GAVI Alliance

Annual Progress Report 2012

Submitted by

The Government of

Sudan

Reporting on year: **2012**
Requesting for support year: **2014**
Date of submission: **5/15/2013 6:51:56 PM**

Deadline for submission: 9/24/2013

Please submit the APR 2012 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

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

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

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

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 the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

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

RETURN OF FUNDS

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

SUSPENSION/ TERMINATION

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

ANTICORRUPTION

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

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

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

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

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

USE OF COMMERCIAL BANK ACCOUNTS

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

ARBITRATION

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

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed 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.

1. Application Specification

Reporting on year: **2012**

Requesting for support year: **2014**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	2014
Routine New Vaccines Support	Rotavirus, 2 -dose schedule	Rotavirus, 2 -dose schedule	2014
Routine New Vaccines Support	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	2014
INS			
Preventive Campaign Support	Meningococcal type A, 10 dose(s) per vial, LYOPHILISED		2012

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2012	Request for Approval of	Eligible For 2012 ISS reward
VIG	No	N/A	N/A
COS	Yes	N/A	N/A
ISS	Yes	next tranche: N/A	N/A
HSS	Yes	next tranche of HSS Grant No	N/A
CSO Type A	No	Not applicable N/A	N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2012: N/A	N/A
HSFP	No	N/A	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2011 is available here.

2. Signatures

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

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

For the Government of Sudan

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

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Bahar Idrees AbuGarda	**Name**	Ali Mahmoud
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
Dr.Magdi Salih Osman	EPI Manager	00(249)123922225	mgdosman@yahoo.com
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Dr Nagla Eltagani ELFADIL	GAVI/GF HSS Focal person, Sudan	00(249)123250037	nagla114@gmail.com
Mr. Ali Babiker MOHAMED	GAVI/HSS Financial mangement officer	00(249)912234020	alifmoh@gmail.com
Mr. Hassan TAGELDIN	PHC/EPI Financial Manager	00(249)12684973	hassant@gmail.com

2.2. ICC signatures page

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

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

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

2.2.1. ICC report endorsement

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

Name/Title	Agency/Organization	Signature	Date

Dr. Alamin Osman / MOD /Rep	Ministry of Defense		
Mr. Hassan Ibrahim /State development dept manager	MO Finance		
Dr. Babiker Mubasher / MOI Rep	Ministry of Interior		
Dr. Mohamed Ali Y.ALabassi / Director General	Planning &International health /FMOH		
Dr. Talal Alfadil ALmahdi /Director Genral	Baisc Health Care/FMOH		
Dr. Anshu Banarjee /WHO/WR	WHO		
Mrs. Sawsan Omer Abolkailk / MOI /Rep	Bureau of local government		
Mr. Mohamed Hussein Dafalla /Representative	Humanitarian Aid Commission (HAC)		
Dr.Magdi Salih Osman / EPI Manager	FMOH		
Dr.Amani Abed Almoniem / planning Manager	Planning & Policy FMOH		
Ms Dorothy Ochalo Odongo / Chief of Health	UNICEF		
Mr. Sohaib ELbadawi /Representitive	Rotary International		
Mr. Osama Mustafa / Representative	SRCS		

Mrs.Nadia Mohammed ALamin /Representative	Minstry of Co-operation		

ICC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

The major comments were as follows:

- Co-financing must be fulfilled by Ministry of Finance (MoF) as soon as possible. /The IACC member representing MoF informed the meeting that the remaining portion of the 2012 co-financing is issued today.
- The gender issue of the coverage data has to be explained. /The issue has been explained.
- The challenge/constraint in social mobilization has to be further clarified. /This point has been clarified in this version.
- Review the implementation of the table under item 5.6.1. /The table has been updated accordingly.
- The amount of the paid co-financing should be written in table 7.4. /The amount has been written.

The date of the intention of the 2014 co-financing has to be written. /It is done

Comments from the Regional Working Group:

The Core RWG appreciates the efforts undertaken by the country team for preparation of the draft GAVI APR 2012 and suggests the following comments for consideration while finalizing the GAVI APR 2012

General

- Complete the information and secure the required signatures as appropriate: Government Signatures page for all GAVI support, List the members of the ICC, ICC Signatures page, HSCC signatures page & Signatures page for GAVI Alliance CSO support if relevant. / done
- Please make sure that the data reported in the APR 2012 are in line with other data sources like the cMYP, or the JRF 2012 / done
- Mention the meeting which will be held for final endorsement of the GAVI APR 2012 and attach the minutes / done
- Countries may use MICS survey if applicable to respond to some of the gender questions formulated in the GAVI APR 2012 form / EPI used the data from the last census in 2008.
- Please refer to Section 13 of the GAVI APR 2012 where all mandatory requirements for GAVI APR submission are stated and attach as appropriate. The list could be visualized online. Please note that it has been customized on a country by country basis so no need to attach those that are not mandatory./ done
- Please ensure that all clarifications requested in the 2011 Independent Review Committee (IRC) report sent to you have been addressed. For this purpose, you may wish to consult the relevant IRC report by clicking on the link that appears at the end of section 1 of the GAVI APR labeled Application Specification/ done
- Countries should ensure in the GAVI APR 2012 all activities which took place and highlight clearly any new request for new vaccine or need for reprogramming/ activities were done
- Specific: Some areas and numbers on the report to be edited and revised / done

2.3. HSCC signatures page

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

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

Name/Title	Agency/Organization	Signature	Date
MOHAMED ALI YHYA AL ABASI	Undersecretary of FMOH		
EHSANULLAH TARIN	Reprehensive of WHO		
MOHAMOUD ELGAYEM ABDALLA	Reprehensive of Khartoum state MOH		
FAHAD AWAD ALI	NATIONAL MALARIA PROGRAM		
ISABEL	WORLD BANK		
ETHAR AWADALLA	PLANNING DIRECTORATE-NATIONAL MINISTRY OF HEALTH		
IMADDIN ABDELRHMAN	INTERNATIONAL FEDERATION OF RED CRESCENT		
TATEK MAWRCH	UNDP/GF		
ALI IBRAHIM ALI	LOCAL HEALTH SYSTEM/NATIONAL MINISTRY OF HEALTH		
SEHAM A.JABER	SNAP-NATIONAL HIV/AIDS PROGRAM-NATIONAL MINISTRY OF HEALTH		
IMAD ELDIN A M ISMAIL	INTERNATIONAL HEALTH _NATIONAL MINISTRY OF HEALTH		

HIBA KAMAL	NATIONAL TUBERCULOSIS PROGRAM-NATIONAL MINISTRY OF HEALTH		
MUTAZ AHMED	PRIMARY HEALTH CARE_NATIONAL MINISTRY OF HEALTH		
SAMIRA M.OSMAN	EXPANDED IMMUNIZATIO PROGRAM _NATIONAL MINISTRY OF HEALTH		
ABDELRHMAN MOHAME	HUMANITARIAN AID COMMISSION		

HSCC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

- □□□□□□□Justify the delay in funds for the 4th year
- □□□□□□□Separate the ISS funds
- □□□□□□□Revise the table of exchange rate
- □□□□□□□For the activities implemented by GAVI & GF,highlight the contribution of GF
- □□□□□□□Link the programmatic and financial performance
- □□□□□□□Find a mechanism to facilitate the implementation ofactivities implemented by both GAVI & GF (mainly HIMS)

Comments from the Regional Working Group:

Item

Comments

Recommendations

1. Has the report been endorsed by the relevant country coordination mechanisms (HSCC or equivalent) Have signed minutes been provided

No documents are available on the portal. Ensure all signed minutes are provided for the listed HSCC meetings in section 9.9.3 .

Please provide documentation on HSCC meetings occurring in 2012-2013 with signed minutes. Also, provide the signed minutes of the HSCC endorsing the APR.

2. Does the APR provide details on the expenditure of HSS funding audit report financial statements? Are opening and closing balances consistent to expenditure tables provided (9.1.3 a & B + audit reports)

Total funding received is not consistent. ISS funding should be reported in the ISS section 6.1 of the APR. Calculation error in the balance carried forward.

Please provide financial statements that are reconciled with the APR financial tables 9.1.3 a & B. Please ensure consistency with opening and closing balances. Remove the ISS reporting from the HSS financial tables. Confirm HSS disbursement with GAVI decision letters (12,751,500).

3. Has the financial management arrangements and process been described? Are the HSS funds included in the national health sector plan and budgets?

Yes the financial management arrangements are described. HSS funding is reported on the health sector budget

Please attach the consolidated financial reports as highlighted in the financial management section.

4. Does the report describe any issues/delays in the financial implementation of the HSS funds? Does the report address these financial bottlenecks? (financial management section and 9.4.7)

No issues highlighted

5. Has the progress of HSS activities been described fully with % of activity complete, explanation about progress achievements and constraints and the source of information/data if relevant (table 9.2 and 9.2.1)

The implementation is not consistent with the 2011 APR where implementation was listed a very high.

Please review the activity implementation % in regards to previous reporting and given that this the end of the HSS proposal. Provide sources of information that can better show impact of activities ie traning participation or meeting reports

6. Are the objectives and activities listed in table 9.2 consistent to the approved HSS proposal or previously approved reprogramming? (table 9.2, 2011 APR, HSS proposal)

The activities listed are consistent with the proposal

As above, please review the activity implementation as per previous implementation reported in 2011 APR

7. Has a detailed explanation been provided as to why activities have not been implemented or modified with references? (Section 9.2, 9.2.1, 9.2.2)

Yes, however this should be updated from the 2011 APR

8. Does the grant provide national health human resources incentives? If so, does the report provide evidence as to how it has contributed to the implementation of the national Human Resource policy or guidelines? (9.2.3)

GAVI / HSS management receives small incentives from management costs

Activity 1.1.5 is to improve work environment and provide key office equipment which was fully implemented in 2008. Please clarify. Also provide more details on the results of the incentives for staffing. It is sustainable and provided through the MoH?

9. Is the information on indictors provided in full - targets, baselines/sources provided? Are indictors provided aligned to the approved proposal/ previously approved reprogramming and baselines/sources and targets? (table 9.3)

Please provide all indicators from the approved HSS grant. i.e DTP3 coverage.

Achievements need to be provided for the duration of the grant. (use the online portal version)

10. Does the report provide explanation if targets are not achieved? (9.3)

The status of the indicators need to be updated from the 2011 APR

Provide clear justification if the 2012 targets are not complete. Please provide updates to the indicator status for 2012 following the portal format and consistent to previous indicator reporting. Report on all approved indicators

11. Is a detailed report on the major accomplishments implementation provided? Is it consistent to the activity, budget and indicator implementation provided? (9.4.1, Table 9.3, 9.2, 9.13 a &b

Yes a detailed report is provided. Can not verify consistency as tables on activity and indicator implementation and status is not updated consistently with the 2011 APR.

Please ensure consistency of the narrative and the tables on fiscal, activity and indicator implementation

12. Has the M&E arrangements been described in full and the extent that they are integrated within existing monitoring mechanisms. (section 9.4.3 and 9.4.4)

Yes, the implementation of activities are presented at team meetings twice a year with GF/HSS activities

Please provide documentation of these meetings and reconcile the progress to the table 9.2 on the progress of HSS activities in 2012

13. Has the country provided identified the key stakeholders in the implementation of the grant and their function (including CSO's) (section 9.4.5 and 9.4.6)

Yes, there is a detailed list of stakeholders.

Please provide details on the roles and responsibilities of the stakeholders

14. Does the report describe any issues/delays in the financial implementation of the HSS funds? Does the report address these financial bottlenecks? Is section 9.4.7 consistent to the section on Financial management of HSS funds?

No issues highlighted

15. Is the table on the Planned HSS activities for 2013 complete? Is the 2013 budget aligned to the request for the next tranche? (tables 9.5, 9.1.3a /b and section 9.1.2)

Unclear if table is up-to-date based on the actual 2012 implementation of activities and funding and carryover from 2012.

Please update the table with latest implementation and remaining fund to be disbursed and carryover from 2012 and aligned to 2012 activity implementation. This table is for 2013 activities and budget.

