Application Form for: Government of Southern Sudan

GAVI Alliance Health System Strengthening (HSS) Applications

March 2008 (re-submitted in August 2008)

An electronic version of this document is available on the GAVI Alliance website (www.gavialliance.org) and provided on CD. Email submissions are highly recommended, including scanned documents containing the required signatures. Please send the completed application to:

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Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline. Proposals received after that date will not be taken into consideration for that review round. GAVI will not be responsible for delays or non-delivery of proposals by courier services.

All documents and attachments should be in English or French. All required information should be included in this application form. No separate proposal documents will be accepted by the GAVI Secretariat. The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents may be shared with the GAVI Alliance partners, collaborators and the general public.

Please direct all enquiries to:
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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
APR	Annual Progress Report
ARI	Acute Respiratory Infections
BDN	Basic Development Needs initiative
BPHS	Basic Package of Health Services
CBA	Child Bearing Age women
CCM	Country Coordinating Mechanism for GFATM
CHW	Community Health Worker
CMOH	Central Ministry of Health
cMYP	Comprehensive Multi-Year National Immunization Plan
CO	Clinical Officer
CPA	Comprehensive Peace Agreement
CSO	Civil Society Organization
DC	Drafting Committee
DG	Director General
DOTS	Directly Observed Treatment Short Course for Tuberculosis
DPT	Diphtheria, Pertussis and Tetanus
EC	European Commission
EmONC	Emergency Obstetrics and Neonatal Care
EMRO	WHO East Mediterranean Regional office
EPI	Expanded Programme on Immunization
EPI/ICC	EPI Inter-Agency Coordinating Committee
GAVI	Global Alliance for Vaccines and Immunization
GAVI/HSS	Global Alliance for Vaccines and Immunization / Health Systems Strengthening
GAVI/ISS	Global Alliance for Vaccines and Immunization / Immunization Services Support
GDF	Global Drug Facility
GFATM	Global Fund to fight against AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
GNI	Gross National Income
GNP	Gross National Product
GoSS	Government of Southern Sudan
GoSSHA	Government of Southern Sudan Health Assembly
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HRD	Human Resource Development
HSCC	Health Sector Coordination Committee
HSS	Health Systems Strengthening
ICC - EPI	Inter-Agency Coordination Committee for EPI
IEC	Information, Education and Counseling
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ITNs	Insecticide Treated Bed Nets
JICA	Japanese International Cooperation Agency
JSI	John Snow Institute
LLINs	Long Lasting Insecticide Treated Nets
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MDTF	Multi Donor Trust Fund
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MoF	Ministry of Finance
MoH	Ministry of Health
OLS	Operation Lifeline Sudan
OR	Operational Research
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
RBM	Roll Back Malaria strategy
SHHS	Sudan Household Survey
SA	Situational analysis
SIA	Supplementary Immunization Activity
SMART	Specific, Measurable, Achievable, Reliable and Time-bound
SMoH	State Ministry of Health
SPLM/A	Sudan People's Liberation Movement/Army
SWOT	Strengths, Weaknesses, Opportunities and Threats
TA	Technical Assistance
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TNA	Training Needs Assessment
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nation Population Fund
UNICEF	United Nations Children’s Fund
US$	United States Dollar(s)
USAID	United States Agency for International Development
USD	United States Dollar(s)
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

Background: Southern Sudan, having an area of about 800,000 sq kms occupies a highly unique, incomparable and unenviable position in the comity of nations, having a nascent government born out of more than two decades of intensive civil strife, and general discontent with violent episodes dating back to half a century. The relative state of peace emerging in January 2005 has enabled Southern Sudan to embark on developmental activities, despite daunting challenges. The population estimated at around 12.5 million has an enormous proportion of poverty (est. 90%), and most of its social and demographic indicators are understandably amongst the poorest in the world. The Ministry of Health is actively engaged in reducing an unacceptably high infant mortality rate (IMR), the highest maternal mortality ratio (MMR) in the world, and rampant communicable and neglected diseases; while providing technical guidance to all the ten state ministries of health.

Health Situation / Barriers To Health Care: The ravages of the long civil war have eroded all the social sector and economic institutions, and destroyed the entire health infrastructure in Southern Sudan, necessitating its reconstruction on a priority basis. In the absence of governmental health structures to cover for the most part of Southern Sudan, health care delivery, including preventive programs such as EPI, has been largely left to the CSOs, whose services are limited to certain specific and mostly urban areas, and the few functional health facilities available provide highly insufficient access to the bulk of the rural population. Lack of regulation or proper MoUs with the CSOs often results in lack of reporting to the central or state governments. The almost total lack of a trained workforce for health with exclusive reliance on expatriates for 'quick fixes' though inevitable is also negatively impacting the health status of the Southern Sudanese population. Clearly identified targets are lacking at all levels making monitoring program progress almost impossible. EPI services being virtually non-existent in 60% of the country, most routine immunization services provided on an ad hoc basis, absence of functioning health facilities, challenges in maintaining the cold chain, high wastage of vaccines, inadequate administrative personnel and health staff at all levels, insufficient logistics and transport, inadequate funding at all levels, security concerns and harsh weather conditions, are some of the main barriers for immunization, maternal and child health. These factors combine to make it imperative for the Ministry of Health to tap every available opportunity in order to strengthen its health system at all levels and assign a very high priority to this over-arching activity, which makes all other intervention subservient.

Existing Health Infrastructure: Health Services are organized in a three-tiered system including 576 Primary Health Care Units (PHCU) staffed by community health care workers (CHWs) and Traditional Birth Attendants (TBAs); 157 Primary Health Care Centers (PHCC) staffed by medical assistants, and 51 Hospitals / Specialized institutions staffed by doctors, clinical officer (CO), nurse, midwife, maternal health care worker, health care worker and TBAs, providing both preventive and curative care. Seventy per cent of these facilities are organized by CSOs. Revise the numbers of the health facilities, as necessary to remove inconsistencies

Policy Development: In this grim scenario, the Ministry of Health, Government of South Sudan (MoH-SS) has gone about addressing health issues with remarkable commitment, alacrity and technical expertise, resulting in considerable progress over the last two years. The National Health Policy announced in 2006, regards Health Systems Strengthening (HSS) at all levels as one of the five critical cornerstones for bringing about a massive turnaround in the health situation of South Sudan. Towards this end, the MoH-SS has gone about building partnerships for health with elected representatives, UN agencies, donor agencies, international and national CSOs and other civil society organizations. The pragmatic policy has been backed up by an interim Health Strategy, envisaging a Basic Package of Health Services (BPHS) ensuring a minimum level of quality, access and affordability, particularly to the most marginalized segments of the population. A Maternal, Neonatal and Reproductive Health Strategy for Southern Sudan is also on the anvil.

Overcoming Barriers to Health Care: In addition to substantial governmental health spending, which is vital for the overall economic development, the government intends to implement a Basic Package of Health Services in a standardized and equitable manner using uniform staffing patterns and essential drug lists, and provision of adequate human resources for health particularly female paramedics or outreach workers. A workable system for monitoring and supervision of health facilities will be put in place initially at the Central and State levels and ultimately at the County level, while community participation in health issues will be fostered. Despite a critical shortage of data and considerable variation amongst the states, the average routine EPI coverage for Southern Sudan has been estimated at below 20%. A comprehensive multi-year plan (cMYP) for immunization was therefore designed envisaging establishment of massive infrastructure to significantly improve the routine immunization coverage in Southern Sudan, with high capital costs.

Barriers to be addressed through GAVI-HSS: Preventive programs for women and children cannot, however, deliver any tangible results in the absence of a relatively robust health system. The current application for GAVI-HSS support therefore focuses on acting as a catalyst for building a sustainable workforce at the central and state levels, enhancing the planning and managerial capacity of governments, and establishing a proper system for logistic supply and management of drugs, vaccines and other consumables to increase the access of the population to these vital commodities resultantly increasing the facilities to mothers and children including immunization, which is the most cost-effective investment in health, and absolutely essential for attaining the MDGs. The application, which envisions systematic and logical progress towards achieving the goals and targets set in the Health Policy of the Government of Southern Sudan, and its accompanying interim Health Strategy, is the result of a highly inclusive and participatory approach involving all stakeholders, totally aligned and harmonized with the country's own homegrown policies and addressing identified gaps not likely to be addressed through direct government spending or other funding sources.

