GAVI Alliance

Annual Progress Report 2014

Submitted by

The Government of

Sudan

Reporting on year: **2014**
Requesting for support year: **2016**
Date of submission: **15/05/2015**

Deadline for submission: 27/05/2015

Please submit the APR 2014 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavi.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: **2014**

Requesting for support year: **2016**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	2016
Routine New Vaccines Support	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	2016
Routine New Vaccines Support	Rotavirus, 2-dose schedule	Rotavirus, 2-dose schedule	2016
Preventive Campaign Support	Yellow Fever, 10 dose(s) per vial, LYOPHILISED	Not selected	2019

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

Type of Support	Vaccine	Start year	End year
Routine New Vaccines Support	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	2017	No extension
Routine New Vaccines Support	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	2017	No extension
Routine New Vaccines Support	Rotavirus, 2-dose schedule	2017	No extension

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2014	Request for Approval of	Eligible For 2014 ISS reward
VIG	Yes	Not applicable	No
COS	Yes	Not applicable	No
HSFP	Yes	Next tranch of HSFP Grant No	No
HSS	Yes	next tranche of HSS Grant No	No

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2013 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 High Level Review Panel (HLRP) 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	Mr. Bahar Idris Abo Garda	**Name**	Mr. Abd Elrahman Dirar
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
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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
ICC , NHSCC and CCM-HSS sub-committee were merged in one committee to strengthen the coordination and to improve the harmonization and alignment of different development supported programmes	ICC , NHSCC and CCM-HSS sub-committee were merged in one committee to strengthen the coordination and to improve the harmonization and alignment of different development supported programmes		

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

All comments will be treated confidentially

Comments from Partners:

ICC , NHSCC and CCM-HSS sub-committee were merged in one committee to strengthen the coordination and to improve the harmonization and alignment of different development supported programmes

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), NHSCC CCM HSS Sub-committee , 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
ICC , NHSCC and CCM-HSS sub-committee were merged in one committee to strengthen the coordination and to improve the harmonization and alignment of different development supported programmes	ICC , NHSCC and CCM-HSS sub-committee were merged in one committee to strengthen the coordination and to improve the harmonization and alignment of different development supported programmes		

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

All comments will be treated confidentially

Comments from Partners:

ICC , NHSCC and CCM-HSS sub-committee were merged in one committee to strengthen the coordination and to improve the harmonization and alignment of different development supported programmes

Comments from the Regional Working Group:

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

Sudan is not reporting on CSO (Type A & B) fund utilisation in 2015

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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.

Please also note that if the country applies the WHO multi-dose vial policy for IPV, the maximum indicative wastage rates are 5%, 15% and 20% for the 1-dose, 5-dose and 10-dose presentations respectively.

Number	Achievements as per JRF		Targets (preferred presentation)			
	2014		2015		2016	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2014	Current estimation
Total births	1,526,477	1,526,116	1,549,582	1,570,017	1,593,549	1,612,699
Total infants' deaths	163,205	162,321	166,943	167,506	175,230	172,002
Total surviving infants	1363272	1,363,795	1,382,639	1,402,511	1,418,319	1,440,697
Total pregnant women	1,526,477	1,526,116	1,549,582	1,570,017	1,593,549	1,612,699
Number of infants vaccinated (to be vaccinated) with BCG	1,434,988	1,445,191	1,472,102	1,491,516	1,513,870	1,532,064
BCG coverage*[1]*	94 %	95 %	95 %	95 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with OPV3	1,267,843	1,285,792	1,313,507	1,332,385	1,347,402	1,368,663
OPV3 coverage*[2]*	93 %	94 %	95 %	95 %	95 %	95 %
Number of infants vaccinated (to be vaccinated) with DTP1*[3]*	1,363,272	1,373,630	1,382,639	1,402,511	1,418,319	1,440,697
Number of infants vaccinated (to be vaccinated) with DTP3*[3][4]*	1,267,843	1,286,020	1,313,507	1,332,385	1,347,402	1,368,663
DTP3 coverage*[2]*	93 %	94 %	95 %	95 %	95 %	95 %
Wastage*[5]* rate in base-year and planned thereafter (%) for DTP	3	1	3	3	3	3
Wastage*[5]* factor in base-year and planned thereafter for DTP	1.03	1.01	1.03	1.03	1.03	1.03
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib	1,363,272	1,373,630	1,382,639	1,402,511	1,418,319	1,440,697
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib	1,267,843	1,286,020	1,313,507	1,332,385	1,347,402	1,368,663
DTP-HepB-Hib coverage*[2]*	93 %	94 %	95 %	95 %	95 %	95 %

Wastage[5] rate in base-year and planned thereafter (%)	0	1	3	3	3	3
Wastage[5] factor in base-year and planned thereafter (%)	1	1.01	1.03	1.03	1.03	1.03
Maximum wastage rate value for DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	0 %	5 %	0 %	5 %	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Pneumococcal (PCV13)	1,363,272	1,380,273	1,382,639	1,402,511	1,418,319	1,440,697
Number of infants vaccinated (to be vaccinated) with 3rd dose of Pneumococcal (PCV13)	1,267,843	1,319,054	1,313,507	1,332,385	1,347,402	1,368,663
Pneumococcal (PCV13) coverage[2]	93 %	97 %	95 %	95 %	95 %	95 %
Wastage[5] rate in base-year and planned thereafter (%)	5	1	5	5	5	5
Wastage[5] factor in base-year and planned thereafter (%)	1.05	1.01	1.05	1.05	1.05	1.05
Maximum wastage rate value for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	0 %	5 %	0 %	5 %	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Rotavirus	1,363,272	1,226,167	1,354,986	1,402,511	1,389,952	1,440,697
Number of infants vaccinated (to be vaccinated) with 2nd dose of Rotavirus	1,291,520	1,167,510	1,313,507	1,332,385	1,347,402	1,368,663
Rotavirus coverage[2]	95 %	86 %	95 %	95 %	95 %	95 %
Wastage[5] rate in base-year and planned thereafter (%)	5	1	2	2	2	2
Wastage[5] factor in base-year and planned thereafter (%)	1.05	1.01	1.02	1.02	1.02	1.02
Maximum wastage rate value for Rotavirus, 2-dose schedule	0 %	5 %	0 %	5 %	0 %	5 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	1,226,945	1,176,191	1,285,854	1,304,335	1,347,402	1,368,663
Measles coverage[2]	90 %	86 %	93 %	93 %	95 %	95 %
Pregnant women vaccinated with TT+	915,886	804,998	1,007,228	1,020,511	1,115,483	1,128,889

TT+ coverage[7]	60 %	53 %	65 %	65 %	70 %	70 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0
Vit A supplement to infants after 6 months	0	0	0	0	0	0
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	7 %	6 %	5 %	5 %	5 %	5 %

[1] Number of infants vaccinated out of total births

[2] Number of infants vaccinated out of total surviving infants

[3] Indicate total number of children vaccinated with either DTP alone or combined

[4] Please make sure that the DTP3 cells are correctly populated

[5] 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.

[7] Number of pregnant women vaccinated with TT+ out of total pregnant women

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 2014 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2014.** The numbers for 2015 - 2016 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

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

- Justification for any changes in **births**

  - By the end of 2013 some states achieved Penta first dose coverage more than 100%.
  - The achieved Penta1 coverage in 2013 is used as baseline in states where the achieved first dose coverage is higher

  than 100% and higher than the projected census estimates.(No above one year children are counted here)

  - By using these estimates the births for 2014 are increased
  - 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 Survivinginfants estimates

- 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.** For IPV, supporting documentation must also be provided as an attachment(s) to the APR to justify ANY changes in target population.

  NA

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

  wastage rates for Pentavalent vaccine, and Rota vaccine have been changed to lower values than planned wastage in the 2 previousAPR (5%) because we achieved 1.1% in Penta and 1% in Rota in 2014

5.2. Monitoring the Implementation of GAVI Gender Policy

5.2.1. 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? **yes, 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
EPI administrative data	2014	49%	51%
EPI administrative data	2013	47%	53%
EPI administrative data	2012	49%	51%
EPI administrative data	2011	48%	52%

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

NO

5.2.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Not selected**

5.2.4. 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/)

NO

5.3. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.3a** 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$ = 5.96	Enter the rate only; Please do not enter local currency name

Table 5.3a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	**Expenditure Year 2014**	**Source of funding**						
		Country	**GAVI**	**UNICEF**	**WHO**	**0**	**0**	**0**
Traditional Vaccines*	1,320,403	0	0	1,320,403	0	0	0	0
New and underused Vaccines**	36,671,514	2,818,768	33,735,746	0	117,000	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	136,313	0	136,313	0	0	0	0	0
Cold Chain equipment	3,275,797	0	346,439	2,779,358	150,000	0	0	0
Personnel	2,418,818	2,088,600	209,000	0	121,218	0	0	0
Other routine recurrent costs	5,424,124	1,315,120	1,941,000	1,156,426	1,011,578	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	18,766,500	2,325,997	3,683,677	3,906,401	8,850,425	0	0	0
0		0	0	0	0	0	0	0
Total Expenditures for Immunisation	68,013,469							
Total Government Health		8,548,485	40,052,175	9,162,588	10,250,221	0	0	0

Traditional vaccines: BCG, DTP, OPV, 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

5.4. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2014? **4**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2015 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 5.3 Overall Expenditures and Financing for Immunisation

- □□□□□□□□ The balanced fund from the last year has been approved by the committee to be used for cold chain equipment procurement through UNICEF to contribute
- □□□□□□□□ After the revision of 2014 APR the committee has approved the report for the submission

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

If Yes, which ones?

List CSO member organisations:
Sudanese Red crescent society
Rotary international

5.5. Priority actions in 2015 to 2016

What are the country's main objectives and priority actions for its EPI programme for 2015 to 2016

1. To achieve and sustain 95% coverage of the third dose of Penta-valent vaccine and 65% TT2+ nationally.
2. To increase and sustain Penta 3 coverage by improving both equitable access and utilization of immunization services as part of integrated PHC package in all districts
3. To introduce IPV in 2015.
4. To maintain Sudan polio-free
5. To achieve and maintain Measles elimination.
6. To contribute to and maintain NNT elimination.
7. To reduce morbidity and mortality caused by Yellow Fever.
8. To strengthen an integrated Surveillance system of VPDs/AEFI.
9. To strengthen Program managerial capacity.
10. To ensure sufficient fundfor EPI activities.

5.6. 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 2014

Vaccine	Types of syringe used in 2014 routine EPI	Funding sources of 2014
BCG	AD & reconstitution syringes	Government & UNICEF
Measles	AD & reconstitution syringes	Government & UNICEF
TT	AD	Government & UNICEF
DTP-containing vaccine	AD	GAVI & Government
IPV	AD	GAVI & Government
PCV	AD	GAVI & Government

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)

Nomajor obstacles were faced; the implementation is strengthened using GAVI Fund

Please explain in 2014 how sharps waste is being disposed of, problems encountered, etc.

