+S)</td>
<td>7,870,254</td>
</tr>
<tr>
<td>U Total country co-financing</td>
<td>I x country co-financing per dose (cc)</td>
<td>0</td>
</tr>
<tr>
<td>V Country co-financing % of GAVI supported proportion</td>
<td>U / (N + R)</td>
<td>0.00 %</td>
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### Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

<table>
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<tbody>
<tr>
<td></td>
<td>Total</td>
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</tr>
<tr>
<td>A Country co-finance</td>
<td>V</td>
<td>9.35 %</td>
</tr>
<tr>
<td>B Number of children to be vaccinated with the first dose</td>
<td>Table 5.2.1</td>
<td>1,392,037</td>
</tr>
<tr>
<td>C Number of doses per child</td>
<td>Vaccine parameter (schedule)</td>
<td>3</td>
</tr>
<tr>
<td>D Number of doses needed</td>
<td>B X C</td>
<td>4,176,111</td>
</tr>
<tr>
<td>E Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td>1.25</td>
</tr>
<tr>
<td>F Number of doses needed including wastage</td>
<td>D X E</td>
<td>5,220,139</td>
</tr>
<tr>
<td>G Vaccines buffer stock</td>
<td>(F – F of previous year) * 0.25</td>
<td>637,638</td>
</tr>
<tr>
<td>H Stock on 1 January 2012</td>
<td>Table 7.11.1</td>
<td>5,857,777</td>
</tr>
<tr>
<td>I Total vaccine doses needed</td>
<td>F + G – H</td>
<td>11,815,137</td>
</tr>
<tr>
<td>J Number of doses per vial</td>
<td>Vaccine Parameter</td>
<td>10</td>
</tr>
<tr>
<td>K Number of AD syringes (+ 10% wastage) needed</td>
<td>(D + G – H) * 1.11</td>
<td>5,343,262</td>
</tr>
<tr>
<td>L Reconstitution syringes (+ 10% wastage) needed</td>
<td>I / J * 1.11</td>
<td>0</td>
</tr>
<tr>
<td>M Total of safety boxes (+ 10% of extra need) needed</td>
<td>(K + L) /100 * 1.11</td>
<td>59,311</td>
</tr>
<tr>
<td>N Cost of vaccines needed</td>
<td>I x vaccine price per dose (g)</td>
<td>11,815,137</td>
</tr>
<tr>
<td>O Cost of AD syringes needed</td>
<td>K x AD syringe price per unit (ca)</td>
<td>11,815,137</td>
</tr>
<tr>
<td>P Cost of reconstitution syringes needed</td>
<td>L x reconstitution price per unit (cr)</td>
<td>0</td>
</tr>
<tr>
<td>Q Cost of safety boxes needed</td>
<td>M x safety box price per unit (cs)</td>
<td>345</td>
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<tr>
<td>R Freight cost for vaccines needed</td>
<td>N x freight cost as of % of vaccines value (fv)</td>
<td>708,909</td>
</tr>
<tr>
<td>S Freight cost for devices needed</td>
<td>(O+P+Q) x freight cost as % of devices value (fd)</td>
<td>24,881</td>
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<tr>
<td>T Total fund needed</td>
<td>(N+O+P+Q+R+S)</td>
<td>12,797,734</td>
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<tr>
<td>U Total country co-financing</td>
<td>I x country co-financing per dose (cc)</td>
<td>1,171,556</td>
</tr>
<tr>
<td>V Country co-financing % of GAVI supported proportion</td>
<td>U / (N + R)</td>
<td>9.35 %</td>
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Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 3)

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<tbody>
<tr>
<td>A Country co-finance</td>
<td>V</td>
<td>9.76%</td>
</tr>
<tr>
<td>B Number of children to be vaccinated with the first dose</td>
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<td>Table 5.2.1</td>
</tr>
<tr>
<td>C Number of doses per child</td>
<td>Vaccine parameter (schedule)</td>
<td>3</td>
</tr>
<tr>
<td>D Number of doses needed</td>
<td>B X C</td>
<td>4,238,994</td>
</tr>
<tr>
<td>E Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td>1.18</td>
</tr>
<tr>
<td>F Number of doses needed including wastage</td>
<td>D X E</td>
<td>5,002,013</td>
</tr>
<tr>
<td>G Vaccines buffer stock</td>
<td>(F – F of previous year) * 0.25</td>
<td>0</td>
</tr>
<tr>
<td>H Stock on 1 January 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Total vaccine doses needed</td>
<td>F + G – H</td>
<td>5,002,013</td>
</tr>
<tr>
<td>J Number of doses per vial</td>
<td>Vaccine Parameter</td>
<td>10</td>
</tr>
<tr>
<td>K Number of AD syringes (+ 10% wastage) needed</td>
<td>(D + G – H) * 1.11</td>
<td>4,705,284</td>
</tr>
<tr>
<td>L Reconstitution syringes (+ 10% wastage) needed</td>
<td>I / J * 1.11</td>
<td>0</td>
</tr>
<tr>
<td>M Total of safety boxes (+ 10% of extra need) needed</td>
<td>(K + L) /100 * 1.11</td>
<td>52,229</td>
</tr>
<tr>
<td>N Cost of vaccines needed</td>
<td>I x vaccine price per dose (g)</td>
<td>9,668,892</td>
</tr>
<tr>
<td>O Cost of AD syringes needed</td>
<td>K x AD syringe price per unit (ca)</td>
<td>218,796</td>
</tr>
<tr>
<td>P Cost of reconstitution syringes needed</td>
<td>L x reconstitution price per unit (cr)</td>
<td>0</td>
</tr>
<tr>
<td>Q Cost of safety boxes needed</td>
<td>M x safety box price per unit (cs)</td>
<td>303</td>
</tr>
<tr>
<td>R Freight cost for vaccines needed</td>
<td>N x freight cost as of % of vaccines value (hv)</td>
<td>580,134</td>
</tr>
<tr>
<td>S Freight cost for devices needed</td>
<td>(O+P+Q) x freight cost as % of devices value (ld)</td>
<td>21,910</td>
</tr>
<tr>
<td>T Total fund needed</td>
<td>(N+O+P+Q+R+S)</td>
<td>10,490,035</td>
</tr>
<tr>
<td>U Total country co-financing</td>
<td>I x country co-financing per dose (cc)</td>
<td>1,000,403</td>
</tr>
<tr>
<td>V Country co-financing % of GAVI supported proportion</td>
<td>U / (N + R)</td>
<td>9.76%</td>
</tr>
</tbody>
</table>

Table 7.11.1: Specifications for Measles, 10 dose(s) per vial, LYOPHILISED
<table>
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<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of surviving infants</td>
<td>Table 4</td>
<td>#</td>
<td>1,525,759</td>
<td>1,454,847</td>
<td>1,464,625</td>
<td>1,475,282</td>
<td>1,470,863</td>
</tr>
<tr>
<td>Number of children to be vaccinated with the first dose</td>
<td>Table 4</td>
<td>#</td>
<td>1,344,922</td>
<td>1,309,363</td>
<td>1,332,809</td>
<td>1,357,301</td>
<td>1,367,902</td>
</tr>
<tr>
<td>Number of children to be vaccinated with the second dose</td>
<td>Table 4</td>
<td>#</td>
<td>1,163,878</td>
<td>1,142,407</td>
<td>1,180,262</td>
<td>1,206,107</td>
<td>5,939,193</td>
</tr>
<tr>
<td>Immunisation coverage with the second dose</td>
<td>Table 4</td>
<td>%</td>
<td>0.00 %</td>
<td>80.00 %</td>
<td>78.00 %</td>
<td>80.00 %</td>
<td>82.00 %</td>
</tr>
<tr>
<td>Number of doses per child</td>
<td>Parameter</td>
<td>#</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td>#</td>
<td>1.82</td>
<td>1.67</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Vaccine stock on 1 January 2012</td>
<td>Table 4</td>
<td>#</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of doses per vial</td>
<td>Parameter</td>
<td>#</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Reconstitution syringes required</td>
<td>Parameter</td>
<td>#</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safety boxes required</td>
<td>Parameter</td>
<td>#</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>g Vaccine price per dose</td>
<td>Table 7.10.1</td>
<td>$</td>
<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
</tr>
<tr>
<td>cc Country co-financing per dose</td>
<td>Co-financing table</td>
<td>$</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>ca AD syringe price per unit</td>
<td>Table 7.10.1</td>
<td>$</td>
<td>0.0465</td>
<td>0.0465</td>
<td>0.0465</td>
<td>0.0465</td>
<td>0.0465</td>
</tr>
<tr>
<td>cr Reconstitution syringe price per unit</td>
<td>Table 7.10.1</td>
<td>$</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>cs Safety box price per unit</td>
<td>Table 7.10.1</td>
<td>$</td>
<td>0.0058</td>
<td>0.0058</td>
<td>0.0058</td>
<td>0.0058</td>
<td>0.0058</td>
</tr>
<tr>
<td>fv Freight cost as % of vaccines value</td>
<td>Table 7.10.2</td>
<td>%</td>
<td>14.00 %</td>
<td>14.00 %</td>
<td>14.00 %</td>
<td>14.00 %</td>
<td>14.00 %</td>
</tr>
<tr>
<td>fd Freight cost as % of devices value</td>
<td>Parameter</td>
<td>%</td>
<td>10.00 %</td>
<td>10.00 %</td>
<td>10.00 %</td>
<td>10.00 %</td>
<td>10.00 %</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ID</th>
<th>Source</th>
<th>2016</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of surviving infants</td>
<td>Table 4</td>
<td>#</td>
<td>1,466,517</td>
</tr>
<tr>
<td>Number of children to be vaccinated with the first dose</td>
<td>Table 4</td>
<td>#</td>
<td>1,378,525</td>
</tr>
<tr>
<td>Number of children to be vaccinated with the second dose</td>
<td>Table 4</td>
<td>#</td>
<td>1,246,539</td>
</tr>
<tr>
<td>Immunisation coverage with the second dose</td>
<td>Table 4</td>
<td>%</td>
<td>85.00 %</td>
</tr>
<tr>
<td>Number of doses per child</td>
<td>Parameter</td>
<td>#</td>
<td>1</td>
</tr>
<tr>
<td>Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td>#</td>
<td>1.00</td>
</tr>
<tr>
<td>Number of doses per vial</td>
<td>Parameter</td>
<td>#</td>
<td>10</td>
</tr>
<tr>
<td>AD syringes required</td>
<td>Parameter</td>
<td>#</td>
<td>Yes</td>
</tr>
<tr>
<td>Reconstitution syringes required</td>
<td>Parameter</td>
<td>#</td>
<td>Yes</td>
</tr>
<tr>
<td>Safety boxes required</td>
<td>Parameter</td>
<td>#</td>
<td>Yes</td>
</tr>
<tr>
<td>g Vaccine price per dose</td>
<td>Table 7.10.1</td>
<td>$</td>
<td>0.24</td>
</tr>
<tr>
<td>cc Country co-financing per dose</td>
<td>Co-financing table</td>
<td>$</td>
<td>0.00</td>
</tr>
<tr>
<td>ca AD syringe price per unit</td>
<td>Table 7.10.1</td>
<td>$</td>
<td>0.0465</td>
</tr>
<tr>
<td>cr Reconstitution syringe price per unit</td>
<td>Table 7.10.1</td>
<td>$</td>
<td>0</td>
</tr>
<tr>
<td>cs Safety box price per unit</td>
<td>Table 7.10.1</td>
<td>$</td>
<td>0.0058</td>
</tr>
<tr>
<td>fv Freight cost as % of vaccines value</td>
<td>Table 7.10.2</td>
<td>%</td>
<td>14.00 %</td>
</tr>
<tr>
<td>fd Freight cost as % of devices value</td>
<td>Parameter</td>
<td>%</td>
<td>10.00 %</td>
</tr>
</tbody>
</table>