Main Focus of the Application: The application puts together innovative approaches to be applied according to local situations, fosters enhanced involvement of communities in decision making on health issues, encourages operational research, is based on SMART (specific, measurable, achievable, relevant and time-bound) targets using cost-effective strategies. Somewhat high initial, one time capital costs but low recurrent costs/overheads allow for better sustainability of the proposed interventions and are expected to lay a solid foundation for a viable health system to emerge over a given period of time on a sustainable basis. The critical interventions such as creating a sizable workforce for health and capacity building are proposed to be carried out on a war footing, as warranted by the situation on the ground, in this highly fragile state. The logical framework of the proposal is virtually similar to the model adopted for health system strengthening in countries with similar situations such as Afghanistan. The strategies to be adopted are, however, tailor-made for addressing the institutional and programmatic barriers that are not being taken up by any governmental or donor funding mechanism in Southern Sudan.

The GAVI-HSS support requested is mainly for three objectives namely improved access to quality health care delivery particularly by women and children, strengthening the frail workforce for health and putting in place good governance practices, amounting to US$ 5.335 million over a period of two years from 2009 to 2010. Subsequently US$ 8.613 million will be requested for the next three years 2011-2013. This will provide the necessary complementarities and support to the Comprehensive Multi-Year Plan (cMYP), polio eradication effort and mass measles campaign being taken up concurrently and enable the achievement of its targets on a sustainable basis. The main objectives of the application are to, 1. Improve health care service delivery particularly to vulnerable population segments, 2. strengthen the fragmented health workforce for ensuring better health outcomes, and 3. to ensure better governance, policies and mechanisms for Health Financing at Central and State levels.

Main Activities: The main activities envisaged in the plan include:

Technical Assistance: In addition to long term TA spread over 2 years for all aspects of HSS particularly for the County level, short term TA of 3 months duration will be sought for carrying out a situational analysis, training needs assessment, inventory of health financing, streamlining logistics, HIS, sustainability and regulation of private sector

Infrastructure: Renovation and provision of furniture/equipment to all hospitals, specialized institutions, PHCCs and PHCUs; provision of 79 small warehouses at the county level for proper storage of logistics and vaccines; 178 motorcycles and 1,164 bicycles will be distributed amongst county staff/CSOs and CHWs respectively; buffer stock of HIS tools will be printed for provision at all levels, and office equipment will be provided at central, state and county levels

Capacity Building: On job capacity building for 225 doctors, 443 medical assistants, 272 laboratory personnel, 1,144 CHWs, 20 community support officers to enable proper delivery of quality health care services, training in health financing/management will be provided to key MoH, SMoH and county officers

Social Mobilization for Health: Hiring of 10 social mobilizers (1 for each state) for demand creation in health. This activity will be incremental to the IEC campaign already launched by the government

Research: Operational Research will be carried during the first two years on community participation, gender empowerment and other service delivery issues. Subsequently community-based initiatives will be launched in Southern Sudan based on the evidence generated.

Effective **program management, monitoring, supervision, and evaluation** will be ensured

Major Outputs Expected through GAVI-HSS: Indicator	**Data Source**	**Baseline 2006**	**Source**	**Targets -2010**
1. DPT3 coverage (%)	SHHS	20%	EPI/MoH	45%
2. Counties achieving ≥80% DPT-3 coverage		Not available	EPI/MoH	10%
3. % children 6-59 months received vitamin-A supplementation within last 6 months	SHHS	40%	EPI/MoH	60%
4. % deliveries attended by skilled personnel	SHHS	10%	SMoH/CMoH	30%
5. Antenatal care by skilled personnel	SHHS	26%	SMoH/CMoH	33%
6. Under-5 Mortality Rate	SHHS	135/1000	CMoH	130/1000
7. Use of Oral Rehydration Therapy	SHHS	64%	CMoH	70%

All GAVI-HSS activities will be carried out through the oversight of the HSCC, under the guidance and supervision of the Under Secretary and the Director General for Planning, Research and Health System Development, Ministry of Health, Government of Southern Sudan. The Government of Southern Sudan and all its development partners are highly appreciative of the support already received from GAVI under the ISS window, and look forward to the over-arching support to its health system through GAVI-HSS window, paving the way for effective health service delivery and implementation of priority programs, particularly benefiting women and children. **The application was originally submitted to GAVI in March 2008 and is being re-submitted in light of the IRC recommendations after its approval by the HSCC.**

Funds requested for two years (2009-2010): US$ 5.335 million

Section 1: Application Development Process

1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent): Health Sector Coordination Committee

HSCC operational since: April 2007

The Health Sector Coordination Committee has been constituted by the Government of Southern Sudan specifically in April 2007, in order to provide guidance in all matters pertaining to health systems strengthening, and monitoring all external assistance in this regard. This committee comprises of representatives of all stakeholders in the area of primary health care including communicable disease control, under the guidance of the Director General, Research, Planning and Health System Development. The committee has met on several occasions, and spearheaded the development process of this application for GAVI/HSS support and fostered a highly inclusive and participatory approach concerning this matter. Certain other high-level forums in the Health Sector include the Inter-Agency Coordination Committee (ICC) for EPI, while the Country Coordinating Mechanism (CCM) deliberates on all issues relating to the Global Fund to fight Against HIV/AIDS, Malaria and Tuberculosis (GFATM).

Organizational structure (e.g., sub-committee, stand-alone):

The HSCC is a stand alone committee with the primary objective of deliberating on all issues of technical cooperation, resource mobilization, efficient program implementation, and ensuring transparency and accountability within the Ministry of Health, and overseeing the process for the development of GAVI/HSS proposal. Some of its sub-committees include a Technical Working Group (TWG) and a Drafting Committee (DC) which meet more frequently. The Drafting Committee met for over two weeks virtually on a day to basis and included representatives from MoH, WHO, UNICEF, USAID, JSI, and representatives of CSOs. This mechanism was highly successful in developing a need-based, focused and technically sound proposal.

Frequency of meetings:

Several HSCC and TWG meetings were held averagely on a monthly basis, the minutes of which are attached at Annex-1. The members of the NHSCC meet with the WHO-GAVI Joint Mission from 21-24 November 2007, during which the important parameters of the GAVI-HSS application were agreed upon. E-mails were also exchanged to resolve or clarify any issues, which can be seen at Annex-2. The group along with the WHO TA Coordinator for proposal development had several meetings with the State Director Generals of Health and subsequently at a UNFPA workshop held on 26 November 2007 where they were requested to provide on a simple standardized data tool. The Drafting Committee met frequently to discuss the activities proposed by the Directors General and incorporated in the proposal and allied issues. Some group members also met to address specific issues.

Overall role and function:

Health Systems Coordination Committee
The HSCC brings together all the stakeholders and provides guidance on all policy issues including the proposal development process by extensively reviewing the proposed set of activities and their financial implications. Following the approval of the application, the committee guides the lead implementation agency, oversees procurement and the overall management of GAVI/HSS support. The committee reviews and approves the reports for submission to the GAVI secretariat, after its endorsement by the Ministers of Finance and Health.

Technical Working Group
This group working under the guidance of the NHSCC meets more frequently and carries out in-depth discussions on the barriers hindering the efficiency and effectiveness of all the programs for MCH including EPI and makes recommendations to the NHSCC. The TWG also provides guidance to the Drafting Committee in its work and deliberates on optimal and most cost-effective use of resources. The NHSCC finally approves the GAVI-HSS application for approval before its submission for peer review and ultimately finally to the GAVI Alliance.

Drafting Committee
The Drafting Committee comprising core technical team, representing MoH (including the Focal Person or Director General Planning, Research and HSD, Director HRD and EPI Manager), WHO, UNICEF, USAID, and NGO representatives including JSI, Tearfund and Medair. It gathers data from key stakeholders, draws on the experience of the TWG members and develops budgetary details to match the text, and finally submits the draft application to the TWG for approval and submission before the NHSCC.

1.2: Overview of application development process
The Meetings of the HSCC / TWG with regard to proposal development were held on 3 July 2007, 27 July 2007, 2 August 2007, 14 November 2007, 22 November 2007, 23 November 2007, 4 December 2007 and 5 February 2007, the signed minutes of are annexed. A meeting with the Director Generals of the State Ministries of Health was conducted on 20 February 2008 during an extraordinary session of a MoH meeting to discuss the micro-planning for GAVI-ISS activities. Meanwhile the drafting committee continued its work, particularly in collecting and analysing data received from the States on the standardized data collection tool.

