Joint Appraisal Report

Country	Democratic People's Republic of Korea
Reporting period	June 2014-June 2015
cMYP period	2011-15
Fiscal period	January – December
Graduation date	Not Applicable

1. EXECUTIVE SUMMARY

1.1. Gavi grant portfolio overview

DPRK is requesting for renewal of vaccine support for Pentavalent vaccine in its existing presentation. HSS renewal is not requested.

DPR Korea has achieved substantial gains in immunization coverage in the last decade, and now has a high-performing national immunization programme, with no districts reporting DTP3 coverage less than 80%. These gains have been associated with a halving of the U5MR since 2000. For 2014, there continues to be greater than 98% coverage reported for all antigens, except for DTP-HepB-Hib, which is 94%. AEFI surveillance launched in 2013 has shown so far only one case of severe AEFI identified up to 2014, meaning that vaccine safety and quality in the country are well maintained.

The sustainable gains are closely linked to Gavi support. Of the total immunization costs borne by the country, more than one-third is provided by Gavi. Areas of support include new vaccine (Pentavalent and IPV at present; MCV 2 in the recent past), injection supply and cold chain equipment.

DPRK is on the verge of completing cycle 1 of Gavi HSS support, which has provided impetus in sustaining and strengthening immunisation achievements. This 2007-14 US$ 4.3m grant supported capacity building, cold chain, service delivery and coordination, which have yielded positive results in overall immunization performance.

Note that high immunization coverage extensively supported by GAVI through HSS may be linked to the decline in DPR Korea's childhood mortality rate from 58/1000 live-births in 2000 to 27/1,000 live-births in 2014 Child Immunization is the only programme to have universal coverage in the country. HSS1 end of grant evaluation is scheduled for August-September 2015.

The US$ 26m HSS 2 Grant is currently addressing bottlenecks in the immunization system by strengthening micro-planning, planning of outreach and catch up sessions in geographically hard-to-reach areas and expanding cold chain up to Ri hospital level.

Other challenges were limited government budget to cover co-financing for introduction of new vaccines, banking channel disruption due to tightening of international sanctions, and travel restrictions related to government quarantine measures on Ebola between October 2014 and March 2015.

There is a close alignment within the portfolio of Gavi grants between vaccines and health systems strengthening support. Country was able to fully utilize Gavi new vaccine support only through appropriate strengthening of weak links in health system like management and coordination, cold chain, service delivery system and monitoring and supervision. These were given priority during implementation of HSS1 and provided an enabling environment.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

1.1. GAVI grant portfolio overview

GAVI's relative financial contribution to the total budget for immunization (including government spending and all external funding sources) as included in the **APR Table 5.5a: Overall Expenditure and Financing for Immunization** for 2014 is around 37%. Total expenditure in immunization was US$ 7.46m, of which GAVI's contribution was US$ 2.8m.

The proportion of funding for immunization by GAVI, government and other sources remains consistent for the last five years. The bulk of government expenditure is for personnel, payment of co-financing and for other recurrent routine costs. However, the government resources are limited, and for introduction of new vaccines, there is not enough government funding to pay for the additional amount of co-financing- a challenge for introducing new vaccines like Rubella containing vaccine, Rota, pneumococcal vaccine and JE.

Gavi funded vaccines have been rolled out successfully and as planned. In 2008, MCV2 was introduced in DPR Korea with Gavi support; so after completion of 5 years, MCV2 in the country is supported by UNICEF, with some support from ROK. Coverage by measles containing vaccines has gone up from 80% in 2008 to above 98% for both doses.

Gavi supports Pentavalent vaccine since July 2012 and IPV from April 2015. Both introductions went smoothly and so far without any severe AEFI. High level of coverage of penta3 (>93%, nationally) was achieved immediately and is being sustained in 2013 and 2014. However, the Penta PIE planned for 2014 has not been done due to operational reasons and it is planned to be combined with PIE of IPV in April-May 2016.