16. Does the country request a reprogramming/shift from the original proposal/previously approved reprogramming for 2013? (table 9.5)

Unclear as table is not up to date

Any changes need to be approved by the HSCC and evidence provided in the attached minutes

17. Is an explanation for the changes to the activities or budget for 2013? Is this change in budget greater than 15% per activity? (table 9.5)

Unclear as table is not up to date

Any changes need to be approved by the HSCC and evidence provided in the attached minutes

18. Is the table on the Planned HSS activities for 2014 complete? Is the budget aligned to the 2014 committed tranche? (tables 9.6, 9.1.3a /b)

Grant to be completed by 2014

19. Does the country request a reprogramming/shift from the original proposal/previously approved reprogramming for 2014? Is this aligned to the activities planned for 2013 (table 9.5 and 9.6)

Grant to be completed by 2014

20. Is an explanation for the changes to the activities or budget for 2014? (table 9.6)

Grant to be completed by 2014

21. Does the country provide details on the other sources of HSS funding in the country? (Table 9.8)

Yes GFATM

Please provide information on other sources of HSS funding

22. Is the information provided in the report validated? (data sources provided) (table 9.9)

Table is not completed

Please complete table and ensure annexes highlighted are attached in the submission

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

Sudan is not reporting on CSO (Type A & B) fund utilisation in 2013

3. Table of Contents

This APR reports on Sudan's activities between January – December 2012 and specifies the requests for the period of January – December 2014

Sections

4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Number	Achievements as per JRF		Targets (preferred presentation)			
	2012		2013		2014	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation
Total births	1,438,651	1,438,651	1,459,538	1,486,286	1,499,079	1,526,477
Total infants' deaths	153,929	153,929	156,079	158,969	160,246	163,205
Total surviving infants	1284722	1,284,722	1,303,459	1,327,317	1,338,833	1,363,272
Total pregnant women	1,438,651	1,438,651	1,459,538	1,486,286	1,499,079	1,526,477
Number of infants vaccinated (to be vaccinated) with BCG	1,337,945	1,321,918	1,371,966	1,397,109	1,424,125	1,450,153
BCG coverage	93 %	92 %	94 %	94 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,220,486	1,176,164	1,238,286	1,234,405	1,271,891	1,295,109
OPV3 coverage	95 %	92 %	95 %	93 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1	1,284,722	1,278,884	1,303,459	1,314,044	1,338,833	1,363,272
Number of infants vaccinated (to be vaccinated) with DTP3	1,220,486	1,177,206	1,238,286	1,234,405	1,271,891	1,295,109
DTP3 coverage	95 %	92 %	95 %	93 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	0	0	0	0	0
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.00	1.00	1.00	1.00	1.00
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	1,269,096	1,278,884	1,303,459	1,314,044	1,338,833	1,363,272
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	1,269,096	1,177,206	1,303,459	1,234,405	1,271,891	1,295,109
DTP-HepB-Hib coverage	95 %	92 %	95 %	93 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%)	0	1	0	0	5	0
Wastage[1] factor in base-year and planned thereafter (%)	1.05	1.01	1.05	1	1.05	1
Maximum wastage rate value for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1 dose of Pneumococcal (PCV13)		0	1,303,459	663,659	1,338,833	1,363,272
Number of infants vaccinated (to be vaccinated) with 3 dose of Pneumococcal (PCV13)		0	1,303,459	597,293	1,271,891	1,295,109

Number	Achievements as per JRF		Targets (preferred presentation)			
	2012		2013		2014	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation
Pneumococcal (PCV13) coverage	0 %	0 %	95 %	45 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%)		0	0	5	5	5
Wastage[1] factor in base-year and planned thereafter (%)		1	1.05	1.05	1.05	1.05
Maximum wastage rate value for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1 dose of Rotavirus	1,269,096	1,044,757	1,303,459	1,207,859	1,338,833	1,363,272
Number of infants vaccinated (to be vaccinated) with 2 dose of Rotavirus	1,269,096	958,506	1,303,459	1,128,220	1,271,891	1,295,109
Rotavirus coverage	90 %	75 %	95 %	85 %	95 %	95 %
Wastage[1] rate in base-year and planned thereafter (%)	0	5	0	5	5	5
Wastage[1] factor in base-year and planned thereafter (%)	1.05	1.05	1.05	1.05	1.05	1.05
Maximum wastage rate value for Rotavirus, 2-dose schedule	5 %	5 %	5 %	5 %	5 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,143,403	1,092,258	1,199,182	1,194,585	1,258,503	1,281,476
Measles coverage	89 %	85 %	92 %	90 %	94 %	94 %
Pregnant women vaccinated with TT+	748,098	679,781	963,295	891,772	1,094,327	1,068,534
TT+ coverage	52 %	47 %	66 %	60 %	73 %	70 %
Vit A supplement to mothers within 6 weeks from delivery	0	293,562	0	1,338,362	0	1,374,399
Vit A supplement to infants after 6 months	0	5,898,677	0	6,143,969	0	6,143,969
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	5 %	8 %	5 %	6 %	5 %	5 %

** Number of infants vaccinated out of total surviving infants

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

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

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

5. General Programme Management Component

5.1. Updated baseline and annual targets

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

The numbers for 2012 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2012.** The numbers for 2013 - 2014 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

- Justification for any changes in **births**

•□□□□□□□□ In 2011 APR Operational targets are used, projections from 2011 targets are estimated to be the targets for the next years.

•□□□□□□□□ By the end of 2012 some states achieved Penta1coverage more than 100%.

•□□□□□□□□ The achieved Penta1 coverage in 2012 is used as baseline in states where the achieved first dose coverage is higher than 100% and higher than the projected census estimates.(children above one year were not counted here)

•□□□□□□□□ By using these estimates the births for 2013 are increased

•□□□□□□□□ Projections for 2013 - 2014, use the same 2011 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 center in FMOH,

- Justification for any changes in **surviving infants**

Based on the above justifications for change in births. The change in Surviving infants estimates for 2013 are due to the same above mentioned justifications

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

Changes in Target by vaccines are following the above mentioned changes in the births , surviving infants, and the actual achieved coverage by vaccines in 2012

- Justification for any changes in **wastage by vaccine**

NA

5.2. Immunisation achievements in 2012

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2012 and how these were addressed:

Achievements of immunization programme against targets addressing various GIVS components:
A / Protecting more people
Achievements of Immunization Coverage against targets in 2012 are as following:

	target	Achieved
BCG coverage	93%	92%
Penta3 coverage	95%	91.6%
Measles coverage	<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />	
89%	85%	
Rota2 coverage	90%	74.4%
DOR	5%	8%

- 12 states out of 17 achieved Penta 3 of 90% or more coverage rate.

- 2 states achieved (80-89% coverage rate)

133 localities out of 162 localities achieved more than 80% Penta3 coverage rate

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 micro planning guidelines to include all updated immunization issues.
- Conducting the state workshops for preparation of162 locality micro plans which are saved as soft and hard copies for monitoring purposes.

Institutional Capacity & Training
- Basic & Refresher EPI training courses for service providers at locality level
- Training of 4 states cold chain officers on VSSM.
- Training of 28 participants on AEFI Causality assessment

- Training of 102 participants on AEFI Investigation & technical committee.
- Continuous cold chain rehabilitation to maintain functionality of the cold chain at sub-national levels.
- Installation of (9) new cold rooms at state level,(2) cold rooms at locality level and (2) at central store and (71) refrigerators at the service delivery sites to expand the immunization network and increase the storage capacity and maintaining high quality of vaccines

A.1.2/Expanding the vaccination activities through fixed sites and outreach strategies
- Increased accessibility through more immunization sites by:
- The new fixed sites from 1657 fixed sites to 1698 and outreach from 4236 sites 4280 sites.
- Improved the quality of the outreach services & mobile activities that were conducted with total sessions implementation rate of (96% for fixed sites, 95% for out reach and 70% for mobile teams.
- Because of the critical situation in Darfur zone, one acceleration campaign of 3 rounds for routine immunization, covering 53 localities were implemented.

A.1.3Supportive supervision
- Planned supervisory visits to the states were conducted. 14 states were visited once or more annually with implementation rate of 80% out of the planned visits.
- 42% of localities were visited.
- 103 fixed immunization sites were visited by the National EPI personnel

- 1038 fixed immunization sites were visited by states and localities personal.
- DQS tool was used as a supervision tool enabled immediate analysis of the findings and feedback at state, district and health facility levels.
- The overall implementation of the planned supervision activities were affected by the competing priorities (NIDs &Meningitis and YF campaigns)

A.1.4/ Link with community
- Celebration of Annual Immunization week at national and sub-national levels
- Implementation of social mobilization activities in high risk special population, with NIDs & Meningitis(A) campaign

A.1.5/Monitoring for action
- Review and evaluation meetings at National and state level to assess the implementation of the plans were executed in 2012.
- Follow up and monitoring of monthly EPI meetings at sub national level, assessing progress indicators regularly at district level with emphasis 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
- Monthly monitoring review meetings at state level (states with localities & localities with service providers) were conducted.

I**mmunization Safety;**
AEFI surveillance system was strengthened in all 15 Northern states. Overall 39 AEFI incidents were reported & investigated.

EPI Disease surveillance: All EPI diseases were reported from sentinel sites.
Case based surveillance for AFP & measles continued at high quality in 2012. Both polio and measles National lab rotaries achieved the accreditation certificate with proficiency test of 100%
Lab based surveillance activities for Rota virus gastroenteritis and BMS continued in 2012.
Other EPI disease surveillance maintained. (The data of the mentioned activities is included in the joint report)

B/ Introducing new vaccines & technologies…
- NITAG meetings were held to follow up on the new vaccine introduction decision (PCV13)
- Country co- finance share for Pentavalent and Rota new vaccines was fulfilled Partially.

- Post introduction evaluation (PIE) for Rota vaccine introduction implemented.

C/ Linking with other health interventions…
- Vitamin A was distributed to children during the Polio NIDs. The total children who received vitamin A was 5,898,677

Constraints & Challenges:

- Aging of the transportation means at all levels
- Delayed co -financing
- insecurity in some areas of South kordofan , Blue Nile and Darfur zone

- The fund for regular social mobilization activities for routine immunization was limited.
- Formation of new localities & administrative structures every year.
- Competing and emergency activities such as YF outbreak.

Each of the above mentioned constraints were dialed with separately by special plan and special team to act on and follow it .

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

•□□□□□□□□ Yellow fever outbreak in Darfur states affected the implementation of the accelerated routine immunization activities in the last quarter of the year<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

•□□□□□□□□ Insecurity in some areas of South kordofan (3 localities were inaccessible) , Blue Nile state (partial inaccessible in 3 localities) and partial inaccessible in one locality in Central Darfur , one locality in South Darfur .

5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **no, not available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls
	J		

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

*□□NA□

Although EPI adopted the policy of coverage data collection segregated by gender, some states (Darfur states) did not report the coverage data by gender. Therefore, it was difficult to calculate the coverage rates by gender at the national level. The reason for not reporting by gender was administrative data management problem□

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Yes**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

.

* Corrective measures were taken with Darfur EPI staff to target the issue of gender disaggregated data.

5.4. Data assessments

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

*The only source of immunization coverage in 2012 was the administrative coverage data (EPI monthly reports). Although a coverage<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

survey combined with MenA evaluation was done in 10 states, the final results were not discussed yet.

* Please note that the WHO UNICEF estimates for 2012 will only be available in July 2013 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2011 to the present? **Yes**

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

*The verification factor at different levels is usually monitored, Regularly is done as part of the DQS activities (in separate sheet)<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

calculating the reported coverage against the registered coverage for one previous year at the time of the visit

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2010 to the present.

•□□□□□□□□□□□□□□□□□□

* Revision and update of the information guidelines and tools
• Printing and availing the information documents and data records at all levels
. Refresher trainings for service providers on registration and reporting
• Continuous supervision for data system at all levels and monitoring of verification factor and quality index.
• Follow-up and monitoring of quality index and verification factor at all levels visit during 2012<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />
• Archive and back up of EPI data and information for the years 1996-2012

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

•□□□□□□□□ Mini-surveys and home visits during supervision for the catchment areas to assess the catchment area coverage<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

•□□□□□□□□ Coverage surveys for selected states

•□□□□□□□□ Training of the new focal persons and refresher trainings for service providers

•□□□□□□□□ 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

•□□□□□□□□ Printing and distribution of the information guidelines

•□□□□□□□□ Revision, update and print the documentation records to include the new vaccines as required

5.5. Overall Expenditures and Financing for Immunisation

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

Exchange rate used	1 US$ = 5.8	Enter the rate only; Please do not enter local currency name

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

Expenditure by category	Expenditure Year 2012	Source of funding						
		Country	GAVI	UNICEF	WHO	NA	NA	NA
Traditional Vaccines*	7,287,101	0	0	7,287,101	0	0	0	0
New and underused Vaccines**	30,993,463	1,078,483	29,914,980	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	1,033,319	0	1,023,342	9,977	0	0	0	0
Cold Chain equipment	1,923,264	0	1,839,174	84,090	0	0	0	0
Personnel	2,639,150	2,275,257	231,503	28,172	104,218	0	0	0
Other routine recurrent costs	1,965,620	452,816	1,139,095	19,914	353,795	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	19,144,148	393,103	9,941,764	1,161,855	7,647,426	0	0	0
NA		0	0	0	0	0	0	0
Total Expenditures for Immunisation	64,986,065							
Total Government Health		4,199,659	44,089,858	8,591,109	8,105,439	0	0	0

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

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2013 and 2014

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />There were tow exchanag rates in 2012 = 1USD = 2.58 from Jan- June

1USD = 5.8 July - Dec.

- The Government contribution to primary health care is very low compared to the actual needs. This due to low budget allocated to health in general due to different country competing priorities and conflicts
- The cost of the traditional vaccines for 2013, & 2014 will be covered by UNICEF

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Yes, fully implemented**

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

Action plan from Aide Mémoire	Implemented?
Provide official translation of ISS 2009 and 2010 audit reports	No
For ISS, the PHC Finance Unit shall provide reports comparing actual expenditure with the EPI budget to the EPI Manager at least quarterly. As outlined above, a pre-requisite for this is for EPI to prepare a detailed annual work plan and budget showing all activities by funding source	Yes
EPI and Planning Directorate to formulate guidelines and design a transparent process to attribute staff incentives paid from GAVI HSS and ISS funds. These guidelines shall be reviewed and approved by the NHSSC and the ICC respectively.	No
EPI shall prepare a detailed annual work plan and budget showing all activities by funding source. This work plan and budget shall be submitted to the ICC for review and approval	No

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

- **The 2013 annual work plan is prepared based on the multi-year EPI plan (cMYP) showing the planned activities by source of funding. Due to heavy schedule of vaccination activities, Yellow Fever outbreak and vaccination campaigns, the plan was not submitted to the ICC. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />**

•□□□□□□□□

•□□□□□□□□ **An incentive top-up salary has been developed and shared with GAVI secretariat.**

•□□□□□□□□

•□□□□□□□□ **The actual expenditure report for the EPI planned activities is produced quarterly by the PHC finance unit, this is implemented for the year 2013 and will be continued.**

•□□□□□□□□

The translation of the ISS 2009-2010 is still under process, as this required permission and approval from the External Audit Chamber to proceed for the translation and to get their endorsement. Now the translation s ongoing and will provided to GAVI secretariat as soon as it is ready.

