Annual Progress Report 2009

Submitted by

The Government of

North SUDAN

Reporting on year: **2009**

Requesting for support year: **2011**

Date of submission: 15 May 2010

Deadline for submission: 15 May 2010

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

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.

Note: *Before starting filling out this form get as reference documents the electronic copy of the APR and any new application for GAVI support which were submitted the previous year.*

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

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

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

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

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

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

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

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY
The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

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

ARBITRATION
Any dispute between the Country and the GAVI Alliance arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.
For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.
The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application..

By filling this APR the country will inform GAVI about :

- *accomplishments using GAVI resources in the past year*
- *important problems that were encountered and how the country has tried to overcome them*
- *Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners*
- *Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released*
- *how GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.*

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

By signing this page, the Government hereby attest the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in page 2 of this Annual Progress Report (APR).

For the Government of **North SUDAN**
Please note that this APR 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.

Minister of Health: (or delegated authority):	**Minister of Finance (or delegated authority):**
Title:	**Title: …….....**
Signature: .....……	**Signature: ……**
**Date: .....…….. **	**Date: …….....**

This report has been compiled by:

Full name: Dr. Amani A.M. Mustafa **Position:** National, EPI Mnager, FMOH **Telephone:** 00(249)912218575 **E-mail**: **amanisara2000@yahoo.com**	**Full name**: Dr. Mustafa Salih Mustafa **Position:** Assistant undersecretary for Planning, Policy and Research (FMOH) **Telephone:** 00(249)912163760 **E-mail:** mustafa.sm@fmoh.gov.sd
Full name: Dr.Nagla El Tigani El Fadil **Position:** GAVI/HSS focal person, Sudan **Telephone:** 00(249)904888602 **E-mail:** nagla114@gmail.com	**Full name:** Ali Babikir Mohamed **Position**..GAVI/HSS Financial management Officer **Telephone:** 00(249)912234020 **Email:** alifmoh@gmail.com
Full name: Mr. Adil Mohamed **Position:** PHC/EPI Financial Manager, FMOH **Telephone:** 00(249)12684973 **E-mail**:	

ICC Signatures Page

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

We, the undersigned members of the immunisation Inter-Agency Co-ordinating Committee (IACC) 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.

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

Name/Title	Agency/Organisation	Signature	Date
Dr. Igbal Ahmed Albasheer A.U. Baisc Health Care	**Baisc Health Care FMOH**		
Dr. Eltayeb Ahmed Elsayed A.U Public Health & Emergency	**Public health &Emerg. /FMOH**		
Dr. Mustafa Salih A.U. for Planning, Policy & Res.	**Planning &Research/ FMoH**		
Dr. Amani Abdelmuniem EPI National Director	**EPI / FMOH**		
Mrs. Manal Alageb MOF rep.	**Ministry of Finance**		
Dr. Babiker Mubasher MOI rep.	**Ministry of Interior**		
Dr. Elamin Osman MOD rep.	**Ministry of Defence**		
Mrs. Sawsan Omer MO Int. co rep.	**Ministry of International**		
Dr. Mohammed Abdur Rab / **Representitive**	**WHO**		
Mr. Iyabod Olisulmani / Representitive	**UNICEF**		
Dr. Mohamed Hussain Dafalla/ Representative	**Humanitarian Aid**		
Dr. Abdelrahman Hamid / Representative	**SRCS**		
Mr. Sohab Elbadawi Representative	**Rotary International**		

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

Comments from partners:

(Mentioned as a part of the ICC Comments written in the last pages of this report)

Comments from the Regional Working Group:

The Core RWG appreciated the efforts undertaken by the country team for preparation of the draft GAVI APR 2009 and suggested the following for consideration while finalizing the GAVI APR 2009.

General

- Complete the information and secure the required signatures as appropriate on page 3-5 i.e Government Signature, ICC Signature & HSCC signature. (DONE)
- Attach all the required supporting documents with proper numbering. (DONE)
- Update the checklist with the attached documents. (DONE)

Specific

- To elaborate more on the justification for change in births to make it clearly understood (DONE)
- Regarding the challenges and constraints, To describe what actions were undertaken to overcome these challenges. (Most of the challenges are due to financial or political issues, financial problems will be addressed in the new 2010 plan if the required funds are secured)
- *Overall Expenditure and financing for immunization section , to complete the table (DONE)*

- *Detailed expenditure of ISS funds during the 2009 Calendar year. To provide the financial statement as the annex provided. (DONE)*

HSCC Signatures Page

If the country is reporting on HSS
Attached as (Annex1 (d) HSCC signatures page MAY 2010)

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

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

Name/Title	Agency/Organisation	Signature	Date

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

Comments from partners:

.....

.....

Comments from the Regional Working Group:

- Complete documents, signatures and annexes. (Done)
- Highlight achievements, outcomes, indicators and figures more than long text. (Done)
- Endorsement by HSCC meeting and documentation of minutes and signatures. (Done)

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

(NOT APPLICABLE)

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 to help implement the GAVI HSS proposal or cMYP (for Type B funding).

We, the undersigned members of the National Health Sector Coordinating Committee, …… (insert name of committee) endorse this report on the GAVI Alliance CSO Support.

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 2009: Table of Contents

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List of supporting documents attached to this APR

1. *Expand the list as appropriate;*
2. *List the documents in sequential number;*
3. *Copy the document number in the relevant section of the APR*

Document N°	Title	APR Section
1	Calculation of ***[Country's]*** ISS-NVS support for 2011 *(Annex 1)*	1.1; 2.4; 3.7
2a,2b,2c	Minutes of all the ICC meetings held in 2009	1.5
3	Financial statement for the use of ISS funds in the 2009 calendar year	2.3
	External audit report of ISS funds during the most recent fiscal year (if available)	2.3
NA	Financial statement for the use of New Vaccines Introduction Grant funds in the 2009 calendar year	3.2.3
NA	Report of the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA)	3.4
NA	Minutes of the ICC meeting endorsing the change of vaccine presentation (if not included among the above listed minutes)	3.5
4	New cMYP for the years	3.6
2a	Minutes of the ICC meeting endorsing the country request for extension of new vaccine support for the years 2011 -2014 (if not included among the above listed minutes)	3.6
	Minutes of the HSCC meetings held in 2009 including those on discussion/endorsement of this report	5.1.8
	Latest Health Sector Review Report	5.1.8
	Financial statement for the use of HSS funds in the 2009 calendar year	5.8
	External audit report for HSS funds during the most recent fiscal year (if available)	5.8
NA	CSO mapping report	6.1.1
NA	Financial statement for the use of CSO 'Type B' funds in the 2009 calendar year	6.2.4
NA	External audit report for CSO 'Type B' funds during the most recent fiscal year (if available)	6.2.4

1. General Programme Management Component

1.1 *Updated baseline and annual targets (fill in Table 1 in Annex1-excell)*

The numbers for 2009 in Table 1 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2009.** The numbers for 2010-15 in Table 1 should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

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

The changes in table 1 regarding the number of the births from the 2008 APR are due to the followings:

- The base line data in 2008 APR is based on the projections from the 1993 census, as usually estimated projections were used in the previous years of ISS .
- The usual projections for the following years (2010 – 2014) used in 2008 APR, are estimated projections from the old population census in 1993.
- New census was conducted in 2008; its data could not be used, because it is not completed yet to show the different age groups and the new growth rates. It only show the population size without specific age groups or its rates as well for no new growth rate.
- **The achieved Penta1 coverage by end of 2009 was found higher** than the surviving infants calculated from the new census population but using the old census age groups rates and growth rate projections (as new figures are not released yet) .
- At the same time the old census projections could not be used here as in the previous years, because there is an official new census released.
- Technical EPI group discussed the situation and reached consensus on using:
- Operational target achieved using Penta1 coverage in 2009 is used as baseline for 2010.
- Projections for 2011 - 2014, use the 2010 base line and apply the available growth rates.
- This decision was shared and agreed upon by the Under secretary, the planning directorate and the National information centre in FMOH,

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

- Based on the above justifications in births, changes in Surviving infants are due to the same above mentioned justifications

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

- Target by vaccines are following the above mentioned changes in the surviving infants,and the achieved coverage in 2009

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

- No changes on vaccine wastage

1.2 *Immunisation achievements in 2009*

Please comment on the achievements of immunisation programme against targets (as stated in last year's APR), the key major activities conducted and the challenges faced in 2009 and how these were addressed:

Achievements of immunization programme against targets addressing various GIVS components:

A / Protecting more people…

A.1/ Routine Immunization Coverage

Antigen	Target	Achievement
BCG	87%	86%
Penta3	93%	91.8%
Measles	82%	83%
TT	48%	44%
DOR	7%	7%

81% of localities achieved 80% or more Penta3 coverage

Key Major Activities Conducted in regard to strengthen routine immunization services using RED approach are:

A.1.1/ Planning and management of resources;

Planning

- Update of the microplanning guidelines to include all updated immunization issues.
- Conduction of state workshops for preparation of 143 locality micro plans which is saved as soft and hard copies

Institutional Capacity &Training

- Mid-Level Management training for 33 EPI locality officers from 9 states
- Refresher training for 588 service providers at state level
- Basic EPI training for 406 vaccinator at state level.
- Refresher training on AEFI in 6 states.
- Conduction of Inter country training Workshop for cold chain and logistic management tools facilitated by EMRO for 35 participants from 9 EMRO countries.

(All the training activities were supported by WHO & UNICEF)

Cold chain

- Maintaining the functionality of the cold chain at sub-national levels to 86%
- Award of excellence from GAVI was given to Sudan cold chain during the GAVI Partners Forum

A.1.2/ Re-establishment of outreach vaccination

Immunization sites

- Increase accessibility through more immunization sites, which increased by adding 85 New fixed sites in 2009, (as total the F.S are 1462 compared to 1377 in 2008), SOS are 4012 compared to 3877 in the year 2008, also the Mobile services are (245 compared to 228 in 2008),

- Sustained Outreach services & mobile activities were conducted with sessions implementation rate of (105 % for fixed sites, 83% for out reach and 60% for mobile which is affected due to lack of ISS funds in 2009)
- - Because of the critical situation in Darfour zone, acceleration 2 campaigns of 3 rounds each for routine immunization, in 45 localities were implemented,

with support from WHO & UNICEF emergency funds.

A1.3/ Supportive supervision

- Planned supervisory visits to the states were conducted (all15 northern states (100%) were visited once or more with implementation rate of 75% out of the planned visits.
- 35 localities were visited (40% of the target).
- 117 fixed immunization sites were visited by the National EPI personnel (45% of the planned),

DQS tool used as a supervision tool enabled immediate analysis of the findings and feedback at state, district and health facility levels.
Main results of the supervision regarding verification factor at locality level 100% of localities achieved 0.8 or more, and 97% of the health facilities achieved 0.8 or more.
The overall implementation of the planned supervision activities were affected by the delay of GAVI funds transfer also.
-

A.1.4/ Link with community

- Celebration of Annual Immunization Day at national and sub-national levels
- Implementation of social mobilization activities in high risk special population and with NIDs campaign.

A.1.5/ Monitoring for action

- Conduction of 1 National interstate review and evaluation meetings on RED and implementation of the plans with all 15 northern 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.
- Weekly administrative EPI meetings at the federal level were conducted
  (Conduction of 63 meetings at central level for close follow up for surveillance & routine performance)
  - Monthly monitoring review meetings at state level (localities with states) were conducted.
  -

Immunization Safety ;AEFI surveillance system was strengthened and functioning in all 15 Northern states during 2009 (11 AEFI cases reported , investigated and reported on)

EPI Disease surveillance:

AFP: In 2009 Sudan had 5 imported wild polio virus in two stats. Last confirmed case was reported on March 2009 no further transmission was reported.
The AFP surveillance system sustained the high quality indicators for performance as recommended according to the international criteria. Based on the AFP review conducted in 2009 AFP surveillance system in Sudan is sensitive
The National polio lab. achieved high score (100%) proficiency test.

Measles: Measles case based surveillance system is strengthened where 783 cases of measles were reported to the system in 2009 with 96% blood sampling.

- Confirmed cases 70
- Clinically diagnosed 27
- Lab confirmed 27
- Measles epi-link 16

The incidence rate/1000,000 population is 1.96 compared to 3.3 in 2008

National Measles lab achieved 100% in the Proficiency test.

Other EPI Disease: All other EPI disease were reported on where 1094 report were received (100%). Diphtheria 4 cases
Neonatal TT 148 cases
Whooping cough 6 cases
All these cases are clinically diagnosed cases.

