Joint appraisal report

Country	**South Sudan**
Reporting period	*Month/Year of the last appraisal report* **July 2014** *Month/Year of the current appraisal* - **September 2015**
cMYP period	**2012 to 2016**
Fiscal period	**July - June**
Graduation date	***NA***

1. EXECUTIVE SUMMARY

(MAXIMUM 2 PAGES)

1.1. Gavi grant portfolio overview

As world's youngest country with conflict-ridden history that has left its infrastructure in disrepair and considering the ignition of more armed conflict just two years after independence, the needs for strengthening all aspects of the health sector in the Republic of South Sudan are prodigious and far-reaching. The government is almost completely dependent on foreign donors to meet these needs. The Gavi Alliance has made a significant contribution to a key area of South Sudan health services ensuring that new born, young children and women of child bearing age are vaccinated against vaccine preventable diseases.

Since 12 years, Gavi has been supporting the Republic of South Sudan through five windows of support. Initially Injection Safety Support (INS) was provided from 2002-2004, Immunization Service Support (ISS) from 2002-2009 and 2012 to build up the foundation of routine immunization service delivery by covering the cost of injection safety, vehicle and transportation, personnel, training, procurement of cold chain equipment and late from 2009 rolling out RED approach to boost immunization coverage in low performing counties. Disbursement of ISS funds was not fully completed due to outstanding audit reports (2010-2012). Health System Strengthening from 2009 to 2011. The third window , as funding for Health Systems Strengthening (HSS 2009-2011) attempts were to fill operational gaps in the national and State level EPI system

The 4th and 5th windows are the ongoing New Vaccine Support (NVS 2014-2016) and Vaccine Introduction Grant (VIG 2014-2015) provided for the purchase of vaccines including Pentavalent introduction operational costs in the country.

1.2. Summary of grant performance, challenges and key recommendations

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

Achievements:

- Existence of Public Health Act to guide government leadership of the immunization program and there are Health Sector Development Plan, cMYP and the EPI Policy and Technical Protocols to guide program management.
- An Inter-agency Coordination Committee (ICC) exists for decision making and oversight support to the MoH and a NITAG recently created to provide technical guidance to MoH to enable evidence-based decision-making
- There are program management structures at all levels of the system (National, State, County & Payam)
- UNICEF provide support in communication and socio mobilization and procures vaccines and cold chain equipment for and on behalf of the Ministry of Health

- The country successfully introduced pentavalent vaccine in July 2014 mainly supported by Gavi funds. There was an increase coverage in DTP3 (63% in 2013) and Penta3 (83% in 2014) in the 7 stable states
- The government co-financed procurement of pentavalent vaccine for routine immunization in 2014.
- The Gavi HSS strategy (goal, objectives and activities) outlined in the 2008 proposal aligned with the cMYP, and health sector plans.
- Integrated Disease Surveillance and response (IDSR) system is improving over time however, completeness (46%) and timelines (36%) remains weak in 2014.
- Existence of District Health Information System (DHIS) software at County level. The system is supported by one Data officer at the national level and M & E officer in each of the 7 stable states
- Demand generation for immunization mostly through the implementation of Reach Every Community (REC) approach linking community to services
- Demand generation further strengthened by Health Committees and Home Health Promoters Implementation guides.

Challenges

- Decline in government health expenditure as a result of austerity measures. No allocation for EPI operational costs as well as budget line for the procurement of traditional vaccines.
- Government contribution to the immunization program is mostly limited to staff salaries, while funds for program operational costs remain insignificant, as program financing remains heavily donor dependent.
- Continued moratorium on staff recruitment at all levels leading to absolute shortage of MOH staff at all levels. Those on board lack required technical and management skills
- Over 80% of program implementation continues to be led by NGOs
- Lack of effective coordination of multiple inputs and partners by MOH resulting in inadequate program management, limited accountability and transparency in the use of resources.
- ICC is functional however, needs to strengthen the body. The recently created NITAG remains largely non-operational.
- The Adverse Events Following Immunization (AEFI) Surveillance remains adhoc only during Supplementary Immunization Activities and not established into routine services.
- Delays in government decision-making on alternative disbursement options for the new approved HSS funds, due to pending audit reports for previous grant.
- No updated cold chain inventory, more than 50% of health facilities remain without cold chain equipment, only two qualified cold chain technicians exist in the country, limiting capacity for preventive maintenance, repairs and installation of new equipment provided
- Deficient vaccine management practice at all level, though more pronounced at peripheral level, without monitoring of vaccine utilization and wastage rate.
- The DHIS functionality at county level remains sub-optimal due to limited infrastructure and skilled personnel.
- Completeness and timeliness of reporting remain poor, while data quality analysis and data audit mechanisms are yet to be established
- Lack of an evidence-driven communication strategy for demand generation and promotion of sustainable practices for immunization program.
- Shift in focus and prioritization of resources to humanitarian assistance due to the ongoing crisis with limited efforts to use the opportunity to strengthen the program
- Late engagement with implementing partners to plan resource mobilization for funds to cover gaps and supplement the penta Vaccine Introduction Grant (VIG), especially in the face of high operational costs and unanticipated high inflation.
- Delay in payment of the 2014 co-financing component of the vaccine procurement cost by the government
- Extremely high operational costs due to poor infrastructure and vey high inflation rate further exacerbated by the current security situation

- Lack of information on EPI resources available through fund managers and implementing NGOs.

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

The following recommendation are proposed to sustain equitable routine immunization coverage in the country,

- **Leadership and governance**
  - Advocacy for enhanced government ownership for immunization program
  - Create budget line and provide funds for both traditional and new vaccines including operational and logistics
  - Strengthen ICC,
  - Make the existing NITAG operational
  - Strengthen the existing state level health cluster coordination mechanism and initiate similar coordination at County level where they don't exist
- **Human Resource & Financial Management**
  - Enhance human resource capacity both in number and skill (including the staff of implementing partners/Fund managers) at all levels
  - Enhance financial management system and build capacity to enable proper fund managements at all levels
  - Implement recommendations from Gavi Financial Management Assessment
  - Quarterly program performance and financial monitoring by ICC
- **Effective Program management**.
  - Start implementing and monitoring of new HSS grant.
  - Develop medium term road map for routine immunization strengthening
  - Conduct needs assessment in the three conflict affected states
  - Develop new cMYP for 2017 to 2021
  - Introduce IPV as scheduled and prepare plans for introduction in the three conflict affected states.
  - Finalize preparation for tOPV to bOPV switch in April 2016
  - Conduct EVM follow-up assessment of the Vaccine Supply Chain of the country
  - Conducting "Temperature Monitoring Study' of the vaccine supply chain
  - Implementation of EVM improvement activities'
  - Establishment of sustainable CC inventory and vaccine management system
- **Communication and demand generation**
  - Develop evidence based Social and behavioural change communication strategy for EPI including state specific plans.
  - Strengthen community engagement and mobilization to reach all children in hard to reach areas and for defaulter tracking.

5. Surveillance, Data, Monitoring and reporting

- Establishment of sentinel surveillance for Rota and Paediatrics Bacterial Meningitis (PBMS)
- Establish AEFI surveillance and response system at all level.
- Strengthen the existing DHIS to meet the EPI data requirements
- Develop data quality improvement plan and start implementing

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

- *Renewal of Pentavalent vaccine in the existing presentation*
- *Renewal of IPV vaccine in the existing presentation*

Health systems strengthening support

- A new HSS proposal was approved in 2013. It is a cash support grant of 29.258 million USD for a period of 5 years (2014 through 2018). However, due to multiple factors including the current conflict delayed the implementation of the new HSS grant. The country tailored approach has been developed and will begin implementation through WHO and UNICEF in the 4th quarter of 2015

1.4. Brief description of joint appraisal process

A joint appraisal was conducted in South Sudan from 24-28 August 2015. Preparations were started for the mission from June 2015, starting with country's agreement to have the joint appraisal and dates for the appraisal. A desk review was conducted of various documents such as APR, cMYP, EPI comprehensive review etc. The in-country joint mission was held from 24-28 Aug 15 by a team comprising of Gavi Secretariat, WHO HQ& IST and UNICEF ESARO. The team was supported by EPI/MoH and by WHO and UNICEF in-country offices.

- Several teleconferences (Gavi, WHO, UNICEF) on mission preparation and development of preliminary JA report.
- The Preliminary joint appraisal report developed by the in country joint appraisal committee and shared to team coming to Juba for review and additional input
- External joint appraisal team composed of WHO-HQ, Gavi secretariat, WHO-Afro regional office and UNICEF- ESARO join the country team in Juba to provide technical assistant in the preparation of the report
- Five day joint appraisal mission was conducted in Juba from 24th to 28th of August 2015 with external team to finalize the joint appraisal report
- Debriefing meeting was conducted on 28th of August 2015. During the debriefing the summary of findings and key recommendations were presented to the ICC for discussion. The committee agreed to endorse the final version of the report after adding inputs from the ICC meeting.
- The JA mission was concluded by the ICC debriefing meeting Chaired by the Acting Undersecretary, Dr John Rumunu and attended by 25 ICC members

2. COUNTRY CONTEXT

(MAXIMUM 1-2 PAGES)

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

South Sudan is a landlocked country located in Eastern Africa bordering Ethiopia and Kenya in the East, Uganda in the South, Central African Republic and Democratic Republic of Congo to the West and Sudan to the North. It is a vast territory of approximately 640,000 square kilometers with a population density of 15 per square kilometer. The country has an estimated population of 10.6 million based on an annual growth rate of 3.2% from the 2008 South Sudan census, which is acknowledged by experts to have covered only 89% of the country's population. The working population figures stands at 11,212,276. The majority (88%) of the population lives in rural areas and dispersed settlements[1.]

In about two years after independence, the country has receded into another cycle of armed conflict which has been started in December 2013. According to UN OCHA update on August 2015, approximately 2.2 million displaced from their home of which 1.6 million were displaced internally and 615,000 have fled to neighboring countries. This has resulted in an over-stretch of an already fragile health system.

Despite the deteriorating security situation in the country, efforts of coordination to enhance routine immunization service continue in the seven stable states. In 2014 the administrative coverage of Penta 3 in the seven stable states was 83% while the three conflict affected states was only 11% whereby 40% of the counties are located. As a result the overall national Penta-

[1] Government of South Sudan 2010 household health survey

3 coverage declined to 57%. The recent cVDPV outbreak occurred in Rubkona (Sept 2014) and Mayom (April 2015) counties of Unity state are an indications of low immunity profile among the community mainly due to poor routine immunization coverage.
South Sudan has been receiving Gavi support since 2002. Gavi has provided US$ 22.1 million till date against a commitment of US$ 57.7 million. 37% of the support is for vaccines and 63% for non-vaccine support. The country has received vaccine introduction grants $354,678 for Pentavalent introduction in 2014. The grant was managed by WHO and Unicef. New HSS grant of US$ 29.25 million has been approved and will be disbursed as per the CTA after government of South Sudan concurs with the financial management and fund channeling mechanism. The grant will address the challenges in the immunization service delivery, human resource requirements, infrastructure, cold chain and capacity building of health workers.