Immunization activities supported by GAVI, including HSS are integrated in MoPH plan and are accordingly implemented, monitored and reported in their annual report. There is a special team within MoPH, which plans, implements and monitors activities supported through Gavi, which is known as Gavi programme management unit (PMU).

The first cycle of HSS support was utilized mainly to overcome challenges in weak management system, insufficient human resources capacity, shortage of financial resources and of financial management capacity, and inadequate infrastructure; including cold chain system.

Without full scale post implementation evaluation of the grant for HSS1, it is difficult to accurately reflect the impact HSS1 grant had on whole HSS or on the immunization system in the country. The evaluation is scheduled for August-September 2015. However, it is evident from the progress of indicators described in **Table 8.3** of APR 2014, that the HSS1 grant had a positive impact on immunization system strengthening in this country.

The HSS2 Grant proposal to Gavi was prepared as a continuation of HSS1, with additional emphasis on the equity issues considering the findings and recommendations of EPI bottleneck analysis workshop of 2013 and on further strengthening of monitoring and evaluation.

1.2. Summary of grant performance, challenges and key recommendations

Achievements

In addition to the immunization gains mentioned in Section 1.1, other achievements partially contributed to by Gavi grants are:

Polio. Coverage at 99% (WHO/UNICEF estimate)
MNT. The absence of neonatal tetanus cases in the country in recent years, 98% of deliveries by trained health staff and 97% TT2 coverage, indicating that DPRK has likely maintained maternal and neonatal elimination status.
Measles. MCVI coverage had 80% baseline coverage in 2007 (JRF 2007), increased to 99% in 2014 (JRF 2014). More than 98% coverage of 2 doses of measles and 99% coverage in the measles catch-up campaign in 2007 indicate that the country might have already met the goal of measles elimination. The response to isolated cases of measles in bordering district of Sinuiju in June 2014 successfully limited the outbreak only to 4 cases, reflects the strong immunization programme.
Pentavalent. In 2014 Penta dropout rate was 0.8%, and vaccine wastage rate was 5%. Wastage target is being reduced from 1.03 in 2013 to 1.01 in 2014. There are no reported gender coverage discrepancies.
IPV. IPV introduction in April 2015, which went according to plan.
HSS. Successful implementation of GAVI supported activities especially in the areas such as capacity building, cold chain strengthening and integrated surveillance.

Challenges

Challenges from the 2013 'Bottleneck analysis workshop' for the 5 geographically hard-to-reach north-eastern provinces where Penta coverage is less than national average were lack of specific micro-plans, lack of cold chain facilities at the Ri levels, reporting gaps in information system, and frequent turnover of immunization staff. These areas have been addressed in the new HSS grant proposal through context specific approach.

Introduction of rubella containing vaccine into routine programme is being hindered due to non-availability of funding support; which in turn, is a big challenge towards achievement of the Regional Goal of Measles Elimination and Rubella control by 2020.

Some other challenges in implementation of Gavi- supported activities were:

Banking channel disruption: Due to recent international situation during the past two years, there has been major disruption of banking channels for operations of all UN Agencies in DPR Korea including UNICEF and WHO. There has been shortage of funds available in offices of WHO and UNICEF and so activities for which local payments were needed (training, local procurement, local travel) had faced considerable delays and difficulties in implementation of the activities. In late 2014, the problem has been resolved, but there is apprehension that it might return anytime

Varied level of competencies by respective managers; need is felt for refresher training for the managers and the surveillance focal points on general management including financial management and also on disease specific surveillance and response.

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

The following are the key recommended actions to achieve target for sustained coverage and equity that has been reflected in the new HSS grant agreement.

- Revision of micro-planning guidelines and annual micro-planning with annual EPI review;
- Establish cold chain system covering up to Ri hospital level;
- Establish system of outreach immunization, especially in the geographically hard-to-reach areas;
- Sustain the efforts of further strengthening capacity of immunization management by mid and senior level management;
- Strengthen data management and information system; and
- Establish functional system of supportive supervision and monitoring of the programme.