Thewaste management part in relation to having incinerators is not implemented asthis is found costly for EPI and it is rather a national health systemissue accordingly it was addressed in the HSS cash support proposal for the period 2014-2018 submitted in February 2014

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2014

Sudan is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.2. Detailed expenditure of ISS funds during the 2014 calendar year

Sudan is not reporting on Immunisation Services Support (ISS) fund utilisation in 2014

6.3. Request for ISS reward

Request for ISS reward achievement in Sudan is not applicable for 2014

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

7.1. Receipt of new & under-used vaccines for 2014 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2014 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2014 vaccinations against approvals for 2014

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

	[A]	[B]	[C]	
Vaccine type	**Total doses for 2014 in Decision Letter**	**Total doses received by 31 December 2014**	**Total doses postponed from previous years and received in 2014**	**Did the country experience any stockouts at any level in 2014?**
Pneumococcal (PCV13)	4,854,800	5,398,350	136,800	No
DTP-HepB-Hib	3,753,700	5,256,691	2,132,196	No
Rotavirus	2,092,300	2,400,000	258,000	No

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? ...)

  Delay in shipments

  - No problems with cold chain

  - No doses discarded

  - No stock-out 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
  - 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 YF vaccine
  - 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 2014

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2014, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 1 dose(s) per vial, LIQUID		
Nationwide introduction	Yes	15/10/2005
Phased introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	

When is the Post Introduction Evaluation (PIE) planned? **August 2013**

Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
Nationwide introduction	Yes	11/09/2013
Phased introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	

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

Rotavirus, 1 dose(s) per vial, ORAL		
Nationwide introduction	Yes	10/08/2011
Phased introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	

When is the Post Introduction Evaluation (PIE) planned? **December 2011**

7.2.2. 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))

PIE for PCV 13 introduction conducted as part of the EPI review and progress on recommendations was shared with 2013 APR

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**

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:

NA

7.3. New Vaccine Introduction Grant lump sums 2014

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2014 (A)	1,040,500	6,201,380
Remaining funds (carry over) from 2013 (B)	32,142	191,566
Total funds available in 2014 (C=A+B)	1,072,642	6,392,946
Total Expenditures in 2014 (D)	1,072,642	6,392,946
Balance carried over to 2015 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2014 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2014 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

There were no major activities done in 2014regard the introduction of new vaccine because all grand used to cover the fundgap of YF campaign phase1 and affected the implementation of the IPV plan timeframe.

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 2015 onwards

NA

7.4. Report on country co-financing in 2014

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2014?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-	1,127,733	462,000

Hib, 1 dose(s) per vial, LIQUID		
Awarded Vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1,071,696	306,000
Awarded Vaccine #3: Rotavirus, 1 dose(s) per vial, ORAL	619,339	250,500
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2014 from the following sources?	
Government	2,818768	
Donor	0	
Other	0	
	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 2016 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2016	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	September	Government
Awarded Vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	September	Government
Awarded Vaccine #3: Rotavirus, 1 dose(s) per vial, ORAL	September	Government
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	No needs for the time being	

Note: co-financing is not mandatory for IPV

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/programmes_systems/supply_chain/evm/en/index3.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? **December 2013**

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? **December 2015**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2014

7.6.1. Vaccine Delivery

Did you receive the approved amount of vaccine doses for Yellow Fever 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)**
8400000	01/12/2014	28/10/2014 (2,000,000 doses), 1/10/2014 (752,300 doses), 30/9/2014(5,647,700 doses)

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

NA

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?

NA

7.6.2. Programmatic Results of Yellow Fever 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
Phase1 (7 states)	1 -10 Dec 2014	7599597	7190778	95	96	5	251	285

*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?" **No**

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

- According riskassessment had been calculated for all district, in additionto attack rate for the last out break 2012-2013

- Consideringdemographic exchange for S.kordpfan (2005)

- In addition to special considering for difficult toreach and hard to reach

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?

o The campaign exceeded the target for the reasonsdescribed above

What lessons have you learned from the campaign?

-Good coordination with all related sectors.
- Proper vaccine management.
- Proper waste disposal.
- High participation & acceptance from community
- Good access to all areas in spite of security problems
- Positive role of school teachers and pediatrics
- Active Supervision at all levels in technical support
- determine federal Supervisor at each locality contributed of problems solution
- Positive and supportive role of NGOs
- Good reporting of cases of side effects
- Rapid response to AEFI

7.6.3. Fund utilsation of operational cost of Yellow Fever preventive campaigns

Category	Expenditure in Local currency	Expenditure in USD
Social mobilization, IEC and advocacy	535365	3382972
Other training and meetings	104867	662656
Document production	667758	4219562
Human resources and incentives	661897	4182527
Cold chain equipment	295790	1869094
Transport for implementation and supervision	3164504	19996502
Immunization session supplies	63353	400325
Waste management	51979	328457
Surveillance and monitoring	175194	1107051
Evaluation	100000	631900
Planning and preparations	19871	125562
Technical assistance	20000	126380
Total	**5860578**	**37032988**

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 2015

If 2015 is the last year of approved multiyear support for a certain vaccine and the country wishes to extend GAVI support, the country should request for an extension of the co-financing agreement with GAVI for vaccine support starting from 2016 and for the duration of a new Comprehensive Multi-Year Plan (cMYP).

The country hereby requests an extension of GAVI support for the years to for the following vaccines:

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**
* **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID**
* **Rotavirus, 2-dose schedule**

At the same time it commits itself to co-finance the procurement of the following vaccines in accordance with the minimum Gavi co-financing levels as summarised in section 7.11 Calculation of requirements.

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**
* **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID**
* **Rotavirus, 2-dose schedule**

The multi-year support extension is in line with the new cMYP for the years to , which is attached to this APR (Document N°**16**). The new costing tool is also attached (Document N°**17**) for the following vaccines:

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**
* **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID**
* **Rotavirus, 2-dose schedule**

The country ICC has endorsed this request for extended support of the following vaccines at the ICC meeting whose minutes are attached to this APR. (Document N°**18**)

* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID**
* **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID**
* **Rotavirus, 2-dose schedule**

7.9. Request for continued support for vaccines for 2016 vaccination programme

In order to request NVS support for 2016 vaccination do the following

Confirm here below that your request for 2016 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don’t confirm, please explain

NA

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigen	Vaccine Type	2011	2012	2013	2014	2015	2016	2017
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID				3.40 %	3.50 %	3.60 %	4.40 %
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID				4.40 %	4.50 %	3.00 %	4.50 %
Rotavirus, 2-dose schedule	Rotavirus, 2-dose schedule				3.90 %	4.20 %	4.40 %	4.40 %
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	Yellow Fever, 10 dose(s) per vial, LYOPHILISED				7.50 %	7.50 %	7.40 %	7.20 %

Vaccine Antigen	Vaccine Type	2018	2019
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	4.40 %	4.40 %
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	4.60 %	3.10 %
Rotavirus, 2-dose schedule	Rotavirus, 2-dose schedule	4.40 %	4.40 %
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	Yellow Fever, 10 dose(s) per vial, LYOPHILISED	6.80 %	6.80 %

7.11. Calculation of requirements

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

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	1,363,272	1,382,639	1,440,697	4,186,608
	Number of children to be vaccinated with the first dose	Parameter	#	1,363,272	1,382,639	1,440,697	4,186,608
	Number of children to be vaccinated with the third dose	Parameter	#	1,267,843	1,313,507	1,368,663	3,950,013
	Immunisation coverage with the third dose	Parameter	%	93.00 %	95.00 %	95.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.00	1.03	1.03	
	Stock in Central Store		#	2,031,720			

	Dec 31, 2014						
	Stock across second level Dec 31, 2014 (if available)*		#	361,077			
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#				
	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	
cc	Country co-financing per dose	Parameter	$		0.30	0.35	
ca	AD syringe price per unit	Parameter	$		0.0448	0.0448	
cr	Reconstitution syringe price per unit	Parameter	$		0	0	
cs	Safety box price per unit	Parameter	$		0.0054	0.0054	
fv	Freight cost as % of vaccines value	Parameter	%		3.50 %	3.60 %	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

- There is no difference between closing and opening stock
- The stock physical count conducted regularly in quarterly bases 31March, 30 June, 30Sep and 31 Dec
- The inventory done for each type of vaccine and by Batch No. and matching the result with the vaccine stock management system and do lost and adjustment if needed

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

4.5

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

Co-financing group	Intermediate

	2014	2015	2016
Minimum co-financing	0.26	0.30	0.35
Recommended co-financing as per			0.35
Your co-financing	0.26	0.30	0.35

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

		2014	2015	2016
Number of vaccine doses	#	3,291,700	3,598,400	3,259,700
Number of AD syringes	#	3,620,800	3,844,000	3,471,900
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	40,225	42,300	35,875
Total value to be co-financed by GAVI	$	6,954,500	7,444,500	6,224,500

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

		2014	2015	2016
Number of vaccine doses	#	462,000	610,400	731,600
Number of AD syringes	#	508,200	652,000	779,300
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	5,650	7,175	8,050
Total value to be co-financed by the Country *[1]*	$	976,000	1,263,000	1,397,000

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

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-finance**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,363,272	1,382,639		
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,267,843	1,382,639		
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	3,955,262	4,050,441		
E	**Estimated vaccine wastage factor**	*Table 4*	1.00	1.03		
F	**Number of doses needed including wastage**	*D x E*		4,171,955		
G	**Vaccines buffer stock**	***Buffer on doses needed** + **buffer on doses wasted*** ***Buffer on doses needed** = (D - D of previous year original approved) x 0.375* ***Buffer on doses wasted** =* • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375* • *else: (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0*				
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*				

H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	512,673	2,031,720		
H3	**Shipment plan**	*Approved volume*		4,208,800		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		4,208,800		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
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*				

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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

		Formula	2016		
			Total	**Government**	**GAVI**
A	**Country co-finance**	*V*	18.33 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,440,697	264,076	1,176,621
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	1,368,663	250,872	1,117,791
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B - 0.41 x (B - B1))*	4,220,524	773,610	3,446,914
E	**Estimated vaccine wastage factor**	*Table 4*	1.03		
F	**Number of doses needed including wastage**	*D X E*	4,347,139	796,818	3,550,321
G	**Vaccines buffer stock**	***Buffer on doses needed** + **buffer on doses wasted** **Buffer on doses needed** = (D - D of previous year original approved) x 0.375 **Buffer on doses wasted** = • if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F -*	65,695	12,042	53,653