Leadership, governance and program management
The leadership of the immunisation program in the Republic of South Sudan is guided by the Public Health Bill[2], the Health Sector Development Plan (2012 – 2016), the Country Multiyear Plan (2012 – 2016) and the EPI Policy and Technical Protocols. These instruments provide the decision making guidance to the MoH through the engagement of stakeholders in defining policies and strategic direction at the ICC. The Operations of the Immunisation System in the country is headed by DGs Primary Health Care with technical support by EPI managers who chaired the Technical Working (TWG) and Coordination teams at national, state and county levels. The MoH with the approval of donors has engaged three Fund Managers who have contracted NGOs to provide Basic Primary Health and Nutrition Service (BPHNS) and system strengthening at the county level.

South Sudan has an ICC, but no functional NITAG as of yet. Membership comprises representatives from ministries of health, finance, planning, and information as well as the WHO, UNICEF, World Bank, the NGO forum, Islamic Council, Council of Churches, and Juba South Sudan Red Cross. CSOs sit on the ICC and were included as signatories to the ICC approval minutes. In 2014 about 4 ICC meetings were conducted and the main agendas discussed were Men A campaign, Introduction of Penta and IPV, Endorsement of EPI annual progress report and global update and south Sudan achievement in Polio eradication initiative. About 50% of the meetings were chaired by DG of Policy planning budgeting and DG of Primary Health care.

Program Management
Before the signing of the Comprehensive Peace Agreement (CPA) and the early phase of transition period, immunization services were delivered predominantly as part of humanitarian programs by NGOs and UN-agencies (WHO and UNICEF) with minimal if at all any involvement of the government. Towards the end of the transitional period and the aftermath of independence the Ministry of Health of the Republic of South Sudan (MoH-RSS) in collaboration with health development partners developed a National Health Policy, National Health Strategy Plan and the Comprehensive Multi Year Plan for EPI which were critical for providing the strategic framework for initiating and strengthening the routine immunization services and systems in the country.

WHO, UNICEF and other partners, has been so far providing most of support to the MoH-RSS, and initiated a routine immunization system in each of the states according to programmatic distribution of responsibilities, The detail distribution list is on Annex G.

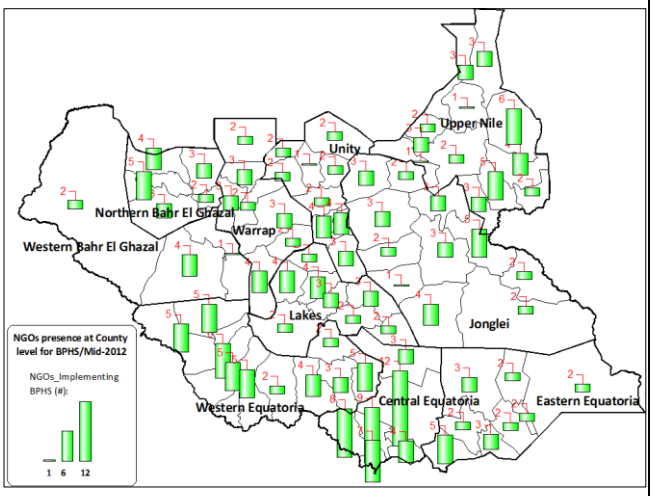
However, in spite of the previous and ongoing initiatives to improve routine immunization services in South Sudan, glaring management gaps are still existent which is reflected in low immunization coverage outlined in the grant performance section:

- Most investments aimed at improving primary health care service delivery, including routine immunization services in RSS are fragmented, falling short of a holistic

[2] Laws of South Sudan, National Public Health Bill. Final Draft Text, Directorate of Legislation Ministry of Justice, January 2013

approach and functional coordination mechanism at national, state and county levels; this could enhance mitigation of potential for duplications and ultimately improve efficiency.

Figure 1: *County level presences by NGOs providing BPHS*



- A geographic illustration of the above, is the merged NGOs operational picture which seems on paper giving an equitable distribution of access to EPI services through provisions of the BPHS by 258 county level NGOs presences: in fact before the ongoing conflict, from a minimum presence of one per county to a maximum of 12 per county, the count and distribution revealed through the NGO matrix in South Sudan indicates that every county is assisted at least by one NGO providing PHC.

Among other issues, the character of fragmented EPI operations in the Republic of South Sudan by stakeholders may have been exacerbated also because of lack of systematic dissemination of existing South Sudan policy and operational guidelines as found during the 2011 external EPI review:

Fund Managers implementation modality

Ministry of Health and Development Partners worked to develop three funding mechanisms to support a streamlined method to provide assistance for primary healthcare. To prevent overlap, donor funding (IMA, HPF and MCHIP/JHPIEGO) has been aligned per state and each state has only one funding mechanism that operates through one lead NGO per county. The lead NGO is recruited by the donor and coordinates the activities of all local NGOs in the state.

Each funding mechanism aims to improve access to and quality of health services, with particular focus on providing the basic package of health care in South Sudan. They all have a common objective of harmonizing efforts in various areas namely (i) harmonizing health workers' salary scale, (ii) using the national Health Management Information Systems (HMIS) as reporting tools, and (iii) the presence of project coordinators located in each of the 10 state capitals. Accordingly, thirty NGOs in 80 counties have been engaged by the fund managers to implement BPHNS including strengthening of routine immunization. However, the program implementation is fragmented. The coordination and monitoring mechanisms by MOH and fund managers remains weak, in order to improve this poor coordination and monitoring mechanism.

- There is a need to harmonize and coordinate the work of fund managers and NGO implementing basic primary health care in states/counties and health facilities. A strong steering mechanism, led by the MoH should be put in place that will guide the planning, implementation, monitoring of activities and results of the NGO on regular basis.
- The fund managers should be given proper guidelines including a basic package defining the components that they need to plan, implement and monitor and report to improve EPI in health facilities that they operate in.
- The fund managers and lead NGO should be incorporated in the ICC/HSCC and their representatives should be part of the EPI technical working group.

Costing and financing

While the government of South Sudan is committed to the immunization program as a pillar for child survival, this commitment has not translated to funding of the program. Partners such as

UNICEF, WHO and Gavi have been supporting the program. The country has not been accessing funds from Gavi due to accountability challenges in the country and it has been agreed between the MOH, Gavi and partners to use a country tailored approach to enable the country to receive support from Gavi. Fund Managers such as HPF, JHPIEGO and IMA support the immunization program at county level through a lead NGO per county.

The Gavi HSS Grant of 2009 in South Sudan is channelled through three parties namely WHO, UNICEF and Ministry of Health. Nearly 93% of the total Gavi HSS approved grant is managed by UNICEF and WHO. (UNICEF- US$ 3,293,295[58%] and WHO - US$ 1,969,705 [35%]) as per the approved MoU. The total funds received for HSS support for South Sudan from 2010 to date is 5, 196,350 USD whilst the total amount approved as per the original HSS proposal was 5,635,000 USD. UNICEF confirmed the balance of 325.04USD returned to GAVI, hence the balance at the end of 2014 is nil. In addition the HSS fund component for MOH (US$ 372,000) has not been disbursed to date due non submission of audit reports.

In 2014 the country received $293,620 for Pentavalent and $434,047 for IPV introduction through UNICEF & WHO. Whilst in 2015 South Sudan received $3,300,219 for Men A campaign (UNICEF 1,106,873 & WHO 2,193,346). The total expenditure from Pentavalent introduction grant is 233,895. Men A campaign have not yet started but planned to be implemented early next year (January 2015).

Even though Gavi funding has remained key in immunization services, non-submission of audit reports from 2012 to 2013 and issues highlighted in submitted audit reports (2009 to 2010) delayed disbursement of funds from the currently approved HSS grant affecting the implementation of immunization improvement activities.

Human resources management

The Human Resources requirement is at critical levels. Annual health worker production is low, due to the limited capacity and number of training institutions in the country as well as lack of capacity to train certain health cadres. Although efforts are being made to strengthen the human resources availability and management in the country, it is not commensurate with the high demands. Access to doctors stands at 0.15 per 10,000 and midwife/nurse 0.2 per 10,000[3] population. Moreover, majority of staff at post are semi-skilled and or are on temporary engagement terms with implementing agencies. Staffing for the immunization systems remains woefully inadequate and mainly dependent on implementing agencies.

The 2011 external EPI review revealed that - Limited number of trained health personnel specialized in management of EPI service at all levels, with acuity at national and at the front line of service delivery. The downsizing of the Government of the Republic of South Sudan (GROSS) work force due to austerity measures as result of the conflict with Sudan has ever overstretched the already limited human resource capacity:

- Actually the staffing of the program at National level (MoH), has been filled below the proportion of 22% of the required EPI positions, made up with only 3 personnel; the EPI Director, the Deputy EPI Director and the Data Officer[4].
- The HR picture is somewhat better at state level, where all SMoH EPI services are led by state EPI Managers on GROSS payroll, further assisted by National Focal Points (on WHO contracts). However, the State is still lacking adequate qualification, leadership and ownership; not all the states have cold chain officers neither communication officers on GROSS payroll and the high turnover of WHO TIFPs makes difficult to keep on track numerous positives initiatives on the state EPI program directions.
- At the county level, all counties visited had a county EPI supervisor and cold chain officers. However, the combination with information obtained from the review of documents indicated that there were variations across the country in term of skills of cold chain officers to perform assigned duties. Furthermore currently only 39 Counties (out of 88) have of

[3]South Sudan, Ministry of Health, Health Sector Development Plan 2012-2016

[4] Organogram of Human Resource in the Republic of South Sudan (EPI Policy)

WHO supported Field Supervisors and 247 payams (out of 526) have WHO supported Field Assistants.

- At the health facility level, the notable challenge documented during the review was high number of vaccinators who were not health facility staff (volunteers), providing such an essential service and there were no immediate or firm plans for recruitment.

In conflict affected states, more segmentations of jurisdictions areas, staff relocation and travel restrictions due to insecurity have worsened the already deficient human resource capacity. Although there are existing training modules and manuals, the staff have been trained using the opportunity of new vaccine introduction (Penta) but still the staff knowledge and skills remain deficient.

Cold chain and logistics

UNICEF procures vaccines and cold chain equipment using the WHO PQS pre-qualified products for and on behalf of the Ministry of Health. In 2014, the government of South Sudan started to co-finance the procurement of Pentavalent vaccine for routine immunization. There are only two qualified cold chain technicians even though over 50% of cold chain equipment are non-functional according to the 2012 Cold Inventory report. Only 44% of counties have sufficient cold chain infrastructure. The criteria score for effective vaccine management is below 80% indicating wider gaps in improving key elements in vaccine management (EVMA, 2012). It is critical that the Government HR capacity is improved to take responsibility for the management of in-country vaccine supply chain.

Since 2012 to date, UNICEF provided 499 cold chain equipment reaching 49% of health facilities with functional cold chain equipment as of July 2015. The remaining 523 health facilities are still without cold chain equipment.

The TORs for national and state level cold chain technicians to be recruited by MOH with Gavi-HSS funding have been developed and shared with the MOH; these will be advertised once Gavi-HSS funds available. UNICEF is recruiting one cold chain technician and one cold chain and logistics officer (the process of contract is ongoing). UNICEF also is recruiting a cold chain specialist for 3 months consultancy.

The increased time and resources required to move personnel, equipment and supply constitutes a major obstacle. Given the security situation and poor road conditions almost all movement in the country is by air. The security and systems bureaucracy as well as the costs involved make it impossible for the MOH to organize the logistics system. They depend completely on partner organizations.

