Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	Democratic People's Republic of Korea
Reporting period	*Jan 2015 – June 2016*
Fiscal period	*Jan 2015 – June 2016*
If the country reporting period deviates from the fiscal period, please provide a short explanation	
Comprehensive Multi Year Plan (cMYP) duration	*2010-2015 (new cMYP is being developed)*
National Health Strategic Plan (NHSP) duration	*2010-2015 (new MTSP is being developed)*

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *Penta in existing presentation*	*Renewal*	*2017*	*98%*	*US$*	*US$*
NVS – *IPV in existing presentation*	*Renewal*	*2017*	*98%*	*US$*	*US$*
HSS – *3rd tranche*	*Renewal*	*2017*	*N/A*	*N/A*	*US$ 4,949,497*

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	MR	*2017*	*2018*
	PCV	*TBD*	*TBD*

**Not applicable for countries in final year of Gavi support*

2. COUNTRY CONTEXT *(maximum 1 page)*

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

Leadership and governance programme management

Since February 2015 regular meetings between the Ministry of Public Health (MoPH), WHO and UNICEF have been taking place on a monthly basis to oversee implementation of Gavi support (Pentavalent vaccine support and HSS), and as a result discussions between the MoPH and the partners on opportunities and challenges in implementation has become more open and transparent. The new forum functions as a technical working group under the ICC/HSCC which itself meets on ad-hoc basis.

During the reporting period a NITAG has been formed and is now formally established and functioning. However, the NITAG needs to be further developed and strengthened to be fully functional. Primarily it needs to include independent in-country immunisation experts.

Coverage and equity

Outreach sessions have been conducted in two of the five previously lowest performing provinces with the aim of reaching unimmunised children. This is the first time this approach has been introduced in the country, and it has contributed to improved coverage and geographic equity in the country. Catch-up campaigns are planned in these provinces from July to September every year from 2016. These new strategies are the result of a closer collaboration between MoPH, WHO and UNICEF, and a greater openness from the DPRK Government side to discuss challenges such as geographical equity and gender equity in the immunisation programme. Another example of this new approach and openness is the establishment of Child Data Management Unit at CBS (Central Bureau of Statistics) and introduction of gender disaggregated data.

There is now an increased openness to discuss data quality issues in the country. This has resulted in an EVM assessment and plans to conduct an independent EPI coverage evaluation survey (CES). It has also resulted in a greater focus on quality issues including quality assurance of vaccines and reporting (e.g. better quality of reporting of 2015 JRF, reporting of temperature monitoring data, sharing of the cold chain inventory.).

Immunisation financing

Since the country started co-financing in 2009 the Government has honoured its obligations (paying its share from its own resources). However, during the reporting period DPRK defaulted and co-financing for 2015 was not paid until May 2016. During the JA mission the DPRK Vice Minister confirmed that DPRK will fulfil its co-financing obligations in the future and that the country will not default again. This public statement is of significance and a strong signal that co-financing will be honoured by the country in the future. However, it should be noted that funding of traditional vaccines continues to be a challenge – as it remains dependent on support from UNICEF.

Another contextual factor of importance is the effects of international sanctions against DPRK. Due to these sanctions it is increasingly difficult to transfer cash into the country, which is having an impact on implementation of activities, for example local training, printing of materials, and mobility including for supportive supervision. It has also delayed planned outreach activities.

Other factors

The cMYP 2016-2020 is currently being developed. First draft is ready. The Medium Term Strategic Plan for Health (2016 – 2020) is also being developed and will be finalised by the end of 2016.

3. GRANT PERFORMANCE AND CHALLENGES *(maximum 3-4 pages)*

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: programmatic performance of each vaccine programme against approved targets and planned activities, including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarity between all cash grants]

Coverage

NVS performance is in line with agreed targets for the period. DPRK has been able to sustain a high coverage of Pentavalent vaccine since the introduction in 2012. During the reporting period the country managed to increase national penta 3 coverage (admin) with three percentage points from 93% in 2014 to 96% in 2015, and essentially met the target of 97% coverage The absolute numbers also increased, from 317,962 to 326,916 (8,954 additional) children vaccinated with penta 3.

Equally, the global target of introducing IPV in the second quarter of 2015 was met by DPRK. IPV was introduced into the EPI programme on the 8th April 2015 reaching 98% coverage. The introduction was followed by the switch from tOPV to bOPV on the 18th of April 2016. However, IPV vaccination has been discontinued since March 2016 due to the global shortage of the vaccine.

