Annual Progress Report 2008

Submitted by

The Government of

North SUDAN

Reporting on year**:** **2008**
Requesting for support year: **2010**

Date of submission: **14 May 2009**

Deadline for submission: 15 May 2009

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

and any hard copy could be sent to :

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

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

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

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

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

For the Government of **SUDAN**

Minister of Health: Dr. Tabeeta Butross Shokai	**Minister of Finance:**
Title: **Federal Minister of Health**	Title:
Signature:	Signature:
Date:	Date:

This report has been compiled by: (In consultation with N EPI M & GAVI HSS focal person)

Full name: **Dr. Amani Abdelmoniem M. Mustafa**

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ICC Signatures Page

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

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

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

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

Name/Title	Agency/Organisation	Signature	Date
Dr. Eltayeb Ahmed Elsayed PHC National Director	**PHC /FMOH**		
Dr. Nissren Mussa Widaa EPI National Director	**EPI / FMOH**		
Mrs. Manal Mohammed Magbool Rep MOF.	**Ministry of Finance**		
Dr. Alfatih Gariballah Rep MOI .	**Ministry of Interior**		
Dr. Elamin Osman Rep MOD.	**Ministry of Defence**		
Mrs. Sawsan Omer Rep MO Int. cop.	**Ministry of Int.l Cooperation**		
Dr. Mohammed Abdur Rab / **Representitive**	**WHO**		
Mr. Iyabod Olisulmani / Representitive	**UNICEF**		
Mr. Sohab Elbadawi Representative	**Rotary International**		
Dr. Abdelrahman Hamid / Representative	**SRCS**		
Dr. Mohamed Hussain Dafalla/ Representative	**Humanitarian Aid Commission (HAC)**		

Comments from partners:

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

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

.....

YES this report has been reviewed by GAVI core RWG

.....

.....

HSCC Signatures Page

If the country is reporting on HSS, CSO support

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

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

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

Name/Title	Agency/Organisation	Signature	Date

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

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

NOT APPLICABLE
(Sudan is not eligible for type B CSO support, and did not apply for type A)

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

Name: ……

Post: ……

Organisation:……...

Date: ……

Signature: ……

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

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

Name: ……

Post: ……

Organisation:……...

Date: ……

Signature: ……

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

Name/Title	Agency/Organisation	Signature	Date

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

Annual Progress Report 2008: Table of Contents

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

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

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

Number	Achievements as per JRF	Targets						
	2008	2009	2010	2011	2012	2013	2014	2015
Births	1,253,861	1,320,785	1,349,185	1,385,883	1,423,579	1,462,300	1,502,075	1,542,931
Infants' deaths	132,583	140,710	144,363	148,289	152,323	156,466	160,722	165,094
Surviving infants	1,121,278	1,180,075	1,204,822	1,237,593	1,271,256	1,305,834	1,341,353	1,377,838
Pregnant women	1,253,861	1,320,785	1,349,185	1,385,883	1,423,579	1,462,300	1,502,075	1,542,931
Target population vaccinated with BCG	1,068,122	1,149,083	1,200,775	1,247,295	1,309,693	1,359,939	1,411,950	1,465,785
BCG coverage*	85%	87%	89%	90%	92%	93%	94%	95%
Target population vaccinated with OPV3	1,033,602	1,097,470	1,132,533	1,175,714	1,207,693	1,240,542	1,274,285	1,308,946
OPV3 coverage**	92.2%	93 %	94%	95%	95%	95%	95%	95%
Target population vaccinated with DTP (DTP3)*** Included with Penta cov. below (As combined vaccine)								
DTP3 coverage** Included with Penta cov. below (As combined vaccine)								
Target population vaccinated with DTP (DTP1)*** Included with Penta cov. below (As combined vaccine)								
Wastage[1] rate in base-year and planned thereafter								

[1] The formula to calculate a vaccine wastage rate (in percentage): [(A – B) / A] x 100. Whereby : A = The number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period. For new vaccines check table α after Table 7.1.

Duplicate these rows as many times as the number of new vaccines requested									
Target population vaccinated with **3rd dose** of Pentavalent		**1,040,787**	**1,097,470**	**1,132,533**	**1,175,714**	**1,207,693**	**1,240,542**	**1,274,285**	**1,308,946**
Pentavalent Coverage**		**92.8**	**93 %**	**94%**	**95%**	**95%**	**95%**	**95%**	**95%**
Target population vaccinated with **1st dose** of Pentavalent		**1,129,330**	**1,180,075**	**1,204,822**	**1,237,593**	**1,271,256**	**1,305,834**	**1,341,353**	**1,377,838**
Wastage[1] rate in base-year and planned thereafter		**4.1**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
Target population vaccinated with **1st dose** of Measles		**895,363**	**976,662**	**1,012,051**	**1,064,330**	**1,118,705**	**1,175,251**	**1,234,045**	**1,308,946**
Target population vaccinated with **2nd dose** of Measles		**NA**							
Measles coverage**		**80%**	**82%**	**84%**	**86%**	**88%**	**90%**	**92%**	**95%**
Pregnant women vaccinated with TT+		**550,055**	**633,977**	**660,393**	**742,052**	**803,812**	**854,147**	**950,495**	**1,051,452**
TT+ coverage****		**44%**	**48%**	**50%**	**55%**	**58%**	**60%**	**65%**	**70%**
Vit A supplement	Mothers (<6 weeks from delivery)								
	Infants (>6 months - under five yrs Through ACSI Campaign coverage	**4,370,742** **99%**	**99%**	**99%**	**99%**	**99%**	**99%**	**99%**	
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100		**7.8%**	**7%**	**6%**	**5%**	**5%**	**5%**	**5%**	**5%**
Annual Measles Drop out rate (for countries applying for YF)		**13%**	11%	10%	9%	7%^	5%	3%	0

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

Table B: Updated baseline and annual targets

Number	Achievements as per JRF	Targets						
	2008	2009	2010	2011	2012	2013	2014	2015
Births	**1,253,861**	**1,320,785**	**1,349,185**	**1,385,883**	**1,423,579**	**1,462,300**	**1,502,075**	**1,542,931**
Infants' deaths	**132,583**	**140,710**	**144,363**	**148,289**	**152,323**	**156,466**	**160,722**	**165,094**
Surviving infants	**1,121,278**	**1,180,075**	**1,204,822**	**1,237,593**	**1,271,256**	**1,305,834**	**1,341,353**	**1,377,838**
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OPV3 coverage**	**92.2%**	**93 %**	**94%**	**95%**	**95%**	**95%**	**95%**	**95%**
Target population vaccinated with DTP (DTP3)*** Included with Penta cov. below (As combined vaccine)								
DTP3 coverage** Included with Penta cov. below (As combined vaccine)								
Target population vaccinated with DTP (DTP1)*** Included with Penta cov. below (As combined vaccine)								

Wastage[2] rate in base-year and planned thereafter								
Duplicate these rows as many times as the number of new vaccines requested								
Target population vaccinated with **3rd dose** of Pentavalent	**1,040,787**	**1,097,470**	**1,132,533**	**1,175,714**	**1,207,693**	**1,240,542**	**1,274,285**	**1,308,946**
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Vit A supplement — Infants (>6 months - under five yrs Through ACSI Campaign coverage	**4,370,742 99%**	**99%**	**99%**	**99%**	**99%**	**99%**	**99%**	**99%**
Annual DTP Drop out rate [(DTP1-DTP3)/DTP1] x100	**7.8%**	**7%**	**6%**	**5%**	**5%**	**5%**	**5%**	**5%**
Annual Measles Drop out rate (for countries applying for YF)	**NA**							

* Number of infants vaccinated out of total births
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1. Immunization Programme Support (ISS, NVS, INS)

1.1 Immunization Services Support (ISS)

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

YES

The funds received for ISS on-budget in 2008, reflected in Ministry of Health budget. The received ISS funds are pooled directly into the federal ministry of health / EPI account and released according to the regulations of the ministry of finance and ministry of health system which approves the release of funds according to the planned activities.

1.1.1 Management of ISS Funds

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

Sudan received GAVI ISS funds as follows:

- Sudan had received 4 instalments during the period 2002-2004
- (673,700 US$) , (745,581US$), (584,136US$), and (704,183 US$).
- 2 rewards in 2005-2006, (1,279,362 US$) and (679,000 US$).
- The reward for 2006 achievements (224,000 US$) was received in 2008.
- The reward for 2007 achievements was approved as (1,794,500 US$). Only (11,500 US$) was received in 2008 up to date, out of the total approved by GAVI.
- The disbursements were made through the same bank account which was agreed upon by ICC &GAVI secretariat for all first five disbursements,
- The disbursement made in 2006 was received through UNICEF due to delay in the transfer process into the bank account.
- The disbursement of the last two transfers during 2008 was made through the bank account agreed upon for HSS Support.
- Federal Ministry of Health regulates the utilization of I.S.S funds through its auditing system of finance and according to the Federal Ministry of Finance rules.

Utilization and internal distribution of the ISS support is based on:

- Annual revision, update, approval and endorsement of locality micro plans
- According to the updated micro plans, the localities calculate the number of un-immunized children expected to be reached every year and identify the strategy by which those children could be reached and accordingly the needs and cost for this strategy is determined, in order to achieve the targeted coverage.
- States MOH distribute the support to the districts according to the budget in their micro plans to conduct outreach and mobile immunization sessions.
- States are monitored and accounted according to:
  - the number of immunization sessions and children to be vaccinated every month
  - Significant performance, and efficient use of EPI supplies in regard to their different situations
  - Feedback and monthly liquidation
- State local contributions is monitored and recorded against GAVI ISS.
- No problems were encountered through the implementation of this process internally.

Role of the I.C.C:

- To review & endorse the EPI annual plan including the funding plan which usually conducted in the first quarter of the year.
- To follow-up on the implementation of endorsed plan
- To review progress reports on performance and budget release
- To review & endorse the final settlement of accounts and annual reports
-

Problems encountered for use of funds:

- Delayed approval of reward for the year 2007 achievements due to misinterpretation of the extra vaccinated children, which was corrected later on and the reward was approved.
- Delayed transfer of the approved reward support, the funds are not transferred up to April, 2009 (only 11,500 US$).
- This delay affected the implementation of the planned sessions especially for mobile out reach services, to vaccinate the targeted children according to the plan; this was partially corrected lately by enforcing, accelerating and conducting local immunization days with the support of WHO and UNICEF in low coverage districts.
- Printing of the immunization updated registers was delayed, and the IEC materials production was postponed.

1.1.2 Use of Immunization Services Support

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

Funds received during 2008: **235,500**
Remaining funds (carry over) from 2007: **zero**
Balance to be carried over to 2009: **zero**

Table 1.1: Use of funds during 2008*

Area of Immunization Services Support	Total amount in US $	AMOUNT OF FUNDS			
		PUBLIC SECTOR			PRIVATE SECTOR & Other
		Central	Region/State/Province	District	
Vaccines	0	0	0	0	0
Injection supplies	0	0	0	0	0
Personnel	**105,000**	**8,000**	**5,000**	**92,000**	0
Transportation	**95,000**	**14,000**	**8,000**	**73,000**	0
Maintenance and overheads	0	0	0	0	0
Training	0	0	0	0	0
IEC / social mobilization	0	0	0	0	0
Outreach	0	0	0	0	0
Supervision	**19,000**	**7,000**	**7,000**	**5,000**	0
Monitoring and evaluation	0	**0**	**0**	**0**	0
Epidemiological surveillance	0	0	0	0	0
Vehicles	0	0	0	0	0
Cold chain equipment	**6,500**	**2,000**	**1,000**	**3,500**	0
Other (vaccines transportation)	**10,000**	**7000**	**3000**	**0**	0
Total:	**235,500**	**38,000**	**24,000**	**173,500**	**0**
Remaining funds for next year:	**ZERO**	**ZERO**	**ZERO**	**ZERO**	**ZERO**

1.1.3 ICC meetings

How many times did the ICC meet in 2008? ***Two times***
Please attach the minutes (DOCUMENT N° ISS1) from all the ICC meetings held in 2008 specially the ICC minutes when the allocation and utilization of funds were discussed.