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

Co-financing group Low
<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum co-financing</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Your co-financing</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum co-financing</td>
<td>0.00</td>
</tr>
<tr>
<td>Your co-financing</td>
<td>0.00</td>
</tr>
<tr>
<td>Year</td>
<td>Value</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>2016</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>0.00</td>
</tr>
</tbody>
</table>
Table 7.11.2: Estimated GAVI support and country co-financing *(GAVI support)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of vaccine doses</th>
<th>Number of AD syringes</th>
<th>Number of re-constitution syringes</th>
<th>Number of safety boxes</th>
<th>Total value to be co-financed by GAVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>2,429,600</td>
<td>1,831,300</td>
<td>269,700</td>
<td>23,325</td>
<td>765,500</td>
</tr>
<tr>
<td>2013</td>
<td>1,142,500</td>
<td>1,268,100</td>
<td>126,900</td>
<td>15,500</td>
<td>381,000</td>
</tr>
<tr>
<td>2014</td>
<td>1,189,800</td>
<td>1,320,600</td>
<td>132,100</td>
<td>16,125</td>
<td>396,500</td>
</tr>
<tr>
<td>2015</td>
<td>1,212,600</td>
<td>1,346,000</td>
<td>134,600</td>
<td>16,450</td>
<td>404,500</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of vaccine doses</th>
<th>Number of AD syringes</th>
<th>Number of re-constitution syringes</th>
<th>Number of safety boxes</th>
<th>Total value to be co-financed by the Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2013</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2014</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2015</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of vaccine doses</th>
<th>Number of AD syringes</th>
<th>Number of re-constitution syringes</th>
<th>Number of safety boxes</th>
<th>Total value to be co-financed by the Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of vaccine doses</th>
<th>Number of AD syringes</th>
<th>Number of re-constitution syringes</th>
<th>Number of safety boxes</th>
<th>Total value to be co-financed by the Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 7.11.4: Calculation of requirements for Measles, 10 dose(s) per vial, LYOPHILISED (part 1)

<table>
<thead>
<tr>
<th>Formula</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Country co-finance</td>
<td>V</td>
<td>0.00 %</td>
</tr>
<tr>
<td>B Number of children to be vaccinated with the first dose</td>
<td>Table 5.2.1</td>
<td>0</td>
</tr>
<tr>
<td>C Number of doses per child</td>
<td>Vaccine parameter (schedule)</td>
<td>1</td>
</tr>
<tr>
<td>D Number of doses needed</td>
<td>B \times C</td>
<td>0</td>
</tr>
<tr>
<td>E Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td>1.82</td>
</tr>
<tr>
<td>F Number of doses needed including wastage</td>
<td>D \times E</td>
<td>0</td>
</tr>
<tr>
<td>G Vaccines buffer stock</td>
<td>(F – F of previous year) \times 0.25</td>
<td>485,920</td>
</tr>
<tr>
<td>H Stock on 1 January 2012</td>
<td>Table 7.11.1</td>
<td>0</td>
</tr>
<tr>
<td>I Total vaccine doses needed</td>
<td>F + G – H</td>
<td>2,429,597</td>
</tr>
<tr>
<td>J Number of doses per vial</td>
<td>Vaccine Parameter</td>
<td>10</td>
</tr>
<tr>
<td>K Number of AD syringes (+ 10% wastage) needed</td>
<td>(D + G – H) \times 1.11</td>
<td>1,831,276</td>
</tr>
<tr>
<td>L Reconstitution syringes (+ 10% wastage) needed</td>
<td>I / J \times 1.11</td>
<td>269,686</td>
</tr>
<tr>
<td>M Total of safety boxes (+ 10% of extra need) needed</td>
<td>(K + L) / 100 \times 1.11</td>
<td>23,321</td>
</tr>
<tr>
<td>N Cost of vaccines needed</td>
<td>I \times vaccine price per dose (g)</td>
<td>587,963</td>
</tr>
<tr>
<td>O Cost of AD syringes needed</td>
<td>K \times AD syringe price per unit (ca)</td>
<td>85,155</td>
</tr>
<tr>
<td>P Cost of reconstitution syringes needed</td>
<td>L \times reconstitution price per unit (cr)</td>
<td>998</td>
</tr>
<tr>
<td>Q Cost of safety boxes needed</td>
<td>M \times safety box price per unit (cs)</td>
<td>136</td>
</tr>
<tr>
<td>R Freight cost for vaccines needed</td>
<td>N \times freight cost as % of vaccines value (fv)</td>
<td>82,315</td>
</tr>
<tr>
<td>S Freight cost for devices needed</td>
<td>(O+P+Q) \times freight cost as % of devices value (fd)</td>
<td>8,629</td>
</tr>
<tr>
<td>T Total fund needed</td>
<td>(N+O+P+Q+R+S)</td>
<td>765,196</td>
</tr>
<tr>
<td>U Total country co-financing</td>
<td>I \times country co-financing per dose (cc)</td>
<td>0</td>
</tr>
<tr>
<td>V Country co-financing % of GAVI supported proportion</td>
<td>U / (N + R)</td>
<td>0.00 %</td>
</tr>
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</table>
### Table 7.11.4: Calculation of requirements for Measles, 10 dose(s) per vial, LYOPHILISED (part 2)

<table>
<thead>
<tr>
<th>Formula</th>
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</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>Country co-finance</td>
<td>V</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Number of children to be vaccinated with the first dose</td>
<td>Table 5.2.1</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Number of doses per child</td>
<td>Vaccine parameter (schedule)</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Number of doses needed</td>
<td>B X C</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>Estimated vaccine wastage factor</td>
<td>Table 4</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>Number of doses needed including wastage</td>
<td>D X E</td>
</tr>
<tr>
<td><strong>G</strong></td>
<td>Vaccines buffer stock</td>
<td>(F – F of previous year) * 0.25</td>
</tr>
<tr>
<td><strong>H</strong></td>
<td>Stock on 1 January 2012</td>
<td>Table 7.11.1</td>
</tr>
<tr>
<td><strong>I</strong></td>
<td>Total vaccine doses needed</td>
<td>F + G – H</td>
</tr>
<tr>
<td><strong>J</strong></td>
<td>Number of doses per vial</td>
<td>Vaccine Parameter</td>
</tr>
<tr>
<td><strong>K</strong></td>
<td>Number of AD syringes (+ 10% wastage) needed</td>
<td>(D + G – H) * 1.11</td>
</tr>
<tr>
<td><strong>L</strong></td>
<td>Reconstitution syringes (+ 10% wastage) needed</td>
<td>I / J * 1.11</td>
</tr>
<tr>
<td><strong>M</strong></td>
<td>Total of safety boxes (+ 10% of extra need) needed</td>
<td>(K + L) /100 * 1.11</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>Cost of vaccines needed</td>
<td>I x vaccine price per dose (g)</td>
</tr>
<tr>
<td><strong>O</strong></td>
<td>Cost of AD syringes needed</td>
<td>K x AD syringe price per unit (ca)</td>
</tr>
<tr>
<td><strong>P</strong></td>
<td>Cost of reconstitution syringes needed</td>
<td>L x reconstitution price per unit (cr)</td>
</tr>
<tr>
<td><strong>Q</strong></td>
<td>Cost of safety boxes needed</td>
<td>M x safety box price per unit (cs)</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>Freight cost for vaccines needed</td>
<td>N x freight cost as of % of vaccines value (fv)</td>
</tr>
<tr>
<td><strong>S</strong></td>
<td>Freight cost for devices needed</td>
<td>(O+P+Q) x freight cost as % of devices value (fd)</td>
</tr>
<tr>
<td><strong>T</strong></td>
<td>Total fund needed</td>
<td>(N+O+P+Q+R+S)</td>
</tr>
<tr>
<td><strong>U</strong></td>
<td>Total country co-financing</td>
<td>I x country co-financing per dose (cc)</td>
</tr>
<tr>
<td><strong>V</strong></td>
<td>Country co-financing % of GAVI supported proportion</td>
<td>U / (N + R)</td>
</tr>
</tbody>
</table>
Table 7.11.4: Calculation of requirements for Measles, 10 dose(s) per vial, LYOPHILISED (part 3)

<table>
<thead>
<tr>
<th>Formula</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Country co-finance</td>
<td>V</td>
<td>0.00 %</td>
</tr>
<tr>
<td>B Number of children to be vaccinated with the first dose</td>
<td>Table 5.2.1</td>
<td>1,206,107</td>
</tr>
<tr>
<td>C Number of doses per child</td>
<td>Vaccine parameter (schedule)</td>
<td>1</td>
</tr>
<tr>
<td>D Number of doses needed</td>
<td>B X C</td>
<td>1,206,107</td>
</tr>
<tr>
<td>E Estimated vaccine wastage factor</td>
<td>Table 4</td>
<td>1.00</td>
</tr>
<tr>
<td>F Number of doses needed including wastage</td>
<td>D X E</td>
<td>1,206,107</td>
</tr>
<tr>
<td>G Vaccines buffer stock</td>
<td>(F – F of previous year) * 0.25</td>
<td>6,462</td>
</tr>
<tr>
<td>H Stock on 1 January 2012</td>
<td>Table 7.11.1</td>
<td></td>
</tr>
<tr>
<td>I Total vaccine doses needed</td>
<td>F + G – H</td>
<td>1,212,569</td>
</tr>
<tr>
<td>J Number of doses per vial</td>
<td>Vaccine Parameter</td>
<td>10</td>
</tr>
<tr>
<td>K Number of AD syringes (+ 10% wastage) needed</td>
<td>(D + G – H) * 1.11</td>
<td>1,345,952</td>
</tr>
<tr>
<td>L Reconstitution syringes (+ 10% wastage) needed</td>
<td>I / J * 1.11</td>
<td>134,596</td>
</tr>
<tr>
<td>M Total of safety boxes (+ 10% of extra need) needed</td>
<td>(K + L) /100 * 1.11</td>
<td>16,435</td>
</tr>
<tr>
<td>N Cost of vaccines needed</td>
<td>I x vaccine price per dose (g)</td>
<td>293,442</td>
</tr>
<tr>
<td>O Cost of AD syringes needed</td>
<td>K x AD syringe price per unit (ca)</td>
<td>62,587</td>
</tr>
<tr>
<td>P Cost of reconstitution syringes needed</td>
<td>L x reconstitution price per unit (cr)</td>
<td>499</td>
</tr>
<tr>
<td>Q Cost of safety boxes needed</td>
<td>M x safety box price per unit (cs)</td>
<td>96</td>
</tr>
<tr>
<td>R Freight cost for vaccines needed</td>
<td>N x freight cost as of % of vaccines value (fv)</td>
<td>41,082</td>
</tr>
<tr>
<td>S Freight cost for devices needed</td>
<td>(O+P+Q) x freight cost as % of devices value (fd)</td>
<td>6,319</td>
</tr>
<tr>
<td>T Total fund needed</td>
<td>(N+O+P+Q+R+S)</td>
<td>404,025</td>
</tr>
<tr>
<td>U Total country co-financing</td>
<td>I x country co-financing per dose (cc)</td>
<td>0</td>
</tr>
<tr>
<td>V Country co-financing % of GAVI supported proportion</td>
<td>U / (N + R)</td>
<td>0.00 %</td>
</tr>
</tbody>
</table>
8. Injection Safety Support (INS)

Myanmar is not reporting on Injection Safety Support (INS) in 2012
9. Health Systems Strengthening Support (HSS)
Instructions for reporting on HSS funds received

1. Please complete this section only if your country was approved for and received HSS funds before or during January to December 2011. All countries are expected to report on:
   a. Progress achieved in 2011
   b. HSS implementation during January – April 2012 (interim reporting)
   c. Plans for 2013
   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2011, or experienced other delays that limited implementation in 2011, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2011 fiscal year starts in January 2011 and ends in December 2011, HSS reports should be received by the GAVI Alliance before 15th May 2012. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2012, the HSS reports are expected by GAVI Alliance by September 2012.

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

4. If you are proposing changes to approved activities and budget (reprogramming) please explain these changes in this report (Table/Section 9.5, 9.6 and 9.7) and provide explanations for each change so that the IRC can approve the revised budget and activities. Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval. The changes must have been discussed and documented in the HSCC minutes (or equivalent).