		D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0.375 • *else:* (F - D - ((F - D) of previous year original approved)) x 0.375 >= 0			
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0.375)*	421,637	77,285	344,352
H1	**Calculated opening stock**	*H2 (2015) + H3 (2015) - F (2015)*	2,008,605	368,172	1,640,433
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*Approved volume*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	3,991,200	731,576	3,259,624
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	4,251,041	779,204	3,471,837
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	43,904	8,048	35,856
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	7,172,187	1,314,641	5,857,546
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	190,447	34,909	155,538
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)*	239	44	195
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	258,199	47,328	210,871
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)*	7,621,072	1,396,920	6,224,152
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	1,396,920		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	18.33 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	1,363,272	1,382,639	1,440,697	4,186,608
	Number of children to be vaccinated with the first dose	Parameter	#	1,363,272	1,382,639	1,440,697	4,186,608
	Number of children to be vaccinated with the third dose	Parameter	#	1,267,843	1,313,507	1,368,663	3,950,013
	Immunisation coverage with the third dose	Parameter	%	93.00 %	95.00 %	95.00 %	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.05	1.05	1.05	
	Stock in Central Store Dec 31, 2014		#	853,105			
	Stock across second level Dec 31, 2014 (if available)*		#	333,708			
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#	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	
cc	Country co-financing per dose	Parameter	$		0.26	0.30	
ca	AD syringe price per unit	Parameter	$		0.0448	0.0448	
cr	Reconstitution syringe price per unit	Parameter	$		0	0	
cs	Safety box price per unit	Parameter	$		0.0054	0.0054	
fv	Freight cost as % of vaccines value	Parameter	%		4.50 %	3.00 %	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

- There is no difference between closing and opening stock
- The stock physical count conducted regularly in quarterly bases 31March, 30 June, 30Sep and 31 Dec
- The inventory done foreach type of vaccine and by Batch No. and matching the result with the vaccinestock management system and do lost and adjustment if needed

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

Co-financing group	Intermediate

	2014	2015	2016
Minimum co-financing	0.23	0.26	0.30
Recommended co-financing as per			0.30
Your co-financing	0.23	0.26	0.30

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

		2014	2015	2016
Number of vaccine doses	#	4,549,400	4,057,200	4,194,600
Number of AD syringes	#	4,793,500	4,251,400	4,395,100
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	53,250	46,775	46,150
Total value to be co-financed by GAVI	$	16,638,000	14,729,000	14,791,500

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

		2014	2015	2016
Number of vaccine doses	#	305,400	315,000	390,100
Number of AD syringes	#	321,700	328,200	408,700
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	3,575	3,625	4,300
Total value to be co-financed by the Country ***[1]***	$	1,117,000	1,137,000	1,375,500

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

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-finance**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,363,272	1,382,639		
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B x C*	4,089,816	4,147,917		
E	**Estimated vaccine wastage factor**	*Table 4*	1.05	1.05		
F	**Number of doses needed including wastage**	*D x E*		4,355,313		
G	**Vaccines buffer stock**	***Buffer on doses needed + buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*				
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	0	853,105		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		4,372,200		
J	**Number of doses per vial**	*Vaccine Parameter*				
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*				
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*				
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*				
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 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 2)

		Formula	2016		
			Total	Government	GAVI
A	**Country co-finance**	*V*	8.51 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,440,697	122,566	1,318,131
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B x C*	4,322,091	367,698	3,954,393
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses needed including wastage**	*D x E*	4,538,196	386,083	4,152,113
G	**Vaccines buffer stock**	***Buffer on doses needed + buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*	44,976	3,827	41,149
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*	0	0	0
H2	**Reported stock on January 1st**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	4,584,600	390,031	4,194,569
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	4,803,774	408,677	4,395,097
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(I / 100) x 1.10*	50,431	4,291	46,140
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	15,486,779	1,317,523	14,169,256
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	215,210	18,309	196,901
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)*	275	24	251
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	464,604	39,526	425,078
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)*	16,166,868	1,375,380	14,791,488
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	1,375,380		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	8.51 %		

Table 7.11.1: Specifications for Rotavirus, 2-dose schedule

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	1,363,272	1,382,639	1,440,697	4,186,608
	Number of children to be vaccinated with the first dose	Parameter	#	1,363,272	1,354,986	1,440,697	4,158,955
	Number of children to be vaccinated with the second dose	Parameter	#	1,291,520	1,313,507	1,368,663	3,973,690
	Immunisation coverage with the second dose	Parameter	%	94.74 %	95.00 %	95.00 %	
	Number of doses per child	Parameter	#	2	2	2	
	Estimated vaccine wastage factor	Parameter	#	1.05	1.02	1.02	
	Stock in Central Store Dec 31, 2014		#	888,723			
	Stock across second level Dec 31, 2014 (if available)*		#	306,954			
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#				
	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	
cc	Country co-financing per dose	Parameter	$		0.30	0.35	
ca	AD syringe price per unit	Parameter	$		0.0448	0.0448	
cr	Reconstitution syringe price per unit	Parameter	$		0	0	
cs	Safety box price per unit	Parameter	$		0.0054	0.0054	
fv	Freight cost as % of vaccines value	Parameter	%		4.20 %	4.40 %	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

- There is no difference between closing and opening stock
- The stock physical count conducted regularly in quarterly bases 31March, 30 June, 30Sep and 31 Dec
- The inventory done for each type of vaccine and by Batch No. and matching the result with the vaccine stock management system and do lost and adjustment if needed

Co-financing tables for Rotavirus, 2-dose schedule

Co-financing group	Intermediate

	2014	2015	2016
Minimum co-financing	0.26	0.30	0.35
Recommended co-financing as per			0.35
Your co-financing	0.30	0.30	0.35

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

		2014	2015	2016
Number of vaccine doses	#	1,842,800	1,665,000	2,371,600
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by GAVI	$	4,640,500	4,418,000	5,586,000

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

		2014	2015	2016
Number of vaccine doses	#	249,500	213,000	414,000
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country *[1]*	$	628,000	563,500	975,000

Table 7.11.4: Calculation of requirements for Rotavirus, 2-dose schedule (part 1)

		Formula	2014	2015		
				Total	Government	GAVI
A	Country co-finance	*V*				
B	Number of children to be vaccinated with the first dose	*Table 4*	1,363,272	1,354,986		
C	Number of doses per child	*Vaccine parameter (schedule)*	2	2		
D	Number of doses needed	*B x C*	2,726,544	2,709,972		
E	Estimated vaccine wastage factor	*Table 4*	1.05	1.02		
F	Number of doses needed including wastage	*D x E*		2,764,172		
G	Vaccines buffer stock	***Buffer on doses needed** + **buffer on doses wasted*** ***Buffer on doses needed** = (D - D of previous year original approved) x 0.25* ***Buffer on doses wasted** = (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*				
H	Stock to be deducted	*H2 of previous year - 0.25 x F of previous year*				
H2	Reported stock on January 1st	*Table 7.11.1*	1,486,419	888,723		
I	Total vaccine doses needed	*Round up((F + G - H) / vaccine package size) x vaccine package size*		1,878,000		
J	Number of doses per vial	*Vaccine Parameter*				
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) x 1.10*				
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*				
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*				
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 7.11.4: Calculation of requirements for Rotavirus, 2-dose schedule (part 2)

		Formula	2016		
			Total	Government	GAVI
A	**Country co-finance**	*V*	14.86 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	1,440,697	214,093	1,226,604
C	**Number of doses per child**	*Vaccine parameter (schedule)*	2		
D	**Number of doses needed**	*B x C*	2,881,394	428,185	2,453,209
E	**Estimated vaccine wastage factor**	*Table 4*	1.02		
F	**Number of doses needed including wastage**	*D x E*	2,939,022	436,749	2,502,273
G	**Vaccines buffer stock**	***Buffer on doses needed + buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0.25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0.25*	43,238	6,426	36,812
H	**Stock to be deducted**	*H2 of previous year - 0.25 x F of previous year*	197,680	29,376	168,304
H2	**Reported stock on January 1st**	*Table 7.11.1*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	2,785,500	413,935	2,371,565
J	**Number of doses per vial**	*Vaccine Parameter*	1		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	0	0	0
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*	0	0	0
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	6,284,088	933,837	5,350,251
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)*	276,500	41,089	235,411
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)*	6,560,588	974,925	5,585,663
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	974,925		
V	**Country co-financing % of GAVI supported proportion**	*U / T*	14.86 %		

8. Health Systems Strengthening Support (HSS)

Please use this APR section (8. Health Systems Strengthening Support) to report on grant implementation of the previous HSS grant which was approved before 2012. In addition, please complete and attach the HSS Reporting Form to report on the implementation of the new HSS grant which was approved in 2012 or 2013.

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 2014**. All countries are expected to report on:

   a. Progress achieved in 2014

   b. HSS implementation during January – April 2015 (interim reporting)

   c. Plans for 2016

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

For countries that received HSS funds within the last 3 months of 2014, or experienced other delays that limited implementation in 2014, 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 2014 fiscal year starts in January 2014 and ends in December 2014, HSS reports should be received by the GAVI Alliance before **15th May 2015**. 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 2015, the HSS reports are expected by GAVI Alliance by September 2015.

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@gavi.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 8.1.2.

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 2014

   b. Minutes of the HSCC meeting in 2015 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2014 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

8. 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.

8.1. Report on the use of HSS funds in 2014 and request of a new tranche

For countries that have previously received the final disbursement of all GAVI approved funds for the HSS grant and have no further funds to request: Is the implementation of the HSS grant completed ? **Not selected**

If NO, please indicate the anticipated date for completion of the HSS grant.

Please attach any studies or assessments related to or funded by the GAVI HSS grant.

Please attach data disaggregated by sex, rural/urban, district/state where available, particularly for immunisation coverage indicators. This is especially important if GAVI HSS grants are used to target specific populations and/or geographic areas in the country.

If CSOs were involved in the implementation of the HSS grant, please attach a list of the CSOs engaged in grant implementation, the funding received by CSOs from the GAVI HSS grant, and the activities that they have been involved in. If CSO involvement was included in the original proposal approved by GAVI but no funds were provided to CSOs, please explain why not.

Please see http://www.gavialliance.org/support/cso/ for GAVI's CSO Implementation Framework

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

Please attach the latest reported National Results/M&E Framework for the health sector (with actual reported figures for the most recent year available in country).

8.1.1. Report on the use of HSS funds in **2014**

Please complete Table 8.1.3.a and 8.1.3.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 8.1.3.a and 8.1.3.b.

8.1.2. Please indicate if you are requesting a new tranche of funding **Yes**

If yes, please indicate the amount of funding requested: **6330000** US$

These funds should be sufficient to carry out HSS grant implementation through December 2016.