Are any Civil Society Organizations members of the ICC: ***[Yes/No]***
if yes, which ones? ***YES***

List CSO member organisations
Rotary International
ICRC

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

1. Infrastructure building

***1.1*- Immunization sites**

- Increase accessibility through more immunization sites, which increased by adding 79 New fixed sites in 2008, (as total the F.S are 1377), SOS are 3877 compared to 4249 in the year 2007, also the Mobile services are reduced (228 compared to 248 in 2007), this reduction is as a result of delayed transfer of GAVI funds

1.2 Cold chain

- Maintaining the functionality of the cold chain above 80% (which is achieved through utilization of HSS, ISS , UNICEF & WHO support)

- Accreditation certificate **(WHO/UNICEF Effective Store Management Initiative)** for cold chain was achieved with highest score **(94%)** compared to the other three countries achieved the certificate before Sudan**.**
The final assessment for cold chain accreditation (Global WHO/UNICEF certificate) was conducted by an external team from WHO &UNICEF,

2- Capacity building:

2.1. Administrative Performance

- Weekly administrative EPI meetings at the federal level were conducted (Conduction of 63 meetings at central level for close follow up surveillance + routine performance)
- Monthly monitoring review meetings at state level (localities with states) were conducted
- MLM course materials updated
- The microplan guidelines updated

2.2. Basic data Information board

- EPI computerised profile and database was updated for the year 2008

2.3. Training

The Training activities regarding immunization conducted in 2008 were:

- Refresher training for 41 service providers in 2 states (50% of the planned target)
- Basic EPI training for 188 vaccinator in 4 states.
- Training for 29 locality EPI officers and 2 state EPI officers, which are conducted by federal staff at central EPI (100% of the planned).
- Conduction of Regional training for Vaccine management facilitated by EMRO where 8 EPI Operation officers from Sudan and 15 participants from four EMRO countries were trained .

All the training activities were supported by WHO, UNICEF and the support for the new vaccine introduction.

2.4. Supervision and Monitoring:

- Planned supervisory visits to the states were conducted (all15 northern states (100%) 46 localities (60% of the target) and 156 fixed immunization sites were visited by the National EPI personnel (60% of the planned), the overall planned supervision activities were affected by the delay of GAVI funds transfer also.
- Use of the DQS tool as a supervision tool enabled immediate analysis of the findings and feedback at state, district and health facility levels.
- Conduction of 2 National interstate review and evaluation meetings on RED and implementation of the plans with all states.
- Follow up and monitoring of monthly EPI meetings at sub national level, assessing progress indicators regularly at district level with emphases on use of monitoring chart
- Follow up of the implementation of the supervisory plan to be conducted at state, locality level and recipient and revision of their reports.
- Implementation of zonal meetings at state level for experience sharing

2.5. Quality of recording and reporting system:

- Printing and distribution of all new recording, reporting and self monitoring forms Including the new vaccine. The production of these materials was delayed due to late funding transfer.
- Follow up on the recoding and reporting system in all states at all levels
- Follow up and monitoring of system index and verification factor at all levels visited during 2008.
- Archive of EPI data and information for the years 1996-2008

3. Routine Immunization Activities

- 134 locality Micro plans were updated for 2008) and saved as software in computers (one locality in N.Darfour was not accessible completely
- Sustained Outreach services & mobile activities were conducted with sessions implementation rate of (93.1% for fixed sites, 93% for out reach and 61% for mobile) over all implementation rate for all sessions was 89%. This implementation and number of sites also affected by the delay of transfer of GAVI funds.
- 85% of localities achieved 80% or more Penta3/DPT3 coverage

- Because of the critical situation in Darfour zone, acceleration 6 rounds campaigns for routine immunization in 45 localities were implemented,

4. Immunization Safety

- AEFI surveillance system was strengthened and introduced into all 15 Northern states during 2008 (27 cases reported in 2008 compared to 6 cases in 2007)

5. Social mobilization

- Celebration of Annual Immunization Day at national and state levels
- Implementation of social mobilization activities for the introduction of the new Pentavalent vaccine

6. Polio Eradication

- Conduction of one SNIDs and 4 NIDs rounds each targeting over 6,000,000 under five children, coverage was ranged between **101% - 103%** in the last round

*In 2008 Sudan had an imported wild polio virus from Chad **(wpv3)** which was reported in West Darfour state.*

The AFP surveillance system sustained the high quality indicators for performance as recommended according to the international criteria.

The National polio lab. Achieved high score (99%) proficiency test.

7. Measles Elimination

- Conduction of measles follow up campaigns in 9 states targeting more than 2,774,511 children aged 9 month – five years. This was implemented as a part of Accelerated Child Survival Initiative campaign (ACSI) along with other interventions Coverage was **98.2%**.
- Continued case-based measles surveillance activities
- National Measles lab achieved 100% in the Proficiency test
- ***Maternal and neonatal tetanus Elimination***
    - Implementation of the first round of WCBA vaccination campaign in 20 localities in three states as part of the strategies of the MNT elimination targeting high risk areas, 735,602 women were vaccinated ,coverage is 90%

9.ACSI

Sudan has started the implementation of Accelerated Child Survival Initiative (ACSI) activities to improve the child health and reduce child morbidity and mortality in order to achieve the MDG4.

High impact multi interventions were delivered for under five children:

-Vitamin A (99% coverage)

- Deworming (Albendazole) (91% coverage)

- Long Lasting Impregnated Insecticide Treated Nets (LLITN), coverage 99%.

-Health education and awareness campaign

- Measles vaccination, polio vaccination (98% &101 coverage)

-Iodine containing capsules (Lipidol) distributions.(79% coverage)

EPI programme was leading the implementation process along with other related

programmes. All interventions coverage was high above the targeted rates.

Problems encountered are

1. Insecurity in Darfour zone
2. Population displacement and movement.
3. Competing program activities (polio campaigns, ACSI CAMP.).
4. Community participation and irregular social mobilization activities for routine immunization

(Note: Most of these activities were supported by WHO & UNICEF)

Attachments:

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

a) Signed minutes (DOCUMENT N° ISS 2) of the ICC meeting that endorse this section of the Annual Progress Report for 2008. This should also include the minutes of the ICC meeting when the financial statement was presented to the ICC.
b) Most recent external audit report (DOCUMENT N°……) (e.g. Auditor General's Report or equivalent) of **account(s)** to which the GAVI ISS funds are transferred.
c) Detailed Financial Statement of funds (DOCUMENT N°……) spent during the reporting year (2008).
d) The detailed Financial Statement must be signed by the Financial Controller in the Ministry of Health and/or Ministry of Finance and the chair of the ICC, as indicated below:

1.1.4 Immunization Data Quality Audit (DQA)

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

List major recommendations

NO DQA was implemented in 2007 0r 2008

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

YES ✓ *NO* ☐

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

The recommendations of the last DQA in 2004:

- Provision of recording and reporting forms.
- Continue Capacity building activities
- Establishing AEFI system at states level

progress of implementation

- All the needed reporting, recording and monitoring forms were updated printed and distributed.
- Redefinition of health structures for level below (avoid sub districts) was implemented except for few large states where administrative units are subdivided from localities but reports are received as locality reports.
- Continuous Capacity building of immunization personnel at all levels, training needs were assessed through supportive supervision and training plans prepared and implemented accordingly.
- AEFI system was introduced into 15 states (100%)

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

DQA plan (2005-2008) was discussed in the technical ICC group meeting, in 2004, approved and implemented, follow up on implementation of the recommendation was sent to GAVI secretariat with the APR reports of 2004/2005 with a copy of the plan (accepted)

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

List studies conducted in 2008:

- *National Cold Chain Assessment for all levels in all the 15 Northern states was conducted with a support from UNICEF, Data collected and entered. Analysis and report writing is in process.*
- *A proposal for National coverage survey was prepared, approved by WHO & UNICEF to be conducted in 2009*

List challenges in collecting and reporting administrative data:

- *There are no challenges or major problems in collecting and reporting administrative data*
- *The reporting system is very clear at all levels with availing a unified reporting format at all levels, the same copies of a reports should be kept at different levels .*
- *Clear guidelines are shared with all levels to deal with late reports from remote or inaccessible areas.*
- *The annual targets are revised and updated yearly whenever there is more than 100% coverage area (the dominator used in Sudan is an estimated projections from 1993 census).*
- *The population data will be updated according to the 2008 census findings when the final figures are approved and released.*

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

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

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

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

- **Pentavalent liquid vaccine (DTP+HepB+Hib)** introduced in 2008

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

- *One dose vial was approved and received.*
- *No change in presentation or dose per vial*

Dates shipments were received in 2008.

Vaccine	Vials size	Total number of Doses	Date of Introduction	Date shipments received (2008)
Pentavalent liquid vaccine	**One dose vial**	**827,500**	**January 2008**	**27 Nov.2007**
Pentavalent liquid vaccine	**One dose vial**	**827,500**	**January 2008**	**3 Dec..2007**
Pentavalent liquid vaccine	**One dose vial**	**827,600**	**January 2008**	**25 Feb.2008**
Pentavalent liquid vaccine	**One dose vial**	**827,500**	**January 2008**	**19 May 2008**
Pentavalent liquid vaccine	**One dose vial**	**827,500**	**January 2008**	**29 June 2008**
Pentavalent liquid vaccine	**One dose vial**	**114,200**	**January 2008**	**17 Dec 2008**

Please report on any problems encountered.

N omajor problems were encountered regarding the vaccines recipient
The VVM was not very bright white when received at central level, this was reported to UNICEF.

1.2.2. Major activities

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

2008 is the first year for the introduction of Pentavalent liquid vaccine into the routine immunization services in Sudan.
Preparation activities for the introduction of the new vaccine started in 2007 addressing all the introduction plan components which facilitated smooth introduction process without major problems.
Activities conducted in 2008 were:

- *Rehabilitation of the cold chain & installation of new equipments were implemented in all*

the 15 states at all levels.

- *Advocacy and Distribution of social mobilization materials and implementation of community mobilization activities for the new vaccine*

- *Distribution of updated immunization cards, tally sheets, reporting forms and registers*

- *Distribution of the updated vaccinator guide that included the information about the introduction of the new vaccine to all the vaccinators in the targeted states*

- *Special supervision plan implemented with specific check list.*

- *Routine monitoring and evaluation activities*

No major problems were encountered,

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

These funds were received on: ***[28/ 05/ 2008]***

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

Year	Amount in US$	Date received	Balance remaining in US$	Activities	List of problems
2008	100,000	28/ 05/ 2008	Zero	-*Rehabilitation of the cold chain.* *- Printing of immunization documents* *- Supervision activities* *- Social mobilization activities*	*delay in availability (transfer) of funds for programme use* slowed down the implementation of some activities
Funds from other sources (WHO & UNICEF) were used to complete the above mentioned activities					

1.2.4. Effective Vaccine Store Management/Vaccine Management Assessment

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? *[Jan/2008]*

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

The EVSM conducted in 2008 , (WHO/UNICEF Effective Store Management Initiative) certificate was achieved with highest score (94%).

major recommendations:

- To provide cold room at air port level
- Insurance for internal shipments

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

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

- All activities to sustain the high performance are continued.
- Main activity conducted is the implementation of the Cold chain assessment to have a complete situation analysis fort all levels. Results will be used as a tool to plan and address all the gaps at all levels

previous recommendations implemented were:
- The central cold store capacity was increased.

-Freeze tags were included in every vaccine shipment of freeze sensitive vaccines to the state level

When will the next EVSM/VMA* be conducted? **2010 (as guided below)**

**All countries will need to conduct an EVSM/VMA in the second year of new vaccines supported under GAVI Phase 2.*

Table 1.2

Vaccine 1: Pentavalent liquid vaccine	
Anticipated stock on 1 January 2010	**929,309**
Vaccine 2:	
Anticipated stock on 1 January 2010	**.....**
Vaccine 3:	
Anticipated stock on 1 January 2010	**.....**

1.3 Injection Safety

1.3.1 Receipt of injection safety support (for relevant countries)

Are you receiving Injection Safety support in cash or supplies? **NO**

If yes, please report on receipt of injection safety support provided by the GAVI Alliance during 2008 (add rows as applicable). ***Not Applicable***

Injection Safety Material	Quantity	Date received

Please report on any problems encountered.