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

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

7. Please attach all required supporting documents. These include:
   a. Minutes of all the HSCC meetings held in 2011
   b. Minutes of the HSCC meeting in 2012 that endorses the submission of this report
   c. Latest Health Sector Review Report
   d. Financial statement for the use of HSS funds in the 2011 calendar year
   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:
   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;
   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;
   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

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

9.1. Report on the use of HSS funds in 2011 and request of a new tranche

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

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

9.1.2. Please indicate if you are requesting a new tranche of funding Yes
If yes, please indicate the amount of funding requested: 7459586 US$

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

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

Table 9.1.3a (US$)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original annual budgets (as per the originally approved HSS proposal)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3649218</td>
</tr>
<tr>
<td>Revised annual budgets (if revised by previous Annual Progress Reviews)</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3649218</td>
</tr>
<tr>
<td>Total funds received from GAVI during the calendar year (A)</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>2807506</td>
<td>0</td>
</tr>
<tr>
<td>Remaining funds (carry over) from previous year (B)</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1950586</td>
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<tr>
<td>Total Funds available during the calendar year (C=A+B)</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>2807506</td>
<td>1950586</td>
</tr>
<tr>
<td>Total expenditure during the calendar year (D)</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>856920</td>
<td>757563</td>
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<tr>
<td>Balance carried forward to next calendar year (E=C-D)</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1950586</td>
<td>0</td>
</tr>
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<td>Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>7459586</td>
<td>9883249</td>
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Table 9.1.3b (Local currency)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original annual budgets (as per the originally approved HSS proposal)</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Total funds received from GAVI during the calendar year (A)</td>
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<td>0</td>
</tr>
<tr>
<td>Remaining funds (carry over) from previous year ((B))</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1506827924</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>-----------------</td>
</tr>
<tr>
<td>Total Funds available during the calendar year ((C=A+B))</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2168798848</td>
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</tr>
<tr>
<td>Total expenditure during the calendar year ((D))</td>
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<td>0</td>
<td>0</td>
<td>661970924</td>
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<tr>
<td>Balance carried forward to next calendar year ((E=C-D))</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1506827924</td>
<td>0</td>
</tr>
<tr>
<td>Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]</td>
<td>0</td>
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<td>5762530185</td>
<td>7639751477</td>
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</tbody>
</table>

### Report of Exchange Rate Fluctuation

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

#### Table 9.1.3.c

<table>
<thead>
<tr>
<th>Exchange Rate</th>
<th>2007</th>
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<th>2009</th>
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<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening on 1 January</td>
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<td></td>
<td></td>
<td></td>
<td>851</td>
<td>807.5</td>
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<tr>
<td>Closing on 31 December</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>791</td>
<td></td>
</tr>
</tbody>
</table>

### Detailed expenditure of HSS funds during the 2011 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2011 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. *(Document Number: 9)*

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

### Financial management of HSS funds

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

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

Financial Management of GAVI HSS funds are done as per the Aide Memoire signed between CEO GAVI on 26/1/2011 and Minister of Health, Myanmar on 4/2/2011 *(annexure IV)*.

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

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

Detailed budget by implementing partners are included in annexure III.

Funds are managed as follows:

a. UNICEF received a total of USD 396,000 in year one, and it has been used for the procurement of life saving drugs and supplies in the implementation of the strategy of reaching every community;

b. WHO received a total of USD 2,437,405 for the first year of the HSS programme. WHO is responsible for the overall...
management and administration of the GAVI HSS programme and activities; provision of technical assistance to all aspects of
the programme including cross cutting support in capacity building, research, planning and monitoring and evaluation; and;
recruitment of technical staff and international consultants;
c. Third Party is to be identified to manage and implement the construction part. In 2011, government had negotiated with UNOPs
as third party, but due to the high management cost (more than 20%) proposed by UNOPs. Government had to reconsider this
option. Government re-visited the need of construction through health system assessment conducted in first year in 20
townships. The assessment results from the 20 GAVI HSS townships showed 117 sub-centers with no building at all to facilitate
the staff to work and also proper storage of essential medicines and equipment. Considering the need for construction of sub-
centers as an essential factor to motivate the midwives for providing services to the communities especially EPI, Government is
negotiating with one of the National NGO named “Myanmar Red-Cross Society” (MRCS) for the construction of the new sub-
centers for year two with management cost within 7%. After signing the letter of agreement between MOH and MRCS, the
proposal will be submitted to GAVI board for approval. If approved by GAVI board, MRCS will undertake the construction for year
two 2012-2013. Further the country is now preparing for the introduction of 2 new vaccines and many challenges with
cold chain improvements are noticed. Hence, funds ($ 1.26 Million) budgeted for construction, refurbishments and
Management Training for year one 2011 ($ 780,000) and $ 480,000 budgeted for refurbishment of health centers in year
two 2012, has been re-programmed to support vaccine introduction.

**Funds managed by UNICEF**

UNICEF is responsible for procurement of supplies for the GAVI-supported townships. A Letter of Agreement covering the 4-year
period dated April 2009 between MOH-Myanmar and UNICEF has been signed for UNICEF’s role in procurement of supplies.
UNICEF Country Office has procured the supplies through UNICEF Supply Division at Copenhagen. The MoH-Myanmar receives at
the port of entry, gets customs clearance and distributes all supplies to township level. UNICEF supports the government in
supervision and monitoring of distribution and usage of these supplies. UNICEF provides utilization of funds reports annually to the
Focal Point for GAVI-HSS in the MoH-Myanmar.

**Funds managed by WHO**

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

WHO Country Office has recruited staff, both national and international, through the existing HR arrangements and procedures used
by WHO. WHO is directly responsible for procurement of supplies and equipment, special service agreements, fellowships and study
tours, and recruitment and travel of WHO staff.

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

a. Each contract signed between WHO and the MoH-Myanmar has a clear time frame for implementation. Monitoring of
implementation are undertaken through generation of regular reports in WHO’s GSS system as well as through monitoring
officers in WHO. Quarterly statements of expenditure/progress reports of WHO are compiled and consolidated by MoH-Myanmar
and WHO respectively and presented to the National Health Sector Coordinating Body for Health System Strengthening (NHSC),
sometimes referred to as Health Sector Coordination Committee (HSCC). Contractual arrangements for Agreements for the
Performance of Work (APWs) and Direct Financial Cooperation (DFCs) between WHO and MoH are signed by both the WHO
Representative to Myanmar, 12A Floor, Traders Hotel, 223 Sule Pagoda Road, Kyauktada Township, Yangon, 11182,
Myanmar and the GAVI-HSS Focal Point, Director of Planning, Department of Health, Ministry of Health, Building 4, Zeyerathiekd, Naypyitaw, Myanmar.

b. Prior to disbursement, all the GAVI HSS activities are incorporated in the WHO details work plan (Biennium 2010-11 and 2012-
13). WHO then receives a proposal from MoH-Myanmar for the specific activity in the agreed work plan. WHO conducts technical
review of the proposals and process fund transfer through its finance and administration office. The administrations of the funds
are in accordance with WHO Financial Regulations and Financial Rules as well as its financial procedures and practices
(including financial monitoring).

**NHSC:**

The National Health Sector Coordinating (NHSC) body, convened to support GAVI HSS proposal development and implementation
and which has been operational since the beginning of 2007, oversees the GAVI HSS programme. The NHSC, chaired by the Director
General of the Department of Health and with members drawn from the MoH-Myanmar and in-country development partners, meets
on a quarterly basis.

In 2011-12, (3) NHSC meetings were held to:

- **Oversee**, through receipt of financial statements/progress reports prepared by the MoH-Myanmar GAVI HSS Focal
  Point/WHO, programme implementation and approve financing arrangements of the programme;
- **Review and approve** the Annual Progress Report submitted to GAVI, including year-end financial statements in a format
  prescribed by GAVI and included in the APR guidelines;
- **Request** that MoH-Myanmar’s internal audit department undertake, at appropriate times throughout the year, periodic
  reviews of the funding mechanisms (detailed below) used to manage HSS funds received by the MoH-Myanmar from WHO;
- **Ensure that** the external audit of the MOH-Myanmar HSS programme is conducted within agreed time frames and that
At central level

a. Funds from WHO are disbursed to MOH through cheques according to arrangements described above (section 'Funds managed by WHO') and set out in Annex IV and in line with workplan schedules for activities. These cheques in the name of GAVI Focal Point (Director Planning) are submitted to the Budget Management Committee (BMC) for information. The Director of Planning (as secretary to the BMC) reviews the cheques (amount to be implemented for activity) and forwards them to Head of the Budget Section (DoH).

b. The Budget Section DOH then produces a consolidated cash book for GAVI HSS, record all income and expenditures, and reconcile bank accounts at least monthly. Budget section then deposits the cheques into Ministry and Department MD 010556 Government Account at Myanmar Economic Bank, Tarmwe, Yangon through the “Chalan” system.

c. In order to withdraw the fund for specific activities, a Program Officer of GAVI HSS submits a withdrawal of cash form with budgetary breakdown to the BMC. The Director of Planning, as the secretary of BMC, reviews the form and forwards it to the Head of Budget section with approval for the withdrawal of funds for specific activities. All the activities in the work plan and detailed budget are presented to NHSC for approval at the start of GAVI HSS implementation.

d. These forms are reviewed by Budget section who then submit a budget withdrawal form, with mode of delivery of funds (disbursement mechanism), to the BMC. At least three responsible persons from the committee are required to sign for approval after checking the form i.e. the Director of Finance, the Director of Planning and the Director of Administration. The Director General of DoH must give final approval and signature.

e. At the central MoH, in order to support preparation and monitoring of budgets, a financial officer is recruited by WHO as one of the HSSO placed at the central level, designated from within the Division of Finance and Planning DoH as part of the Leadership programme for GAVI HSS. Three other Health System Strengthening officers (HSSO) from with in the DoH are recruited by WHO to focus exclusively on GAVI HSS programming. These officers are also responsible for training and research, monitoring and evaluation (including supplies and assets), financing and programme management. They are working together in the preparation of proposals for implementation of the activities in the townships. The proposals are developed in line with the HSS assessments and the Coordinated Township Health Plan (CTHP). 14 HSS Officers are recruited by WHO and deployed in the townships to support the Township Medical Officer in implementing and monitoring GAVI HSS activities and compiling plans and budgets at township level.

f. The consolidated plans and detailed budgets for each year are then presented to the NHSC for approval before the start of activities.

g. The MoH HSS Focal Point (Director of Planning) ensures the preparation of statements of income and expenditure (by Finance Officer) using formats provided by GAVI. These are prepared on quarterly basis for central level and township level expenditure. The statements are presented to the quarterly NHSC meetings for approval. At the end of the financial year, and as part of GAVI’s APR process, the MOH year-end financial statements are presented to the NHSC along with the APR, and approved by them prior to submission to the GAVI Secretariat. A copy of the MOH year-end financial statement that includes expenses on GAVI HSS is submitted to the Auditor General’s office.

h. A fixed asset register is maintained by the HSS Finance Officer, recording items of capital expenditure (vehicles, medical equipment, office equipment, IT equipment, all other equipment purchased for health facilities using GAVI funds) and include details of purchase price, purchase date, invoice reference and payment reference at time of purchase and supplier details, description of equipment, identifying serial number, make and model, unique asset register number (recorded on the item of equipment, office equipment, IT equipment, all other equipment purchased for health facilities using GAVI funds) and include details of the asset manager (person responsible for taking delivery, maintenance and reporting faults).

i. The existing MoH internal audit team will undertake random, unannounced reviews of the townships which are part of the HSS and ISS programmes in Early May. Internal audit’s responsibility will be extended to the management arrangements established by the Township Health Committees, the TMO and his/her accounting staff in near future. Subsequent audit findings and audit reports are presented to the Director General and the NHSC for information and follow-up.

j. The Office of Auditor General (Ministerial Level) conducted an external audit of MOH HSS programme financial statements. The Auditor General was notified well in advance of the end of the financial year of the obligations to GAVI for external audit and the Terms of Reference for the external audit (to be provided by GAVI before the end of the first year of implementation). An external Audit report on MOH HSS is provided to the NHSC and to the DG MoH. An independent 3rd party firm of accountants or auditors (preferably from within Myanmar) will be employed to undertake an enhanced external audit of the MOH HSS programmes if required.

At Township level

k. In each of the GAVI HSS implementing townships, a Coordinated Township Health Plan (CTHP) was developed once HSS...
assessments have been conducted. These plans were developed by Township Medical Officer (TMO) and Basic Health Staff in close consultation with the Township Health Committee (THC), representatives from Central GAVI, HSSO and local NGO and INGO implementing health activities in the township. The Township Health Committee is a committee formed at every township health system in the country and chaired by the chief of the township local authority.

i. At every township where refurbishment and rehabilitation of facilities activities will take place, there will be a Township Hospital Supervisory Committee (THSC) that oversees the general management of reconstruction and financial management of GAVI HSS funds, including reporting to the township health department and the GAVI HSS Focal Point. In order to fulfill this financial monitoring responsibility the clerical staffs at the townships are trained on financial management and they supports the THSC in managing GAVI HSS funds at the townships. He/she is placed in the TMO office. These accountants are local, have an accounting degree, and are well known to the THSC in a personal and professional capacity.

m. The THSC are given additional responsibility of recording and managing GAVI inflow and outflow of funds for the townships activities to the township health department. This has been applied to all GAVI supported townships through a standing order signed by the DG of the Department of Health. Funds earmarked for the “Management Support Fund” which is now termed as “Hospital Equity Fund” is deposited into the Other Account (OA) at the township bank with TMO as a drawing officer. In order to ensure accountability of use of these funds, a supervisory committee, overseen by the township health committee, is formed at the AVI supported townships.

At least two persons from the monitoring committee will be required to approve the withdrawal by TMO of cash from the OA account for community needs to support poor mother and children for accessing emergency inpatient care (food, transportation and medical care).