Who coordinated and provided oversight to the application development process?
A working group designated by the HSCC was chaired by the Director General, Planning, Research and Human Resource Development, MoH, GoSS who coordinated the entire proposal development process including convening of meetings of the ICC-EPI, HSCC, TWG and DC. Preliminary draft and final drafts were vetted by key stakeholders of the HSCC.

Who led the drafting of the application and was any technical assistance provided?
The Drafting Committee headed by the Director General Planning, Research and Health System Development, MoH, GoSS worked under the overall guidance and support of the Under Secretary MoH, worked in the light of the deliberations of the TWG. WHO stationed a Technical Assistance Coordinator in Juba to provide technical support in developing the draft application, based on collective inputs from various sources, and present if before the TWG, which approved it with minor amendments. UNICEF and USAID were also on the committee, which reviewed the entire existing literature and based the draft on the actual needs of Southern Sudan.
Who was involved in reviewing the application, and what process was adopted?
After the draft was approved by the TWG on 4 December 2007, it was considered by the NHSCC members and sent for peer review to the WHO Regional Office for the Eastern Mediterranean who in turn forwarded it to the WHO HQ and GAVI Alliance in Geneva. After securing the peer review comments the amendments were carried out in the draft and the proposal formally placed before the HSCC for review and approval. After the HSCC approval on 5 March 2008, the ministers for Health and Finance officially endorsed the application, enabling its formal submission by the Minister for Health, Government of Southern Sudan to the GAVI Alliance Secretariat. A WHO national focal person ensured that the application was complete in all respects and the annexes were attached properly and all the key formalities were completed some time before the formal deadline of submission of proposals. Prior to that, the proposal by reviewed by Dr Mounir Farag WHO Regional Focal Point for GAVI-HSS and other WHO experts. It is apparent that a highly participatory approach of all partners was adopted right from the start till the culmination of the process and any difference of opinion at any point was effectively addressed to ensure absolute unanimity of all partners on the contents of the application.

Who approved and endorsed the application before submission to the GAVI Secretariat?
After exhaustive consultations, there was a unanimous recommendation for approval from GAVI/HSS working group during the meeting held on 5 March 2008; The Central Ministers for Health and Finance endorsed the application following its approval by the NHSCC.

The timeline of activities, meetings and reviews is as under:

8 July 2007 - HSCC Meeting
27 July 2007 - HSCC Meeting with WHO Regional Focal Person
2 August 2007 - HSCC Meeting
8 November 2007 - Arrival of Int'l TA
14 November 2007 - TWG meeting
22 November 2007 - TWG meeting
23 November 2007 - HSCC meeting with GAVI/WHO Mission
26 November 2007 - First meeting with DGs of SMoHs – data tool distributed
4 December 2007 - TWG meeting for approval of first draft
Dec 2007 – Jan 2008 - Peer Review by the Regional Office
February 2008 - Second draft prepared in light of peer review comments
20 February 2008 - Second meeting with DGs of SMoH - inputs received
5 March 2008 - Final approval of the application
6 March 2008 - Application endorsed by the ministries of Health and Finance
7 March 2008 - Application finally submitted to the GAVI Secretariat by H.E. the Minister for Health GoSS
14 June 2008 - TWG Meeting approved in principle the revised application
Aug 2008 - The revised proposal is approved for submission to GAVI by the HSCC

1.3: Roles and responsibilities of key partners (HSCC members and others)
The HSCC comprised more than 20 members drawn from various organisations, both in the public as well as private (the government decree constituting the HSCC decree is attached as Annex A). The roles and responsibilities of the key organisations/stakeholders involved in preparing/ vetting the proposal and possibly implementing a host of interventions is given below.

Title / Post	Organisation	HSCC member	Roles and responsibilities of key partners in the GAVI HSS application development
Undersecretary	CMoH, GoSS	Yes	The civil service head of MoH served as the chairperson to facilitate decision making and reaching a consensus in HSCC meetings. He guided the entire process, keeping proposal and the interventions in accordance with national health policy and strategic plans.
Director General Planning, Research and Health System Development	MoH, GoSS	Yes	Served as the Secretary of HSCC and Chair of the TWG and coordinated all the meetings. In addition, he was available for consultation to the DC. But, the most important input was to bring in the health system perspective to the proposal, and informed about other initiatives and plans that are ongoing.
National Program Officer for EPI	MoH, GoSS	Yes	He actively participated in the process for proposal development, bringing in EPI perspective and keeping the proposal in line for improving the immunisation, while input is made into the health system as a whole; and that there is no duplication to the input from GAVI/ISS and other sources.
Director General, Primary Health Care	MoH, GoSS	Yes	Served as a member of TWG, brought in the PHC perspective as a comprehensive means to support immunisation and complementary interventions for addressing the maternal and child health issues. The need for strengthening PHC network to act as fixed EPI sites and base for outreach and mobile was emphasized. In implementing the proposal, his role will be vital and essential.
Director General	Ministry of Finance, GoSS	Yes	To vet the proposal as being in line with the economic policies of the government and recommend to the Minister for Finance to endorse the proposal
Director General Human Resource Development	MoH, GoSS	Yes	s/he ensured that the capacity building and refresher trainings proposed were in line with the existing human resource development policy of the government of southern Sudan
Director General, External Assistance	MoH, GoSS	Yes	The external aid flow to MoH-GoSS is channelized through him. In this capacity, he was a key resource person in identifying the gaps that remain in supporting immunisation; and that there is no duplication of input and efforts in improving EPI.
Director Generals	State Ministries of Health	Yes	Participated in HSCC meetings and reviewed the final draft and endorsed the application for submission. He brought the state perspective to the contents and the issues health system faces at the state level.
Head of Office	WHO Southern Sudan	Yes	Assigned a Health Systems Specialist to be the member of TWG and DC to provide insight into the health system, relating different components to MCH/EPI service delivery. Coordinated support of Focal Person GAVI-HSS WHO

			EMRO who assisted in understanding best practices for GAVI/HSS application process; and reviewed final draft prepared by the DC and TWG. Assigned Technical Officer, EPI/Polio Eradication to be the member of TWG.
Head of Office	UNICEF, Southern Sudan	Yes	Assigned the Programme Officer for Health / EPI to be the member of TWG and DC to participate in the proceedings and assist in drafting / reviewing the application. The input also included the defining details on interventions for addressing the continuing poor indicators.
Head of Office	UNFPA Southern Sudan	Yes	Assisted MoH, GoSS in developing the Southern Sudan draft Maternal, Neonatal and Reproductive Health Strategy 2008-2011
Heads of Office	USAID, EC and JICA	Yes	Assisting MoH in several programmatic areas of primary health care including hospitals and MCH issues
CSO Representatives	Tearfund, Medair, Capacity Project, JSI	Yes	Their role has been critical in providing health services, and their participation in the meetings brought ground realities in developing the proposal and to consider how they could be involved in implementing the GAVI/HSS support.

1.4: Additional comments on the GAVI HSS application development process

Coming in the wake of the Comprehensive Peace Agreement of 2005, the GAVI-HSS application development process secured substantial political commitment as all the stakeholders realized the significance assumed by health system strengthening given the existing scenario in this most 'fragile' of all states. The Drafting Committee was often handicapped by a lack of certain baseline data but managed to tap a reliable source to obtain any indicators or demographic information. Securing data from the grassroots level also posed a challenge that was addressed through various means and information sources mostly with the EPI program.

WHO was assigned the task of providing a lead to the Technical Assistance. As a result, the Focal Person for GAVI-HSS WHO-EMRO visited Juba twice during the consultative process. Furthermore an international TA Coordinator was stationed in Juba from November – December 2007 and subsequently from February-March 2008, who played an active role in drafting and editing the application taking into account the views of all members of the Drafting Committee and Technical Working Group, and the policy guidelines provided by NHSCC/ICC-EPI. The key ingredients of the GAVI-HSS application were drawn from several WHO documents and adapted to suit the context of Southern Sudan, which has perhaps no parallel in the world in relation to the extremely weak health system and poor quality of health services offered to about 30% of the population, with the remaining 70% virtually deprived of access to any proper health facility. The consensus of the group was to focus on the strengthening the central, state and county levels for the next 5 years or so, and then focus on lower level interventions, unless funding was available from some other source. However, an important cornerstone of the application is the focus on community involvement and effective mobilization of community health workers at the grassroots level with due weightage given to operational research. The responses provided by the Directors General of the States also gave the DC/TWG a rare insight into the exact situation at the grassroot level.