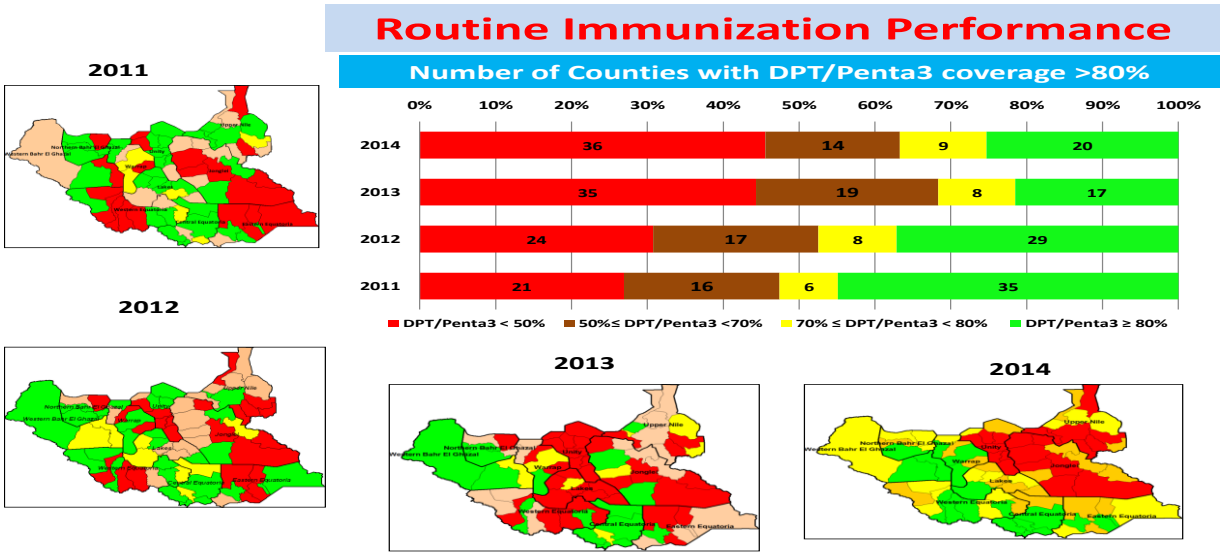
There is a strategic prioritization of facilities for cold chain equipment support;

- The program usually identify facilities with infrastructure, appropriate catchment undeserved population, availability of health workers who are trained in carrying out immunization activities, the nearest facility providing immunization services and then cold chain takes on the task of estimating the required cold chain capacity and equipment type needed and source from available equipment.
- The backhauling of cold boxes remains a challenge for the three conflict affected states despite the institutionalized system for return of cold boxes.
- Returning of unused vaccine vials and reporting on vaccine utilisation and wastage rate is not conducted on routine bases.

Immunization service delivery

Routine immunization services are delivered through fixed sites (1,457), outreach services (1,960) and accelerated campaigns that use the same service delivery points to mop up immunization defaulters (drop outs or missed children) before the recent crisis broke out in Dec 2013. The administrative coverage of DPT3 consistently decline from 75% in 2012 to 64% in 2013 and only 57% in 2014, with only 17 (21%) and 20 (25%) of the counties achieving a coverage of 80% or more in 2013 and 2014 respectively. Figure 2 below shows the performance trends of routine immunization from 2011 to 2014. The EPI Coverage Survey of 2012 reported that 45% of children less than one year had received DTP3 of which only 34% had been fully immunized. The dropout rate has decreased from 39% in 2009 to 21% in 2014 which is still higher than the standard 10%. The major challenge that the immunization service has facing is the lack of access for the majority of the community. The outreach strategy has proven very effective in reaching many children with immunization services but this has been hampered due to non-disbursement of Gavi funds and worsened by the ongoing crisis.

Figure 2: Trends in EPI performance from 2011 to 2014



Surveillance and Data management

The Integrated disease surveillance and response (IDSR) system is improving over time. However, completeness and timelines of report from facilities remains weak. In 2014 the surveillance bulletin records Facility based report completeness and timeliness is at 46% and 36% respectively (Weekly Surveillance Bulletin week 52 of 2014). The IDSR capacity to promptly detect disease outbreaks remains weak and still focuses on limited number of disease of public health importance. A very sensitive Acute Flaccid Paralysis (AFP) Surveillance exists but is less integrated with IDSR to incorporate the gathering of information on other vaccine preventable diseases as per global standards. The performance indicators for AFP are above universal standards (NPAFP[5] in 2014 was 3.9/100,000 under fifteen year's children and 92% stool adequacy). However, in the three conflict affected states, the Non-polio AFP rate was below the standard (1.3/100,000) and as of August 2015 there are about 56% blind areas (silent counties) due to insecurity. The Measles case based surveillance established since 2010 and as of 2014 the system recorded a total of 558 suspected measles cases with 124 laboratory confirmed cases. In 2014 a non-Measles febrile/rash illness rate of 1.1/100,000 population was recorded as compared to the target ≥2/100,000. Profiling of case based or sentinel surveillance for diseases targeted of new vaccines not yet established

The Adverse Events Following Immunization (AEFI) Surveillance remains adhoc only during supplementary immunization activities and not established into routine services.

[5] Non-polio AFP≥2/100,000 under fifteen years children and Stool adequacy ≥80%

The DHIS software is available at County level; however, its functionality is sub-optimal due to limited infrastructure and skilled personnel. Completeness and timeliness of reporting have therefore been poor which compromise the quality of data. The DHIS has not been upgraded to DHIS2 and there are still existing gaps in capturing vital routine immunization data including vaccine stock data, type of session and new vaccines introduced. In 2014, the parallel EPI reporting system recorded a county level completeness of 73% (37% for conflict affected states). Thus, this coverage does not represent the health facility completeness. Data quality analysis and data audit mechanisms are yet to be established.

No national assessment or audit of the administrative data systems was conducted since 2008. DQA/DQS was identified as a strategic activity for the year 2011, but were not carried out because of the human resource crisis. Data quality validation visits were conducted in 4 out of the 10 selected states in 2012. Reports indicate that prioritization of the EPI information management tools and protocols were yet to be done. The recruitment of technical persons and provision of necessary HMIS tools was not possible given the fact that MOH/RSS never received its portion of Gavi HSS funds.

The 2011 external EPI review noted a lack of supportive supervision. The comparison of 2010 administrative data and data from the coverage survey conducted in 2011 (see the Table in Annex E) suggests significant data quality issues. Random checks of recording and reporting of services as well as vaccine stock management at PHCC and PHCU levels suggests a need for massive on-the-job training and supervision. The situation remains the same till date.

Demand generation and communication

The REC guideline outlines the framework for community engagement and outreach services in South Sudan. EPI communication activities are articulated in both the cMYP and annual plans of action for the immunization program. This is further strengthened by the MOH approach to working with health committees[6] and home health promoters Implementation guide[7] and provides an opportunity and framework to engage communities in provision, oversight and consumption of health services including immunisation services. However, there is a clear need for an evidence-driven explicit strategy which stresses on demand generation factors and creating sustainable practices for immunization program. However, the country has been collecting and utilizing social data from the polio program, which will be useful to some extent for routine immunization communication work also. Limited effort has been observed on use of new and innovative strategies such as mobile technologies, mass media content etc., and community participation somewhat lagging behind.

The consistent shortages of funds have limited the focus of EPI program to the SIAs/ campaigns. Routine Immunization outreach have seen to be more sporadic, adhoc and staggered initiatives with limited support of community engagement activities. Lack of tools and aids to support outreach initiatives at the county level also impacted the quality of outreach activities including community engagement.

The advocacy and awareness efforts carried out throughout the pentavalent introduction preparations and vaccine launch in 2014, which focused on the benefits of the vaccine, were observed to be successful, with penta-3 coverage subsequently increasing. However, the activities were time bound and could not be sustained through routine immunization program due to limitation of funds.

Due to the current humanitarian context and evolving priorities, EPI will continue to need support of political leaders and decision makers. In particular, routine immunization which has been the "victim" of campaigns and other intense short term immunization activities. Advocacy

[6] Republic of South Sudan, Ministry of Health. Approach to Working with Health Committees. 2011

[7] Republic of South Sudan, Ministry of Health. Home Health Promoters Implementation Guidelines. 2011

at central level must be high on routine EPI and must similarly be intensified at the others levels of the health system.

Other factors/events
The current crisis has shifted orientation and prioritization of resources to humanitarian assistance. The resurgence of conflict has put additional pressure on the country's limited resources, that is human, financial and logistics. These resources have been further stretched to deal with the current humanitarian crisis on top of numerous other national health priorities including immunization. In spite of the current crisis, the government of South Sudan will continue to mobilize additional resources and ensure that the funds from Gavi and other donors are used for intended purposes and are properly accounted for in order to secure continued support for immunization. It should be noted, however, that South Sudan needs substantial additional resources from the global community for it to effectively address all national health priorities including the current humanitarian crisis. The new HSDP and Health System Policy, being developed for the year 2016 – 2020, will clearly articulate the current situation and plans for the sector.

Outbreaks of cholera, Measles and circulating Vaccine-derived Polio virus have been persistent following the humanitarian crisis. This notwithstanding, developmental agenda continues with the introduction of IPV in the last week of September 2015, Men-A campaign (Jan 2016) preparations and Switch Plan for tOPV to bOPV (April 2016) are in the pipeline.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

(MAXIMUM 3-5 PAGES)

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

Performance against approved coverage targets and activities;
The introduction of pentavalent vaccine in South Sudan was originally scheduled for April 2014, but due to political unrest which began in December 2013, the official launch was delayed until July 2014. Despite the continued instability in some areas of the country, the MOH officially launched the vaccine in 7 of the 10 states, with roll-out planned for the remaining three conflict-affected states, once stability is assured and subsequent training conducted. Unfortunately, due to the continued crisis in the three remaining states, it was not possible to carry out the cascade trainings to the frontline health workers until end of 2014. Despite, the instability in these states, there are a few stable counties that provide immunization services through Protection of Civilians (POC) facilities and implementing partners in some of the counties out of the POC sites. MOH and TWG have strongly advised partners in these states to provide orientation training to their health workers before introducing pentavalent in their facilities.

Overall, the performance of routine immunization coverage dropped in 2014 largely as an impact of the conflict, with national coverage of DPT/Penta-3 at 57% (238,592 children) of which 137,869 (33%) of them received their 3rd dose of Pentavalent.

The country was not able to achieve the planned DPT/Penta-3 coverage target of 60% in 2014 as stipulated in the cMYP, as routine immunization services had not yet been re-established in most counties of the conflict affected states. The Penta-1 to Penta-3 drop-out rate nationally was 18% versus the target of 20% in the cMYP. The national level coverage is highly affected by poor performance from the three conflict affected states as 32 out of 80 counties are found in these states. In 2014 DPT/Penta3 coverage of the three states was 11% as compared to 83% coverage from the seven stable states. Only 20 counties managed to achieve 80% and above Penta-3 coverage nationally in 2014.

Vaccines received:
The country received a total of 1,190,500 doses of Pentavalent vaccine by 31 December 2014, against the approved 1,324,000 doses planned. The total number of doses planned was not received, as there was a delay in the payment of the co-financing component of the vaccines from the government. Nevertheless, there was no pentavalent vaccine stock-out experienced in 2014, as the roll-out of the pentavalent introduction was slowed down due to inaccessibility in the 3 conflict affected states. Despite of poor monitoring system of vaccine utilization at all levels; the overall vaccine utilization was lower than expected for the reporting year.

