Joint appraisal report

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

Country	**South Sudan**
Reporting period	***December 2016***
Fiscal period	***July - June***
If the country reporting period deviates from the fiscal period, please provide a short explanation	***Planned JA in July was affected by the multiple priority interventions and the crisis***
Comprehensive Multi Year Plan (cMYP) duration	***2012 to 2016***
National Health Strategic Plan (NHSP) duration	***2012 to 2016***

1. SUMMARY OF RENEWAL REQUESTS

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

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS – *Pentavalent* existing presentation	Extension	*2017*	*452,649*	*Tbd*	US$ 1,775,500
NVS – IPV	Renewal	*2017*	*225,348*	*tbd*	US$ 551,000

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year

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

2. COUNTRY CONTEXT *(maximum 1 page)* *This section does not need to be completed for joint appraisal update in interim years*

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

South Sudan still remains a fragile country and this was again reaffirmed by the recent surge in the ongoing conflict that occurred in July 2016 which resulted in large scale fighting in Juba and other parts of the country with increased numbers of states directly affected by conflict from known former three affected to eight states. This has brought additional challenges with the scale down of NGO's presence from 67 to 11 immediately after the crisis (July) with a slight improvement to 26 by October 2016 with a resultant reduction in the number of staff. These NGOs are mandated to provide immunization as part of their health service delivery package. However this does not usually translate into reality due to various factors including non-availability of cold chain equipment, staff and limited allocated funding. Also health resources and infrastructures have been looted and vandalized which has led to the suspension of health services from a large number of health facilities.

Currently, the health services sector is highly dependent on partners with 80% of health facilities managed by NGOs with the government allocation to health approximately 4% and with actual expenditure less than 0.001% allocated to EPI. The value of the South Sudan Pound against the US dollar has dropped

from 3.2 SSP in January 2015 to the current 85.00 SSP in November 2016.The inflation rate in the country is put at over 800%. There have been adjustments in the salaries of the lower support staff which are not commensurate with the rate of inflation and government workers have also been owed salaries upwards of 3 months.

Due to the inflation planning for activities have to take this into consideration. In view of this the stipend of participants in the SIA's has been reviewed but due to the rate of this inflation planning has become difficult. In some counties in Upper Nile vaccinators have refused to accept payment in the local currency and requested payment in USD instead.

In terms of health services delivery during the rainy season almost 60% of the roads become inaccessible. This has major implications for vaccine delivery which takes place on a sporadic basis during this period through UNICEF charter flights. This is not always guaranteed as large portion of the airstrips remain non accessible and hence there are long periods within which vaccine deliveries do not take place. The cost of this air supply makes service delivery in the country extremely costly. In the current situation security clearance to allow these flights may not be obtained in time.

The Fund Manager mechanisms for health services financing was established in 2013 to streamline funding of NGOs. Improvement in the implementation of the basic package of health services was evident in the years that followed including EPI. In 2016 the funding cycle ended and transition into the new cycle has not been smooth with interim arrangements still in place. This lack of clarity has led to a drop in immunization during the first half of 2016. Additionally, one of the three Fund Managers, JHPIEGO, has been abolished with the states assigned to it moved to the Health Pool Funding Mechanism (HPF). There is a shortage of funds for NGOs to deliver basic health services. Currently a new funding agreement has been agreed and established. The process of identifying the implementing CSO's is finalized but the actual allocation of health facilities and implementation of activities in the field is still awaited

The coordination between the government and NGOs is limited. While the MOUs between fund managers and NGOs define the need to deliver immunization services there appears to be issues in coordination and reporting. There are examples of NGOs that bring vaccines into the country without the involvement of the government and by and large there is little sharing of data with government. The government is aiming to address this issue through a coordination mechanism that will require the NGOs to submit monthly activity plans and attend monthly meetings.

In December 2015, the government declared that the country will be administratively managed under 28 states from the previous 10. Consequently, the numbers of counties are still undergoing changes without attendant infrastructures in these new administrative structures. Planning and reporting has become difficult with each state asking for full complement of partners' presence and activities despite the lack of human resources and infrastructure.

The government of South Sudan has suffered from understaffing emanating from the austerity measures that were implemented since 2011. The central EPI unit has employed only three out of 16 staff members. To mitigate the situation the CDC/AFNET has hired national staff called nSTOPers. These include 8 at national level officers for SIAs (1), EPI operations (1), surveillance (1), communication for development (1), EPI logistics (1) and cold chain technicians (2) and 48 staff (4 per state/Administrative areas) at former states (hubs).

The joint appraisal report of 2015 outlined a number of areas that required technical assistance of which MoH and Gavi commissioned JSI to provide. In line with this, JSI continued providing technical assistance through (1) Staff (Technical Advisor) with support from HQ with the two-years ''Gavi-Strengthening Routine Immunization (Gavi-SRI)'' project which will run to the end of 2017 in areas of strengthening leadership, capacity building in program management, improvement in information sharing, data quality and use and supporting CSOs in demand creation for immunization in the communities.

The MOH with support of GAVI HSS through UNICEF has also recruited four cold chain technicians out of the budgeted 12. Efforts are underway to finalize recruitment of the remaining eight to allow training

and deployment to occur. These will be paid at the same salary scale as the government staff. After a period of three years, the government will be expected to absorb them into the MOH payroll. This is a positive development which allows the government to enhance human resource capacity in the field. It will however remain critical that these positions are sustained through partner support for the interim and by the government in the long term keeping in view the impact of devaluation.
The security situation stopped the re-deployment of 20 international WHO/CDC STOPers into the country during the second half of the year leading to the loss of their support to EPI/PEI activities in the field. They are expected to return to the country in February 2017.

The low recruitment rate is partly due to the fact that many skilled people are reluctant to apply due to low MOH salaries. Additional issues include the assignment of individuals to areas outside of their regional background which can cause exposure to potential danger. These are and remain on ground realities that require consideration.

Programme Management
In 2016, the Inter Agency Coordination Committee for immunization (ICC) met three times specifically on approval of: 1) the Annual Work Plan, Plans for Switch and MenAfriVac interventions in February; 2) Review of measles outbreak responses following the crisis in July 2016; and 3) the approval of the Cold Chain Equipment Optimization proposal to Gavi in September.

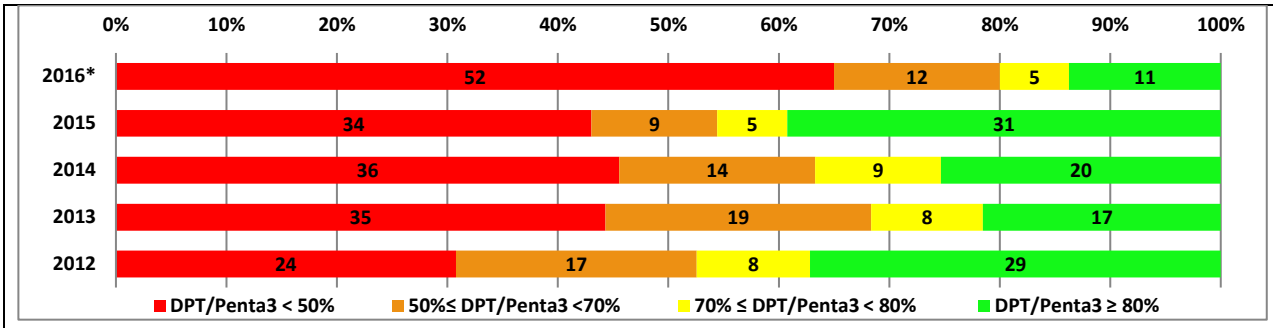
Following the formation of South Sudan Immunization Technical Advisory Group (SSITAG) in November 2015 the orientation of the members was conducted in May 2016. Official Launch is proposed in the first quarter of 2017.

The EPI Technical Working Group (TWG) holds regular weekly meeting to address both programmatic and technical issues. This group discusses the situation for routine immunization and operational plans for improvement; planning implementation and assessment of SIAs; identification and response to outbreaks and coordination between EPI and fund managers/NGOs. This strong forum is chaired by EPI director from MOH and is seen as an effective platform for implementation.

The MoH is in consultation with partners on the appropriate administrative processes to fill the vacancies to be supported by Gavi. The administrative changes due to creation of the new 28 states and the still uncertain number of counties are delaying the process.

EPI Service delivery
Routine immunization services are delivered through a mix of fixed site, outreach and mobile approaches. According to the report from EPI bottle neck analysis conducted in 2013 an estimated 44% of the population has access to health facilities. Hospital and PHCC level where all are supposed to be providing routine EPI, only 64% are providing static immunization services (DHIS). The UNICEF/WHO Joint Reporting Form reported a decline in routine immunization (DTP3) from 75% in 2012 to 62% in 2015, with 31 of the 80 counties (39%) achieving a coverage of 80% and above of which majority are from former 7 stable states . The annualized Penta3 coverage as of Sept 2016 is 45% with only 11 out of 80 counties achieved 80% and above coverage as indicated in the Figure below.