Delay in Fund Receipt:

In spite of late arrival of funds to Myanmar, the implementation and progress of HSS activities in first year is reasonably good at (57% financial rate as of March 31st, 2012). Initially agreement was that GAVI HSS program will commence soon after the signing of the final Aide Memoire. Aide Memoire (signed between CEO GAVI on 26/1/2011 and Minister of Health, Myanmar on 4/2/2011). However, funds reached the WHO Country Office only in June 2011. Fund disbursement process between MoH and WHO begun in later part of June 2011 following WHO's financial procedures. Implementation for first activity started only in July 2011.

Has an external audit been conducted? Yes

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

9.2. Progress on HSS activities in the 2011 fiscal year

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

Please provide the following information for each planned activity:
- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2011 reporting year

<table>
<thead>
<tr>
<th>Major Activities (insert as many rows as necessary)</th>
<th>Planned Activity for 2011</th>
<th>Percentage of Activity completed (annual) (where applicable)</th>
<th>Source of information/data (if relevant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health System Assessment and CTHP Development</td>
<td>Activity 1.1: SURVEY Conduct survey to establish base line indicators &amp; outcome, impact and research for operations (including mapping)</td>
<td>100</td>
<td>Division of Planning, DOH, MOH Myanmar (HSS assessment guideline- Annexure VIII Health System Assessment results of 20 townships- Annexure IX)</td>
</tr>
<tr>
<td>Procurement and distribution of essential drugs</td>
<td>Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans</td>
<td>90</td>
<td>UNICEF (list of medicines and equipments procured/ disbursed to CMSD- Annexure X) CMSD (Distribution breakdown of medicine and equipments to 20 townships- Annexure XI)</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Activity 1.3: INFRASTRUCTURE 540 RHCs and 324 sub-RHCs in 180 HSS-targeted Townships will be renovated/constructed including construction of sanitary latrines and improve access to safe water source by 2015, based on needs identified in coordinated township health plans. Installation of solar at the RHC at HTR areas</td>
<td>20</td>
<td>All NHSC meeting minutes-Annexure XIII</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Identification of 3rd party</td>
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<td></td>
<td>Letter from MoH to UNOPs-Annexure XII</td>
</tr>
<tr>
<td>Need assessment for construction</td>
<td></td>
<td></td>
<td>Health System Assessment results of 20 townships-Annexure IX</td>
</tr>
<tr>
<td>Reprogramming to ISS</td>
<td></td>
<td></td>
<td>3rd NHSC meeting minutes-Annexure XIV</td>
</tr>
<tr>
<td>Increased access to EPI, MCH</td>
<td>Activity 1.4: TRANSPORT Provision of essential transport for township and BHS to reach hard-to-reach areas 1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans</td>
<td>100</td>
<td>Quarterly meeting minutes from townships-Annexure XIV NHSC meeting minutes-Annexure XIV</td>
</tr>
<tr>
<td>Identify hard to reach</td>
<td></td>
<td></td>
<td>Sample CTHP from the townships-Annexure XVII</td>
</tr>
<tr>
<td>Transportation support</td>
<td></td>
<td></td>
<td>Breakdown of transportation allowance to BHS from 20 townships Annexure XIII Quarterly meeting minutes from townships-Annexure XV M &amp;E reports from townships-Annexure XVI</td>
</tr>
<tr>
<td>Procurement &amp; Supply of Motorcycles</td>
<td>Activity 1.4.2: Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan</td>
<td>50</td>
<td>NHSC minutes (10th May 2012)-Annexure XIV</td>
</tr>
<tr>
<td>Social Mobilization activities</td>
<td>Activity 1.5: SOCIAL MOBILIZATION: Involving NGOs, local authorities and Community Health Workers in developing and implementing coordinated township Health plans in 100% of HSS-targeted townships by 2011)</td>
<td>100</td>
<td>NHSC meeting minutes-Annexure XIV</td>
</tr>
<tr>
<td>Establish Review Mechanisms</td>
<td></td>
<td></td>
<td>Quarterly meeting minutes from 20 townships-Annexure XV</td>
</tr>
<tr>
<td>Recruitment and training of AMWs and CHWs</td>
<td>Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) &amp; supervision at all levels (including checklists)</td>
<td>100</td>
<td>CTHP guideline-Annexure XIX Guideline for Hospital Equity Fund: Annexure XX. Supervision checklist- Annexure XXI</td>
</tr>
<tr>
<td>Activity 2.2: HEALTH FINANCING RESEARCH</td>
<td>Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships by 2012.</td>
<td>70</td>
<td>Finding of feasibility study of community health initiative for maternal and child health in Myanmar: Annexure XXII. Policy brief of MVS, Guideline and SOP of MVS From Department of Health Planning (DHP), MOH: Annexure XXIII Report on Mapping of Health Financing Schemes in Myanmar: Annexure XXIV</td>
</tr>
<tr>
<td>Management Training (Reprogram to ISS)</td>
<td>Activity 2.4: TRAINING Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011</td>
<td>10</td>
<td>NHSC meeting minutes-Annexure XIV</td>
</tr>
<tr>
<td>Hospital Equity Fund</td>
<td>Activity 2.5: PLAN DEVELOPMENT Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines (activity 2.1) and framework at all levels 2.5.1 Management Support (from Township Coordinated Plans) Includes supervision and planning activities ($10,000 per Township per annum scaling up to 180 Townships by 2011)</td>
<td>80</td>
<td>2nd NHSC meeting minutes Annexure XIV Guideline from DOH for formation of budgetary sub-committee-Annexure XX V. Guideline for Hospital Equity Fund Refer Annexure XX</td>
</tr>
<tr>
<td>Annual Program Review (Central) and NHSCs.</td>
<td>Activity 2.6: RESEARCH &amp; EVALUATION Assess process and impact of coordinated State &amp; Township coordinated health planning, and then disseminate findings 2.6.1 Annual Program Review Central Level</td>
<td>70</td>
<td>NHSC meeting minutes. Annexure XIV</td>
</tr>
<tr>
<td>Annual Program Review at townships</td>
<td>2.6.2 Annual Program Review State and Division Level Evaluation reports Annexure XX VI.</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Health System Research</td>
<td>2.6.4 Establish Health Systems Research Fund</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Research on motivation and retention of MWs</td>
<td>Activity 3.1: RESEARCH Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010. (complementary Funding through AAAH, but with specific research studies funded by GAVI - evaluation of financial -allowances, research on performance based systems and motivational factors of rural health workforce)</td>
<td>50</td>
<td>Draft report on motivation and retention of MWs in hard to reach rural areas of selected townships Annexure XX VII Health system assessment results of 20 townships. 2nd NHSC meeting Minutes (Annexure XIV)</td>
</tr>
<tr>
<td>Development of HR strategic plan</td>
<td>Activity 3.2: HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1 (complementary Funding through AAAH, but with National HR Conference funded through GAVI)</td>
<td>20</td>
<td>Draft Nation Health Plan (2011-2016) HR component Annexure XX VIII</td>
</tr>
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<tr>
<td>Policy brief for retention Health workforce</td>
<td>Activity 3.3: HR PROPOSAL Development of Proposal to MOH recommending appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retention scheme options that include financial incentives. (complementary Funding through AAAH)</td>
<td>20</td>
<td>Expression of interest (EOI) on policy mapping and analysis on rural retention policy selected by AAAH Annexure XXIX</td>
</tr>
<tr>
<td>Provision of package of services to HTR areas</td>
<td>3.3.1 HR costs (HR Finance incentive scheme for health staff in remote areas - identified in Township Coordinated Plans) ($5,500 per Township per Year)</td>
<td>100</td>
<td>Reports from HSSOs- Annexure XXX Expenditure statements of Package of Services- Annexure XXXI</td>
</tr>
<tr>
<td>Dissemination workshop</td>
<td>Activity 3.4: CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition &amp; EH training programs applying the principles of MEP (Capacity Building from Township Coordinated Plans) (complementary Funding through UN Agencies) 3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Training workshop on economic evaluation</td>
<td>3.4.2 International Short Courses Health Financing</td>
<td>100</td>
<td>Economic Evaluation, Health Communication Campaign Workshop for MCH Voucher Scheme in Myanmar -Annexure XXXII</td>
</tr>
<tr>
<td>Experience sharing among HSS countries:</td>
<td>3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Recruitment of HSS Officers (HSSOs)</td>
<td>3.4.4 Leadership Development Program</td>
<td>100</td>
<td>Human Resource for GAVI HSS Unit (WHO)- Annexure XXXIII.</td>
</tr>
<tr>
<td>Office equipments (Central)</td>
<td>Support costs Office Equipment Central</td>
<td>100</td>
<td>List of office equipments procured - Annexure XXXIV</td>
</tr>
<tr>
<td>Logistic support</td>
<td>Transport/Vehicles for DOH and local transport costs</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Office equipments (States and Regions)</td>
<td>Computers Central and States/Divisions</td>
<td>100</td>
<td>List of office equipments procured - Annexure XXXIV</td>
</tr>
<tr>
<td>Office equipments (Townships)</td>
<td>Computers Townships</td>
<td>100</td>
<td>List of office equipments procured - Annexure XXXIV</td>
</tr>
<tr>
<td>Management support (WHO)</td>
<td>Management costs Administration and Management Cost (WHO)</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Management support (DOH)</td>
<td>Administration Costs Central Level (DOH) (Communications, Printing, Staff Hire 2)</td>
<td>100</td>
<td></td>
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<td>--------------------------</td>
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<tr>
<td>International Technical Assistance</td>
<td>International Technical Assistance Health Systems Advisor (WHO)</td>
<td>100</td>
<td>As agreed in Aid Memorie</td>
</tr>
<tr>
<td>External consultant (Financial Management)</td>
<td>Financial Management Consultancies</td>
<td>30</td>
<td></td>
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<tr>
<td>External consultant (Planning)</td>
<td>Planning Consultancies</td>
<td>100</td>
<td>Income and Expenditure HSS (WHO) Annexure III</td>
</tr>
<tr>
<td>External consultant (HR)</td>
<td>Management Effectiveness Programme Consultancies</td>
<td>3rd NHSC minutes: Annexure XIV</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Major Activities (insert as many rows as necessary)</th>
<th>Explain progress achieved and relevant constraints</th>
</tr>
</thead>
</table>
| Health System Assessment and CTHP Development | Progress
- HSS Assessment Guideline developed in both English and Myanmar language
- 80 Surveyors trained before assessment.
- Health System Assessment survey conducted
- Compilation and Documentation of survey results completed.
- Assessment findings incorporated in coordinated Township Health Plans (CTHPs) |
| Procurement and distribution of essential drugs | Progress
- Essential medicine and equipment procured and distributed to 20 townships up till sub-RHC level. |
| Infrastructure | Constraints:
- Identification and Negotiating with the third party was difficult, much of time is lost in the process |
| - Identification of 3rd party | Progress
- Identification of third party for construction/renovation of infrastructure
Negotiation with UNOPs dropped due to the high management cost (more than 20%). Government is now negotiating with one of the National NGO named Myanmar Red-Cross Society for the construction of the new sub-centers with management cost within 7%. After signing the letter of agreement between MOH and MRCS, the proposal will be submitted to GAVI board for approval. |
| - Need assessment for construction | Progress
- Infrastructure needs assessment in 20 townships:
The health system assessment results from the 20 GAVI HSS townships showed 117 sub-centers with no building at all. It demonstrates the need for construction of sub-centers as essential to motivate the midwives for providing services (especially EPI) to the communities |
| - Reprogramming to ISS | Progress
- Reprogramming certain portion of the HSS funds to support ISS to facilitate introduction of new vaccines (pentavalent & measles 2nd dose).
- Total of $780,000 from year one HSS funds is reprogrammed to ISS.
Country is now preparing for the introduction of 2 new vaccines. To facilitate the new vaccine introduction funds budgeted for construction of sub centers and refurbishments of RHCs for year one 2011 ($750,000 USD) is reprogrammed for ISS. |
| Increase access to EPI, MCH | Progress |
| - Identify hard to reach | Progress
Hard to reach areas in twenty townships mapped.
Mapping hard to reach areas was done through a participatory approach by involving BHS, TMOs & central surveyors.
Access to essential components of EPI, MCH, and Nutrition and Environmental health for the hard to reach communities increased through coordinated efforts and package of service delivery. |
| - Transportation support | Transportation allowance provided to:  
- BHS for provision of package of service.  
- Senior supervisors for supervision of service delivery (EPI, MCH, Nutrition and Environmental health). |
| --- | --- |
| Procurement & Supply of Motorcycles | Progress:  
- Need for transportation facility identified through assessments and focus group discussions.  
Originally it was planned to provide bicycles and trolley jeeps. Now with the recent developments on roads and easy availability of motorcycles, BHS demanded motorcycles instead of bicycles and trolley jeeps. Considering the cost efficiency and better utility of motorcycles to support the coordinated approach by group of health workers, it was decided to provide motorcycles(65 numbers) to 20 townships (refer 3rd NHSC minutes).  
- Provision of 65 motocycles to 20 townships.  
- Purchasing order for motorcycles placed by WHO Procurement section. |
| Social Mobilization activities | Progress:  
- CTHP for twenty townships drafted in collaboration with the relevant stakeholders(UN agencies- WHO, UNICEF, INGOs and NGOs, BHS, Township Health committees). |
| - Establish Review Mechanisms | Review Mechanisms in place  
Quarterly review meetings conducted at RHCs and township level participated by BHS, TMOs, Township/village health committees, INGOS,NGOs and volunteers. |
| - Recruitment and training of AMW and CHWs | Recruited Auxiliary Midwives and Community Health Workers (800 in total) for 20 townships.  
40 trainers trained as Training of Trainers to train AMW and CHW conducted in April 2012.  
Identified 800 AMW and CHWs by the local communities and they will be trained in respective townships in later part of May 2012. |
| Production of guidelines | Progress:  
- Production of CTHP guideline.  
Finalized and printed the CTHP guideline.  
Around 1200 BHS including TMOs from 20 townships were trained on using the guide.  
CTHP drafted according to the guidelines at 20 township.  
- Guideline for Hospital Equity Fund drafted.  
Around 40(TMOs & Accountants) were trained on financial management at the township level.  
Developed the supervision checklists to monitor the service quality of EPI, MCH,Nutrition and environmental health at the HSS townships  
Package service delivery supervised byTMOs (Township Medical Officers) and Health system strengthening Officers (HSSOs) using the supervision checklist since January 2012. |
| Explore strategic Health Financing options | Progress  
- Feasibility study of community health initiative for maternal and child health in Myanmar conducted in collaboration with HITAP through WHO support.  
Findings disseminated through dissemination workshop.  
Report Published.  
Policy brief, guidelines and SOP for Maternal Voucher Scheme (MVS) developed.  
Preparation for MVS to be completed by end May 2012. (Advocacy meeting, training and community mobilization)  
Voucher model will be reviewed and revised by the external technical experts in early June 2012.  
Implementation of Maternal Voucher Scheme in one pilot township will start in June 2012:  
This scheme is also designed with the objective to expand EPI services for poor mother and children from the unreached areas.  
Mapping of Health Financing Schemes in Myanmar conducted - Funded by DFID. |
| Management Training (Reprogrammed to ISS) | Progress  
- Fund reprogrammed to support capacity building to facilitate new vaccine introduction |
<table>
<thead>
<tr>
<th>Hospital Equity Fund</th>
<th>Progress:</th>
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<tbody>
<tr>
<td>- Focus Group Discussion to identify areas to be supported by Management Fund held.</td>
<td></td>
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<tr>
<td>- Decided to use management fund as an operational investment to improve MCH access in hard to reach area and termed it as Hospital Equity Fund. Hospital Equity Fund is created as a financial instrument to reach the vulnerable group of mothers and children who are deprived of EPI and other basic primary health care services.</td>
<td></td>
</tr>
<tr>
<td>- Budgetary sub-committee formed to manage the fund at the townships in January-February 2012.</td>
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<tr>
<td>- Clerical staffs (accountants) at townships trained on financial management to support TMO in fund management.</td>
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<tr>
<td>- Accounts and TMOs (40 numbers) trained on fund management in December 2011.</td>
<td></td>
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<tr>
<td>- Seed money for Hospital Equity Fund (HEF) for 20 townships ($10,000 per year/township) distributed in May 2012.</td>
<td></td>
</tr>
<tr>
<td>- Contribution by other interested parties (MMCWA) to HEF received.</td>
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<tr>
<td>- Guideline for hospital equity fund developed.</td>
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<table>
<thead>
<tr>
<th>Annual Program Review (Central) and NHSCs.</th>
<th>Progress:</th>
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<tbody>
<tr>
<td>- Conducted NHSC meetings on a timely manner.</td>
<td></td>
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<tr>
<td>- 3 NHSC meetings conducted as of now.</td>
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<tr>
<td>- Annual Program Review at central level will be conducted in November 2012.</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Annual Program Review at townships</th>
<th>Progress:</th>
</tr>
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<tbody>
<tr>
<td>- Evaluation at 20 townships conducted by using 63% of the planned budget. The balance fund were used to address the findings from evaluation.</td>
<td></td>
</tr>
<tr>
<td>- Evaluation also showed the need for TOT to provide refresher training to the AMWs and CHWs on the introduction of new vaccines and other innovative MCH interventions. Hence, out of the $40,000 budgeted for Evaluation; there was balance of $14,873. Out of this balance, ($8000) was reallocated to Train the trainers for AMWs and CHWs.</td>
<td></td>
</tr>
<tr>
<td>- Results showed around 20 refrigerators are needed for vaccine storage in the RHCs with electricity.</td>
<td></td>
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<tr>
<td>- The rest of the balance ($6873) from evaluation fund will be used to procure refrigerators.</td>
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<thead>
<tr>
<th>Health systems Research</th>
<th>Progress:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- HSR training to States/Regions:</td>
<td></td>
</tr>
<tr>
<td>- Deputy Health Directors from 17 States and Regions, 10 TMOs from 20 townships are selected to be trained on Health system research:</td>
<td></td>
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<tr>
<td>- After the training there will be a call for expression of interest from the trainees, develop protocol and submit to Ethical Board of DOH for defense.</td>
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<tr>
<td>- 3-4 Research grants will be permitted especially to those protocols with HSS issues linking to EPI/MCH.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Research on motivation and retention of MWs</th>
<th>Progress:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Research on motivation and retention of Midwives in hard to reach rural areas for 6 selected townships is ongoing.</td>
<td></td>
</tr>
<tr>
<td>- Dissemination of 20 HSS township assessment results and rural retention research will be done in July, 2012.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Development of HR strategic plan</th>
<th>Progress:</th>
</tr>
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<tbody>
<tr>
<td>- Development of HR strategic plan (planned in July 2012):</td>
<td></td>
</tr>
<tr>
<td>- Hire external expert</td>
<td></td>
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<tr>
<td>- Research and analysis</td>
<td></td>
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<tr>
<td>- Disseminate the findings</td>
<td></td>
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<tr>
<td>- Drafting the Plan</td>
<td></td>
</tr>
<tr>
<td>- Finalization and Printing of document</td>
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</tr>
<tr>
<td>- Need for National Strategic Plan for Human Resource is reflected in Draft National Health Plan 2011-2016. It also came out as one of the major recommendations from the recent conference on Development Policy Option.</td>
<td></td>
</tr>
</tbody>
</table>
| **Policy brief for retention of Health workforce.** | **Progress:**  
- Expression of interest (EOI) for policy mapping and analysis on rural retention policy - submitted to AAAH on 15-3-2012  
- EOI from Myanmar group of researchers headed by GAVI focal point was selected.  
- Attended workshop on development of protocol by group of Researchers from six countries.  
- Finalized the draft protocol and sent to AAAH.  
- Research will be conducted and results be disseminated in the 7th AAAH conference in December 2012 in Bangladesh. |
| **Provision of package of services to HTR areas** | **Progress:**  
- Package of service to increase access to essential components of PHC (EPI, MCH, Nutrition and environmental health) for hard to reach population delivered in 20 townships:  
- Previous trends show independent visits by BHS to the community for different programs. This increased burden on the health workers having to make many visits with no transportation costs. It further decreased coverage of services (EPI, MCH, Nutrition and Environmental Health) which were the core elements of PHC especially to the hard to reach areas.  
- In order to make these services available to the hard to reach areas in a cost efficient manner, it is planned to make these services available for the hard to reach population in a package (EPI, Nutrition, MCH and Environmental health) through coordinated efforts.  
- Accordingly, group of health workers now visit the hard to reach community and deliver comprehensive package of PHC (EPI, MCH, Nutrition and Environmental health) services.  
- Transportation costs and per-diem are provided to facilitate visit by BHS to cover the hard to reach areas.  
- This is also practiced to study the feasibility of pay for performance to improve the performance of the health workers and rationalize utilization.  
- If found feasible, strategic policy options will be explored to sustain this system.  
- **Constraints:**  
  - Many stakeholders expressed the need to expand the scope of CTHP and integrate other health interventions/programs, beyond EPI, Nutrition, MCH and Environmental Health. |
| **Dissemination workshop** | **Progress:**  
- CTHP drafted and implemented in the townships.  
- Dissemination of CTHP along with assessment results planned in July 2012 |
| **Training workshop on economic evaluation** | **Progress:**  
- Training workshop on economic evaluation and health communication regarding MVS by HITAP team (Health Intervention and Technology Assessment Program -Bangkok) conducted in August 2011.  
- Around 40 people (HSSO,TMOs and central medical officers) were trained |
| **Experience sharing among HSS countries:** | **Progress:**  
- Experience sharing among HSS countries:  
  - HSS Countries to visit identified (Lao PDR and Cambodia), participants selected by government and WCO Myanmar is now processing the visit. |
| **Recruitment of HSS Officers (HSSOs)** | **Progress:**  
- Health system strengthening Officers were recruited by WHO through Special Service Agreement, to facilitate implementation GAVI health system strengthening officers at all levels (central, state and region and townships).  
- 4 HSSOs at the Central level and 14 HSSOs at the township level were recruited for year one against the planned number of 20 |
| **Office equipments (Central)** | **Progress**  
- procured :  
  - Desktop computer + Printer (3), Printer toner (5), Copier (1),  
  - Copier toner (9), Multimedia projector (1), Office table (2), Chair (15), Air con (1), Cupboard (1), File shelves (2), Box file (30), A4 paper (50) rims |
| **Logistic support** | **Progress:**  
- Requisition for two cars and 65 motor bikes to support the implementation, monitoring and supervision of HSS interventions.  
- WHO is processing procurement as per their procurement rules. |
9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Not Implemented</th>
<th>Modified/Reprogrammed</th>
</tr>
</thead>
</table>