The main thrust of the proposal is to strengthen health system adopting a holistic approach, by overcoming institutional and programmatic barriers, so that it is of particular benefit to programs contributing to the health of women of child bearing age and young children. Furthermore, the activities contained in the proposal will complement and be incremental to those being carried out through direct government spending, MDTF or GFATM, without designing any new structures or programs, or proposing any parallel staff. The cost of the project has also been kept at a modest level especially during the last three years keeping in view the utilization capacity and sustainability issues. All the proposed activities will be carried out through the oversight of the HSCC, under the guidance and supervision of the Under Secretary and the Director General for Planning, Research and Health System Development, Ministry of Health, Government of Southern Sudan to ensure that there are no implementation delays. The latter will also be responsible for program evaluation and ensuring transparency in the recruitment and procurement processes. It is expected that the interventions proposed in the application prepared through a highly consultative and inclusive process will augur well for sustainability and lay a solid base for strengthening the health system as a whole in Southern Sudan by overcoming system barriers to particularly benefit women and child and augment immunization, which happens to be the most cost-effective activity in the entire Health Sector. Multiple drafts of the application were revised trough inputs given by a wide range of stakeholders / states. The rich contribution of CSOs and their special role in health service delivery, monitoring and supervision is acknowledged. Feedback received through the peer review process was incorporated. While the recommendations of the fine tuning and consensus building workshop were also given prime importance, and the application and its budgeting amended following this activity.

The application was originally submitted to GAVI in March 2008 and is being re-submitted in light of the IRC recommendations after its approval by the HSCC.

Section 2: Country Background Information

2.1: Current socio-demographic and economic country information[1] of Southern Sudan

Information	Value	Information	Value
Population of Southern Sudan	12,500,000	GNI per capita** 2004 estimate (it is still estimated below US$ 365)	US$ 90*
Annual Birth Cohort	510,319	% Government expenditure on Health	7.5%
Surviving Infants	433,771	Percentage of GNI allocated to Health	Not known
Percentage of GNI allocated to Health by MoF	Not known		

* New Sudan Centre for Statistics and Evaluation in association with UNICEF. *Towards a Baseline: Best Estimates of Social Indicators for Southern Sudan.* June 2004. p. 68.

Summary Table of Key Findings relating to Maternal and Child Health
Sudan Household Health Survey (SHHS), Southern Sudan, 2006

Indicator	Value
Proportion of people living on less than S1/day	90% (UNDP, 2005)
Per capita health expenditure	US$ 7.3
Chronic Malnutrition among <5 children	45%
Infant Mortality Rate	102/1,000
Under-5 Mortality Rate	135/1,000
Maternal Mortality Ratio	2,054/100,000
Fully immunized children	17%
Deliveries attended by qualified personnel	9%
Deliveries in health facilities	14%
Contraceptive Prevalence Rate	Less than 5%

[1] If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested.

2.2: Overview of the National Health Sector Strategic Plan

Following the CPA, the Ministry of Health, Government of Southern Sudan has moved swiftly to develop an interim Health policy for 2006-2011, backed with a Health Strategy for 2006-2008, which gives some strategic information on the direction and scope of work of the ministry over the next three years. The **Mission Statement** of the Ministry of Health is in reality a commitment "to ensure equitable, sector wide, accelerated and expanded quality health care for all people in Southern Sudan, especially women and children."

The **National Health Policy** of 2006, largely based on the Alma Ata principles and aimed at achieving MDGs 4, 5, 6 and 8 regards Health Systems Strengthening (HSS) at all levels as one of the five critical cornerstones for bringing about a massive turnaround in the health situation of South Sudan. Based on the ground realities in 2008, the new **Health Strategy** will be prepared for the period 2009-2011 remaining within the policy framework. It is incumbent on each state, county, municipality and community to prioritize their activities in line with the Health Strategy adopting it according to the specific challenges and needs at their level, and reflect the same in their annual plans, and contributing to the achievement of planned outputs and outcomes at the national levels.

Despite a critical shortage of data and considerable variation amongst the states, the average routine EPI coverage for Southern Sudan has been estimated at below 20%. A **Comprehensive Multi-Year Plan (cMYP) for Immunization** has therefore been developed envisaging establishment of massive infrastructure to improve the routine immunization coverage in Southern Sudan, with high capital costs. The targets of the cMYP, may need to be advanced by a year in view of several impediments including funding constraints, and it is now expected the DPT-3 coverage to rise to 30% by end-2008, ultimately achieving 90% coverage in Southern Sudan level with 80% DPT-3 coverage in each of the eighty counties by 2010. Furthermore, Polio Eradication activities have been speeded up and elimination of measles has been targeted by 2010, necessitating the measles coverage to reach 70% and 80% in 2008 and 2009, respectively. The mass measles campaign will be completed in 2008 and another follow-up campaign will be conducted in 2010. The plan also seeks to eliminate maternal and neonatal tetanus (MNT) by the year 2009, through a national-wide phased campaign planned for 2008 and 2009 targeting all women of child bearing age (CBA). Despite the obvious infrastructure challenges, Southern Sudan has successfully interrupted polio transmission through a national polio eradication network of AFP surveillance established in 2000, and supplementary immunization with OPV implemented regularly since 1998, reaching the whole country. Recently Southern Sudan has used the polio network and other resources to conduct effective national measles supplementary immunization, reaching high national coverage. Thus Southern Sudan has the knowledge and ability to reach every community; this asset should be put to good use in strengthening the health system.

The **Basic Package of Health Services** (BPHS) prepared for implementation in Southern Sudan includes curative, preventative, managerial and health promotion activities, whether provided by the Ministry of Health (MoH) or contracted out to implementing partners. The BPHS profiles the services, infrastructure, equipment, essential drug supply, and human resources at five levels in the health system – community, primary health care unit (PHCU), primary health care center (PHCC), county hospital, and county health department. The development of the BPHS was guided by the values defined in the MoH Policy Paper, namely: the right to health, equity, pro-poor, community ownership, and good governance. The existence of the BPHS is assisting CSOs to standardize services, staffing, and functions, and enhancing the capacity of the MoH for monitoring and supervision has to be strengthened. Furthermore, in view of the large geographic diversity in terms of existing health structures and human resource availability the implementation arrangements of the BPHS may initially differ by region.

The report of the **First Government of Southern Sudan Health Assembly (GOSSHA)** held in Juba from 18 - 21 June, 2007 and attended by over three hundred representatives from the Ministries of Health of all ten states, international agencies and civil society organizations of Southern Sudan, is highly illustrative of the actual situation prevailing on the ground. Some of the key recommendations of the Assembly include strengthened coordination amongst partners, provision of better communication facilities, infrastructure, rehabilitating existing structures,

equipping facilities, retraining the existing workforce, increasing health personnel in the states, establishing/strengthening support systems, and improved health financing both in the public and private sectors.

Meanwhile, efforts are underway to ensure that the implementation keeps pace with the policy and strategy documents by adopting the best practices at the national / international level, fostering partnerships, renovating health facilities, strengthening emergency obstetric care, capacity building and focus on preventive programs, with systems in place for monitoring, supervision and evaluation. The main areas for Health Services Strengthening to be brought about through evidence based decision making, effective partnerships, capacity building, effective monitoring and supervision and resource mobilisation address key priorities such as provision of primary health care (PHC) services, strengthening hospitals and the remaining health infrastructure and institutional capacity building through the strategies outlined below:

Provision of PHC Facilities

- Reducing inequalities in access to health care through mobilising communities, developing effective partnerships, and extending the coverage of basic health services
- Strengthening community participation through active participation of, and support for, village health committees and volunteers
- Implementing the Basic Package of Health services
- Improving delivery of maternal and child health interventions through making relevant services accessible and acceptable, especially obstetric services and integrated disease prevention and control programmes.
- Employing integrated and cost-effective strategies for control of communicable diseases and key non-communicable diseases, and addressing malnutrition through inter-sectoral collaboration

Strengthening the Health Infrastructure

- Developing a good network of health facilities by implementing a coverage plan and an infrastructure policy
- Developing and implementing a basic package of essential hospital services
- Strengthening the management of services such as laboratories, blood banks, and medical supplies

Institutional Capacity Building

- Enhancing the institutional development of the ministry to enable provision of effective leadership, ensure good governance and enabling sound management practices and transparency
- Carrying out human resource development on a war footing
- Promoting operational research in order to develop an evidence-based culture for planning and designing pragmatic health strategies
- Enhancing health sector financing particularly for basic health services
- Closer attention to be paid to data management and evolving of an effective HIS
- Ensuring that quality standards established by MoH are implemented in all public and private health care delivery settings; in this connection a legal regulatory framework will be drawn up
- Strengthening inter-sectoral and intra-sectoral coordination within the Health Sector

Conclusion: The current application focuses on all the three principal tiers of the health services, values the importance of community involvement, and is entirely aligned and harmonized with all the homegrown policies and strategic documents of the GoSS, in line with the Paris Declaration for Aid Effectiveness.