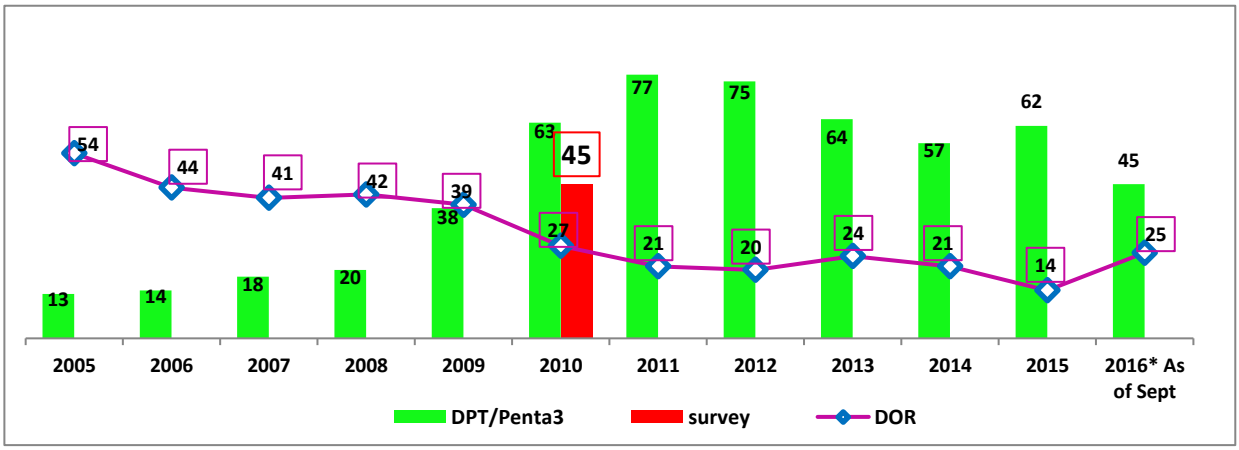
Figure 1: Number of Counties with their DPT3/Penta3 coverage category from 2012 to 2016*.



**2016 data is annualized Coverage as at 30th September*

The dropout rate has decreased from 39% in 2009 to 14% in 2015 however; the trend changed this year unlike the previous years to 25% as of 30th Sept 2016 mainly due to the recent crisis broke out in July 2016. The major challenges to delivery of immunization service are limited human resource capacity and lack of access for the majority of the community due to multiplicity of factors including insecurity and geographic access. Implementation of the various outreach strategies has proven effective in reaching many children with immunization services but this has at times been hampered by lack of funds. Re-allocation of available Gavi resources will provide a more sustainable planning for these outreach activities which at times are the only means of providing immunization service.

Figure 2:National DPT3/Penta3 coverage and dropout rate from 2005 to 2016*



Cold chain and vaccine management

The programme is currently managing six vaccines, namely BCG, OPV, TT, IPV, Pentavalent, and Measles, for routine immunization purposes. Over a period of January to October 2016, 524,660 doses of BCG, 2,762,580 doses of bOPV, 4,617,960 doses of tOPV (Jan to Apr), 157,893 doses of IPV, 613,500 doses of Pentavalent, 1,422,050 doses of Measles, 1,399,520 doses of TT, and 5,150,166 doses of Men A vaccines have been distributed to States and subsequent levels to render routine and supplemental immunization activities.

Cold chain inventory was conducted in 2012 and updated in 2015 and 2016. According to the 2016 report, 63.3% of equipment's were working while 34.8% were found to be non-functional. Almost 96% of the CCE were found to comply with PQS requirements. Out of the 80 counties, 37 counties do not have vaccine storage facilities, while only 47% of the 43 counties with cold chain facility had sufficient cold storage capacity.

There is an ongoing effort to improve CCE availability throughout the country. Over the period of 2012 to 2016 (June), 167 Freezers, 456 Refrigerators, 1022 Cold Boxes, and 8732 vaccine carriers were distributed and installed. However, lack/high price of power, lack of maintenance, insecurity and vandalization of equipment, obsolete equipment (absorption types and solar batteries) and shortage of skilled manpower remain pressing issues to-date. South Sudan applied for the CCEOP support in 2016.

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

Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

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

IPV Introduction

South Sudan is among the countries which submitted the application for IPV introduction in September 2014. This followed a recommendation by WHO's Strategic Advisory Group of Experts (SAGE) that all countries introduce at least one dose of IPV into their routine immunization schedule by the end of 2015. Ministry of Health with support from UNICEF and WHO introduced IPV in the routine immunization schedule of South Sudan as of 1st December 2015. Due to challenges experienced in the conflict affected states IPV was introduced in counties based on accessibility of the area and availability of cold chain facilities. Accordingly, out of 80 counties in the country 13 (16%) which are in the conflict affected states are yet to introduce. From the monthly routine immunization report, 81% of children who vaccinated with Penta3 also received IPV during as of September 2016.

Communication for Development played a pivotal role in the roll-out of IPV in South Sudan. Its role was particularly significant in capacity building of all concerned from national level MoH officials to village level social mobilizers. A national level committee for the roll-out of IPV was formed which used to meet on weekly basis, and facilitated country wide training for vaccinators and social mobilizers. A KAP study conducted by C4D in seven stable states guided an appropriate strategy for introduction of IPV in the country and development of a training package. State level C4D officers provided crucial facilitation during launching and training of vaccinators and social mobilizers at the subnational level.

IEC materials were disseminated to the States. Funding was also given to national and state Ministry of Health for IPV launch at both levels and advocacy activities including community orientation and sessions with local leaders and village health committees.

South Sudan received IPV introduction grants from Gavi in 2015 amounting of $ 334,072.00 USD through UNICEF ($ 169,777.00) (Grant SC150197) and WHO ($ 164,295.00). The amount spent through WHO was $106,043 mainly for training of supervisors and vaccinators at national, state, county and health facility level and associated costs. The remaining balance of $ 58,252.00 which was meant for training of counties in the conflict affected states have not been conducted to date due to insecurity and lack of health facilities. UNICEF expenditure against the allocated was $ 157,145.72.

MenAfriVac Campaign

The 1st phase of MenAfriVac campaign was conducted in six of the former seven stable states due to insecurity in the former Western Equatoria state. Implementation of the 1st phase was initially planned in 2015 however; the preparation phase took longer than anticipated and implementation was eventually done in March 2016 covering 92% of the target population. Phase II was planned in the 4th quarter of 2016 to cover the remaining states but is delayed further due to the July crisis hindering contracting of the consultant.

Table 1: MenAfriVac campaign administrative result for Phase I, March 2016

Former State	# of counties	Target Population (1-29 years)	Total vaccinated	Coverage (%)
Central Equatoria State	6	1037022	890474	86
Eastern Equatoria State	8	851467	727873	85
Lakes State	8	634721	576674	91
Northern Bahir El Ghazal	5	657682	676909	103
Warrap	7	887612	897542	101
Western Bahir El Ghazal	3	304192	254187	84
National (Six states)	**37**	**4372696**	**4023659**	**92**

Communication & Social Mobilization Plans

Large scale communication and social mobilization efforts have played an instrumental role in successful implementation of MenAfriVac campaign. Youth mobilization using social media platforms and advocacy from popular figures brought in by Ministry of Education and Youth contributed towards mass dissemination of information. Community mobilization through targeted coordination meetings at all levels from national to payam level was also undertaken to enhance community level engagement. Launching events were organized across the country; the national level was conducted in Yei town attended by Hon. Minster of MOH his Excellency Dr. Riek Gai Kok. Similar exercise of launching was done in 6 former states and in selected counties within the state. Furthermore, intensive use of radio involving youth icons, airing multiple multilingual public service announcements and talk shows involving professionals to raise the public's consciousness on the importance of Meningitis A vaccination.

The total operational budget allocated for implementation of phase I campaign was $2, 193346.00 (WHO) including former Western Equatorial State which was not implemented due to insecurity and shifted to the states planned for Phase II. Therefore, the total amount of operational cost expended during implementation was $ 1,239,939.00 which is 57% of the fund allocated for phase I. The major expenditures were human resource, training and meetings, equipment and supply, transportation, data collection and monitoring tools printing and other operational costs. The expenditure by UNICEF of the allocated $ 1,034,460.75 (Grant SC150209) was about $ 690,527.90 leaving a balance of $343,932.85 against the grant to be used for the remaining state to be covered Western Equatoria State in the 2nd phase of campaign. The expenditures are mainly for staff travel: $27,485.64; Cold Chain & supplies Logistics: $214,665.07 and Communication & social mob: $448,377.20.