**Activity 1.3: INFRASTRUCTURE**

540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source by 2011, based on needs identified in coordinated township health plans.

- Identification of third party for construction/ renovation of infrastructure
- Negotiation with UNOPs dropped due to the high management cost (above 20%). Government is now negotiating with one of the National NGO
named Myanmar Red-Cross Society for the construction of the new sub-centers with management cost within 7% for year two.

After signing the letter of agreement between MOH and MRCS, the proposal will be submitted to GAVI board for approval.

- Number of Construction of Sub-RHC:

As per the original proposal, it was planned to construct 36 Sub-RHC in the year one. However due to high management cost proposed by third party added change in exchange rate over the years the budgeted, this activity was not implemented as planned.

- Meanwhile, country needed support to introduce new vaccines and Total of $ 750,000 for construction of sub centers and refurbishment of Rural Health centers for year one is reprogrammed to support vaccine introduction. Activity details attached as (annexure XXXV)

**Activity 2.4:** TRAINING Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011.

- Township Medical Officers and BHS were provided with basic skills on coordinated planning and management during the training on CTHP guideline and drafting of CTHP:

- Reprogrammed $30,000 planned for this to support introduction of new vaccine: (activity details annexure xxxv)

**Activity 3.2:** HR PLAN Develop HR Plan recommending strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1 (complementary Funding through AAAH, but with National HR Conference funded through GAVI)

- This activity is very much dependent on the output of activity 3.1 which is ongoing now. Further it is interdependent to activity 3.3, which will start by end of May 2012. Hence, it is planned in the later part of 2012.

- Development of HR strategic plan for Myanmar capturing the health workforce from both public and private sector - planned to start July 2012 onwards:

  Hire external expert

  Research and analysis

  Incorporating findings from Research on motivation and retention of midwives in hard to reach areas.

  Disseminate the findings

  Drafting the Plan

  Finalization and Printing of document

**Activity 3.3:** HR PROPOSAL

Development of Proposal to MOH recommending appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives. (complementary Funding through AAAH)

- This activity was planned to be conducted through complementary funding by AAAH:

  Expression of interest (EOI) for policy mapping and analysis on rural retention policy was called by AAAH in Early March 2012 and likewise proposal from Myanmar was submitted on 15-3-2012

  EOI from Myanmar group of researchers headed by GAVI focal point was selected

  Attended workshop on development of protocol by group of Researchers from six countries.

  Finalized the draft protocol and sent to AAAH.

  Research will be conducted and results be disseminated in the 7th AAAH conference in December 2012 in Bangladesh.