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals
New and underused vaccine support • *Renewal of vaccine* **DTP-HepB-Hib, 1 dose(s) per vial, LIQUID** *in the* ***existing*** *presentation* **Health systems strengthening support** • *None*

1.4. Brief description of joint appraisal process

The joint appraisal report was prepared through coordinated efforts of MoPH, WHO and UNICEF. The data used for preparation of the report included: activity proposals and reports, statements of expenditure submitted to WHO and UNICEF by MoPH, annual reports from MoPH, WHO-UNICEF joint reporting form for immunization coverage (JRF) and WHO Annual report form (AERF). Data were also obtained from demographic survey conducted by MoPH and from census report published by Central Bureau of Statistics (CBS). Information gathered was verified to prepare the draft report. This was then reviewed by GAVI PMU, other concerned officials of MoPH and partners (WHO and UNICEF) and reviewed by the Gavi Secretariat. The final report was reviewed by members of the ICC-HSCC and was approved.

2. COUNTRY CONTEXT

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

Leadership, governance and programme management

The National Immunization programme in DPR Korea is executed through National immunization Programme in Ministry of Public Health under the overall guidance of ICC/HSCC. This high level body comprises of membership from different stakeholders within the government of DPR Korea and partner agencies (WHO & UNICEF). ICC/HSCC is highly empowered and led by the Vice-Minister, Ministry of Public Health.

Costing and financing

As evident form the table 5.3a of APR 2014, the government of DPR Korea provides a substantial amount of resources for immunization programme, more than US$ 2.5m, which is an evidence of high level of political commitment towards the immunization programme. However, it is still only about one-third of the required amount. Data on total expenditure on health by government and other sources is not available.

With the available US$2.5m, government of DPR Korea is covering the payment of co-financing requirement for new and underutilized vaccines, personnel and staff cost, and other routine recurrent costs associated with operations of the Programme However, it is understood that this amount is maximum that the MOPH has access to for utilization in immunization programme; any extra need of funds from the government (for example, payment of additional co-finance related to any new vaccine introduction such as, pneumococcal vaccine or Rota virus vaccine) may not be possible.

ICC/HSCC will advocate with appropriate authorities to contribute in financing traditional vaccines.

Other system components

Human resources management

- Of concern is that most of the large health workforce does not have access to latest advancement and global standards in health. Therefore, continued medical education and

professional learning through on the job training, supportive supervision, e-learning, and in some cases training outside the country, require support.

- To build a specialized group of field epidemiologists, government has currently undertaken a project for establishment of short course in the subject through Pyongyang Medical University.
- Support for building appropriate human resources for health, especially as it relates to strengthening of immunization programme, had been provided through GAVI HSS grant 1 and is also emphasized in HSS Grant 2.

Cold chain and logistics

- There has been a significant improvement in cold chain capacity and standard in this country since the overhauling of cold chain system based on assessment of 2008. Last EVM assessment took place in 2011, recommending EVM improvement plan. Recommended activities have been mostly completed. Follow up EVM assessment jointly supported by WHO and UNICEF is planned for August 2015.
- The country has adequate cold chain system up to the county level, which is planned for expansion to Ri hospital level with support from Gavi.

Immunization service delivery

- Immunization service delivery system is strong as exhibited through high level of immunization coverage throughout the country. However, there are a few bottlenecks hindering further strengthened immunization service delivery, as indicated in the Medium term strategic plan (MTSP) and comprehensive multiyear plan (cMYP). Service delivery related bottlenecks have been addressed in new HSS Grant proposal consisting of *increased accessibility, availability and coverage of immunization services through installation and implementation of micro-planning and outreach systems for remote areas.* These activities will aim to contribute to sustainable immunization coverage increase in low performing counties, particularly in the more remote north eastern parts of the country.