A.2/ Supplementary Immunization Activities.
Target: To achieve Global, regional and national targets for Polio Eradication, Measles and Neonatal Tetanus Elimination

A.2.1/ Polio Eradication
- Conduction of 4 NIDs rounds each targeting over 6,000,000 under five children, coverage ranged between 101% - 104% in the last round
- Conduction of 2 Sub NIDs coverage ranged between 100% -103%

A.2.2/ Maternal and neonatal tetanus Elimination
- Implementation of the second round of WCBA vaccination campaign in 20 localities in three states as part of the strategies of the MNT elimination targeting high risk areas,coverage is 85%

B/ Introducing new vaccines & technologies…
- Post introduction evaluation (PIE) of the NVI was conducted by an external team from EMRO & CDC, Conclusion was successful introduction of the new vaccine into the routine EPI services
- NITAG formation and conduction of 3 meetings
-
- Application for introduction of two new vaccines, Rotavirus vaccine and Pneumococcal vaccine was submitted to GAVI in September 2009.
- Country co- finance share for Pentavalent new vaccine was fulfilled.

C/ Linking with other health interventions…

Accelerated Child Survival Initiative
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.
Target: To integrate child survival package of interventions into EPI services.

High impact multi-health interventions were delivered for under five children in two campaigns during the year 2009 in coordination with MCH and Malaria programmes:
- Vitamin A coverage,102%
- Deworming (Albendazole), coverage 101%.
- polio vaccination coverage 99%
- Fefol for pregnant women, coverage 64%.
- Distribution of ILL bed nets
- Distribution of Iodine containing capsules in high risk areas
- Health education and awareness campaign

EPI programme was leading the implementation process along with other related programms.

Overall Main Achievements in 2009:

- Central cold chain… Award of Excellence form GAVI .
- Post introduction evaluation of the NVI (PIE) – March 09 …Successful.
- AFP surveillance system review …..Sensetive.
- Update of the cMYP.
- National polio lab… 100% proficiency test.
- Achievement of 91% third dose coverage
- Co-finance of the Penta v.
- Conduction of inter-country training workshp in VSSM (35 participants from 9 countries).
- Celebration of Annual Immunization day.
- Formation of NITAG.
- Application for 2 new vaccines
- ACSI.

(Note: All of the above mentioned activities were mainly supported by WHO & UNICEF)

Constraints & Challenges:

- Delay of the transfer of the ISS rewards.
- Low routine social mobilization activities.
- High turn over of trained LOO
- Aging of the transportation means at all levels
- Sustainability of achievements & co -finance…
- Denominator
- Hard to reach population/ war affected…
- Formation of new localities & administrative structure…

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

Main reason for not achieving the targeted coverage is the delay of transfer of the approved rewards for 2007& 2008 by GAVI , Only 11,500 US$ funds were transferred in April, 2009 .
This delay affected the implementation of the planned sessions especially for mobile and outreach 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.

1.3 ***Data assessments***

1.3.1 Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)[1].

Reported Coverage: Is the official immunization coverage which is based on registration of doses administered by health care providers.

The WHO/UNICEF Estimate of National Immunisation Coverage for 2009 is not available yet.

No Survey data was conducted for 2009 data

1.3.2 Have any assessments of administrative data systems been conducted from 2008 to the present? **[NO]**. If YES:

Please describe the assessment(s) and when they took place.

NA

1.3.3 Please describe any activities undertaken to improve administrative data systems from 2008 to the present.

Activities undertaken to improve administrative data systems are:

- Refresher training for information focal persons at state level
- Revision and update of the information guidelines
- Printing and availing the information documents and data records at all levels
- Continuous supervision for data system at all levels and monitoring of verification factor and quality index.
- Follow up and monitoring of system index and verification factor at all levels visited during 2009.
- Archive of EPI data and information for the years 1996-2009

1.3.4 Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

Plans to improve administrative data system:

- Assign information focal persons in states that do not have
- Training of the new focal persons
- Conduct continuous supervision for the data system and monitor quality performance
- Monitoring system index for quality and verification factor for data quality at all levels by conducting Data Self Assessments

[1] *Please note that the WHO UNICEF estimates for 2009 will only be available in July 2010 and can have retrospective changes on the time series*

- Printing and distribution of the information guidelines
- Update and print the documentation records to include the new vaccines

1.4 *Overall Expenditures and Financing for Immunisation*

The purpose of Table 2 is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Table 2: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$.

Expenditures by Category	**Expenditure Year 2009**	**Budgeted Year 2010**	**Budgeted Year 2011**
Traditional Vaccines[2]	1,031,795	1,521,432	1,500,942
New Vaccines	12,756,090	12,135,279	45,984,427
Injection supplies with AD syringes (all)	1,049,639	1,407,614	1,836,534
Cold Chain equipment	736,743	$1,987,493	$1,932,738
Operational costs	3,354,676	8,536,577	8,850,247
(SIAs)	14,628,152	$9,388,160	$7,686,994
Other (c,apital +shared cost)	769,965	1,094,529	1,059,198
Total EPI	**34,327,060**	**$ 36,071,084**	**$ 68,851,080**
Total Government Health	**$ 4,181,485**	**$ 5,242,364**	**$ 7,247,716**

Exchange rate used	
1 USD	2.32 SDG

Please describe trends in immunisation 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 immunisation program over the next three years; whether the funding gaps are manageable, challenging, 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.

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

The total expendature on immunization programme for 2009 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 2009, beside that the operational cost (outreach and mobile activities) was less than what was planned, that no GAVI ISS funds were recieved in 2009 and most of the operational expenses were covered from extra buetary resources by WHO & UNICEF. While for SIAs actual cost exceeded what was planned; this is due to implemintation of extra rounds of NIDs & Sub NIDs due to the importation of wild polio virus into two states, implemintation of ACSI campaign and MNT campaign in three states

For routine activities; the major cost driver was the new vaccine cost and 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) , out reach and mobile activities. Cold chain expansion and rehabilitation,

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 2009 ie: (the reward for 2007 & 2008 achievements) has not been received upto the end of the year-date.

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.
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 to sustain the immunization coverage achiements.
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, beside the perssonel regular salaries.

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. that after reaching high coverage rates (91%), the number of the extra immunized children will reduce markedly during the coming years, this beside the new system of calculating the reward based on the WHO /UNICEF coverage estimates which is not known how it is calculated?. In this cases the reward will not cover the cost to reach old & new children. 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 markedly.

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 / delay of 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 and private sectors to support the programme

1.5 *Interagency Coordinating Committee (ICC)*

How many times did the ICC meet in 2009? 2 times
Please attach the minutes **(Document N°.2a, 2b, 2c)** from all the ICC meetings held in 2009, including those of the meeting endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on items 1.1 through 1.4

- Timely Country co-finance to the new Pentavalent vaccine, to avoid risk of default system
- To assure the country commitment for the co-finance of the other two new vaccines in the pipeline (Rotavirus & PCV).
- Expansion of the cold chain and preparations for the introduction of the Rotavirus and PCV vaccines should start immediately after the final approval from the GAVI board.
- To advocate with Government and new partners for mobilization of resources for EPI to assure sustainability of the achievements.

Are any Civil Society Organisations members of the ICC ?: **[Yes].** If yes, which ones?

List CSO member organisations:
Rotary International
ICRC

1.6 *Priority actions in 2010-2011*

What are the country's main objectives and priority actions for its EPI programme for 2010-2011? Are they linked with cMYP?

EPI Priorities and Objectives for 2010-2011:

1. To achieve and sustain 93% coverage of the third dose of Penta-valent vaccine by increasing and improving both access and utilization of immunization services in 26 (40%) low performing districts.
2. To strengthen Surveillance system of VPDs/AEFI.
3. To enhance surveillance of diseases prevented by new vaccines in the selected sentinel sites
4. To achieve a certification of polio eradication by maintaining high immunity profile
5. Conduction of measles follow up campaigns and introduction of the second measles dose to achieve and maintain Measles elimination.
6. Conduction of MNT campaigns to contribute to and maintain MNT elimination.
7. To ensure sufficient fund for EPI activities and ensure new vaccines co-finance.
8. To strengthen Programme institutional& managerial capacity.
9. To reduce morbidity and mortality among <5yrs children caused by Rota virus and S. Pneumonia by introducing new vaccines.

All planned actions are in line with the cMYP

2. Immunisation Services Support (ISS)

1.1 *Report on the use of ISS funds in 2009*

Funds received during 2009: US$.: **11,500.**
Remaining funds (carry over) from 2008: US$ **Zero.**
Balance carried over to 2010: US$ **Zero.**

Please report on major activities conducted to strengthen immunisation using ISS funds in 2009.

The 11,500 US$ is used for Supervision activities only.
Results and details of supervision are mentioned above
Detailed expenditure of the mentioned ISS budget is included in the financial statement annex

1.2 *Management of ISS Funds*

Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2009 calendar year? **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

NO (FMA) CONDUCTED IN 2009

Part A: briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of ISS funds.

NA

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

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

Financial Management Arrangements & Process are as follows:
The funds are received into the HSS or ISS commercial bank accounts in US Dollars or EUROS.
The funds are transferred into the EPI Programme Government account in local currency.
Federal Ministry of Health regulates the utilization of I.S.S funds through its auditing system of finance and according to the Ministry of Finance rules and regulations.

- Budgets are approved to support the states, according to the revised planed targets which is based on the locality microplans annual revision, update, approval and endorsement
- According to the updated micro plans, the localities calculate the number of un-immunized children expected to be reached every year and identify the strategies by which those children could be reached to achieve the targeted coverage and accordingly the needs and cost for these strategies is calculated according to specific guidelines.

- Funds channelled from national level to the Sub-national levels through the states MOH accounts
- States MOH distribute the support to the districts according to the budget in their micro plans to conduct outreach and mobile immunization sessions and supervision activities.

- 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.

Over all role of the IACC in this process is

- 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 involving the use of ISS funds:

- Delayed transfer of the approved rewards for 2007 and 20008 achievement,
- Only 11,500 US$ was received during 2009.
- This delay affected the implementation of the planned sessions especially for mobile & out- reach services, to vaccinate the targeted children according to the plan, which had affected the overall planned coverage;

- This was partially corrected lately by enforcing, accelerating and conducting local immunization days in low coverage districts with support from WHO and UNICEF.

- Supervisory visits could not be implemented as planned

- Printing of the immunization updated guidelines and registers was delayed, and the IEC materials production was postponed.

1.3 *Detailed expenditure of ISS funds during the 2009 calendar year*

Please attach a detailed financial statement for the use of ISS funds during the 2009 calendar year **(Document N°3).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

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

1.4 ***Request for ISS reward***

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

a) if the number of children vaccinated with DTP3 is higher than the previous year's achievement (or the previous high), and

b) if the reported administrative coverage of DTP3 (reported in the JRF) is in line with the WHO/UNICEF coverage estimate for the same year.

If you may be eligible for ISS reward based on DTP3 achievements in 2009 immunisation programme, estimate the $ amount by filling Table 3 in Annex 1.[3]

Based on the DPT3 achievements in 2009, Table 3 is completed which showed:
Rounded-up estimate of expected reward is (US$ 684,000)

[3] The Monitoring IRC will review the ISS section of the APR after the WHO/UNICEF coverage estimate is made available.

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

3.1 *Receipt of new & under-used vaccines for 2009 vaccination programme*

Did you receive the approved amount of vaccine doses that GAVI communicated to you in its decision letter (DL)? Fill Table 4.

Table 4: Vaccines received for 2009 vaccinations against approvals for 2009

	[A]		[B]	
Vaccine Type	**Total doses for 2009 in DL**	**Date of DL**	**Total doses received by end 2009 ***	**Total doses of postponed deliveries in 2010**
Pentavalent Liquid, one dose vial vaccine	**3,539,400**	**8 September.2008**	**3,228,400**	

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

If numbers [A] and [B] are different,

What are the main problems encountered? *(Lower vaccine utilisation than anticipated? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date?...)*	• No major problems were encountered • 320,000 d oses were kept out of use for some time , due to change of VVM colour inside the central cold chain since its arrival , without any reported problem in the storage temperature, this was communicated to UNICEF and mentioned in the VAR. • Later this was clarified by WHO consultant after communicating with the supplier and identified the problem in the type of the VVM used and not in vaccine or temperature. • These quantities was used after this clarification
What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF SD)	• The national shipment plan remained as planned & requested (6 shipments) • Sub-national levels few adjustments in the number of shipments were made to deliver the vaccines to state level • Vaccine wastage rate is monitored at all levels • Vaccine stock out is monitored at all levels • Vaccine management indicators are included as part of the routine supervision check list for all levels.

3.2 *Introduction of a New Vaccine in 2009* ***(Not relevant)***

3.2.1 If you have been approved by GAVI to introduce a new vaccine in 2009, please refer to the vaccine introduction plan in the proposal approved and report on achievements.