  Policy mapping for rural retention of health workforce using the output of activity 3.1 & 3.2 and findings from this research.

  Policy options will be field tested through complementary funding by GAVI.

**Activity 3.4:** CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition & EH training programs applying the principles of MEP (Capacity Building (from Township Coordinated Plans) (complementary Funding through UN Agencies)

3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines

CTHPs for 20 townships drafted and implemented since January 2012.

Currently central team is revisiting the CTHPs to track:

- Whether the targets set were realistic,

- Whether any activities missed, whether there is overlap of activities and cost between the different systems areas, funding gaps etc.
Once revision of CTHPs is completed by end of May, a dissemination meeting is planned in July 2012 to disseminate CTHPs and Health System Assessment Results.

All the relevant stakeholders (UN agencies, INGOs, Donors, NGOs and central, states, regions and townships) will be invited to attend.

Financial Management Consultancies
- Financial Management Consultant is needed mainly to assess the health financing schemes in Myanmar and conduct feasibility study on community health Initiatives.

Fortunately, international experts were recruited through the support of WHO SEARO and DFID whereby the above activities were implemented already.

Therefore, another financial expert will be recruited to review the guidelines on Maternal Voucher Scheme and Hospital Equity Fund and design appropriate implementation design for the two strategies in June 2012 by WHO.

Management Effectiveness Programme Consultant
HR consultant will be hired to draft National Strategic Plan for Human Resource.

- Human Resource is noticed as a cross cutting barrier for all the programs. Need for strategic intervention to address shortage and capacity of Health Workforce is reflected in the current National Health Plan.

- Hence, need for external expert on Health Human Resource is felt crucial to guide the plan design. It is then decided by the NHSC on 10th May 2012 to reprogram this fund to recruit external expert to draft the HR strategic plan.

Drugs Supply System Consultant
Reallocated to recruit HR consultant.

- External expert for drug supply system is not found essential for year one, since all the essential drugs that has been procured is as per the Kit A&B from WCHD program for year one.

- Later in year two we may need an external expert to review the needs.

Hence, this budget is reprogrammed to fill the funding gap for recruiting external expert for HR(Refer 3rd NHSC meeting Minutes)

Way forward:
- In the Year two the scope of Package of service will be upgraded with inclusion of health education and advocacy on the introduction of new vaccines.

- Any support for the implementation of new vaccines could be included in the Coordinated Township Health Plans of 60 HSS townships.

- The Community Health Workers and Auxiliary Midwives will provide support to ISS on community mobilization and advocacy on new vaccines to the hard to reach areas in 60 HSS townships.

- Health system strengthening Officers will coordinate and monitor immunization campaigns in the 20 HSS townships as they did for Measles Campaign in early March 2012.

- Priority Human Resource needs (capacity building, deployment, management etc) to support immunization services in the country will be addressed in the National Human Resource Strategic Plan.

- Focus will be given to address priority needs for strengthening EPI services while designing comprehensive health system strengthening strategies and researches.

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?
Healthsystem assessments showed following barriers in delivering and accessing essential health care service in Myanmar among which Human Resource (low performance and low retention) was observed as across cutting issue:

- **Service Delivery Barriers**: Access to immunization and child health care service were determined by demand side barriers like cultural, geographic, and economic and security factors in Myanmar. Further it was compounded by supply side barriers like infrastructure, logistics, Human Resource and transport and supply systems.

- **Organizational, Management and Coordination Barriers**: fragmentation of health organization along vertical program lines, underperformance in the area of health management lead to inefficiencies and inequalities in health service provision. Limited capacity in planning and information management was observed as another concern at the state/division and township level affecting the service delivery. All these lead to overburdening of the midwives at the peripheral level (sub rural health centre).

**Human Resource Barriers**: A major barrier to Public health service delivery was noted as lack of human resource development opportunities (skill up-gradation), excessive workload, no clear job description and no standard distribution of human resources. An essential need is observed to develop an appropriate national strategy for human resource guiding HR planning, production, deployment and utilization.

Human Resource assessments from 20 townships showed: Out of 115 RHCs, none has standard Human Resource[1] in Place. The ratio of midwives to PHS 2 is only 10:1, showing huge work burden on the midwives. There are significant portion of posts vacant for midwife (41%) and PHS 2 (43%) across 20 twenty townships, especially in more remote areas.

Another challenge is to deploy and retain health workforce in the rural and hard to reach areas. Government is now exploring strategic options to retain rural health workforce to strengthen health care service delivery in the hard to reach areas. Most recently Government has approved hardship allowance for the rural health workers.

Complementing Governments endeavor on retaining the rural health work force, GAVI HSS funds were invested in the following:

- Providing Per diem and Travel Allowance for BHS/TMOs for delivery of package of service, M&E and Supervision to the hard to reach areas. (This in fact is used to test the feasibility of financial incentive in improving the performance of health workers in rural areas. The outcome will be assessed and if found feasible, recommendations will be submitted to government to institute these incentives in the national system).

- Training of BHS/TMOs and States and Regional Deputy Health Directors on Planning, Financial Management,

- To upgrade the capacity of health workers at the state, regions and townships on Health System Research Methodology and provision of research grant to conduct operational research at the township levels.

- Recruitment and training of 800 health volunteers (Community Health Workers and Auxiliary Midwives) to support and help the performance of midwives in the 20 townships.

- Supply of essential medicines and kits to BHS.

- Supply of transportation means (motorcycles) for the rural health workers to reach the unreached.

- Investments are also made to conduct research to identify the underlying causes of attrition of rural health workforce.

Later in June, investments will be made in formulating a national strategic Plan on Human Resource for Health using the evidence generated from the research and assessments on Health Workforce in Myanmar. Investments will be made to support construction of Sub-Rural Health centers and solar power supply to the selected priority Rural Health Centers in the hard to reach areas to motivate the health workers in delivering basic primary health care service (EPI, MCH, Nutrition and Environmental Health).

[1] HealthAssistant, 1 Lady Health Visitor, 5 Midwives, 5 public Health Supervisor level 2 and 1 watchmen.

**9.3. General overview of targets achieved**
Please complete Table 9.3 for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2010 from your original HSS proposal.

### Table 9.3: Progress on targets achieved

<table>
<thead>
<tr>
<th>Name of Objective or Indicator (Insert as many rows as necessary)</th>
<th>Baseline</th>
<th>Agreed target till end of support in original HSS application</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Data Source</th>
<th>Explanation if any targets were not achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. National DPT3 coverage (%)</td>
<td>70%</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MICS (2009-2010)</td>
<td>achieved 95%</td>
</tr>
<tr>
<td>2. No: / % of districts achieving ≥80% DTP3 coverage</td>
<td>75 Townships (23%)</td>
<td>WHO-UNICEF joint report, DoH (2006)</td>
<td>325 Townships</td>
<td>330 Townships</td>
<td></td>
<td></td>
<td></td>
<td>c MYP (2006-2011)</td>
<td>284 Townships (86%)</td>
</tr>
<tr>
<td>3. Under five mortality rate (per 1000) (national)</td>
<td>66.1%</td>
<td>HMIS Survey DoH/UNICEF 2003</td>
<td>38.5 MDG Target by 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MICS (2009-2010)</td>
<td>46.1/1000 LB in 2009-10 MICS</td>
</tr>
<tr>
<td>4. Delivery by Skilled Birth Attendants (HSS target)</td>
<td>67.5%</td>
<td>Union of Myanmar MDG report 2006 Fertility Reproductive Health Survey/2003</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MICS (2009-2010)</td>
<td>70.6%</td>
</tr>
<tr>
<td>5. Rate of ORS Use of &lt; 5 children (National)</td>
<td>53%</td>
<td>Dept. of Health Planning Public Health Statistics Annual Report 2006</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MICS (2009-2010)</td>
<td>National coverage is 66%. The achievement rate for urban is 77% whereas it's only 62% for rural areas.</td>
</tr>
<tr>
<td>% of townships have developed and implemented coor</td>
<td>0</td>
<td>Annual Program Review (Annual Evaluation Report)/2006</td>
<td>55% (180 townships out of 325)</td>
<td>6% (20 townships out of 330)</td>
<td></td>
<td></td>
<td></td>
<td>DoH</td>
<td>achieved</td>
</tr>
<tr>
<td>No./% of RHC (in 180 HSS tsp) visited at least 6 t</td>
<td>0</td>
<td>Base line survey</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HSS assessments</td>
<td>Not achieved yet since January 2012, supervision by TMO, HA and LHV using qualified checklist has started.</td>
</tr>
<tr>
<td>No: of managers/trainers / BHS trained for MEP</td>
<td>300 BHS and 50 managers and trainers for MEP</td>
<td>Annual Program Review</td>
<td>9000 BHS and 100 Managers &amp; trainees</td>
<td>1200 BHS including TMOS trained on CTHP</td>
<td></td>
<td></td>
<td></td>
<td>DOH</td>
<td>(1200) BHS and Managers were trained on Coordinated Township Health Planning. Fund budgeted for this in the year one is reprogrammed to support EPI.</td>
</tr>
<tr>
<td>Proportion of RHCs with no stock out of essentia</td>
<td>0</td>
<td>Base line survey</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>DOH</td>
<td>0% with no stock out till December 2011. Essential supplies are dispatched in 20 townships by January 2012.</td>
</tr>
</tbody>
</table>
9.4. Programme implementation in 2011

9.4.1. Please provide a narrative on major accomplishments in 2011, especially impacts on health service programs, notably the organization program
Myanmar could make substantial improvement in its health system foundations to better manage and improve the access to Primary Health Care service for hard to reach areas in priority 20 townships:

**Governance:**

Streamlined the Planning system at the township level through introduction of Coordinated Township Health Plans. The capacity for the Township Health Managers were upgraded in the field of planning and financial management. Introduced the system of need based planning lead by Health System Strengthening Assessments. Culture of participatory planning approach is introduced at the township level by encouraging participation and involvement of all relevant stakeholders (TMOs, PHS, Midwives and AMWs) community health leaders, INGOs and NGOs.

**Serviced delivery:**

Realigned the health service delivery mechanism to reach the hard to reach areas by delivering package of service (EPI, MCH, Nutrition and Envt. Health) through coordinated efforts. Health System Strengthening Assessments facilitated in mapping hard to reach areas in 20 townships.

Compared to the past where no visit has been made to the hard to reach areas, today 690[1] hard to reach villages are covered in twenty HSS townships by the package of services (EPI, MCH, Nutrition and Environmental Health)

HSS assessments and Coordinated township health plans further identified the need to strengthen health system elements (infrastructure, logistics, transport, social mobilization, human resource and health financing) to address public health issues in a holistic/comprehensive manner.

**Human Resource:**

Health system strengthening initiatives by GAVI has immensely benefited the Human Resource Development in Myanmar. Human Resource issues (low skills and less numbers) has been observed as a cross cutting issue for all the programs. Another underpinning HR problem faced in Myanmar is the difficulty in retaining rural health work force, which impeded the delivery of all public health interventions for the hard to reach areas. GAVI HSS funds supported the research on “leading cause of attrition of rural health work force” which is under process (preliminary report attached as annexure XXVII). It is envisaged that the findings from this study will support development of evidence based National Strategic HR plan to address Human Resource Deployment, Development and Management issues in future.

Inadequate planning and management skills of the TMOs led to weak planning and monitoring of all the programs at the townships. Around 1200BHS including TMOs were trained on coordinated township Health Planning and Financial Management through GAVI HSS support.

Investments were also made to reduce the work burden of midwives in Myanmar by recruiting and training 1200 numbers of volunteers (Community Health Workers and Auxiliary Midwives). Volunteers will be conducting productive community mobilization activities, whereby Midwives can focus on delivering basic health care services (EPI, MCH, and Nutrition and Environmental health).

[1] Monthly reports from the Health System Strengthening Officers (figure compiled by Planning Unit, DOH-MOH)

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

The major problem encountered in implementing HSS in Myanmar was the difficulty in identifying third party to implement infrastructure component. The identified party proposed huge management cost (more than 20% of the fund). Another problem experienced was the increase in construction cost due to inflation and change in exchange rates compared to the time when the original proposal was framed (difference between 2007 and 2011). This lead to reduction in number of products (eg; proposed number of construction of subcenters for year one was 36, however with the current value of money, only 30 sub centers can be constructed in year one).

The Health System Assessment conducted in the twenty townships in 2011 shows 117 midwives with no sub-centers to work in. This demonstrates the need for infrastructure identified as very essential in 2007, still remains valid today. Absence of health infrastructure also makes it difficult to store vaccines and other essential medical equipment.

Even today very few sub centers are connected with electricity supply produced by generators and this further brings in the difficulty to maintain cold chains and storage of other medical supplies in required temperatures.