Surveillance and reporting

In general surveillance of vaccine preventable diseases is at reasonable level, evidenced by maintenance of surveillance standard acute flaccid paralysis at certification level needed for fulfilling requirements under polio eradication and maintenance of maternal and neonatal tetanus elimination (MNTE) status. However, there are areas identified, that need further enhancement. These are:

- Establishment of case-based measles rubella surveillance and establishment of sentinel surveillance system for congenital rubella syndrome;
- Establishment of sentinel surveillance for acute encephalitic syndrome (AES), influenza like illnesses and severe acute Respiratory syndrome (ILI & SARI), diarrhoeal diseases in children, etc.;
- Expansion of integrated disease surveillance system and
- Strengthening system of public health laboratory network so that laboratory diagnosis has the capacity to support field and hospital surveillance in early detection of major emerging and re-emerging infectious diseases including VPDs that would require early detection and response.
- For better quality data management, trainings on data management have been conducted, data quality self-audit (DQSA) has been introduced and process of establishing e-reporting system has been initiated. Follow up actions have been planned, that are to be supported by HSS2 grant.

In the previous EVM the recommendation on vaccine wastage at all levels was as follows: 'Wastage in unopened vials should be calculated and used in vaccine planning and management'. This was achieved by 2012. The upcoming EVM assessment in September 2015 will include a vaccine wastage study.

Demand generation and communication

At present immunization services, mainly, are provided passively by the health care providers at the community level and not through active demand by the recipients of the services. Aims in the next few years are:

- Increasing demand for immunization through extension of community IMNCI and demand side strategy to 25% of provinces by 2018 with particular emphasis to north-eastern provinces.
- Developing IEC materials on various aspects of immunization, including on AEFI ,
- Extension of Community IMCI initiative (building on the clinical IMCI strategy in HSS1) rest of the provinces; and
- Supporting Institutional development of the MOPH (National and provincial institutes on health education) to sustain development of communication strategies and materials.

Other factors/events

One of the important factors that impeded implementation of activities in DPR Korea, especially in relation to HSS, was **banking channel disruption** due to the sanctions imposed on local banks to carry out international transactions, which led to unavailability of the funds at country offices of all UN agencies including UNICEF and WHO. This meant that the activities needing in-country payment (local procurement, training, local travels, printing, etc.) had to be delayed. The procurement that happened outside DPR Korea needed more time for reaching the end user.

Towards the end of 2014, this problem has eased out but there is apprehension, current banking channels may also get disrupted anytime. Therefore, WHO and UNICEF are keeping procurement services that could be obtained through off-shore banking as the priority mode of functioning.

In October 2014 **travel restrictions were imposed on any travelers coming from outside DPR Korea**, in relation to Ebola virus disease outbreak in West Africa, meant that even the staff of WHO or UNICEF upon their return from leave or duty travel outside DPR Korea would be subject to restricted movement and be able only to work from home for 21 days. All international missions were not permitted by UNDSS directives. So any activity that needed participation of experts from outside like HSS1 review or National FETP launching had to be postponed. However, from March 2015, the quarantine measures have been eased; and almost normal services have resumed.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

The Pentavalent vaccine supported by Gavi is well in progress and set targets have been achieved and current national coverage remains at 94 percent. The immunization is well planned and being implemented across the country as per WHO recommended schedule without any major challenges. Micro-planning for immunization is now used by all counties.

According to the administrative report, Penta coverage is 4 points lower than the other antigens, and at 94% lower than target. The Immunisation Programme uses number of live births as denominator for Penta coverage, and has noted that there is a problem with this, as the number of live births and number of surviving infants probably do not conform with the projected population target and there are unconfirmed reports that population growth rate recorded in the cMYP in 2011 may have come down, so the actual number of live births are less than the projected ones. However, this is yet to be confirmed by Central Bureau of Statistics (CBS). This issue may be answered after the planned coverage evaluation survey in August-September 2015.