Section 3: Situation Analysis / Needs Assessment

3.1: Recent health system assessments from 2006 onwards (see Annex-B)

Title of the assessment	Participating agencies	Areas / themes covered	Dates
1. Southern Sudan National Health Policy 2006-2011	Ministry of Health, Government of South Sudan	Entire health sector	2006
2. Building an equitable health system for Southern Sudan: Options for GAVI Health Systems strengthening funding – Health Assessment	USAID	The parameters for GAVI-HSS support in Southern Sudan	2007
3. Comprehensive Multi-Year National Immunization Plan 2007-2011	MoH, GoSS in collaboration with WHO and UNICEF	An extensive situation analysis on the EPI programme including immunization coverage; and proposed plan for 2006-10.	2006
4. Sudan Household Health Survey, 2006	Central Bureau of Statistics, GOSS, in collaboration with UNICEF, PAPFAM, WFP, UNFPA, WHO, USAID and Arab League	An assessment of the situation of children and women to monitor the progress towards selected MDG indicators.	2006
5. The Basic Package of Health Services in Southern Sudan	MoH, GoSS in collaboration with WHO	Determining the basic quality standards to be delivered by primary health care facilities across the board in South Sudan.	2006
6. South Sudan Interim Health Strategy 2006-2008	MoH, GoSS	A strategic document to complement the National Health Policy with a concrete work plan for three years	2006
7. Towards a baseline: best estimates of social indicators for South Sudan 8. gaps	New Sudan centre for statistics and evaluation in association with UNICEF May 2004	The GNI per capita is given at p.61	2004
8. The report of the First Government of Southern Sudan Health Assembly (GOSSHA) held in Juba	Central and States ministries of Health, CSOs, CSOs, International agencies	Problems at macro, meso and micro levels	18-21 June 2007
9. Southern Sudan strategic plan for Human Resources for Health 2007-2017	MoH, GoSS in collaboration with WHO	Strategic Plan for all issues governing human resource development in the Health Sector	2007
10. Southern Sudan Policy for Human Resources for Health	MoH, GoSS,	Policy for all issues governing human resource development in the Health Sector	2007

Health system strengths and weaknesses

Based on the review of the above policy documents, recent assessment and focus group discussion, the SWOT (Strengths, Weaknesses, Opportunities and Threats) Analysis with regard to achievement of the MDGs relating to maternal and child death appears to be as shown below in Table - below:

Table : SWOT Analysis of Health in Southern Sudan

Strengths	***Weaknesses***
• Strong political will and commitment • Rapid development of sound policies and strategies within the Health Sector • The presence of enormous technical expertise in the higher echelons of the Ministry of Health • Wide range of partners working in harmony with each other • Community involvement and participation • A national polio eradication network for AFP surveillance and NIDs which has achieved international standards of quality.	• Poor health and demographic indicators • Dependence on external resources • Poor infrastructure • Few trained health personnel • Lack of baseline data • Collapse of endemic disease control programmes • Poor quality of health care services delivery • High fertility rate with virtually no family planning • Lack of expertise for logistics and supply at state level

Opportunities	Threats
• The Comprehensive Peace Agreement • The Interim National Constitution, the South Sudan Constitution, and the Bill of Rights • Untapped resources • Primary health care can help improve utilization of services and better quality of life • Anticipated decentralization of government and health services • Some good practices in traditional medicine • Very active CSOs and faith based organizations with great potential, which could be integrated in the health care system with some effort • Growing expectations of the people concerning health services • Availability of a national AFP surveillance network for surveillance of other diseases. • Establishment of cold chain hubs through the national mass measles campaign.	• Insecurity • Undermining of the peace agreement • Slow disbursement of funds from national and international sources • Low levels of literacy, especially among women • Poor nutritional status • Population explosion • Widespread corruption • Inadequate response to epidemics • Unsupportive environment such as swamps, harsh climate, flooding, and famines • Unhealthy lifestyles • Delays in seeking health care • Inaccessible areas • Large migrant populations • Limited government resources for rapid expansion and delivery of accessible, affordable and quality primary health care services

3.2: Major barriers to improving immunization coverage identified in recent assessments

Immunization services, which are an integral part of the overall MCH package, are provided through fixed sites, outreach workers and mobile clinics during campaigns. It is imperative, however, to boost routine immunization through supplementary immunization activities (SIAs) for polio, measles, maternal and neonatal tetanus. Routine EPI services are virtually non-existent in 60% of Southern Sudan, and in the remaining areas also the following main barriers are experienced:

- **Fragile infrastructure of health facilities** with poor health care delivery, and cold chain resulting in high wastage of vaccines and other logistics
- **Immunization services** are provided by CSOs on an adhoc basis
- There is **no reliable system for reporting**
- **Weak workforce for health with inadequate administrative personnel and health staff at all levels** due to limited supply of qualified people, poor working conditions, and inadequate remuneration
- **Insufficient logistics and transport to implement routine EPI activities** in all ten states
- **Inadequate funding** or fund-flow mechanisms at the State level and below
- **Inadequate technical capacity and office facilities** for carrying out health system strengthening
- **Inadequate demand for health services; poor social mobilization**
- I**nsecurity** caused due to land mines, particularly in the outskirts of Juba, Malakal, and Wau, restricting access to many locations
- Several **geographical barriers** such as harsh weather conditions, particularly during the rainy seasons, difficulty in crossing islands
- **Inadequate technical capacity** for grappling with all aspects of HSS, carrying out a training needs assessment, inventory of health financing, HIS, and regulation of private sector
- **Inadequate provisions for** renovation and provision of furniture/equipment/logistics to the entire health facilities **infrastructure** including warehouses at central and state levels
- **Lack of transport facilities in the peripheral levels Mobility support** to PHC supervisors and CHWs
- Lack of **Office equipment** at central and state levels
- **Capacity Building required** for all cadres of health professional and health care staff
- **Social Mobilization**: for demand creation to augment the IEC campaign of the government
- **Lack of HIS** tools at the Central and State levels
- Largely ineffective **program management, monitoring, supervision, and evaluation**
- Lack of a culture for **Operational Research**

3.3: Barriers that are being adequately addressed with existing resources

Certain barriers are being addressed through direct government support and support of its development partners. The roles played by various agencies in addressing some of the barriers are described below:

Certain gaps in Immunization services relating to cold chain/logistics are being addressed by the EPI program and GAVI-ISS support; however certain gaps still exist.

Social mobilization is being carried out in states but is inadequate.

The condition of the existing health facilities at all levels is being improved but not at a relatively brisk pace requiring additional support to improve access.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

GAVI-HSS support can be largely instrumental in carrying out activities to remove health system barriers, which are not being addressed by any other source, such as Human Resource redistribution and capacity building, and barriers to physical access. The main barriers to be addressed and included in the plan are summarized below:

- **Technical Assistance** for all aspects of HSS, particularly a training needs assessment, inventory of health financing, HIS, sustainability and regulation of private sector
- Renovation and provision of furniture/equipment/logistics to the existing health facilities **infrastructure** including warehouses at central and state levels
- **Mobility support** to PHC supervisors and CHWs
- Provision of **Office equipment** at central and state levels
- **Capacity Building** for all cadres of health professional and health care staff
- **Social Mobilization** creation to augment the IEC campaign of the government
- **Operational Research** will be carried out to foster community involvement, and other aspects if health care services including logistics management.
- Provision of **HIS** tools will be ensured at the Central and State levels
- **Supply and logistics capacity** through focal points and appropriate resources at state level
- Effective **program management, monitoring, supervision, and evaluation**

Section 4: Goals and Objectives of GAVI HSS Support

4.1: Goal of GAVI HSS support

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.