Equity

Geographic equity in immunisation coverage is also high. The country reached the geographic equity targets with coverage (admin) above 95% in all provinces. Outreach sessions were carried out in two selected provinces during the reporting period to further improve coverage and geographic equity. This has contributed to the high geographic equity of coverage in the country.

Although, culturally, there is gender-equity in the access and utilisation of services in the country, the data reporting system has been revised to capture sex-disaggregated data for further assurance.

Financial utilisation remained above 96% for VIG (IPV) and the remaining balance is reserved for conducting the PIE that is being planned to be conducted in 2016. No cases of vaccine preventable diseases, including measles, rubella and neo-natal tetanus were reported in 2015 and that only one serious case of AEFI has been reported in 2014.

Key implementation bottlenecks

A major issue of concern is the difficulty to fill agreed posts (international staff) for programme implementation both in WHO and UNICEF offices. These positions were agreed between WHO/UNICEF and the Government of DPR Korea when the HSS2 support was developed. Up until now only 2 out of 4 international positions have been filled.

Another key bottleneck relates to gaps in knowledge and skills of health care workers and managers. This inevitably affects the quality of the services, for example reporting of AEFI. Although the system is in place and well-functioning, the AEFI reporting practice needs to improve. The JA found that as per WHO standards, fewer than expected AEFI were reported during the reporting period, and the problem is primarily due to lack of knowledge and skills among health workers on how to report. Therefore continuous good quality training is critical to ensure quality of service delivery and sustained coverage. The HSS2 support includes activities to address these issues such as training of health workers.

Vaccine supply is working well and vaccines are available at all levels, no stock outs are reported (apart from IPV). Supply of vaccines from the central level to provincial, country and Ri levels is

functioning but the system needs to be strengthened especially in the area of maintenance including cold chain equipment and fleet of vehicles. Cold-chain expansion is implemented according to plan through the HSS support. The expansion accommodates introduction of projected new vaccines in line with the revised cMYP 2016-2020.

Unstable supply of electricity at county and Ri levels is a concern. Responding to the issue, SDD ice lined refrigerators are being provided to all the county medical warehouses for ensuring the safe storage and thence the potency of stored vaccines. The same problem of electricity in combination with problems of water supply at the public health laboratories is also a problem risking functionality of laboratory activities with resultant effect on VPD surveillance. There is currently no plan in the HSS support to address this.

The impact of international sanctions against DPRK and limited availability of in-country cash is a major bottleneck for implementation of activities. It primarily affects activities such as training, transportation, printing of IEC and training material and field supervision and monitoring etc. Some of these activities can still take place thanks to the government temporarily covering the costs, but the situation is not sustainable.

As mentioned above DPRK defaulted in co-financing payments in 2015. The country managed to settle the payment in May 2016. The issue was raised with the MoPH during the JA, and the JA team were informed that DPRK will honour its co-financing obligations in the future. The JA found this to be an important statement by the representative of the DPRK Government. It creates a certain amount of confidence that DPRK will in fact not default at least in the near future.

It should also be noted that during the mission the team had extensive discussions about new vaccine introductions and its implications on co-financing for the country. These discussions were also taken into account when the MoPH made the statement regarding co-financing.

3.1.2. NVS future plans and priorities

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]

For vaccines already in the national vaccination schedule:

- Pentavalent – revise the 2016 target from 100% to 98%
- IPV – resume vaccinations in Q4 2017, target 98%

The revised cMYP includes the introduction of four new vaccines. Prioritisation of vaccine introduction will be in the following order, however the timeline for introduction will depend on availability of resources (co-financing):

- MR (April 2017); PCV; Rota; JE

The major risk to future implementation is primarily related to co-financing capacity. Cold chain capacity should not be an issue as the cold chain expansion has been designed through the current HSS2 grant to accommodate for these future vaccines.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunisation, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]

The HSS2 grant is well aligned with the identified system bottlenecks and is designed to contribute to improved coverage and equity. Minor gaps were identified. These gaps include the following areas:

Implementing micro planning is an important component of HSS2. Currently management planning is being introduced at provincial level. There is a need to introduce proper micro planning with a bottom up approach at RI and county levels (in line with WHO/UNICEF standards). WHO and UNICEF can provide the technical support to do this.

In the current plan cold-chain expansion is designed to address both capacity issues and functionality. 1200 SDD refrigerators are being installed at all levels. There is currently an unmet need for SDDs at 280 county level hospitals. There is also a need to invest more in maintenance and securing access to spare parts, especially for the fleet of cold-chain vehicles.