Advocacy and Social Mobilization:
Pentavalent introduction witnessed highest level political commitment in the country. It was demonstrated by the coordination and leadership provided from His Excellency the Vice-President James Wani Igga, the Honorable Minister of Health Dr. Riak Gai Kokister, Dr. Martin Elia Lomuro, Minister for Cabinet Affairs, and different Director Generals from MOH to make the National launch successful. In addition, the ICC and EPI TWG were actively involved in review and endorsement of the new vaccine introduction tools and materials, as well as throughout the planning and implementation of the vaccine roll-out.

In order to engage the major stakeholders and update them on the Pentavalent orientation, advocacy, communication and social mobilization efforts were conducted by the MOH and partners and targeted at key health managers, academia, and political and religious leaders. These included, a national and state launches, production and distribution of IEC material development, and production and airing of radio spots to sensitize the community, Visits to political, religious, and traditional leaders to request their assistance in resource mobilization and information dissemination in their constituencies; training of Health Workers on the new vaccine; and use of social media.

However, among the lessons learnt it was very clear that at the state and county levels, community involvement and partnerships, including through Civil Society Organizations (CSOs) and Non-Governmental Organizations (NGOs), need to be strengthened beyond campaigns and emergency assistance to support routine EPI activities and be part of health committees to help build the health system that is needed to sustain pentavalent implementation and future new vaccine introductions.

Results from Equity analysis (Socioeconomic, geographic, gender or other barriers)
There is no study or analysis conducted that clearly shows the above mentioned thematic issues. However, the geographic barriers affect communities living in hills and those staying in or surrounded by water in river line areas. Some boats have been procured to address the challenges of offering EPI services to inhabitants in river line areas, but security remains a concern in South Sudan that threatens to hamper delivery of health services to people in need. Data available from a recent coverage survey (2012) show that there is almost no gender differences in immunization utilization as judged by either DTP3 coverage or DTP1 to DTP3 drop-out. The 2010 South Sudan Household Survey report indicated that educated mothers in richer households were more likely to vaccinate their children.

Progress in the implementation of new introductions/campaign in the reporting period
The ongoing change of the country context affects time of introduction of new vaccine in addition to the default situation of co-financing of Pentavalent. The country got approval for IPV introduction in Nov 2014; the VIG has been sent to WHO and UNICEF. The national IPV launch is planned to be conducted at the end of September 2015.The Country also got approval for Men A Vaccine catch-up campaign to be implemented in 2016. The process was however delayed due to various reasons including ever changing security situation in the country leading to rescheduling of campaign dates, change of work plans. The grants are now with partners and the proposed date of implementation is tentatively first quarter of 2016.

Key lessons learned to inform future routine vaccination introduction or campaigns

- MoH's budget allocation for co-financing of new vaccine introduction is very critical
- Timely engagement of implementing partners to ensure integrated resource mobilization through the synchronization of budget cycles could be an avenue of bridging resource gaps.
- The undefined role and engagement of civil society negatively affected harnessing enough support and inputs for advocacy, communication and social mobilization.
- The role of JSI funded by Gavi to support the pentavalent introduction was very critical in facilitating the pre-introduction activities including training, resource mobilization from partners for printing of the training materials and follow up supportive supervision visits in the seven states.

Overall programmatic capacity entity to manage NVS grants
While efforts are made to improve national capacity on financial management systems, the reliance on key partners UNICEF and WHO in managing NVS grants have relatively been successful and has satisfactorily provided support for introducing new vaccines in the country.

Actual versus planned financial expenditure
In addition to the funds received for HSS, the country received additional grant from Gavi for Immunization system strengthening activities including introduction of new vaccines. In 2014 the country received $293,620 for Pentavalent and $434,047 for IPV introduction through UNICEF & WHO. Whilst in 2015 South Sudan received $3,300,219 for Men A campaign (UNICEF 1,106,873 & WHO 2,193,346). The total expenditure from Pentavalent introduction grant is 233,895. Men A campaign have not yet started but planned to be implemented early next year (January 2015).

WHO expended a total of 50,000USD from Penatvalent introduction operational costs mainly for training of health workers on the new vaccine and for printing of Pentavalent field guide for vaccinators. A balance of 58,862 USD was reported at the end of 2014 and it is mainly the portion of the 3 conflict affected states.

Most of the funds from UNICEF were spent on communication and social mobilization and on printing of monitoring and data tools. The actual costs for the activities were much higher than anticipated. The balance against the grant of USD 898.00 was due to an erroneous expenditure against the grant that was later reversed, releasing the funds back into the grant after its duration of validity.

Financial performance and challenges
Any key challenges *(regarding the financial management of VIGs or operational costs (note cross-cutting NVS/HSS financial management issues to be highlighted in Section 3.4)*

The main challenge in the management of the grant was due to disparity between the plan and actual cost as a result of delays in fund disbursement, high operational costs and inflation, making it difficult to adhere to planned budget line amounts. Activities related to social mobilization and communication were paramount to the introduction of pentavalent vaccine and being UNICEF mandate, was fully implemented. Additional support from partners to cover some of the budget line items such as printing of training materials, contributed to availing additional funding for underfunded activities. Alternate funding was also available for the construction of additional storage space at central vaccine store, thus funding earmarked for this activity was utilized for printing of the data collection and monitoring tools.

Supportive supervision activities planned under vaccine introduction plan were not implemented due to lack of funds. However, supportive supervision and monitoring of the roll-out of a new vaccine remains critical especially in the context of South Sudan where phased introduction occurred.

To fill some of the gaps supportive supervision visits were carried out in the seven stable states by two senior officers hired by JSI through Gavi support together with MOH staff with the same support from Gavi. The fund manager's immunization officers also conducted supervision visits in their respective states. This component needs to be improved in subsequent new vaccine introductions.

Other challenges

- The Vaccine Introduction Grant was not enough to support the planned activities due to high operational costs and unanticipated high inflation.
- Late engagement with implementing partners to plan for resource mobilization to cover the anticipated financial gaps for preparatory activities especially at the lower level.
- There was a delay in paying of the 2014 co-financing component of the vaccine procurement cost by the government of South Sudan. However, this was paid in 2015.
- Low profile of advocacy contributed to delayed response to the issues of co-financing.
- Inadequate human resource at all levels (only 3 out of 16 post filled at national level).
- Only 49% of health facilities have sufficient cold chain infrastructure.
- Additional resources are required for re-establishing cold chain infrastructure in the conflict affected states
- Due to the poor infrastructure further exacerbated by the current security situation the cost of operations in the country is extremely high.
- Lack of information on EPI resources available through fund managers and implementing NGOs.
- Low government allocation to EPI activities (only limited to staff salary and co-financing of Pentavalent introduction in 2014)
- No government allocation for EPI operational costs and no budget line for procurement of traditional vaccines. .

3.1.2. NVS renewal request / Future plans and priorities

The country is requesting

- *Renewal of Pentavalent vaccine in the existing presentation*
- *Renewal of IPV vaccine in the existing presentation*

Reasonableness of targets for next implementation year

In 2014 the Penta-3 coverage reported was 57%. The target for 2015 and 2016 are 62% and 66% respectively. These targets can be achieved in the implementing year, 2015 and 2016, provided the current crisis is curtailed. The IPV doses targeted for 2015 is 159,900. For 2016 the planned doses are 254,400. This may increase depending upon security situation. The country will inform Gavi about any changes for 2016. Other HSS related indicators as contained in APR 2014 remain same for the year 2015 (see Table 9 of APR 2014 Annex E).

Plans for change in any vaccine presentation(s) or type(s)

There is no plan for change of vaccine presentations; however there are plans to implement the global switch tOPV to bOPV in April 2016. The new Food and Drugs Authority have already licensed routine vaccines including bOPV, notwithstanding, it will be engaged in the planning process to advise accordingly. The ICC will reinforce the monitoring of all vaccines including Inactivated Polio Vaccines in 2015. In addition the newly established NITAG will advice government on future new vaccines introduction.

Risks to future implementation and mitigating actions

There are uncertainties as a result of the current crisis; feasibility of introduction of new vaccines such as Rota and PCV, are still possible however it may be costly as compared to global costing estimates. Also a staggered phased approach may be the only strategy. The other critical challenges include limited cold chain capacity, human resources and high operational cost.

Some of the major risks would be;

1. Continued conflict and insecurity situation in the country
2. limited capacity of the government to meet the co-financing commitment in the face of many new vaccine introduction;
3. Continued challenges with government financial management systems, which could lead to delayed in the disbursement of further tranches or new grants;
4. Continued limited HR capacity (number and quality) at the different levels
5. High operational cost and continued high inflation rates
6. Other competing priorities in the country including immunization campaigns.

Mitigating actions could include:

1. In the case of the conflict - use scenario planning, which allows for specific actions/strategies based on the specific scenario;
2. Feed quality financial gaps analyses, including clear analyses of financial fiscal space into cMYP and NVI plans;
3. Evolve alternative strategies to address the HR issues at the different levels in the short-medium term.
4. Start implementing the recommendation from Gavi FMA report sent in May 2015.
5. The planning takes into consideration of high operational cost and high inflation rates
6. Harmonize suplimentary immuniation activities with routine EPI during micro planning

New applications or new immunization program priorities:

Any expected future applications to Gavi for new vaccine introductions or campaigns*(in the next two years)*

Subject to meet Gavi routine immunization coverage requirements for Rota vaccine introduction proposed for 2017.

Emerging new priorities for the national immunization programmed *(based on the latest cMYP and annual work plans)*

The following are the main priority activities for the national immunization program to be implemented in 2015/16.

- Continue cVDPV2 outbreak response in 2015
- Develop new cMYP for 2017 to 2022
- Conduct the EPI review and finalize the report by end of 2015
- Conduct Men-A campaign in Jan 2016
- Introduce IPV end of Sept. 2015
- Switch from tOPV to bOPV in April 2016
- Explore feasibility of setting up sentinel surveillance sites for Rota and PBMS

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

HSS Grant Overview

The Country has been benefitting from Gavi-HSS grant from 2009 to date. Although the grant was approved in 2009, and to have been completed in two years (2009-2010), approximately 45% of the funds were not received in-country from Gavi until 2012 (the 2nd tranche of the fund not received until December 2012). However, the HSS fund component for MOH (US$ 372,000) has not been received to date due to non-submission of audit reports.