Now with the introduction of new vaccines, it will be very essential that these facilities be provided with solar power to facilitate vaccine management.

Solution:

1. Identified a local NGO who has experience in construction of schools and health centers in the country as the third party to undertake construction for year two. Their management cost is within 7% of the budget. Details of the organization are attached for reference. Annexure XIII.

2. Funds budgeted for construction and refurbishments of (Sub centers and RHCs) and Management Effectiveness training in year one and funds budgeted for refurbishments of health centers in year two are now reprogrammed to support implementation of new vaccines. Refer annexure xxxv

3. As per the Aide-mémoire the funds budgeted for installing solar power are to be managed by third party. Now instead of third party, it is proposed through the 3rd NHSC, that the solar be procured as S&E by WHO and the EPI program to manage the installation. This is proposed because the solar will be installed mainly to benefit the introduction of new vaccines in the HSS townships.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.
Different Monitoring and Evaluation Mechanisms are instituted at different levels as explained below:

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

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

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

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

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

Annual Auditing was conducted for the GAVI HSS funds by the Auditor Generals Office, report attached as annexure VII.

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

Support from GAVI for health System strengthening is captured in the annual budget of the country and also in the National Plan (2011-2016) of the Country.

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

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

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

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

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

Major organizations that were involved in the implementation of GAVI HSS in Myanmar are WHO and UNICEF (Refer Annexure IV for their role).

Further JICA, Save the Children and MERLIN, ACF, representative from Donor Consortium (CCM) are the NHSC members and contribute in M&E and decision making.

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.
Myanmar Maternal and Child Welfare Association (MMCWA) & Myanmar Women's Affairs Federation: facilitates community mobilization to access package of services (EPI, MCH, Nutrition and environmental health), especially in hard to reach areas. Myanmar Medical Association and Myanmar Red Cross Association are members of NHSC and contribute in decision making and M&E of the GAVI HSS interventions.

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

Myanmar Maternal and Child Welfare Association (MMCWA) has committed to contribute referral fees for the poor pregnant mothers with need of emergency care (that will be added to Hospital Equity Fund at townships), Clean Delivery Kits (CDK), weighing machines and labour beds and to all HSS 20 townships in year one. (3rd NHSC meeting minutes)

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

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

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

9.5. Planned HSS activities for 2012

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

Table 9.5: Planned activities for 2012

<table>
<thead>
<tr>
<th>Major Activities (insert as many rows as necessary)</th>
<th>Planned Activity for 2012</th>
<th>Original budget for 2012 (as approved in the HSS proposal or as adjusted during past annual progress reviews)</th>
<th>2012 actual expenditure (as at April 2012)</th>
<th>Revised activity (if relevant)</th>
<th>Explanation for proposed changes to activities or budget (if relevant)</th>
<th>Revised budget for 2012 (if relevant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health System Assessment and CTHP Development</td>
<td>Activity 1.1: SURVEY Conduct survey to establish baseline indicators &amp; outcome, impact and research for operations (including mapping)</td>
<td>80000</td>
<td>31509</td>
<td></td>
<td>Explanation for Column 3 Original Budget for 2012 (Column 3) is the budget for the activities planned in Year Two (2012-2013) and no expenditure is incurred from this budget since Myanmar did not receive the fund for Year Two yet.</td>
<td>80000</td>
</tr>
</tbody>
</table>
### Procurement and Distribution of Essential Drugs

#### Activity 1.2: SUPPLIES
Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans

<table>
<thead>
<tr>
<th>Expenses</th>
<th>1080000</th>
</tr>
</thead>
</table>

- Explanation for Column 4:
  - Expenses in the Column 4 are not against the budget shown in Column 3. Column 4 shows the expenses incurred from July 2011 to March 2012 against the budget for Year One (2011). Myanmar has just received the fund for Year One (2011) in June 2011 and activity implementation started from July 2011, it will go on till June 2012. Actual expenditure for April 2012 is not available from the Accounting System of WHO and MOH at this point. Annexure III will explain the detail expenses.

### Infrastructure

#### Activity 1.3: INFRASTRUCTURE
540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source by 2011, based on needs identified in coordinated township health plans.

<table>
<thead>
<tr>
<th>Expenses</th>
<th>1586000</th>
</tr>
</thead>
</table>

- Explanation for Column 4:
  - $480,000 reprogrammed to fill funding gap for new vaccine introduction. Refer Annex 35

### Increase access to EPI,MCH

#### Activity 1.4: TRANSPORT
Provision of essential transport for township and BHS to reach hard-to-reach areas

<table>
<thead>
<tr>
<th>1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans.</th>
<th>300000</th>
<th>99059</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Expenses</th>
<th>300000</th>
</tr>
</thead>
</table>

#### Activity 1.4.2 Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan

<table>
<thead>
<tr>
<th>Expenses</th>
<th>100000</th>
</tr>
</thead>
</table>

- Explanation for Column 4:
  - $480,000 reprogrammed to fill funding gap for new vaccine introduction. Refer Annex 35

### Procurement & Supply of Motorcycles

<table>
<thead>
<tr>
<th>Expenses</th>
<th>100000</th>
</tr>
</thead>
</table>

- Explanation for Column 4:
  - 100000

---

Annexure III will explain the detail expenses.
<p>| Social Mobilization Activities | Activity 1.5: SOCIAL MOBILIZATION: Involving NGOs, local authorities and Community Health Workers in developing and implementing coordinated township health plans in 100% of HSS-targeted townships by 2011 | 400000 | 170580 | 400000 |
| Production of guidelines | Activity 2.1: GUIDELINES DEVELOPMENT | Develop national guidelines for coordinated township health planning (including financial management and health financing) &amp; supervision at all levels (including checklists) | 20000 | 33796 | 20000 |
| Explore strategic Health Financing options | Activity 2.2: HEALTH FINANCING RESEARCH | Complete a research program on financial management capacity and feasibility and effectiveness of health financing schemes in all HSS targeted townships by 2012. | 40000 | 3321 | 40000 |
| Health Financing Scheme | Activity 2.3: HEALTH FINANCING | Training and Piloting of health financing schemes, according to national guidelines in 50 townships by 2015. | 300000 | | 300000 |</p>
<table>
<thead>
<tr>
<th>Management Training</th>
<th>Activity 2.4: TRAINING</th>
<th>Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011</th>
<th>60000</th>
<th>60000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Equity Fund</td>
<td>Activity 2.5: PLAN DEVELOPMENT</td>
<td>Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines (activity 2.1) and framework at all levels 2.5.1 Management Support (from Township Coordinated Plans) includes supervision and planning activities ($10,000 per Township per annum scaling up to 180 Townships by 2011)</td>
<td>600000</td>
<td>600000</td>
</tr>
<tr>
<td>Annual Program Review (Central) and NHSCs</td>
<td>Activity 2.6: RESEARCH &amp; EVALUATION</td>
<td>Assess process and impact of coordinated State &amp; Township coordinated health planning, and then disseminate findings 2.6.1 Annual Program Review Central Level</td>
<td>20000</td>
<td>5423</td>
</tr>
<tr>
<td></td>
<td>2.6.2 Annual Program Review State and Division Level</td>
<td></td>
<td>51000</td>
<td>51000</td>
</tr>
<tr>
<td></td>
<td>2.6.4 Establish Health Systems Research Fund</td>
<td></td>
<td>72049</td>
<td>41028</td>
</tr>
<tr>
<td>Activity 3.1: RESEARCH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010. (complementary Funding through AAAH, but with specific research studies funded by GAVI - evaluation of financial allowances, research on performance based systems and motivational factors of rural health workforce)</td>
<td>10000 7263 10000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity 3.2: HR PLAN</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop HR Plan recommendin g strategies for retention and deployment of staff in hard-to-reach areas, based in part on research from activity 3.1 (complimentary Funding through AAAH, but with National HR Conference funded through GAVI)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity 3.3: HR PROPOSAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of Proposal to MOH recommendin g appropriate deployment number and pattern of MW and PHS2 in hard-to-reach areas, assessing retentions scheme options that include financial incentives. (complimentary Funding through AAAH)</td>
<td>10000 10000</td>
</tr>
<tr>
<td>Activity</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>3.3.1</td>
<td>HR costs (HR Finance incentive scheme for health staff in remote areas - identified in Township Coordinated Plans) ($5,500 per Township per Year)</td>
</tr>
<tr>
<td></td>
<td>Activity 3.4: CONTINUING TRAINING Conduct coordinated MCH, EPI, Nutrition &amp; EH training programs applying the principles of MEP (Capacity Building (from Township Coordinated Plans) (complementary Funding through UN Agencies) 3.4.1 Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines</td>
</tr>
<tr>
<td>3.4.2</td>
<td>International Short Courses Health Financing</td>
</tr>
<tr>
<td>3.4.3</td>
<td>Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems</td>
</tr>
<tr>
<td>3.4.4</td>
<td>Leadership Development Program</td>
</tr>
<tr>
<td></td>
<td>Support costs Office Equipment Central</td>
</tr>
<tr>
<td></td>
<td>Transport/Vehicles for DOH and local transport costs</td>
</tr>
<tr>
<td></td>
<td>Computers (Central, S/R)</td>
</tr>
<tr>
<td></td>
<td>Computers (Townships)</td>
</tr>
<tr>
<td>Management Support (WHO)</td>
<td>Management costs Administration and Management Cost (WHO)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Management Support (DOH)</td>
<td>Administration Costs Central Level (DOH) (Communications, Printing, Staff Hire 2)</td>
</tr>
<tr>
<td>International Technical Assistance</td>
<td>International Technical Assistance Health Systems Advisor (WHO)</td>
</tr>
<tr>
<td>External Consultant (Finance)</td>
<td>Financial Management Consultancies</td>
</tr>
<tr>
<td>External Consultant (Planning)</td>
<td>Planning Consultancies</td>
</tr>
<tr>
<td>External Consultant (Management)</td>
<td>Management Effectiveness Programme Consultancies</td>
</tr>
<tr>
<td>External Consultant (HSR)</td>
<td>Operational Health Systems Research Consultancies</td>
</tr>
<tr>
<td>External Consultant (Drug Supply System)</td>
<td>Drugs Supply System Consultancies</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 9.6. Planned HSS activities for 2013