[List problems]

(Not Applicable)

Note:

- **GAVI support for injection safety was for 3 years started in 2002 and ended by 2004.**

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

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

[List sources of funding for injection safety supplies in 2008]

- In 2008, the Government **(Ministry of Finance)** secured and provided the needed funds according to the EPI/FMOH request to procure the routine injection safety equipments for routine immunization services in 2008.
- The supplies were procured through UNICEF procurement system.
- UNICEF supported Sudan by first quarter need of injection safety equipments, by the time the Government release its funds.

Please report how sharps waste is being disposed of.

- Routinely as an immunization safety policy, safety boxes distributed with all vaccine deliveries to the vaccination sites for immunization sharp waste disposal.
- Incineration (burning) of the safety boxes is recommended in the national EPI policy
- Dig, Burn and Bury is the practiced procedure, in few sites burning in a pit then burial is also practiced.
  .
- Building of incinerators as planned was not implemented due to lack of funds
- The main problems encountered during implementation of the plan of injection safety are that, this policy has not been implemented in the other health sector services rather than immunization services; they lack sufficient supplies to implement safe injection and sharps waste management.

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

No major problems encountered during the implementation of the transitional plan *for safe injection and sharps waste.*
By the time funds are released from MOF for procurement of supplies, it is agreed with UNICEF to secure first quarter needs, beside that buffer quantities are kept and always replaced in case any delay occurred.

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

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

[List items funded by GAVI Alliance cash support and funds remaining by the end of 2008]

Not applicable

(No GAVI Alliance injection safety cash support received)

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

Table 2.1: Overall Expenditures and Financing for Immunization

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

	Reporting Year 2008	**Reporting Year + 1**	**Reporting Year + 2**
	Expenditures	Budgeted	Budgeted
Expenditures by Category			
Traditional Vaccines (UNICEF)	4,922,377	4,885,494	4,586,977
New Vaccines(GAVI+Government)	15,836,000	17,234,068	17831903.96
Injection supplies(Government)	784,863	771,254	821,868
Cold Chain equipment(UNICEF)	1,353,365	736,743	751,235
Operational costs(GAVI,WHO,UNICEF,GOV)	18,570,737	18,806,742	18,834,957
Other (Transportation + maintenance)	696,863	2,604,837	3211141.252
Capital cost (WHO)	1,304	1,941,053	1,947,920
Total EPI	**42,165,510**	**46,980,191**	**47,986,002**
Routine	27,912,598	36,095,254	38,097,898
SIAs	14,252,912	10,884,937	9,888,104
Total Government expenditure on EPI	7,989,169	11,839,605	12,692,069

Exchange rate used	**1 $ = 2.3 SDG**

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

The total expendature on immunization programme for 2008 was less than planned in cMYP 2006-2010. but if considered expenditure as routine and supplementary activities, routine expenditure was less than what was planned this is mainly because planned capital cost was and remained a funding gap througout 2008. while for SIAs actual cost exceeded what was planned; this is due to implemintation of five rounds of NIDs according to the current situation after importation of wild polio virus from Chad into Darfour state.

For routine activities; the major cost driver was the operational cost which covered personnel, transport (cost of vaccine transport to the states was very high compared to the transport cost of traditional vaccies) and out reach and mobile activities. Followed by expenditure on new vaccine introduction ie: vaccines, cold chain expansion and rehabilitation, printing and update of all registersand preparation of social mobilization materials and activities.

Despite the above funding situation , accelrated vaccination activities had been conducted in the three darfoure states with support from unicef and WHO to sustain high routine coverage.

Despite actual expenditure on routine activities remained less than what was planned in cMYP funding gap was larger than what was expected, this is because in addition to known gaps; expected GAVI support which was proposed to be received during 2008 ie: (the reward for 2007 achievements) has not been received upto-date.

UNICEF & WHO support was much higher than what was planned: first; due to the more frequent Implementation of SIAs that are completey covered by both agencies. second; from extra budgetary resources which enabled implementation of the above mentioned activities.

National government support was mainly to cover immunization safety equipments need (this was sustained and fulfilled as planned for the second year.), and the new vaccine co-finance.

The financial sustainability prospects for the immunization program over the coming three years are **alarming,** because in addition to funding gap already mentioned; the ISS GAVI support to the immunization activities is decreasing based on the current reward system of extra immunized children only. So after reaching high coverage rate (92%), the number of the extra immunized children will reduce markedly during the coming years, so the reward will not cover the cost to reach old & new children. So this gap might reflect negatively on the performance from which the coverage will decline back again. Beside that introduction of another new vaccines in the pipeline will increase the pogramme cost.

The main sources of these gaps is a combination of growing expenditures in certain budget lines e,g (new vaccine transportation to the districts due to large quantities of the one dose vial of new vaccine), beside that the loss of some funding sources for example less ISS support from GAVI due to high coverage achieved and ultimately less extra children to be reached.

Strategies being pursued to address the gaps are to increase the government contribution to the immunization activities at the national, states and districts level, and to increase the fixed immunization sites strategy to deliver the immunization services that 50% of the cost goes for outreach and mobile stratigies.
Sustaining the commitment from traditional donors to continue their support and advocacy for new donors to support the programme

Future Country Co-Financing (in US$)

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

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

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

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

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

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

1st vaccine: Pentavalent Vaccine		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose		$0.10	$0.15	$0.15	$0.15	$0.15	$0.15
Number of vaccine doses	#	114,800	188,600	207,100	268,400	302,100	331,100
Number of AD syringes	#	121,400	199,400	219,000	283,800	319,400	350,200
Number of re-constitution syringes	#	0	0	0	0	0	0
Number of safety boxes	#	1,350	2,225	2,450	3,175	3,550	3,900
Total value to be co-financed by country	**$**	**$381,500**	**$589,000**	**$605,000**	**$621,500**	**$638,000**	**$655,500**

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

2nd vaccine:……		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Co-financing level per dose							
Number of vaccine doses	#						
Number of AD syringes	#						
Number of re-constitution syringes	#						
Number of safety boxes	#						
Total value to be co-financed by country	**$**						

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

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

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

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

Q. 2: How Much did you co-finance?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (specify)	475,000	**114,200**
2nd Awarded Vaccine (specify)	NA	NA
3rd Awarded Vaccine (specify)	NA	NA

Q. 3: What factors have slowed or hindered or accelerated mobilization of resources for vaccine co-financing?
1. Delay of release o funds for new vaccine co- finance was due to other competing and priority activities to the MOF & MOH
2.
3.
4.

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

The country is not in default

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

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

3.1. Up-dated immunization targets

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

Are there changes between table A and B? Yes/no

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

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

No changes to births, updated estimated population projections from the last 1993 census were used as usual.
New census was conducted in 2008, the final figures are not yet released
updates will be shared with GAVI

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

No changes to surviving infants ,updated estimated population projections from the last 1993 census were used as usual.
New census was conducted in 2008, the final figures are not yet released.
updates will be shared with GAVI

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

No changes to targets for vaccine

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

No changes to vaccine wastage

Vaccine 1: .Pentavalent Vaccine

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

- Please complete the "Country Specifications" Table in Tab 1 of Annex 1, using the data available in the other Tabs: Tab 3 for the commodities price list, Tab 5 for the vaccine wastage factor and Tab 4 for the minimum co-financing levels per dose.
- Please summarise the list of specifications of the vaccines and the related vaccination programme in Table 3.1 below, using the population data (from Table B of this APR) and the price list and co-financing levels (in Tables B, C, and D of Annex 1).
- Then please copy the data from Annex 1 (Tab "Support Requested" Table 1) into Table 3.2 (below) to summarize the support requested, and co-financed by GAVI and by the country.

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

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

Table 3.1: Specifications of vaccinations with new vaccine

	Use data in:		**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Number of children to be vaccinated with the third dose	*Table B*	#	1,132,533	1,175,714	1,207,693	1,240,542	1,274,285	1,308,946
Target immunisation coverage with the third dose	*Table B*	#	94%	95%	95%	95%	95%	95%
Number of children to be vaccinated with the first dose	*Table B*	#	1,204,822	1,237,593	1,271,256	1,305,834	1,341,353	1,377,838
Estimated vaccine wastage factor	*Excel sheet Table E - tab 5*	#	1.05	1.05	1.05	1.05	1.05	1.05
Country co-financing per dose *	*Excel sheet Table D - tab 4*	$	$0.10	$0.15	$0.15	$0.15	$0.15	$0.15

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

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

		2010	**2011**	**2012**	**2013**	**2014**	**2015**
Number of vaccine doses	#	3,700,000	3,735,800	3,824,000	3,872,300	3,951,300	4,037,900
Number of AD syringes	#	3,912,400	3,950,500	4,043,800	4,094,900	4,178,400	4,270,000
Number of re-constitution syringes	#	0	0	0	0	0	0
Number of safety boxes	#	43,450	43,875	44,900	45,475	46,400	47,400
Total value to be co-financed by GAVI	**$**	12,300,500	11,664,500	11,167,500	8,962,000	8,347,000	7,993,000

Vaccine 2: NA

Same procedure as above (table 3.1 and 3.2)

Table 3.3: Specifications of vaccinations with new vaccine

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

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

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

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

Vaccine 3: NA

Same procedure as above (table 3.1 and 3.2)

Table 3.5: Specifications of vaccinations with new vaccine

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

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

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

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

4. Health Systems Strengthening (HSS)

Instructions for reporting on HSS funds received

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

4.1 Information relating to this report (annex1):

a) Fiscal year runs from: **January** (month) to **December** (month).

b) This HSS report covers the period from: **June 2008** to **April 2009**

c) Duration of current National Strategic Health Plan is from: **2007** to **2011**

d) Duration of the immunisation cMYP: from **2006**-**2010**

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

It is important for the IRC to understand key stages and actors involved in the process of putting the report together.

This report was prepared by the GAVI HSS management unit (GMU). It sums up the regular reports presented by GMU members and referred to activity reports supplemented by implementing departments and institutions. All these reports were previously discussed and approved by GAVI HSS steering committee within the regular meeting.

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any clarifications			
Sara Hassan Mustafa	**National Ministry of Health**	**Preparation**	**Email: hsarra@gmail.com** **Telephone: 00 (249) 122773711**
Other partners and contacts who took part in putting this report together			
Mustafa Salih Mustafa	National Ministry of Health	Preparation	Email: ms_mustafa2006@fmoh.gov.sd Telephone: 00 (249) 912163760
Amani Abdelmoniem	National Ministry of Health	Preparation ISS rept., Coordination & compilation with GAVI HSS	E.mail: amanisara2000@yahoo.com Mobile: 00 (249) 912218575

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

Sources of information:

- **Activity implementation reports**
- **States Ministry of Health Reports**
- **Fund accounting and procurement reports**
- **Mapping of health facilities survey**

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

No

4.2 Overall support breakdown financially

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

	Year								
	2007	2008	2009	2010	2011	2012	2013	2014	2015
Amount of funds approved		**3,063,620**	**3,144,806**	**3,228,143**	**3,313,689**	**3,401,503**			
Date the funds arrived		May 2008							
Amount spent		**2,266,190**							
Balance		**797,430**							
Amount requested		0	**3,144,806**	**3,228,143**					

Amount spent in 2008: **2,266,190**
Remaining balance from total: **797,430**

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

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

Table 4.3 HSS Activities in reporting year (ie. 2008)						
Major Activities	**Planned Activity for reporting year**	**Report on progress[3] (% achievement)**	**Available GAVI HSS resources for the reporting year (2008)**	**Expenditure of GAVI HSS in reporting year (2008)**	**Carried forward (balance) into 2009)**	**Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements**
Detailed planning, annual review as part of operational research and preparation of annual report	Detailed planning, annual review as part of operational research and preparation of annual report		10,000		10,000	
Component-1: Improve institutional capacity, organization and management for sustainable health system financing and development						
Objective 1: By end of 2012, strengthen/build core systems and capacities (organization and management; health planning and						