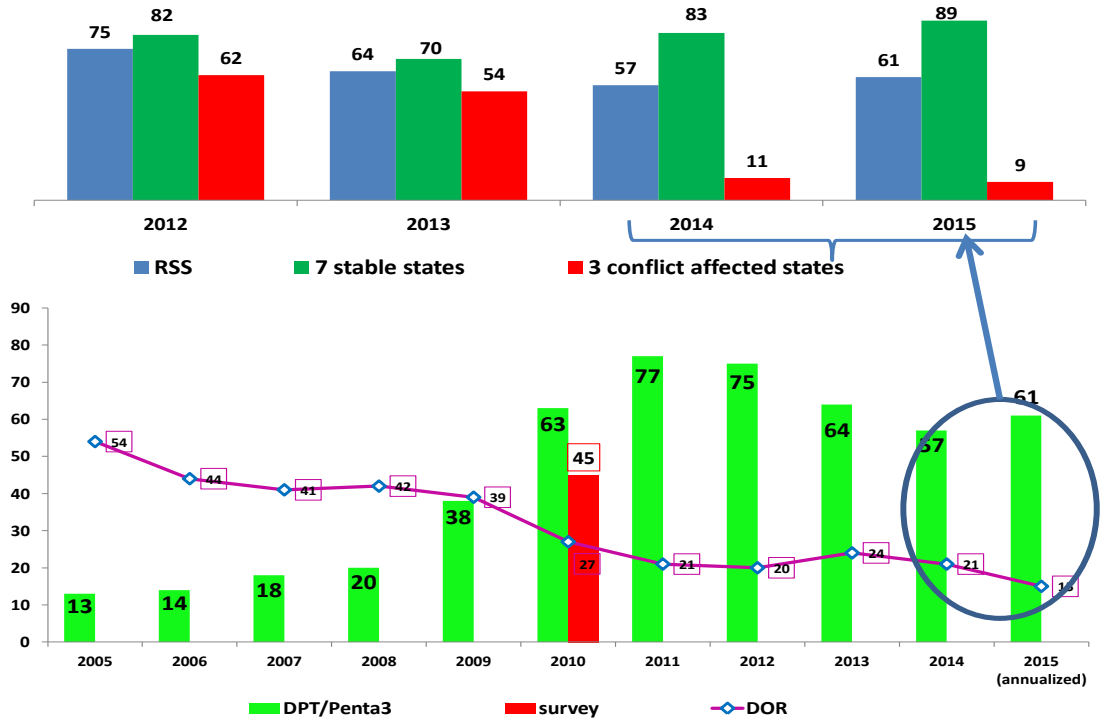
The Gavi HSS strategy (goal, objectives and activities) outlined in the 2008 proposal aligned with the cMYP, EPI review and health sector plans. However, the initial investment of time and resources was to cover 2009 and 2010 followed by a larger grant. In the event the modest two year HSS start up plan was used over a period of 6 years (2009-2014) and some activities never implemented (reference non-receipt of funds to be used by the MOH for staff recruitment).

Many of the activities promoted in the proposal are those which the two managing entities (WHO and UNICEF) routinely supporting the MOH to implementing in the country. Gavi financing allows the agencies to provide more, do more, and move faster than they could using only their own resources. A few of the most significant activities (technical assistance to support strengthening of systems management and financing) are not within the comparative advantage of the two agencies.

Achievement of Targets: Despite the significant delay in receipt of funds, South Sudan managed by 2010 to meet or surpass most of the targets set in the original proposal (as reported in the SSHS conducted in 2010). See Annex E, the updated Table 9.3 (Progress on targets) taken from the HSS section of the 2014 APR that reference the original 2008 Gavi HSS proposal. The original targets set were very low and were based on the 2006 Sudan House Hold Survey.

Immunization indicators: All the immunization targets in the 2008 Gavi Grant document were substantially exceeded by 2014 relying on administrative data (e.g., reported DPT3 coverage for children <1 year of age for 2014 was 57% compared to the end-of-grant target of 30%). The national EPI coverage survey conducted in 2011 reported a crude DPT3 coverage rate of 45% compared to the target of 30%. The fact that immunization targets were significantly exceeded 60% before the Gavi funds were expended suggests that either the targets were unrealistically low or that annual "acceleration" campaigns rather than system strengthening accounted for the unusually rapid increase in coverage. DPT3 immunization administrative coverage data reached its highest levels in 2012 but declined in 2013/2014 as activities in three states (Upper Nile, Unity and Jonglei) were curtailed due to insecurity. The graph below shows the impact of the recent crisis on aggregated country performance:

Figure 3: Trend of Routine immunization coverage in South Sudan 2005-2015
(and the impact of the collapse of activities in the 3 conflict states)



Maternal and other child health indicators: By 2010 the % of deliveries attended by skilled personnel had risen to 14.7% compared to the grant target of 15% and the % of antenatal care conducted by skilled personnel had risen to 30% compared to the target of 33%. In the same period the under five mortality rate declined from 135/1000 to 106/1000 live births in 2010 exceeding the target of 120/1000 to be achieved by the end of the grant period.

Despite this record, beginning in 2012 and accelerating in 2013, the country saw a reversal in the measured indicators as activities in three conflict affected states were significantly curtailed.

Actual Compared to Planned Activity Implementation: Some 30 activities were listed in the grant proposal under the three objectives to be implemented from 2009 to 2010. Due to several factors including slow implementation and delay in fund release (the last trench of 2.57 million dollars was released in 2012). The Annual Progress Reports (APR) provide a year-by-year record of activity-implementation compared to planned implementations. By 2014, out of the 30 activities originally planned, 24 were reported as completed, three were excluded and funds reprogrammed to complete other activities. That is, over 85% of the activities funded by Gavi were completed by the end of 2014, albeit many significantly later than planned. A summary of the progress made for each activity and completion status is provided in Annex F**.**

The remaining three activities were never started. The total fund amounting 372,000USD to be channeled through the MOH were not received from Gavi due to non submission of audit reports. MOH will submit proposal to use funds for other activities to be channeled through the two partners (WHO and UNICEF).

Participation of Key Stakeholders:

The Inter-agency Coordination Committee is the official mechanism for reporting and review of the whole Gavi (ISS and HSS) progress in Southern Sudan.

The Health Sector Coordination Committee (HSCC) is the institutional framework that provides oversight to the implementation of the HSS component of the Gavi grant, by conducting regular supervisory visits and review meetings whenever appropriate, during the periods of activities implementation. The HSCC is supposed to be composed of major donors and projects involved in health systems strengthening however the committee is currently nonfunctional and the ICC is playing the role, but challenges remain in terms of monitoring activities.

The implementation of the Gavi HSS was mainly through two agencies (UNICEF and WHO). The national MOH and 10 state Ministries of Health are the major implementing partners. This was achieved through signed annual joint work plans between UNICEF and the Ministries of health at state level. The involvement of CSOs in this regard was minimal in the past. CSOs have been included in the newly proposed/approved Gavi HSS grant for South Sudan.

Currently the three fund managers (HPF, MCHIP/Jhpiego and IMA) are supporting management and governance at county level and immunization services within the broader primary care services in the ten states through implementing partners. DFID, USAID and WB are the main donors for these three fund managers.

Implementation Bottlenecks and Lessons Learned

- ✓ The complex, ever-changing, security situation is a significant obstacle to health system strengthening. The following updates are taken from OCHA "Dashboard" published on 8th of August, 2015:
  - Approximately 2.2 million displaced from their homes of which 1.6 million shift internally and 615,000 have fled to nearby countries
  - Inside South Sudan, the estimated 1.6 million displaced persons are scattered across a vast area often shifting to avoid conflict and find food. Some 166,000 have fled to Protection of Civilian (PoC) sites in UN bases while the majorities take temporary shelter wherever they find it. "Shifting frontlines are forcing many people to flee several times. The influx of people overwhelms host communities, leading to tension and further movement. As many as 465,000 displaced persons are in flood-prone zones, where they risk being cut off from assistance as rains intensify."
  .
  - As reported in and earlier OCHA report "The conflict has decimated South Sudan's fragile health services. Over 30 health facilities have been destroyed or looted in Jonglei, Unity and Upper Nile states. Another 129 are closed or not functional due to insecurity and departure of partners. With damaged cold chain facilities and vaccines and withdrawal of staff, routine immunization has not been done. Emergency surgical and obstetrical care has been severely curtailed."

Bottlenecks related to financial and Human Resource management

- Significant delays in receipt of approved funds;
  - Requires constant re-planning of activities, reorganization, reprogramming (a significant drain on scarce resources human as well as financial)
  - Long delays in fund release resulted in purchase of lesser amounts of equipment; prices often increased dramatically during the many months (sometimes years) between estimates at time of planning and actual cost at time of purchase.
- The non-receipt of key HSS funds by the MOH. There was weak oversight of HSS grant implementation by ICC and partners.
- The HSS grant was to cover 2009 and 2010. However the last of the approved funds was not received until the end of 2012. Delays in receipt of funds (and thus use) required constant re-planning and reorganization (staff energy and time better used elsewhere). The MOH agreed to reprogram the remaining balance from 1st HSS grant to different activities to be implemented through WHO and UNICEF. The proposal will be submitted to Gavi in the coming days.

Most of the "bottlenecks" described are outside of MOH/partner/Gavi intervention and are directly or partially related to political and community conflict. A few of the bottlenecks can be addressed and progress can be achieved;

- ✓ The number of MOH staff available at every level must be significantly increased. They must be trained and mentored for a significant period of time.
- ✓ MOH management systems (personnel, finance, logistics) at all levels require substantial inputs if staffs are to learn from and help manage current health system strengthening activities.
- ✓ Selected RSS government ministries/departments that have major impact on the health system (e.g., the health related sections of Ministries of Finance, Communications, etc.) require substantial inputs technical, equipment/supply, and financial.

There is a need to harmonize and coordinate the work of fund managers and NGO implementing basic primary health care in states/counties and health facilities. A strong steering mechanism, led by the MoH should be put in place that will guide the planning, implementation, monitoring of activities and results of the NGO on regular basis.

The fund managers should be given proper guidelines including a basic package defining the components that they need to plan, implement, and monitor and report to improve EPI in health facilities that they operate in. The fund managers and lead NGO should be incorporated in the ICC/HSCC and their representatives should be part of the EPI technical working group.

Follow-up of Recommendations from any HSS Evaluation Report
There has been no HSS Evaluation Report to date.

Programmatic Capacity of Entities Managing HSS Grants
The three entities involved in managing HSS grant monies for South Sudan are MOH, UNICEF and WHO. Both UNICEF and WHO continue to face high staff turnover and often multiple unfilled positions. The combination of staff shortage and immense challenge to manage the HSS grant and it's reporting requirements. .

FINANCIAL PERFORMANCE AND CHALLENGES

Actual Compared to Planned Financial Expenditure

The Gavi HSS Grant of 2009 in South Sudan is channelled through three parties namely WHO, UNICEF and Ministry of Health. Nearly 93% of the total Gavi HSS approved grant is managed by UNICEF and WHO. (UNICEF- US$ 3,293,295[58%] and WHO - US$ 1,969,705 [35%]) as per the approved MoU. The total funds received for HSS support for South Sudan from 2010 to date is 5,196,350 whilst the total amount approved as per the original HSS proposal was 5,635,000 USD. UNICEF confirmed the balance of 325.04 USD returned to GAVI, hence the balance at the end of 2014 is nil. In addition the HSS fund component for MOH (US$ 372,000) has not been disbursed to date due non submission of audit reports.

A table, showing year-by-year fund receipt, expenditure and balance carried forward, for the life of the 2009 approved HSS funds, is shown in Annex D. Examination of the data in the table suggests that expenditure generally followed availability. In the two years that this was not the case (2009 and 2012) the explanation is clear: the funds for 2009 were received in September and the funds for 2012 were received in December. The controlling factor was not "planning" but the actual time of receipt.

Challenges Regarding Financial Management
According to the Financial Management Assessment (FMA) report released on May 2015 some of the critical financial management issues are;

- The country's political and security situation that developed in December 2013 will adversely impact on the gains made in PFM to date, DP funding in the MOH are ring fenced off budget and not integrated in the sector PFM information reduces the credibility and comprehensiveness of budgets, Manual accounting systems and lack of

a PFM procedures manual and chart of accounts contribute to poor and delayed reporting witnessed through the States to the National level;
- Lack of substantive legal frameworks for procurement and internal audit, leaves the personnel responsible without the authority to execute their responsibilities.
- Low organization capacity across the PFM at MOH, National, State, Oversight institutions, lack of a reporting templates continue to hamper the comprehensiveness of the accounting and reporting process.