If none has been implemented, briefly state below why those requirements and conditions were not met.

All requirements related to ISS are implemented/or under implementation

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2012? **1**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2013 endorsing this report.

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

The ICC revised the APR for 2011, The key concerns were;

•□□□□□□□□ Coverage & accessibility in the new conflict areas.

•□□□□□□□□ The new Rota vaccine 2nd dose coverage

•□□□□□□□□ The timely country co-finance

•□□□□□□□□ Sustainability of achievements & availability of resource mobilization

Main Recommendations were:

•□□□□□□□□ To monitor situation and have special plans and NGOs in the field to address the conflict areas with accelerated immunization activities when ever the situation is favorable

•□□□□□□□□ To monitor the Rota vaccine coverage and implement more social mobilization activities.

To implement strong advocacy resource mobilization campaign including private sector donors to sustain achievements and ensure timely co-financing

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

If Yes, which ones?

List CSO member organisations:
Rotary International and SRCS

5.8. Priority actions in 2013 to 2014

What are the country's main objectives and priority actions for its EPI programme for 2013 to 2014

EPI Priorities and Objectives for 2013-2014:

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

1. To achieve and sustain 95% coverage of the third dose of Penta-valent vaccine and 70% TT2+ nationally.
2. To increase and sustain Penta 3 coverage by improving both access and utilization of immunization services all 167 districts.
3. To maintain Sudan Polio-free
4. To achieve and maintain Measles elimination.
5. To contribute to and maintain NNT elimination.
6. To introduce the PCV13 in 2013.
7. To reduce morbidity and mortality caused by Rota virus, N. Mengitidis, S. pneumoniae and Yellow Fever.
8. To strengthen Surveillance system of VPDs/AEFI.
9. To enhance surveillance of diseases (Rota GE, Bacterial Meningitis and Yellow Fever) prevented by new vaccines in the selected sentinel sites
10. To strengthen Programme managerial capacity.
110. To ensure sufficient fund for EPI activities and ensure new vaccines co-finance

5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety

Please report what types of syringes are used and the funding sources of Injection Safety material in 2012

Vaccine	Types of syringe used in 2012 routine EPI	Funding sources of 2012
BCG	AD & reconstitution syringes	Government
Measles	AD & reconstitution syringes	Government & UNICEF
TT	AD	Government
DTP-containing vaccine	AD	Government & GAVI

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

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

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

•□□□□□□□□ No major obstacles were faced; the implementation is strengthened using GAVI ISS.

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

•□□□□□□□□ The AEFI surveillance system is established and strengthened.

- The waste management part in relation to having incinerators is not implemented as this is found very costly for EPI and it is rather a national health system issue than EPI responsibilities

Please explain in 2012 how sharps waste is being disposed of, problems encountered, etc.

- Routinely as an immunization safety policy, safety boxes distributed with all vaccine deliveries to the vaccination sites for immunization sharp waste disposal as a bundle supply.
- 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 high cost
- 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 due to lack of sufficient supplies to implement safe injection and sharps waste management.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2012

	Amount US$	Amount local currency
Funds received during 2012 *(A)*	1,652,500	9,584,500
Remaining funds (carry over) from 2011 *(B)*	816,863	1,927,797
Total funds available in 2012 *(C=A+B)*	2,469,363	11,512,297
Total Expenditures in 2012 *(D)*	1,370,582	7,949,374
Balance carried over to 2013 *(E=C-D)*	1,098,781	3,562,923

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

ISS Funds have been included in the National health sector plans and budget

Financial Management Arrangements & Process are as follows:

Federal Ministry of Health regulates the utilization of ISS funds through its auditing system of finance and according to the Ministry of Finance rules and regulations. The ISS financing system comes under the PHC financing system. It has an internal auditing system as well as the external auditing system.

- Budgets are approved according to plans (central and states).<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

- Support to the states is according to the revised planed targets which is based on the locality micro-plans that are annually updated , revised, approved and endorsed
- 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 in order to achieve the targeted coverage. Thereafter, the needs and cost for these strategies is calculated according to specific guidelines.
- The states funds are transferred to the State MOH, and it is following the rules and regulation of the MOH.

Financial reports are provided to the central level

Problems encountered involving the use of ISS funds:

- No major problems were encountered involving the use of ISS funds

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

•□□□□□□□□ 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.

Funds channeled from national level to the Sub-national levels through the states MOH accounts

- States MOH distributes the support to the districts according to the budget in their micro plans to conduct outreach, mobile immunization sessions and supervision activities.

- States are monitored and accounted according to:
o Number of immunization sessions and children to be vaccinated every month
o Significant performance, and efficient use of EPI supplies in regard to their different situations
o 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**

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2012

The major activities conducted to strengthen immunization using ISS funds in 2012 are:

•□□□□□□□□ Out-reach and mobile immunization activities (Personnel and transportation cost).

•□□□□□□□□ Monitoring and supervision

•□□□□□□□□ Cold chain maintenance and rehabilitation

•□□□□□□□□ Training activities

•□□□□□□□□ Social mobilization activities

•□□□□□□□□ Programme management

•□□□□□□□□ Vaccines transportation & distribution

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

6.2. Detailed expenditure of ISS funds during the 2012 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2012 calendar year (Document Number 7) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **No**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number 8).

6.3. Request for ISS reward

Request for ISS reward achievement in Sudan is not applicable for 2012

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

7.1. Receipt of new & under-used vaccines for 2012 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2012 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2012 vaccinations against approvals for 2012

	[A]	[B]		
Vaccine type	**Total doses for 2012 in Decision Letter**	**Total doses received by 31 December 2012**	**Total doses of postponed deliveries in 2012**	**Did the country experience any stockouts at any level in 2012?**
DTP-HepB-Hib	3,997,653	2,238,900	1,454,400	No
Rotavirus	2,735,859	2,914,500	562,600	No
Pneumococcal (PCV13)		0	0	Not selected

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

If values in [A] and [B] are different, specify:

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

  DTP-HepB-Hib = 750,000 (received in 2013) / 1,454,400 (not received)

  Rotavirus = 1,956,000 (received in 2012) + 958,500 (belong to 2011)

  For Pentavalent vaccine

  - There are delayed shipments which are received in 2013, while there are 1,454,400 doses still not received.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />
  - Delay of the co-financing portion of the vaccines
  - No problems with cold chain
  - No doses discarded
  - No stockouts at any level .

  For Rota vaccine

  - There are delayed shipments to be received in 2013
  - Delay of the co-financing portion of the vaccines
  - Lower coverage than anticipated
  - No problems with cold chain
  - No doses discarded
  - No stockouts at any level

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

- The national shipment plan remained as planned & requested <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />
- At Sub-national levels few adjustments being followed in order to maintain cold chain storage capacities at State and locality levels to secure storage spaces for meningitis Conj A
- Use of VSSM tool at sub national level as a pilot.
  - 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 checklist for all levels

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

NA

7.2. Introduction of a New Vaccine in 2012

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2012, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 1 dose(s) per vial, LIQUID		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	NA

Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	NA

Rotavirus, 1 dose(s) per vial, ORAL		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	NA

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **November 2012**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9))

Post Introduction Evalation for Rota vaccine conducted in November 2012 & the summary of implementation of the recommendation as bellow :

Implementations of PIE of Rota vaccine recommendation <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Main recommendations

Implementation status

Remarks

National level

Political commitment and financial sustainability including co-financing of new vaccine from the Government is critical

1) 50.4% of 2012 co-financing agreement has been paid and transferred to UNICEF (US$ 600,000)

2)The government was paid the other cost for EPI (Salaries, building, local expenses… etc)

Many efforts had been made to mobilize the remaining fund and sustainability for 2013 (under process)

Continue to sustain the excellent coverage attained these last year using the RED approach

On-going strategy

The remaining localities which not reach 80/80 indicators **(26%)** were under special considerations

Continue to rely more and more on fixed and outreach strategy instead of mobile where possible

On-going as per sustainability plan for 2013

Fixed sites increased while mobile immunization activities decreased during 2013

Maintain the progress made by the EPI programme in strengthening the supportive supervision at all level

On going

States and localities supervisory visits to fixed sites are (78%) up to feb.2013

Continue effort to strengthen NITAG for the EPI programme

On going

The up coming scheduled meeting will be in April 2013

Continue to sustain the Post Marketing surveillance for Intussusceptions

On going

Out of 242, up to March 2013, (165) cases were reported (65%). No case reported within the 1st Wk following Rota vaccination

As Sudan is planning to introduce more new vaccines, human resource component for the cold chain at National and State level should be considered and well planned ahead

Under consideration

The proposal will be finalized and submitted to human resources unit by the end of June 2013

Refresher training of health workers should highlight in addition to vaccination, preventive measures against diarrhoea diseases

Under consideration

It will be part of the new training modules in coordination with IMCI program

Sudan planned to introduce Pneumococcal vaccine and other vaccines. Necessity to find a way to dispose all medical waste in collaboration with others departments.

Under consideration

Based on the coordination during previous measles, MNT and meningitis campaigns the new waste management plan will be developed

Locality (District) and HF level

Continue refresher training on good injection practice for new vaccine but also for others traditional vaccines

On going

All vaccinators will be trained in the period May to June 2013 in refresher training including new vaccine introductions

Update Basic information on cost of vaccine for HCW at Health Facilities level

Under consideration

In the new addition of the HW manual

Continue the separate recording and reporting of the population from outside the catchments areas at Health facility Level

On going

Partially in the main HF that does not have a catchment areas

Reinforce the home visit for defaulter tracing in the form of training, guidelines and checklist

pending

It will be considered in the upcoming refresher training

Develop an inter personal communication training for the health care workers

pending

Plan developed in collaboration with UNICEF

Develop and make available at health facility level flyers related to all vaccines with images showing the diseases they prevent

pending

Depending on financial availability

A plan for repair and maintenance of the cold rooms, generators, and other equipments should be available in written form at State level

On going

Letter will be send to all states

Continue refresher training on appropriate arrangement of vaccines in the cold box and vaccine carrier at Locality and health facility level

On going

Part of the vaccine management and vaccinators module

Policy for waste disposal should be reinforced at State and Locality level

pending

Should be part of over- all waste management policy

Extension of the collection and disposal system to all States and Localities

On going

Unique policy should be applied by the end of 2013

Pits should be deep, contents completely burned, and disposal sites located far away from the Health setting and fenced

pending

Letter will be issued to states to follow the instructions

Increase collaboration between EPI and other departments on clinical waste disposal at HF level

pending

Should be part of over- all waste management policy

Necessity to have if possible one shared incinerator in each State Hospital

pending

Should be part of over- all waste management policy in applicable areas with collaboration with MoH

Develop vaccine management training at health facility level which will include vaccine forecasting and ordering

pending

2nd half of 2013

Dry storage capacity should be increased at State level for routine but also for campaign purpose

Under consideration

With collaboration with MoH and other partners

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFI expert review committee? **Yes**

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **No**

Is the country sharing its vaccine safety data with other countries? **No**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **No**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **Yes**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

Does your country conduct special studies around:

a. rotavirus diarrhea? **No**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **Yes**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

7.3. New Vaccine Introduction Grant lump sums 2012

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2012 (A)	0	0
Remaining funds (carry over) from 2011 (B)	0	0
Total funds available in 2012 (C=A+B)	0	0
Total Expenditures in 2012 (D)	0	0
Balance carried over to 2013 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2012 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2012 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

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

NA

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

NA

Please describe the activities that will be undertaken with any remaining balance of funds for 2013 onwards

NA

7.4. Report on country co-financing in 2012

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2012?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	539,242	204,500
Awarded Vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
Awarded Vaccine #3: Rotavirus, 1 dose(s) per vial, ORAL	539,242	145,000
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2012 from the following sources?	
Government	USD 1,078,483	
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	0	0
Awarded Vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	0	0
Awarded Vaccine #3: Rotavirus, 1 dose(s) per vial, ORAL	0	0
	Q.4: When do you intend to transfer funds for co-financing in 2014 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2014	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	June	Goverment
Awarded Vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	June	Goverment

Awarded Vaccine #3: Rotavirus, 1 dose(s) per vial, ORAL	June	Goverment
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	No Need For the time being	

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

NA

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

7.5. Vaccine Management (EVSM/VMA/EVM)

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

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

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **June 2010**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

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

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

If yes, provide details

NA

When is the next Effective Vaccine Management (EVM) assessment planned? **October 2013**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2012

7.6.1. Vaccine Delivery

Did you receive the approved amount of vaccine doses for Meningococcal type A Preventive Campaigns that GAVI communicated to you in its Decision Letter (DL)?