Vaccine introduced:	.....
Phased introduction [YES / NO]	Date of introduction .....
Nationwide introduction [YES / NO]	Date of introduction .....
The time and scale of introduction was as planned in the proposal? If not, why?	•

3.2.2 Use of new vaccines introduction grant (or lumpsum) ***(Not relevant)***

Funds of Vaccines Introduction Grant received: US$	Receipt date:

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

(Not relevant)

Please describe any problems encountered in the implementation of the planned activities:

(Not relevant)

Is there a balance of the introduction grant that will be carried forward? [YES] [NO]
If YES, how much? US$..... **(Not relevant)**

Please describe the activities that will be undertaken with the balance of funds:

(Not relevant)

3.2.3 Detailed expenditure of New Vaccines Introduction Grant funds during the 2009 calendar year **(Not relevant)**

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2009 calendar year **(Document N°.....).** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Not relevant)**

3.3 *Report on country co-financing in 2009 (if applicable)*

Table 5: Four questions on country co-financing in 2009

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 2009**	**Actual Payments Date in 2009**	**Proposed Payment Date for 2010**
	(month/year)	(day/month)	
1st Awarded Vaccine (specify)	October 2009	December 2009	October 2010
2nd Awarded Vaccine (specify)	NA	NA	NA
3rd Awarded Vaccine (specify)	NA	NA	NA

Q. 2: Actual co-financed amounts and doses?		
Co-Financed Payments	Total Amount in US$	Total Amount in Doses
1st Awarded Vaccine (Pentavalent Liquid vaccine)	425,800	95,000
2nd Awarded Vaccine (specify)	NA	NA
3rd Awarded Vaccine (specify)	NA	NA

Q. 3: Sources of funding for co-financing?
1. Government
2. Donor (specify) NA
3. Other (specify) NA

Q. 4: What factors have accelerated slowed or hindered mobilization of resources for vaccine co-financing?
1. Delay release of funds for the new vaccine co- finance, was due to other competing, priorities as well as emergency activities to the MOF & MOH

If the country is in default please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy http://www.gavialliance.org/resources/9___Co_Financing_Default_Policy.pdf

The country is not in default

3.4 *Effective Vaccine Store Management/Vaccine Management Assessment*

When was the last Effective Vaccine Store Management (EVSM)/Vaccine Management Assessment (VMA) conducted? ***[01/2008]***

If conducted in 2008/2009, please attach the report. (**Document N°**.....)
An EVSM/VMA report must be attached from those countries which have introduced a New and Underused Vaccine with GAVI support before 2008.
Was an action plan prepared following the EVSM/VMA? ***[YES]***

If yes, please summarise main activities to address the EVSM/VMA recommendations and their implementation status.

- All activities to sustain the high performance are continued.
- Analysis of the Cold chain assessment to have a complete situation analysis for all levels. Results 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 is the next EVSM/VMA* planned? *[mm/**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.

3.5 *Change of vaccine presentation*

If you would prefer during 2011 to receive a vaccine presentation which differs from what you are currently being supplied (for instance, the number of doses per vial; from one form (liquid/lyophilised) to the other; ...), please provide the vaccine specifications and refer to the minutes of the ICC meeting recommending the change of vaccine presentation. If supplied through UNICEF, planning for a switch in presentation should be initiated following the issuance of Decision Letter for next year, taking into account country activities needed in order to switch as well as supply availability.

Please specify below the new vaccine presentation:

No change in the new vaccine (Pentavalent) presentation

Please attach the minutes of the ICC meeting **(Document N°.....)** that has endorsed the requested change.

3.6 *Renewal of multi-year vaccines support for those countries whose current support is ending in 2010*

If 2010 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support starting from 2011 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby request for an extension of GAVI support for ***Pentavalent [liquid)]*** vaccine for the years 2011- *2014.* At the same time it commits itself to co-finance the procurement of ***Pentavalent [liquid)]*** vaccine in accordance with the minimum GAVI co-financing levels as summarised in Annex 1.

The multi-year extension of ***Pentavalent [liquid)]*** vaccine support is in line with the new cMYP for the years **2010 - 2014** which is attached to this APR **(Document N°4).**

The country ICC has endorsed this request for extended support of ***Pentavalent [liquid)]*** vaccine at the ICC meeting whose minutes are attached to this APR. **(Document N°.2 a)**

3.7 *Request for continued support for vaccines for 2011 vaccination programme*

In order to request NVS support for 2011 vaccination do the following:

1. Go to Annex 1 (excel file)
2. Select the sheet corresponding to the vaccines requested for GAVI support in 2011 (e.g. Table4.1 HepB & Hib; Table4.2 YF etc)
3. Fill in the specifications of those requested vaccines in the first table on the top of the sheet (e.g. Table 4.1.1 Specifications for HepB & Hib; Table 4.2.1 Specifications for YF etc)
4. View the support to be provided by GAVI and co-financed by the country which is automatically calculated in the two tables below (e.g. Tables 4.1.2. and 4.1.3. for HepB & Hib; Tables 4.2.2. and 4.2.3. for YF etc)
5. Confirm here below that your request for 2011 vaccines support is as per Annex 1:

[YES, CONFIRMED]

If you don't confirm, please explain:
NA

4. Injection Safety Support (INS)

In this section the country should report about the three-year GAVI support of injection safety material for routine immunisation. In this section the country should not report on the injection safety material that is received bundled with new vaccines funded by GAVI.

4.1 *Receipt of injection safety support in 2009 (for relevant countries)*

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

If INS supplies are received, please report on receipt of injection safety support provided by the GAVI Alliance during 2009 (add rows as applicable).

Table 7: Received Injection Safety Material in 2009 **(Not relevant)**

Injection Safety Material	Quantity	Date received

Please report on any problems encountered:

(Not relevant)

Note:

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

4.2 *Progress of transition plan for safe injections and management of sharps waste.*

Even if you have not received injection safety support in 2009 please report on progress of transition plan for safe injections and management of sharps waste.

If support has ended, please report what types of syringes are used and the funding sources:

Table 8: Funding sources of Injection Safety material in 2009

Vaccine	Types of syringe used in 2009 routine EPI	Funding sources of 2009
BCG	AD	Government + unicef
Measles	AD	Government
TT	AD	Government
DTP-containing vaccine	AD	Government + GAVI

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.

Does the country have an injection safety policy/plan? **[YES]**
If YES: Have you encountered any problem during the implementation of the transitional plan for safe injection and sharps waste? (Please report in box below)
IF NO: Are there plans to have one? (Please report in box below)

- No problems were encountered during the implementation of the transitional plan
- In 2009, 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 2009.
- 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.

4.3 *Statement on use of GAVI Alliance injection safety support in 2009 (if received in the form of a cash contribution)*

The following major areas of activities have been funded (specify the amount) with the GAVI Alliance injection safety support in the past year: **(NOT RELEVANT)**

Fund from GAVI received in 2009 (US$): .....
Amount spent in 2009 (US$):.....
Balance carried over to 2010 (US$):.....

Table 9: Expenditure for 2009 activities: **(NOT RELEVANT)**

2009 activities for Injection Safety financed with GAVI support	Expenditure in US$
Total	

If a balance has been left, list below the activities that will be financed in 2010:

Table 10: Planned activities and budget for 2010: **(NOT RELEVANT**)

Planned 2010 activities for Injection Safety financed with the balance of 2009 GAVI support	Budget in US$
Total	

5. Health System Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. This section **only needs to be completed by those countries that have been approved and received funding for their HSS application before or during the last calendar year**. For countries that received HSS funds within the last 3 months of the reported year this section can be used as an inception report to discuss progress achieved and in order to enable release of HSS funds for the following year on time.
2. All countries are expected to report on GAVI HSS on the basis of the January to December calendar year. In instances when countries received funds late in 2009, or experienced other types of delays that limited implementation in 2009, these countries are encouraged to provide interim reporting on HSS implementation during the 1 January to 30 April period. This additional reporting should be provided in Table 13.
3. HSS reports should be received by 15th May 2010.
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** (HSCC or equivalent) in terms of its accuracy and validity of facts, figures and sources used. Inaccurate, incomplete or unsubstantiated reporting may lead the Independent Review Committee (IRC) either to send the APR back to the country (and this may cause delays in the release of further HSS funds), or to recommend against the release of further HSS funds or only 50% of next tranche.
5. Please use additional space than that provided in this reporting template, as necessary.
6. Please attach all required supporting documents (see list of supporting documents on page 8 of this APR form).

Background to the 2010 HSS monitoring section

It has been noted by the previous monitoring Independent review committee, 2009 mid-term HSS evaluation and tracking study[4] that the monitoring of HSS investments is one of the weakest parts of the design.

All countries should note that the IRC will have difficulty in approving further trenches of funding for HSS without the following information:

- Completeness of this section and reporting on agreed indicators, as outlined in the approved M&E framework outlined in the proposal and approval letter;
- Demonstrating (with tangible evidence) strong links between activities, output, outcome and impact indicators;
- Evidence of approval and discussion by the in country coordination mechanism;
- Outline technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year
- Annual health sector reviews or Swap reports, where applicable and relevant
- Audit report of account to which the GAVI HSS funds are transferred to
- Financial statement of funds spent during the reporting year (2009)

5.1 *Information relating to this report*

5.1.1 Government fiscal year (cycle) runs from **1st January** to **31 December**.

[4] All available at http://www.gavialliance.org/performance/evaluation/index.php

5.1.2 This GAVI HSS report covers 2009 calendar year from **1st January** to **31 December.**

5.1.3 Duration of current National Health Plan is from **2007** to **2011 (in addition, the 25 year national strategic plan covers period from 2004-2027)**

5.1.4 Duration of the current immunisation cMYP is from **2006** to **2010**

5.1.5 Person(s) responsible for putting together this HSS report who can be contacted by the GAVI secretariat or by the IRC for possible clarifications:

[It is important for the IRC to understand key stages and actors involved in the process of putting the report together. For example: '*This report was prepared by the Planning Directorate of the Ministry of Health. It was then submitted to UNICEF and the WHO country offices for necessary verification of sources and review. Once their feedback had been acted upon the report was finally sent to the Health Sector Coordination Committee (or ICC, or equivalent) for final review and approval. Approval was obtained at the meeting of the HSCC on 10th March 2008. Minutes of the said meeting have been included as annex XX to this report.*']

Name	Organisation	Role played in report submission	Contact email and telephone number
Government focal point to contact for any programmatic clarifications:			
Nagla El Tigani El Fadil	Federal Ministry of Health	Preparation	Email: nagla114@ gmail.com Mobile: 00 (249) 0912234020
Focal point for any accounting of financial management clarifications:			
Ali Babikir Mohamed	Federal Ministry of Health	Preparation of financial statements	Email: alifmoh@gmail.com Mobile: 00 (249) 0912234020
Other partners and contacts who took part in putting this report together:			
Mustafa Salih Mustafa	Federal Ministry of Health	Preparation	Email: mustafa. ms@fmoh.gov.sd Mobile: 00 (249) 912163760
Amani Abdelmoniem	Federal Ministry of Health	Preparation ISS rept., Coordination & compilation with GAVI HSS	E.mail: amanisara2000@yahoo.com Mobile: 00 (249) 912218575

5.1.6 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 (especially financial information and indicators values) and, if so, how were these dealt with or resolved?

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

Main sources of information used:

Activity progress reports from different implementing bodies:

- WHO First Quarterly progress report- December 2009, Management Capacity building Component (Annex 4)
- IT progress report 2009, Planning software (Annex 5)
- WHO 4th Quarterly progress report, Health Financing Component (Annex 6)

- IT progress report, Health System Observatory December 2009 (Annex 7)
- M& E report 2010 (Annex 8a), Draft of M&E framework(Annex 8b), M&E work plan (Annex 8c)
- Civil Engineering Department report 2009 (Annex 9)
- Academy of Health Sciences annual progress report 2009 (Annex 10)
- EPI progress report 2009 (Annex11a), EPI-Details of monthly budgets sent to the states for outreach activities, Nov. & Dec. 09 (Annex11b), EPI-Details of monthly budget sent to each state for outreach activities, Nov-Dec 09 (Annex11c), EPI Federal Supervision cost Nov-Dec 09 (Annex11d)
- Report on supervisory visit to GAVIHSS target states (Annex 12)

Financial statements:

- SOE 2009 for Management Capacity Building Component, WHO, Country office, Sudan(Annex 13)
- SOE 2009 for Health Financing Component**,** WHO, Country office, Sudan (Annex 14)
- SOE 2009 for Academy of Health Sciences, Khartoum, Sudan (Annex 15)
- Detailed expenditure of HSS funds during the calendar year 2008 (Annex 16a), 2009 (Annex 16b), 2008-2009 (Annex 16c)
- Advance to WHO, Capacity building component 2008-2009 (Annex 17a), Advance to WHO, Financial Component (Annex b),Advance to Academy of Health Sciences (Annex c)

In addition documents produced by the Health Economics Department (GAVI/HSS Health Financing Component) in the FMOH were consulted for preparing this report:

5.1.7 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?