The Vaccine Introduction Grant for IPV was received in January 2015, well on time to undertake planned activities. The funds used as per IPV introduction plan. There were only slight changes in the introduction plan due to different reasons including 5 dose IPV and other logistic arrangement. The initial plan of October 2014 was change to April 2015, this gave sufficient time for preparation for successful implementation.

The country provides data regularly on vaccine coverage, and the verification is planned by coverage evaluation survey in august 2015. In addition, data quality self-audit (DQS) is being currently introduced.

On 8th April 2015 DPR Korea successfully introduced Inactivated Polio Vaccine (IPV) in routine immunization program. A series of activities between 11th March 2014 (*first advocacy meeting with minister*) and 8th April 2015 (*launching of IPV*) took place including: planning of IPV introduction, advocacy, capacity building, awareness creation, vaccine and logistic support. UNICEF and WHO provided extensive support to MoPH.

GAVI support, MoPH, UNICEF and WHO highly acknowledged GAVI support in facilitating the process by providing introduction grant, vaccine and logistics to make this introduction a success. IPV monitoring is now incorporated in regular monitoring checklist for routine immunization. PIE will occur in 2015.

A detailed review was held with MoPH to present the findings, lessons learned and recommendations:

- The Government lead role and strong coordination among key partners remained the key to success.
- IPV Taskforce, with clear and well defined roles and responsibilities played a vital role in IPV introduction, and same approach with further improvement should be applied in future for success.
- Training of staff is very important to ensure service provision as per WHO protocols. The training sessions including practical sessions on administration of vaccine at all levels should be observed to ensure quality.
- Field monitoring and supportive supervision is MUST as an integral part of the implementation plan for any new introduction of vaccine to avoid difficulties.
- The team realized the need for expanding the storage capacity at Central Medical Warehouse. It should be further discussed with MoPH for appropriate actions, already included and agreed in GAVI HSS2 funding.
- Advocacy Kits-such events provide an excellent opportunity to interact and seek support from decision makers, lack of an “Advocacy kit” for policy makers/ministers found missing in the advocacy plan. This will be discussed with communication colleagues and Regional office for future support.
- Inclusion of another injection for children was not liked by some of the parents as the child was getting two injections during same immunization visits. However, there were no refusal for IPV, which reflects proper communication with parents on importance of immunization in general and IPV in particular.

Financial performance and challenges: nothing significant as the funds allocated were managed through UNICEF and WHO as per joint planning. The approved budget was as per need and was fully utilized. The HSS funds and VIG certainly complement each other as the new vaccine introduction relied on the infrastructure and system already established through HSS support. The system well in place to ensure timely and quality management of the allocated funds for the purpose. Detailed financial report on VIG for IPV will be provided with annual report of 2015.

3.1.2. NVS renewal request / Future plans and priorities

The country is requesting for renewal of vaccine support for Pentavalent vaccine in its existing presentation.
The targets for the year are based on population projections in line with cMYP, with a slight deviation. The available data through routine reporting suggest that the population growth rate is close to zero. Taking that into consideration preliminary assumption is to keep the targets for the next five years constant. However, this is subject to modification after verification by Central Bureau of Statistics and also by data that should come up during review of the current cMYP and preparation of the next cMYP later this year.
With the financial crunch faced by MoPH, introduction of planned new vaccines, for example, Rubella containing vaccine to add to existing measles containing vaccines, pneumococcal vaccine and Rota virus vaccine, is hindered by inability to identify source of additional payment that would be required for co-financing these vaccines. Present co-financing commitments are met duly by the government, however, with some delays. The existing cMYP covered the years 2011-15. The new cMYP will cover the updated plans on NVI, which will be finalized by end 2015.
The country is also preparing for next steps/phases of **SWITCH** and **WITHDRAWAL** (withdrawal of OPV type2 and switch from tOPV to bOPV), as recommended by Global SAGE. Technical support and guidance will be required to facilitate this as per global polio endgame strategy.