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

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

#### Table 9.6: Planned HSS Activities for 2013

<table>
<thead>
<tr>
<th>Major Activities (insert as many rows as necessary)</th>
<th>Planned Activity for 2013</th>
<th>Original budget for 2013 (as approved in the HSS proposal or as adjusted during past annual progress reviews)</th>
<th>Revised activity (if relevant)</th>
<th>Explanation for proposed changes to activities or budget (if relevant)</th>
<th>Revised budget for 2013 (if relevant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Description</td>
<td>Budget (HHS)</td>
<td>Budget (WHO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>--------------</td>
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</tr>
<tr>
<td><strong>Health System Assessment and CTHP Development</strong></td>
<td>Activity 1.1: SURVEY Conduct survey to establish baseline indicators &amp; outcome, impact and research for operations (including mapping)</td>
<td>120000</td>
<td>120000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>External Consultancy</strong></td>
<td>Operational Health Systems Research Consultancies</td>
<td>15000</td>
<td>15000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>International Technical Assistance</strong></td>
<td>Health Systems Advisor (WHO)</td>
<td>99000</td>
<td>99000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Management Support (DOH)</strong></td>
<td>Management costs Administration Costs Central Level (DOH) (Communications, Printing, Staff Hire 2)</td>
<td>30000</td>
<td>30000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Computers (Townships)</strong></td>
<td>Computers Townships</td>
<td>120000</td>
<td>120000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Computers (Central &amp; S/R)</strong></td>
<td>Computers Central and States/Divisions</td>
<td>30000</td>
<td>30000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Logistic Support</strong></td>
<td>Transport/ Vehicles for DOH and local transport costs</td>
<td>60000</td>
<td>60000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recruitment of HSS Officers</strong></td>
<td>3.4.4 Leadership Development Program</td>
<td>331200</td>
<td>331200</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Experience sharing among HSS countries</strong></td>
<td>3.4.3 Asia Region Study Tour for selected State and Division and Township Health Department in PHC Planning and Delivery Systems</td>
<td>40000</td>
<td>40000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>International Short Course</strong></td>
<td>3.4.2 International Short Courses Health Financing</td>
<td>50000</td>
<td>50000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Description</td>
<td>Budget 2010</td>
<td>Budget 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4: CONTINUING TRAINING</td>
<td>Conduct coordinated MCH, EPI, Nutrition &amp; EH training programs applying the principles of MEP (Capacity Building (from Township Coordinated Plans) (complementary Funding through UN Agencies)</td>
<td>120000</td>
<td>120000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4.1</td>
<td>Continuing training and dissemination of Coordinated Township Planning and Programme Implementation Guidelines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3.1 HR costs</td>
<td>(HR Finance incentive scheme for health staff in remote areas - identified in Township Coordinated Plans) ($5,500 per Township per Year)</td>
<td>693000</td>
<td>693000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1: RESEARCH</td>
<td>Conduct Research program for HR planning focusing on distribution mix function and motivation and management capacity (including financing), by 2010. (complementary Funding through AAAH, but with specific research studies funded by GAVI - evaluation of financial allowances, research on performance based systems and motivational factors of rural health workforce)</td>
<td>10000</td>
<td>10000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6.4 Establish Health Systems Research Fund</td>
<td></td>
<td>72049</td>
<td>72049</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area</td>
<td>Activity</td>
<td>Amount</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------</td>
<td>---------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>External Review of Program</strong></td>
<td>2.6.3 External Review of progress of HSS</td>
<td>50000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Program Review at townships</strong></td>
<td>2.6.2 Annual Program Review State and Division Level</td>
<td>51000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Program Review (Central) and NHSCs</strong></td>
<td>Activity 2.6: RESEARCH &amp; EVALUATION Assess process and impact of coordinated State &amp; Township coordinated health planning, and then disseminate findings</td>
<td>20000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Equity Fund</strong></td>
<td>Activity 2.5: PLAN DEVELOPMENTT Develop and monitor coordinated health planning of HSS-targeted townships according to new national planning guidelines (activity 2.1) and framework at all levels</td>
<td>1200000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Management Training</strong></td>
<td>Activity 2.4: TRAINING Implement the training program on coordinated management through the modified MEP program (includes health planning and supervision) in HSS-targeted townships by 2011.</td>
<td>90000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 2.3: HR FINANCING Training and Piloting of health financing schemes, according to national guidelines in 50 townships by 2011</td>
<td>600000</td>
<td>600000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Production of Guidelines</td>
<td>20000</td>
<td>20000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 2.1: GUIDELINES DEVELOPMENT Develop national guidelines for coordinated township health planning (including financial management and health financing) &amp; supervision at all levels (including checklists)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Mobilization Activities</td>
<td>600000</td>
<td>600000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity 1.5: SOCIAL MOBILIZATION: Involving NGOs, local authorities and Community Health Workers in developing and implementing coordinated township Health plans in 100% of HSS-targeted townships by 2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement and Supply of Motorcycles 1.4.2 Supply of transport capital to Townships based on needs identified in Township Coordinated Health Plan</td>
<td>150000</td>
<td>150000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase access to EPI, MCH 1.4.1 Supply of Recurrent Transport costs based on needs identified in Township Coordinated Plans.</td>
<td>600000</td>
<td>600000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9.7. Revised indicators in case of reprogramming

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

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

<table>
<thead>
<tr>
<th>Name of Objective or Indicator (Insert as many rows as necessary)</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Data Source</th>
<th>Baseline value and date</th>
<th>Baseline Source</th>
<th>Agreed target till end of support in original HSS application</th>
<th>2013 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure Activity 1.3: INFRASTRUCTURE 540 RHCs and sub-RHCs in 180 HSS-targeted Townships will be renovated including construction of sanitary latrines and improve access to safe water source by 2011, based on needs identified in coordinated township health plans.</td>
<td></td>
<td>2336000</td>
<td></td>
<td></td>
<td></td>
<td>2336000</td>
<td></td>
</tr>
<tr>
<td>Procurement and Distribution of Essential Drugs Activity 1.2: SUPPLIES Increase availability of Essential Supplies and equipment based on needs identified in coordinated Township health plans</td>
<td></td>
<td>2160000</td>
<td></td>
<td></td>
<td></td>
<td>2160000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9667249</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country’s objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:
Table 9.8: Sources of HSS funds in your country

<table>
<thead>
<tr>
<th>Donor</th>
<th>Amount in US$</th>
<th>Duration of support</th>
<th>Type of activities funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**9.9. Reporting on the HSS grant**

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:
- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

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

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

Some of the foot notes and explanation in the tables cannot be put into the online portal and this report in full text has to be put up as Attachment.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2010?? **2**

Please attach:
1. The minutes from all the HSCC meetings held in 2010, including those of the meeting which discussed/endorsed this report (Document Number: 8)
2. The latest Health Sector Review report (Document Number: 23)
10. Strengthened Involvement of Civil Society Organisations (CSOs): Type A and Type B

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

Myanmar is not reporting on GAVI TYPE A CSO support for 2012
10.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

Myanmar is not reporting on GAVI TYPE B CSO support for 2012
11. Comments from ICC/HSCC Chairs

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

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR IMMUNISATION SERVICES SUPPORT (ISS) AND NEW VACCINE INTRODUCTION GRANTS

I. All countries that have received ISS / new vaccine introduction grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

   a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)
   
   b. Income received from GAVI during 2011
   
   c. Other income received during 2011 (interest, fees, etc)
   
   d. Total expenditure during the calendar year
   
   e. Closing balance as of 31 December 2011
   
   f. A detailed analysis of expenditures during 2011, based on your government’s own system of economic classification. This analysis should summarise total annual expenditure for the year by your government’s own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2011 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country’s external audit for the 2011 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country’s financial year.
### Summary of income and expenditure – GAVI ISS

<table>
<thead>
<tr>
<th>Local currency (CFA)</th>
<th>Value in USD *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance brought forward from 2010 (balance as of 31 Decembre 2010)</td>
<td>25,392,830</td>
</tr>
</tbody>
</table>

**Summary of income received during 2011**

- Income received from GAVI: 57,493,200
- Income from interest: 7,665,760
- Other income (fees): 179,666

**Total Income**: 38,987,576

**Total expenditure during 2011**: 30,592,132

**Balance as of 31 December 2011** (balance carried forward to 2012): 60,139,325

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

### Detailed analysis of expenditure by economic classification ** – GAVI ISS

<table>
<thead>
<tr>
<th>Salary expenditure</th>
<th>Budget in CFA</th>
<th>Budget in USD</th>
<th>Actual in CFA</th>
<th>Actual in USD</th>
<th>Variance in CFA</th>
<th>Variance in USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wedges &amp; salaries</td>
<td>2,000,000</td>
<td>4,174</td>
<td>0</td>
<td>0</td>
<td>2,000,000</td>
<td>4,174</td>
</tr>
<tr>
<td>Per diem payments</td>
<td>9,000,000</td>
<td>18,785</td>
<td>6,150,000</td>
<td>12,836</td>
<td>2,850,000</td>
<td>5,949</td>
</tr>
</tbody>
</table>

**Non-salary expenditure**

- Training: 13,000,000
- Fuel: 3,000,000
- Maintenance & overheads: 2,500,000

**Other expenditures**

- Vehicles: 12,500,000

**TOTALS FOR 2011**: 42,000,000

**Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.**
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR HEALTH SYSTEMS STRENGTHENING (HSS)

I. All countries that have received HSS grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

   a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)
   b. Income received from GAVI during 2011
   c. Other income received during 2011 (interest, fees, etc)
   d. Total expenditure during the calendar year
   e. Closing balance as of 31 December 2011
   f. A detailed analysis of expenditures during 2011, based on your government’s own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government’s originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government’s own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2011 (referred to as the “variance”).

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country’s external audit for the 2011 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country’s financial year.
### Summary of income and expenditure – GAVI HSS

| Local currency (CFA) | Value in USD *
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance brought forward from 2010</strong> (balance as of 31Decembre 2010)</td>
<td>25,392,830</td>
</tr>
</tbody>
</table>

#### Summary of income received during 2011

<table>
<thead>
<tr>
<th></th>
<th>Local currency (CFA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income received from GAVI</td>
<td>57,493,200</td>
</tr>
<tr>
<td>Income from interest</td>
<td>7,665,760</td>
</tr>
<tr>
<td>Other income (fees)</td>
<td>179,666</td>
</tr>
</tbody>
</table>

| | Value in USD *
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Income</td>
<td>38,987,576</td>
</tr>
<tr>
<td>Total expenditure during 2011</td>
<td>30,592,132</td>
</tr>
<tr>
<td><strong>Balance as of 31 December 2011</strong> (balance carried forward to 2012)</td>
<td>60,139,325</td>
</tr>
</tbody>
</table>

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

### Detailed analysis of expenditure by economic classification ** - GAVI HSS

<table>
<thead>
<tr>
<th></th>
<th>Budget in CFA</th>
<th>Budget in USD</th>
<th>Actual in CFA</th>
<th>Actual in USD</th>
<th>Variance in CFA</th>
<th>Variance in USD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salary expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wedges &amp; salaries</td>
<td>2,000,000</td>
<td>4,174</td>
<td>0</td>
<td>0</td>
<td>2,000,000</td>
<td>4,174</td>
</tr>
<tr>
<td>Per diem payments</td>
<td>9,000,000</td>
<td>18,785</td>
<td>6,150,000</td>
<td>12,836</td>
<td>2,850,000</td>
<td>5,949</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budget in CFA</th>
<th>Budget in USD</th>
<th>Actual in CFA</th>
<th>Actual in USD</th>
<th>Variance in CFA</th>
<th>Variance in USD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-salary expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>13,000,000</td>
<td>27,134</td>
<td>12,650,000</td>
<td>26,403</td>
<td>350,000</td>
<td>731</td>
</tr>
<tr>
<td>Fuel</td>
<td>3,000,000</td>
<td>6,262</td>
<td>4,000,000</td>
<td>8,349</td>
<td>-1,000,000</td>
<td>-2,087</td>
</tr>
<tr>
<td>Maintenance &amp; overheads</td>
<td>2,500,000</td>
<td>5,218</td>
<td>1,000,000</td>
<td>2,087</td>
<td>1,500,000</td>
<td>3,131</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budget in CFA</th>
<th>Budget in USD</th>
<th>Actual in CFA</th>
<th>Actual in USD</th>
<th>Variance in CFA</th>
<th>Variance in USD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vehicles</td>
<td>12,500,000</td>
<td>26,090</td>
<td>6,792,132</td>
<td>14,177</td>
<td>5,707,868</td>
<td>11,913</td>
</tr>
</tbody>
</table>

- **TOTALS FOR 2011** | 42,000,000 | 87,663 | 30,592,132 | 63,852 | 11,407,868 | 23,811 |

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

FINANCIAL STATEMENTS FOR CIVIL SOCIETY ORGANISATION (CSO) TYPE B

I. All countries that have received CSO ‘Type B’ grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed CSO ‘Type B’ grants in 2011, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2011 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

   a. Funds carried forward from the 2010 calendar year (opening balance as of 1 January 2011)
   b. Income received from GAVI during 2011
   c. Other income received during 2011 (interest, fees, etc)
   d. Total expenditure during the calendar year
   e. Closing balance as of 31 December 2011
   f. A detailed analysis of expenditures during 2011, based on your government’s own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government’s originally approved CSO ‘Type B’ proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government’s own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2011 (referred to as the “variance”).

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country’s external audit for the 2011 financial year. Audits for CSO ‘Type B’ are due to the GAVI Secretariat 6 months following the close of each country’s financial year.
MINIMUM REQUIREMENTS FOR CSO ‘Type B’ FINANCIAL STATEMENTS

An example statement of income & expenditure

<table>
<thead>
<tr>
<th>Summary of income and expenditure – GAVI CSO</th>
<th>Local currency (CFA)</th>
<th>Value in USD *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance brought forward from 2010 (balance as of 31 Decembre 2010)</td>
<td>25,392,830</td>
<td>53,000</td>
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<td>Summary of income received during 2011</td>
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<tr>
<td>Income received from GAVI</td>
<td>57,493,200</td>
<td>120,000</td>
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<tr>
<td>Income from interest</td>
<td>7,665,760</td>
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<td>Other income (fees)</td>
<td>179,666</td>
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<td>Total Income</td>
<td>38,987,576</td>
<td>81,375</td>
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<tr>
<td>Total expenditure during 2011</td>
<td>30,592,132</td>
<td>63,852</td>
</tr>
<tr>
<td>Balance as of 31 December 2011 (balance carried forward to 2012)</td>
<td>60,139,325</td>
<td>125,523</td>
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* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

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<tr>
<th>Detailed analysis of expenditure by economic classification ** - GAVI CSO</th>
<th>Budget in CFA</th>
<th>Budget in USD</th>
<th>Actual in CFA</th>
<th>Actual in USD</th>
<th>Variance in CFA</th>
<th>Variance in USD</th>
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<td>4,000,000</td>
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<td>1,000,000</td>
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** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.
### 13. Attachments

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