Financial Capacity of Entities Managing HSS grant expenditure
The three entities involved in managing HSS grant monies for South Sudan are MOH, UNICEF and WHO. MOH is improving its financial management system and is currently relying on WHO and UNICEF to manage HSS grant. However, there is need for additional human resources in both organizations to effectively manage the HSS grants.

MOH: not involved

WHO Managed Portion of Gavi HSS: Gavi disburses funds to WHO/HQ in Geneva which then links these funds to WHO South Sudan Gavi work plan through the Global System of Management (GSM) of the WHO. The system ensures effective activity based budgets linked to results; and further validated by internal and external auditing processes.

UNICEF Managed component of Gavi/HSS: Funds were disbursed through UNICEF's financial systems at all level. Procurement of supplies was based on supply forecasting, procurement and distribution plan developed jointly with Government of the Republic of Southern Sudan. Funds to support implementation of planned HSS activities including renovation of Health facilities were disbursed through a Direct Cash Transfer (DCT) to the State Ministries of Health based on approved joint work plans and a request letter from the government.

3.2.2. Strategic focus of HSS grant

The 2008 Gavi-HSS proposal requested US$ 5.335 million over a period of two years from 2009 to 2010. The proposal envisioned a further need for US$ 8.613 million as follow-on to cover the next three years 2011-2013. The goals of the 2008 proposal were to: bring about a tangible reduction in the maternal and child mortality and morbidity in Southern Sudan by adopting a holistic approach for strengthening the health system by improving the access of vulnerable groups to quality health care, carrying out capacity building and optimal utilization of the health work force, and improving governance and stewardship at the Central and State levels, while addressing implementation issues at the County level and below.

The proposal outlined 30 activities under the three objectives to be implemented in the 2009-2010 period. In the event, the 2008 proposal for support of activities 2009 to 2010 was approved by Gavi and funds released over the following four years (up to the end of 2012) with major expenditure in 2013 and a final expenditure of USD 130,627 in 2014.

A new HSS proposal was approved in 2013. It is a cash support grant of 29.258 million USD for a period of 5 years (2014 through 2018). However, due to multiple factors including the current conflict delayed the implementation of the new HSS grant. The country has developed a country tailored approach and will begin implementation through WHO and UNICEF in the 4th quarter of 2015. The strategic focus of this grant is:
- Scale up access to routine immunisation services
- Improve demand generation for Immunisation services.
- Strengthen capacity of the Ministry of Health for Cold chain and Vaccine Management.
- Strengthen the capacity of the MOH to provide stewardship

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

In 2013, in response to the situation as described, South Sudan put forward a Health Systems Strengthening (HSS) Cash Support proposal for 29.258 million USD to run for five years. Gavi approved this proposal in November 2013 with a specified start-date of January 2014.

The proposal is richly detailed with activities and costs specified for each of the years (2014 through 2018) with an initial disbursement plan for 2014 of 6,890,276.39. Under the CTA the grants will be managed by WHO and Unicef for year 1 & 2 of the grant. The release of first tranche is being requested.

3.3. Graduation plan implementation *(if relevant)*

NA

3.4. Financial management of all cash grants

Cash Utilization performance and financial capacity constraints
There is the need for enormous improvement in the cash utilization and financial reporting systems in the country; some of the main challenges are;

- ✓ Poor financial management system at all levels
- ✓ Weak human resource (numbers and capacity)
- ✓ Poor infrastructure especially at sub national level for banking transactions.
- ✓ Security situations that may affect financial transactions
- ✓ The weak local currency coupled with high inflation rates

Modification, if any, made to the financial management arrangements
Decision has been taken for the disbursement of Gavi funds through WHO and UNICEF. This in lieu of weak financial management system at MoH which can meet Gavi requirements.

Any major issues arising from Cash Program Audits or Monitoring Review
The latest 2011 audits reports have highlighted procedural, documentation and systemic gaps requiring attention the major ones are the following,

- Most procurements was done on single sources basis without any justification
- Fixed assets register is not maintained according to the project; grant agreement
- Bank reconciliations are not prepared on monthly basis as requested by IPSAS
- The states were not complying with the requirements of transparency and accountability
- Internal controls are weak and could not be relied upon.

. **Degree of compliance with Financial Management Requirements**
Submitted Audit Reports for 2009 – 2011 however that for 2012 and 2013 are pending

3.5. Recommended actions

No	Actions	**Responsibility** (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
1	**Leadership and governance**			
1.1	Advocacy for enhanced government ownership for immunization program	WHO,UNICEF, Gavi, BMGF, JSI, other stakeholders	Starting September 2015	Respective organization
1.2	Strengthen ICC and revitalize HSCC	MOH and in country partners	Starting September 2015	None
1.3	Make the existing NITAG operational	MOH and WHO	Q-I, 2016	WHO, SIVAC
1.4	Strengthen the existing state level health cluster coordination mechanism and initiate similar coordination at County level	MOH and in country partners	Start Q-I 2016	SMOH,WHO, HSS
1.5	Create budget line and provide funds for both traditional and new vaccines including operational and logistics	MOH	Q-I of 2016	MOH
1.6	Establish a Logistics Working group involving all immunization partners to address the ISCM issues in the country	MOH, UNICEF and in country partners	Starting Q1 2015	JA and Gavi
2	**Human Resource**			
2.1	Enhance human resource capacity (including the staff of implementing partners/Fund managers) and numbers at all levels (including CC technician	MOH and in country partners	As per the work plan of HSS	HSS
3	**Financial Management**			
3.1	Enhance financial management system and build capacity to enable proper fund managements at all levels	MOH and in country partners	As per the work plan of HSS	HSS
3.2	Implement recommendations from Gavi FMA	MOH and in country partners	To be completed by the end of 2nd year of HSS	MOH, partly HSS
4	**Communication and demand generation**			
4.1	Develop evidence based Social and behavioral change communication strategy for EPI including state specific plans	MOH, UNICEF	By the end of 2nd year HSS implementation	UNICEF

4.2	Strengthen community engagement and mobilization to reach all children in hard to reach areas and for defaulter tracking Scale up the social mapping initiated in certain counties	UNICEF	By the end of 2nd year HSS implementation	UNICEF
5	**Program management**			
5.1	**Start implementing and monitoring of new HSS proposal.**	WHO, UNICEF, MOH and Gavi	Start QIV 2015	HSS
5.2	Develop medium term road map for routine immunization strengthening	MOH and in country partners	QI of 2016	MOH, UNICEF, WHO and Gavi
5.3	Conduct needs assessment in the three conflict affected states	MOH and in country partners	As situation improves	MOH, UNICEF, WHO and Gavi
5.4	Develop new cMYP for 2017 to 2022	MOH, WHO and UNICEF	QII -III of 2016	WHO and UNICEF
5.5	Complete the introduction of Pentavalent in all counties of the three conflict affected states	MOH, WHO and UNICEF	As situation improves	MOH, UNICEF, WHO and Gavi
5.6	EPI/Surveillance review and PIE should be completed as planned	MOH and partners	October 2015	UNICEF, WHO and partners
5.7	Introduce IPV as scheduled and prepare plans for introduction in the three conflict affected states	MOH and in country partners	Start 30th September 2015	MOH, UNICEF, WHO and Gavi
5.8	Finalize preparation for tOPV to bOPV switch in April 2016	MOH, WHO and UNICEF	QII of 2016	WHO and UNICEF
5.9	Conduct EVM follow-up assessment of the Vaccine Supply Chain of SS	MoH and UNICEF	Q2-Q3 2016	UNICEF and Gavi
5.10	Conducting “Temperature Monitoring Study’ of the vaccine supply chain of SS	MoH and UNICEF	Q2-Q32016	UNICEF and Gavi
5.11	Implementation of EVM improvement activities’	MoH, UNICEF and in-country partners	Q3-Q4 2016	MOH, UNICEF, WHO and Gavi
5.12	Establishment of sustainable CC inventory and maintenance management system	MoH and UNICEF	Q1-Q4 2016	UNICEF and Gavi
6	**Surveillance, Data, Monitoring and reporting**			
6.1	Establishment of sentinel surveillance for Rota and PBM	WHO	Start QII of 2016	WHO
6.2	Establish AEFI surveillance and response system at all level.	MOH,WHO	Start QIV of 2015	WHO

6.3	Strengthen the existing DHIS to meet the EPI data requirements	MOH, WHO	Start QI of 2016	WHO
6.4	Develop data quality improvement plan and start implementing	MOH, UNICEF, WHO	Start QIV of 2015	MOH, UNICEF, WHO

4. TECHNICAL ASSISTANCE

(MAXIMUM 1 PAGE)

4.1 Current areas of activities and agency responsibilities

Technical Assistance to be provided for:	Implementing partner	Status	Comment
Operational research into community empowerment and involvement at health facility level	WHO	Not done	Reprogrammed to produce IEC materials for EPI and MCH health to be distributed to all the 10 States Reprogrammed
Operational research on logistics management and revival of the BDN program in selected areas	WHO	Yes	Consultant deployed to the Directorate of Pharmaceuticals
Training needs assessment of all health care professionals and providers	WHO	No	Reprioritization was done and this activity was excluded this activity.
Health Management Information System data compilation, analysis and use for decision making in the states	WHO	Yes	Consultant was deployed in the M&E Unit of the MOH to support data analysis and production of reports using data reported from the states.
Sustainability of private sector health facilities and establishment of additional public sector facilities at carefully selected sites	WHO	No	Reprogrammed to Training of 105 County Health Management Team members drawn from all the 79 Counties on the District Health Management Team Manuals
An inventory of Health Financing in South Sudan	WHO	Yes	A consultant reviewed the current health financing framework. MOH reprioritized remaining funds to support review and update of the national health policy.
Regulation and standard setting of public and private health care providers	WHO	Yes	A consultant supported the development of a regulatory framework for private and public health workers and facilities
Long Term support to all aspects of Health System Strengthening particularly at county level	WHO	Yes	Long term TA deployed to support implementation of Gavi HSS activities and successfully supported the development of a new Gavi HSS proposal
EVM follow-up assessment of the National Vaccine Store	UNICEF	done	UNICEF RO supported to conduct the NVS assessment by the other level is expected to be conducted in 2016
EVM follow-up assessment at the state, county and HF level	UNICEF	Not done	Decision made to shift the EVM assessment to 2016

Introduction of Central Temperature Monitoring System at the NSV level	UNICEF	On-going	Procurement of device on-going. Installation and training expected in Q4
Temperature Monitoring Study of the Vaccine Supply Chain	UNICEF	Not done	Shifted to 2016 due to computing priorities
HR Capacity building at state and county level focusing on the CCL and maintenance management (training and materials)	UNICEF	Not done	Due to delay in the recruitment of CC technician by the government
Conducting National CCI and development of a multi-year cold chain equipment replacement and expansion plan	UNICEF	on going	
Strengthening the stock management and the vaccine handling practices at the national vaccine store	UNICEF	On-going	UNICEF support the MoH/EPI on the day-to-day management of the NVS
Developing / updating Effective Vaccine Management training materials and SOPs in the context of South Sudan	UNICEF	On-going	Consultant recruitment is finalized and expected to commence work in Mid Sep. 2015
CCE selection and procurement, installation	UNICEF	On-going	