[A]	[B]	[C]
Total doses approved in DL	**Campaign start date**	**Total doses received (Please enter the arrival dates of each shipment and the number of doses of each shipment)**
18900000	10/7/2012	1st shipment 2,292,000 received on 16/8/2012 , 2nd 2, 412,000 received on 18/8/2012 , 3nd 2,388,000 received on 19/8/2012 , 4th 2,304,000 received on 27/8/2012 , 5th 2,304,000 received on 28/8/2012 , 6th 2,400,000 received on 17/9/2012 , the last one 2,410,000 received on 20/9/2012

If numbers [A] and [C] above are different, what were the main problems encountered, if any?

No Different

- No major problems encountered<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />
- Delayed arrival of last shipments

If the date(s) indicated in [C] are after [B] the campaign dates, what were the main problems encountered? What actions did you take to ensure the campaign was conducted as planned?

All shipments were received before the campaign date, the campaign was conducted as planned

7.6.2. Programmatic Results of Meningococcal type A preventive campaigns

Geographical Area covered	Time period of the campaign	Total number of Target population	Achievement, i.e., vaccinated population	Administrative Coverage (%)	Survey Coverage (%)	Wastage rates	Total number of AEFI	Number of AEFI attributed to MenA vaccine
10 states	7-18/10/2012	16903090	16302107	97	95	6	669	0

*If no survey is conducted, please provide estimated coverage by indepenent monitors

Has the campaign been conducted according to the plans in the approved proposal?" **Yes**

If the implementation deviates from the plans described in the approved proposal, please describe the reason.

The implementation done according to the plans in the approved proposal

Has the campaign outcome met the target described in the approved proposal? (did not meet the target/exceed the target/met the target) If you did not meet/exceed the target, what have been the underlying reasons on this (under/over) achievement?

- **The campaign achieved the target described in the approved proposal in all states<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />**
- **Security compromised areas in Blue Nile state were excluded.**

What lessons have you learned from the campaign?

- **Government comment and collaboration with partners<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />**
- **Proper and early Planning**
- **Cascade training at all level**
- **Proper Vaccine management and Immunization safety.**
- **AEFI training and monitoring**
- **Waste management planning**
- **Post campaign evaluation (Coverage survey, Independent monitors)**

7.6.3. Fund utilsation of operational cost of Meningococcal type A preventive campaigns

Category	Expenditure in Local currency	Expenditure in USD
Cold Chain	10667208	1839174
Monitoring & Evaluation Pre & Post	2092316	360744
Personnel	6442200	1110724
Federal Supervision	898240	154869
Immunization Safety	1842609	317691
Social Mobilization	5213434	898868
Printing	2489230	429178
Training	2202428	379729
Transportation	22325395	3849206
Surveillance	3489170	601581
Total	**57662230**	**9941764**

7.7. Change of vaccine presentation

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

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2013

Renewal of multi-year vaccines support for Sudan is not available in 2013

7.9. Request for continued support for vaccines for 2014 vaccination programme

In order to request NVS support for 2014 vaccination do the following

Confirm here below that your request for 2014 vaccines support is as per 7.11 Calculation of requirements **Yes**

If you don't confirm, please explain

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID

ID		Source		2012	2013	2014	TOTAL
	Number of surviving infants	Table 4	#	1,284,722	1,327,317	1,363,272	3,975,311
	Number of children to be vaccinated with the first dose	Table 4	#	1,278,884	1,314,044	1,363,272	3,956,200
	Number of children to be vaccinated with the third dose	Table 4	#	1,177,206	1,234,405	1,295,109	3,706,720
	Immunisation coverage with the third dose	Table 4	%	91.63 %	93.00 %	95.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.01	1.00	1.00	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	727,056			
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	727,056			
	Number of doses per vial	Parameter	#		1	1	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.04	2.04	
cc	**Country co-financing per dose**	Co-financing table	$		0.26	0.26	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

NA

Co-financing tables for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID

Co-financing group	Intermediate

	2012	2013	2014
Minimum co-financing	0.20	0.23	0.26
Recommended co-financing as per APR 2011			0.30
Your co-financing	0.20	0.26	0.26

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2013	2014
Number of vaccine doses	#	3,496,400	3,644,600
Number of AD syringes	#	3,881,000	4,045,500
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	43,100	44,925
Total value to be co-financed by GAVI	$	7,780,000	8,109,500

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

		2013	2014
Number of vaccine doses	#	462,700	482,300
Number of AD syringes	#	513,500	535,300
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	5,700	5,950
Total value to be co-financed by the Country ^[1]	$	1,029,500	1,073,000

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 1)

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	11.69 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	1,278,884	1,314,044	153,547	1,160,497
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B X C*	3,836,652	3,942,132	460,641	3,481,491
E	**Estimated vaccine wastage factor**	*Table 4*	1.01	1.00		
F	**Number of doses needed including wastage**	*D X E*	3,875,019	3,942,132	460,641	3,481,491
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*		16,779	1,961	14,818
H	**Stock on 1 January 2013**	*Table 7.11.1*	727,056			
I	**Total vaccine doses needed**	*F + G – H*		3,958,961	462,607	3,496,354
J	**Number of doses per vial**	*Vaccine Parameter*		1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*		4,394,392	513,488	3,880,904
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*		48,778	5,700	43,078
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		8,060,445	941,868	7,118,577
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		204,340	23,878	180,462
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		28,292	3,306	24,986
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		515,869	60,280	455,589
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*		8,808,946	1,029,331	7,779,615
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		1,029,330		
V	**Country co-financing % of GAVI supported proportion**	*U / T*		11.69 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID (part 2)

		Formula	2014		
			Total	Government	GAVI
A	**Country co-finance**	*V*	11.69 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	1,363,272	159,300	1,203,972
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B X C*	4,089,816	477,898	3,611,918
E	**Estimated vaccine wastage factor**	*Table 4*	1.00		
F	**Number of doses needed including wastage**	*D X E*	4,089,816	477,898	3,611,918
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*	36,921	4,315	32,606
H	**Stock on 1 January 2013**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*F + G – H*	4,126,787	482,218	3,644,569
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*	4,580,679	535,255	4,045,424
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*	50,846	5,942	44,904
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	8,402,139	981,795	7,420,344
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	8,402,139	24,890	188,112
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	29,491	3,447	26,044
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	537,737	62,835	474,902
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	9,182,369	1,072,965	8,109,404
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	1,072,965		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	11.69 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / T*

Table 7.11.1: Specifications for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

ID		Source		2012	2013	2014	TOTAL
	Number of surviving infants	Table 4	#	1,284,722	1,327,317	1,363,272	3,975,311
	Number of children to be vaccinated with the first dose	Table 4	#	0	663,659	1,363,272	2,026,931
	Number of children to be vaccinated with the third dose	Table 4	#	0	597,293	1,295,109	1,892,402
	Immunisation coverage with the third dose	Table 4	%	0.00 %	45.00 %	95.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.00	1.05	1.05	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	0			
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	0			
	Number of doses per vial	Parameter	#		1	1	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		3.50	3.50	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.23	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.00 %	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

<P><FONT style="BACKGROUND-COLOR: #ffeeee">NA (PCV13 planned to <SPAN style="LINE-HEIGHT: 115%; FONT-FAMILY: 'Arial','sans-serif'; BACKGROUND: #ffeeee; FONT-SIZE: 8pt">Introduce </SPAN> on july 2013</FONT></P>

Co-financing tables for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

Co-financing group	Intermediate

	2012	2013	2014
Minimum co-financing		0.20	0.23
Recommended co-financing as per APR 2011			0.23
Your co-financing		0.20	0.23

Table 7.11.2: Estimated GAVI support and country co-financing (GAVI support)

		2013	2014
Number of vaccine doses	#	2,476,200	4,551,100
Number of AD syringes	#	2,642,000	4,836,700
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	29,350	53,700
Total value to be co-financed by GAVI	$	9,326,500	17,140,500

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

		2013	2014
Number of vaccine doses	#	138,900	296,100
Number of AD syringes	#	148,200	314,600
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	1,650	3,500
Total value to be co-financed by the Country ^[1]	$	523,000	1,115,000

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 1)

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	5.31 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	0	663,659	35,241	628,418
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B X C*	0	1,990,977	105,721	1,885,256
E	**Estimated vaccine wastage factor**	*Table 4*	1.00	1.05		
F	**Number of doses needed including wastage**	*D X E*	0	2,090,526	111,007	1,979,519
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*		522,632	27,752	494,880
H	**Stock on 1 January 2013**	*Table 7.11.1*	0			
I	**Total vaccine doses needed**	*F + G – H*		2,614,958	138,855	2,476,103
J	**Number of doses per vial**	*Vaccine Parameter*		1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*		2,790,106	148,155	2,641,951
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*		30,971	1,645	29,326
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		9,152,353	485,990	8,666,363
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		129,740	6,890	122,850
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		17,964	954	17,010
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		549,142	29,160	519,982
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*		9,849,199	522,992	9,326,207
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		522,992		
V	**Country co-financing % of GAVI supported proportion**	*U / T*		5.31 %		

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 2)

		Formula	2014		
			Total	Government	GAVI
A	**Country co-finance**	*V*	6.11 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	1,363,272	83,254	1,280,018
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B X C*	4,089,816	249,760	3,840,056
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D X E*	4,294,307	262,248	4,032,059
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*	550,946	33,646	517,300
H	**Stock on 1 January 2013**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*F + G – H*	4,847,053	296,003	4,551,050
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*	5,151,246	314,580	4,836,666
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*	57,179	3,492	53,687
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	16,964,686	1,036,010	15,928,676
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	16,964,686	14,628	224,905
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*	0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*	33,164	2,026	31,138
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	1,017,882	62,161	955,721
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*	18,255,265	1,114,823	17,140,442
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	1,114,823		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	6.11 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / T*

Table 7.11.1: Specifications for Rotavirus, 1 dose(s) per vial, ORAL

ID		Source		2012	2013	2014	TOTAL
	Number of surviving infants	Table 4	#	1,284,722	1,327,317	1,363,272	3,975,311
	Number of children to be vaccinated with the first dose	Table 4	#	1,044,757	1,207,859	1,363,272	3,615,888
	Number of children to be vaccinated with the second dose	Table 4	#	958,506	1,128,220	1,295,109	3,381,835
	Immunisation coverage with the second dose	Table 4	%	74.61 %	85.00 %	95.00 %	
	Number of doses per child	Parameter	#	2	2	2	
	Estimated vaccine wastage factor	Table 4	#	1.05	1.05	1.05	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#	1,486,419			
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	1,486,419			
	Number of doses per vial	Parameter	#		1	1	
	AD syringes required	Parameter	#		No	No	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		No	No	
g	**Vaccine price per dose**	Table 7.10.1	$		2.55	2.55	
cc	**Country co-financing per dose**	Co-financing table	$		0.26	0.30	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		5.00 %	5.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

NA

Co-financing tables for Rotavirus, 1 dose(s) per vial, ORAL

Co-financing group	Intermediate

	2012	2013	2014
Minimum co-financing	0.20	0.23	0.26
Recommended co-financing as per APR 2011			0.30
Your co-financing	0.23	0.26	0.30

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2013	2014
Number of vaccine doses	#	2,368,900	2,615,900
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Total value to be co-financed by GAVI	$	6,343,000	7,004,500

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

		2013	2014
Number of vaccine doses	#	254,800	330,100
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Total value to be co-financed by the Country ^[1]	$	682,500	884,000

Table 7.11.4: Calculation of requirements for Rotavirus, 1 dose(s) per vial, ORAL (part 1)

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	9.71 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	1,044,757	1,207,859	117,290	1,090,569
C	**Number of doses per child**	*Vaccine parameter (schedule)*	2	2		
D	**Number of doses needed**	*B X C*	2,089,514	2,415,718	234,580	2,181,138
E	**Estimated vaccine wastage factor**	*Table 4*	1.05	1.05		
F	**Number of doses needed including wastage**	*D X E*	2,193,990	2,536,504	246,309	2,290,195
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*		85,629	8,316	77,313
H	**Stock on 1 January 2013**	*Table 7.11.1*	1,486,419			
I	**Total vaccine doses needed**	*F + G – H*		2,623,633	254,770	2,368,863
J	**Number of doses per vial**	*Vaccine Parameter*		1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*		0	0	0
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*				
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		6,690,265	649,662	6,040,603
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		0	0	0
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*		0	0	0
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*		0	0	0
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		334,514	32,484	302,030
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	**Total fund needed**	*(N+O+P+Q+R+S)*		7,024,779	682,145	6,342,634
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		682,145		
V	**Country co-financing % of GAVI supported proportion**	*U / T*		9.71 %		

Table 7.11.4: Calculation of requirements for Rotavirus, 1 dose(s) per vial, ORAL (part 2)

		Formula	2014		
			Total	Government	GAVI
A	Country co-finance	*V*	11.20 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	1,363,272	152,748	1,210,524
C	Number of doses per child	*Vaccine parameter (schedule)*	2		
D	Number of doses needed	*B X C*	2,726,544	305,496	2,421,048
E	Estimated vaccine wastage factor	*Table 4*	1.05		
F	Number of doses needed including wastage	*D X E*	2,862,872	320,771	2,542,101
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	81,592	9,142	72,450
H	Stock on 1 January 2013	*Table 7.11.1*			
I	Total vaccine doses needed	*F + G – H*	2,945,964	330,081	2,615,883
J	Number of doses per vial	*Vaccine Parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	0	0	0
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*			
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	7,512,209	841,705	6,670,504
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	7,512,209	0	0
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	375,611	42,086	333,525
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	7,887,820	883,791	7,004,029
U	Total country co-financing	*I x country co-financing per dose (cc)*	883,790		
V	Country co-financing % of GAVI supported proportion	*U / T*	11.20 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / T*

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for and received HSS funds before or during January to December 2012**. All countries are expected to report on:

   a. Progress achieved in 2012

   b. HSS implementation during January – April 2013 (interim reporting)

   c. Plans for 2014

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2012, or experienced other delays that limited implementation in 2012, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2012 fiscal year starts in January 2012 and ends in December 2012, HSS reports should be received by the GAVI Alliance before **15th May 2013**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2013, the HSS reports are expected by GAVI Alliance by September 2013.