Table :2 MenAfriVac campaign budget allocated and expenditure for Phase I

Agency	Allocated for Phase I Men A campaign (USD)	Expenditure	Balance
WHO	$ 2,193,346.00	$ 1,239,939.00	$ 953,407.00
UNICEF	$ 1,034,406.00	$ 690,527.90	$ 343,932.85

Major Challenges during implementation of MenAfriVac

Due to the volatile security context of the country, the campaign implementation plan has changed several times which had an impact on the planning of other immunization activities. Due to the delay in implementation discrepancy of target population between the original micro plan and the micro plan developed at state level using the current population that has further implication on the costs and the vaccine required.

As a result of the constraint of budgeting during the GAVI Proposal development, critical areas were not considered, assuming that the country would bridge those gaps. Those gaps were waste management, emergency situation handling (including AEFIs), supportive supervision and other logistics and the CTC Approach. As that proposal became operational, no funds came from the government of South Sudan. In view of the above, the under-utilized Gavi budget lines were used to fund those gaps made possible due to currency devaluation.

Social mobilization is a key component in ensuring success of the campaign, however, the limited availability of skilled human resources of C4D at national, state and county level had an implication on the quality of social mobilization activities during the campaign. Hence, there is a dire need of technical support for quality campaign implementation.

Limited Time: The campaign had to be implemented before or by the end of March, 2016 based on Gavi requirements. As a result the campaign was carried out under a tight schedule which might have compromised the quality of preparation of the campaign.

Infrastructural Challenge: Given the state of infrastructure transport of the vaccines was a challenge and added to the complexities and eventual high cost of the activity.

Post Campaign Evaluation: Preparations were done with the recruitment of a consultant finalized in 3rd week of June 2016, however, evaluation activities could not commence due to the crisis in July 2016 leading to disengagement of the consultant.

3.1.2. NVS future plans and priorities

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

The country planned to introduce new vaccines between 2017 and 2020. (draft cMYP)

- The proposed schedule for MCV2 and HPV (demonstration) in 2018, Rota and PCV in 2019. The country will work with partners to develop a comprehensive five year plan for measles and rubella elimination. This will include the implementation of measles follow up campaigns subsequent introduction of MCV2 and the eventual introduction of MR.
- Yellow fever to be introduced in late 2017 with target population of 452,649 under one children

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

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

The 1st HSS grant which was submitted in 2008 to be implemented for the period of 2 years 2009 and 2010 with the main goals of bringing about a tangible reduction in the maternal and child mortality and morbidity in South Sudan. This was to be undertaken by adopting a holistic approach for strengthening 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 both the County and sub-county level.

The current GAVI-HSS grant which was approved in 2013 with a cash support of 29.258 million USD to be implemented for a period of 5 years (2014 to 2018). However, due to multiple factors including the

current crisis, which was started in Dec. 2013, delayed the implementation of the new HSS. The country has developed a country tailored approach and begun implementing the grant by channelling through WHO and UNICEF for the first two years (2016 and 2017) amounting 12,387,935.00 USD. Accordingly, WHO ($ 6,960,465.00) and UNICEF ($ 5,427,470.00) (Grant SC150567) received their respective fund at the end of 2015 to start implementation of activities in the 1st quarter of 2016.

The strategic objectives of this grant are to:

-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

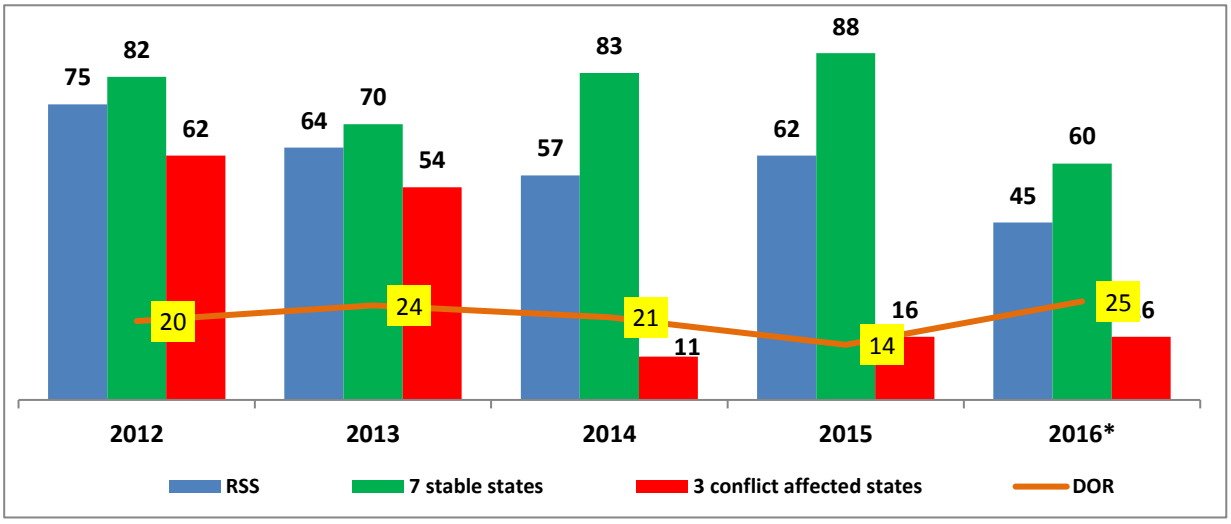
1.1.1. Grant performance and challenges

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

Immunization Coverage:

As of September 2016, the annualized Penta3 coverage of the country is only 45%, with 25% drop out rate of Penta1-Penta3. Only 11 of 80 former counties have recorded Penta3 coverage of ≥80% and 52/80 reported Penta3 coverage <50%. Even though completeness of reporting stands at 50% in September 2016, planned vaccination sessions have not been conducted for several reasons, including withdrawal of support by NGOs early 2016 due to the funding review and inability to roll out planned outreach in most states because of high inflation rates (>800%) after currency devaluation and worsened by the July 2016 crisis. The poor performance of routine immunization in 2016 is worsening the immunity gap of children for protection against vaccine preventable diseases. The graph below shows performance of routine immunization in South Sudan over the years between 2012 and 2016 in comparison with the conflict and non-conflict affected states.

Figure 3: Trend of Routine immunization coverage in South Sudan 2012-2016*



The Grant Performance Framework (GPF) for South Sudan was drafted in early 2016 but could not be finalized due to numerous issues that were identified by Gavi for redressal by the country. The pending issues included:

- Lack of definitions of the indicators

- Weak results chain and need for realignment with the revised work-plan
- Lack of baselines and targets for the indicators
- Lack of specifications of data sources and reporting schedule

In order to address the above issues and finalize the GPF, a sub-group of JA team discussed the issues in a workshop mode during the Joint Appraisal mission. The sub-group comprised of members from MOH, Gavi and in-country technical partners. As a first step the group agreed on a results chain aligned to the revised work-plan for the intermediate and process level results chain as shown in the table below.

Objectives	Intermediate result	Process result
Objective 1	- Development and update of micro plans (all health facilities have micro plans) - outreach operational costs (reduction in drop out) - Service delivery (percentage offering immunisation services through fixed sites) - Number of mobile teams	- Micro plans implemented - Proportion of positions filled (also relates to Objective 4) - Proportion of outreach completed
Objective 2	- Demand (Reduced Penta1 to 3 drop out drop out) - Knowledge and perception (community perception based on EPI coverage survey)	- Establishment of health unit management committee (number of units established and operational) - Megaphone as the source of information for immunization information (data source to be determined) - Number of quarterly sensitization meetings
Objective 3	- Functioning cold chain equipment (also related to supervision visits) - Functioning cold stores in the country	- Number of cold chain technicians trained - Cold chain equipment deployed
Objective 4	- Supervision conducted as planned - Timely reports from all facilities - Complete reports from all facilities	- Proportion of positions filled (also relates to Objective 4) - Number of supervision visits (from state and national) - Number of quarterly data quality reports available (WHO reports)

Based on the above results chain, the existing indicators in the draft GPF were reviewed and where-ever necessary, new tailored indicators were defined. After all the indicators were defined, data sources and reporting frequency and reporting schedules were finalized. Some of the information that was not finalized due to lack of readily available data included baselines and targets for some indicators. In order to complete the remaining work, individuals were identified to follow up and provide further details. It was agreed that the GPF will be finalized along with the JA report. During the discussion, it was pointed out that there was need for a fresh training on using the Gavi portal for reporting and setting up the GPF. It was therefore agreed that Gavi will organize refresher training for country and partners on using the Gavi portal.