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

development, health financing; health management information system and monitoring and evaluation) in 15 Northern SMOHs and 20 Localities/districts						
1.1: **Improving management and organization**						
Activity 1.1.1:	short and long term TA to assist in building the capacity of 15 northern states and 20 localities	0	45,000		45,000	A proposal has been developed by WHO for Building organization and management capacity of decentralized health system and accordingly an agreement between WHO and the Federal Ministry of Health, Government of National Unity, Sudan has been finalized to cover activities in subcomponents 1.1 and 1.2 and thus perform the following interventions: - Develop state/locality health management teams - Assessment of the health system organization and management capacity at state and locality level - Assessment of the health system organization and management capacity at state and locality level - Design material for training the state and locality health management teams - Training of state and locality health management teams Annex 8 proposal and contract for Building organization and management capacity of decentralized health system
Activity 1.1.2:	train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings		45,000		45,000	
Activity 1.1.3:	TA for undertaking training needs assessment of public health managers both at state and locality level		60,000		60,000	
Activity 1.1.4:	train senior and mid-level health managers in all 11 northern states and 20 localities on short courses/on-job capacity building programme on health planning, district health management, leadership (11 states*4 each = 44) (20 localities * 3 each =60)		50,000		50,000	
Activity 1.1.5:	improve work environment	100%	66,000	66,000.00	0	An Open competitive tender was conducted to

	and provide key office equipment for SMOH in 11 states (PCs=2, faxes 1, printers=2, photocopiers (1).					procure IT equipment under Sudan government procedures. The equipment was distributed to state ministries of health of 11 states and to 20 localities in 4 states at the Half Annual Planning Meeting held on the 5th of Feb2009. (94 PC, 45 Fax, 74 Printer, 44 Photocopiers, 4Scanners, 4 Projectors). The remaining four states received the same package through the MDTF project. Annex 2i- Photos of IT equipment prior to distribution The related activities are; o Activity 1.1.5: o Activity 1.1.6: o Activity 1.2.6: (see below) Activity 2.2.3: (see below
Activity 1.1.6:	improve work environment and provide key office equipment for 20 districts (PCs=2, faxes 1, printers=1)	100%	60,000	60,000.00	0	
Activity 1.1.7:	support 11 SMOH to undertake supervision of services delivery though provision 4WD double cap vehicle (1) each (11 states * 1 vehicles = 22).	100%	385,000	385,000.00	0	- Activity 1.1.7: An Open competitive tender was conducted to procure 14, 4WD double cap vehicles. These were distributed at the Half annual planning meeting on the 5rd of Feb2009. The vehicles were assigned to planning directors to empower the planning process and supervision. Annex 2i and 2ii -press release & report ,distribution of IT equipment and 4WD double cap vehicles at The Half Annual planning meeting for State Ministries 2009
Activity 1.1.8:	support Health Management Teams in 20 localities to undertake supervision of services delivery though provision vehicle (1) each = 20 districts* 1 each = 20		0		0	Planned for 2009. Funds for 2009 are expected to be received on May 2009.
Activity 1.1.9:	provide TA to 11 Northern	0	60,000		60,000	Not started. It is linked to activities 1.1.1 to 1.1.4 and

	states for defining/adapting job descriptions, service package for different levels of care/facilities, staffing and resource requirements					must be aligned with them.
Activity 1.1.10:	train admin and financial staff in 11 northern states on budgeting and financial and resources management.	Planned for 2009	0		0	
1.2: **Strengthening of health planning capacities**						
Activity 1.2.1:	purchase/design and install planning software for the three levels of governance and train staff on its use in the Directorates of Health Planning in all 15 northern states and 20 localities. Also, provide copies of the planning and instructional manual	Planned for 2009	0		0	
Activity 1.2.2:	provide copies of the planning and instructional manual to 11 SMOH and 20 Localities Management Teams	Planned for 2009	0		0	
Activity 1.2.3:	develop a system for short course/on-job capacity building programme (2-3 weeks duration) on planning of health system recovery and development in a local university/ institute;	Planned for 2009	0		0	
Activity 1.2.4:	train a group of 6 experts (at national level) to act as trainers for the short course/on-job capacity building programme on the planning for recovery and development of health	Planned for 2009	0		0	

	system;					
Activity 1.2.5:	train at least two staff from each of 15 Directorates of Health Planning in Northern states and one staff from 20 localities on planning of health system recovery and development	Planned for 2009	0		0	
Activity 1.2.6:	provide PC (1), fax (1), printer (1), photocopier (1), to the Directorates of Health Planning in 11 states		0	0	0	- This activity has been conducted ahead of schedule, originally planned for the second year but has been implemented together with activities 1.1.5 -1.1.6 & 2.2.3 in one tender
1.3: **improve capacities and knowledgebase for equitable and sustainable health financing**			174620	335215	-160,595	The allotment of 174,620 was made in the inception report. - $ 45,000 transferred from Activity 6.1 - $ 129,620 which was un allocated fund in the final proposal
Activity 1.3.1:	conduct household expenditure and health services utilization research in 11 northern states	30% Started before schedule.	-	-	-	- A contract signed with WHO to complement the Financial Component of Multi Donor Trust Fund (MDTF) supported decentralized Health System Development (DHSD) project in implementing collaboratively with the National Ministry of Health (FMOH) the financial component for a sum of $734,737 namely household expenditure and utilization survey and National Health Accounts (NHA). Implementation of the activities started since January 2008 as follows; o TA provided by WHO (21-24 January 08) to design and develop work plan to implement NHA. o An orientation workshop was conducted on
Activity 1.3.2:	train 2 senior staff of Health Economic Unit in health economics/financing at Master/Diploma level		0		0	
Activity 1.3.3:	provide TA for developing/adapting pro-poor, comprehensive and sustainable health financing policy in 11 Northern states		0		0	
Activity: 1.3.4	provide TA for developing PHC services and immunization sustainability plans for national level and 11 Northern states		-	-	-	

						NHA. o Meetings were held with stakeholders and partners on defining the boundaries of the health system. o The second visit of the consultant was from 29 June – 1st July 2008, the mission of the visit was to agree upon the consultants to carry out the assignment, negotiate the contract of the financing sources, agents, and providers survey with Centre of Health Economics in University of Khartoum and to hold meetings and discussions with Health Economics Section to Negotiate contract with Central Bureau of Statistics to conduct household health services utilization & expenditure survey. o A workshop to identify the Health systems boundaries was held on 12-14 of August 2008 with the aims of, Identify the different aspects of health system boundaries in Sudan as a preparatory work to conduct the first round of NHA in Sudan. o A workshop was held on 21-23 of August 2008 to prepare detailed protocols for the household survey of health services utilization and health expenditure. o A workshop regarding the mapping of the main health financiers and providers was held on 26-28 of August 2008 with the aim of preparing for the development of classifications of the Health system as a preparatory work to conduct the first round of NHA in Sudan and to advocate for the first round of NHA account

						among different stakeholders. o A second workshop regarding the mapping of the main health financiers and providers was held on 21-23 of October 2008 with the aim of finalizing the development of classifications of the Health system as a preparatory work to conduct the first round of NHA in Sudan and to advocate for the first round of NHA account among different stakeholders. o A National workshop was held from 10th to -13th of November 2008 for Comprehensive training on the Household health Expenditure & Utilization Survey questionnaire and fieldwork plan. The participants of this workshop were National Health Accounts core team and states coordinators to prepare them as TOT (training of trainers), also to prepare them to advocate and manage the survey in their States. The training workshop was attended by the technical assistant (Dr. Mohamed Ben Kassimi from (AUB)) to supervise the training program, piloting and finalize the questionnaire. o Household Health Expenditure & Utilization Survey and the KAP survey were among the tasks that should be fulfilled to implement the national health account in Sudan, once the preparations were completed for the surveys and the proposals were ready along with the data collection tools (questionnaires), A pilot study was conducted on 14th -16th November 2008 in three administrative units in Khartoum state which are not part of the selected sample

						of (AUs) in Khartoum state, which were selected purposively to represent population groups from the different 15 Northern states targeted by the survey . o A contract was signed on 5 January 2009 between CBS & FMOH & WHO for conducting Household expenditure and Health services utilization survey. o Preparations for the KAP (activity 4.3.4) and Household Health and Expenditure Survey were carried out by the National management team from 8 -11 March 2009. A two day refresher training for the National coordinators was then conducted from 15-16 March 2009 which was followed by a pre-test. Printing of materials for the survey was done over an eight day period from 19-26 March 2009. After the budget was distributed by the accountant at the National level, The National Coordinators travelled to the states for claiming of budget details. This was followed by the transport of questionnaire and manual to the states followed by preparations and advocacy and recruitment for supervisors and interviewers at state level. Training of supervisors and interviewers was conducted from 1-4 April 2009. Data collection at state level which commenced on 5 April is expected to last for a period of twenty days until 24 April 2009. Supervision and office editing at state level began on 8 April 2009 is due to end on 25 April 2009. Supervision by National Coordinators had begun since 28 March 2009 and will proceed until 27 April 2009. On 28 April State Coordinators are

						expected to send in the filled-in questionnaires to the centre. Office editing at National level will then follow on 29 April 2009 until 13 May2009. Data entry is expected to begin at national level on 8 May and is to be completed by 22 May 2009**.** o Annex 3i- contract with WHO to implement the Financial Component o Annex 3ii- GAVI Financial Component report
1.4: **Strengthening of health Information system**						
Activity 1.4.1:	TA to support designing of a community based health information system	Planned for 2009	0		0	
Activity 1.4.2:	support to implement community based health information system in 12 states (excluding the three Darfur states) 2 localities in each=24 localities	Planned for 2009	0		0	
Activity 1.4.3:	design and establish a comprehensive integrated information base at national and state level (in 11 states)	Planned for 2009	0		0	
Activity 1.4.4:	develop a health system observatory that could provide output using GIS and set up mechanisms for the regular updating of health system profile.	Planned for 2009	0		0	- It is planned that by end of 2010 a health system observatory that could provide output using GIS will have been developed and by the end of 2011 mechanisms would be developed for its regular updating. The monitoring of health systems and reforms is one of the key functions of the observatory, the basic idea being to establish a national electronic resource centre that would

						include a national database on selected indicators, and based on those state/locality level profiles will be developed on standardized template using relevant information about health system. This activity has started ahead of schedule. Proposed sources of data are State profile, National and state report for The Sudan Household health survey 2006, Baseline survey (mapping), Human resource for health observatory, Mortality and morbidity indicators for Annual Statistical Health reports, Health System Studies, Health sector policies, Health System support, National Programmes. Currently the main data base is under development. The design is almost complete with two functioning links namely, The House Hold Health Survey conducted in 2007 and The Baseline survey of health facilities conducted in 2008. Currently other links are in progress and will soon be functioning as well. The Health System observatory is being integrated within the main website for the National Ministry of Health. (Annex 4- Health System observatory)
Activity 1.4.5:	provide TA for designing a comprehensive monitoring and evaluation system, both for national and state level, for the decentralized health system	0	60,000		60,000	The M&E component of the GAVI/HSS for strengthening The Health information system has been rescheduled to be aligned with the ongoing work for the Decentralized Health System Development Project. The project consists of a technical package consisting of three main components of which one is strengthening the M&E system by providing technical assistant to design a comprehensive national M&E system with concentration on the Decentralized health system concept. Thus the release of budget allocated for technical assistance (Activity 1.4.5) is reserved for supporting the implementation at state level (activity 1.4.6) and is planned to commence in August 2009.
Activity 1.4.6:	Support to establish comprehensive monitoring and evaluation system in all 15 Northern states.	0	55,000		55,000	

Objective 2: By end of 2012 develop health human resources and strengthen the capacity of 11 SMOH to produces, deploy and retain PHC workers focusing on nurses, midwifes, lab technician and multipurpose health workers in						
2.1: **Develop health human resources systems and policies**						