Table 8.1.3a (US)$

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)	3144806	3228143	3313689	3401503	3402000	7919859
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	1597472	3471572	5011500	2142767	3402000	
Total funds received from GAVI during the calendar year (*A*)		6151832		3878228	3106974	7509045
Remaining funds (carry over) from previous year (*B*)	1772092	91192	4654681	1785948	3959082	1744280

Total Funds available during the calendar year (*C=A+B*)	1772092	6243023	4654681	5664176	7066057	9253325
Total expenditure during the calendar year (*D*)	1680900	1588342	2868733	1705094	5321776	6053094
Balance carried forward to next calendar year (*E=C-D*)	91192	4654681	1785948	3959082	1744280	3200232
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	3228143	3313689	3401503	3401503	3402000	7919859

	2015	2016	2017	2018
Original annual budgets (*as per the originally approved HSS proposal*)	6330000	6330000	6330000	6330000
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)	0			
Remaining funds (carry over) from previous year (*B*)	3200232			
Total Funds available during the calendar year (*C=A+B*)	3200232			
Total expenditure during the calendar year (*D*)	1945450			
Balance carried forward to next calendar year (*E=C-D*)	1254782			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	6330000	6330000	6330000	6330000

Table 8.1.3b (Local currency)

	2009	2010	2011	2012	2013	2014
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*)		14149211		22917000	16829446	40433321
Remaining funds (carry over) from previous year (*B*)	4028404	230923	10726948	3541815	21983990	10390268
Total Funds available during the calendar year (*C=A+B*)	4028404	14380134	10726948	26458815	38813436	50823589
Total expenditure during the calendar year (*D*)	3797481	3653186	7185133	4474825	28423168	35713255
Balance carried forward to next calendar year (*E=C-D*)	230923	10726948	3541815	21983990	10390268	15110334
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	6918573	7101914	8284222	8843907	14968800	459351822

	2015	2016	2017	2018
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]	39060000	39060000	39060000	39060000

Report of Exchange Rate Fluctuation

Please indicate in the table Table 8.3.c below the exchange rate used for each calendar year at opening and closing.

Table 8.1.3.c

Exchange Rate	2009	2010	2011	2012	2013	2014
Opening on 1 January	2.2	2.2	2.5	2.6	4.4	5.8
Closing on 31 December	2.2	2.4	2.6	4.4	4.4	6.2

Detailed expenditure of HSS funds during the 2014 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2014 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 2015 period are reported in Tables 8.1.3a and 8.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

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)

8.2. Progress on HSS activities in the 2014 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 8.2. 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 8.2: HSS activities in the 2014 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
1.1	Provide integrated on-job trainings (bridging course) for 900 medical assistants on PHC package including EPI (900 participants* 45 days (30 training workshops	0	
1.2	Provide integrated on-job trainings (bridging course) for 2000 community health workers and village midwives	30	M&E reports
1.4	Provide integrated on-job trainings (bridging course) for 900 vaccinators and nutrition workers (including private and CBOs/NGOs) in the target 6 states (30 participants * 6 states * 40 days per year for five years)	40	M&E reports
1.8	Rehabilitate/upgrade (4) Family Health Centers (FHCs) in each of the six target states (24 FHC)	80	Technical reports
1.9	Rehabilitate/upgrade (6) Family Health Units (FHUs) in each of the six target states (36 FHU)	80	Technical reports
1.13	UNICEF- Provide cold chain equipment to 12 health facilities annually (currently not fixed EPI sites) and replacement for aging equipments (to those rendering EPI services) functional to enable them functioning as fixed sites for immunization	70	Estimate received from UNICEF and Cash transfer to UNICEF
1.14	Provide state, locality and sub-locality cold store (6) with cold chain equipment to accommodate routine and newly introduced vaccines	70	Estimate received from UNICEF and Cash transfer to UNICEF
1.15	Provide spare-parts for cold chain (preventive and corrective maintenance) annually for 5 years	70	Estimate received from UNICEF and Cash transfer to UNICEF
1.16	conduct training on cold chain stock management software (VSSM) for 210 state and locality officers (8 from federal, one per states (18) and one per 184 localities)	50	Technical report
1.17	Training on cold chain management to 750 vaccinators from public, CSOs/NGOs and private facilities	50	Technical report
1.19	Develop annual EPI and PHC integrated micro-plans in all states with especial focus on hard to reach and disadvantaged populations (1 Federal 18 States (184 localities))	100	microplans

1.20	Develop strategy for sustaining immunization services during emergency situation	25	fund transfer
1.21	conduct refresher training for 540 vaccinators annually from public, CSOs/NGOs and private facilities (30 participants*18staes*3days*5years	0	not requested
1.22	Update, print and distribute 4000 copies of immunization and defaulter tracing guidelines to health facilities every two years for service providers	50	updated guidelines
1.23	conduct 4 home visits/ month / health facility annually (25 facilities*10 localities* 6 states* $4) for 5 years	100	EPI Data
1.24	Conduct integrated outreach services focusing on localities with low EPI coverage	100	EPI Data
1.25	Conduct integrated EPI/PHC Mobile sessions for disadvantaged populations and communities with low access to fixed facilities in rural and remote settings	100	EPI Data
1.26	Conduct 6 rounds of accelerated immunization activities in security compromised areas	50	EPI Data
1.27	Design documentaries and advocacy materials to improve household knowledge and health seeking behavior with focus on immunization and introduction of new vaccines	0	Proposal
1.28	Print and disseminate documentary and advocacy materials to improve household knowledge and health seeking behavior with focus on immunization and introduction of new vaccines (50,000 copies per year)	0	Proposal
1.29	Support production of TV and Radio spots and community session/dialogue on selected PHC and immunization topics including and introduction of new vaccines to improve awareness and utilization of services	0	Proposal
1.30	TA for mapping and assessment of the capacity and engagement of CSOs/NGOs and the private sector in PHC service delivery including EPI (2 national consultants)	30	Proposal provided by the network and consultant contract
1.31	TA to Design and implement a comprehensive framework of partnership and code of conduct (including financing, accountability, etc) with CSOs/NGOs and the private sector in the six target states	0	-
1.32	Support for coordination of partnership between the public, private and CSOs (meetings, joint missions) twice a year in federal and the six target states (2 visits + 2 meetings at federal and six states twice a year for 5 years)	20	Missions and visits reports

2.1	Technical Assistance to review and streamline the HMIS Organizational Structure (OS) at national and sub-national level	0	-
2.2	Support regular HMIS coordination mechanism and annual review and planning meetings (bi-annual national, quarterly state and monthly at locality level)	0	-
2.3	Conduct advocacy and sensitization seminars for investing on an integrated HIS to decision makers and stakeholders at national and state level (7 seminars every 2 yrs)	70	HIS Department Data
2.4	Training of HIS staff (2 staff*10 localities*6 states *2 years+30 TOT) on the use of DHIS tool	0	-
2.5	Support 2 rounds of overseas short course training for 5 staff at DHIS Academy	100	training technical report
2.7	Training of data producers on data management and data quality assurance (2 staff*10 localities*6 states *2 years+30 TOT)	0	-
2.11	Conduct regular HMIS supportive supervision including Community health information system (1 visit*6 states from National level and 2 visits*10 localities*6 states)	0	-
2.16	Provide basic office equipments (PCs, Printers) to 300 health facilities (5 FHC * 60 localities)	100	technical report
2.18	Undertake Data Quality Assessment every two years (national and states)	0	-
2.19	Training of MOH staff at national and sub-national levels on Lot Quality Assurance (90 staff members)	0	-
2.20	Conduct periodic regular surveys for EPI coverage and health system performance focusing on PHC and EPI performance using Service availability and Readiness Assessment (SARA) and Lot Quality Assurance Survey (LQAS)	0	-
2.22	Support to conduct 4th and 5th rounds of Sudan Household Health Survey in 2014 and 2018	0	
2.23	Provide support to operationalize and sustain the health observatory	0	www.sho.gov.sd
2.26	Training of Community Health Workers, village midwives and health statistics clerks and volunteers (600) on community health information system	0	-
2.27	Printing of community health information system tools (registers and report forms 3000 copies annually)	0	-
2.31	Support printing of 2000 copies of annual statistical report	0	-
3.1	Conduct policy brief on "Human Resource for Health (HRH)	0	-

	gender, retention and migration" research findings and HRH projections to key government policy makers and stakeholders to enhance review/development and implementation of HRH policies and strategies (2 events)		
3.4	Fellowships on leadership to EPI mid level management staff (4 staff/year for 5 years)	0	-
3.5	Conduct Work Load Indicator for Staffing Needs assessment using WISN tool in 2 states to improve HRH management	50	HRH department data
3.6	Provide top-up incentives for states and localities EPI/PHC focal persons(18states focal persons*300$*12month*5year+60 localties focal persons*150$*12month*5years)	67	EPI Data
3.7	Provide support for national human resource for health observatory (NaHRO)to conduct annual inventory of posts	0	-
3.10	Provide tution fees annually to 20 candidates per state from the 6 target states to attend basic midwifery training	30	PHC Data
4.1	TA to assist in the implementation of the organizational structures and job description for states' ministries of health and localities	0	-
4.3	Long term TA to support 17 states and 184 localities in building leadership and management capacities (5 zonal coordinators	25	zonal technical unit inception report
4.5	Provide copies of the planning and instructional manual to 18 SMOH and 60 Locality Management Teams	100	planning manual
4.6	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on leadership, planning and management (10 days training for 384 staff)	35	Training reports
4.7	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on integrated PHC approach (including EPI management) and supervision (7 days training for 384 staff)	40	ongoing) M&E reports
4.8	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on EPI Vaccine Management (7 days training for 376 staff)	40	ongoing) M&E reports
4.9	Provide Tuition fees for 15 students (States and locality health team mangers) to attend leadership diploma in the Public Health Institute	50	-
4.10	Provide Tuition fees for 15 students (States and locality health team mangers) to attend MCH diploma programme in the Public Health Institue	50	-

4.12	Conduct integrated supportive supervisory visits from states (6 visits x 6 states x 5 years of 4 days each	0	-
4.13	Conduct integrated supportive supervisory visits from localities (12 visits x 10 localities x 6 states x 5 years of 4 days each	40	PHC Department Data
4.14	Support Health Management Teams in 30 localities to undertake supervision of services and supply delivery though provision of vehicles (1) each	100	Procurement report
4.15	Support Health Management Teams in 60 localities to undertake supervision of services and integrated surveillance activities though provision of Motorcycles (1) each	100	Procurement report
5.2	Fellowship for PMU staff on project management (8 staff for 3 weeks	100	Training Technical report
5.3	Support 10 staff to attend M&E regional training course	0	
5.4	Support supervisory visits to states and localities implementing grant supported activities	100	States' supervision reports