The GPE is already finalized following the inputs from the JA mission which was conducted from 29th of Nov to 2nd of Dec 2016 and is submitted together with the final Joint Appraisal report.

HSS grant utilization

South Sudan received the Gavi-HSS grant towards the end of 2015 through WHO and UNICEF to implement year I and II activities amounting $ 12,387,935.00. Under the CTA grants to be managed by WHO and UNICEF for year 1 & 2 of the grant. (Earmarked fund to be channeled through MOH will be implemented through WHO by direct financial cooperation (DFC) account mechanism).

Proportion of grant utilized on HSS activities in the year 2016 is very low against the allocated amount, the table below presents the details of the grant utilization by respective partners.

Table 3:South Sudan Gavi-Hss Grant utilization in 2016

Partner	Budget granted for 2016	Budget granted for 2017	Total Budget for 2016 and 2017	Budget spent in 2016	Annual Utilization 2016 (%)
WHO	2,292,298	2,875,343	5,167,640	96,992	**4**
MOH-DFC	963,189	829,636	1,792,825		**-**
UNICEF	3,154,542	2,272,928	5,427,470	1,019,981	**32**

WHO only utilized US $ 96,992 out of US $ 3,255,486.71 allocated for year I (2016) the only expense goes to the three rounds of outreach activities implemented in the former seven stable states which was released before the July 2016 crisis.

UNICEF country office received a total US $5,427,469.45 for 2 years duration under the GAVI-HSS grant of which US $ 3,819,155.84 was allocated for cold chain systems strengthening and US $ 1,608,313.61 was allocated for communication activities. The expenditure reported in 2016 is US $1,019,981.43 with a balance of US $4,407,540.86.

Through the direct financial co-operation mechanism US $ 1,792,825 was allocated to Ministry through WHO, which was not disbursed by WHO to MOH due to DFC account issue explained in detail below.

Overall 36% of the grant was utilized in 2016 in the country.

The major challenges for low utilization of the grant:

The key challenges which delayed the implementation of HSS activities and grant utilization are presented below.

- During Q1 and Q2 of 2016, the country team was involved in multiple intense and high priority EPI related activities. These activities included IPV introduction, MenAfriVac campaign, SWITCH from tOPV to bOPV and two rounds of polio SIAs for the response to the cVDPV2 outbreak. The implementation of these activities did not allow the country team adequately to concentrate on implementing HSS activities.
- The July 2016 crisis and security situation thereafter brought the implementation to standstill. The service delivery affected after the July crisis.
    - Majority of partners scaled down during crisis.
        - 11/67 partners only confirmed presence immediately post July crisis;
        - Minimal critical staff;
        - Limited field presence;
        - Majority of INGOs evacuated, leaving national NGOs on their own
    - Reduction of functional/reporting health facilities after crisis;
    - Insecurity affected redeployment of critical staff for maternal and child health (MCH) services and mentoring of national staff (midwives)
    - In addition, areas that were accessible before the July 2016 crisis have become inaccessible after the crisis, limiting access and capability of service delivery.
- Ministry unable to receive grant from WHO: The process of finalizing the account for DFC (Direct financing co-operation) was disrupted by the July 2016 crisis; productive discussions are ongoing to revitalize this process. The major challenge has been on agreeing on the signatories to the GAVI -HSS account in the Ministry to ensure adequate checks and controls by the EPI directorate as per guidance/recommendation from previous GAVI audit and JA 2015 recommendations. This has now been resolved and now waiting for the account from MOH.

Discussions are ongoing with the core GAVI HSS implementation oversight team(MOH;UNICEF;WHO) on how to expedite implementation once DFC is done, as well as a secondary plan for HSS activities to be implemented through Direct Implementation(DI).

- Limited capacity of EPI staff at national, state and county level. The activities related to this could not be implemented due to DFC issues.
- Ongoing revision of fund managers (HPF and IMA): partners supported by them have not yet received their fund for this year to facilitate delivery of basic package of primary health care at the state and county level.
- Due to the changes in the government structure, with the division of the country into 28 States and creation of additional new counties, it has been challenging to implement some of the GAVI-HSS activities as planned. This has delayed implementation of some activities such as distribution of supplies (10 multi-purpose vehicles, bicycles and motorcycles) that have been already procured based on the former 10 states.
- Devaluation of the local currency resulted in high inflation and affects program operations.
- Continuous looting and vandalization of health resources and infrastructure: Vandalization of buildings and medical equipment in hospitals, clinics and warehouses, Looting of program vehicles, motorcycles, speed boats and ambulances, Vandalization and looting of generators and solar equipment for cold chain has affected the health service delivery.

The progress of HSS activities implementation:

Activities implemented from September 2015 to November 2016 include:

1. Microplanning: The county level micro plan was updated to enhance routine immunization service delivery through dry season outreach activities in 44 counties of the former seven stable states funds are ready for disbursement .
2. Despite the preparation for training of health facility level microplanning, the activities are not yet rolled out to states and counties mainly due to other competing priorities and delay of renewal of lead agencies at county level to support the EPI activities.
3. Provision of transport for immunization – bicycles:
   UNICEF procured 650 bicycles for the country. These have been received in-country and are awaiting distribution based on the approved distribution plan that will be provided by the Ministry of Health.
4. Provision of field operations motorcycle/quadbike:
   Seventy-five motorcycles have been procured and received in-country. Based on the initial plan in the proposal, these 75 motor-cycles were intended for 75 counties and 4 quadbikes were to be procured for selected hard-to-reach counties, based on the 2008 census where the country was administratively divided into 79 counties. However, the country has now created new counties. This has now proved a challenge in determining the distribution of the procured motorcycles. A tentative distribution list has been developed based on the previous counties and has been submitted to the Ministry of Health for approval.
5. Cold Chain Equipment Deployment:
   a. From January 2015 to October 2016, UNICEF South Sudan distributed 877 cold boxes, 6,544 vaccines carriers, 10,000 ice packs, 54 electric freezers, 59 electric Ice liners, 26 generators, and 188 solar fridges among them 144 have been installed. Due to the unpredictable security situation in South Sudan unfortunately 77 solar fridges, 25 electric fridge, 6 kerosene fridge and 7 generators were looted due to the flare up of the conflict. In addition to the distribution of the cold chain equipment as indicated above, 83 cold chain equipment across South Sudan have been assessed and repaired during the reporting period.
   b. In each of the locations visited by the cold chain technicians, the health workers have been briefed on the monitoring of temperature and cold chain management for improved vaccine efficacy. Three four days training sessions on cold chain and vaccine management were also conducted in Yei for participants from CES and EES; in Wau for participants from NBEG, WBEG and Warrap , in Rumbek for those from Lakes state and in Yambio for those from WES. A total of 114 health workers were trained.

6. Provision of multipurpose vehicle to support supervision, management of EPI services, distribution of supplies, integrated monitoring of health services delivery:
    a. UNICEF South Sudan has procured 11 vehicles under the GAVI-HSS grant. One for national level and 10 for State levels. The one for national level has been handed over to the MoH, but the 10 vehicles for state level have not yet been distributed. This is because, the 10 vehicles were previously planned for 10 States that were existing in the country based on the 2008 census. However, as of 2016, the country has created new States, bringing the total States to 28. This has created a challenge on decision making as to which State will receive the procured. A final decision is being awaited from the Ministry of Health on the distribution plan for the procured vehicles.
7. Supportive supervision and monitoring:
    Supportive supervision visits have also been implemented but supported by others grants. This has included visits for effective vaccine management monitoring, routine immunization, IPV introduction and Men A campaign.
8. Develop and implement a logistics management information system at all stores :
    Support has been provided towards achievement of this activity with provision of 4 desktops, 4 laptops, scanner and printer for the EPI Ministry of Health, as well as electrical installation costs and training costs. Standard Operating Procedures (SOP) for cold chain and vaccine management have been developed and printed. The next step is the training on the use and distribution.
9. Procurement of megaphones for community mobilization :
    Six hundred megaphones have been procured along with 6,000 batteries for the megaphones as support in implementation of communication for development (C4D) activities.
10. Technical Assistance:
    Salaries for three cold Chain technicians have been provided one employed by UNICEF and two by MOH. The cold chain advisor to support EPI MOH team has been recruited also and he is already on board. The grant has also been used to cover the cost of the travel of cold chain technician for installation, assessment and repair cold chain equipment and other technical assistance costs like vaccine store assistant at state level.
11. Progress on KAP survey and EPI coverage survey:
    Although no expenses have been incurred against these activities yet, the EPI coverage survey ToR was developed and signature ongoing while the KAP survey ToR were developed, signed, advertised and in selection process of the institution to conduct the survey when the July crisis occurs. The delay in improvement of security in addition to focus on emergency response has made both surveys to be postponed to next year 2017.