Activity 2.1.1:	provide TA for developing a comprehensive human resource plan for 11 Northern states, essentially addressing the issues like skill imbalances and geographical inequalities	0	45,000		45,000	- Agreement signed on 15th of June 2008 with the Academy of Health Sciences (AHS) to execute activities related to Human resources for a sum of $1, 6 million to be implemented over five years. The agreement consists basically of four outputs stated as follows; - **Output one:** to develop curricula for selected paramedics; - Taskforce was formed to revise categories of PHC workers and decide on priority categories to start with. Taskforce came out with three categories using the policy of AHS; the critical shortage in numbers; critical health problems in the country. These categories are: nursing, midwifery, and general medical assistant. - Another taskforce was formed to hold desk review sessions on selected curricula and to identify curricula in lines and performance shortage. - These taskforces came out with drafts for two curricula (nursing and midwifery). - Now the ASH is preparing to conduct consensus-building workshops for two curricula drafts. - **Output two:** to enroll 1500 students at ASH in 7 selected states (300 annually). - Taskforce (steering committee) held three meetings to develop selection criteria for students to be enrolled in ASH. Criteria considered equity, diversity and transparency.
Activity 2.1.2:	institute innovative approaches like financial and non-financial incentives as operational research for improving the		0		0	

	retention of health staff					- Local advertisement was made at the 7 targeted states and a taskforce select the students according to selection criteria . - Students selected and transparency report was written and together with the lists of selected students sent to GMU.
Activity 2.2: Rationalize and invest in training institutions for PHC workers focusing on Nurses, Midwifes, Lab technicians and multi purpose health worker						
Activity 2.2.2:	provide audio-visual equipment, furniture, computers for skill lab and books for library to four Academies of Health Sciences in 11 SMOH	65%	40,000	24,273	15,727	- **Output three:** to institutionalize CPD training programs for selected categories of PHC workers at ASH in four selected states. - Taskforce (steering committee) held three meetings to develop a framework of the Continuous Professional Development Policy. - A taskforce committee was formed by the Undersecretary' decree with terms of reference that match the requested out-put (National CPD Policy). - Two sub-contracts were signed with two expertise, the first to develop a framework that suites the Sudan context; the other one to develop Staff Development Policy. - The first draft of both contractors were received and discussed and recommendations were made. - The framework was presented to the grand committee for their comments and approval and it was approved. - Small taskforce (part of the Steering Committee-AHS) was formed to tackle the second out-put which is Training Needs Assessment of PHC Workers at four targeted states (Khartoum,
Activity 2.2.4:	provide TA for adapting curricula for paramedics and development of training material for the training of medical assistance as multi-purpose health workers;	85% of first year targeted activities. Implemented as a package.	30,000	30,000.00	0	
Activity 2.2.5:	provide tuition fees in every academic year (2009-12), to 40 students of different categories in AHSs in the 7 SMOH (300 annually).		210,000		210,000	
Activity 2.2.6:	support to institutionalize Continuing Professional Development programmes as a pilot in four AHSs (Khartoum, Gezira, White Nile, and Gadarif)		40,000		40,000	
Activity: 2.2.7:	provide integrated on the job training for PHC workers to enable with the skill necessary for the provision of essential services such as immunization, child and maternal care in the 4 targets states (4		90,000	90000	0	

	localities/districts each) (4 states* 4 localities/districts * 20 PHC workers= 320 annually * 5 years					Gazira, White Nile, Gadarif). - The committee held two meetings for revising the situation analysis of PHC workers at these targeted states. - Action plan was proposed and will be discussed with the PHC Directorate-FMOH for consensus. - **Output four:** to train 1600 PHC workers of the selected categories. - This outcome depends on finalizing the third outcome. - First round report - Action plan for PHC workers - CPD strategy Annex 5-Academy of Health Sciences first round report, Action plan for PHC workers and CPD strategy
Activity 2.2.1:	rehabilitate 2 Academy of Health Sciences in 2 SMOH	70%	100,000	116,000.00	-16,000 (requirements for minimum rehabilitation were more than the allocated amount)	Three of the four targeted GAVI HSS states the AHS were rehabilitated by the government. Nyala AHS in South Darfur state was selected as an alternative due to the great need for PHC workers in this state. The need of rehabilitation when assessed by the engineering team was found to exceed the budget which necessitates shifting from other budget lines. Open competitive bidding was conducted and contracts signed with two firms to rehabilitate the two targeted branches of the academy of health sciences in Sinnar and Nayla cities. Currently both academies of health sciences are under rehabilitation.
Activity 2.2.3:	provide PCs (1), faxes (1), printers (1), to Directorates of Health Human Resource in 11	100%	22,000	22,000.00	0	This activity was implemented with activities 1.1.5 - 1.1.6 and 1.2.6 in one tender

	SMOH					
Component -2: improving service delivery and equitable access to quality PHC services.						
Objective 3: By end of 2012, contribute to the achievement of 90% EPI coverage in all 15 Northern states through increasing fixed site by 25% from the current level of 1,260 facilities and support to outreach services						
Activity: 3.1:	provide cold chain to support health facilities to work as fixed sites for immunization (60 annually) (4 states * 15 health facilities * 5 years = 300 health facilities)	100%	200,000	200,000	0	- The financial support provided by GAVI/HSS to the EPI National programme to provide cold chain and support outreach services together with financial support from UNICEF helped in increasing the EPI coverage of DPT3/Penta3 in the four GAVI target states during the period: July-Dec.2008 as follows: ❖ N.Kordofan: from 42% in Jun. to 97% by the end of 2008 ❖ White Nile: from 36% in Jun. to 90% by the end of 2008 ❖ Sennar: from 35% in Jun. to 100% by the end of 2008 ❖ Gedarif: from 35% in Jun. to 98% by the end of 2008 - Regarding the cold chain in these states, 40 refrigerators have been procured through UNICEF and they are expected to be received within the first quarter of 2009
Activity 3.2:	support to outreach services targeting underserved and districts with low immunization coverage (2 districts * 4 sates * 5 years = 60) * 30,000 US$ each district	100%	200,000	200,000	0	

						Annex 6- EPI progress report
Objective 4: By end of 2012, contribute to the achievement of 75% equitable coverage and access to quality PHC services necessary for improved maternal health and child survival in the 4 targeted states.						
4.1: **Invest in PHC infrastructure network and equipments**						
Activity 3.1.1:	provide TA for developing comprehensive investment plan for health system development in 8 states (White Nile, North Kordafan, Sinnar Gadarif, Khartoum, Gezira, Northern, and River Nile)	20% (combined with activity 6.1)	60,000		60,000	This activity is implemented as one unit with activity 6.1 of undertaking the baseline survey. The investment plan is to be based on the information of mapping of health facilities which is part of this activity. The Mapping of health facilities is conducted in all 15 northern states with GAVI HSS and government support.
Activity 3.1.2:	rehabilitate 1 rural hospital annually, in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (1*4*5=20)n (focus on maternal, neonatal and EmOC)	Planned for 2009	0		0	This activity is planned for 2009 (fund expected to be received on May 2009. However, anticipating a lengthy process preparatory work started by; - Sites for rehabilitation were selected by 4 states and based on the mapping survey data. This was discussed in a participatory workshop including national MCH programmes and the 4 states senior staff. This workshop was supported by an additional fund from the World Bank which provided a consultant to assist in planning for this component. Selected sites represented the most in need areas.
Activity 3.1.3:	rehabilitate/upgrade 3 dispensaries/Primary Healthcare Units annually in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (3 HF * 4 states * 2 years = 24 + 6* facilities *4 state*2= 48 in 3 and 4)	Planned for 2009	0		0	

Activity 3.1.4:	rehabilitate 2 rural health centers in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (2 * 4 states * 5 years = 40)	Planned for 2009	0		0	- Assessment of health facilities in the four GAVI/HSS target states for civil works was conducted by The Engineering department at the FMOH in March 2009. Currently the bill of quantities and costs are being determined for GAVI/HSS civil works for the year 2009 in order to proceed with the bidding process. Annex7- List of identified sites for GAVI/HSS civil works 2009
Activity: 3.1:5	provide essential equipment and future (according to standards) for 2 hospitals annually in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (2 hospital * 4 states *5 years = 40) (focus on maternal, neonatal and EmOC)	100%	120,000	120,000	0	- A list of medical supplies for MCH services was prepared by GMU in collaboration with relevant directorates and state planning directors reflecting the need at state level for the four GAVI/HSS target states. Performa invoices were obtained from Central Medical Stores (CMS), the National Corporation entrusted with government purchase of Medicines and Medical Supplies. Approval was obtained from the Ministry of Finance for purchasing the suggested lists of items and procurement finalized. On 8 Feb 2009 equipment and medical supplies to cover delivery rooms, minor and major operation theatres and laboratories, to support eight rural hospitals were delivered to State ministries in an official ceremony at the Federal Ministry of health attended by high officials from both national and State levels.
Activity: 3.1:6	provide essential equipment and furniture (according to standards) for 3 dispensaries/PHCUs in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (3 facilities * 4 states * 5 years = 60)	100%	24,000	24,000	0	
Activity 3.1.7:	provide essential equipment and furniture (according to standards) for 4 urban health centers in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (4 health centers * 4 states * 5 years = 80 HCs)	100%	80,000	80,000	0	
4.2: **Provision of medicines and medical**						

supplies essential for child and maternal health						
Activity 4.2.1:	provide medicines for the treatment of key child health problems (ARI and diarrhoeal diseases); Vitamin A; Anti-helminthes; Iron and folic acid supplements for pregnant women to 25 Health centers and dispensaries annually in each of the targeted four states (20 PHC facilities * 4 states * 5 years = 500) *6000 US$ each facility per year	100%	120,000	120,000	0	- A list of Medicines for MCH services was prepared by GMU in collaboration with relevant directorates and state planning directors reflecting the need at state level for the four GAVI/HSS target states (simultaneously with the previous activities 3.1.2-3.1.3-3.1.4). Performa invoices were obtained from Central Medical Stores (CMS), the National Corporation entrusted with government purchase of Medicines and medical supplies. Approval was obtained from the Ministry of Finance for purchasing the above stipulated items. Items were procured and distributed to the 4 states. A criteria for distribution of these items was set, priority in distribution of drugs is given to most needy areas and being assessed through an operational research. Annex 9- list of drugs, medical supplies and equipment for MCH services
Activity 4.2.2:	provide medicines for the treatment of key child health problems (ARI and diarrhoeal diseases); Vitamin A; Anti-helminthes; Iron and folic acid supplements for pregnant women to 4 rural hospital in each of the targeted four states (4 Rural Hospitals * 4 states * 5 years = 80) * 12000 US$ for each facility per year	100%	192,000	192,000	0	
Activity 4.2.3:	provide essential laboratory supplies for testing (urine, Hb, BFFM, etc) necessary for improving maternal and child care to 4 rural hospital in each of the targeted four states (4 Rural Hospitals * 4 states * 5 years = 80) * 250 US$ each facility	0	48,000		48,000	Not started
Activity 4.2.4:	provide essential laboratory supplies for testing (urine, Hb, BFFM, etc) necessary for	0	50,000		50,000	Not started

	improving maternal and child care to 25 Health centers and dispensaries annually in each of the targeted four states (25 PHC facilities * 4 states * 5 years = 500) * 2000 US$ each facility per year.					
Activity 4.2.5:	provide long lasting insecticidal mosquito bed nets for distribution in the rural and hard to reach areas of the 4 states (5,000 bed nets * 4 states * 5 years * 5 US$ per nets)	100%	100,000	95,033	4,967	International competitive bidding was conducted. The support from GAVI/HSS for the provision of mosquito bed nets allowed for only 15,000 to be purchased. These a arrived on February and it was decided that they would be distributed in rural and hard to reach areas of the four states through The National Malaria Control Programme. According to The Concentration Distribution Policy adopted by The National Malaria programme, the amount of bed nets acquired was insufficient to produce an impact if distributed to the four states. Thus these bed nets are going to be distributed to only one locality in one GAVI target state annually. White Nile State (Ghabiesh locality) was selected for this year due to the malaria epidemic encountered recently. The bed nets provided by GAVI will complement that provided by GFTAM. 80% coverage of households in the selected locality is expected.
Activity 4.2.6:	Provide HMIS printed supplies for providing to 100 PHC facilities in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (100 facilities * 4 states * 5 years) * 50 US$ annually for each facility	0	20,000		20,000	Not started (delayed to be combined with HIS activities)
4.3: **Address the demand side barriers to access health services (Immunization, care seeking behaviour for children, RH, harmful tradition to mother and**						

child)						
Activity 4.3.1:	design documentaries and advocacy material	0	10,000		10,000	Not started (delayed to be based on the KAP survey results)
Activity 4.3.2:	print and disseminate documentaries and advocacy material for improving household knowledge and making informed decisions about health in the 4 targeted states (4 * 5000 US$ each)	0	20,000		20,000	Not started ((delayed to be based on the KAP survey results))
Activity 4.3.3:	conduct operational research in selected to test interventions for alleviating financial barriers to access primary health care and the impact of these subsides on the demand for services).	Planned for 2009	0		0	
Activity 4.3.4:	conduct KAP studies in all 4 northern states for determining the social and cultural barriers and defining measures for addressing these.	40% (started before schedule)	0		0	This activity was planned for 2009 but implemented before schedule to go together with activity 1.3.1: o A consensus workshop for KAP study for determining the barriers to access to PHC services was held on the29 of October with the aim of reaching an agreement on the proposal and data collection tools of the study and to discuss the Main issues of primary health care in Sudan. o A workshop was held on 11-13 of November 2008 regarding KAP study of PHC services barriers of access with the aim of training KAP study national and states data collectors' team on the data collection tools and research management. o Data collection was done on April 2009.
5: **Management of**			127,000	73,668.97	53,331	