8.2.1 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**
Provide integrated on-job trainings (bridging cour	This activity is complementing GF support. 330 medical assistances have been trained using GF support. 150 MA are planned to be trained in May Using GAVI support. The priority was given to implement GF activities since the grant ended in March 2015. Acceleration plan has been developed to implement MA training supported by GAVI before end of June 2015
Provide integrated on-job trainings (bridging cour	Proposal has been developed by the PHC directorate & fund has been released. Selection process for the candidates has been done to train 450 CHWs and VMWs, the training will be finalized by the end of July 2015
Provide integrated on-job trainings (bridging cour	180 vaccinators and nutrition workers will be trained in May 2015. This support is complementing government contributing as part of PHC Universal Health Coverage project. And the allocated amount of fund has been released to PHC directorate to start the implementation (preparation)
Rehabilitate/upgrade (4) Family Health Centers (FH	80% of the civil work in 7 FHC has been accomplished (based on the updated PHC Health Map)
Rehabilitate/upgrade (6) Family Health Units (FHUs	80% of the civil work in 13 FHU has been accomplished
UNICEF- Provide cold chain equipment to 12 health	Estimate for procuring cold chin equipments has been received through UNCEF supply division and the allocated amount of fund has been transferred to UNICEF
Provide state, locality and sub-locality cold sto	Estimate for procuring cold chin equipments has been received through UNCEF supply division and the allocated amount of fund has been transferred to UNICEF and procured items will support
Provide spare-parts for cold chain (preventive and	Estimate for procuring cold chin equipments has been received through UNCEF supply division and the allocated amount of fund has been transferred to UNICEF
conduct training on cold chain stock management s	Has been implemented by the EPI programme
Training on cold chain management to 750 vaccinato	Has been implemented by the EPI programme
Develop annual EPI and PHC integrated micro-plans	PHC integrated micro-plans have been updated by the EPI programme

Develop strategy for sustaining immunization servi	Allocated fund has been released to the EPI programme and technical taskforce has been formulated to start working on the strategy development
conduct refresher training for 540 vaccinators ann	Not requested
Update, print and distribute 4000 copies of immun	Immunization defaulters' guidelines have been updated. Will be printed and distributed by the end of may
conduct 4 home visits/ month / health facility an	This activity has been implemented
Conduct integrated outreach services focusing on l	This activity has been implemented
Conduct integrated EPI/PHC Mobile sessions for dis	This activity has been implemented
Conduct 6 rounds of accelerated immunization activ	3 rounds of accelerated immunization activities have been conducted
Design documentaries and advocacy materials to imp	A proposal has been developed by the health promotion department to design documentaries and advocacy materials to improve knowledge and health seeking behaviors. A contract between PMU and health promotion department has been signed and the fund will be released to start the implementation
Print and disseminate documentary and advocacy mat	This activity will follow the previous one it is part of the proposal developed by the health promotion department
Support production of TV and Radio spots and commu	A proposal has been developed by the health promotion department & contract between PMU and health promotion department has been signed and the fund will be released to start the implementation
TA for mapping and assessment of the capacity and	TORs for mapping have been developed. National consultant was selected. The implementation will start in May 2015
TA to Design and implement a comprehensive framewo	Steering committee from SCOs has been formulated to facilitate the establishment of Sudan Health Network. This network will include all national and international NGOs working in the health sector. Capacity Development Plan was developed to improve and ensure meaningful engagement of CSOs in the planning and implementation of health sector plans. GF is also contributing to the implementation of this plan
Support for coordination of partnership between th	Joint missions have been conducted in March and April at six states
Technical Assistance to review and streamline the	OS at national level was revised through national process from national resources as a starting point and TORs is being developed for the TA using GAVI support to complement what has been implemented
Support regular HMIS coordination mechanism and an	Different meetings at different levels (national and sub-national) have been conducted using GAVI supervision resources (2013)
Conduct advocacy and sensitization seminars for in	Some activities have been conducted using national resources and making use of other planned activities (states ministers of health meetings, DGs meetings, radio spot campaigns and back to back supervision with training activities) to advocate for the HIS. More advocacy activities will be implemented in the second half of 2015 after full implementation
Training of HIS staff (2 staff*10 localities*6 sta	TOT has been conducted using WHO/GF resources. GAVI funds were used to support states and localities training
Support 2 rounds of overseas short course training	6 staff have been trained on DHIS2 (second round) to complement the first round supported by WHO/GF
Training of data producers on data management and	This activity has been delayed waiting for implementation of integrated HIS and DHIS. Data quality will come as second step.
Conduct regular HMIS supportive supervision includ	States' supervision has been conducted
Provide basic office equipments (PCs, Printers) t	This activity has been implemented
Undertake Data Quality Assessment every two years	This activity has been delayed waiting for implementation of integrated HIS and DHIS. Data quality will come as second step.
Training of MOH staff at national and sub-national	TA was provided by UNICEF in February 2015 to adopt the methodology and sampling framework. Consensus workshop was organized with participation of staff from federal and states levels.
Conduct periodic regular surveys for EPI coverage	Fund allocated is not enough
Fellowship for PMU staff on project management (8	2 training modules on fund raising & resource mobilization and project management have been conducted in collaboration with

	the CSOs network. 20 participants from the ministry including PMU staff and other 20 from the CSOs have been trained. A diploma certificate will be provided after accomplishment of other 2 modules.
Support 10 staff to attend M&E regional training c	3 from the PMU staff have been trained.
Support supervisory visits to states and localitie	
Support annual review and planning meetings at nat	This activity will be implemented by the end of 2015 to support conduction of Joint Annual Review for the health sector (JAR)
Support grant management cost (stationaries, fuel,	
provide performance based incentives to PMU staff	Technical reports and payment sheet
Annual external audit of the grant	External audit has been conducted and audit report is developed
training of Community Health Workers, village midw	Under implementation
Printing of community health information system to	Under implementation
Support printing of 2000 copies of annual statisti	Under process
Conduct policy brief on "Human Resource for Health	TORs have been developed. A task force was established to support the implementation of this activity.
Fellowships on leadership to EPI mid level managem	
Conduct Work Load Indicator for Staffing Needs ass	WISN is a WHO tool to assess the work load for health care providers (particularly MAs). Its implementation is aiming at providing evidence on the feasibility of integrated PHC service package provision for supporting the PHC Universal Health Coverage plan. Total amount allocated is released to the HRHD and 50% of the activity has been accomplished.
Provide top-up incentives for states and localitie	The allocated fund has been released to the EPI account and a proposal has been developed by the programme based on the incentives scheme adopted by GF grants
Provide support for national human resource for he	Allocated fund for this activity has been requested and will be released
Provide tuition fees annually to 20 candidates per	This activity will be implemented as in-service midwifery training instead of basic one and that is mainly because of government has allocated big amount of support for the basic midwifery training under the PHC expansion project to achieve UHC. Fund has been released to PHC department to start the implementation
TA to assist in the implementation of the organiza	
Long term TA to support 17 states and 184 localiti	A proposal for establishing 5 zonal units to provide technical assistance for the states and localities has been developed
Provide copies of the planning and instructional m	Arabic version of the planning manual GAVI support will be used to accomplish the rest of the activity
Train 8 staff from each of 18 Directorates of Heal	6 training workshops have been conducted at 6 states with participation of the planning directors at states localities and their partners on the planning manual with focus on the operational planning using one plan one budget and one report approach
Train 8 staff from each of 18 Directorates of Heal	Fund has been released to PHC to start the implementation
Train 8 staff from each of 18 Directorates of Heal	Fund has been released to PHC to start the implementation
Provide Tuition fees for 15 students (States and l	
Provide Tuition fees for 15 students (States and l	
Conduct integrated supportive supervisory visits f	
Conduct integrated supportive supervisory visits f	The activity is ongoing and the objective is set to be conduction of post training assessment for the medical assistance training programme
Support Health Management Teams in 30 localities t	Distribution report
Support Health Management Teams in 60 localities t	Distribution report
Train 8 staff from each of 18 Directorates of Heal	Fund has been released to PHC to start implementation
Provide support to operationalize and sustain the	FMOH has established the Sudan Health Observatory SHO with support from GAVI and GF. The website was launched in December 2014. For more information please visit

	www.sho.gov.sd support will continue to sustain the SHO
Support to conduct 4th and 5th rounds of Sudan Hou	3rd round of Sudan Household Survey is supported by Government of Sudan, UNICEF and GAVI. The customization has been finalized. The survey will be implemented in 2015.There is a gap to analyze and write the report for the collected maternal mortality data that will be covered by GAVI funds for this activity.

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

- Activity 2.20 has been delayed because of that, allocated fund to conduct EPI coverage survey is not enough, so other support will be provided from other partners to undertake this activity.

- Activity 5.2 has been implemented in collaboration with CSOs 20 participants from FMOH and 20 from CSOs have been trained on module (resource mobilization and project management. Diploma certificate will be provided for the trainees after completing other two modules in September 2015

- Most of unimplemented activities have been delayed because of the reason of that, the implementation of those activities is mainly aiming at complementing other activities supported by other partners (GF).

8.2.3 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?

- (GAVI) support development of the HRH retention policy (GAVI and GF supported the HRH gender, retention and migration research).
- FMOH is implementing a program aiming at producing multi-tasked health care providers (to support PHC UHC plan).
- Technical assistance is being provided to improve the quality of the curricula at different training institutions.
- As well the support being provided by GAVI in incentivizing and top-ups for the people managing and implementing HSS activities under the incentives scheme developed and adopted.

8.3. General overview of targets achieved

Please complete **Table 8.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2013 from your original HSS proposal.