Acceleration of Implementation 2017

JA team decided that the implementation of pending activities of 2016 and planned activities of 2017 both to be implemented in 2017 in order to strengthen service delivery and prevent accumulation of susceptible leading to huge outbreaks. WHO and UNICEF looked into work-plan and discussed with JA team following points were put forward.

WHO Joint Appraisal feedback and way forward

- Funds allocated for 2016 and activities not implemented will be done in the first 2 quarters of 2017.
    - ✓ Health Facility level Microplanning
    - ✓ Mapping of catchment areas, migratory routes and needs assessment need to be done properly using bottom-up approach
    - ✓ Recruitment of vaccinators including the newly created 18 states needs to be moved to DFC.
- Guidance on how to operate within the 28 states
    - ✓ More HR and office assets required
    - ✓ Operational costs associated

- Recruitment of staff by MOH for year I was not done. MOH to decide to combine Year I and II recruitment in 2017.
- Challenges on Cash transfer to conflict affected states
  - ✓ No banking system in the former three conflict affected states and Physical cash transfer through individual staff is becoming risky
  - ✓ Due to local currency inflation the physical cash amount to be transferred via staff is also too bulky.
- Finalize the outstanding DFC issues with MOH and WHO

Unicef Joint Appraisal Feedback and Way Forward

Taking into account ongoing HSS supported activities and prevailing needs on ground, including transport and distribution costs, opportunity to integrate LMIS with EVM training, have reduced a few budget lines and increased others to accommodate needs of transportation and fuel for cold chain. (See updated budgeted UNICEF activity matrix in the annexes).

With regard to HR, UNICEF has added two staff in the C4D activity line up to support the implementation of communication related activities, knowing that in 2017 there is be high demand for RI and SIAs (polio, measles, Men A, and MNT). In addition, the realignment of budget lines will contribute to maintain five national health field officers positions who has full responsibility to support routine EPI and SIA activities, including EPI coordination at state level with support from the EPI manager. This brings the GAVI HR support to 5 staffs, already existing.

In 2017 and subsequent years, UNICEF will continue to advocate for additional funding to support staff costs.

- Budget for 2016 revised as per needs, including programmable funds from 2017 which is re-aligned from the line budgets
  - Provision for fuel for cold chain at national and state level ($400,000 supported from GAVI HSS activity budgeted for national & state vaccine store construction out of 2,400,000 required for 2017)
  - $80,000 to be programmed out of 1million need (2017) for transport of distribution of EPI supplies (budgeted from EVM assessment)
- KAP ToR to be revised for implementation in 2017
  - GAVI will be updated on the feasibility of the study in 2017 by Feb 2017
- Certain communication activities included in the WHO budget
  - Activity 4.6 – Inter Personal Communication training to be done by WHO, rather UNICEF skillset
- All activities pending for 2016 will be programmed based on priority along with 2017 activities
  - Performance management indicators will be monitored & reported from 2017
- Technical assistance for C4D will be supported from the program activities in the work- plan

Next steps for HSS

- Accelerate Implementation of activities
- Direct finance cooperation (DFC) account to be sorted out soon and start hiring national and state level HR for ministry.
- 10 -28 states issue: Need to develop guidance on how to operate within the 28 states a taking pragmatic approach with other donor resources
- Develop a distribution plan for Bicycles, Bikes and four wheelers and ensure programmatic use.

- Ensure Co-financing of approved CCEOP from HSS fund
- Reallocation of the grant across the objectives reviewed and approved by ICC to be submitted for HLRP.
- Revised Work-plan, budget and performance framework to be submitted with JA report
- Quarterly review of the progress in the implementation and changing security contexts of the country

Potential areas for additional Gavi support:

- **Support the expansion of state EPI units**
  - The US CDC presently supports 40 state level technical staff (national STOP team personnel, aka nSTOPers) to augment EPI state capacity in the following areas: immunization service delivery, VPD surveillance, immunization communication and advocacy and data management. With the recent Government of South Sudan (GoSS) decision to increase the number of states from 10 to 28, there is a resource gap to extend this model of support to the additional 18 states. The advantage of the model is that staffs are hired through government processes, receive Government salaries and work through the Integrated Disease Surveillance Reporting (IDSR) network for vaccine preventable disease surveillance matters.

    Budget considerations: Monthly salaries are approximately US$ 300 per month per technical officer (TO). The estimated annual cost is US$ 21,600 for 72 TOs (4 staff in each of the additional 18 states paid at the current salary of US$ 300 per month).
- **Strengthen vaccine preventable disease (VPD) surveillance**
  - ✓ There is an opportunity to leverage the extensive polio funded acute flaccid paralysis (AFP) community-based surveillance network and the US CDC-GoSS nSTOPers programme to strengthen the identification, reporting and immunization response to specific VPDs, i.e., measles, maternal and neonatal tetanus. For measles, this will include support for specimen collection training and materials for health center staff (county and Payam level), reimbursement for specimen shipment (when this cannot be piggy-backed on AFP stool specimen transport), and resources to the national measles reference laboratory to ensure availability of lab reagents and supplies. This investment would also provide the possibility to link with the proposed Boma Health Initiative.
  - ✓ Support to establish new vaccine disease surveillance for rotavirus and invasive bacterial diseases (Hib, meningococcal, pneumococcal) ahead of the introduction of new vaccines (i.e., pneumococcal conjugate and rotavirus vaccines). At minimum, one sentinel site should be established (likely in Juba) to provide baseline rates of disease.

    Budget considerations: [forthcoming]

- **Support for minimum elements of vaccine safety surveillance.**
  - ✓ Presently there is no AEFI surveillance in South Sudan; the country has not reported a single AEFI case in its JRF reporting during the past 15 years. Understanding the realities of the country as well as the multiple competing priorities, initial but limited key activities to establish minimum standards of adverse events following immunization (AEFI) surveillance can be envisioned. A draft AEFI Guidelines was developed in 1st quarter of 2016 with the inputs from WHO South East-IST. A roll out of the guidelines and relevant structures is necessary

    Budget considerations: [forthcoming but minimal]

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

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

To be agreed upon and decided by all partners (UNICEF, MoH and WHO)

1. **Revised Workplan and budget:** WHO and UNICEF with ICC approval the revised work plan, budget and activities for the 2017 to be submitted (annex C and D of Joint Appraisal report): Correspondingly Performance framework to be updated.
2. **Reallocation and No cost extension:** As the budget and activities were outlined for 2016 and 2017, Country have to implement Pending activities of 2016 as well as planned activities of 2017.The revised work plan and budget required for 2017 and no cost extension or realignment request and need to be sent to GAVI secretariat for HLRP approval.
3. Co-financing of approved CCEOP from HSS fund to be included in the UNICEF budget sheet.
4. Support activities of NITAG from HSS grant(realign activities and resources under objective 2)
5. Linking GAVI/HSS and nSTOP transition into MOH

3.2.3. Transition planning *(if relevant)*

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

NA

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

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

Cash Utilization performance and financial capacity constraints

Grant reference	Expiration date	Purpose	Amount programmable (USD)	Amount Spent	Balance
SC140165/ SC150017	31-12-16	RI	205,000.00	205,000.00	0.00
SC150016	31-3-16	GBP	393,000.00	393,000.00	0.00
SC150197	7/7/2016	IPV	157,200.93	157,200.93	0.00
SC150209	31-12-17	Men A	1,034,460.75	690,527.90	343,932.85
SC150567	28-9-17	HSS	5,427,469.00	1,019,929.00	4,407,540.00
SC160101	31-7-17	CTA	313,360.00	156,045.69	157,314.31
SC160470	31-03-17	Transition Plan	92,000.00	0.00	92,000.00
		TOTAL	**7,622,490.68**	**2,621,703.52**	**5,000,787.16**

There is the need for enormous improvement in the cash utilization and financial reporting systems in the country particularly within the Ministry of Health. Poor management of funds has partially contributed to the delay in the launching of the IPV introduction and slow utilization of funds for both the GAVI-IPV and GAVI-HSS grants.