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

Programmatic performance and challenges:

Achievements of targets and of intermediate results, and feasibility of targets set in the original proposal

- All the indicators set in the 1st cycle of HSS have been met (please refer to **Table 8.3 in APR 2014**)
- From next year indicators set in the new second cycle of HSS grant proposal will be used.

Actual versus planned activity implementation, based on approved workplan

- Most of the activities completed; (of 19 major activities 14 activities were fully completed ,in progress; 5 activities were delayed and are being completed in 2015)

Degree of **participation of key stakeholders** in the implementation of the HSS proposal, including **civil society organizations**

- Key stakeholders, MoPH, WHO and UNICEF were involved in the implementation of the planned activities, their monitoring and supervision.
- The civil society in DPR Korea is not similar to the same group in other countries; some voluntary groups, groups of professional and local community leaders were engaged wherever deemed feasible, especially that require community awareness and participation. Efforts are underway to involve more and more members of civil society in future.

Implementation bottlenecks, corrective actions, and lessons learned to improve future performance

- Procedural delays in proposal preparation, report writing, technical document preparation in programme management unit (PMU) looking after GAVI supported activities within MoPH - measures taken to strengthen PMU technically and with appropriate logistic support
- Lack of mobility of PMU for monitoring and supervision of activities - measures taken: Two vehicles procured for this activity for use by members of GAVI PMU
- Delay for initiating activity through partner agencies- need to send quality activity proposals well ahead of time
- Unavailability of funds at the country level by WHO and UNICEF due to geopolitical situation and banking channel disruption during most of 2014 was a notable hindrance to implement activities- mechanisms to explore activities with offshore modality of payment identified

Compliance with data quality and survey requirements

- Administrative data generated by national EPI programme had proved to be conforming mostly to survey data (EPI Coverage Evaluation Survey-2008); however for past several years, coverage evaluation survey (CES) has not been conducted. Next CES is planned for August- September 2015
- Data quality self-audit (DQS) is being introduced now with DQS guideline prepared in 2014 and trainings are planned in 2015.
- These two activities will lead to drawing of data quality improvement plan.
- Gavi support is being used for supporting data management capacity building (training of data managers), for building better data management system (system of e-reporting) and for data quality monitoring through periodic CES and through developing DQS system.

Follow-up on recommendations from any **available HSS evaluation report- Not applicable.**

Overall programmatic capacity of entity managing HSS grants

GAVI programme management unit (PMU) within MoPH, plans, implements and monitors activities supported by GAVI. There is coordinated effort between PMU, specific programmes directly or indirectly benefited by GAVI support (EPI, Communicable disease department, central hygiene and anti-epidemic station and other departments in MoPH) and with partners (WHO and UNICEF).

PMU has dedicated technical professionals who are directly responsible for implementing GAVI supported activities. Their overall programmatic and management capacity is at acceptable level; but due to some procedural formalities the programme implementation sometimes gets delayed. There have been also issues of quality project and activity proposal development and report writing. Other issues included restricted mobility needed for movement of the managers to different parts of the country for monitoring and supportive supervision.

To address these issues with support from GAVI and other partner organizations, PMU members and other high officials have been provided training on general and financial management through national workshops and study tours and fellowships abroad; support for operational cost of PMU has been budgeted within HSS2 proposal and two vehicles have been procured in 2014 for facilitating monitoring and supervision.

The funds used are channeled through WHO and UNICEF and are subject to additional monitoring and reporting. Both WHO and UNICEF have their own M&E, Internal audit and oversight system of monitoring the GAVI-HSS activities in regards to both technical and financial aspects.

As explained during the HSS2 proposal preparation and review in 2013-14, with the increase of Grant amount under HSS support from Gavi for the country, the implementing agencies responsible for GAVI activities in the country, WHO and UNICEF had been facing problem of Grant Management due to lack of adequate number of staff. Gavi Alliance has accepted the requirement of additional human resources, both national and international within these organizations and has allocated funding support for that. However, the extra human resources yet to be on board, which could hinder future pace of implementation of Gavi supported activities. The deployment of additional staff is under discussion with MoPH.