Table 8.3: 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	2014 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2010	2011	2012	2013	2014		
percent of underserved/disadvantaged population covered by DTP3	68%	"Program (EPI) report Routine (EPI) report"	90%	73%					74%	EPI Data	
Percent of target population served by fixed immunization sites	44%	"Program (EPI) report Routine (EPI) report"	75%	55%					55%	EPI Data	
Percent of PHC facilities providing essential package including immunization	24%	PHC mapping survey	80%	30%					-		PHC mapping survey was not conducted. The survey planned for next year.
Number of target health and community workers	0	Training reports	1174	882					1140		Currently 1140 health cadres

received training according to the standards											are being trained as planned. Training will be completed in July 2015
Number of localities with functional CSOs engaged in EPI activities	124	Supervision report (State to locality)	184	130					179		
Number of states that have cold chain functionality of 80% or mo	11	Administrative data	18	13					14	EPI Data	
Percent of PHC facilities in target states with system quality index of 80% or above	TBC	Supervision report (State to Locality, facility survey)	90%	50%					-		
Percent of health facilities that submit, accurate and complete EPI reports in time according to standar	95% Timeliness	"Routine health facility report; Program (EPI) report "	95%	95%					96%	EPI Data	completeness for EPI is 100%
Percent of PHC facilities at target states submitting regular integrated reports according to standards;	32%	Routine health facility report	80%	50%					hospitals 78% Health Centers 32% PHC centers 5% the average is 38%	annual statistical report 2012	this is a simple average which is not true because we should consider the load of the health facilities for each category
Percent of health facilities regularly submitting surveillance data on reportable diseases including VPD and AEFI (integrated disease surveillance)	100%completeness -92%Timeliness	Health facility surveillance report	98%	95%					95%		
Number of states conducting data quality monitoring and shared reports (during the quarter)	0	Supervision report (State to locality level)	18	10					18	HIS supervision	
Percent of PHC facilities (disaggregated by urban/rural) with the required number and quality of staff according to standard at six target states	20%	HRH observatory	70%	30%					-		Arrangements have been made to conduct facility based HRH survey by Human Resource for Health Observatory. The results will be available in October 2015.
Number of health training institutions graduating target number and quality of allied health workforce at six target states	TBC	supervision report(federal to state)	12	4					4		
Annual dropout rate of health managers at target states and localities	TBC	Supervision report (State to locality)	<10%	<30%					-		This indicator will be measured following the completion of the supervisory visits and HRH reports collection and analysis in

											June 2015.
Number of states and localities implementing the revised organizational structure	0	Supervision report (State to locality)	6 states/ 60 localities	3 states/ 0 localities					9 states		
Proportion of locality health management teams in 6 target states conducting regular integrated supervisory visits (during the quarter)	TBC	Supervision report (State to locality)	90%	25%					25%		Several interventions have been implemented to support the locality health management teams to conduct the integrated supervisory visits.
Number of localities with functional health management teams	92	Supervision report (State to locality)	152	102					-		Several interventions have been implemented to support the locality health management. These include leadership and management training and provision of vehicles, motorcycles and IT equipment.The indicator will be measured after completing supervision in June 2015.
DTP3 coverage - % of surviving infants receiving three doses of the diphtheria-tetanus-pertussis vaccine (DTP3)	92%	Official country estimate	95%	95%					94.3%		there were 5 districts not accessible
DTP3 coverage numerator (number of doses administered through routine services)	1177206	Country administrative data	1442100	1295108					1286020		
DTP3 coverage denominator (number in target group)	1284722	Country administrative data	1518000	1363272					1363795		
MCV1 coverage - % of surviving infants receivi	85%	Country administrative data	95%	91%					86.2%		
MCV1 coverage numerator (number of doses administered through routine services)	1092258	Country administrative data	1442100	1240578					1176191		
MCV1 coverage denominator (number in target group)	1284722	Country administrative data	1518000	1363272					1363795		
Geographic equity of DTP 3 coverage - % of districts that have at or above 80% DTP3 coverage	82%	Country administrative data	100%	80%					90%		
Drop out rate - percentage point difference between DTP1 and DTP3 coverage	8%	Country administrative data	5%	9%					6%		
TT2+ Coverage: Proportion of pregnant women vaccinated with TT2+	47%	Country administrative data	80%	60%					53%		

Proportion of population within five kilometers of a service delivery point offering "Essential PHC Package"	42%	PHC mapping survey	80%	50%							
Number and percent of VPD outbreaks and health emergencies timely (within 72 hours) detected and responded to (at state level)	71%	EPI data	100%	100%					80%		VPD outbreaks

8.4. Programme implementation in 2014

8.4.1. Please provide a narrative on major accomplishments in 2014, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

HSS is supporting the MOH in achieving UHC of PHC services as one of the main strategic objectives that health sector is working to achieve, in terms of supporting integrated approach adopted by the ministry, focusing on multi-tasked health workers and developing policies and strategies to retain the health workers, strengthening the planning, managerial, leadership skills at the different levels national and sub-national, strengthening PSM as well as the support provided and being provided to strengthen the HMIS and health financing. GAVI support has been used in a complementarity manner with other partners to achieve equity in health services with more focus on under-served and disadvanteged populations.

Successful implementation of GAVI grants has been used as an evidence by other DPs (GFATM) in their decision to change the implementation modality to work directly with the Government of Sudan as a PR for the health system component of the new GF grant .This means that the GF will use the national systems as GAVI is doining. This step y the GF will save to the country additional $ 3,000,000 which used to go to the intermediaries.

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

- Weak capacity at sub-national levels is considered to be one of the challenges that are facing the health system, to address this issue, TA is being provided to states and localities by establishing 5 zonal units to provide the needed technical support.
- Conflict in some states and neighboring countries (IDPs, Refugees) that will be addressed through Strengthen integrated service delivery in emergency settings.
- Insufficient domestic resources, and as one of the partial solution Health Financing policy is currently being developed
- High staff turnover that will be addressed by the retention policy which I currently being developed.

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

The PMU M&E officers are the responsible persons who track the implementation based on the M&E framework and they report to the project manager. Implementation group representing the implementing departments meets twice a month with the PMU staff for implementation follow-up. After implementation of the different activities, implementers provide technical report for the PMU in addition to the financial clearance that is usually provided to the finance in the PMU. Moreover supportive supervision is being provided during the implementation by the PMU staff.

8.4.4. 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.

Since that the HSS grant has been developed based on the NHSSP and the strategic objectives in a way that complementing government and other grants , and based on that the PMU is under the planning department so HSS is being monitored under the directorate general plan contributing to the same expected result in the NHSSP. support being provided by the government and health partners to adopt the integrated HIS which aims at an integrated HIS and HMIS.

8.4.5. 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.

Different key stakeholders have participated in the development and implementations of the HSS proposal by providing technical assistance in different technical working groups during the development and some of them also are participating in the implementation of the HSS proposal m(UNICEF in the procurement of the cold chain equipments and implementation of DHSS, WHO is also providing the technical assistance during the implementation)

8.4.6. 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.

As one of the main health partners CSOs have participated in the implementation of GAVI HSS grant following their participation in the proposal development, NHSSP development, as well as implementation of some activities in the HSS plan.

Arrangements have been made to conduct CSOs mapping to support the establishment of the CSOs data base. Two training workshops on fund raising and project management were conducted to strengthen the capacities of the CSOs and to ensure their meaningful engagement in the implementation of GAVI and other partners grants.

Support was provided to establish the Sudan Health Network for the NGOs and CSOs involved in the healthsector at national and sub-national levels.

Some of the CSOs are:

1- Patient Helping Fund;

2- Plan Sudan;

3- Environmental Conservative association;

4- Sudan Family Planning Association;

5- Sudan AIDS Network;

6- Global Health Foundation;

7- ISRA;

8- Ana El- Sudan;

9- SSAC and

10- Sudan Volunteers.

8.4.7. 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

- The management of the HSS is being done in an integrated way and approach to maximize is benefits and to avoid any overlap in the HSS grant. One PMU is managing the biggest HSS grants GF and GAVI and EU in the three eastern states to strengthen the health service at locality level will be also managed by this PMU to assure the complementary.
- Some of the main internal constrains are: conflicts in some areas, weak capacity at sub-national levels and high rapid turnover.
- Some actions have been taken to address these issues such as the human resources retention policy that is being developed to address the turn over
- building and developing the leadership and managerial capacities at states and locality levels

8.5. Planned HSS activities for 2015

Please use **Table 8.5** to provide information on progress on activities in 2015. If you are proposing changes to your activities and budget in 2015 please explain these changes in the table below and provide explanations for these changes.

Table 8.5: Planned activities for 2015

Major Activities (insert as many rows as necessary)	Planned Activity for 2015	Original budget for 2015 (as approved in the HSS proposal or as adjusted during past annual progress reviews)	2015 actual expenditure (as at April 2015)	Revised activity (if relevant)	Explanation for proposed changes to activities or budget (if relevant)	Revised budget for 2015 (if relevant)
	objective 1					
1.1	Provide integrated on-job trainings (bridging course) for 900 medical assistants on PHC package including EPI (900 participants* 45 days (30 training workshops))	150000				
1.2	Provide integrated on-job trainings (bridgi	115820				
1.3	Provide basic training (9 months) on integrated PHC including EPI to 450 community health workers from target states (3 workshops *50 participants * 3 years)	150000				
1.4	Provide integrated on-job trainings (bridging course) for 900 vaccinators and nutrition workers (including private and CBOs/NGOs) in the target 6 states (30 participants * 6 states * 40 days per year for five years)	90000				
1.11	Provide essential equipment and furniture, according to standard, to two Family Health Units (FHUs) annually in each of the six target states (newly rehabilitate/upgraded)	26000	0	Rehabilitate and construct health facilities according to standards in the six targeted states	Provision of the equipments for the HF is being tackled by the government under the PHC expansion project aiming at UHC	26000
1.12	Provide essential equipment for existing PHC facilities that are not providing the full PHC package with focus on immunization: for (3) FHCs and (3) FHUs annually in the six target states	558000	0	Rehabilitate and construct health facilities according to standards in the six targeted states	Provision of the equipments for the HF is being tackled by the government under the PHC expansion project aiming at UHC	558000
1.13	Provide cold chain equipment to 12 health facilities annually (currently not fixed EPI sites) and replacement for aging equipments (to those rendering EPI services) functional to enable them functioning as fixed sites for immunization	84000				
1.14	Provide state, locality and sub-locality cold store (6) with cold chain equipment to accommodate routine and newly introduced vaccines	90000				
1.15	Provide spare-parts for cold chain (preventive and corrective maintenance) annually for 5 years	35000				
1.16	conduct training on cold chain stock management software (VSSM) for 210 state and locality officers (8 from federeal, one per states (18) and one per 184 localities)	31480				
1.17	Training on cold chain management to 750 vaccinators from public, CSOs/NGOs and private facilities	26030				
1.18	Provide short course training on cold chain maintenance to 100 technicians from states and localities cold chains	20400				
1.19	Develop annual EPI and PHC integrated micro-plans in all states with especial focus on hard to reach and disadvantaged	66500				