Improvements in data quality is another area which needs further attention. At the lower levels (Country and Ri levels) the information system is still paper based. There is a need to invest in upgrading of the HIS for higher quality.

Finally the JA also recognized the need to further strengthen the capacity of the PMU.

Some of the NVS implementation bottlenecks listed in 3.1.1 above are addressed through the existing HSS2 support, some could be addressed through either reprogramming of current HSS or through a PBF grant. The JA identified potential activities which could be implemented through the PBF grant including refurbishment of the vaccination rooms in all Ris of the country, further expansion of the cold chain to also include county level hospitals, improvements in service and maintenance of existing fleet of cold chain trucks and vehicles further expanding community IMNCI, and strengthening of the NITAG.

3.2.2. Grant performance and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: achievements of targets and intermediate results; actual versus planned activity implementation and financial expenditure; use of PBF reward and budgets/plans; degree of participation of key stakeholders in implementation of HSS proposal; implementation bottlenecks and key challenges regarding financial management of HSS grant; compliance with data quality and survey requirements]

Completion of HSS 1
Remaining HSS1 activities were completed in 2015 including procurement and installation of 130 Solar Direct Drive (SDD), Measles/Rubella case based surveillance training, setting up of national FETPC training center, operational support to Gavi PMU and Human Resource support to WHO. Evaluation of HSS1 support is pending, however plans are underway for the evaluation to be conducted in Q4 2016.

HSS 2 Implementation:
The HSS 2 grant (2014-18), for which implementation began in 2015, is addressing bottlenecks in the immunization system by strengthening micro-planning, outreach and catch-up session planning in geographically hard to reach areas and expanding cold chain up to Ri hospital level. The grant is administered by WHO and UNICEF.

Objective 1: Service Delivery
Out of planned five key activities in 2015 three were fully implemented, one is in progress and one could not be implemented due to non-availability of a suitable consultant. These activities contributed to development of micro plan with M&E targets for 208 counties, conducting two catch up campaigns reaching the unreached/partially immunized children in five north-east provinces. The intermediate result “system readiness assessment for vaccination” could not be completed.

Objective 2: Cold Chain and vaccine
All four key activities planned for 2015 were completed. These activities contributed to establishment of refrigerated solar cold chain systems in 630 Ri hospitals.

Objective 3: Increasing demand for immunization service
Out of planned four key activities in 2015 all have been initiated and are currently being implemented. These activities contributes to community Integrated Management of Neonatal and Childhood Illnesses (IMNCI) in the selected 50 target counties. (This activity will continue until 2018). Activities have been responsive to current programme needs – e.g. against a target of two, in fact ten different immunization-specific communication materials have been developed and disseminated this year.

Objective 4: Improved Management
Out of planned eight key activities in 2015 six have been completed, two have been shifted to 2016. This was due to non-availability of a suitable consultant for CES and unavailability of in-country cash. The completed activities have contributed to introduction of AEFI system in 11 provinces, and DQS system in 208 counties. Three AES sentinel sites and 39 ILI/SARI were established. Diarrhoea sentinel surveillance sites will be initiated in 2016.

Objective 5: Project Management
Out of planned three key activities for 2015 all have been initiated and will be completed in 2016. These activities will lead to the development of cMYP, MTSP and a Coverage Evaluation Survey (CES - covered in Objective 4).

Summary:
Overall HSS 2 is on track. Out of the 24 key activities planned for 2015, 20 have been or are on track for completion. These activities contributed to; development of micro plan, expansion of the cold chain infrastructure to Ri level with solar systems, increased access to community IMNCI, introduction of AEFI surveillance and DQS systems, development of cMYP, MTSP and Coverage Evaluation Survey. The intermediate result "system readiness assessment for vaccination" could not be completed, however the consensus is that system readiness is at a high level: HSS 2 has contributed to increased access, addressed equity and ensured quality of vaccines.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]

Not applicable

3.3. Transition planning *(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]

Not applicable

3.4. Financial management of all cash grants *(e.g. HSS, VIG, campaign operational cost grant, transition grant)*

[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]

All funds are channeled through UNICEF and WHO, which follow their respective financial management procedures as per the individual Grant Agreements. Therefore there are no external audits, CPA's or PCA's applicable.

Despite programmatic delays caused by administrative requirements, the cash utilization to date remains high as follows:

	Budget	Disbursed	Expenditure	Utilisation
2014	6,097,880	3,122,602	-	
2015	5,032,836	3,033,257	5,496,362	
2016	4,949,497	-	350,875	
Total	**16,080,213**	**6,155,859**	**5,847,237**	**95%**

Due to administrative delays, no funds have been transferred to WHO for HSS 2 – despite implementation of programme activities. WHO have used their own resources.