GAVI/HSS support						
Activity 5.1:	Support the DGHP&D in the FMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support	100%	45,000	0	45,000	
Activity 5.2:	Providing equipment to DGHP&D to enhances its capacity to coordinate, monitor and report on the implementation of the GAVI/HSS support	**100%**	**-**		0	Computers and accessories and other office equipment and furniture were provided for the national and state planning directorates to improve the environment in these departments. No separate offices were provided to manage GAVI HSS fund. The existing planning departments offices were supported to overtake this activity as part of their mandate of improving the health system.
Activity 5.3:	Support the DGHP&D in the 4 SMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support	**100%**	**-**		0	
Activity 5.4:	Providing equipment to DGHP&D in each of the 4 states to enhances its capacity to coordinate, monitor and report on the implementation of the GAVI/HSS support	100%	-		0	
6: **Monitoring and evaluation for GAVI/HSS support**						
Activity 6.1:	Undertake baseline (in 2008) and evaluation research (in 2012)	100%		33,000.00	-33,000 (combined with activity 3.1.1)	- Preparation for the Base Line Survey (BLS) started in May 2008 by nomination of the National technical committee (NTC), the Fieldwork team (FWT) and a consultant with specific term of reference for each. The NTC held the first meeting on the 15th of May, during that meeting the followings were discussed and agreed upon: - The draft proposal - The inclusion of non GAVI States in the baseline survey using additional government

						resources. Based on the meeting recommendations; Amendments were included to the draft document and presentation of the document was carried to the States' Directors general and planning directors on the 2nd of June 2008. Further amendments were suggested by that forum and then the survey document was finalized by the consultant with the assistance of the FWT. Then a guide for data collectors was developed by the consultant. Two members from each STC (the EPI and planning directors) together with national supervisors were trained at national level on survey methodology and tools. Orientation of the State's senior officials was conducted by the National supervisor. The last with the two STC members who were nationally trained conducted the training of the locality heath team (LHT) comprising the director of the locality health affairs and EPI manager. Data collection took place at the locality levels by the LHT assisted by their technical staff as guided by the survey documents. Data collected from 135 localities from the 15 Northern States. The remaining localities (11) in West (6), North (1) and South Darfur (3) were inaccessible due to insecurity issues and thus their LHT couldn't attend the training at the States' capitals and were not included in data collection. The national supervisor filled in the State and locality questionnaire with the concerned senior staff. A national team was nominated for data management (attached). Data entry took place at national level and it was involved staff from 9 States to build states capacities in this regard. Data was analyzed using the indicators from the template report. Separate report for each State together with a national one were written by the consultant assisted by members from STC and the national supervisors and were reviewed by STC . A template for the investment plans was developed by

						the FWT and was discussed with the States' planning directors at national level.
total	**total**	**73.9%**	**3,063,620**	**2,266,190**	**797,430**	

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

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

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

Major Activities	Planned Activity for current year (ie.2009)	Planned expenditure in coming year (2009 as written in the original proposal)	Balance available (To be automatically filled in from previous table)	Request for 2009	Explanation of differences in activities and expenditures from original application or previously approved adjustments**
Detailed planning, annual review as part of operational research and preparation of annual report	Detailed planning, annual review as part of operational research and preparation of annual report	10000	10,000	10,000	
Component-1: Improve institutional capacity, organization and management for sustainable health system financing and development			0		
Objective 1: By end of 2012, strengthen/build core systems and capacities (organization and management; health planning and development, health financing; health management information system and monitoring and evaluation) in 15 Northern SMOHs and 20 Localities/districts			0		
1.1: **Improving management and organization**			0		
Activity 1.1.1:	short and long term TA to assist in building the capacity of 15 northern states and 20 localities	45,000	45,000	45,000	

Activity 1.1.2:	train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings	45,000	45,000	45,000	
Activity 1.1.3:	TA for undertaking training needs assessment of public health managers both at state and locality level	0	60,000	0	
Activity 1.1.4:	train senior and mid-level health managers in all 11 northern states and 20 localities on short courses/on-job capacity building programme on health planning, district health management, leadership (11 states*4 each = 44) (20 localities * 3 each =60)	50,000	50,000	50,000	
Activity 1.1.5:	improve work environment and provide key office equipment for SMOH in 11 states (PCs=2, faxes 1, printers=2, photocopiers (1).	66,000	0	66,000	
Activity 1.1.6:	improve work environment and provide key office equipment for 20 districts (PCs=2, faxes 1, printers=1)	0	0	0	
Activity 1.1.7:	support 11 SMOH to undertake supervision of services delivery though provision 4WD double cap vehicle (1) each (11 states * 1 vehicles = 22).	-	0	-	
Activity 1.1.8:	support Health Management Teams in 20 localities to undertake supervision of services delivery though provision vehicle (1) each = 20 districts* 1 each = 20	-	0	-	
Activity 1.1.9:	provide TA to 11 Northern states for defining/adapting job descriptions, service package for different levels of care/facilities, staffing and resource requirements	60,000	60,000	60,000	
Activity 1.1.10:	train admin and financial staff in 11 northern states on budgeting and financial and resources management.	30,000	0	30,000	
1.2: **Strengthening of health planning capacities**			0		
Activity 1.2.1:	purchase/design and install planning software for the three levels of governance and train staff on its use in the Directorates of Health Planning in all 15 northern states and 20 localities. Also, provide copies of the planning and instructional manual	80,000	0	0	-
Activity 1.2.2:	provide copies of the planning and instructional manual to 11 SMOH and 20 Localities Management Teams	10,000	0	0	
Activity 1.2.3:	develop a system for short course/on-job capacity building programme (2-3 weeks duration) on planning	60,000	0	0	

	of health system recovery and development in a local university/ institute;				
Activity 1.2.4:	train a group of 6 experts (at national level) to act as trainers for the short course/on-job capacity building programme on the planning for recovery and development of health system;	45,000	0	0	
Activity 1.2.5:	train at least two staff from each of 15 Directorates of Health Planning in Northern states and one staff from 20 localities on planning of health system recovery and development	60,000	0	0	
Activity 1.2.6:	provide PC (1), fax (1), printer (1), photocopier (1), to the Directorates of Health Planning in 11 states	44,000	0	44,000	
1.3: **improve capacities and knowledgebase for equitable and sustainable health financing**			-160,595		
Activity 1.3.1:	conduct household expenditure and health services utilization research in 11 northern states	330,000	0	330,000	
Activity 1.3.2:	train 2 senior staff of Health Economic Unit in health economics/financing at Master/Diploma level	50,000	0	50,000	
Activity 1.3.3:	provide TA for developing/adapting pro-poor, comprehensive and sustainable health financing policy in 11 Northern states	60,000	0	60,000	
Activity: 1.3.4	provide TA for developing PHC services and immunization sustainability plans for national level and 11 Northern states	60,000	0	60,000	
1.4: **Strengthening of health Information system**			0		
Activity 1.4.1:	TA to support designing of a community based health information system	60,000	0	60,000	
Activity 1.4.2:	support to implement community based health information system in 12 states (excluding the three Darfur states) 2 localities in each=24 localities	-	0	-	
Activity 1.4.3:	design and establish a comprehensive integrated information base at national and state level (in 11 states)	60,000	0	60,000	
Activity 1.4.4:	develop a health system observatory that could provide output using GIS and set up mechanisms for the regular updating of health system profile.	60,000	0	0	

Activity 1.4.5:	provide TA for designing a comprehensive monitoring and evaluation system, both for national and state level, for the decentralized health system	-	60,000	-	
Activity 1.4.6:	Support to establish comprehensive monitoring and evaluation system in all 15 Northern states.	-	55,000	-	
Objective 2: By end of 2012 develop health human resources and strengthen the capacity of 11 SMOH to produces, deploy and retain PHC workers focusing on nurses, midwifes, lab technician and multipurpose health workers in			0		
2.1: **Develop health human resources systems and policies**			0		
Activity 2.1.1:	provide TA for developing a comprehensive human resource plan for 11 Northern states, essentially addressing the issues like skill imbalances and geographical inequalities	45,000	45,000	45,000	
Activity 2.1.2:	institute innovative approaches like financial and non-financial incentives as operational research for improving the retention of health staff	45,000	0	45,000	
Activity 2.2: Rationalize and invest in training institutions for PHC workers focusing on Nurses, Midwifes, Lab technicians and multi purpose health worker			0		
Activity 2.2.2:	provide audio-visual equipment, furniture, computers for skill lab and books for library to four Academies of Health Sciences in 11 SMOH	0	15,727	0	
Activity 2.2.4:	provide TA for adapting curricula for paramedics and development of training material for the training of medical assistance as multi-purpose health workers;	0	0	0	
Activity 2.2.5:	provide tuition fees in every academic year (2009-12), to 40 students of different categories in AHSs in the 7 SMOH (300 annually).	0	210,000	0	
Activity 2.2.6:	support to institutionalize Continuing Professional Development programmes as a pilot in four AHSs	-	40,000	-	

	(Khartoum, Gezira, White Nile, and Gadarif)				
Activity: 2.2.7:	provide integrated on the job training for PHC workers to enable with the skill necessary for the provision of essential services such as immunization, child and maternal care in the 4 targets states (4 localities/districts each) (4 states* 4 localities/districts * 20 PHC workers= 320 annually * 5 years	210,000	0	210,000	
Activity 2.2.1:	rehabilitate 2 Academy of Health Sciences in 2 SMOH	40,000	-16,000	40,000	
Activity 2.2.3:	provide PCs (1), faxes (1), printers (1), to Directorates of Health Human Resource in 11 SMOH	90,000	0	90,000	
Component -2: improving service delivery and equitable access to quality PHC services.			0		
Objective 3: By end of 2012, contribute to the achievement of 90% EPI coverage in all 15 Northern states through increasing fixed site by 25% from the current level of 1,260 facilities and support to outreach services			0		
Activity: 3.1:	provide cold chain to support health facilities to work as fixed sites for immunization (60 annually) (4 states * 15 health facilities * 5 years = 300 health facilities)	200,000	0	200,000	
Activity 3.2:	support to outreach services targeting underserved and districts with low immunization coverage (2 districts * 4 sates * 5 years = 60) * 30,000 US$ each district	200,000	0	200,000	
Objective 4: By end of 2012, contribute to the achievement of 75% equitable coverage and access to quality PHC services necessary for improved maternal health and child survival in the 4 targeted states.			0		
4.1: **Invest in PHC infrastructure network and equipments**			0		