4.2 Future needs

TA needs	Justification / Actions	Intended outcome	Modalities	Possible provider	Included in HSS	Tentative Cost (US$)
Efficient Technical support to the Ministry of Health in order to provide high quality immunization services to prevent morbidity, mortality and disability from vaccine preventable diseases was not addressed in the HSS project	An International Immunization Specialist will be necessary for implementing articulated project strategies in terms of: 1. Strategic planning (development of cMYP, Annual Plans) of routine immunization activities 2. Expand the program including vaccines introduction 3. Technical oversight on Data Management and Information sharing 4. Through different events and modalities, capacity building of MoH staff 5. Working closely with the Director of EPI and the Director for Primary Health Care in the MoH to progressively empower the local leadership and enhance the sense ownership	1. cMYP updated; National EPI Annual plan available 2. Regular EPI bulletin 3. More new vaccines introduced 4. Institutional capacity build up 5. Coordination mechanisms strengthened	12 months renewable (100%)	Gavi	No	252,000

Extended field Technical support to ensure that The Reaching Every County strategic approach should be recast as "Reaching Every Community"	5 International EPI field-support officers able to move in the field to support county-to-facility implementation of M&E, support-supervision and community involvement as specified in the REC approach—deployed for a minimum of two years (1 per two states)	1. Basic EPI systems established at field level 2. Grant Targets met	12 months renewable (100%)	Gavi	No	1,200,000
Need assessment in three conflict affected states is crucial to reshape project interventions and targets in the affected communities	The ongoing conflict started after the application, as such 5 short term International Investigators (1 Epidemiologist, 1 EPI Specialist, 1 Cold chain and Logistic Specialist, 1 C4D specialist and 1 Security Officer) will be need to rapidly assess the need for readjustments of operations in these states	3. Initial Assessment of the three conflict affected states done	1 month (100%)	Gavi	No	100,000
Ensuring continue Assistance to WCO from IST/Regional or HQ	Not specified in IP, 6 short term consultancy missions will be necessary for development of: 1. Surveillance tools and operational guidelines for VPDs targets of NUVs 2. Proposal and IP for NUVs 3. cMYP 2017-2021 coasting 4. AEFI Management committee 5. Quality SIAs (Measles FUP Campaign) 6. Data Quality Improvement Plan	Planning, policy & implementation guidelines granted	2 months each with travel arrangement per mission (100%)	Gavi	No	240,000
EVM follow-up assessment, improvement and implementation support including introduction of new technology and practices	The country is due to conduct EVM follow-up assessment, improvement plan and its implementation. Besides, CCE maintenance management is a bottleneck which will require innovative thinking taking into consideration the context including HR capacity building.	ISCM improvement in key priority area based on the assessment recommendation	Financial support to UNICEF CO	Gavi	Partially	215 659
For the guidance, coordination and follow-up of the implementation of CCL strengthening activities	Assessment of the cold chain capacity in the context of introduction of new vaccines; implementation of the CC rehabilitation and maintenance plan; Set a systematic monitoring of the status of CC equipment; Training and supervision of CC Logistician and technician on CC and vaccine management	Improvement of CC system and vaccine management at all levels	Financial support to UNICEF CO	Gavi	Activities are funded in Gavi HSS but not the staff who will conduct, manage,	257,479

					coordinate and report	
For the guidance and coordination to strengthen communication activities at national and sub national levels	Guide communication planning and implementation of RI and NUVI at national and sub national levels Support capacity development of partners in community engagement, AEFI management and client management at health facility Collaborate and strengthen coordination mechanism at national and subnational levels for synergistic communication among CSO and fund manager partner NGO	C4D staff at state level have improved capacity to plan and implement EPI SBCC strategy and work plans at national & sub-national level	Support for UNICEF CO technical assistance (30%) of 12 months	Gavi	Activities are funded but not the staff who will guide, coordinate and supervise the C4D staff at state level	65 617
For tracking, monitoring, analyzing, and reporting on RI topics	Track performance of inputs level indicators every quarter at national and sub national level and consolidate the reporting Monthly monitoring reports of the status of CC equipment and implementation of the CC rehabilitation and maintenance EVM improvement plan and GAVI Business Plan	Performances and implementation status of CC, EVM and GAVI Business plan regularly updated, documented and shared	Support for UNICEF CO technical assistance (100%) 12 months	Gavi	Activities are funded but not the person who will coordinate and ensure the follow-up.	218 724

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

(MAX. 1 PAGE)

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism:
Issues raised during debrief of joint appraisal findings to national coordination mechanism: • ICC needs to have a clear TOR with the correct member composition represented from the right agencies. The ICC meeting should be chaired by the Minster or under secretary • MOH agreed the new HSS grant to be channeled through WHO and UNICEF for two years. • Delay in fund release from Partners also affecting on the timely implementation of the program • The staff to be recruited for MOH should be based in MOH office. • The fund managers should bring out their contribution (fund analysis) as compared to the allocated budget and their program performance. • The peace agreement signed on 26th of Aug 2015 will end the conflict and things will be back to normal and will no longer be a risk related to insecurity due to conflict. • Limited HR capacity (both number and skill) • High operational cost and high inflation rate with the signing of agreement the operational cost will improve and inflation rate will reduce there are few signs for the last two days • Existing Health cluster coordination at state level can be used as a good forum to discuss on routine immunization service delivery at state level if it is effectively coordinated by SMOH and state EPI team. • Vaccine preventable disease surveillance is improving through time however; the quality of the overall surveillance activity is sub optimal. Introducing laboratory facilities in the surveillance system should be a priority for the country to have sensitive more sensitive surveillance for all vaccine preventable diseases. Currently, samples are being sent outside of the country for investigation that delays the intervention. • AFP/Measles surveillance is going parallel and we need this program should be included with IDSR to have strong surveillance system as a country. • The data of IDSR report completeness needs to be revised it is reported at 96% while only 49% of the health facilities are functional in the country due to the current crisis.
Any additional comments from • Ministry of Health: • Partners: • Gavi Senior Country Manager:

6. ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]

- **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
Technical support • To strengthen capacity to collect disaggregated data • For injection safety plan development	Not started
Data quality • Ensure that strengthening data quality is included in Country's priority areas for 2014/15 and that a coverage survey be conducted as soon as conditions allow.	Started (Assessment of EPI data management was conducted from (19 to 25th July 2015)
HSS financial liability • Increase Gavi liability of first HSS programme (2009-2010) by US$250,606.	Completed
Integration of routine immunization and polio • Use 2014 Penta launch as opportunity to begin to monitor integration of routine immunization and polio campaigns.	Completed
HSS • Release of the remaining HSS funds approved for the current grant, in the amount of $372,000, pending clearance of outstanding audit reports for 2009 and 2010 • Gavi and alliance partners to support the South Sudan to develop a country tailored approach with an objective of strengthening immunization systems and service delivery in the current context (conflict situation).	Pending audit reports and a revised workplan from MoH, including approval to channel funds through partners Completed
EPI Financing and Sustainability • Country to start allocating government funding to traditional vaccines and progressively increasing it • Country to secure funding for co-financing Pentavalent vaccine from 2014 onwards	Not completed Completed

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

A joint appraisal was conducted in South Sudan from 24-28 August 2015. Preparations were started for the mission from June 2015, starting with country's agreement to have the joint appraisal and dates for the appraisal. A desk review was conducted of various documents such as APR, cMYP, EPI comprehensive review etc. The in-country joint mission was held from 24-28 Aug 15 by a team comprising of Gavi Secretariat, WHO HQ& IST and UNICEF ESARO. The team was supported by EPI/MoH and by WHO and UNICEF in-country offices.

- Several teleconferences (Gavi, WHO, UNICEF) on mission preparation and development of preliminary JA report.
- The Preliminary joint appraisal report developed by the in country joint appraisal committee and shared to team coming to Juba for review and additional input
- External joint appraisal team composed of WHO-HQ, Gavi secretariat, WHO-Afro regional office and UNICEF- ESARO join the country team in Juba to provide technical assistant in the preparation of the report
- Five day joint appraisal mission was conducted in Juba from 24th to 28th of August 2015 with external team to finalize the joint appraisal report
- Debriefing meeting was conducted on 28th of August 2015. During the debriefing the summary of findings and key recommendations were presented to the ICC for discussion. The committee agreed to endorse the final version of the report after adding inputs from the ICC meeting.
- The JA mission was concluded by the ICC debriefing meeting Chaired by the Acting Undersecretary, Dr John Rumunu and attended by 25 ICC members

Joint Appraisal team

External members

- K.O Antwti-Agyei - JSI
- Mutale Mumba – WHO/IST/ESA, Harare
- Kaushik Banerjee – WHO/HQ, Geneva
- Karan Sagar - Gavi Secretariat, Geneva
- Nasir Yusuf – UNICEF/ESARO, Nairobi

In-country members

- Anthony Laku – MoH/South Sudan
- Bimpa Dieu-Donné – WHO/South Sudan
- Melisachew Ferede – WHO/South Sudan
- Boniface Ambani – WHO/South Sudan
- Lydie Maoungou – UNICEF/South Sudan
- Anu Puri – UNICEF/South Sudan
- Carl Hasselblad - BMGF

- **Annex D. HSS grant overview**

General information on the HSS grant							
1.1 HSS grant approval date			***26 August 2009 (Final Grant Agreement)***				
1.2 Date of reprogramming approved by IRC, if any							
1.3 Total grant amount (US$)			***$ 5,335,000.00***				
1.4 Grant duration			***Two years (2009-2010)***				
1.5 Implementation year			month/year – month/year				
(US$ in millions)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
1.6 Grant approved as per Decision Letter							
1.7 Disbursement of tranches	***0***	***1,725,910***	***895,000***	***0***	***2,575,440***	***0***	***0***
1.8 Annual expenditure	***0***	***879,969***	***1,231,887***	***490,485***	***0***	***2,463,382***	***130,627***
1.9 Delays in implementation (yes/no), with reasons			***Yes. Late disbursement of funds***				
1.10 Previous HSS grants (duration and amount approved)			***None***				

1.11 List HSS grant objectives

1. ***Improved delivery of accessible, equitable and affordable health care services having minimal quality standards to the entire population but particularly to women of child bearing age and children under the age of five years.***

2. ***Strengthening all cadres of the fragmented workforce for health, including doctors, nurses, paramedics, support staff and community outreach workers, in order to achieve better health outcomes.***

3. ***Better governance and stewardship of the Health Sector using good governance practices, including efficient health financing and focusing on effective implementation of health policies and strategies.***

1.12 Amount and scope of reprogramming (if relevant)

Five activities reprogrammed between 2009 and 2014 due to delay in funding , inability to meet criteria or changes in priority (see activity completion summaries in Annex F)

Annex E: HSS Progress against targets (Table 9.3 from the 2014 HSS Report: Progress on targets)

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline		Agreed target till end of support in original HSS application	2013 Target	Year							Data Source	Explanation if any targets were not achieved & Remarks
	Baseline value	Baseline source/date			2008	2009	2010	2011	2012	2013	2014		
DPT3 administrative coverage (%) *	20%	SHHS	45%	**30%**	20%	38%	63%	77%	75%	64%	57%	MOH/EPI & WHO	
DPT3 survey coverage (%)								45%				MOH/RSS Coverage Survey (2011/2012)	24% valid coverage (45% crude DPT3 coverage)
% children 6-59 months received vitamin-A supplementation	40%	SHHS	60%	**50%**			6%	74%	85%	82%		SHSS (for 2010) and polio NIDs implementation reports (2012 & 2013)	The low coverage in 2010 was due to the fact that 6 months before the survey there were no vitamin A supplementation to children. The sharp increase is because vitamin A has been integrated in to the polio NIDs.
% deliveries attended by skilled personnel	10%	SHHS	15%	**15%**			14.7%					SHSS 2010	No new survey carried.
Antenatal care by skilled personnel	26%	SHHS	33%	**33%**			30%					SHSS 2010	Current status unknown: no new survey carried out
Counties achieving >80% DPT3 coverage	not available	MOH/GOSS Routine EPI data	10%	**35%**			34%	46%	41%	76%	25%	MOH/RSS Routine EPI data	Activities in three states (Upper Nile, Unity & Jonglei) essentially came to a halt due to insecurity
Under five mortality rate	135/1000	SHHS	130/1000	**120/1000**			106/1000					SHSS 2010	Current status unknown: no new survey carried out
Use of Oral Rehydration Therapy	64%	SHHS	70%	**75%**			62%					SHSS 2010	Current status unknown: no new survey carried out