The present challenge facing the HSS programme is the ability to transfer funds into the country. The current funding disruptions are affecting all UN agencies. UN agencies are now under "cash conservation mode" to continue life-saving interventions only.

For Gavi HSS 2, efforts are being made to prioritise activities, obtain government lines of credit, and conduct off-shore procurement activities whilst alternative solutions are investigated.

If a banking solution is not found and UNICEF/WHO cannot access funds in country, there will be an adverse impact on programme implementation to all areas.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Prioritised strategic actions from previous joint appraisal / HLRP process	Current status
1.Enhanced process of implementation of HSS 2	HSS 2 started and being implemented according to the plan.
2.Training of PMU staff on project proposal writing and reporting	Two training sessions have been conducted, Partners have assessed the outcome to be of good quality.
3. Training of PMU staff on supportive supervision	Training of the PMU staff has been completed and has been assessed to be of good quality

5. PRIORITISED COUNTRY NEEDS[1]

[Summarise the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]

Prioritised needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?* *(yes/no)* If yes, indicate type of assistance needed
Resolve the problems of transfer of cash to the country	Efforts are ongoing to find a solution,	No
Resolve the problem of recruitment of international staff to support the programme	MoPH will look into the issue	No
Capacity building of PMU	Linked to the recruitment of international staff	Yes, will be provided by WHO and UNICEF through staff positions allocated for the implementation of the programme.

[1] Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS

This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	A summary of the findings was presented to the ICC. The findings were discussed and after giving comments to the findings the ICC endorsed the findings.
Issues raised during debrief of joint appraisal findings to national coordination mechanism	The ICC underlined the need to strengthen the capacity of the PMU to ensure government ownership of the programme. The ICC stressed the need to speed up the establishment of a Study Centre (included in the HSS2 proposal), progress has been slow to date (partly due to lack of in-country cash). The ICC also underlined the need for investment in maintenance and spare parts as the country expands and upgrade the cold-chain. The ICC also commented on the findings that very few cases of AEFI are reported. The ICC concluded that the system has to be more sensitive and report all the cases. The ICC also made a general comment on data quality and concluded that a quality assurance system is important to be able to assess coverage of immunisation.
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	The MoPH confirmed that DPRK will honor its co-financing payments. MoPH confirmed that they will look into the delays in approving agreed staff positions in WHO and UNICEF. The MoPH will develop a draft plan and budget for how potential PBF funds can/should be used. The MoPH commented on the role of the partners and their importance for the EPI programme. The MoPH also requested that the UN collectively should work together to find a solution to the problem of cash transfers to DPRK.

7. ANNEXES

This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

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

The joint appraisal report was prepared through coordinated efforts of MoPH, WHO, UNICEF and Gavi Secretariat. The data that was used for the preparation of the report included activity proposal and reports, statements of expenditures submitted to WHO and UNICEF by MoPH, and statement of expenditures from WHO and UNICEF. Additional data sources were WHO-UNICEF joint reporting form (JRF). Relevant statistics was also obtained from Central Bureau of Statistics (CBS). The findings were thoroughly discussed in a series of meetings and workshops including the JA Team (MoPH, WHO, UNICEF and Gavi Secretariat). The final outcome was presented to and endorsed by MoPH and the ICC at the mission end.

JA Team members:

MoPH DPRK

Dr Kim Chol Su, Gavi Focal Point
Dr Ri Hak Pom, Cold-Chain manager
Dr Kim Nam Hyok, Gavi PMU
Dr Hwang Yun Mi, Gavi PMU
Dr Yun Kyong Mi, Gavi PMU

Country Partners:
Dr Zobaid Khan, Medical Officer, WHO
Dr Muhammad Younus, Chief of Health, UNICEF, DRPK
Dr Muhammad Tariq Iqbal, Health Specialist, UNICEF DPRK

Regional Partners:
Dr Xiaojun Wang, Immunisation Adviser UNICEF EA Office
Dr Pushpa Wijisinghe, Medical Officer, WHO SEARO

Gavi Secretariat:
Charlie Whetham, Regional Head, AP Team
Par Eriksson, Senior Country Manager, AP Team
Gurleen Hans, Senior Manager Programme Finance

Annex B: Changes to transition plan *(if relevant)*

Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result
Not relevant					