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

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

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

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

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2012

   b. Minutes of the HSCC meeting in 2013 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2012 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

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

9.1. Report on the use of HSS funds in 2012 and request of a new tranche

Please provide data sources for all data used in this report.

9.1.1. Report on the use of HSS funds in **2012**

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

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

9.1.2. Please indicate if you are requesting a new tranche of funding **No**

If yes, please indicate the amount of funding requested: US$

These funds should be sufficient to carry out HSS grant implementation through December 2014.

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

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

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)				4665745		257408774
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				69978	3628697	1796333
Total funds received from GAVI during the calendar year (*A*)				4735723	3792203	441657774
Remaining funds (carry over) from previous year (*B*)				1107026	1995870	2783215375
Total Funds available during the calendar year (*C=A+B*)				3628697	1796333	163336237
Total expenditure during the calendar year (*D*)						
Balance carried forward to next calendar year (*E=C-D*)						
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)				
Total Funds available during the calendar year (*C=A+B*)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)		6739964		14149211		1801926357
Revised annual budgets (*if revised by previous Annual Progress Reviews*)			4028404	230923	10726948	4031815
Total funds received from GAVI during the calendar year (*A*)		6739964	4028404	14380134	11216948	22217244
Remaining funds (carry over) from previous year (*B*)		2711560	3797481	3653186	7185133	10783059
Total Funds available during the calendar year (*C=A+B*)		4028404	230923	10726948	4031815	11434185
Total expenditure during the calendar year (*D*)		6739964	6918573	7101914	8284222	
Balance carried forward to next calendar year (*E=C-D*)						
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]						

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)				
Total Funds available during the calendar year (*C=A+B*)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]				

Report of Exchange Rate Fluctuation

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

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January		2.2	2.2	2.2	2.5	2.6
Closing on 31 December		2.2	2.2	2.4	2.6	4.3

Detailed expenditure of HSS funds during the 2012 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2012 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2013 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

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

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

Theoverall management of GAVI HSS funds is the responsibility of the Sudan FederalMinistry of Health (FMOH), this is carried out in accordance with governmentguidelines and procedures, laid down by the Ministry of Finance and NationalEconomy. The National Health Sector Coordination Committee (NHSCC) includingrepresentatives of GAVI development partners and non-government organizations, oversees the GAVI HSS programmeactivities.

Followingthe 2012, FMA recommendations, a bank account denominated in Euro was openedat Blue Nile El Meshreg Bank which ismaintained by the International Health Directorate to receive GAVI payments aswell as to pay for programme expenditures eligible for GAVI programmefinancing. Joint signatories to this bank account are the Global HealthInitiatives Coordinator and the HSS Finance Manager.

In accordance with the Aide Memoire signed inNovember, 2012 between GAVI and FMOH, an annual work plan and budget outliningGAVI HSS activities is prepared by GAVI Management team at the beginning of theGovernment of Sudan financial year and is presented for the NHSCC for reviewand approval. Funds received from GAVI secretariat are thus disbursed to theeligible recipients/contractors against approved activities in the Annual WorkPlan. Financial reports are prepared by the financial officer and presented tothe GAVI/HSS Coordinator on monthly basis. A monthly bank reconciliation,together with a copy of the cash book is provided for review and sign off toboth Global Health Initiatives Coordinatorand Internal Auditor

Has an external audit been conducted? Yes

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

9.2. Progress on HSS activities in the 2012 fiscal year

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

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2012 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Activity 1.1.1:	Short and long term TA to assist in building the capacity of 15 northern states and 20 localities	60	
Activity 1.1.2:	Train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings	60	Annex 3: health management teams training report Annex 4: LHMT Proposal
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 loclaities * 3 each =60	30	Annex 5: leadership training course report

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	100	Annex 6: List of taskforce assigned to develop the job descriptions Annex 7: Job descriptions
Activity 1.1.10	Train admin and financial staff in 11 northern states on budgeting and financial and resources management.	100	
Activity 1.2.1:	Support planning process (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)	90	Annex 8: Training on planning software list of participants Annex 9: Pre- JANS TORs and mission program Annex 10: OneHealth tool Annex 11: JANS mission report
Activity 1.2.2:	provide copies of the planning and instructional manual to 11 SMOH and 20 Localities Management Teams	10	
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;	100	
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	
Activity 1.3.3:	provide TA for developing/adapting pro-poor, comprehensive and sustainable health financing policy in 11 Northern states	90	Annex 12: WHO Health Financing Report
Activity: 1.3.4:	provide TA for developing PHC services and immunization sustainability plans for national level and 11 Northern states	100	Annex 12: WHO Health Financing Report
Activity 1.4.1:	TA to support designing of a community based health information system	80	
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	60	Annex13 :List of selected CHW students at Red Sea State
Activity 1.4.3:	design and establish a comprehensive integrated information base at national and state level (in 11 states	0	
Activity 1.4.4:	develop a health system observatory that could provide output using GIS and set up mechanisms for the regular updating of health system profile.	90	Annex 14: list of observatory indicators Annex 15: list of observatory documents

Activity 2.1.2:	institute innovative approaches like financial and non-financial incentives as operational research for improving the retention of health staff	90	Annex16: Ecological case study report survey
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).	100	
Activity 2.2.6:	Support to institutionalize Continuing Professional Development programmes as a pilot in four AHSs (Khartoum, Gezira, White Nile, and Gadarif)	100	
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 annuly * 5 years	30	Annex17: Medical assistant training curricula Annex 18 : Medical assistant training report
Activity: 3.1:	provide cold chain to support health facilities to work as fixed sites for immunization (60 annually) (4 states * 15 health afcilties * 5 years = 300 health afcilties)	100	
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	
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	100	
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* facilites *4 state*2= 48 in 3 and 4)	100	
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)	100	
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)	40	

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)	40	
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)	40	
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	40	Annex 19: Project proposal for covering pregnant women with FEFOL
Activity 4.2.2: year	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	40	Annex 19: Project proposal for covering pregnant women with FEFOL
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	40	
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.	40	
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)	90	
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	10	

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)	30	
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).	25	
Activity 5.1	Support the DGHP&D in the FMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support	70	
Activity 5.3	Support the DGHP&D in the 4 SMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support	40	

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

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**
Detailed planning, annual review as part of operat	Detailed plans with budget breakdown for 4th year activities of the grant were developed by implementing departments during October and November, 2012, following the disbursement of funds. These work plans formed the bases for the contracts that were later on signed with the departments to implement activities. Prior to that progress in implementation was reviewed at National Health Sector Coordination Committee Meeting held on May 2012 and previously on March 2012 to endorse 3rd year activities held in March, 2012 (Annex 20: National Health Sector Coordination Committee Meeting May 2012)

Activity 1.1.1: short and long term TA to assist i	As a follow up on the assessment of the Health Planning System in the Public Health Sector of Sudan (PHI) conducted by a team of consultants from the University of Leeds in November 2011, a Local Technical Assistant from the Public Health Institute in Sudan was assigned in March, 2013 to develop and update the planning guidelines and manual for state and locality Health Management Teams. This mission aims at unifying the health system planning manual across state levels in order to improve the quality of the planning process by providing a uniform reliable tool. The updated manual will support the introduction of a standardized framework for the planning process at all levels of the system and serve as a legitimate guide for health system planning. The Mapping of Health facilities conducted in 2011-12 by TA teams, with the purpose of expanding primary health care services, revealed that 24% and 9% of PHC facilities provide the minimum and comprehensive PHC package respectively. Expanded Program for Immunization, Anti natal Care, Nutrition and Integrated Management of Childhood Illnesses (IMCI), currently have a coverage of 74%, 55%, 34% and 40% respectively which is far beyond the accepted national and international standards. Based on these findings and data from the PHC package and costing of the PHC has fed into developing a plan for expanding the primary health care (activity1.3.4) which is currently being implemented. (Annex 21: PHC Expansion Plan) Expansion of PHC services (horizontally by expanding the network and the range of services offered and vertically by reaching out to communities) is aimed at improving equity in access and providing an integrated, high quality, patient centered approach. It is one of the strategic directions of The Sudan National Health Sector Strategic Plan, 2012-13 that aim at achieving universal coverage with appropriate and affordable services and thus achieving the overall health goals set for the country.
Activity 1.1.2: train health management teams in 1	The Public Health Institute (PHI) Leadership Diploma Program that had been previously planned for 2010 but had been delayed, due to ineligibility of candidates for the course, was rolled out in 2012 from other sources. Course duration is 27 week (18/11/2012 -23/05/2013). This course qualifies for a diploma. It was developed to meet the health system needs at locality level by engaging public health workers in powerful leadership and personal growth development experiences. It also covers the managerial skills needed for work. It requires students to design projects to be applied at one of the localities; these projects will ensure learning is transferred directly to the work environment in different localities in Sudan. Below are the proposed students projects that are being supported under GAVI/HSS (Annex 5: Leadership training course report) : 1. Developing a system for human resource performance management in White Nile State, Rabak Locality, 2013 2. Facilitating an enabling environment to implement effective integration in health services in alkamleen locality 3. Development of Management Capacity of Health Centers Mangers in Shaikan Locality, North Kordofan State 2013 4. Strengthening Health Information System in Gutiena Locality, Sudan 2013 Students enrolled in PHI Diploma Program (Batch 1) are from North Kordofan, White Nile and Gazira states as well as Federal Ministry of Health. These students vary in background and years of experience and include (4) doctors, (6) Public health officers, (2) nutritionists, (1) Liberian and (2). economists.

Activity 1.1.9: provide TA to 11 Northern states f	To accomplish this task, The Public Health Institute (PHI) provided technical support for developing TORs and Job descriptions for secondary and tertiary care level (alongside this assignment, TORs and job descriptions for PHC were developed by PHI under GF/HSS). A taskforce was formulated (Annex 6: List of taskforce assigned to develop the job descriptions) to work on the gaps identified in developing job descriptions. TORs and job descriptions for secondary and tertiary care were developed for the following positions: - Senior medical specialist - Medical Doctor - General hospital manager - Chief nurse officer - Medical officer Each position included the following; job title, job specifications, job summary & general role, organizational relationships and impact, qualifications and duties & responsibilities as in attached (Annex 7: Job descriptions).
Activity 1.1.10: train admin and financial staff i	One hundred and twenty five participants were trained on administration and finance during April-May, 2012. An extra 37 participants were trained late May, 2012 to reach the target of 160 by CPD in collaboration with PHC and Health Economics departments. In January, 2013 another 150 participants were trained to compliment trainings on leadership and management conducted by GF (mentioned in 1.1.2) in an integrated manner since funds allocated were insufficient and estimated prior to the era of integration. In 2013, 228 participants are planned to undergo training with support from GF/HSS Phase II Grant (linked to activity 1.1.2 and 1.2.5, to be implemented in an integrated manner, using the integrated management and leadership training manual mentioned in activity1.1.2).
	National Health Sector Strategic Plan(NHSSP),2012-16: In support of developing the National Health Sector Strategic Plan (NHSSP),2012-16 and other planning processes, the following activities were conducted during 2012-13: Pre-JANS Mission A pre-JANS mission was conducted during the period 08 to 10 May, 2012 by a team of experts, comprising a member of IHP+ Core Team together with Senior Health Advisor, Africa Region, World Bank Kenya Country Office. The main purpose of this visit was to seek advice of the IHP+ Core Team on the process and contents of the strategy. Furthermore, this opportunity was made of in sensitizing and raising awareness amongst donors and partners on the importance of supporting the National Strategy for improved aid effectiveness and drawing their attention towards development needs in the health sector. Pre - JANS TORs and mission program attached Annex 9: Pre- JANS TORs and mission program. Technical Assistance for Costing of NHSSP 2012-2016 Through WHO, technical support (the Swiss Centre for International Health (SCIH) at the Swiss Tropical and Public Health Institute (SwissTPH), Basel, Switzerland) was availed during the period 17 to 29 June, 2012 to introduce and support the FMOH in implementation of OneHealth tool for the costing of NHSSP. The mission involved a workshop specifically aimed to build capacities within FMOH staff and costing of the NHSSP, i.e entering Sudan data in the tool and revising the default values. A dedicated team was assigned to continue the work following the mission since the time lines were the terms of reference for this consultancy were not realistic. (Annex 10: OneHealth Tool). Technical Assistance for Developing the Monitoring and Evaluation Component of NHSSP 2012-2016 Technical Assistance was provided during the period 7 to 13 July, 2012 with the aim of designing a common (government and donors') monitoring and evaluation framework for the strategy to