Activity 3.1.1:	provide TA for developing comprehensive investment plan for health system development in 8 states (White Nile, North Kordafan, Sinnar Gadarif, Khartoum, Gezira, Northern, and River Nile)	0	60,000	0	
Activity 3.1.2:	rehabilitate 1 rural hospital annually, in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (1*4*5=20)n (focus on maternal, neonatal and EmOC)	200,000	0	200,000	
Activity 3.1.3:	rehabilitate/upgrade 3 dispensaries/Primary Healthcare Units annually in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (3 HF * 4 states * 2 years = 24 + 6* facilities *4 state*2= 48 in 3 and 4)	120,000	0	120,000	
Activity 3.1.4:	rehabilitate 2 rural health centers in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (2 * 4 states * 5 years = 40)	120,000	0	120,000	
Activity: 3.1:5	provide essential equipment and future (according to standards) for 2 hospitals annually in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (2 hospital * 4 states *5 years = 40) (focus on maternal, neonatal and EmOC)	120,000	0	120,000	
Activity: 3.1:6	provide essential equipment and furniture (according to standards) for 3 dispensaries/PHCUs in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (3 facilities * 4 states * 5 years = 60)	24,000	0	24,000	
Activity 3.1.7:	provide essential equipment and furniture (according to standards) for 4 urban health centers in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (4 health centers * 4 states * 5 years = 80 HCs)	80,000	0	80,000	
4.2: **Provision of medicines and medical supplies essential for child and maternal health**			0		
Activity 4.2.1:	provide medicines for the treatment of key child health problems (ARI and diarrhoeal diseases); Vitamin A; Anti-helminthes; Iron and folic acid supplements for pregnant women to 25 Health	120,000	0	120,000	

	centers and dispensaries annually in each of the targeted four states (20 PHC facilities * 4 states * 5 years = 500) *6000 US$ each facility per year				
Activity 4.2.2:	provide medicines for the treatment of key child health problems (ARI and diarrhoeal diseases); Vitamin A; Anti-helminthes; Iron and folic acid supplements for pregnant women to 4 rural hospital in each of the targeted four states (4 Rural Hospitals * 4 states * 5 years = 80) * 12000 US$ for each facility per year	192,000	0	192,000	
Activity 4.2.3:	provide essential laboratory supplies for testing (urine, Hb, BFFM, etc) necessary for improving maternal and child care to 4 rural hospital in each of the targeted four states (4 Rural Hospitals * 4 states * 5 years = 80) * 250 US$ each facility	48,000	48,000	18,806	
Activity 4.2.4:	provide essential laboratory supplies for testing (urine, Hb, BFFM, etc) necessary for improving maternal and child care to 25 Health centers and dispensaries annually in each of the targeted four states (25 PHC facilities * 4 states * 5 years = 500) * 2000 US$ each facility per year.	50,000	50,000	20,000	
Activity 4.2.5:	provide long lasting insecticidal mosquito bed nets for distribution in the rural and hard to reach areas of the 4 states (5,000 bed nets * 4 states * 5 years * 5 US$ per nets)	100,000	4,967	100,000	
Activity 4.2.6:	Provide HMIS printed supplies for providing to 100 PHC facilities in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (100 facilities * 4 states * 5 years) * 50 US$ annually for each facility	20,000	20,000	20,000	
4.3: **Address the demand side barriers to access health services (Immunization, care seeking behaviour for children, RH, harmful tradition to mother and child)**			0		
Activity 4.3.1:	design documentaries and advocacy material	0	10,000	0	

Activity 4.3.2:	print and disseminate documentaries and advocacy material for improving household knowledge and making informed decisions about health in the 4 targeted states (4 * 5000 US$ each)	20,000	20,000	20,000	
Activity 4.3.3:	conduct operational research in selected to test interventions for alleviating financial barriers to access primary health care and the impact of these subsides on the demand for services).	40,000	0	40,000	
Activity 4.3.4:	conduct KAP studies in all 4 northern states for determining the social and cultural barriers and defining measures for addressing these.	40,000	0	40,000	
5: **Management of GAVI/HSS support**		110,000	53,331	110,000	
Activity 5.1:	Support the DGHP&D in the FMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support	-	45,000	-	
Activity 5.2:	Providing equipment to DGHP&D to enhances its capacity to coordinate, monitor and report on the implementation of the GAVI/HSS support		0		
Activity 5.3:	Support the DGHP&D in the 4 SMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support		0		
Activity 5.4:	Providing equipment to DGHP&D in each of the 4 states to enhances its capacity to coordinate, monitor and report on the implementation of the GAVI/HSS support		0		**Un planned budget in 2010**
6: **Monitoring and evaluation for GAVI/HSS support**		-	0	-	
Activity 6.1:	Undertake baseline (in 2008) and evaluation research (in 2012)		-33,000		
total		**3,519,000**	**797,430**	**3,144,806**	The budgeted activities in 2009 exceeded the total by 374,194 $. The excess amount deducted from activities 1.2.1- 1.2.2- 1.2.3 – 1.2.4 – 1.2.5 -4.2.4 – 1.4.4

Table 4.5 Planned HSS Activities for next year (ie. 2010 FY) This information will help GAVI's financial planning commitments					
Major Activities	**Planned Activity for current year (ie.2010)**	**Planned expenditure in coming year (2010)**	**Balance available (To be automatically filled in from previous table)**	**Request for 2010**	**Explanation of differences in activities and expenditures from original application or previously approved adjustments****
Detailed planning, annual review as part of operational research and preparation of annual report	Detailed planning, annual review as part of operational research and preparation of annual report	10,000		10,000	
Component-1: Improve institutional capacity, organization and management for sustainable health system financing and development					
Objective 1: By end of 2012, strengthen/build core systems and capacities (organization and management; health planning and development, health financing; health management information system and monitoring and evaluation) in 15 Northern SMOHs and 20 Localities/districts					

1.1: **Improving management and organization**					
Activity 1.1.1:	short and long term TA to assist in building the capacity of 15 northern states and 20 localities	45,000		45,000	
Activity 1.1.2:	train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings	45,000		45,000	
Activity 1.1.3:	TA for undertaking training needs assessment of public health managers both at state and locality level	0		0	
Activity 1.1.4:	train senior and mid-level health managers in all 11 northern states and 20 localities on short courses/on-job capacity building programme on health planning, district health management, leadership (11 states*4 each = 44) (20 localities * 3 each =60)	50,000		50,000	
Activity 1.1.5:	improve work environment and provide key office equipment for SMOH in 11 states (PCs=2, faxes 1, printers=2, photocopiers (1).	0		0	
Activity 1.1.6:	improve work environment and provide key office equipment for 20 districts (PCs=2, faxes 1, printers=1)	0		0	
Activity 1.1.7:	support 11 SMOH to undertake supervision of services delivery though provision 4WD double cap vehicle (1) each (11 states * 1 vehicles = 22).	0		0	
Activity 1.1.8:	support Health Management Teams in 20 localities to undertake supervision of services delivery though provision vehicle (1) each = 20 districts* 1 each = 20	350,000		350,000	
Activity 1.1.9:	provide TA to 11 Northern states for defining/adapting job descriptions, service package for different levels of care/facilities,	0		0	

	staffing and resource requirements				
Activity 1.1.10:	train admin and financial staff in 11 northern states on budgeting and financial and resources management.	30,000		30,000	
1.2: **Strengthening of health planning capacities**					
Activity 1.2.1:	purchase/design and install planning software for the three levels of governance and train staff on its use in the Directorates of Health Planning in all 15 northern states and 20 localities. Also, provide copies of the planning and instructional manual	80,000		80,000	-
Activity 1.2.2:	provide copies of the planning and instructional manual to 11 SMOH and 20 Localities Management Teams	0		0	
Activity 1.2.3:	develop a system for short course/on-job capacity building programme (2-3 weeks duration) on planning of health system recovery and development in a local university/ institute;	60,000		60,000	
Activity 1.2.4:	train a group of 6 experts (at national level) to act as trainers for the short course/on-job capacity building programme on the planning for recovery and development of health system;	45,000		45,000	
Activity 1.2.5:	train at least two staff from each of 15 Directorates of Health Planning in Northern states and one staff from 20 localities on planning of health system recovery and development	60,000		60,000	
Activity 1.2.6:	provide PC (1), fax (1), printer (1), photocopier (1), to the Directorates of Health Planning in 11 states	0		0	
1.3: **improve capacities and knowledgebase for**					

equitable and sustainable health financing					
Activity 1.3.1:	conduct household expenditure and health services utilization research in 11 northern states	0		0	
Activity 1.3.2:	train 2 senior staff of Health Economic Unit in health economics/financing at Master/Diploma level	50,000		50,000	
Activity 1.3.3:	provide TA for developing/adapting pro-poor, comprehensive and sustainable health financing policy in 11 Northern states	0		0	
Activity: 1.3.4	provide TA for developing PHC services and immunization sustainability plans for national level and 11 Northern states	0		0	
1.4: **Strengthening of health Information system**					
Activity 1.4.1:	TA to support designing of a community based health information system	0		0	
Activity 1.4.2:	support to implement community based health information system in 12 states (excluding the three Darfur states) 2 localities in each=24 localities	240,000		240,000	
Activity 1.4.3:	design and establish a comprehensive integrated information base at national and state level (in 11 states)				
Activity 1.4.4:	develop a health system observatory that could provide output using GIS and set up mechanisms for the regular updating of health system profile.	-		-	
Activity 1.4.5:	provide TA for designing a comprehensive monitoring and evaluation system, both for national and state level, for the decentralized health system	-		-	

Activity 1.4.6:	Support to establish comprehensive monitoring and evaluation system in all 15 Northern states.	-		-	
Objective 2: By end of 2012 develop health human resources and strengthen the capacity of 11 SMOH to produces, deploy and retain PHC workers focusing on nurses, midwifes, lab technician and multipurpose health workers in					
2.1: **Develop health human resources systems and policies**					
Activity 2.1.1:	provide TA for developing a comprehensive human resource plan for 11 Northern states, essentially addressing the issues like skill imbalances and geographical inequalities				
Activity 2.1.2:	institute innovative approaches like financial and non-financial incentives as operational research for improving the retention of health staff	45,000		45,000	
Activity 2.2: Rationalize and invest in training institutions for PHC workers focusing on Nurses, Midwifes, Lab technicians and multi purpose health worker					
Activity 2.2.2:	provide audio-visual equipment, furniture, computers for skill lab and books for library to four Academies of Health Sciences in 11	0		0	

	SMOH				
Activity 2.2.4:	provide TA for adapting curricula for paramedics and development of training material for the training of medical assistance as multi-purpose health workers;	0		0	
Activity 2.2.5:	provide tuition fees in every academic year (2009-12), to 40 students of different categories in AHSs in the 7 SMOH (300 annually).	0		0	
Activity 2.2.6:	support to institutionalize Continuing Professional Development programmes as a pilot in four AHSs (Khartoum, Gezira, White Nile, and Gadarif)	0		0	
Activity: 2.2.7:	provide integrated on the job training for PHC workers to enable with the skill necessary for the provision of essential services such as immunization, child and maternal care in the 4 targets states (4 localities/districts each) (4 states* 4 localities/districts * 20 PHC workers= 320 annually * 5 years	210,000		210,000	
Activity 2.2.1:	rehabilitate 2 Academy of Health Sciences in 2 SMOH	-		-	
Activity 2.2.3:	provide PCs (1), faxes (1), printers (1), to Directorates of Health Human Resource in 11 SMOH	90,000		90,000	
Component -2: improving service delivery and equitable access to quality PHC services.					
Objective 3: By end of 2012, contribute to the achievement of 90% EPI coverage in all 15 Northern states through increasing fixed site by					

25% from the current level of 1,260 facilities and support to outreach services					
Activity: 3.1:	provide cold chain to support health facilities to work as fixed sites for immunization (60 annually) (4 states * 15 health facilities * 5 years = 300 health facilities)	200,000		200,000	
Activity 3.2:	support to outreach services targeting underserved and districts with low immunization coverage (2 districts * 4 sates * 5 years = 60) * 30,000 US$ each district	200,000		200,000	
Objective 4: By end of 2012, contribute to the achievement of 75% equitable coverage and access to quality PHC services necessary for improved maternal health and child survival in the 4 targeted states.					
4.1: **Invest in PHC infrastructure network and equipments**					
Activity 3.1.1:	provide TA for developing comprehensive investment plan for health system development in 8 states (White Nile, North Kordafan, Sinnar Gadarif, Khartoum, Gezira, Northern, and River Nile)	0		0	
Activity 3.1.2:	rehabilitate 1 rural hospital annually, in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (1*4*5=20)n (focus on maternal, neonatal and EmOC)	200,000		200,000	