	populations (1 Federal 18 States (184 localities))					
1.21	conduct refresher training for 540 vaccinators annually from public, CSOs/NGOs and private facilities (30 participants*18staes*3days*5years)	45738				
1.23	conduct 4 home visits/ month / health facility annually (25 facilities*10 localities* 6 states* $4) for 5 years	288000				
1.24	Conduct integrated outreach services focusing on localities with low EPI coverage	726000				
1.25	Conduct integrated EPI/PHC Mobile sessions for disadvantaged populations and communities with low access to fixed facilities in rural and remote settings	693000				
1.26	Conduct 6 rounds of accelerated immunization activities in security compromized areas	60000				
1.27	Design documentaries and advocacy materials to improve household knowledge and health seeking behavior with focus on immunization and introduction of new vaccines	10000				
1.28	Print and disseminate documentry and advocacy materials to improve household knowledge and health seeking behaviour with focus on immunization and introduction of new vaccines (50,000 copies per year)	50000				
1.29	Support production of TV and Radio spots and community session/dialogue on selected PHC and immunization topics including and introduction of new vaccines to improve awareness and utilization of services	20000				
1.32	Support for coordination of partnership between the public, private and CSOs (meetings, joint missions) twice a year in federal and the six target states (2 visits + 2 meetings at federal and six states twice a year for 5 years)	15540				
1.33	Organize and train a network of health promoters (women-groups) and scale-up community initiatives and networks such as "friends of immunization" to promote utilization of PHC services and minimize drop-outs (EPI, TB, HIV) (1800 participants)	76830				
1.34	TA to undertake a rapid assessment of the current medical waste management situation and develop an appropriate and feasible method of medical waste management (6 nationals)	45150				
1.35	Print, disseminate and distribute guidelines on medical waste management and infection control (6000)	15000				
5.8	Annual external audit of the grant	10000				
	objective 5					
5.1	Technical assistance to support PMU on grant implementation	15000				
5.2	Fellowship for PMU staff on project management (8 staff for 3 weeks)	19600				
5.3	Support 10 staff to attend M&E	14700				

	regional training course					
5.4	Support supervisory visits to states and localities implementing grant supported activities	17400				
5.5	Support annual review and planning meetings at national and states levels	100000				
5.6	Support grant management cost (stationaries, fuel, maintainance etc.)	50000				
5.7	provide performance based incentives to PMU staff	100000				
	objective 4					
4.3	Long term TA to support 17 states and 184 localities in building leadership and management capacities (5 zonal coordinators)	180000				
4.4	TA to develop/up-date planning manual and tools for states and localities	15000				
4.6	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on leadership, planning and management (10 days training for 384 staff)	101150				
4.7	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on integrated PHC approach (including EPI management) and supervision (7 days training for 384 staff)	71600				
4.8	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on EPI Vaccine Management (7 days training for 376 staff)	67100				
4.11	Provide PC (1), fax (1), printer (1), photocopier (1), to Locality Health Management Teams in 60 localities	114600				
4.12	Conduct integrated supportive supervisory visits from states (6 visits x 6 states x 5 years of 4 days each)	108720				
4.13	Conduct integrated supportive supervisory visits from localities (12 visits x 10 localities x 6 states x 5 years of 4 days each))	286272				
4.16	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on EPI Mid level Management Module (7 days training for 376 staff)	98840				
4.17	TA to support development of National Health Financing Strategy	38684				
4.18	TA to support institutionalization of National Health account at national and states levels	18850				
	objective 3					
3.2	Technical assistance to develop HRH retention policy and implementation plan	36812				
3.4	Fellowships on leadership to EPI mid level management staff (4 staff/year for 5 years)	19600				
3.6	Provide top-up incentives for states and localities EPI/PHC focal persons(18states focal persons*300$*12month*5year+60	17800				

	localities focal persons*150$*12month*5years)					
3.8	Technical assistance to improve education programmes including curricula review of health training institutions to be oriented towards PHC needs, including EPI (including workshop and printing)	32000				
3.10	Provide tuitions fees annually to 20 candidates per state from the 6 target states to attend basic midwifery training	120000				
3.11	Provide reference books, teaching aids and skill labs to 12 AHS and CPDs (3 facilities x 4 years)	135000				
	objective 2					
2.2	Support regular HMIS coordination mechanism and annual review and planning meetings (bi-annual national, quarterly state and monthly at locality level)	52780				
2.4	Training of HIS staff (2 staff*10 localities*6 states *2 years+30 TOT) on the use of DHIS tool	51000				
2.5	Support 2 rounds of overseas short course training for 5 staff at DHIS Academy	24500				
2.6	Training of 40 Federal 10 per state and 2 per locality HMIS staff (including EPI) on data management and analysis (220)	40800				
2.7	Training of data producers on data management and data quality assurance (2 staff*10 localities*6 states *2 years+30 TOT)	51000				
2.8	Training of 80 staff (5 national and 2* 6 states + 60 locality managers) on M&E	54340				
2.10	Update, print and distribute 150000 copies of HIS tools every two years for service providers	150000				
2.11	Conduct regular HMIS supportive supervision including Community health information system (1 visit*6 states from National level and 2 visits*10 localities*6 states)	48770				
2.13	Print guidelines, case definitions and SOPs for an integrated surveillance (3000)	15000				
2.14	Train staff on the use of guidelines, case definitions and SOPs (15 staff members *10 localities* 6 states) 900	20862				
2.15	Training of trainers on IDC10 (60 staff from National and state level)	9835				
2.16	Provide basic office equipments (PCs, Printers) to 300 health facilities (5 FHC * 60 localities)	127200				
2.19	Training of MOH staff at national and sub-national levels on Lot Quality Assurance (90 staff members)	20400				
2.23	Training of MOH staff at national and sub-national levels on Lot Quality Assurance (90 staff members)	20000				
2.26	Training of Community Health Workers, village midwives and health statistics clerks and volunteers (600) on community health information system	81600				
2.27	Printing of community health information system tools (registers	15000				

	and report forms 3000 copies annually)					
2.29	Technical Assistance to review and reform legal framework for registration of vital statistics events	17000				
2.30	TA support the development of national and state health profiles	32000				
2.31	Support printing of 2000 copies of annual statistical report	40000				
2.32	Conduct a study for resource mapping and to explore the financing options to ensure sustainability of PHC services including the gains of vaccination	25000				
		6174303	0			584000

8.6. Planned HSS activities for 2016

Please use **Table 8.6** to outline planned activities for 2016. 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 8.6: Planned HSS Activities for 2016

Major Activities (insert as many rows as necessary)	**Planned Activity for 2016**	**Original budget for 2016** (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 2016** (if relevant)
1.1	Provide integrated on-job trainings (bridging course) for 900 medical assistants on PHC package including EPI (900 participants* 45 days (30 training workshops))	150000			
1.2	Provide integrated on-job trainings (bridging course) for 2000 community health workers and village midwives	127402			
1.3	Provide basic training (9 months) on integrated PHC including EPI to 450 community health workers from target states (3 workshops *50 participants * 3 years)	150000			
1.4	Provide integrated on-job trainings (bridging course) for 900 vaccinators and nutrition workers (including private and CBOs/NGOs) in the target 6 states (30 participants * 6 states * 40 days per year for five years)	90000			
1.6	Technical assistance (2 nationals) to develop/ update SOPs, protocols and guidelines for integrated PHC service delivery	15050			
1.7	Printing and distribution of SOPs, protocols and guidelines to PHC facilities and management levels (10000 (copies)	30000			
1.11	Provide essential equipment and furniture, according to standard, to two Family Health Units (FHUs) annually in each of the six target states (newly rehabilitate/upgraded)	26000			
1.12	Provide essential equipment for existing PHC facilities that are not providing the full PHC package with	558000			

	focus on immunization: for (3) FHCs and (3) FHUs annually in the six target states				
1.13	Provide cold chain equipment to 12 health facilities annually (currently not fixed EPI sites) and replacement for aging equipments (to those rendering EPI services) functional to enable them functioning as fixed sites for immunization	84000			
1.14	Provide state, locality and sub-locality cold store (6) with cold chain equipment to accommodate routine and newly introduced vaccines	90000			
1.15	Provide spare-parts for cold chain (preventive and corrective maintenance) annually for 5 years	35000			
1.17	Training on cold chain management to 750 vaccinators from public, CSOs/NGOs and private facilities	26030			
1.19	Develop annual EPI and PHC integrated microplans in all states with especial focus on hard to reach and disadvantaged populations (1 Federal 18 States (184 localities	66500			
1.21	conduct refresher training for 540 vaccinatorsannualy from public, CSOs/NGOs and private facilities (30 participants*18staes*3days*5years)	45738			
1.22	Update, print and distribute 4000 copies of immunization and defaulter tracing guidelines to health facilities every two years for service providers	20000			
1.23	conduct 4 home visits/ month / health facility annualy (25 facilities*10 localities* 6 states* $4) for 5 years	288000			
1.24	Conduct integrated outreach services focusing on localities with low EPI coverage	621450			
1.25	Conduct integrated EPI/PHC Mobile sessions for disadvantaged populations and communities with low access to fixed facilities in rural and remote settings	693000			
1.26	Conduct 6 rounds of accelerated immunization activities in security compromized areas	60000			
1.27	Design documentaries and advocacy materials to improve household knowledge and health seeking behavior with focus on immunization and introduction of new vaccines	10000			
1.28	Print and disseminate documentry and advocacy materials to improve household knowledge and health seeking behaviour with focus on immunization and introduction of new vaccines (50,000 copies per year)	50000			
1.29	Support production of TV and Radio spots and community session/dialogue on selected PHC and immunization topics including and introduction of new vaccines to improve awareness and utilization of services	20000			
1.32	Support for coordination of partnership between the public	15540			

	private and CSOs (meetings, joint missions) twice a year in federal and the six target states (2 visits + 2 meetings at federal and six states twice a year for 5 years)				
1.33	Organize and train a network of health promoters (women-groups) and scale-up community initiatives and networks such as "friends of immunization" to promote utilization of PHC services and minimize drop-outs (EPI, TB, HIV) (1800 participants)	76830			
2.2	Support regular HMIS coordination mechanism and annual review and planning meetings (bi-annual national, quarterly state and monthly at locality level)	52780			
2.3	Conduct advocacy and sensitization seminars for investing on an integrated HIS to decision makers and stakeholders at national and state level (7 seminars every 2 yrs)	28000			
2.6	Training of 40 Federal 10 per state and 2 per locality HMIS staff (including EPI) on data management and analysis (220)	40800			
2.8	Training of 80 staff (5 national and 2* 6 states + 60 locality managers) on M&E				
2.9	Train 60 locality information focal persons on the computerized reminder system for defaulter tracing				
2.11	Conduct regular HMIS supportive supervision including Community health information system (1 visit*6 states from National level and 2 visits*10 localities*6 states)				
2.12	TA to support development/up-date of integrated disease surveillance and response system including VPD and AEFI				
2.14	Train staff on the use of guidelines, case definitions and SOPs (15 staff members *10 localities* 6 states) 900				
3.7	Provide support for national human resource for health observatory (NaHRO)to conduct annual inventory of posts				
3.9	Technical assistance to develop/update training protocols, guidelines and materials for AHS to improve the quality of training programmes				
3.10	Provide tution fees annually to 20 candidates per state from the 6 target states to attend basic midwifery training				
3.11	Provide reference books, teaching aids and skill labs to 12 AHS and CPDs (3 facilities x 4 years)				
3.12	Rehabilitate and refurbish 12 AHS and CPD facilities -2 facility/state				
4.2	TA for developing/up-dating the integrated PHC services and immunization sustainability plans for national level and 18 states				