Activity 1.2.1: Support planning process (purchase	measure the progress in aid effectiveness and partnership, as well as progress in achieving MDGs at national and state level. The product of this TA was a handbook on common M&E framework for aid effectiveness, attached as Technical Assistance for Finalization of NHSSP 2012-2016 This consultancy took place during the period 21-31 July, 2012. Its aim was to assist the National Team with finalizing the NHSSP, including shaping its appeal for donors support. This was achieved by reviewing background documents and the draft NHSSP within JANS framework for its overall structure, manner in which it was developed, its linkage with other planning processes, linkages between the different levels of objectives and proposed interventions as well as technical and financial feasibility. State Planning Directors Coordination Meeting A planning meeting for the states was held in July, 2012 with the purpose of reviewing state strategic plans and to double check their alignment with NHSSP, 2012-16. JANS Mission A Joint Assessment of National Strategies (JANS) of NHSSP was conducted during the period 18- 30 November 2012. The sector strategy was assessed with an in-depth review of programme specific strategies (One JANS), this included HIV, TB, Malaria and immunization Improve synergy between sector and programme strategies (address fragmentation and inconsistency) This was carried out by an independent team composed of national and international members. The attached report presents the findings (strengths, weaknesses and recommendations Annex 11: JANS mission report). Currently recommendations outlined in the report are being implemented by a team that has been dedicated to finalizing the strategy by the mid April,2013. Mid-term review and reprogramming of WHO Biennium, 2012-13 This activity was implemented during the period 23 Jan-6 Feb and was followed by a two day meeting in which the departments at FMOH presented their plans and reached a consensus on having a 2013 comprehensive plan “One Plan” which included plans of all partners (WHO, UNICEF, UNFPA, UNAIDS, GF, GAVI and others). Tentative plans were also made to conduct Joint Annual Health Sector Review (JAR) in June, 2013. local country compact Preparations are underway for a local country compact to be signed between local partners and the government with the aim of aligning and harmonizing aid and funding of the national strategy. Planning Software: Comprehensive planning software has been granted to The Federal Ministry Of Health by The Egyptian Government. This has been customized and adopted to the health system in Sudan. Training of more than 100 participants from the Federal Ministry of Health on the software was conducted .The system was planned to be launched in April, 2013 but has been delayed due to some network connectivity issues. GAVI/HSS funds had been utilized to cover the cost of trainees and per diem for participants, list of participants attached. Work load Indicator Survey for HRH The Directorate of Human Resources for Health Directorate is implementing the work load survey , WISN which is analytical planning tool of staffing needs (a newly WHO recommended tool) which will assist in: • Determining how many health workers are required to cope with actual workload in a given facility • Estimating staffing required to deliver expected services of a facility based on workload • Calculating workload and time required to accomplish tasks of individual staff categories • Comparing staffing between health facilities and administrative areas The tool is currently being applied to all personnel categories (medical, allied health professions and non-medical staff) in 2 of the GAVI/HSS states. Implementation began in 14 March, 2013 and will continue until the end of the year .Annex 27

Activity 1.2.2: provide copies of the planning and	The printing of the planning and instructional manual is under process.
Activity 1.2.3: develop a system for short course/	A system has been developed for building capacities in planning together with leadership, management, admin and finance training at the Center for Continuous Professional Development, Khartoum, Sudan as indicated in activities 1.1.2 and 1.1.10.
Activity 1.2.5: train at least two staff from each	This activity has been carried over from 2009 due to the Ministry's interest in integrating training at primary health care level. Following the development of integrated training package of leadership, management which includes (leadership, management, administration & finance and Planning), this activity is being implemented within this package. A new training centre for leadership and management has been established at Abuoshar locality at Gezira State aiming at institutionalizing this training and taking over this role from Center for Continuous Professional Development, Khartoum, Sudan.
Activity1.3.3: provide TA for developing/adapting	This activity is part of The Health Financing Component for which a contract was signed with WHO in 2008 and that was extended till 30 June, 2012 due to several issues namely; unwillingness of consultants to work in Sudan for security reasons, underestimated cost and duration of activities (fieldwork for most of the surveys), harmonization of inputs from other projects(Multi Donor Trust Fund supported decentralized Health System development Project), disagreement of involved parties (Federal ministry of health and National Health Insurance Fund) on methodology for some of the surveys (in-depth review of National health insurance fund). The following documents, produced as part of the health financing component, will be used for framing the national policy for sustainable health financing: - National health accounts (Round one) - Household health services utilization (activity 1.3.1) - In depth review of National health insurance fund - Comprehensive PHC package (activity 1.3.4) - Cost of the PHC package (activity 1.3.4) - KAP study of household health behavior (activity 4.3.4) Despite all the evidence generated, framing of the national health financing policy is being delayed due to the Ministry's preference in using the WHO tool (OASIS) for organizational Assessment for improving and Strengthening Health Financing. The exercise for OASIS is in progress and training of the national team on this tool was organized by WHO/EMRO and is expected that the assessment results will soon be available. That will be followed by developing a policy brief and organizing a dialogue involving broader stakeholders. (Annex12: WHO Health Financing Report) The above documents produced have also provided valuable input in developing the National Health Sector Strategic Plan, 2012-16.
Activity: 1.3.4 provide TA for developing PHC serv	This activity is part of The Health Financing Component for which a contract was signed with WHO in 2008 and that was extended till 30 June, 2012 due to delays in defining the PHC package, cancelation of a contract with one consultant and signing with another to conduct the assignment. Finally a comprehensive PHC package has been developed and costing conducted (benefiting from the findings of the KAP Study – Activity 4.3.4). The data from the PHC package and costing of the PHC has fed into developing a plan for expanding the primary health care, mentioned in activity 1.1.1. (Annex12: WHO Health Financing Report).

Activity 1.4.1: TA to support designing of a commu	Previously, in 2010 a manual for community based health information system was developed. Based on that in 2012- 2013 eight workshops were conducted to build consensus around the proposed community based health information system. Supportive and advocacy supervisory visits have also been conducted for raising awareness.
Activity 1.4.2: support to implement community bas	he National Health Information Center is planning to conduct (in 2013) TOT for Federal, State and locality coordinators on the designed community health information system and training of data collectors at localities, communities and facilities as well as community health workers. Information system Federal/ States infrastructure support was provided for 34 localities and 15 at Federal level. The Primary Health Care Department, together with the Academy of Health Sciences have started to train a pool of community health workers (CHWs) to fill the gap in this health care provider and implement the community based health information system at the Red Sea State (based on the PHC Expansion Plan). Annex13 :List of selected CHW students at Red Sea State. 100 Students were selected from the various localities according to the agreed upon selection criteria, the list of the selected students is attached (annex 12).Accommodation was arranged and provided to the selected students. Students are given living allowances on weekly basis (to maintain the sustainability and their continuity with the program).The study and the training began on the 2nd of March 2013 and will continue until December 2013. On the other hand, GAVI states (Sinnar, North Kordofan, White Nile and Gedraif) have submitted proposals for the development and implementation of a comprehensive integrated community based health information system to serve their states. Special emphasis has been given to creating a unified reporting system and increasing the reporting rates. It also covers the training of health information workers at locality and community levels, printing components of data collection formats as well as monitoring & evaluation of the program implementation.
Activity 1.4.3: design and establish a comprehensi	A proposal was developed late in 2011 to reform the Health Information System (HIS) by TA availed through WHO. This has contributed to delay in implementation of all HIS activities (1.4.1, 1.4.2, 1.4.3). A framework for detailed design of integrated health management information system has been developed by TA availed through GF. Another TA developed a comprehensive list of indicators for routine health information system data. June 2012, TA availed through GF developed template for data dictionary and then data collection tools at facility level and also trained the health facility staff on these tools. Supervisory visits will be conducted at states and locality levels under GAVI/HSS after implementation of the comprehensive integrated information system.

Activity 1.4.4: develop a health system observator	Sudan Health System Observatory Progress in 2012; 1. Designing Sudan Health system Observatory Website : • Data Analysis Phase Completed. • Backend specifications for different modules (indicators, knowledge hub, health intelligence, news/events, and gallery) agreed upon and work on Backend to be completed by January. • Frontend design final layout reached. 2. Development of indicators database: • Indicators to be included in observatory were identified and a master sheet for indicators and Meta data designed. (Annex 14: list of observatory indicators) 3. Knowledge Hub (E-library): • The Documents to be uploaded were selected and the inclusion and exclusion criteria for them was developed accordingly 105 documents identified Annex 15: list of observatory documents 4. Health Intelligence: • Preparatory meetings for guidelines and themes for trend analysis and automated health system profiles were done Next Steps in 2013 (some already started): 1. Sudan Health system Observatory website: • Testing and Final institution of Backend and Frontend in FMOH • Soft and final Launching of SHO in July 2013 2. Indicators Database: • Data Compilation & entry (All data on Indicators from 1990-2012) 3. Knowledge Hub: • Completion of All documents to be included • Editing of Documents (word doc. to Pdf, cover pages) • Uploading onto the Website 4. Health Intelligence: • Policy brief and trend analysis • Health System Profiles :automated and manual (National and State) 5. Capacity Strengthening • Training for SHO teams

Activity 2.1.2: institute innovative approaches li	Based on the seven previously identified areas in 2011 related to the operational research on gender, migration and retention of health staff that were distributed to postgraduate students as part of the capacity building in health system research, the following are being conducted: 1. Compilation of all HRH plans and initiatives starting from 2001 at the federal and state levels using a case study approach to establish the HRH context in Sudan 2. A study on the impact of decentralization on human resource management practices on retention and migration. 3. A study on the impact of the career pathway on retention of human resources 4. A study on the role of CPD with respect to enrolment/attraction to category of health work, motivation and job satisfaction 5. A survey of registrars at Sudan Medical Specialization Board to quantify their previous experience of rural working and to explore how gender perspectives impact on the availability and access to health services, both in rural and urban areas. 6. A survey was among doctors in Khartoum aiming to quantify dual practice among public sector doctors and to explore its effect on rural retention. 7. A review of the current routine information sources, specifically for migration. Data has been collected and is now being analyzed. These researches cover all the states in Sudan with in-depth data collection from particular selected states for each specified topic. Due to the exploratory nature of this research all the studies combined mixed methods with qualitative in-depth analysis. These will be completed by mid-May, 2013. The project also aims to provide evidence for policy makers to guide decisions for appropriate strategies to attract, retain and distribute human resources for health. A senior researcher was also appointed to provide assistance in conducting this operational research and has also produced a report in November, 2012 on: the distribution of health workforce in Sudan: An ecological case study of impact on maternal health and mortality (Annex16: Ecological case study report survey)
Activity 2.2.5: Provide tuition fees in every acad	In 2013, the Academy of Health Sciences (AHS) began to support training of students from different categories in the AHS branches in each of the four targeted SMOH (Sinnar, Gadarif, North Kordufan &White Nile states). Support has been provided to train and enroll 1209 students under the PHC Expansion Initiative as follows: o Midwifery Students : a total of 1035 candidates for the Midwifery training program in four states (Gedarif, W.Nile, N.Kordofan & Sinnar) o CHW Students: a total of 174 students for the CHW training program in two states (Gedarif & W.Nile)
Activity 2.2.6: support to institutionalize Contin	Based on the MOU signed between the CPD & AHS, a committee composed of members from the AHS; CPD & PHC was assigned to develop the integrated medical assistant training package. (Annex 16) Subsequently TOT training was conducted during the period September- December, 2012 targeting AHS trainers from the targeted states (carried out at federal level and funded by the government) after which they some of the states were assessed at state level while conducting the training. This is linked to the activity below

Activity: 2.2.7: provide integrated on the job tra	Under GF/HSS support 430 medical assistants were trained from the following states; (North Krodufan, River Nile, White Nile, South Kordofan and Northern State.) using the above mentioned curricula. This covered the following areas; (MCH, essential drugs, non- communicable, communicable disease, reporting on epidemics, emergency medicine, ophthalmic diseases, health promotion and PHC and health administration). (Annex17: Medical assistant training curricula). In 2012, from GAVI support CPD conducted a TOT training for 41 participants on the integrated package of primary health care. In addition to another 60 nutritionist in 2013. In 2013, integrated training will be provided in immunization, nutrition and health promotion at the four GAVI states in May.
Activity: 3.1: Provide cold chain to support healt	To expand the fixed sites to raise the storage capacities at locality levels, according to the locality needs and micro planning the following cold chain equipments were purchased and distributed to 60 sites, 15 per state (GAVI states) at April 2013; • solar refrigerator • Ice lined refrigerator • Ice back refrigerator The activity is completed 100%
Activity 3.2: Support to outreach services target	After identification of number of outreach and mobile teams according to the targets in the remote areas. The implementation of outreach services as planned. The activity is completed 100%
Activity 4.1.2: rehabilitate 1 rural hospital annu	The rehabilitation activities are planned to be conducted into two phases, as follow: The first phase: Started with the assessment that has been was conducted in March, 2013 by a team of FMOH engineers for 30 health centers (HC) & PHC units and 7 hospitals (blood bank, delivery rooms, theater- focusing on improving EMOC services) in 3 states (excluding Gadarif state because it is planned to cover its civil work activities by the fund availed from the government to the PHC expansion project). Selection was based on health map which is the bases for PHC expansion project. Based on this assessment the selection of rural hospitals and health centers will be rehabilitated and PHC units upgraded were done. After the selection advertisement for competitive bidding was done at Federal level and the company to undertake the implementation was agreed upon. States had nominated a focal person for local supervision, based on the recommendations set in the Audit report, 2011. The last sub activity within the first phase is signing the contract with the implementing company, and this will take place on Sunday 19th of May. So the first phase of the activity implementation is 100% completed. The second phase: This phase will start after signing the contracts with the implementing company and will after three month. It is expected to finish by end of August 2013.
Activity 4.1.3: rehabilitate/upgrade 3 dispensarie	See Activity 4.1.2 progress
Activity 4.1.4: rehabilitate 2 rural health cente	See Activity 4.1.2 progress
Activity: 4.1:5: provide essential equipment and f	Assessment was done at state level to measure the gaps in medical equipment. EMOC equipment will be provided to rural hospitals according to the gaps, and a new set of supplies will be provided to HC & PHC units. Assessment report has been sent to the Central Medical Supplies to initiate the bidding process by the end of April 2013.
Activity: 4.1:6: provide essential equipment and f	See activity 4.1.5
Activity 4.1.7: provide essential equipment and fu	See activity 4.1.5