Any major issues arising from Cash Program Audits or Monitoring Review

The last 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

3.2.5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL *[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]*

Prioritised strategic actions from previous joint appraisal / HLRP process	Current status
1. Establish a Logistics Working group involving all immunization partners to address the ISCM issues in the country (Starting Q1 2015, MoH and UNICEF)	Logistics working group in place and was instrumental in the tOPV to bOPV switch
2. Develop evidence based Social and behavioral change communication strategy for EPI including state specific plans (By the end of 2nd year HSS implementation, MoH and UNICEF)	Not yet achieved, target is by the end of 2nd year of HSS
3. Strengthen community engagement and mobilization to reach all children in hard to reach areas and for defaulter tracking (By the end of 2nd year HSS implementation, MoH and UNICEF)	Not yet achieved, target is by the end of 2nd year of HSS
4. Start implementing and monitoring of new HSS proposal.	Implementation commenced
5. Develop new cMYP for 2017 to 2022	cMYP has been drafted to be finalized in 2017
6. Complete the introduction of Pentavalent in all counties of the three conflict affected states	Achieved
7. Finalize preparation for tOPV to bOPV switch in April 2016	Done
8. Conduct EVM follow-up assessment of the Vaccine Supply Chain of SS	Target is by the end of 2nd year of HSS grant
9. Conducting "Temperature Monitoring Study' of the vaccine supply chain of SS	National level assessment done with support of Regional Office
10. Implementation of EVM improvement activities'	Ongoing

i. PRIORITISED COUNTRY NEEDS[1]

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

Prioritised needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?* *(yes/no)* If yes, indicate type of assistance needed
1. Enhance human resource capacity (including the staff of implementing partners/Fund managers) and numbers at all levels (including CC technician)	Jan to Dec. 2017	**Yes** Training on the innovation related installation and repair of solar refrigerators and cold rooms
2. Enhance financial management system and build capacity to enable proper fund managements at all levels	Jan to Dec 2017	
3. Develop evidence based Social and behavioral change communication strategy for EPI including state specific plans	Dec 2017	Yes. Two C4D staff needed to plan, implement and monitor indicated activities
4. Develop new cMYP for 2017 to 2020 and EPI/Surveillance review and PIE should be completed as planned	June 2017	Yes: one specialist in CMYP tool management and one Health economist
5. Implementation of EVM improvement activities'	January to December 2017	NO
6. Establishment of sentinel surveillance for Rota and PBM	Jan to Dec 2018	Yes
7. Strengthen the existing DHIS to meet the EPI data requirements	June to Dec 2017	Yes
8. Transition planning process	January - June 2017	Yes
9. Men A campaign	May 2017	No
10. Routine Immunization Equity analysis	June – July 2017	Yes

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

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

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

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	
Issues raised during debrief of joint appraisal findings to national coordination mechanism	• **Accountability framework**: There should be an accountability framework to all partners involved in this grant and supporting MOH. This accountability framework will help the ministry to know who is working what, when and where. • **Supervisory visit to states by high level officials:** During the reprograming of activities this should be considered to be held in quarterly basis. The supervisory team will comprise His Excellency or his delegate, the Rep's of WHO and UNICEF and Heads of other partners. • **Supporting the Boma Health Initiate (BHI):** If the Gavi-grant is flexible enough to engage the community based health interventions; BHI is an excellent plat form to reach the community in delivering the primary health service packages. Therefore, Gavi need to consider how to support BHI to improve the routine immunization coverage. • **Harmonization of activities of Gavi-HSS to the newly created 18 states:** The initial plan was to operate in the 10 states especially the procured assets (Vehicles, motor bikes and bicycles) based on the 10 states and 80 counties. • The long transition period between HPF1 and HPF2 resulted in weak link between fund managers and implementing partners. • Co-financing of the traditional vaccines; the financing issue is under discussion by Gavi board to exempt South Sudan in yearly bases considering the country situation.
Any additional comments from: • **Ministry of Health** • **Gavi Alliance partners** • **Gavi Senior Country Manager**	

3. ANNEXES

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

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

The initial plan for Joint appraisal process was in August 2016 however it was disrupted due to the July 2016 crisis erupted in Juba. Following extensive communication between MOH and the Gavi secretariat the final dates for the appraisal was decided to be 29th of Nov to 2nd of Dec 2016. Accordingly, preparation was started from 4th week of October by forming in country JA team following a desk review to finalize the draft JA report to be shared to the team before the appraisal started.

- Several teleconferences (Gavi, WHO, UNICEF) held on mission preparation and development of the preliminary report
- The preliminary joint appraisal report developed by the in country team and shared to external JA team for review and additional inputs.
- The external JA team composed of Gavi secretariat, WHO-AFRO-Regional office and UNICEF- HQ and ESARO joined the country team in Juba to provide technical assistance in the finalization of the Joint appraisal report. The appraisal was conducted from 29th of Nov to 2nd of Dec 2016 in Juba.
- The JA mission is concluded by debriefing of the ICC members on 2nd of Dec, 2016. The meeting was chaired by Hon. Minster of MOH, H.E Dr. Riek Gai Kok, and attended by Dr. Abdulmumini Usman, WHO Representative and Dr. Ketema Bizuneh, UNICEF Chief of Health. Summary of the findings and recommendations were presented during the debriefing session for discussion. The ICC members agreed to endorse the report after incorporating their input.
- The final JA report was endorsed by all members of the ICC

Joint Appraisal Teams
In Country Members

- Dr. Anthony Laku-MOH/South Sudan
- Dr. Sylvester Maleghemi- WHO/South Sudan
- Mr. Melisachew A. Ferede- WHO/South Sudan
- Dr. Bimpa Die-Donne- WHO/South Sudan
- Mr. Kofi Boateng- WHO/South Sudan
- Dr. Lydie Maoungou – UNICEF/South Sudan
- Mr. Gopinath Durairajan – UNICEF/South Sudan
- Mr. Motuma Abeshu – UNICEF/South Sudan
- Dr. Abdalla Elkasabany- BMGF/ South Sudan
- Dr. William Mbabazi- CDC/AFENET/South Sudan
- Mr. Oniba Opio- JSI/South Sudan

External Members

- Dr. Rehan Hafiz – Gavi Secretariat, Geneva
- Stephen Sosler – Gavi Secretariat. Geneva
- Dr. Raveesha R. Mugali – Gavi Secretariat, Geneva
- Binay Kumar, Gavi Secretariat, Geneva
- Dr. Daniel Fussum, WHO/IST/ESA, Harare
- Helena O'Malley, WHO-AFRO Regional office, Brazzaville
- Dr. Afework Assefa, UNICEF/ESARO, Nairobi
- Dr. Godwin Mindra, UNICEF/HQ, New York.

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

Changes proposed	Rationale for changes	Related cost (US$)	Source of funding for amended activities	Implementation agency	Expected result
NA					

Annex C: WHO/MOH budget revised for 2017

Implementation Agency WHO/MOH	South Sudan
Implementing Period 2016 to 2017	Work Plan for Year I and II(2016/17)

S.N	Activity name and description	Lead agency	Implementation Modality	Year I budget (2016)	Year II budget (2017)	Status of Implementation	Budget used in 2016	Balance remaining from Year I and II		Total budget to be Programmed 2017	New budget for 2017 (Year I and II combined)	Comment
								2016	2017			
Objective 1: To Scale up access to routine immunization services and address inequalities in coverage												
1.1	Develop and update micro plans for each county	WHO	DI	168,988.48	168,988.48	Ongoing	0.00	168,988.48	168,988.48	337,976.96	337,976.96	The existing county level micro plan was updated for non-conflict affected states as well as accessible areas in the conflict affected states. Budget was not utilized for this activity. The comprehensive HF level Micro-plan will be developed in the 1st quarter of 2017.
1.2	Mapping of catchment areas	WHO	DI	37,130.00	0	Ongoing	0.00	37,130.00	0.00	37,130.00	37,130.00	Mobile population and migration route mapping have been developed in Unity, Jonglei and UNL in the course of the cVDPV2 outbreak response. The complete mapping of catchment areas will be conducted together with micro planning development (1.1) in Q I
1.3	Needs assessment of health facility capacity gaps to provide routine immunisation services	WHO	DI	224,360.00	0	ongoing	0.00	224,360.00	0.00	224,360.00	224,360.00	Health facility assessment data tools was developed and shared with State teams in April during Polio SIAs. Data has been collected and are being summarized for submission by CES, EES, WES, NBG, Warrap, WBG and Lakes. To be completed in 2017 the rest of the states