4.2: Objectives of GAVI HSS Support

In broad terms, the **general objectives** for GAVI/HSS support are to ensure:

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.

The **specific objectives** for the GAVI/HSS support by the end of 2013 are to:

1. Ensure improved access to maternal and child health care in all states of Southern Sudan resulting in a 25% reduction in maternal and child mortality in those states
2. Retain, build the capacity, motivate and mobilize all the doctors, nurses, paramedics, support staff and community outreach workers to make all the facilities at central, state and county levels functional and efficient.
3. Enhance managerial including planning and financing capacity of the Central Ministry of Health, all ten State Ministries of Health and all 79 County Health officers, ensuring increased financing and timely flow of funds to the State level and below.
4. Achieve 70% EPI coverage in all the ten states from the current level of less than 20% DPT 3 coverage
5. Have a reliable system for Health Information System in place for use in decision-making at central and state levels.

From the foregoing, it is apparent that GAVI-HSS will address certain barriers not addressed by any other government or donor-assisted program, while retaining linkages with other barriers, which are only being partly addressed.

Section 5: GAVI HSS Activities and Implementation Schedule

Description of the proposal

To provide accessible, affordable and equitable primary health care services of an acceptable quality is the main challenge of any health system. Unfortunately, Southern Sudan has a nascent health system that has emerged out of nearly five decades of intermittent civil war. The infrastructure is totally devastated and in shambles, information systems are weak, the workforce highly disorganized and the private health care providers largely unregulated, while managerial capacities are understandably deficient. All these factors render Southern Sudan's Health System as extremely weak and fragile leading to some of the poorest health outcomes in the world, and nor comparable to any other health system in the world. The proposal, which adopts a holistic approach, mainly focuses on three critical areas, which will jointly address all the barriers currently impeding the smooth delivery of health care services, and not likely to be addressed through any other funding source, to bring about the all-embracing process of Health System Strengthening in Southern Sudan. The objectives and detailed activities are described below:

Objective 1: Improved health care service delivery specially to vulnerable population segments

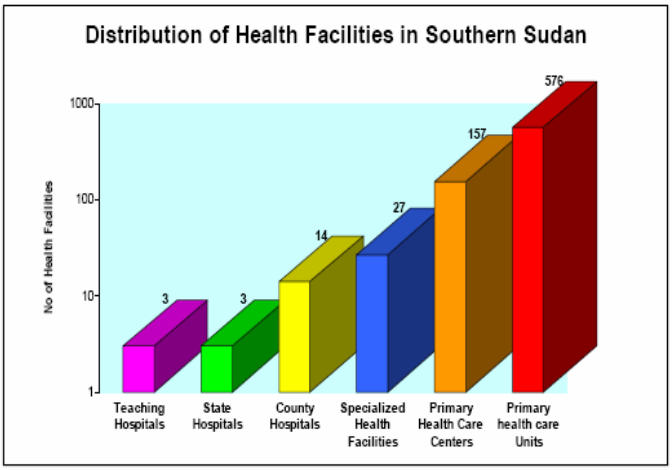
Currently, the break up of the 783 functioning primary health care (PHC) facilities both in the public and private health sector, which are covering only 30% of the population in Southern Sudan, is shown in the table below. All these facilities, 86% of which are run by CSOs/FBOs who are experiencing financial difficulties, are generally in a very poor condition and even major hospitals in Juba, Malakal and Wau are in need of renovation or refurbishment. Furthermore there is a need for better coordination and standardization of facilities. A mapping exercise of the health facilities infrastructure is underway and the government has also developed a Basic Package of Health Services determining the minimum acceptable quality standards at health facilities. While the government is making efforts to increase the geographical access of health services, the present proposal focuses on strengthening existing health facilities.

Type of Health Facilities	Number
Hospitals/specialized treatment facilities	47
PHCCs	157
PHCUs	576
Total	**780**

Certain high-impact services known to reduce child mortality and morbidity rapidly, such as immunization; vitamin A supplementation; bed nets for malaria prevention; oral rehydration therapy/zinc and point-of-use water treatment to avoid diarrheal and other water-borne diseases; community-based treatment of malaria with pre-packed ACT (artemisinin combination therapy) drugs; treatment of acute respiratory infection with antibiotics; and mass-treatment of hyper-endemic communities infected with bilharziasis. The government is already delivering these interventions with the support of the Global Fund against AIDS, TB and Malaria (GFATM) and GAVI. Through GAVI-HSS support master trainers will be developed to train others in containing the three major communicable diseases. Yet there is a need for social marketing for demand creation. Performance-based service delivery envisaged in the long run is also expected to bring about a massive improvement in the health status of the population. The lack of a reliable Health Information System that could be used for decision making is acting as a handicap both for the MoH and NGO personnel and it is imperative that such a system be in place for rapid flow of information couple with a strong health promotion program. Improved service delivery is expected to have a significant impact on MCH including immunization services. Towards this end, the following interventions have been designed:

Activity 1.1: Provision of Logistics and supply experts at state level
Ten logistics and supply experts trained in the Logistics Management Information System (LMIS) will be provided at state level (one for each state) to deal with the day-to-day supply needs of each state. This will include handling health supplies regularly required in every county, and monitoring their use to avoid stock outs.

Activity 1.2: Augmenting governmental efforts in renovation of 11 Hospitals with provision of basic furniture/equipment:
Although the government is trying to improve the condition of the hospitals, particularly those which are non-functional, this activity is likely to entail a lot of time. It is therefore proposed to accelerate the process through GAVI-HSS support. This activity will enable better functioning of hospitals and delivery of quality health care. Provisionally a block allocation has been made based on the number of facilities, but the renovation work will be carried out on an actual needs basis, and it is expected to have a major impact. The unit cost for each hospital will be USD 40,000 but as explained above, some hospitals will need more efforts than others. The remaining hospitals will be taken up during the second phase of the program (2011-2013) if approved.



Distribution of Health Facilities in Southern Sudan; Source: CHAS Survey, 2007

Revise to read 7 state hospitals, 28 (??) county hospitals

Activity 1.3: Augmenting governmental efforts in renovation of 40 PHCCs with provision of basic furniture / equipment
A similar exercise will be carried out involving renovation of 40 PHCCs with a unit cost of USD 700,000 USD per facility. Priority will be assigned to States where the facilities are particularly poor and the disease burden and health indicators the worst. The other PHCCs will be taken up in the next phase (2011-2013) if approved.

Activity 1.4: Augmenting governmental efforts in renovation/Functioning of 250 PHCUs with provision of basic furniture
Two hundred and fifty (250) PHCUs will only be made functional with an approximate investment of USD 4,000 each, with provision of basic furniture and minor repairs. The other PHCUs will be taken up in the next phase if approved.

Activity 1.5: Hiring of 10 Social Mobilizers (1 for each state) for demand creation for Health, particularly preventive programs such as EPI, RBM, HIV/AIDS, Tuberculosis, Nutrition, Ante natal, natal and post natal care, and other life saving interventions.
Each state will be provided one social mobilizer each, who will be in place from the third quarter of the first year after a transparent recruitment process. The personnel are expected to be in place by the second half of the first year after a transparent recruitment process. The main focus of these personnel will be on creating a demand within the communities for life saving interventions for mothers and children and organizing communities with a view to empower them and act as monitors for health facilities.

Activity 1.6: Provision of 10 Cold rooms at the State Level for better storage and management of all logistics, medicines and vaccines
This will be a one-time activity for provision of ten (10) cold chain rooms at the county level for proper storage of all logistics which require to be properly stored under ideal conditions. This activity was not taken up under GAVI-ISS.

Activity 1.7: Enhancing a IEC campaign to create a demand for health care services particularly for mothers and children

As the population of South Sudan generally assigns a very low priority to their health status, governmental efforts for IEC will be supplemented with the help of Social Mobilizers employed in the states. The effort which will be carried out alongside government efforts to improve the quality of health care delivery services in order to ensure that an unmet demand is not created. The major focus of the campaigns will be on the main target groups namely women and children under the age of five years. The campaign will be further strengthened in the phase from 2011-2013 when sufficient improvement has been brought about in the quality of services provided through this program.

Activity 1.8: Provision of ten motorboats

Discussion with Directors Generals of the State Ministries of Health have emphasized upon the difficulties of transporting patients, logistics or supplies in the absence of roads and islands. The problem is most acute in 4-5 states, namely Upper Nile, Wau, Jongolei, Western Equatoria and Unity. It is proposed to provide two motorboats each to these five states to help them in transporting supplies, logistics and patients.