Financial performance and challenges:

Actual versus planned financial expenditure, based on approved budgets
In 2014, budgets related to NVS implementation was 100% implemented; as for HSS of about USD 800,000 budgeted for 2014, about 500,000 were implemented during the calendar year despite various operational and geopolitical problems; which is about 65% of the total budget. The rest activities were either under process or postponed for implementation in 2015.

There were no major challenges in terms of financial management of HSS funds; however, as had been noted earlier, there had been procedural delays to implement some activities apart from operational problems related to funds availability issues. These were related to time spent for

- MOPH and partners had to spend additional time to finalize activity proposals,
- adherence to internal rules and limited flexibility among MoPH and partner agencies (WHO and UNICEF),
- delays due to limited capacity of suppliers,
- delays related to transportation, long distances and cross-border procedures, etc.

Challenges are also faced in programme implementation due to varied level of competencies by respective managers; need is felt for refresher training for the managers and the surveillance focal points on general management and also on disease specific surveillance and response.

- For country that has received **performance payments under the Gavi Performance Based** Funding (PBF) approach:
    - o *Not applicable*

Overall financial capacity of entity managing HSS grants

The mechanism of channeling funds through WHO and UNICEF has been working effectively.
Channeling of funds through WHO and UNICEF needs procedures including proposal development for each activity, monitoring and technical and financial statements.
Financial capacity in the field, already mentioned, is variable. Therefore, the mid and senior level managers need more training on financial management.

3.2.2. Strategic focus of HSS grant

Gavi HSS grants have played an important role in improving and sustaining coverage of all the antigens. However there are a few challenges still remaining.

There are five provinces situated in the North and North-East of the country where the coverage is below the national average. These are the provinces with potentially more challenges in terms of geographical access especially due to harsh winter and mountainous terrain. So, it is not surprising that these areas have small pockets where immunization and other health services might not have reached adequately, especially during winter. To address this HSS2 focuses to provide targeted services through establishing outreach sites and also through conducting catch-up immunization campaign.
Although the programme reports gender parity in terms of getting immunization services, the exact data on this is not available. Therefore, HSS grant is also emphasizing on generating gender disaggregated data, through revision of existing EPI data collection forms. The revised forms are in the process of printing; it is expected that disaggregated data should be available from next year. It will be significant step towards building evidence on gender-based parity. The country is based on socialist economy where there is no wealth inequity; hence, there is no data on any wealth inequalities, or its relationship to immunisation programme.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

The activities that could not be completed in 2014 will be completed in 2015. As indicated, in the APR, several activities planned in 2015, will be postponed to 2016. This is in relation to bulk of activities remaining from HSS1, which had to be completed in 2015 and also related to procedural delays in accessing funds, especially through WHO.
No new tranche is requested for 2016, as the funds for 2015 and 2016 have already been received.

3.3. Graduation plan implementation. Not relevant

3.4. Financial management of all cash grants

- **Cash utilization performance and financial capacity constraints**
  - The level of cash utilization performance in the country is high; however, with the increase in amounts of cash available, HSS2 will require more human resources dedicated to utilization of the resources appropriately for maintenance of high quality of performance.
  - To build further financial capability within country, senior and mid-level managers will need further training on financial management, especially on financial and technical monitoring, programme sustainability, on cost effectiveness and prioritization.
  - Financial accountability system development is also a challenge.
- **Modifications, if any, made to the financial management arrangements**
  - Presently financial management of GAVI support is provided through WHO and UNICEF- and modification of this mechanism is not required.
- **Any major issues arising from Cash Programme Audits or Monitoring Reviews**
  - None.
- **Degree of compliance with Financial Management Requirements** (Annex 6 of Gavi's Partnership Framework Agreement) and **outstanding issues**
  - Not relevant.