We did not experience any difficulties in putting together this report.

5.1.8 Health Sector Coordinating Committee (HSCC)

How many times did the HSCC meet in 2009? **The HSCC met only once on 11th May 2009 to discuss GAVI/HSS APR 2008 and update the members on the progress made.**

Please attach the minutes (**Annex 1a HSCC minutes MAY 09/ HSCC signatures page MAY 09**) from all the HSCC meetings held in 2009, including those of the meeting which discussed/endorsed this report. (**Annex 1 c, HSCC minutes MAY 2010/ Annex 1e, APR 2009 presentation HSCC).**

In addition to HSCC, the steering committee of the GAVI/HSS project has met 4 times and the minutes of 2 of these meetings are attached as Annex 2 (Annex 2a, Steering Committee minutes, July 2009/ Annex 2b, Steering Committee minutes, Dec.2009)

Latest Health Sector Review report is also attached **(Document...).**

A number of studies that will contribute to the overall health sector review are currently underway; and include – Sudan household health survey, 2010, national health accounts, public sector health expenditure review, assessment of free health care initiative, and review of the national health insurance fund. These studies are likely to be completed and reported by the end of 2010, and will provide a comprehensive review of the health sector in Sudan. However, a mapping of the primary health care facilities – an exercise partially supported through GAVI/HSS was undertaken during 2009 and the Arabic version of this report is attached as Annex 3.

5.2 Receipt and expenditure of HSS funds in the 2009 calendar year

Please complete the table 11 below for each year of your government's approved multi-year HSS programme.

Table 11: Receipt and expenditure of HSS funds

	2007	**2008**		**2009**		2010	2011	2012	2013	2014	2015
Original annual budgets (per the originally approved HSS proposal)		**3,063,620**		**3,144,806**		**3,228,143**	**3,313,689**	**3,401,503**			
Revised annual budgets (if revised by previous Annual Progress Reviews)											
Total funds received from GAVI during the calendar year		**3,063,620**		**0**		**0**					
Total expenditure during the calendar year		**1,291,528.06**		**1,680,900**							
Balance carried forward to next calendar year **(Income book)**		local account	361,597	**91,191.75**							
		Designated account	1,408,405								
		Advance for car insurance	**2,090**								
		Total	**1,772,092**								
Balance carried forward to next calendar year **(with GAVI/HSS recipients)**		**WHO** (Health Financing Component)	**161,794**	**WHO** (Health Financing Component	**406**						
		-	**-**	**WHO** (Management Capacity Building Component)	**18,981**						
		Academy of Health Sciences	**75,000**	**Academy of Health Sciences**	**250**						
		Total	**236,794**								
Total balance carried forward (Income book		**1,772,092 + 236,794**	**2,008,886**	**91,191.75 +**	**110,828,75 19,637,00**						

+ recipients)											
Amount of funding requested for future calendar year(s)				3,144,806		3,228,143	3,313,689	3,401,503			

Please note that figures for funds carried forward from 2008, income received in 2009, expenditure in 2009, and balance to be carried forward to 2010 should match figures presented in the financial statement for HSS that should be attached to this APR.

Please provide comments on any programmatic or financial issues that have arisen from delayed disbursements of GAVI HSS *(For example, has the country had to delay key areas of its health programme due to fund delays or have other budget lines needed to be used whilst waiting for GAVI HSS disbursement)*:

The funds for 2009 have not yet been received. This delay has hampered the progress on the activities planned, as detailed below:

- Activities planned for 2009 could not be implemented as scheduled. We had begun implementing some of these activities in 2008, for better performance, postponing others originally planned for the first year. This created further delay in implementation of those activities originally planned for 2008. For this reason other budget lines had to be used for those activities that had been implemented ahead of schedule.
- Contracts with WHO and Academy of Health Sciences were for a period beyond 2008-2009, therefore funds for 2008 tranche needed to be reserved for these activities since they are aligned with other similar ongoing initiatives at the Federal Ministry of Health, targeting the same interventions. This obligation against these contracts led to the delay in implementation of some of the activities planned for 2008-2009.
- We were unable to pay the two contracted firms the full cost of rehabilitation of the two targeted academies of health sciences in Sinnar State and Neyal City.
- State officials seemed to lose faith in the funds from GAVI/HSS support since we were unable to keep our promises which formed the bases for some of their plans.
- Health facilities selected for civil works may need reassessment as it has been a while since they were last assessed. Accordingly, cost estimates might have changed with time.
- Efforts done in the form of availing medical supplies and drugs to selected health facilities in the four GAVI/HSS target states to increase the utilization of MCH services have to be discontinued due to fund delays. As a result it will be difficult to assess the impact of this intervention through an operational research.
- A number of activities planned under GAVI/HSS grant are complimentary to activities planned from other funding sources, including the government. Non-availability of GAVI/HSS funds led to the activities planned from other sources to be also affected.
-

5.3 *Report on HSS activities in 2009 reporting year*

Note on Table 12 below: *This section should report according to the original activities featuring in the HSS application. 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. It is very important that the country provides details based on the M& E framework in the original application and approval letter.*

Please do mention whenever relevant the **SOURCES** of information used to report on each activity.

Table 12: HSS activities in the 2009 reporting year

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	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	100%	
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			
Sub-component 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	25%	Execution of management capacity building component of GAVI/HSS commenced in 2009 instead of 2008. WHO through an agreement (14 May 2009 -31 December, 2010) with Federal Ministry of Health,

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

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Activity 1.1.2	Train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings		Government of National Unity, Sudan is assisting in implementing this component of GAVI/HSS @ USD 202,722.to cover activities 1.1.1, 1.1.2, 1.1.3 and 1.1.4 as below: 1.Undertake assessment of health system capacity at state and locality level using/adopting WHO framework for leadership and management for better health 2. Develop protocols, i.e. membership, their organizational affiliation, and definition of roles and responsibilities of health management teams at state and locality levels 3. Design training material, informed by the finding of the assessment, for training the state and locality health management teams 4. Conduct first round of training in a local institute (Public Health Institute), and part of this exercise to build its institutional capacity to conduct such courses. While a report submitted by WHO Sudan detailing the progress on the above activities is attached (Annex 4), briefly short term TA was availed to develop protocols for the management study and to train the team in qualitative research methods, as the study mainly uses this type of research. Following that data on health systems capacity, including the training needs of health managers has been collected, and a consultant is scheduled by the end of May, 2010 to visit Sudan and conduct analysis. Once the report is available, it is planned that a university will be contracted to undertake this assignment for developing training material and training of the staff.
Activity 1.1.3:	TA for undertaking training needs assessment of public health managers both at state and locality level		
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)		
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).	100% (2008-2009)	Purchased items in 2008 were to cover for activity planned for 2008-2009. These were distributed to the states during the first quarter of 2009.

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Activity 1.1.6:	Improve work environment and provide key office equipment for 20 districts (PCs=2, faxes 1, printers=1)	100% (2008-2009)	Activity planned for 2008, but items were only purchased then. They were distributed to the states during the first quarter of 2009.
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% (2008-2009)	Activity planned for 2008, but items were only purchased then. They were distributed to the states during the first quarter of 2009.
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	0%	This activity planned to be undertaken in 2008, but was carried over to 2009. The idea was to implement it together with activity 1.1.10 through a joint TA. However, with funds delayed, this activity could not be implemented.
Activity 1.1.10:	Train admin and financial staff in 11 northern states on budgeting and financial and resources management.	0%	**As above - the activity was planned for 2009, but not implemented due to delay in funding.**
Sub-component 1.2: **Health Planning**			
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	A planning software for the three levels of governance designed.	Despite there were no funds, given the importance and urgency, activity was embarked upon using Federal Ministry of Health resources. The designing of an electronic system to follow up plans for the three levels of governance (Planning Software) began in 2009 as planned. The idea is to develop standardized planning methods and reporting formats at all levels as well as establishing a system that would serve as an institutional memory for health planning in the Sudan. The program was designed by national staff and uses Visual Basic.net 2005 which enables users to access the system via the Internet from within the ministries of health, federal and state or from abroad.

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			The program was designed and implemented in stages. It was tested at the federal level, discussed at monthly meetings and all comments collected by M&E coordinators in the form of Monthly Reports addressed. Furthermore. The program was discussed with the Planning Directors at state level and their comments were also taken into consideration. Annex 5:, IT progress report 2009, Planning software 2009
Activity 1.2.2:	Provide copies of the planning and instructional manual to 11 SMOH and 20 Localities Management Teams	-A draft of planning and instructional manual produced	Planned for 2009, but not implemented fully due to funding constraints, and is linked to the above activity (1.2.1.) Yet, a first draft of the planning and instructional manual was produced by a taskforce from the Planning Directorate at FMOH supported by WHO consultant. However, this manual needs finalisation, before it is printed and disseminated to all states.
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;	0%	Planned for 2009, but not implemented due to fund delays
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;	0%	Planned for 2009, but not implemented due to fund delays
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	0%	Planned for 2009, but not implemented due to fund delays
Activity 1.2.6:	Provide PC (1), fax (1), printer (1), photocopier (1), to the Directorates of Health Planning in 11 states	100%	Originally planned for 2009, but implemented ahead of schedule in 2008 together with activities 1.1.5, 1.1.6, 1.1.7 & 2.2.3 and 2.2.3 in one tender. Activity was reported in 2008 APR. The IT and other equipment were distributed at the Annual Planning

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			meeting on 5th Feb, 2009.
Objective 2:			
Sub-component 1.3: **Health Financing**			
Activity 1.3.1:	Conduct household expenditure and health services utilization research in 11 northern states	Fieldwork for Household and KAP Survey and the Mapping of financing agents and major health service providers conducted	A contract has been signed with WHO country office in Sudan to assist in implementing activities: 1.3.1, 1.3.2, 1.3.3, and 1.3.4. A detailed report on the progress is attached at Annex 3. Briefly, however, it is as below: 1.3.1: The household health expenditure and utilisation of services has been completed and the data is ready for analysis. 1.3.3: In addition to NHA, a number of complementary studies, like review of the national health insurance fund, public health expenditure review, assessment of the free health care initiative are still ongoing. Therefore, activity 1.3.3 or policy on health financing will be developed after their results are available. 1.3.4: In order to develop a comprehensive plan for PHC a KAP study has been conducted and results are available. In order to accomplish the 1.3.4 activity, an international consultant along side a local consultant is being engaged to work on the plan. 1.3.2: This activity could not be implemented due to funding constraint, as WHO was not paid the instalment, against the contract. Furthermore, it was decided in the project that instead of two candidates going abroad for training at master/diploma level (and for that the funds allocated for that purpose are inadequate) candidates from the states – one from each of the 15 states – will be supported to complete their diploma in health economics from the university of Khartoum. Students have been selected and they were admitted by the university; and their fellowship application is being processed. Annex 6: WHO report, Health Financing Component, 4th Quarterly
Activity 1.3.2:	Train 2 senior staff of Health Economic Unit in health economics/financing at Master/Diploma level		
Activity 1.3.3:	Provide TA for developing/adapting pro-poor, comprehensive and sustainable health financing policy in 11 Northern states		
Activity: 1.3.4	Provide TA for developing PHC services and immunization sustainability plans for national level and 11 Northern states		

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			progress report
Sub-component 1.4: Health Information system			
Activity 1.4.1:	TA to support designing of a community based health information system	0%	Planned for 2009, but not implemented due to funding delays.
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%	Planned for 2009, but not implemented due to the funding delays.
Activity 1.4.3:	Design and establish a comprehensive integrated information base at national and state level (in 11 states)	0%	Planned for 2009, but not implemented, due to funding constraints; and is planned for implementation together with National HRH Observatory.
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.	55% functioning links	Planned for 2009, but was implemented partially with resources from the government, as below: A number of tasks under this activity have been carried out in a bid to develop health system observatory. Accordingly, the upcoming observatory will have 11 main links, out of which the following six have been supplied with relevant data, at the address: http://www.fmoh.gov.sd/sho/ Links supplied with data: 1) Mapping of Health Facilities (Baseline survey)- available in the form of Table & chart report 2) Sudan Household Health Survey - available as GIS but only as a static image. Will be available as a chart report. 3) Human Resources for Health Observatory 4) EMRO Observatory 5) Health Sector Policies 6) Annual Statistical reports – (2004- 2007) Links not supplied with data: 1) State Profile