Activity 3.1.3:	rehabilitate/upgrade 3 dispensaries/Primary Healthcare Units annually in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (3 HF * 4 states * 2 years = 24 + 6* facilities *4 state*2= 48 in 3 and 4)	120,000		120,000	
Activity 3.1.4:	rehabilitate 2 rural health centers in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to standards (2 * 4 states * 5 years = 40)	120,000		120,000	
Activity: 3.1:5	provide essential equipment and future (according to standards) for 2 hospitals annually in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (2 hospital * 4 states *5 years = 40) (focus on maternal, neonatal and EmOC)	120,000		120,000	
Activity: 3.1:6	provide essential equipment and furniture (according to standards) for 3 dispensaries/PHCUs in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (3 facilities * 4 states * 5 years = 60)	24,000		24,000	
Activity 3.1.7:	provide essential equipment and furniture (according to standards) for 4 urban health centers in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (4 health centers * 4 states * 5 years = 80 HCs)	80,000		80,000	
4.2: **Provision of medicines and medical supplies essential for child and maternal health**					
Activity 4.2.1:	provide medicines for the treatment of key child health problems (ARI and diarrhoeal diseases); Vitamin A; Anti-helminthes; Iron and folic acid supplements for pregnant women to 25 Health centers and dispensaries	120,000		120,000	

	annually in each of the targeted four states (20 PHC facilities * 4 states * 5 years = 500) *6000 US$ each facility per year				
Activity 4.2.2:	provide medicines for the treatment of key child health problems (ARI and diarrhoeal diseases); Vitamin A; Anti-helminthes; Iron and folic acid supplements for pregnant women to 4 rural hospital in each of the targeted four states (4 Rural Hospitals * 4 states * 5 years = 80) * 12000 US$ for each facility per year	192,000		192,000	
Activity 4.2.3:	provide essential laboratory supplies for testing (urine, Hb, BFFM, etc) necessary for improving maternal and child care to 4 rural hospital in each of the targeted four states (4 Rural Hospitals * 4 states * 5 years = 80) * 250 US$ each facility	48,000		48,000	
Activity 4.2.4:	provide essential laboratory supplies for testing (urine, Hb, BFFM, etc) necessary for improving maternal and child care to 25 Health centers and dispensaries annually in each of the targeted four states (25 PHC facilities * 4 states * 5 years = 500) * 2000 US$ each facility per year.	50,000		50,000	
Activity 4.2.5:	provide long lasting insecticidal mosquito bed nets for distribution in the rural and hard to reach areas of the 4 states (5,000 bed nets * 4 states * 5 years * 5 US$ per nets)	100,000		100,000	
Activity 4.2.6:	Provide HMIS printed supplies for providing to 100 PHC facilities in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) (100 facilities * 4 states * 5 years) * 50 US$ annually for each facility	20,000		20,000	
4.3: **Address the demand side barriers to access**					

health services (Immunization, care seeking behaviour for children, RH, harmful tradition to mother and child)					
Activity 4.3.1:	design documentaries and advocacy material	0		0	
Activity 4.3.2:	print and disseminate documentaries and advocacy material for improving household knowledge and making informed decisions about health in the 4 targeted states (4 * 5000 US$ each)	20,000		20,000	
Activity 4.3.3:	conduct operational research in selected to test interventions for alleviating financial barriers to access primary health care and the impact of these subsides on the demand for services).	-		-	
Activity 4.3.4:	conduct KAP studies in all 4 northern states for determining the social and cultural barriers and defining measures for addressing these.	-		-	
5: **Management of GAVI/HSS support**		110,000		110,000	
Activity 5.1:	Support the DGHP&D in the FMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support	-		-	
Activity 5.2:	Providing equipment to DGHP&D to enhances its capacity to coordinate, monitor and report on the implementation of the GAVI/HSS support				
Activity 5.3:	Support the DGHP&D in the 4 SMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support				

Activity 5.4:	Providing equipment to DGHP&D in each of the 4 states to enhances its capacity to coordinate, monitor and report on the implementation of the GAVI/HSS support			94,143	**Un planned budget in 2010**
6: **Monitoring and evaluation for GAVI/HSS support**		-			
Activity 6.1:	Undertake baseline (in 2008) and evaluation research (in 2012)				
total		**3,134,000**		**3,228,143**	The budgeted amount in 2010 is less than the total for the year by 94,143. The money allocated to activity 5.4

4.6 Programme implementation for reporting year:

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

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

Summary of Key Areas of Implementation

1. Procurement of office equipments and vehicles for states ministries of health is completed and the equipment and vehicles were availed. They were distributed to the states in the first quarter of 2009 (annex 2i and 2ii).

2. An agreement signed with the Academy of Health Sciences (AHS) to execute activities related to PHC training for a sum of $1, 6 million to be implemented over five years. AHS has implemented a number of activities including enrolment of students and development of policies (annex 5).

3. A contract signed with WHO to complement the Financial Component of MDTF supported DHSDP in implementing collaboratively with FMOH the financial component for a sum of $734,737 namely health services utilization & expenditure survey and National Health Accounts (NHA) to be implemented in two years. A critical mass of local staff is trained to conduct these surveys and a number of key partners were attracted to participate. The surveys are underway with the field work started in the first quarter of 2009 (annex 3ii).

4. A detailed activity plan was developed by the EPI to implement activity 3 supporting the outreach immunization services and the cold chain. With GAVI HSS approach of working through MOH departments, the sum of $ 400,000 was transferred to EPI. The aim is to enable the programme to make use of the fund as part of the comprehensive plan. (annex 6).

5. Support to the Mapping Survey to obtain baseline information for monitoring of GAVI/HSS for a sum of $ 45,000 was provided. The survey is completed and results were discussed in a workshop including the states. The final reports were sent for printing on April 2009.

6. Open competitive bidding finalized and contracts signed with two firms to rehabilitate the two targeted branches of the Academy of Health Science in Sinnar and Nayla cities for a sum of $ 116,000. Most of the work is completed in both academies.

7. The process of direct purchase of Medicines, medical equipment and supplies from CMS implemented as part of service delivery package for a sum of $ 536,000 was completed. Medicines were procured and disseminated to the 4 targeted states..

8. Technical group formed coordinated by MCH department that develops plans for the Service Delivery Component.

9. TORs for contracting Short and long term TA to assist in building the capacity of 15

northern states developed (annex 8).

10. Challenges:

    a) The most important challenge was to ensure effective implementation using existing departments within the ministry of health. The balance was to ensure that activities are implemented as scheduled, with clear accountability and shows the impact of the fund without creating a new vertical or parallel structure within the ministry of health. The management unit consists of MOH staff working in MOH health system departments with no dedicated staff for GAVI HSS. This resulted on:

- Staffs has other assignments as part of their role in the MOH with a lot of competing priorities and is overworked.

- Implementation through MOH departments is faced by the bureaucracy of the system within the ministry of health.

To overcome these challenges this management unit which is a virtual unit extending through different departments is created with tasks assigned and funds flow traced. This has resulted in fast/timely implementation, utilization of funds and ability to monitor and documents results, while contribution to the overall capacity building of the MOH and ensures sustainability. It also facilitated learning and preserved organizational a good memory for the experiences.

    b) Another challenge was the late start during 2008 as the funds were received on May and the year was reduced to six months. This was overcomed by an effective implementation structure that made use of existing capacities within the MOH and complementarity with other health system supporting funds. However, there is still overlap between 2008-2009 activities which is expected to recur annually.

    c) Monitoring is seen as another challenge. For this reason it is planned to implement some of the activities as operation research and to have workshops including health system partners to set monitoring plans.

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

GAVI HSS is being implemented by ministry of health departments and affiliated institutes.

No CSOs are involved directly in the implementation.
The National Ministry of Health is expecting to receive the GTAM fund as the health system proposal was approved in 2009. This proposal was written by the team building on the MDTF

funded DHSDP and the GAVI HSS fund, so all activities are complementing these funds. The ministry of health will use the same structures used to manage these funds for the GFTAM and it will be implemented through the ministry of health existing departments and staff to ensure capacity building and sustainability.

4.7 Financial overview during reporting year:

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

a) Are funds on-budget (reflected in the Ministry of Health and Ministry of Finance budget): Yes/No If not, why not and how will it be ensured that funds will be on-budget ? Please provide details.

Funds are reflected in Government budget. The Fund implementation mechanism is fully integrated within the ministry of health and implemented through its departments and institutes using government staff. The fund is seen as part of the overall budget for health system development and is implemented in full harmony and complementarily with other health system initiatives funded by the government and the donors (e.g. the Multi Donor Trust Fund project of Decentralized Health System Development).

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

The GAVI HSS Management Unit uses government financial and procurement procedures. No issues related to financial management and audit are raised.

a. General overview of targets achieved:
The Implementation of the fund started six months ago and so the time for tracking the progress of the indicators coming in the application is not yet due.
Output Indicators:

Table 4.8 Progress on Indicators included in application

Strategy	Objective	Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target	milestones	Explanation of any reasons for non achievement of targets
Institutional capacity building and organization	By end of 2012, strengthen/build core systems and capacities in 15 Northern SMOHs and 20 Localities/districts	% SMOH with functioning organizational structure as per standard	SMOH with organogram positions filled with qualified and trained key staff	15 Northern SMOH	Administrative reports on standardized checklist	0 (measured versus the standard structure)	Admin. reports	2008	100%	2011		-activity not due in 2008
		% SMOH with functional planning directorates	SMOH with functional planning directorate	15 Northern SMOH	Administrative reports on standardized checklist	0 (measured versus the standard functionality)	Admin. reports	2008	100%	2010	-100% of targeted Planning department in the SMOH (15) received the package of IT equipments - 100% of targeted planning directors	- GAVI HSS provided for 11 states while MDTF for the remaining four states

											(15) received a vehicle to support planning	
		% states planning directorates using standard planning format	States planning directorates using standard planning format	15 Northern SMOH	Administrative reports on standardized checklist	0	Admin. reports	2008	100%	2010	-	- activity not due in 2008
		% SMOH with functioning directorate of human resource	SMOH with functioning directorate of human	15 Northern SMOH	Administrative reports on standardized checklist	0	Admin. reports	2008	100%	2010	--100% of targeted Planning department in the SMOH (15) received the package of IT equipments	- GAVI HSS provided for 11 states while MDTF for the remaining four states
Service delivery, access and utilization	By end of 2012, contribute to the achievement of 75% equitable coverage and access to quality PHC services necessary for improved maternal health and child survival in the 4	% health facilities (RH, RHC, UHC, Dispensary/BHU) providing essential PHC package	Number of health facilities (RH, RHC, UHC, Dispensary/BHU) that provide essential PHC packages as per guidelines	PHC health facilities (RH, RHC, UHC, Dispensary/BHU) in 12 Northern states (excluding 3 Darfur states)	Health facility survey	35%	Health facility survey	2004 (updating planned in 2008)	50	2011	-100% (20 per state) of targted PHC facilities received the essential list of free MCH medicines.	-

	targeted states.											
		% PHC workers who received integrated in-service training during last 1-year	PHC worker who received in-service integrated training	PHC health facilities (RH, RHC, UHC, Dispensary/BHU) in 12 Northern states (excluding 3 Darfur states)	Health facility survey (human resources)	0	Health facility survey	2008	50%	2011	--zero	-not done pending completion of other activities
		Health services utilization rate	Total outpatient consultations in the 15 Northern states	Total population in the 15 northern states	Household health services utilization survey Routine annual statistical report	< 1 per person per year	Annual statistical report – but covers only public sector	2008 - Household health services utilization survey, along with health expenditure survey	> 1 per person per year	2011	-	- No reporting so far
		% PHC facilities reported timely for health information	Health facilities that submit statistical report	PHC facilities in the 15 northern states	Annual statistical report	33%	Annual statistical report	2006	60%	2011	-	- No reporting so far

4.9 Attachments

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

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

Financial Comptroller Ministry of Health:

Name:

Title / Post:

Signature:

Date:

5. Strengthened Involvement of Civil Society Organisations (CSOs)

Not Applicable

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

This section is to be completed by countries that have received GAVI TYPE A CSO support[4]

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

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

5.1.1 Mapping exercise

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

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

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

5.1.2 Nomination process

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

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

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

5.1.3 Receipt of funds

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

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

5.1.4 Management of funds

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

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

Not Applicable

This section is to be completed by countries that have received GAVI TYPE B CSO support[5]

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

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

5.2.1 Programme implementation

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

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

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

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

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

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

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

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

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

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

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

5.2.2 Receipt of funds

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

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

5.2.3 Management of funds

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

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

5.2.4 Monitoring and Evaluation

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

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

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

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

6. Checklist

Checklist of completed form:

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

7. Comments

IACC/HSCC comments:

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review.

- Routine immunization services achievements and reaching more children during 2008 were highly appreciated by all members.

- Recommendation rose to advocate strongly with government and new donors to fulfil the government commitment towards new vaccine co-financing in suitable time for procurement process.

- The overall ISS report was satisfactory to all IACC members

~ End ~