**** Updated records (includes data arriving after reporting deadlines)***

Annex F: Activity Status from APR 2014

ACTIVITY NUMBER	IMPLEMENTING PARTNER	ACTIVITY	% COMPLETE	ACTIVITY STATUS
Objective 1, Activity 1.1	MOH	Provision of ten Logistics and Supply Experts (one for each state) at state level	0	The activity was not implemented since the Ministry did not receive funds from Gavi.
Objective 1, Activity 1.2	UNICEF	Augmenting governmental efforts in renovation of 5 Hospitals with provision of basic furniture/equipment	100	Completed in previous years
Objective 1, Activity 1.3	UNICEF	Augmenting governmental efforts in renovation of 12 PHCCs with provision of basic furniture / equipment	100	Completed in previous years
Objective 1, Activity 1.4	UNICEF	Augmenting governmental efforts in renovation of 40 PHCUs with provision of basic furniture	100	Completed in previous years
Objective 1, Activity 1.5	MOH	Hiring of 10 Social Mobilizers (1 for each state) for demand creation for Health, particularly preventive programs and safe motherhood	0	The activity was not implemented since the Ministry did not receive funds from Gavi.
Objective 1, Activity 1.6	UNICEF	Provision of 5 Cold rooms at the State Level for better storage and management of all logistics, medicines and vaccines	100	Completed in previous years
Objective 1, Activity 1.7	WHO	Enhancing a massive IEC campaign for health care services particularly for mothers and children	0	Reprogramed
Objective 1, Activity 1.8	UNICEF	Provision of ten motorboats for transporting patients, supplies and logistics	100	Completed in previous years
Objective 1, Activity 1.9a	WHO	Produce IEC materials for EPI and MCH health and distribute to all the 10 States	100	Completed in previous years
Objective 1, Activity 1.9b	WHO	Operational research on logistics management and community involvement in health and revival of the BDN program in selected areas of Southern Sudan	100	Completed in previous years
Objective 2, Activity 2.1	WHO	TA for carrying out Training Needs Assessment of all health care professional and health care providers	0	Reprogramed
Objective 2, Activity 2.2	WHO	Refresher training of 1,164 Community Health Workers and Community Support	100	Completed in previous years

ACTIVITY NUMBER	IMPLEMENTING PARTNER	ACTIVITY	% COMPLETE	ACTIVITY STATUS
		Officers to perform all basic health services and serve as a link between communities and health facilities		
Objective 2, Activity 2.3	UNICEF	Provision of 2,280 bicycles to community health workers in the counties	100	Completed in previous years
Objective 2, Activity 2.4	UNICEF	Provision of 6 motorcycles to community support/social officers	100	Completed in previous years
Objective 2, Activity 2.5	UNICEF	Provision of 50 motorcycles to counties	100	Completed in previous years
Objective 2, Activity 2.6	WHO	Training of 225 doctors on the preventive aspects and implementation of the Basic Package of Health Services	100	Completed in previous years
Objective 2, Activity 2.7	WHO	Training of 473 Public Health Officers in the preventive aspect	100	Completed in previous years
Objective 2, Activity 2.8	WHO	Training of 443 Medical Assistants/Clinical Officers on the preventive aspects	0	Reprogramed
Objective 2, Activity 2.9	WHO	Training of 272 Laboratory Personnel	100	Completed in previous years
Objective 2, Activity 2.10	WHO	TA for Health Management Information System Data compilation, analysis and use for decision making in the states	100	Completed in previous years
Objective 2, Activity 2.11	MOH	Provision of buffer stock of HMIS tools at Central and State levels	0	The activity was not implemented since the Ministry did not receive funds from Gavi.
Objective 2, Activity 2.12	WHO	Training of 105 County Health Management Team members drawn from all the 79 Counties on the District Health Management Team Manuals	100	Reprogramed (see 213): Completed in previous years
Objective 3, Activity 3.1	WHO	TA for drawing up an inventory of Health Financing in South Sudan	100	Supported sub national consultative dialogue meetings for the review of the national health policy in the 7 non conflict affected States of South Sudan
Objective 3, Activity 3.2	WHO	Sub national consultative dialogue meetings for the review of the national health policy in the 7 non conflict affected States of South Sudan	100	Reprogramed (see 2013): Completed in 2014 Supported sub national consultative dialogue meetings for the review of the national health policy in the 7 non conflict affected States of South Sudan

ACTIVITY NUMBER	IMPLEMENTING PARTNER	ACTIVITY	% COMPLETE	ACTIVITY STATUS
Objective 3, Activity 3.3	WHO	TA for regulation and standard setting of public and private health care providers	100	Completed in previous years
Objective 3, Activity 3.4	WHO	Provision of 3 weeks training in managerial skills for Program Managers at the Central Level and Director General at the state level	100	Completed in previous years
Objective 3, Activity 3.5	WHO	Provision of two week's training in managerial skills for County Medical Officers	100	Completed in previous years
Objective 3, Activity 3.6	WHO	Long Term TA for all aspects of Health System Strengthening particularly at county level	100	Completed in previous years
Objective 3, Activity 3.7	UNICEF	Provision of office and communication equipment to Central MOH planning wing and State Directors General (11 offices – each with PC with printer, scanner, photocopier, fax and email	100	Completed in previous years
Objective 3, Activity 3.8	UNICEF	Provision of office equipment to 30 County Medical Officers	100	Completed in previous years

Major accomplishments in 2014

Activities 3.2 and 3.1 were reprogramed to support the review and update of the national health policy, which prioritized by the Ministry of Health

Problems encountered and solutions found or proposed to improve future performance of HSS funds

Activities 1.1; 1.5 and 2.11 were not implemented as funding for these activities was not disbursed to the Ministry of Health, which is directly responsible for their implementation. If the Gavi/HSS grant portion for the MOH had been released it would have contributed to implementation of the national human resource guidelines by placement of logistics/supply experts and social mobiliser's in each of the States in South Sudan.

Annex G: Programmatic distribution of roles MoH-WHO-UNICEF

Areas	Activities by Agency		
	WHO	UNICEF	MoH
VPD case bases Surveillance	▪ Support field operations ▪ Transport and communication ▪ Training and meetings ▪ Social mobilization	▪ Provision of vaccine carriers for transportation of specimens. ▪ Social mobilization	▪ Policy development and leadership ▪ MoH Staff recruitment ▪ MoH Staff Salaries ▪ MoH Logistic, forecasting an implementation ▪ Distribution of Funds to States ▪ Planning and implementation of Supportive supervision ▪ Coordination ▪ Data collection, compilation, analysis and dissemination (Meetings)
SIAs/Polio NIDs and Measles FUP Campaign	▪ Payment for vaccinators and supervisors. ▪ Provision of transport for vaccination teams and their supervisors. ▪ Training and micro-planning. ▪ Provision of supplies and equipment including finger markers. ▪ Independent monitoring.	▪ Procurement of vaccines and consumables ▪ Provision of transport for vaccines and supplies distribution. ▪ Social mobilization	
SIAs/MNTE Campaign	▪ Contribution on transport for vaccination teams and their supervisors. ▪ Coordination and Training and micro-planning. ▪ Participate in Independent monitoring.	▪ Procurement of vaccines and consumables ▪ Provision of transport for vaccines and supplies distribution ▪ Payment for vaccinators and supervisors. ▪ Provision of transport for vaccination teams and their supervisors. ▪ Training and micro-planning. ▪ Provision of supplies and equipment. ▪ Independent monitoring. ▪ Social mobilization	
Routine EPI	▪ Payment of incentive for vaccinators and supervisors during defaulter tracing and accelerated immunization activities. ▪ Provision of transport for vaccination teams and their supervisors. ▪ Supportive supervision ▪ Training and meetings ▪ Policy development ▪ Social mobilization	▪ Procurement of vaccines and consumables ▪ Provision of transport for vaccines and supplies distribution. ▪ Cold chain maintenance ▪ Construction of cold chain facilities (and warehousing) ▪ Social mobilization	

Annex H: List Documents used during Joint Appraisal Report preparation

No	Name of the document	Source
1	GAVI HSS Proposal November 2008	MOH
2	MOU & Approval of 1st GAVI HSS Grant (2009-2010): Final Grant Agreement plus Aide Memoire dated August 2009	MOH/GAVI
3	South Sudan cMYP 2012-2016, June 2012 Final	MOH
4	cMYP Costing and Financing Graphs for South Sudan-Baseline Final	MOH
5	South Sudan HSS Proposal – November 2008	MOH
6	2011 External EPI Review Final Report-October 2011 for South Sudan (15 December 2012)	WHO
7	Inception report (EPI Barrier Analysis)– Dr. Sam Agbo, WHO EPI Consultant to South Sudan-September 2013	WHO
8	Bottle neck analysis report September 2013	WHO
10	RSS-EPI Coverage Survey 2011-2012 for South Sudan, Draft Report-August 2012	MOH
11	South Sudan ISS Proposal – August 2007	MOH/GAVI
12	APR-2007 SS	MOH/GAVI
13	APR-2008 SS	MOH/GAVI
14	APR-2009 SS	MOH/GAVI
15	APR-2010 SS	MOH/GAVI
16	APR-2011 SS	MOH/GAVI
17	APR-2012 SS	MOH/GAVI
18	APR-2013 SS	MOH/GAVI
19	APR-2014 SS	MOH/GAVI
20	SDS-01 South Sudan PFA 2013	MOH/GAVI
21	SDS-2013.01 (xaxx)-Penta	MOH/GAVI
22	SDS-2014.01 (xxxa)-Penta	MOH/GAVI
23	SDS-2014.02 (xaxx)-M	MOH/GAVI
24	SDS-2014.05 (xaxx)-Penta Review 2015	MOH/GAVI
25	SDS-2015.01 (xaxx)-IPV	MOH/GAVI
26	SDS-2015.02 (xaxx)-MenA2015 campaign	MOH/GAVI
27	EVMA Report South Sudan 2012	UNICEF
28	EVMA implementation status- April 2015	UNICEF
29	Cold chain inventory report 2012	UNICEF
30	NIP Cost & Financing-Immunization-South Sudan Final	MOH
31	WHO GAVI HSS financial statements 2012	WHO
32	WHO GAVI HSS financial statements 2013	WHO
33	WHO GAVI HSS financial statements 2014	WHO
34	WHO GAVI HSS Report 2013	WHO
35	WHO GAVI HSS Report 2014	WHO
36	Lessons Learned_NVI_SouthSudan_DRAFT_December 2014_JSI	JSI
37	Financial Management Assessment March 2015	MOH/GAVI

- **Annex F. Best practices (OPTIONAL)**