3.5. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	**Timeline**	**Potential financial resources needed and source(s) of funding**
Enhance process of HSS2 implementation	MoPH, WHO, UNICEF	2016	None
Training of PMU staff on project proposal writing and reporting	MoPH, WHO	January 2016	5,000 (part of existing support for operational support to PMU may be used)
Training of PMU staff on supportive supervision	MoPH, WHO	Feb 2016	5,000 (part of existing support for operational support to PMU may be used)

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

In the current reporting year technical assistance was mainly provided by country teams of UNICEF and WHO on IPV introduction planning, preparation, training and implementation; and on other various

routine areas. External support for training of health and immunization staff on vaccine temperature monitoring was provided by a consultant hired by UNICEF.

4.2 Future needs

Technical assistance planned for 2015 and 16, where external consultants including Regional office support to be involved, are 1. Consultant to plan and implement EPI coverage evaluation survey (CES) in August Sep 2015- lead agency UNICEF 2. EVM assessment to be conducted in Aug-Sep 2015- lead agency UNICEF 3. Review of 1st cycle of HSS- Sept 2015- Lead agency WHO 4. Review of cMYP2011-15 and preparation of cMYP 2016-20- Lead agency WHO 5. Post implementation evaluation of Penta and IPV, April-May 2016 - Lead agency WHO

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

The joint appraisal report draft was translated into Korean and shared with the members of ICC/FSCC one week prior to the schedule meeting. During the process some feedbacks were received, and suggestions incorporated into the joint appraisal report. At the same time the draft report was also shared with the Gavi country support team for DPR Korea; valuable feedback along with a few notes for clarification was received. The responses to the comments / queries from Gavi were included in the final draft, which was again shared with ICC/HSCC. On 9 June 2015 ICC/HSCC met and endorsed the joint appraisal report in full. The minutes of that meeting are attached with the submission of the report.
Issues raised during debrief of joint appraisal findings to national coordination mechanism: None
Any additional comments from • Ministry of Health: • Partners: • Gavi Senior Country Manager:

6. ANNEXES

Annex A. Key data (this will be provided by the Gavi Secretariat)

Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Apart from Pentavalent renewal, there were none.	

Annex C. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

This report was prepared through joint work between PMU, UNICEF and WHO. For any queries please contact-

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Annex D. HSS grant overview

General information on the HSS grant							
1.1 HSS grant approval date			April 2008				
1.2 Date of reprogramming approved by IRC, if any							
1.3 Total grant amount (US$)			4.36 million USD				
1.4 Grant duration			5 Years				
1.5 Implementation year			month/year – month/year				
(US$ in million)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
1.6 Grant approved as per Decision Letter	0.45	1.31	1.03	1.03	0.55		
1.7 Disbursement of tranches	1.76	0	0.40	0	0.81	0.84	0.55
1.8 Annual expenditure	0	0.11	0.54	0.84	1.11	0.61	0.53
1.9 Delays in implementation (yes/no), with reasons			Yes; there was procedural delays in disbursement of the funds; thus 1st tranche was received only towards the end of 2008, and the fifth and final tranche only in the beginning of 2014. Delays in implementation also related to various other factors including limited management capacity, limited manpower and operational support and also to other factors related to geo-political situation.				
1.10 Previous HSS grants (duration and amount approved)			This was the first HSS Grant. The second cycle of HSS grant of 26.03 million USD has been sanctioned for 2015-19				
1.11 List HSS grant objectives The goal of the GAVI supported health system strengthening was to promote sustainable gains in immunization coverage through targeted investments in health system strengthening. The strategic focus was on strengthening health management and service delivery systems at the implementation levels of county (district) and ri(PHC). Four major expected outputs were identified to be achieved during the first cycle of HSS: 1. Quality improvement 2. Infrastructure development 3. Health management systems strengthening and							

4. Development of communication strategy and methods.
1.12 Amount and scope of reprogramming (if relevant) *Not relevant*