Activity 4.2.1: provide medicines for the treatmen	Anemia in pregnancy remains to be a major health problem and one of the leading causes of maternal deaths, based on this FEFOL cabs will be provided according to the need, distribution list attached (Annex 19: Project proposal for covering pregnant women with FEFOL) Diarrhea among children under five is one of the major health problems and one of the five main direct causes for under five mortality, based on this zinc supplement will be provided according to the need.
Activity 4.2.2: year provide medicines for the tre	Anemia in pregnancy remains to be a major health problem and one of the leading causes of maternal deaths, based on this FEFOL cabs will be provided according to the need, distribution list attached (Annex 19: Project proposal for covering pregnant women with FEFOL) Diarrhea among children under five is one of the major health problems and one of the five main direct causes for under five mortality, based on this zinc supplement will be provided according to the need. Anemia in pregnancy remains to be a major health problem and one of the leading causes of maternal deaths, based on this FEFOL cabs will be provided according to the need, distribution list attached (Annex 19: Project proposal for covering pregnant women with FEFOL) Diarrhea among children under five is one of the major health problems and one of the five main direct causes for under five mortality, based on this zinc supplement will be provided according to the need.
Activity 4.2.3: provide essential laboratory suppl	Laboratory supplies will be procured through the National Public Health laboratory and their branches in the four GAVI states. Competitive bidding was done. A contract has been signed with the company and direct payment is to made by FMoH.
Activity 4.2.4: provide essential laboratory suppl	the same as above
Activity 4.2.5: provide long lasting insecticidal	10800 insecticidal mosquito bed nets were received by the Malaria program and will be distributed at Gedarif State localities due to the huge gap recorded at this state. Distribution report expected by May 2013
Activity 4.2.6 : Provide HMIS printed supplies for	HMIS printed supplies will be provided to serve Nutrition and RH based on the need identified by the PHC mapping.
Activity 4.3.2: print and disseminate documentarie	Based on the high rates of infection with Hepatitis B virus recorded in 2004-2005 and fatality rate for viral hemorrhagic fevers, support has been provided to the Health Promotion Directorate at FMOH to print educational material to serve this very purpose. Approval for limited competitive bidding was obtained from the Federal Ministry of Finance.
Activity 4.3.3: conduct operational research in se	Attempts to conduct operational research have been disrupted by the delay in fund disbursement and delay in activity implementation.
Activity 5.1: Support the DGHP&D in the FMOH to co	This support was mainly utilized for Implementation Team Meetings, NHSCC Meetings, Incentives for Coordination Team and other supporting staff in addition to other operational activities (e.g. communications, reporting).
Activity 5.3: Support the DGHP&D in the 4 SMOH to	Support has been provided for state focal persons in the form of incentives to coordinate, monitor and report on activities implemented at both state and locality level, in addition to supervisory visits.
Activity 6.1: Undertake baseline (in 2008) and eva	Baseline Survey was undertaken in 2008. Evaluation research will be conducted in 2013 since the project has been extended till then.

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

- Delay in implementation has been attributed to the Delay in release offunds for the 4th year (funds received in October 2012).

- □□□□□□□□ Some of the trainingactivities were delayed due to development of integrated manuals (PHC workers& leadership and management).

- □□□□□□□□The reform of the integrated health information systemresulted in the delay of related activities.

Other activities were longitudinal in nature and tooklonger than was anticipated (PHI diploma, operational research on gender,migration & retention and gender, health financing policy).

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

Currently the staff atGAVI/HSS Management Unit receive small incentives (salary top-ups) from themanagement cost (activity 5.1). These are provided with the intention ofretaining staff since the turn over at the Federal Ministry of Health (FMOH) isvery high. To deal with the problem of high turnover FMOH has developed anincentive/Top-up salary scheme that was presented and endorsed by NHSCC and ispending endorsement by CCM after responding to GFATM CCM clarifications andincluded the performance indicators and simplifying the calculation method.

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2011 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2012 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2008	2009	2010	2011	2012		
% SMOH with functioning organizational structure as per standards	0 (measured versus the standard structure)	Admin. reports	100%	25%						Health facility Mapping, 2011-2012	To date 75% of target achieved. This has been achieved in 2011 As part of the recent proposal to assess the implementation level of organizational at state level.
2. % SMOH with functional Planning Directorates	0 (measured versus the standard functionality)	Admin. Reports	100%	0%						-	

3. % states planning directorates using standard planning format	0	Admin. reports	100%	20%						Planning department quarterly report	To be achieved by 2010. To date 80% of target has been achieved. Several activities have contributed to achieving the above target in previous years. in 2013 planning software was installed and mass training at Federal level has been conducted on it.
4. % SMOH with functioning directorates of human resource	0	Admin. reports	100%	0%						-	100% was achieved in 2010, according to Planned target (reported in APR 2010).
5. % health facilities (RH, RHC, UHC, Dispensary/BHU) providing essential PHC package	35	Health facility survey (Based on estimations)	50%	26%						Health facility Mapping, 2011-2012	50% was to be achieved by the end of 2011. by 2012, 24% was achieved. There was a problem with the baseline since it was based on estimations (previously reported in APR 2010).
6. % PHC workers who received integrated in-service training during last 1-year	0	Health facility survey	50%	50%						-	50% was to be achieved by the end of 2012. To date 31.5% has been achieved. Activities that have contributed to achieving the target: - 13% of the trained PHC workers undergone TOT training, so as to conduct the same training at their states and locality levels.
7. Health services utilization rate	< 1 per person per year	Annual statistical report – but covers only public sector	> 1 per person per year							Sudan Household Health Utilization and expenditure Survey, 2009	To be achieved by 2011 2.6% was attained in 2009. No other survey was conducted since then to obtain data on this indicator
8. % PHC facilities reported timely for health information	33%	Annual statistical report	60%							Annual statistical report, 2010	To be achieved by 2011 13% was attained by the end of 2010. This is the latest data available.

9.4. Programme implementation in 2012

9.4.1. Please provide a narrative on major accomplishments in 2012, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

Underthe health financing component implemented through WHO, several documents wereproduced through the past years of the grant, all of which have providedvaluable input in developing the National Health Sector Strategic Plan, 2012-16(NHSSP). In the process of developing the NHSSP, capacities of Federal Ministryof Health (FMOH) Staff have been strengthened, especially in costing ofnational strategies by using the OneHealth tool and M&E.

In itsNHSSP for the next 5 years the FMoH has given special attention to PHC withspecial focus on disadvantaged and vulnerable groups of the population as thebest approach to achieve the MDGs. In order to achieve this a PHC ExpansionPlan was developed based on the findings of the Mapping of Health facilitiesconducted during 2011-12 and the data from the PHC package and costing of thePHC produced under the health financing component. This Plan is currently underimplementation. Under this initiative, in 2013, GAVI/HSS support has beenprovided to train a total of 1209 students, out of which 1035 are enrolledmidwifery training program in Gedarif,W.Nile, N.Kordofan & Sinnar states and 174 CHW training program in Gedarif& W.Nile states. Assessment was conducted 30 health centers (HC) & PHCunits and 7 hospitals (blood bank, delivery rooms, theater- focusing onimproving EMOC services) in March, 2013 for rehabilitation in 3 of the GAVIstates (excluding Gadarif state). EMOC equipment has been identified to beprovided to rural hospitals according to the gaps, and a new set of supplies toHealth Centers & PHC units. Laboratory supplies will be provided to theNational Public Health laboratory and their branches in the four GAVI states.To increase immunization coverage by expanding fixed sites, according to thelocality needs and micro planning the following cold chain equipments will bepurchased and distributed to 60 sites, 15 per state (GAVI states) by the end ofApril 2013. This aims to improve access to EPI services and decrease the costof immunization services delivery and improve efficiency.

TheNHSSP calls for integration of health services at PHC level and thus theMinistry of Health has taken interest and practical steps in integratingtraining for health cadre, not only at lower levels but at higher levels aswell. An integrated medical assistant training has been institutionalized at theAcademy of Health Sciences and TOT training for 41 participants on theintegrated package of primary health care was conducted in 10-30 July, 2012. Inaddition to similar training of another 60 nutritionist in 2013. The managementand leadership training module that has been used in previous years has beenintegrated to include leadership, management, admin & finance and Planningso as to serve the expansion of PHC services, including immunization. 145participants were trained from different states during the period (8 April-17May 2012). In January, 2013, one hundred and fifty participants were trained inAdmin and Finance to complement what was being conducted by GF in leadershipand management in an integrated manner since funds allocated were insufficientand estimated prior to the era of integration. A new training centre forleadership and management has been established at Abuoshar locality at GeziraState aiming at institutionalizing this training and taking over this role fromCenter for Continuous Professional Development, Khartoum, Sudan at which all trainingshave been carried out up-to-date.

Withthe aim of supporting and strengthening the system to provide health services; comprehensiveplanning software has been customized and adopted to the health system in Sudanand more than 100 participants from the Federal Ministry have been trained onits use. TORs and Job descriptions for secondary and tertiary care level havebeen developed to compliment those developed under GF for PHC.

Consensus has been reached around the proposed communitybased health information system and awareness raising has been attained throughsupportive and advocacy supervisory visits. 100 students have been enrolled tobe trained to become community health workers (CHWs) to fill the gap in thishealth care provider and implement the community based health informationsystem at the Red Sea State (based on the PHC Expansion Plan).

Capacitiesof seven postgraduate students have been strengthened in health systemresearch, namely; to conduct operational research on gender, retention andmigration of health workforce with the ultimate aim of providing evidence forpolicy makers to guide decisions for appropriate strategies to attract, retainand distribute human resources for health. Distribution of health workforce inSudan and its impact on maternal health and mortality was another studyproduced alongside this project. Another source of evidence for generating evidence tosupport decision making, is the Sudan Health system Observatory that has beendesigned and which will be launched in July, 2013.

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

Based on the FMA recommendations,conducted during the period march-April, 2012, banking arrangements have beenchanged and this has certainly prevented currency loses to the disbursementsmade ever since. All other recommendations are being followed to strengthenfinancial controls.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

M&EReports are submitted to GAVI/HSS based on the timelines specified on thecontracts signed with the departments. Progress on Implementation of activities is presented at implementationteam meetings that are held twice per month, together with GF/HSS activities toensure alignment and harmonization. The arrangements has been made at GAVIsupported states to engage more with EPI and other relevant departments tojointly identify and monitor the bottlenecks affecting EPI coverage and to takethe corrective measures accordingly based on agreed upon indicators and submitmonthly report to national level.

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

AllGAVI/HSS activities for the 4 states have been directed to serve the current PrimaryHealth Care Expansion plan 2012-16 and therefore these are reported at weeklyFederal Ministry of Health Undersecretary meetings. Very recently,implementation of GAVI/HSS was reportedat the Mid Term Review (Operational Plan Biennium 2012-2013) and AnnualPlanning Meeting
20th – 21st February 2013.

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

Implementer

Function

Continuous Professional Development center (CPD)

In-service training for health care providers (leadership and management, Integrated training of PHC workers).

Academy of Health Sciences (AHS)

Production of Human Resources for Health, deploy and retain PHC workers focusing on nurses, midwifes, lab technicians and multipurpose health workers.

Public Health Institute (PHI)

leadership and management Diploma, Research.

Expanded Program on Immunization (EPI)

Provision of cold chain and outreach services targeting underserved and districts with low immunization coverage

Development and States Support Department

Construction, rehabilitation and procurement of equipment, medicines and supplies.

National Health Information center

Implement activities aiming at strengthening HIS.

Directorate General of Primary Health Care

Coordination between different stakeholders to ensure harmonization and avoid duplication of activities. Implementation of activities that support immunization services (provision of cold chain to work as fixed sites and support to outreach services).

Department of Planning

Building the capacity of different stakeholders at different levels in planning. Designing and launching of Health System Observatory.

Department of Health Economics

Technical assistance on budgeting, financial and resource management. Provides input for developing sustainable health financing policy

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

Thejoint structure of NHSCC/Sub CCM, comprising representatives from developmentpartners and non-government organizations (Plan Sudan and Sudanese RedCrescent) was previously formed within the national health system toco-ordinate HSS programme activities funded by both GAVI and GF. Thisarrangement was made with the intension of harmonizing HSS funding and ensuringthat HSS support will serve the National Tuberculosis Programme. Taking this astep further, for the purpose of enhancing co-ordination of activities in thehealth sector and ensuring more efficient use of resources, the FederalMinistry of Health has decided to integrate, the Inter-Agency CoordinatingCommittee (ICC) that oversees the GAVI ISS programmme and co-ordinates the workof agencies and donors who are supporting immunization and vaccinationprogrammes, within the existing NHSCC/Sub CCM. This new structure aims to insure that GAVI HSS initiatives are directedtowards strengthening EPI programme and thus improving the coverage andaccessibility of immunization services in Sudan.