1.4	Recruitment and training of vaccinators	WHO	DI	215,522.30	121,231.29	ongoing	0.00	215,522.30	121,231.29	336,753.59	336,753.59	HR template to map all EPI Staff in South Sudan with the corresponding status of appointment have been shared with states since March 2016 to enable identify specific gaps for recruitment on permanent basis. However, temporary recruits have been captured in the current outreach budget covering the year but phased per quarter for review. Due to additional 18 states there will be more vaccinators to be recruited in 2017
1.5	Orientation of health workers on integration of immunization in basic health services	WHO	DI	79,000.00	79,000.00	not done	0.00	79,000.00	79,000.00	158,000.00	158,000.00	To be implemented upon completion of activity 1.11
1.6	Develop and update health facility specific micro plans	WHO	DI	80,000.00	40,000.00	not done	0.00	80,000.00	40,000.00	120,000.00	120,000.00	To be done during micro-plan development considering the newly added states
1.7	Provide child registers and institutionalize drop out tracking	WHO	DI	100,000.00	0	Ongoing	0.00	100,000.00	0.00	100,000.00	100,000.00	All child health registers, tally sheets, summary sheets, child health cards revised and approved by MoH to be printed. It is in the procurement process. Printing can be done in bulk for both year I and II together.
1.8	Provide funding for outreaches and operational costs	WHO	DI	185,550.86	185,550.86	Ongoing	96,992 .00	88,558.86	185,550.86	274,109.72	371,101.72	First batch of funds for outreach activities were released for three months in August 2016. The remaining fund for year I will be combined with Y II and implemented after the micro plan development
1.10	Mapping of migratory routes and settlements	WHO	DI	20,000.00	20,000.00	Ongoing	0.00	20,000.00	20,000.00	40,000.00	40,000.00	Only done for the conflict affected states during the cVDPV2 outbreak response.
1.11	Define the package of services to be integrated with immunisation services	WHO	DI	0.00	29,983.00	Planned for 2017	0.00	0.00	29,983.00	29,983.00	29,983.00	To be implemented in 2017

1.12	Identify and train volunteer community health workers to service as mobile teams	WHO	DI	22,000.00	22,000.00	not done	0.00	22,000.00	22,000.00	44,000.00	44,000.00	To be implemented in 2017. More volunteers to be trained in line with additional 18 states
1.13	Provision of operational funds to support implementation of mobile integrated immunisation sessions	WHO	DI	118,217.62	118,217.62	Ongoing	0.00	118,217.62	118,217.62	236,435.24	236,435.24	Currently, the updated county based micro plans captures mobile populations with corresponding budgets and it was sent along with outreach funds.
1.14	Supervision of Voluntary Community health workers	WHO	DFC to MOH	121,901.25	121,901.25	not done	0.00	121,901.25	121,901.25	243,802.50	243,802.50	The process of finalizing the account for DFC is ongoing
Objective 2: To Improve demand for Immunization Services												
2.4	Establish and support health unit management committee's oversee immunization services	WHO	DFC to MOH	252,508.75	126,254.37	not done	0.00	252,508.75	126,254.37	378,763.12	378,763.12	1st quarter of 2017 will be the establishment of the committee
2.7	Sensitize broadcasters, reporter and media managers on EPI communication and advocacy	WHO	DFC to MOH	23,000.00	23,000.00	not done	0.00	23,000.00	23,000.00	46,000.00	46,000.00	To be started once the DFC issue addressed
2.9	Revitalize inter-ministerial committee on immunization and support quarterly meetings	WHO	DFC to MOH	4,000.00	4,000.00	not done	0.00	4,000.00	4,000.00	8,000.00	8,000.00	To be started once the DFC issue addressed
2.10	Sensitize National and State legislative assemblies	WHO	DFC to MOH	33,000.00	33,000.00	not done	0.00	33,000.00	33,000.00	66,000.00	66,000.00	To be started once the DFC issue addressed
2.11	Conduct annual high level advocacy event-launch of immunization week by president/minister of health	WHO	DFC to MOH	67,750.28	67,750.28	not done	0.00	67,750.28	67,750.28	135,500.56	135,500.56	To be started once the DFC issue addressed
2.12	Establish Governors committee on EPI & conduct biannual meetings and advocacy events at State level	WHO	DFC to MOH	97,750.27	97,750.27	not done	0.00	97,750.27	97,750.27	195,500.54	195,500.54	To be started once the DFC issue addressed
2.13	Develop advocacy messages/briefs for governors & league of tables	WHO	DFC to MOH	20,000.00	20,000.00	not done	0.00	20,000.00	20,000.00	40,000.00	40,000.00	To be started once the DFC issue addressed
Objective 3: To strengthen the capacity of the Ministry of Health for Cold Chain and Vaccine management												
3.15	Support implementation of safe injection practices	WHO	DFC to MOH	60,747.66	25,186.92	not done	0.00	60,747.66	25,186.92	85,934.58	85,934.58	To be started once the DFC issue addressed

3.16	Establish injection safety task force	WHO	DFC to MOH	0	28,261.68	not done	0.00	0.00	28,261.68	28,261.68	28,261.68	To be started once the DFC issue addressed
Objective 4: To Strengthen the capacity of the Ministry of Health to provide stewardship												
4.1	Recruit & fill all and 50% of vacant posts at national and state level respectively.	WHO	DFC to MOH	233,476.69	233,476.69	not done	0.00	233,476.69	233,476.69	466,953.38	466,953.38	The MoH to confirm the year II recruitment, as recruitment was not done for Year I
4.2	Support short and long courses	WHO	DI	80,747.66	0	Planned for 2017	0.00	80,747.66	0.00	80,747.66	80,747.66	Not due,till recruitment has been done
4.3	Conduct MLM training for EPI managers	WHO	DI	0	272,523.36	Planned for 2017	0.00	0.00	272,523.36	272,523.36	272,523.36	Planned for Year II
4.4	Include EPI in HTI curriculum	WHO	DI	0	23,916.45	Planned for 2017	0.00	0.00	23,916.45	23,916.45	23,916.45	Planned for Year II
4.5	Train HTI tutors in EPI	WHO	DI	0	45,420.56	Planned for 2017	0.00	0.00	45,420.56	45,420.56	45,420.56	Planned for Year II
4.6	Train health workers in interpersonal communication skills	WHO	DI	0	190,849.83	Planned for 2017	0.00	0.00	190,849.83	190,849.83	190,849.83	Planned for Year II
4.7	Conduct immunisation in practice training for vaccinators & Health Workers	WHO	DI	0	104,807.47	Planned for 2017	0.00	0.00	104,807.47	104,807.47	104,807.47	Planned for Year II
4.8	Review ,disseminate & promote use of EPI Policy ,guidelines ,supervision check lists	WHO	DI	102,198.99	0	not done	0.00	102,198.99	0.00	102,198.99	102,198.99	EPI policy review planned after the comprehensive EPI Review
4.9	Conduct quarterly supervision/monitoring visits & coordination meetings	WHO	DI	140,805.00	140,805.00	Ongoing	0.00	140,805.00	140,805.00	281,610.00	281,610.00	Held 2 Stakeholders discussions that suspended an initial draft pending considerations from recommendations of the EPI Review after September 2016 With additional 18 states the funds will be used for review meeting
4.11	Conduct County health management team trainings	WHO	DI	0	118,284.76	Not due	0.00	0.00	118,284.76	118,284.76	118,284.76	
4.12	Provision of EPI data collection tools for additional facilities to be operationalized with grant	WHO	DI	140,805.00	140,805.00	not done	0.00	140,805.00	140,805.00	281,610.00	281,610.00	Can be used by printing more tools
4.13	Training and mentoring on data analysis and use	WHO	DI	0	196,676.04	Not due	0.00	0.00	196,676.04	196,676.04	196,676.04	
4.14	Provision of ICT equipment for	WHO	DI	68,130.84	0	not done	0.00	68,130.84	0.00	68,130.84	68,130.84	

	data analysis											
4.15	Conduct quarterly data quality assessments	WHO	DI	140,805.00	140,805.00	not done	0.00	140,805.00	140,805.00	281,610.00	281,610.00	Discussion with MoH to commence
4.16	Support Joint Health Sector Annual Review	WHO	DI	116,580.70	116,580.70	Not due	0.00	116,580.70	116,580.70	233,161.40	233,161.40	This will be done with the health summits in Feb 2017
4.17	Produce annual performance report	WHO	DI	68,384.82	68,384.82	Not due	0.00	68,384.82	68,384.82	136,769.64	136,769.64	Year I report to be prepared in Feb 2017 and for year II the report will be in 2018
4.19	Conduct 2 SARAs (Service Availability and readiness assessment)	WHO	DI	0	197,024.30	Planned for 2017	0.00	0.00	197,024.30	197,024.30	197,024.30	
4.20	Develop financial sustainability plan	WHO	DI	0	49,457.94	Planned for 2017	0.00	0.00	49,457.94	49,457.94	49,457.94	
4.21	Lobby for EPI allocations during budgeting process	WHO	DFC to MOH	3,633.64	3,633.64	not done	0.00	3,633.64	3,633.64	7,267.28	7,267.28	To be started once the DFC issue addressed
4.23	Improve public financial management	WHO	DFC to MOH	45,420.56	45,420.56	not done	0.00	45,420.56	45,420.56	90,841.12	90,841.12	To be started once the DFC issue addressed
Objective 5: Strengthen support for program management												
5.2	Contribute to the deployment of long term HSS advisor	WHO	DI	132,603.05	132,603.05	not done	0.00	132,603.05	132,603.05	265,206.10	265,206.10	Two NPOs being recruited in lieu
5.3	Conduct annual audits	WHO	DI	50,467.29	50,467.29	Not due	0.00	50,467.29	50,467.29	100,934.58	100,934.58	
5.4	Conduct a mid-term and end of term grant evaluation	WHO	DI	0	100,959.96	Planned for 2017	0.00	0.00	100,959.96	100,959.96	100,959.96	
	Sub Total Program-WHO	**WHO**		**3,255,486.71**	**3,704,978.44**		**96,992.00**	**3,158,494.71**	**3,704,978.44**	**6,863,473.15**		
	Program support cost (7%)	**WHO**		**227,884.07**	**259,348.49**							
	Total WHO			**3,483,370.78**	**3,964,326.93**							