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			2) Mortality and Morbidity Indicators 3) Health System Studies 4) National Programmes (FMOH) 5) Health System Support (GAVI/HSS, DHSDP) Annex 7: IT progress report, Health System Observatory December 2009
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	50%	This activity was planned to be undertaken in 2008, but was rescheduled for implementation in 2009 to align with the complimentary interventions under the Decentralized Health System Development Project (DHSDP). The project includes 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 in the context of Decentralized health system. Thus the release of budget allocated for technical assistance (Activity 1.4.5) was reserved for supporting the implementation at state level (activity 1.4.6) that was planned to commence in August 2009 but has to be postponed due to the delays in receipt of funds. As a continuation of the efforts done in 2008 by the technical assistant supported by DHSDP, National Strategies for the Monitoring and Evaluation were adopted. A task Force was set up in the Monitoring and Evaluation Directorate, and that has designed a National Monitoring and Evaluation Framework. The need for a national framework has been recognized to support the national strategy implementation at different levels as part of the health system reform toward informed policy making process. The M&E consultant supported by DHSDP worked for 3-weeks during February -March 2010 with M&E Directorate, and the following two main sub-activities under activity 1.4.6 were accomplished. ▪ Designing and endorsement of the National M&E Framework document ▪ Participatory planning exercise for designing the FMoH M&E Action Plan

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			Accordingly a sum of 20,000 USD out of the allocated budget for activity 1.4.6 was released in Dec 2009 to support implementation. The report is attached as Annex 8(a).
Activity 1.4.6:	Support to establish comprehensive monitoring and evaluation system in all 15 Northern states.	20%	As explained above, the M&E framework at the national level has been drafted and is attached as Annex 8(b). With the receipt of funds, it will be adapted to the state M&E framework. M&E action plan is also attached as Annex 8(c).
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			
Sub-component 2.1: **Human resources for health**			
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%	Implementation planned to commence in 2008, but in order to align it with input from MDTF supported DHSDP project it was postponed to 2009. However, due to the funding constraints, it could not be completed.
Activity 2.1.2:	Institute innovative approaches like financial and non-financial incentives as operational research for improving the retention of health staff	0%	Implementation of this activity was planned to commence in 2009, but could not be started due to the delay in the receipt of funds.
Sub-component 2.2 Human resources for health			

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Activity 2.2.1:	rehabilitate 2 Academy of Health Sciences in 2 SMOH	100% (2008-2009)	The implementation of this activity started in 2008 with calling open competitive bidding. After selection, two firm contracts were signed on 25/01/09 to rehabilitate the two branches of the academy of health sciences in Sinnar state (involving the rehabilitation of its two sites: Sinnar city and Singa city) and Naylaa city. Nayala, which is in South Darfur, was selected instead of the GAVI/HSS target states, because in three (other than Sinnar) of the four targeted GAVI HSS states the AHS have recently been rehabilitated by the government. Nonetheless, in addition to that Darfur is priority on account of area in conflict, there is a great need for PHC workers in this state. Report from the Engineering Department is attached as **Annex 9 (Civil Engineering Department report 2009).** This provides detail of the work done, but briefly it is explained below: Sinnar state academy has two sites: Sinnar city and Singa city: *AHS in Sinnar city*: Rehabilitation of the AHS in Sinnar City included the following: ▪ Rehabilitation of all existing buildings (lecture halls and offices) in the form of repair of roof and floor works, painting, electrical works. ▪ Rehabilitation of AHS fence ▪ Construction of septic tank and a well *AHS in Singa City:* Rehabilitation of the AHS in Singa City included the following: ▪ Rehabilitation of the existing buildings (a lecture hall and an office) in the form of repair of roof and floor works, painting, electrical works. ▪ Rehabilitation of AHS fence ▪ Construction of a new skills lab and an office for the Dean

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			▪ Construction of four new bathrooms Nyala AHS in South Darfur state: Rehabilitation of the AHS in Nyala City included the following: ▪ Rehabilitation of all existing buildings in the form of roof and floor works, painting, electrical works. ▪ Rehabilitation of AHS landscape and construction of interlocking paving tiles ▪ New construction of a kitchen and ablution place The rehabilitation of both academies was completed by 25/08/09. However, the actual cost of rehabilitation exceeded the allocated budget of $100,000 by 6,466.56 USD, which necessitated shifting of funds from other budget lines. There still remains a 5% of the cost of rehabilitation to be paid as a guarantee to the two contracted firms, one year after completion of the sites. Annex 9, Civil Engineering Department report 2009
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	100%	
Activity 2.2.3:	Provide PCs (1), faxes (1), printers (1), to Directorates of Health Human Resource in 11 SMOH	100% (2008 -2009)	
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;	30%	A contract was signed with National Academy of Health Sciences for undertaking a set of activities: 2.2.5, 2.2.6, and 2.2.7. According to plan, activity began in 2008 when the implementation level was about 50%. In 2009 additional 30% of the activity was implemented in continuation to the previous efforts done in 2008. While details are available in Annexure 10, briefly the following was accomplished: 2.2.4: The curricula for the following paramedic cadres was reviewed,

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			up-dated/developed: ▪ The Medical assistant curricula (both for upgrading the existing and Diploma level) ▪ The Community health worker curriculum. ▪ The Midwifery curricula (Diploma and BSc). These curricula have been accredited and approved and only require designing and printing. Training of teachers on the new curricula (which is 20% of activity) remains to be conducted. Annex 10,The academy of health sciences, annual report for the second year of the contract (Jan – December 2009)
Activity 2.2.5:	Provide tuition fees in every academic year (2008-12) to 40-45 students of different categories in AHSs in the 7 SMOH (300 annually).	0%	This activity was part of the agreement with national academy of health sciences (see above). 75% of activity was accomplished in 2008, because then not all targeted academies were operational. But, with the operationalising of the remaining academies and the admission of students in 2009 the implementation improved. In 2009 the same process of advertising for application and interviewing of students in AHS in the 7 targeted states was done as in the previous year. This process was guided by the students' selection criteria developed in 2008. The relevant AHS were contacted and arrangements made for the acceptance of the second batch, and eligible students were selected for supporting them with tuition fee. However since the funds did not come for 2009, students were not paid for. Annex 10: The academy of health sciences, annual report for second year of the contract (January – December 2009)
Activity 2.2.6:	Support to institutionalize Continuing Professional Development programs	20%	In 2008, 40% of the activity was implemented, and during 2009 the work advanced on this activity. While details are available in

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
	as a pilot in four AHSs (Khartoum, Gezira, White Nile, and Gadarif)		Annexure 10, briefly it is reported as below: A national consultant was hired to consolidate different documents developed about CPD in order to facilitate the development of a National CPD Policy. The consultant drafted a document, which was discussed at the level of steering committee and then a grand workshop involving broader stakeholders was held at CPD Centre-Khartoum. The comments received were added to the document, which is now ready for presentation and final approval by the higher authorities at the FMOH. The Staff Development Framework for the Teaching faculty /staff at the Academy of Health Sciences was finalized and approved by the AHS. A national consultant was hired to conduct Training Needs Assessment of PHC workers, focussing at their skill necessary for the provision of essential services such as immunisation, child and maternal care in the four targeted states with the following TOR: ▪ Identify key stakeholders and set the objectives and determine the benefits for the stakeholders. ▪ Identify and select the best and suitable methodology to be adopted to conduct the TNA and develop an action plan. ▪ Conduct the TNA and identify the priority programs and categories and determine best intervention/training approach to be followed. ▪ Develop the training materials for the training of the tutors (TOT) for PHC workers. ▪ Develop the training materials that will be used for training the PHC workers according to the TNA. ▪ Develop and submit a final report of the TNA. The first drafts of the proposed in-service training programs for the PHC workers was developed, and the final report for the TNA from

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			the consultant is expected to be received soon . .Annex 10: The academy of health sciences, annual report for second year of the contract (January – December 2009)
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	0%	This activity depends on finalizing the above activity 2.2.6, which has been partially completed, but funds are not available to proceed with this activity, Annex 10: The academy of health sciences, annual report for second year of the contract (January – December 2009)
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)	0%	Activity not implemented due to fund delays
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%	Financial support of 200,000 $ was provided to EPI to support outreach services in 15 northern states during Nov-Dec 2009, to contribute in increasing routine coverage by the end of 2009 to reach 93% for the 3rd dose of pent-valent vaccine nationwide. This support beside the financial support from WHO and UNICEF helped in achieving the following: - Achievement of 91.1% Penta3 coverage nationally

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			- 82% districts achieved above 80% Penta3 coverage In addition Funds were used to support outreach services and supervisory visits to 3 of the four GAVI/HSS target states(N.Kordofan, Gadarif & Sinnar) in addition to 3 other states (S.Kordofan, Kassala, Red Sea) Annex 11(a),EPI Progress report 2009
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.			
Sub-component 4.1: PHC infrastructure network and equipments			
Activity 4.1.1:	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%	Only 20% of activity was conducted in 2008 together with activity 6.1 (see below). But, could not be completed due to the delay in receipt of funds.
Activity 4.1.2:	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)	0%	Following a study on mapping of health facilities conducted in 2008, the sites were selected for rehabilitation in the four GAVI/HSS target states. In March 2009 an assessment of the selected health facilities was conducted. Bill of quantities and cost estimates were then determined. According to estimates, the cost of rehabilitation of one rural hospital was 800,000 USD which is equivalent to the total budget provided by the project for the rehabilitation of one rural hospital annually for 4 consecutive years. Therefore, given the allocation in the proposal, only one rural hospital in one of the four GAVI target states can be rehabilitated with the total allocated

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
			amount. However, rehabilitation of the rural hospital will commence upon arrival of funds.
Activity 4.1.3:	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)		As above for 4.1.2
Activity 4.1.4:	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)		As above for 4.1.2
Activity: 4.1:5	Provide essential equipment and furniture (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)	0%	The procurement process for equipment and medical supplies for delivery rooms, minor and major operation theatres to support eight rural hospitals was completed and was delivered on 8 Feb 2009 to State ministries in an official ceremony at the Federal Ministry of health attended by high officials from both national and State levels. However, the procurements against the allocation for 2009 could not be made due to funds delay.
Activity: 4.1:6	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)	0%	As above for 4.1.5
Activity 4.1.7:	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)	0%	As above for 4.1.5

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
Sub-component 4.2: 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	0%	The process for the procurement under this activity was accomplished. A list of medicines for MCH services was prepared by GAVI Management Unit in collaboration with relevant directorates and state planning directors reflecting the need at state level for the four GAVI/HSS target states. The above was done simultaneously with activities 3.1.2, 3.1.3, and 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 during 2009. Criteria for distribution of these items were developed, with priority given to most needy areas for the distribution of drugs. But, the procurement against the allocation for 2009 was not implemented due to funding delays.
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		As above for 4.2.1
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%	Activity was not implemented due to the delay in the receipt of funds.

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
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.	0%	Activity was not implemented due to the delay in the receipt of funds.
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)	0%	Planned for 2009, but not implemented due to fund delay.
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%	Planned for 2008, pending completion of other activities.
Sub-component 4.3: Social mobilization			
Activity 4.3.1:	Design documentaries and advocacy material	0%	Planned for 2008. Activity delayed, depending on results of KAP study. However, KAP study (activity 4.3.4) has been conducted and data is being analyzed. The results of this study will feed into the designing of the documentaries and advocacy material.
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%	As above; and is an activity subsequent to the completion of 4.3.1
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	0%	This activity is complimentary to input from MDTF supported DHSD project. Alongside the KAP study a health services utilization and expenditure has been conducted, and the data is now ready for analysis. In addition, public sector expenditure review and

Major Activities	Planned Activity for 2009	Report on progress5 (% achievement)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
	these subsides on the demand for services).		assessment of the government's free health care initiative is being conducted. The results of these studies will be available in the third quarter of 2010 and will lead to defining the subsidized PHC package. In order to support this activity a researcher was hired by the WHO.
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.	100% (2008-2009)	This activity, although planned for 2010 was implemented during 2008-9 to take the benefit of field work being done for another survey. The KAP study was integrated with that of the household study; and the questionnaire of KAP study was also integrated into the larger household questionnaire.
Sub-component 5: Management of 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%	In August 2009 a team was sent on a mission to the GAVI/HSS target States. The following activities were conducted: ▪ Advocacy for GAVI/HSS at SMOH in the four target states ▪ Establishment of a distribution system for free drugs and medical supplies for MCH services provided by GAVI/HSS ▪ Audit and labelling with stickers, free drugs and other GAVI/HSS fixed assets, namely IT equipment ▪ Follow up on the rehabilitation of The Academy of Health Sciences in Sinnar State Total expenditure for the mission = 5,993 SDG (2,598 USD) Annex 12, Report on supervisory visit to GAVI/HSS target states Remaining funds from the allocation under this activity were used for implementing other activities
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%	Not implemented due to the funds not received.

5.4 *Support functions*

*This 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?*

5.4.1 Management

Outline how management of GAVI HSS funds has been supported in the reporting year and any changes to management processes in the coming year:

While there is a GAVI/HSS Management Unit, headed by a manager, for transacting day-to-day business for a number of sets of activities, other partners have been involved. These include WHO, Academy of Health Sciences and EPI. In addition, GAVI/HSS Management Unit works with Ministry of Health departments, e.g. monitoring and evaluation, IT department, engineering department in the implementation of activities. The Assistant Undersecretary for Health Planning, Policy and Research oversees the management of GAVI/HSS activities, and a Steering Committee, comprising all stakeholders, guides and facilitates the implementation process. The HSCC is a top level body responsible for approving the plans and reports, financial as well as technical, of GAVI/HSS.