Activity 1.9: Operational research studies

a. On empowerment and involvement of communities in monitoring and evaluation of health facilities and revival of community-based initiatives such as the Basic Development Needs program

The benefits of community involvement in health have been documented by several researchers, however, in view of the special circumstances prevailing in South Study an operational research study will be undertaken during the first two years to evaluate the importance of communities in the Health Sector and check of feasibility of replicating community-based initiatives such as Basic Development Needs. The results of the study will help in designing more community-based initiatives in Southern Sudan along feasible lines and address a major gap in its health system. It might be pertinent to dilate a little on the BDN program which has been working in Southern Sudan in two sites including Rumbek. The initiative is an integrated socio-economic developmental concept incorporating elements of extensive community involvement and inter-sectoral collaboration, whose merits have been well documented. Currently, the initiative is under implementation in fourteen countries of WHO's Eastern Mediterranean Region, and takes into account the inter-dependent needs of the community both within and outside the Health Sector such as primary health care including nutrition and reproductive health, basic education, provision of safe drinking water, sanitation and a safe environment. The provision of micro-credit schemes for income generation also falls within the purview of the programme. These inputs are, however, preceded by an elaborate exercise aimed at organizing and mobilizing the community with an emphasis on their enhanced awareness on health issues, active participation, gender mainstreaming and self-reliance. Local community representatives, local authorities and public sector line departments share their respective role in programme implementation. A previous study has determined that BDN implementation leads to better outcomes in TB-DOTS and the program is also a recipient of GFATM round 3 grants in the TB and Malaria components in Pakistan.

b. Research for streamlining supply chain management for medicines and other health commodities, and health system related studies

There is a growing realization about the importance of logistics management. An operational research study will look into the best possible strategies to streamline all processes relating to procurement, management, storing, distribution and dispensing of medicines with minimum losses on account of improper procurement procedures, storage conditions, irrational use and/or expiry of drugs. The study taken up as operational research will also look at other logistic and health system related studies, and the findings published in a reputed international journal.

Objective 2: Strengthening of the health workforce to ensure better health outcomes

Activity 2.1: TA for carrying out Training Needs Assessment of all health care professional and health care providers

Keeping in view the singular lack of trained professionals and health care providers, a Training Needs Assessment will be carried out in the first three months of project life so that a comprehensive picture can be drawn up of the training needs of various cadres of Health Care Professionals, particularly at the Central, State and County levels. Certain groundwork has been carried out in the formulation of the HRD Strategy for the next ten years, on the basis of which the numbers of various categories of health staff have been worked out for short duration training. It is however, essential to determine the exact training needs of each cadre of health professional and health care workers.

Activity 2.2: Refresher training of 1,164 Community Health Workers/community support officers to perform all basic health services and serve as a link between communities and health facilities

South Sudan has an estimated 1,164 Community Health Workers doing outreach work on a purely voluntary basis. It is, however, imperative to provide them refresher training in all basic health services and the importance of preventive work. They will subsequently be used during social mobilization campaigns for all public health work and serve as a bridge between the communities and health facilities. The Ministry of Health will explore the issue of providing incentives to all these workers so that they can be retained and made functional. Community support officers will also be trained in this activity, which will repeated in 2011 if funds are available for the same.

Activity 2.3: Provision of 1,164 bicycles to all Community Health Workers

A total of 1,164 (eleven hundred and forty four) community health workers, already involved in health activities, will be provided with bicycles as a sort of incentive, to motivate them to perform better. Furthermore, the government through its own resources will try to absorb them on the payroll by paying them a monthly stipend.

Activity 2.4: Provision of 20 motorcycles to community support officers

In order to improve their motivation, twenty community support officers (CSOs) will be provided with free motorcycles in order to facilitate their work. The selection will be on strictly technical criteria.

Activity 2.5: Provision of 158 motorcycles to the counties

Each of the seventy nine (79) county health department to be provided with two motorcycles to perform all types of outreach work. This will facilitate all sorts of activities including preventive work for the vulnerable segments such as women and children.

Activity 2.6: Refresher Training of 225 doctors on the preventive aspects and implementation of the Basic Package of Health Services

The Ministry of Health has announced a Basic Package of Health Services in order to lay down minimal standards of quality for the health care services at various levels. It is necessary, however, to sensitize the two hundred and twenty five (225) available doctors on the contents of this package and their role in spearheading the implementation process particularly on MCH aspects including immunization. This training will be carried out in 2010.

Activity 2.7: Refresher Training of 473 mid-level health cadres on monitoring and evaluation

Four hundred and seventy three (473) **mid-level health cadres** will be trained on monitoring and evaluation, so that they can perform their duties more efficiently. This training will be carried out in 2009-10. (Please recheck the figures to make sure there is no contradiction)

Activity 2.8: Refresher Training of 443 medical assistants/clinical officers/ related mid-level health cadres

Four hundred and forty three (443) medical assistants / clinical officers / related mid-level cadres working in the health facilities will be provided on job training on all aspects of preventive and curative care particularly during the first year in 2009.

Activity 2.9: Refresher Training of 272 laboratory personnel

Laboratory services play a critical role in the early diagnosis of various diseases, particularly related to the TB-DOTS, EPI, RBM and HIV/AIDS control programs, and it is imperative to give refresher training to the existing 272 laboratory technicians and assistants enabling them to perform better. This training will also be carried out in 2009.

Activity 2.10: TA for Health Information System Data compilation, analysis and use for decision making in the States

Technical assistance will be sought for the establishment of a reliable Health Information System (HIS). The consultant will look into all aspects of the proposed system and make concrete recommendations for having the system in place as soon as practicable.

Activity 2.11: Provision of buffer stock of HMIS tools at Central and State levels

Once the Health Management Information System (HMIS) is in place, tools and instruments will be regularly provided at all levels in order to supplement governmental efforts to enable timely and accurate information for facilitating decision making by policy makers and managers.

Activity 2.12: TA for sustainability of private sector health facilities and establishment of additional public sector facilities at carefully selected sites

As mentioned before an estimated 86% of health care service delivery is carried out by non-governmental organizations including faith based organizations. It is critical to involve every institution, agency or organization involved in public health work fully if a significant dent is to be made in improvement of MCH services and containment of communicable diseases. Towards this end, technical assistance will be sought to determine how best to integrate the working of governmental and non-governmental organizations, retaining private sector organizations, strengthening public sector facilities and if inevitable phasing out of private health care facilities on a sustainable basis.

OBJECTIVE 3: TO ENSURE BETTER GOVERNANCE, POLICIES AND MECHANISMS FOR HEALTH FINANCING AT CENTRAL, STATE AND COUNTY LEVELS

Despite the fact that the Ministry of Health has shown remarkable speed, perseverance and determination in devising policies, strategies and plans of action, in the face of overwhelming odds, it still experiences considerable difficulty in setting of targets, earmarking of allocations for various sub-sectors of Health and utilization of funds. Furthermore, there is an acute dearth of trained managers and health care professionals, and those who are trained are not provided with the basic office equipment to facilitate their working. There is an over-arching need for long term Technical

Assistance to the Ministry of Health of Southern Sudan, while issues such as regulation of the massive private health sector also merits consideration.

Activity 3.1: TA for drawing up an inventory of Health Financing in South Sudan
Through technical assistance, it will be determined what quantum of funds in the health sector is coming from which source. This brief exercise of three months will enable the Ministries of Finance and Health to put into place appropriate budgeting and strategic planning policies on a sustainable basis. It will also be educational for all the developmental partners to know how much they are exactly contributing vis-à-vis the actual requirements of the Health Sector. The Ministry of Finance will be emboldened by the findings of this exercise to enhance the budgetary allocations for health, while the Ministry of Health will be able to determine how best to utilize the funds at its disposal from various sources and work out a long term operational plan with clear cut targets and goals. The roles and responsibilities of health staff working at the State level and below will be carefully delineated, particularly with regard to drawing and disbursement of funds.

Activity 3.2: Provision of 3-month training courses to two senior MoH staff in Health Planning/Economics at a reputed university or teaching institution.
This activity will enhance the technical expertise available in the Ministry of Health by the provision of two trained Health Economists who can guide the working of the preventive programs and ensure their optimum benefits in relation to the investment made. In 2011, it is planned to train another two senior personnel subject to availability of funds.