Annex D: UNICEF/MOH budget revised for 2017

Title/Project Purpose: **Health Systems Strengthening (HSS)**
Type of Funding: Regular Funding
Gross Grant Amount: US $ 5,861,667.00
Total Programmable: US $ 5,427,469.45
Cross sectoral: US $ 1,608,313.61

Start Date	Expiry Date	1st Report Date	Final Report Date
	28.09.2017	31.12.2015	31.12.2017

	ACTIVITY	Year1-2	Year 1	Implementation	Funds consumed	Balance Year 1	Year 2	Balance Y1 + Y 2	Realigned amount Year 2	COMMENTS
2.1	Support quarterly sensitization meetings of boma chiefs, VHC, TBA, HHP, religious leaders	UNICEF	166,367.00	Start implementation	13,206	153,161	166,367.00	319,528.39	319,528.39	Will be completely utilized in 2017
2.2	Develop joint plans with and support civil society conduct community mobilization for immunization	UNICEF	0.00	Start implementation and later guided by KAP guidance	0.00	0	348,764.47	348,764.47	348,764.47	Will be completely utilized in 2017
2.3	Provide mega phones for community mobilization	UNICEF	152,664.06	600 megaphones 6000 batteries procured	45,750	106,914	0	106,914.06	106,914.06	Will be completely utilized in 2017
2.5	Conduct a KAP study	UNICEF	289,288.12	ToR developed, advertised, applications received, Selection of firm was in process when July crisis happened.	0.00	289,288	0.00	289,288.12	289,288.12	To be implemented in 2017
2.6	Develop and disseminate relevant media messages for print & electronic media including IEC materials	UNICEF	0.00	Y2	0.00	0	289,283.12	289,283.12	289,283.12	Will be completely utilized in 2017
2.8	Support civil society, drama groups, youth groups mobilize	UNICEF	0.00	Y2	0.00	0	195,579.64	195,579.64	195,579.64	Will be completely utilized in 2017

	for immunization									
	SUB TOTAL C4D		**608,319.18**		**58,955.61**	**549,364**	**999,994.23**	**1,549,357.80**	**1,549,357.80**	
1.9	Provision of transport for immunization-bicycles	UNICEF	80,000.00	650 bicycles procured (520 gents, 130 ladies), UNICEF waiting for the distribution plan from MOH for dispatching	73,824.28	6,176	0	6,176	6,176	To be used for assembling bicycle
3.7	Provision of field operations motorcycle/quadbike	UNICEF	238,438.12	75 motorcycles procured waiting for the distribution plan from MOH for dispatching	170,725.12	67,713	0	67,713	67,713	To be used for assembling bicycle and motorcycle
4.1	Provision of multipurpose vehicle to support supervision, management of EPI services, integrated monitoring and reporting of health services	UNICEF	482,716.24	11 Toyota pick-ups procured; Written sign already done, waiting for decision on distribution form MOH for dispatching	427,250.66	55,466	0	55,466	55,466	To be used for transport cost of dispatching bicycle and motorcycle to states and counties
	SUB TOTAL Travel means		**801,154.36**		**671,800.06**	129,354	**0**	**129,354**	**129,354**	
3.1	Recruit and deploy cold chain technicians at State level	UNICEF	115,515.25	4/10 cold chain technicians recruited & SMoH cold chain supports provided	34,929.35	80,586	115,515.25	196,101.15	100,000.00	Will be completely utilized in 2017
3.2	Develop and implement a logistics management information system (LMIS) at all stores	UNICEF	45,000.00	Participation to induction meetings	0.00	45,000	45,000.00	90,000.00	70,000.00	Will be completely utilized in 2017
3.3	Train cold chain technicians and facility staff on LMIS	UNICEF	170,669.06	Not done , participation to induction workshop on LMIS	7,551.50	163,118	85,334.53	248,452.09	50,000.00	Wiil be integrated to EVM training
3.4	Provision of tool kits for cold chain maintenance	UNICEF	30,000.00	Tool kits ordered	48,999.04	-18,999	0	-18,999.04	0	waiting for reception in country

3.5	Provision of LMIS materials/registers/tools/vaccine & injection control books/SOPs/specifications	UNICEF	234,669.06	Ongoing: LMIS tools (7 laptops, 2 printers, 1 scanner, 2 monitors & accessories). SOP printing ongoing	71,985.00	162,684	0	162,684.06	50,000.00	Will be completely utilized in 2017
3.6	Develop and implement cold chain maintenance plan	UNICEF	45,000.00	Ongoing	24,371.10	20,629	0	20,628.90	20,629	underfunded additional funding requested in other proposals
3.8	Procurement and deployment of cold chain equipment	UNICEF	236,563.12	first phase of co-financing	0.00	236,563	0	236,563.12	236,563.12	Will be completely utilized in 2017
3.9	Procurement and installation of power sources: generators and solar equipment	UNICEF	86,786.44	first phase of co-financing	0.00	86,786	0	86,786.44	86,786.44	Will be completely utilized in 2017
3.10	Construction and rehabilitation of a national and 3 Regional Vaccine cold stores/warehouses/cold rooms	UNICEF	258,108.60	Not done	54,997.31	203,111	139,808.82	342,920.11	172,920.11	Will be completely utilized in 2017
3.11	Construction and rehabilitation of 3 State level vaccine cold stores/warehouses/cold rooms	UNICEF	-	Ongoing : Rehabilitation of Cold Chain Hubs Malakal and Rumbek	0	0	144,961.78	144,961.78	100,000.00	Will be completely utilized in 2017
	Contribute to provision of fuel for cold chain at national and state level	UNICEF	0	0	0	0	0.00	0.00	400,000.00	New
3.12	Procurement and maintenance of vaccine and cold chain logistics delivery trucks	UNICEF	150,000.00	first phase of co-financing	0.00	150,000	0	150,000.00	150,000.00	Will be completely utilized in 2017
3.13	Conduct cold chain inventory	UNICEF	30,000.00	Not done	0.00	30,000	15,000.00	45,000.00	45,000.00	requested extra funds in TCA
5.1	Contribute to the deployment of long term EPI/Cold chain advisor	UNICEF	96,027.62	Not done	46,340.03	49,688	96,027.62	145,715.21	145,715.21	Will be completely utilized in 2017
	Contribute to the deployment of long term 5 Health Field Officer NOB	UNICEF	0.00	0.00	0.00	0	0.00	0.00	361,557.60	New
	SUB TOTAL COLD CHAIN		**1,498,339.15**		**289,173.33**	1,209,166	**641,648.00**	**1,850,813.82**	**1,989,171.38**	

3.14	Train Staff on EVM and effective vaccine stock management	UNICEF	55,609.53	Ongoing: Done in Yambio (22 participants),	0.00	55,610	55,609.53	111,219.06	111,219.06	Will be completely utilized in 2017
3.17	Support supervision and monitoring of EVM practices	UNICEF	122,109.25	Ongoing	0.00	122,109	122,109.25	244,218.50	150,000.00	Will be completely utilized in 2017
3.18	Develop and implement monthly vaccine delivery/transportation system	UNICEF	30,000.00	Ongoing	0.00	30,000	0	30,000.00	80,000.00	underfunded have been increased
3.19	Conduct annual EVM assessment	UNICEF	0	Y2	0	0	194,139.06	194,139.06	100,000.00	Will be completely utilized in 2017
	SUB TOTAL EVM		**207,718.78**		**0.00**	207,719	**371,857.84**	**579,576.62**	**441,219.06**	
4.18	Conduct 1 EPI coverage survey	UNICEF	298,438.12	TOR developed, advertised when July crisis happened.	0.00	298,438	0.00	298,438.12	298,438.12	Will be completely utilized in 2017
	SUB TOTAL OTHERS		**298,438.12**		**0.00**	298,438	**0.00**	**298,438.12**	**298,438.12**	
	Program support cost - UNICEF (8%)		**252,363.38**				**181,834.21**			
	Grand Total		**3,406,905.59**				**2,454,761.86**	**4,407,540.66**	**4,407,540.66**	**0.00**