In the target states, the state directorates of health planning are the hub of GAVI/HSS activities. Such directorates also house the health economist and health system research offers, which are now in place in all 15 northern states of Sudan. However the major problem has been the brain drain; and to tackle this and to strengthen capacity, one candidate from each of the 15 northern states have been selected to undergo diploma in health economics and health systems research in Khartoum university. The tuition fees and stipend to these candidates will be paid out of funds advanced to WHO for training two health economists at diploma/masters level.

GAVI/HSS (NS) does not have a separate account for foreign currency. Therefore, funds from GAVI secretariat are received and deposited into The International Health Directorate's bank account, which is a governmental account supervised by the Administrative Department, Ministry of Health. GAVI/HSS NS has a bank account in local currency. Thus, funds received in foreign currency in the account of the International Health Directorate are then transferred to the GAVI/HSS local currency account.

Funds received through GAVI/HSS support are managed by an account manager, following the government procedures laid down by the Ministry of Finance and National Economy. The funds from GAVI monies are disbursed by the account manager to eligible recipients/contractors against approved activities for GAVI/HSS support. Regular financial reports are prepared by the account manager for presenting to the HSCC. For procurement of civil works and goods and material from GAVI/HSS funds, government procedures are used and transparent competitive bidding is assured.

We are in the process of opening a separate foreign currency bank account for GAVI/HSS monies that would allow better control and smoother transfer of funds from GAVI secretariat. In addition to that, the accounting and audit of GAVI funds, which currently is a long process, would have been easy. But, given the government regulations it is a long process and protracted process to open a foreign currency account. Yet we are nearly done and the account will soon be operational.

5.4.2 Monitoring and Evaluation (M&E)

Outline any inputs that were required for supporting M&E activities in the reporting year and also any support that may be required in the coming reporting year to strengthen national capacity to monitor GAVI HSS investments:

Support from GAVI/HSS for strengthening M&E was planned in 2008. But this activity was carried forward and rescheduled for implementation in 2009 to align with and complement the ongoing work of the Multi-donor Trust Fund supported Decentralized Health System Development Project.

This project, in addition to other inputs, envisages strengthening the M&E system by providing technical assistant to design a comprehensive national M&E system in the context of decentralized health system. Thus the release of budget allocated for technical assistance under activity 1.4.5 was reserved for supporting implementation at the state level activity (1.4.6) that was planned to commence in August 2009, but was

postponed due to the delays in receipt of funds.

However, as a continuation of inputs through Decentralized Health System Development Project, the National Strategies for Monitoring and Evaluation were developed. One of the strategies, being the designing of a National Monitoring and Evaluation Framework for adoption at all levels of the health system. In order to design this framework, a task force was set up in the Monitoring and Evaluation Directorate. This task force was supported by an international consultant who was hired for 3-weeks through support from Decentralized Health System Development Project. As a result, a National M&E Framework has been designed and endorsed. In addition, through a participatory planning exercise an action plan has also been prepared for setting up monitoring and evaluation system at different levels of the health system in Sudan.

In addition, despite the unavailability of funds a number of activities have been carried out for developing a health system observatory. This upcoming observatory, which is currently online at the following address: **http://www.fmoh.gov.sd/sho/,** has 11 main links, out of which the below six links have been supplied with relevant data.

Links supplied with data:

1. Mapping of health facilities (baseline survey)- available in the form of table & chart report
2. Sudan household health survey - available as GIS but only as a static image. But, it will also be available as a chart report.
3. Human resources for health observatory
4. EMRO observatory
5. Health sector policies
6. Annual statistical reports – (2004- 2007)

Links that are not supplied with data, include: State profile; Mortality and morbidity indicators; Health system studies; National programmes (FMOH); Health system support (GAVI/HSS, DHSDP)

5.4.3 Technical Support

Outline what technical support needs may be required to support either programmatic implementation or M&E. This should emphasize the use of partners as well as sustainable options for use of national institutes:

During 2008 and 2009, technical support has mainly been geared through WHO for implementing GAVI/HSS activities. Also technical support was organized from the Faculty of Health Economics, University of Khartoum for the mapping of financing agents and major providers of health services.

In addition, Federal Bureau of Statistics was partner in undertaking household health expenditure and health services utilization survey. Both these activities were aimed to develop national health accounts, and were key in building the capacity of these national institutions. Furthermore, different activities for developing national health accounts were conducted in partnership with the Health Economics Department, Ministry of Health and Directorates of Health Planning, SMOH in the 15 northern states. This approach led to building their capacity and institutionalization of the health accounts.

Likewise, National Academy of Health Sciences was contracted to design curricula and implement part of the GAVI/HSS grant. This helped in building the capacity and confidence of the academy. This arrangement will continue, but technical assistance will be sought from the universities and institutions abroad for designing curricula/training of health managers etc.

Note on Table 13: This table should provide up to date information on work taking place during the calendar year during which this report has been submitted (i.e. 2010).

The column on planned expenditure in the 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 application. Any significant differences (15% or higher) between previous and present "planned expenditure" should be explained in the last column on the right, documenting when the changes have been endorsed by the HSCC. Any discrepancies between the originally approved application activities / objectives and the planned current implementation plan should also be explained here

Table 13: Planned HSS Activities for 2010

(Since funds to support the implementation of most activities planned for 2009 were not received, these activities have been carried over to 2010; and are planned for implementation during 2010. However, this arrangement also entails in certain activities planned for 2010 will be carried over to 2011. Accordingly, this table (13) reflects this reprogramming of activities.

Major Activities	Planned Activities for 2009 (Not implemented due to funding delay)	Original budget for 2009 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Planned Activity for 2010	Original budget for 2010 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	2010 actual expenditure as at 30 April 2010	Explanation of differences in activities and budgets from originally approved 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	0	
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						
Sub-component 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	Short and long term TA to assist in building the capacity of 15 northern states and 20 localities	45,000	0	Activities 1.1.1, 1.1.2, 1.1.3, 1.1.4 contracted to WHO. A. Total project cost = $202,722 B. Advance received in 2009 = $92,400 C. Expenditure as of 31 Dec, 2009 = $73,419 D. Balance (B - C) carried forward to 2010 = $18,918 Annex 13:SOE
Activity 1.1.2:	Train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings	45,000	Train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings	45,000	0	
Activity 1.1.3:	TA for undertaking training needs assessment of public health managers both at state and locality level	60,000	-	-		
Activity 1.1.4:	Train senior and mid-level health managers in all 11 northern states and 20 localities	50,000	Train senior and mid-level health managers in all 11 northern states and 20 localities on short courses/on-job capacity	50,000	0	

	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)		building programme on health planning, district health management, leadership (11 states*4 each = 44) (20 localities * 3 each =60)			2009 for Management Capacity Building Component, WHO, Country office, Sudan
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	Allocated funds for implementation of activity in 2009 were spent for implementing other activities.
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	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	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	0	Activities carried over from 2008 & 2009 (Allocated funds for implementation of activity in 2008 were spent for implementing other activities.)
Activity 1.1.10:	Train admin and financial staff in 11 northern states on	30,000	Train admin and financial staff in 11 northern states on budgeting and financial and	30,000	0	

	budgeting and financial and resources management.		resources management.			
Sub-component1.2: 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	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	Only preparatory phase was done in 2009, using Federal Ministry of Health resources
Activity 1.2.2:	Provide copies of the planning and instructional manual to 11 SMOH and 20 Localities Management Teams	10,000	-	-	0	
Activity 1.2.3:	Pevelop a system for short course/on-job capacity building programme (2-3 weeks duration) on planning of health system recovery	60,000	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	0	

	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	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	
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	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	
Sub-component 1.3: Health financing						
Activity 1.3.1:	Conduct household expenditure and health services utilization research in 11 northern states	350,000	-	-	0	Together with activities 1.3.1& 4.3.4, contracted to WHO A. Total project cost = $734,737 B. Balance carried
Activity 1.3.2:	Train 2 senior staff of Health Economic Unit in health	50,000	Train 2 senior staff of Health Economic Unit in health economics/financing at Master/Diploma level	50,000	0	

	economics/financing at Master/Diploma level					forward from 2008 = 161,794 USD C. Advance received (2009) = 200,000 USD D. Expenditure 01 January, 2009 till December, 2009 = 361,388 USD Balance (B+C) – D = (406 USD) Annex 14: SOE 2009 for Health Financing Component, WHO, Country office, Sudan The cost of data collection was underestimated by 125,210 USD i.e vis-a vis the allocation of 330,000 USD. The actual amount
Activity 1.3.3:	Provide TA for developing/adapting pro-poor, comprehensive and sustainable health financing policy in 11 Northern states	60,000	-	-	0	
Activity: 1.3.4	Provide TA for developing PHC services and immunization sustainability plans for national level and 11 Northern states	60,000	-	-	0	

						calculated in the contract was: 373,560 USD (for Household Health expenditure survey) plus 81,650 USD for mapping of Financing Agents, amounting to 455,210 USD. In **addition** the program cost support for WHO which is 84,521 USD.
Sub-component 1.4: Health Information system						
Activity 1.4.1:	TA to support designing of a community based health information system	60,000	-	-	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	0	
Activity 1.4.3:	Design and establish a comprehensive integrated information base at national and state level (in 11 states)	60,000	-	-	0	
Activity 1.4.4:	Develop a health system	60,000	-	-	0	Only preparatory

	observatory that could provide output using GIS and set up mechanisms for the regular updating of health system profile.					phase was done in 2009, using Federal Ministry of Health resources with no cost charged to GAVI/HSS.
Activity 1.4.5:	Provide TA for designing a comprehensive monitoring and sevaluation system, both for national and state level, for the decentralized health system	60,000	-	-	0	Activity carried over from 2008
Activity 1.4.6:	Support to establish comprehensive monitoring and evaluation system in all 15 Northern states.	55,000	-	-	0	Activity carried over from 2008. A sum of 20,000 USD from the allocated budget for this activity was released in Dec 2009 to support implementation. Annex 8a: M&E report 2010
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						

Sub-component 2.1: Human resources for health systems						
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	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	0	Activities carried over from 2008 & 2009
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	Institute innovative approaches like financial and non-financial incentives as operational research for improving the retention of health staff	45,000	0	
Sub-component 2.2: Human resources for health systems						
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;	30,000	-	-	0	Activities 2.2.4, 2.2.5, 2.2.6, 2.2.7, are contracted to the Academy of Health Sciences and are implemented as one package over 5 years, for a sum of 1,610,000 USD.

						A. Balance carried forward from 2008 = 75,000 USD B. Advance received in 2009 = 90000 USD C. Expenditure as of Dec,2009 = 164760 USD D. Balance carried forward to 2010 = 240 USD 30% of activity 2.2.4 was implemented in 2009 Annex 15:SOE 2009 for Academy of Health Sciences, Khartoum, Sudan-
Activity 2.2.5:	Provide tuition fees in every academic year (2009-12), to 40 students of different categories in AHSs in the 7	210,000	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	0	Only preparatory phase (selection of students) was implemented in 2009

	SMOH (300 annually).					
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	Support to institutionalize Continuing Professional Development programmes as a pilot in four AHSs (Khartoum, Gezira, White Nile, and Gadarif)	40,000	0	Only 20% of activity was implemented in 2009
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	90,000	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	90,000	0	Activity planned for 2010 is carried over to 2011
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	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	
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	In 2009, EPI was provided 200,000 USDFunds were used to support outreach services and supervisory visits to 3 of the four GAVI/HSS target states(N.Kordofan, Gadarif & Sinnar) in addition to 3 other states (S.Kordofan, Kassala, Red Sea) Annex 11:EPI progress report 2009
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.						
Sub-component 4.1: PHC infrastructure network and equipments						
Activity 4.1.1:	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)	60,000	-	-	0	Activity carried over from 2008. Only 20% of activity was conducted then, in combination with activity 6.1: Conduct baseline survey of health facilities
Activity 4.1.2:	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	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	
Activity 4.1.3:	Rehabilitate/upgrade 3 dispensaries/Primary Healthcare Units annually in each of the four states (White Nile, North Kordafan, Sinnar and Gadarif) according to	120,000	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	

	standards (3 HF * 4 states * 2 years = 24 + 6* facilities *4 state*2= 48 in 3 and 4)					
Activity 4.1.4:	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	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	
Activity: 4.1:5	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	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	
Activity: 4.1:6	Provide essential equipment and furniture (according to standards) for 3 dispensaries/PHCUs in each of the four states (White Nile, North Kordafan, Sinnar	24,000	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	

	and Gadarif) (3 facilities * 4 states * 5 years = 60)					
Activity 4.1.7:	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	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	
Sub-component 4.2: 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	120,000	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	120,000	0	

	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		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	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	
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	48,000	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	0	Activity planned for 2010 is carried over to 2011.

	targeted four states (4 Rural Hospitals * 4 states * 5 years = 80) * 250 US$ each facility					
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	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	0	Activity planned for 2010 is carried over to 2011.
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	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	0	
Activity 4.2.6:	Provide HMIS printed supplies for providing to 100 PHC facilities in each of the four states (White Nile, North Kordafan,	20,000	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$	20,000	0	Activity planned for 2010 is carried over to 2011.