4.3	Long term TA to support 17 states and 184 localities in building leadership and management capacities (5 zonal coordinators)				
4.5	Provide copies of the planning and instructional manual to 18 SMOH and 60 Locality Management Teams				
4.6	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on leadership, planning and management (10 days training for 384 staff)				
4.7	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on integrated PHC approach (including EPI management) and supervision (7 days training for 384 staff)				
4.8	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on EPI Vaccine Management (7 days training for 376 staff)				
4.11	Provide PC (1), fax (1), printer (1), photocopier (1), to Locality Health Management Teams in 60 localities				
4.12	Conduct integrated supportive supervisory visits from states (6 visits x 6 states x 5 years of 4 days each)				
4.13	Conduct integrated supportive supervisory visits from localities (12 visits x 10 localities x 6 states x 5 years of 4 days each))				
4.14	Support Health Management Teams in 30 localities to undertake supervision of services and supply delivery though provision of vehicles (1) each				
4.16	Train 8 staff from each of 18 Directorates of Health Planning and PHC in states and 4 staff from 60 localities on EPI Mid level Management Module (7 days training for 376 staff)				
5.3	Support 10 staff to attend M&E regional training course				
5.4	Support supervisory visits to states and localities implementing grant supported activities				
5.5	Support annual review and planning meetings at national and states levels				
5.6	Support grant management cost (stationaries, fuel, maintainance				

	etc.)				
5.7	provide performance based incentives to PMU staff				
5.8	Annual external audit of the grant				
2.17	Technical Assistance to review/update data quality guidelines and SOPs and adapt/adopt routine data quality assessment tools				
2.18	Undertake Data Quality Assessment every two years (national and states)				
2.20	Conduct periodic regular surveys for EPI coverage and health system performance focusing on PHC and EPI performance using Service availability and Readiness Assessment (SARA) and Lot Quality Assurance Survey (LQAS)				
2,21	Conduct EVM assessment at national and sub-national level (3rd and 5th year)				
2.23	Provide support to operationalize and sustain the health observatory				
2.24	Conduct a study to identify gender-related barriers in the national health system, including in immunization services				
2.25	TA to design and pilot digital birth and deaths registration				
2.26	Training of Community Health Workers, village midwives and health statistics clerks and volunteers (600) on community health information system				
2.27	Printing of community health information system tools (registers and report forms 3000 copies annually)				
2.28	Mid-term evaluation of community health information system in year 3				
2.31	Support printing of 2000 copies of annual statistical report				
3.3	TA to support development of clear career development pathway for allied health workforce				
3.4	Fellowships on leadership to EPI mid level management staff (4 staff/year for 5 years)				
3.6	Provide top-up insentives for states and localities EPI/PHC focal persons(18states focal persons*300$*12month*5year+60 localties focal persons*150$*12month*5years)				
2.16	Provide basic office equipments (PCs, Printers) to 300 health facilities (5 FHC * 60 localities)				
2.15	Training of trainers on IDC10 (60 staff from National and state level)				
		3470120			

8.7. 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@gavi.org

8.8. 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 8.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
EU	11000000	2014-2016	The EU project, which is a follow up project of the recently completed MDTF project, mainly focuses on improving the health status and welfare of communities through effective delivery of basic health services, improving the quality and increasing its utilization in three target states (Red Sea, Kasalla and Gadarif). In addition, the EU project supports the community based health insurance scheme.
Global Fund	22000000	2015-2017	The Global Fund has provided support to HSS since 2010 for 5 years. The support includes improving the referral system from primary to other levels of health care; strengthening the Integrated Health Information System; support scaling-up of training of health workforce; support strengthening and up-grading of the Integrated Procurement and Supply Management System; support strengthening the capacity of the Decentralized Health System and building up health system financing capacity. In this concept note, emphasis is given note only to address key gaps identified in the national strategy, but also to ensure continuity and scale up of investments made so far. The main areas for GF intervention: HSS – Procurement Supply Chain Management HSS – Service Delivery HSS – Health Information Systems and M&E
Government	42000000	2012-2016	The government is responsible mainly for human resource management, salaries and contribute to provision of health services at primary and other levels of health care with more focus on curative care (secondary and tertiary levels) and expansion of services through infrastructure development. This is in addition to what is government providing under the PHC expansion project (this is mainly for the amount mentioned for 2012-2016)
UN	45000000	-	WHO and other UN agencies are providing technical assistance to strengthen the national health system according to the priorities and their respective mandates.

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

8.9. Reporting on the HSS grant

8.9.1. 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 8.9.1: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
1- Training technical reports 2- Supervision reports 3- Programmes' Data 4- M&E reports 5- Surveillance Data	Information collected were cross checked with M&E reports and implementation follow-up meetings	

8.9.2. 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.

- Different information needed for this report in the tables part could be reported in one table instead of three separate tables.

- Short notice of reporting using APR framework. The country is participating in the new GAVI monitoring and reporting system (Live Monitoring GAMR) on quarterly basis. Initial information we have received is that this year there will be no APR, however, in March the country requested to prepare and submit the APR in the old format. This was very challenging due to the short notice.

8.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2014?4

Please attach:

1. The minutes from the HSCC meetings in 2015 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

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

9.1. 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 2014

9.2. 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 2014

10. 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

- The amount of fund allocated to conduct SARA survey is not enough, accordingly a taskforce will be formulate with membership from the EPI programme, UNICEF and WHO to develop for the coverage survey proposal.

- EPI programme will look into and implement a strategy increase provision of fixed immunization services and reducing the acceleration services to achieve sustainable immunization service provision.

11. Annexes

11.1. 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 2014 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.2. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, 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 2014	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.

11.3. 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 2014 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.4. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, 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 2014	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.

11.5. 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 2014 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2014, 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 2014 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 2013 calendar year (opening balance as of 1 January 2014)

b. Income received from GAVI during 2014

c. Other income received during 2014 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2014

f. A detailed analysis of expenditures during 2014, 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 2014 (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 2014 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

11.6. 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 2013 (balance as of *31Decembre 2013*)	25,392,830	53,000
Summary of income received during 2014		
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 2014	30,592,132	63,852
Balance as of 31 December 2014 (balance carried forward to 2015)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2014, the exchange rate at closing 31.12.2014, 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 2014	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. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✔	APR Signature.PDF **File desc:** **Date/time :** 14/05/2015 08:31:19 **Size:** 531 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	✔	APR Signature.PDF **File desc:** **Date/time :** 14/05/2015 08:31:36 **Size:** 531 KB
3	Signatures of members of ICC	2.2	✔	NHSCC-HSCC Sub-CCM.PDF **File desc:** It is one committee for all HSS components NHSCC CCM HSS subcommittee **Date/time :** 14/05/2015 08:32:39 **Size:** 521 KB
4	Minutes of ICC meeting in 2015 endorsing the APR 2014	5.4	✔	HSCC Meeting.docx **File desc:** It is one committee for all HSS components NHSCC CCM HSS subcommittee **Date/time :** 15/05/2015 06:47:31 **Size:** 14 KB
5	Signatures of members of HSCC	2.3	✔	NHSCC-HSCC Sub-CCM.PDF **File desc:** It is one committee for all HSS components NHSCC CCM HSS subcommittee **Date/time :** 14/05/2015 08:18:12 **Size:** 521 KB
6	Minutes of HSCC meeting in 2015 endorsing the APR 2014	8.9.3	✔	HSCC Meeting.docx **File desc:** It is one committee for all HSS components NHSCC CCM HSS subcommittee **Date/time :** 15/05/2015 06:30:32 **Size:** 14 KB
7	Financial statement for ISS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✘	No file loaded
8	External audit report for ISS grant (Fiscal Year 2014)	6.2.3	✘	No file loaded

9	Post Introduction Evaluation Report	7.2.1	✗	No file loaded
10	Financial statement for NVS introduction grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✓	NV & COS 2014 financial statements.pdf **File desc:** NV & COS 2014 financial statements **Date/time :** 14/05/2015 09:36:27 **Size:** 511 KB
11	External audit report for NVS introduction grant (Fiscal year 2014) if total expenditures in 2014 is greater than US$ 250,000	7.3.1	✓	NVC.pdf **File desc:** **Date/time :** 15/05/2015 11:11:02 **Size:** 511 KB
12	Latest EVSM/VMA/EVM report	7.5	✓	Sudan EVM report Dec 2013- Document No (12).pdf **File desc:** Sudan EVM report 2013 **Date/time :** 12/05/2015 07:34:06 **Size:** 1 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✓	EVM improvement plan-Sudan.pdf **File desc:** Sudan- EVM improvement plan **Date/time :** 12/05/2015 07:39:40 **Size:** 530 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✓	EVM PLAN implementation status 2014.pdf **File desc:** EVM improvement plan implementation status 2014 **Date/time :** 14/05/2015 03:13:55 **Size:** 359 KB
16	Valid cMYP if requesting extension of support	7.8	✗	No file loaded
17	Valid cMYP costing tool if requesting extension of support	7.8	✗	No file loaded

18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	No file loaded
19	Financial statement for HSS grant (Fiscal year 2014) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	Bank statement 2013.pdf **File desc:** **Date/time :** 15/05/2015 11:10:15 **Size:** 354 KB
20	Financial statement for HSS grant for January-April 2015 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	8.1.3	✓	2015 bank statement.PDF **File desc:** **Date/time :** 14/05/2015 08:36:10 **Size:** 1 MB
21	External audit report for HSS grant (Fiscal Year 2014)	8.1.3	✓	AuditRep2013.zip **File desc:** **Date/time :** 15/05/2015 10:25:15 **Size:** 11 MB
22	HSS Health Sector review report	8.9.3	✓	(16)Health Systems Performance Assessment (1).pdf **File desc:** **Date/time :** 15/05/2015 06:53:31 **Size:** 2 MB
23	Report for Mapping Exercise CSO Type A	9.1.1	✗	No file loaded
24	Financial statement for CSO Type B grant (Fiscal year 2014)	9.2.4	✗	No file loaded
25	External audit report for CSO Type B (Fiscal Year 2014)	9.2.4	✗	No file loaded
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 2014 on (i) 1st January 2014 and (ii) 31st December 2014	0	✓	Bank statement.pdf **File desc:** **Date/time :** 15/05/2015 10:25:15 **Size:** 1 MB

27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	×	No file loaded
28	Justification for changes in target population	5.1	×	No file loaded
	Other		×	No file loaded