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

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

Management of GAVI/HSS has become more efficientwith time since it is being managed by the same Unit that is managing GF/HSSand thus better coordination, harmonization and efficient use of funds. The FMAassessment conducted last year has assisted with strengthening the finances.This was utilized by GF when conducting a financial assessment of theDirectorate General of International Health to assess the capacity of thedirectorate to take over the role of Direct Sub-recipient (SR) from WHO inmanaging GF/HSS.

9.5. Planned HSS activities for 2013

Please use **Table 9.5** to provide information on progress on activities in 2013. If you are proposing changes to your activities and budget in 2013 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2013 actual expenditure** (as at April 2013)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)
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	45000	3839291		This will be used to support locality health management teams as demonstrated in the below activity: 1.1.2.	
	Activity 1.1.2: train health management teams in 11 states and 20 localities in decision-making, teamwork, and conducting effective meetings	45000				
	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 loclaities * 3 each =60)	50000	56115		PHI diploma on Leadership and management had been delayed since 2010 for participants had not met the criteria to be enrolled in this programme. Later on when students were ready for the course, PHI decided to use GAVI/HSS to support students projects that were to be implemented at the very end of the course, May, 2013.	

	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	57664		The remaining 2,335.77	
	Activity 1.1.10: train admin and financial staff in 11 northern states on budgeting and financial and resources management	0	45000			
1.2: Strengthening of health planning capacities	Activity 1.2.1: Support planning process (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	0	76835		The development of the National Health Sector Strategic Plan was very lengthy. Several attempts were made to purchase and install the planning software until finally done.	
	Activity 1.2.2: provide copies of the planning and instructional manual to 11 SMOH and 20 Localities Management Teams	10000	10000		Related to above activity	
	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	70000		Related to above activity	

	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	105000		Remaining 15,000 (from a total budget of 120,000 for 2010-11	
1.3: improve capacities and knowledgebase for equitable and sustainable health financing	Activity 1.3.3: provide TA for developing/adapting pro-poor, comprehensive and sustainable health financing policy in 11 Northern states	0	0		4,000$ Remaining from WHO contract signed in 2008. Process of developing Health Financing policy required a lot of inputs and was lengthy.	
	Activity: 1.3.4 provide TA for developing PHC services and immunization sustainability plans for national level and 11 Northern states	0	0		Funds transferred in 2008-09	
1.4: Strengthening of health Information system	Activity 1.4.1: TA to support designing of a community based health information system	0	45251		The delay in implementation was mainly due to health information system reform.	
	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	106402		Remaining (240,000 in 2010-106,402.31) =133.59769 +240,000 in 2011= 373,597.69 Funds transferred to AHS 100,000 + implementation	
	Activity 1.4.3: design and establish a comprehensive integrated information base at national and state level (in 11 states)	0	60000		Funds transferred for conducting supervisory visits, delayed by designing of comprehensive integrated health information system	

	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.	60000	26844		Remaining from previous years 40,160 +60,000 =100,160 - 26,844.23=73.31577	
2.1: Develop health human resources systems and policies	Activity 2.1.2: institute innovative approaches like financial and non-financial incentives as operational research for improving the retention of health staff	0	70000		Delay in implementation was due to the longitudinal nature of the activity (research)	
2.2: Rationalize and invest in training institutions for PHC workers focusing on Nurses, Midwifes, Lab technicians and multi purpose health worker	Activity 2.2.5: provide tuition fees in every academic year (2009-12), to 40 students of different categories in AHSs in the 7 SMOH (300 annually).	210000	210000			
	Activity 2.2.6: support to institutionalize Continuing Professional Development programmes as a pilot in four AHSs (Khartoum, Gezira, White Nile, and Gadarif)	0				
	Activity: 2.2.7: provide integrated on the job training for PHC workers to enable with the skill necessary for the provision of essential services such as immunization, child and maternal care in the 4 targets states (4 localities/districts each) (4 states* 4 localities/districts * 20 PHC workers= 320 annuly * 5 years	90000	90823		Remaining 89,176.54	

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 afcilties * 5 years = 300 health afcilties)	200000	0		Remaining 400,000 (2012-2013)	
	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	200000	0		Remaining 400,000 (2012-2013)	
4.1: Invest in 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)	200000	21903			
	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* facilites *4 state*2= 48 in 3 and 4)	240000				

	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)	480000				
	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)	360000	180000			
	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)	720000	36000			
	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)	240000	120000			

4.2: Provision of medicines and medical supplies essential for child and maternal health	Activity 4.2.1: provide medicines for the treatment of key child health problems (ARI and diarrhoeal diseases); Vitamin A; Anti-helminthes; Iron and folic acid supplements for pregnant women to 25 Health centers and dispensaries annually in each of the targeted four states (20 PHC facilities * 4 states * 5 years = 500) *6000 US$ each facility per year	12000	184000			
	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	192000	207316			
	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	48000	25000			

	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	50000	25000			
	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)	100000				
	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	20000	60000			
4.3: Address the demand side barriers to access health services (Immunization, care seeking behavior for children, RH, harmful tradition to mother and child)	Activity 4.3.2: print and disseminate documentaries and advocacy material for improving household knowledge and making informed decisions about health in the 4 targetd states (4 * 5000 US$ each)	20000	39023			

	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).	0				
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	160000	46601			
	Activity 5.3: Support the DGHP&D in the 4 SMOH to coordinate, monitor and report on the implementation of the GAVI/HSS support	60000	70276			
6: Monitoring and evaluation for GAVI/HSS support	Activity 6.1: Undertake baseline (in 2008) and evaluation research (in 2012)	45000				
		3857000	5884344			0

9.6. Planned HSS activities for 2014

Please use **Table 9.6** to outline planned activities for 2014. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

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

Table 9.6: Planned HSS Activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
NA	NA	0	NA	NA	NA
		0			

9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

9.8. Other sources of funding for HSS

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

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
GFATM /HSS	11400000	January 2013- February 2015	HSS Strengthening Activities to Complement GAVI/HSS

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

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Annex 6: List of taskforce assigned to develop the job descriptions		
Annex 1: Financial statement		
Annex 11: JANS mission report		
Annex 12: WHO Health Financing Report		
Annex 13: List of selected CHW students at Red Sea State		
Annex 14: List of observatory indicators		
Annex 19: Project proposal for covering pregnant women with FEFOL		
Annex 20: National Health Sector Coordination Committee Meetings Minutes		
Annex 21: Primary Health Care Expansion Plan		
Annex 24: NHSCC Meeting 19 February, 2013		
Annex 25 : Pre-Final National Health Sector Strategic Plan, 2012-2016		
Annex 26: HSCC endorsement Meeting 15 May, 2013		
Annex 27: WISN Report Final		
Annex 28: GAVI update reports		
Annex 4: Locality Health Management Teams Situation Analysis proposal (LHMTs)		
Annex 7: Job descriptions		
Annex 9: Pre- JANS TORs and mission program		
Annex15: List of observatory documents		

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

We believe that some tables could be merged to include more information.In that way it would be more user friendly and would save us the energy ofgoing up and down the whole document.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2012?4

Please attach:

1. The minutes from the HSCC meetings in 2013 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

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

Sudan **has NOT received GAVI TYPE A CSO support**

Sudan is not reporting on GAVI TYPE A CSO support for 2012

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

Sudan **has NOT received GAVI TYPE B CSO support**

Sudan is not reporting on GAVI TYPE B CSO support for 2012

11. Comments from ICC/HSCC Chairs

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

Commentsof the partners

- □□□□□□□Justify the delay in funds for the 4th year
- □□□□□□□Separate the ISS funds
- □□□□□□□Revise the table of exchange rate
- □□□□□□□For the activities implemented by GAVI & GF,highlight the contribution of GF
- □□□□□□□Link the programmatic and financial performance
- □□□□□□□Find a mechanism to facilitate the implementation ofactivities implemented by both GAVI & GF (mainly HIMS)

Challenges

- Delay in release offunds for the 4th year (funds received in October 2012).
- 5th year funds notreceived yet (the grant will end in December 2013) despite fulfilling allrequirements.
- Under-budgeting ofsome activities (Civil works and equipments).
- Some GAVI supportedactivities are dependent on completion of activities

supported by otherprojects e.g. GFATM (HMIS, Observatory, Planning)

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2012, 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 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2012, 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 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

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 ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2012, 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 2012 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 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, 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 2012 (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 2012 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
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	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & 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 expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

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

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	Signature Minster of Health.pdf File desc: Date/time: 5/15/2013 9:46:31 AM Size: 246930
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Signature MOF.pdf File desc: Date/time: 5/15/2013 9:46:58 AM Size: 608777
3	Signatures of members of ICC	2.2	✓	Signature ICC members.pdf File desc: Date/time: 5/15/2013 9:47:26 AM Size: 71465
4	Minutes of ICC meeting in 2013 endorsing the APR 2012	5.7	✓	ICC May 2013 minutes GAVI APR 2012.pdf File desc: Date/time: 5/15/2013 10:20:30 AM Size: 149761
5	Signatures of members of HSCC	2.3	✗	Endorsement signitures.pdf File desc: Date/time: 5/15/2013 6:29:26 PM Size: 9182950
6	Minutes of HSCC meeting in 2013 endorsing the APR 2012	9.9.3	✓	GAVI-HSS endorsement meeting minitues.docx File desc: Date/time: 5/15/2013 5:30:56 PM Size: 12345
7	Financial statement for ISS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	ISS Statement 2012.pdf File desc: Date/time: 5/15/2013 9:49:10 AM Size: 843886
8	External audit report for ISS grant (Fiscal Year 2012)	6.2.3	✗	External audit report 2011.pdf File desc: Date/time: 5/15/2013 9:50:46 AM Size: 3633043
9	Post Introduction Evaluation Report	7.2.2	✓	ReportPieRotavirusVaccineSudanDec2012.pdf File desc: Date/time: 5/15/2013 10:28:29 AM Size: 1302854

10	Financial statement for NVS introduction grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	NV Statement 2012.pdf File desc: Date/time: 5/15/2013 9:51:52 AM Size: 885034
11	External audit report for NVS introduction grant (Fiscal year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.3.1	✓	The external audit report for 2012 not conduct yet.docx File desc: Date/time: 5/15/2013 10:41:25 AM Size: 12611
12	Latest EVSM/VMA/EVM report	7.5	✓	Sudan VMA Report 2011.pdf File desc: Date/time: 5/15/2013 9:52:51 AM Size: 1519815
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	E VM improvement plan .xls File desc: Date/time: 5/15/2013 9:53:25 AM Size: 24064
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	E VM improvement plan Implemintation staus.xlsx File desc: Date/time: 5/15/2013 9:54:02 AM Size: 11858
15	External audit report for operational costs of preventive campaigns (Fiscal Year 2012) if total expenditures in 2012 is greater than US$ 250,000	7.6.3	✗	The external audit report for 2012 not conduct yet.docx File desc: Date/time: 5/15/2013 10:42:05 AM Size: 12611
16	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	Annex 30GAVIHSS process indicators, 2011and immunization indicators.doc File desc: Date/time: 5/15/2013 6:31:54 PM Size: 56320
17	Valid cMYP if requesting extension of support	7.8	✗	Annex 1b Detailed_analysis_of_expenditure.docx File desc: Date/time: 5/15/2013 6:33:01 PM Size: 14190
18	Valid cMYP costing tool if requesting extension of support	7.8	✓	list of medical assisstants at Red Sea Annex 12.docx File desc:

				Date/time: 5/15/2013 6:35:49 PM Size: 1510176
19	Financial statement for HSS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✗	Annex 1 a Financial statement.PDF File desc: Date/time: 5/15/2013 5:37:29 PM Size: 1977083
20	Financial statement for HSS grant for January-April 2013 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✗	Annex 1 a Financial statement.PDF File desc: Date/time: 5/15/2013 6:29:26 PM Size: 1977083
21	External audit report for HSS grant (Fiscal Year 2012)	9.1.3	✗	Aduit report 2011-4April(1).docx File desc: Date/time: 5/15/2013 5:40:13 PM Size: 45921
22	HSS Health Sector review report	9.9.3	✗	Part I - Executive Summary.doc File desc: Date/time: 5/15/2013 6:45:39 PM Size: 335872
23	Report for Mapping Exercise CSO Type A	10.1.1	✗	list of observatory documents Annex14.docx File desc: Date/time: 5/15/2013 6:45:39 PM Size: 35523
24	Financial statement for CSO Type B grant (Fiscal year 2012)	10.2.4	✗	Annex 7 CPD Trainings.docx File desc: Date/time: 5/15/2013 6:46:33 PM Size: 25230
25	External audit report for CSO Type B (Fiscal Year 2012)	10.2.4	✗	GAVI update March 2013.docx File desc: Date/time: 5/15/2013 6:49:04 PM Size: 25892
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2012 on (i) 1st January 2012 and (ii) 31st December 2012	0	✓	Annex 18(i) National Human Resources for Health Strategic Plan for Sudan, 2012-2016.doc File desc: Date/time: 5/15/2013 6:51:22 PM

				Size: 1191424