	Sinnar and Gadarif) (100 facilities * 4 states * 5 years) * 50 US$ annually for each facility		annually for each facility			
Sub-component 4.3: Social mobilization						
Activity 4.3.1:	Design documentaries and advocacy material	10,000	-	-	0	Activity carried over from 2008 and is dependent on activity 4.3.4
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	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	0	Activity planned for 2010 is carried over to 2011. Dependent on the completion of activity 4.3.1
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	

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				
Sub-component 5: Management of 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	50,000	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	60,000	Support the DGHP&D in the 4 SMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support	60,000	0	
Cost		3,434,000		3,279,000		
TOTAL COSTS	**6,713,000**					

Table 14: Planned HSS Activities for next year (ie. 2011 FY)

(This table contains activities that were not implemented in 2008 and 2009 and are as a result are carried over from 2010 to 2011)

This information will help GAVI's financial planning commitments

Major Activities	Activity carried over from 2010	Original budget for 2010(as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Planned Activity for 2011	Original budget for 2011 (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	Revised budget for 2011 (proposed)	Explanation f differences in activities and budgets from originally approved 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		
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						
Sub-component 1.1: Management and organization						
Activity 1.1.1:	-	-	Short and long term TA to assist in building the capacity of 15 northern states	45,000		

			and 20 localities			
Activity 1.1.2:	-	-	Train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings	45,000		
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		
Subcomponent 1.4: Health Information system						
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		
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	60,000		

			profile.			
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						
2.2: Develop health human resources systems and policies						
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		
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	90,000	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	90,000		Activity carried over from 2010 to 2011

	localities/districts * 20 PHC workers= 320 annually * 5 years					
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		
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		
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.						
Sub-component 4.1: PHC infrastructure network and equipments						
Activity 4.1.2:	-	-	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		
Activity 4.1.3:	-	-	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)	240,000		
Activity 4.1.4:	-	-	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)	240,000		

Activity: 4.1:5	-	-	Rrovide 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)	360,000		
Activity: 4.1:6	-	-	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)	72,000		
Activity 4.1.7:	-	-	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)	240,000		
Sub-component 4.2: 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	120,000		
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		
Activity 4.2.3:	provide essential laboratory supplies for testing (urine, Hb, BFFM,	48,000	Provide essential laboratory supplies for testing (urine, Hb, BFFM, etc) necessary for improving maternal	48,000		Activity planned for 2010 is carried over to 2011.

	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		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			
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	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		Activity planned for 2010 is carried over to 2011.
Activity 4.2.5:			Provide long lasting insecticidal mosquito bed nets for distribution in the rural and hard to reach areas of the 4	100,000		

			states (5,000 bed nets * 4 states * 5 years * 5 US$ per nets)			
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	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		Activity planned for 2010 is carried over to 2011.
Sub-component 4.3: Social mobilization						
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	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		

Sub-component 5: Management of 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	50,000	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	60,000	0	
COST		208,000		3,162,000		
TOTAL COSTS	**3,370,000**					

5.5 *Programme implementation for 2009 reporting year*

5.5.1 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 should be based on the original proposal that was approved and explain any significant differences – it should also clarify the linkages between activities, output, outcomes and impact indicators.

*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.*

GAVI support has been pivotal in moving the government's agenda for strengthening health system in a bid to introduce reforms with the aim to improve performance.

One year on with the GAVI/HSS grant, while it is difficult to see the impact. There have been several major accomplishments (input to output/outcome) that have paved the way to creating impact. The following were the major output/outcomes achieved:

In order to build the health system's organisation and management capacity at locality, state and federal levels, a study to map the existing capacity was launched. This is a qualitative study and since this approach to research is quite new to Sudan, a research team was gathered that was involved in developing study methodology and was trained in qualitative research methods. The team has collected data on the existing management and organisation capacity. This includes the training needs of health managers at different levels. A consultant is scheduled to visit in early June 2010, to assist in analysing the data, and the findings will lead to defining interventions, including training of health managers and inputs to improving work environment for increasing efficiency.

Sudan health system has no uniform template or format for planning. Different levels, be it FMOH, SMOH or verticle programmes use formats often driven by the donors. Although input was not available from GAVI, as funds were delayed, a draft format for planning has been designed for federal level. To support this initiative a software and a user manual has also been drafted. Once agreed by the stakeholders, it will be adapted to the SMOH and programmes.

Through GAVI/HSS input, the directorates of health planning in the GAVI/HSS target states were assisted by providing them equipment and transport. In addition, all these directorates were involved in the exercise for household health expenditure survey and the mapping of financing agents and a number of other studies (public expenditure review, free health care initiative, management capacity building etc). This led to the building of capacity at state level and currently, there are well functioning directorates in all 15 northern states, as against four states in 2007.

Sudan, with the assistance of GAVI/HSS, has been working to develop national health accounts (NHA). Given that the country is constitutionally devolved with states having the authority to do detailed planning and allocate resources, these form the units/building blocks for building national health accounts. The fieldwork for household health expenditure and health services utilisation survey and mapping of the financing agents has been completed and data is ready for analysis and to develop national as well as state accounts. The findings, alongside the results from other studies like public expenditure review, free health care initiative, review of the national health insurance fund and actuarial study for Khartoum state health insurance corporation will contribute to developing an evidence based policy on health financing, assuring equitable distribution of resources and that the health system is made capable to protect families from catastrophic health expenditure. This exercise is expected to be completed around September/October, 2010.

Alongside the above mentioned household survey, a KAP survey of the communities has been conducted and data is ready for analysis. The findings will feed into designing advocacy material and a comprehensive plan for primary health care. Also, together with the findings of the household health services utilisation survey (carried out together with health expenditure survey) will provide evidence for barriers to access. Another study, which is ready to be launched, focusing on the costing of primary healthcare will evaluate the options for subsidised primary health care. The findings of costing study and the comprehensive plan for PHC prepared around the same time the health financing policy is prepared; will be a tool for advocacy with the government for allocating resources for primary health care. According to the national constitution of Sudan, the state is responsible to provide primary care to all its citizens free of cost.

A national monitoring and evaluation framework has been developed. After adoption and approval by the government, it will be adapted to states for implementation. This framework linked to a (dynamic, web based) health systems observatory, which is under construction in the national health information centre, will allow the decision makers to make evidence based decisions. Alongside this another intervention i.e. human resources for health observatory with support from Global Health Workforce Alliance is underway, and will link with the health system observatory, thus improving, inter-alia the human resources management.

The national academy of health sciences, which coordinate and guides the state academies in 15 states was contracted to develop curricula for medical assistants (both upgrade and Diploma), community health workers and midwifes (Diploma and BSc). In addition to the job done, i.e. the curricula has been reviewed, updated, approved and accredited, this initiative has helped the national academy to develop its capacity. In addition, the national academy has assisted in developing a national CPD strategy and staff development policy for the teaching staff at the state academies of health sciences.

Furthermore, two academies in Sinnar and Nyala (Darfur) states have been rehabilitated and students studying in the target state academies were assisted by paying their tuition fee. In this manner, marginalised young persons, who otherwise might not have been able, were enabled to receive training in different allied health disciplines. These students are from localities and remote villages and are more likely to go back and service their communities. Alongside these initiatives, with support from WHO/GHWA, essentially complementing GAVI/HSS input, we are working to develop a national strategic plan for human resources for health.

In addition to providing medical supplies to primary health care facilities in the target states, the EPI programme was supported and US$200,000 was advanced to assist in their immunisation campaign. This financial input needed due to the financial crunch faced by EPI programme helped in achieving the following:

- 91.1% Penta3 coverage nationally
- 82% districts achieved above 80% Penta3 coverage

However, due to the delays in receipt of funds the progress had been hindered. Therefore, importantly continuity of the ongoing support and avoiding such delays in future is essential.

5.5.2 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.

Currently, no civil society organizations are directly involved in the implementation of GAVI/HSS proposal. But, representatives from civil society do sit on the HSCC and have their input assuring the people's voice is counted in programme planning and implementation of GAVI/HSS activities.

In addition, the GAVI/HSS Management Unit is working to develop a proposal for Civil Society Organisation Support. It is likely to be submitted later in 2010.

5.6 *Management of HSS funds*

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year ? **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: further describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of HSS funds.

NA

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

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

HSS funds are included in the national health sector plans and budgets.

The monies from GAVI since GAVI/HSS are received in the government bank account No.611/6723 kept at Faisal Islamic Bank-Branch of Khartoum University. This account is operated by the International Health Directorate in the Federal Ministry of Health; and this arrangement is in place due to GAVI/HSS do not have a foreign currency account of its own.

The International Health Directorate, at the demand of GAVI/HSS Management Unit transfers the authorised amount a local currency account No: 6919-2012030, kept at Central bank of Sudan-Khartoum Branch. This account is operated by GAVI/HSS Management Unit. However, for payments that are effected in USD like to WHO, the GAVI/HSS manager authorises the International Health Directorate to draw cheque and transfer amount to the receipts accounts.

Due to the restrictions and long cumbersome procedures in opening foreign currency accounts, for opening a foreign currency account for receipt of GAVI funds has taken too long but GAVI/HSS NS will soon have its own foreign currency bank account.

The four GAVI/HSS target states have only received support in the first quarter of 2009 as kind in the form of vehicles for supervision, drugs and medical supplies for MCH services and IT equipment. There has been no direct transfer of funds from GAVI/HSS support to the states for local payment yet but according to a memorandum of understanding signed with state DGs; these will be channelled to the states through government account operated by the DG in the SMOH. State Director of Health Planning in the State Ministries of Health coordinate the state and locality level activities and provide reports to GAVI/HSS management Unit at Federal level.

5.7 *Detailed expenditure of HSS funds during the 2009 calendar year*

Please attach a detailed financial statement for the use of HSS funds during the 2009 calendar year **(Annex 16b)** *(Terms of reference for this financial statement are attached in Annex 2).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

If any expenditures for the January – April 2010 period are reported above in Table 16, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document N°.....)**.

External audit reports for HSS, ISS and CSO-b programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your HSS programme during your government's most recent fiscal year, this should also be attached **(Document N°.....)**.

5.8 *General overview of targets achieved*

The indicators and objectives reported here should be exactly the same as the ones outlined in the original approved application and decision letter. There should be clear links to give an overview of the indicators used to measure outputs, outcomes and impact:

Table 15: Indicators listed in original application approved

The progress in indicators is rather slow due to the unavailability of funds in 2009

Output Indicators:

Name of Objective or Indicator *(Insert as many rows as necessary)*	**Numerator**	**Denominator**	**Data Source**	**Baseline Value**	**Baseline Source**	**Date of Baseline**	**Target**	**Date of Target**	**Achievement**	Explanation of any reasons for non achievement of targets
Institutional capacity building and organization										
Objective 1: 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 standards	SMOH with organogram positions filled with qualified and trained key staff	15 Northern SMOH	Administrative reports on a standardized checklist	0 (measured versus the standard structure)	Admin. reports	2008	100%	2011	-	Not done, pending completion of other activities. To be achieved by 2011
% SMOH with functional Planning Directorates	SMOH with functional	15 Northern	Administrative	0 (measure	Admin. reports	2008	100%	2010	30% - all 15 northern state	- GAVI HSS provided for 11

	planning directorate	SMOH	reports on a standardized checklist	d versus the standard functionality)					have a functioning planning directorates (compared to 4 in 2007) - 100% of targeted Planning department in the SMOH (15) received the package of IT equipments - 100% of targeted planning directors (15) received a vehicle to support planning in the first quarter of 2009 (4 through MDTF) -needs assessment of States' capacities conducted	states while MDTF for the remaining four states
% 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	30% An electronic system for standardizing planning formats for the three levels of governance. The program has been implemented in stages and tested at Federal level as well and discussed with state planning directors.	Activity commenced in 2009 as planned
% SMOH with functioning directorates of human resource	SMOH with functioning directorate of human	15 Northern SMOH	Administrative reports on a	0	Admin. reports	2008	100%	2010	20% --100% of targeted Planning department in the SMOH (15)	- GAVI HSS provided for 11 states while MDTF for the

	resources		standardized checklist						received the package of IT equipments in the first quarter of 2009	remaining four states
Service delivery, access and utilization										
Objective 2: 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.										
% 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 (dated in 2008)	50	2011	-	-
% 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	Health facility survey (human resources)	0	Health facility survey	2008	50%	2011	-- 0%	-Not done pending completion of other activities

		3 Darfur states)								
7.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 (bending on releasing the annual FMOH statistical report of 2009
8. % 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 (bending on releasing the annual FMOH statistical report of 2009

In the space below, please provide justification and reasons for those indicators that in this APR are different from the original approved application:

All indicators in this APR are the same as in the original approved application

Provide justification for any changes in the definition of the indicators:

Provide justification for any changes in the denominator:

Provide justification for any changes in data source:

Table 16: Trend of values achieved: Please see the above table				
Name of Indicator *(insert indicators as listed in above table, with one row dedicated to each indicator)*	**2007**	**2008**	**2009**	**Explanation of any reasons for non achievement of targets**
Institutional capacity building and organization				
Objective 1: 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 standards		-	-	Not done, pending completion of other activities. To be achieved by 2011
% SMOH with functional Planning Directorates		30%		IT equipment and vehicles were purchased in 2008 and distributed to the states in the first quarter of 2009
% states planning directorates using standard planning format		0%	30% .	Activity commenced in 2009 as planned
% SMOH with functioning directorates of human resource		20%		
Service delivery, access and utilization				
Objective 2: 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.				
% health facilities (RH, RHC, UHC, Dispensary/BHU) providing essential PHC package		-	-	

% PHC workers who received integrated in-service training during last 1-year		0%	0%	Not done pending completion of other activities
7.Health services utilization rate		0%	0%	No reporting so far (bending on releasing the annual FMOH statistical report of 2009
8. % PHC facilities reported timely for health information		0%	0%	No reporting so far (bending on releasing the annual FMOH statistical report of 2009

Explain any weaknesses in links between indicators for inputs, outputs and outcomes:

There are not weaknesses in link between indicators for inputs, outputs and outcomes.

5.9 *Other sources of funding in pooled mechanism for HSS*

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

Table 17: Sources of HSS funds in a pooled mechanism

Donor	Amount in US$	Duration of support	Contributing to which objective of GAVI HSS proposal			
			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;	**By the 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**	**By end of 2012, contribute to achieving 90% EPI coverage in all 15 Northern states through increasing fixed site by 25% from the current level of 1,260 facilities.**	**By end of 2012, contribute to achieving 75% equitable coverage and access to quality PHC services necessary for improved maternal health and child**

						survival in the 4 targeted states.
Decentralized Health Systems Development Project	70 million (by a ratio of 1 by the Donors community and 2 by the GONU)	2007-2001	capacity building and policy development in health care financing; pharmaceutical supply; health planning, budgeting and management by locality/district health system; and designing and establishing a system for monitoring and evaluation of health system performance;	developing primary health care human resources;	-expanding the primary health care services; -reducing barriers to access to primary health care	investing in primary health care infrastructure and equipment.
The Global fund to fight Aids, Malaria and tuberculosis/HSS R8	34,935,679 million	(2010-2013)	1. Improve health services delivery including laboratory services, assuring quality and equity of access at all levels of health care 2.Strengthen health management information system, including surveillance and setting up a M&E system for measuring the health system's performance 3.Build capacity of the system for drugs, supplies and equipment procurement and management, including quality assurance 5.Strengthen health financing function of the health system for assuring equity and access to health service	4.Scale up, quantitatively and qualitatively, the availability of HRH at different levels of health care that it matches the basic standards		1. Improve health services delivery including laboratory services, assuring quality and equity of access at all levels of health care
Support by Health Metrics Network for strengthening health information system	250,000	The first phase was undertaken in 2007.	Assessing the status of health information system and devising a comprehensive plan for its strengthening			
Collaborative			These programmes carry out a variety of interventions that focus on strengthening the health system.			

programs of the United Nation(WHO, UNICEF)			

6. Strengthened Involvement of Civil Society Organisations (CSOs)

(Not Relevant)

6.1 *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[6]

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:

6.1.1 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 describe the mapping exercise, the expected results and the timeline (please indicate if this has changed). Please attach the report from the mapping exercise to this progress report, if the mapping exercise has been completed (**Document N**°.....).

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.

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

6.1.2 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.

6.1.3 Receipt and expenditure of CSO Type A funds

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type A funds for the 2009 year.

Funds received during 2009: US$.....
Remaining funds (carried over) from 2008: US$.....
Balance to be carried over to 2010: US$.....

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

This section is to be completed by countries that have received GAVI TYPE B CSO support[7]

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:

6.2.1 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).

[7] 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 change in the level and type of involvement by CSOs in immunisation and health systems strengthening (give the current number of CSOs involved, and the initial number).

Please outline any impact of the delayed disbursement of funds may have had on implementation and the need for any other support.

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.

Table 18: Outcomes of CSOs activities

Name of CSO (and type of organisation)	Previous involvement in immunisation / HSS	GAVI supported activities undertaken in 2009	Outcomes achieved

Please list the CSOs that have not yet been funded, but are due to receive support in 2010/2011, 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.

Table 19: Planned activities and expected outcomes for 2010/2011

Name of CSO (and type of organisation)	Current involvement in immunisation / HSS	GAVI supported activities due in 2010 / 2011	Expected outcomes

6.2.2 Receipt and expenditure of CSO Type B funds

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type B funds for the 2009 year.

Funds received during 2009: US$.....
Remaining funds (carried over) from 2008: US$.....
Balance to be carried over to 2010: US$.....

6.2.3 Management of GAVI CSO Type B funds

Has a GAVI Financial Management Assessment (FMA) been conducted prior to or during the 2009 calendar year ? **[IF YES] :** please complete **Part A** below.
[IF NO] : please complete **Part B** below.

Part A: further describe progress against requirements and conditions for the management of CSO Type B funds which were agreed in any Aide Memoire concluded between GAVI and the country, as well as conditions not met in the management of CSO Type B funds.

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

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

6.2.4 Detailed expenditure of CSO Type B funds during the 2009 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2009 calendar year **(Document N°.....).** *(Terms of reference for this financial statement are attached in Annex 4).* Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

External audit reports for CSO Type B, ISS, HSS programmes are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available for your CSO Type B programme during your government's most recent fiscal year, this should also be attached **(Document N°.....)**.

6.2.5 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.

Table 20: Progress of CSOs project implementation

Activity / outcome	Indicator	Data source	Baseline value and date	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.

7. Checklist

Table 21: Checklist of a completed APR form

Fill the blank cells according to the areas of support reported in the APR. Within each blank cell, please type: Y=Submitted or N=Not submitted.

	MANDATORY REQUIREMENTS (if one is missing the APR is NOT FOR IRC REVIEW)	ISS	NVS	HSS	CSO
1	Signature of Minister of Health (or delegated authority) of APR	√	√	√	NA
2	Signature of Minister of Finance (or delegated authority) of APR	√	√	√	NA
3	Signatures of members of ICC/HSCC in APR Form	√	√	√	NA
4	Provision of Minutes of ICC/HSCC meeting endorsing APR	√	√	√	NA
5	Provision of complete excel sheet for each vaccine request		√		
6	Provision of Financial Statements of GAVI support in cash	√	NA	√	NA
7	Consistency in targets for each vaccines (tables and excel)		√		
8	Justification of new targets if different from previous approval (section 1.1)		√		
9	Correct co-financing level per dose of vaccine		√		
10	Report on targets achieved (tables 15,16, 20)			√	NA
11	Provision of cMYP for re-applying		√		

	OTHER REQUIREMENTS	ISS	NVS	HSS	CSO
12	Anticipated balance in stock as at 1 January 2010 in Annex 1		√		
13	Consistency between targets, coverage data and survey data	√	√		
14	Latest external audit reports (Fiscal year 2009)				NA
15	Provide information on procedure for management of cash	√		√	NA
16	Health Sector Review Report				
17	Provision of new Banking details	NA	NA	NA	NA
18	Attach VMA if the country introduced a New and Underused Vaccine before 2008 with GAVI support		NA		
19	Attach the CSO Mapping report (Type A)				NA

8. Comments

Comments from IACC/HSCC Chairs:

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

- Routine immunization services achievements and reaching more children during 2009 in spite the delay of the transfer of GAVI ISS funds, were highly acknowledged and appreciated by all IACC members.

- Recommendation raised to advocate strongly with government and new donors to fulfil the government commitment towards new vaccine co-financing timely for smooth procurement process.

- The IACC endorsed the country request for extension of the new Pentavalent vaccine support for the period of the updated new cMYP for the years 2010 – 2014, and requesting GAVI to approve it.

- The overall ISS report was satisfactory to all IACC members.

- The HSCC appreciated the efforts made and the accomplishments to strengthen the health system.

- Request was raised to include representatives from the four states selected for the focus of the HSS support to be part of the meetings.

- Over all HSS report was satisfactory to all HSCC members

~ End ~

GAVI ANNUAL PROGRESS REPORT ANNEX 2
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR IMMUNISATION SERVICES SUPPORT (ISS) AND NEW VACCINE INTRODUCTION GRANTS

I. All countries that have received ISS /new vaccine introduction grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 2 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2009 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR ISS AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local Currency (CFA)	**Value in USD[7]**
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[8] – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditure						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2009	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

[7] An average rate of CFA 479.11 = USD 1 applied.

[8] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own system for economic classification.

GAVI ANNUAL PROGRESS REPORT ANNEX 3
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR HEALTH SYSTEMS STRENGTHENING (HSS)

I. All countries that have received HSS grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2009 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR HSS FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local Currency (CFA)	**Value in USD[9]**
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[10] – GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
HSS PROPOSAL OBJECTIVE 1: EXPAND ACCESS TO PRIORITY DISTRICTS						
ACTIVITY 1.1: TRAINING OF HEALTH WORKERS						
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
TOTAL FOR ACTIVITY 1.1	**24,000,000**	**50,093**	**18,800,000**	**39,239**	**5,200,000**	**10,854**

[9] An average rate of CFA 479.11 = USD 1 applied.

[10] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own HSS proposal objectives/activities and system for economic classification.

ACTIVITY 1.2: REHABILITATION OF HEALTH CENTRES						
Non-salary expenditure						
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditure						
Equipment	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Capital works	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR ACTIVITY 1.2	**18,000,000**	**37,570**	**11,792,132**	**24,613**	**6,207,868**	**12,957**
TOTALS FOR OBJECTIVE 1	**42,000,000**	**87,663**	**30,592,132**	**63,852**	**11,407,868**	**23,811**

GAVI ANNUAL PROGRESS REPORT ANNEX 4
TERMS OF REFERENCE:
FINANCIAL STATEMENTS FOR CIVIL SOCIETY ORGANISATION (CSO) TYPE B

I. All countries that have received CSO 'Type B' grants during the 2009 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2009, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

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

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2009 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2008 calendar year (opening balance as of 1 January 2009)
b. Income received from GAVI during 2009
c. Other income received during 2009 (interest, fees, etc)
d. Total expenditure during the calendar year
e. Closing balance as of 31 December 2009
f. A detailed analysis of expenditures during 2009, based on ***your government's own system of economic classification***. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2009 (referred to as the "variance").

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

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2009 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

MINIMUM REQUIREMENTS FOR CSO 'Type B' FINANCIAL STATEMENTS:
An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO 'Type B'		
	Local Currency (CFA)	Value in USD[11]
Balance brought forward from 2008 (*balance as of 31 December 2008*)	25,392,830	53,000
Summary of income received during 2009		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	65,338,626	136,375
Total expenditure during 2009	30,592,132	63,852
Balance as at 31 December 2009 (*balance carried forward to* 2010)	60,139,324	125,523

Detailed analysis of expenditure by economic classification[12] – GAVI CSO 'Type B'						
	Budget in CFA	Budget in USD	Actual in CFA	Actual in USD	Variance in CFA	Variance in USD
CSO 1: CARITAS						
Salary expenditure						
Wages & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per-diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
TOTAL FOR CSO 1: CARITAS	**24,000,000**	**50,093**	**18,800,000**	**39,239**	**5,200,000**	**10,854**
CSO 2: SAVE THE CHILDREN						
Salary expenditure						
Per-diem payments	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131

[11] An average rate of CFA 479.11 = USD 1 applied.

[12] Expenditure categories are indicative, and only included for demonstration purposes. Each implementing government should provide statements in accordance with its own CSO 'Type B' proposal and system for economic classification.

Non-salary expenditure						
Training	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Other expenditure						
Capital works	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR CSO 2: SAVE THE CHILDREN	**18,000,000**	**37,570**	**11,792,132**	**24,613**	**6,207,868**	**12,957**
TOTALS FOR ALL CSOs	**42,000,000**	**87,663**	**30,592,132**	**63,852**	**11,407,868**	**23,811**