Activity 3.3: TA for regulation and standard setting of public and private health care providers
Although the private sector is contributing substantially to health care delivery in Southern Sudan, it has been noted that coordination is often lacking with governmental authorities so much so that in many places even proper reporting is not taking place. It is imperative to do away this ‘state within a state’ culture and lay down regulations for the proper norms, standards and conduct of all health care providers whether they are in the public or private health sectors. Technical assistance will be availed for this purpose linked to health system needs assessment.

Activity 3.4: Provision of three week's training in managerial skills for 20 Program Managers at the Central Level and Directors General at the state level
An important linchpin of health system strengthening is capacity building of senior managers such as National Program Officers and Directors General of the State Ministries of Health. Accordingly at least ten senior personnel / program managers working at the Central level and all the DGs of the states will be provided three weeks training on managerial skills during 2009.

Activity 3.5: Provision of two week's training in managerial skills for 79 County Program Managers
The County level is the most neglected and the situation warrants that all the principal medical officers one in each country is also provided with training in managerial skills to enhance capacity where it is required the most. All the seventy nine (79) County Medical Officers will be trained for a period of two weeks each during 2009-2010.

Activity 3.6: Long term TA for all aspects of Health System Strengthening including policy support
In view of the existing position prevailing in Southern Sudan, it is envisaged that long term Technical Assistance will be provided on all aspects of Health System Strengthening, particularly with regard to Maternal and Child Health (EMoC/IMCI) including immunization over the entire program life. The assistance is expected to be in place by the third quarter of the first year. This will considerably facilitate the working of the Ministry of Health and provide a framework for sustainable affirmative action in the Health Sector at all tiers.

Activity 3.7: Provision of logistic support to Central MoH Planning wing and State Directors General
Eleven sets of office equipment will be provided to the Planning/Research wing of MoH and all Directors General of the states including a personal computer, printer, scanner and photocopier to enhance their efficiency and enable improved functioning of these pivotal offices engaged in planning, policy development, and implementation in addition to monitoring, supervision and evaluation.

Activity 3.8: Provision of office equipment to 79 County Medical Officers
A similar set of office equipment will be provided to all 79 Medical Officers heading Health Departments at the County level.

Activity 3.9: Program Management and Evaluation
This will include all the operational and management expenses including a few salaries, audit fees, utilities charges and evaluation costs. The break up of cost is given in the Annex-

5.1: Sustainability of GAVI HSS support
The GAVI/HSS support will essentially be used to complement governmental efforts and no new structure will be created. Certain one time activities undertaken such as renovation of health facilities or provision of equipment will be maintained by the government or its development partners on a recurrent basis. The improvement in quality of health services will lead to public confidence in health facilities and improve the health seeking behavior of the population. This is turn will make them productive members of society. The health-poverty nexus will be partly addressed and some headway made through increased health spending as an investment towards overall economic development. The various aspects of sustainability are discussed below:

Financial sustainability: Through its natural resources and donor support the government will be able not only to sustain but further enhance its health spending. The program will also be complemented by other funding sources including the MDTF, GFATM-HSS and others, in addition to the support already being provided by the government and all its development partners including UN agencies.

Technical sustainability: The institutional capacity building, expertise and proper assigning of roles to NGO will result in technical sustainability, while in social terms; sustainability will be achieved by developing linkages of the community with government and locally elected officials.

5.2: Major Activities and Implementation Schedule

Implementation schedules:

Specific objectives

1. Ensure improved access to maternal and child health care in all states of Southern Sudan resulting in a 10% reduction in maternal and child mortality in those states during the first two years.
2. Retain, build the capacity, motivate and mobilize all the doctors, nurses, paramedics, support staff and community outreach workers to make all the facilities at central and state levels functional and efficient.
3. Enhance managerial including planning and financing capacity of the Central Ministry of Health and all ten State Ministries of Health ensuring increased financing and timely flow of funds to the State level and below.
4. Achieve 45% EPI coverage in all the ten states from the current level of less than 20% DPT 3 coverage by December 2010
5. Have a reliable system for Health Information System in place for use in decision-making at central and state levels.

Barriers:

1. Weak governance and management systems, including a poor Health Information System, particularly at the State level and below;
2. Low level of spending on health and inefficiency in utilization of available resources at the peripheral levels;
3. Inadequate availability of human resource for health with weak capacity and inequitable distribution across geographical regions;
4. Inadequate access to maternal and neonatal services; and
5. Poor infrastructure and inadequate supplies and logistics (medical supplies and equipment, cold chain, transport and communication) for primary health care facilities network.

5.2: Major Activities and Implementation Schedule

Major Activities	Year 1 (2009)				Year 2 (2010)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1: Improved health care service delivery particularly to vulnerable population segments								
Activity 1.1: Provision of ten Logistics and supply experts (one for each state) at state level			X	X	X	X	X	X
Activity 1.2: Augmenting government efforts in renovation of 11 Hospitals with provision of basic furniture/equipment:			X	X	X	X	X	X
Activity 1.3: Augmenting governmental efforts in renovation of 40 PHCCs with provision of basic furniture / equipment			X	X	X	X	X	X
Activity 1.4: Augmenting governmental efforts in renovation/Functioning of 250 PHCUs with provision of basic furniture			X	X	X	X	X	X
Activity 1.5: Hiring of 10 Social Mobilizers (1 for each state) for demand creation for Health, particularly preventive programs such as EPI, TB-DOTS, RBM, HIV/AIDS, Nutrition, ANC and PNC			X	X	X	X	X	X
Activity 1.6: Provision of 10 Cold rooms at state level for proper management of vaccines					X	X		
Activity 1.7: Enhancing a massive IEC campaign to create a demand for health care services particularly for MCH/EPI			X	X	X	X	X	X
Activity 1.8: Provision of ten motorboats			X	X				
Activity 1.9: Operational research on gender empowerment community involvement and logistic management issues			X	X	X	X	X	X
Objective 2: Strengthening of the fragmented health workforce for ensuring better health outcomes								
Activity 2.1: TA for carrying out Training Needs Assessment of all health care professional and health care providers	X							
Activity 2.2: Refresher training of Community Health Workers and Community Social Officers to perform all basic health services and serve as a link between communities and health facilities		X	X	X	X	X	X	X
Activity 2.3: Provision of 1,144 bicycles to community health workers in the counties			X	X	X	X	X	X
Activity 2.4: Provision of Motor cycles to 20 Community Social Officers			X	X				

Activity 2.5: Provision of 158 motorcycles (two in each county)	**X X**	
Activity 2.6: Training of 225 doctors on the preventive aspects and implementation of the Basic Package of Health Services		**X X**
Activity 2.7: Training of 473 public health officers on the preventive aspects		**X X X X**
Activity 2.8: Training of 443 medical assistants/clinical officers on the preventive aspects	**X X**	
Activity 2.9: Training of 272 Laboratory personnel	**X X**	
Activity 2.10: TA for Health Information System Data compilation, analysis and use for decision making	**X X**	
Activity 2.11: Provision of buffer stock of HIS tools at Central and State levels		**X X X X**
Activity 2.12: TA for sustainability of private sector health facilities and establishment of additional public sector facilities at carefully selected sites		**X**

Objective 3: To ensure better governance, policies and mechanisms for Health Financing at Central and State levels		
Activity 3.1: TA for drawing up an inventory of Health Financing in South Sudan		**X**
Activity 3.2: Provision of 3-month training courses to two senior MoH staff in Health Planning/Economics at a reputed university	**X**	
Activity 3.3: TA for regulation and standard setting of public and private health care providers		**X**
Activity 3.4: Provision of three week's training in managerial skills for Program Managers at the Central Level and Directors General at the state level	**X X**	
Activity 3.5: Provision of two week's training in managerial skills for 79 County Medical Officers	**X**	**X**
Activity 3.6: Long term TA for all aspects of Health System Strengthening at all tiers	**X X**	**X X X X**
Activity 3.7: Provision of office equipment to Central MoH Planning wing and State Directors General (for 11 offices) PC with printer, scanner, photocopier, and fax	**X**	
Activity 3.8: Provision of office and communications equipment to County Medical Officers (for 79 offices) PC with printer, scanner, and photocopier	**X**	**X**
Activity 3.9: Program management and Evaluation	**X X X X**	**X X X X**

Section 6: Objectives, Monitoring, and Evaluation (M&E) and Operational Research

6.1: Impact and Outcome Indicators

Major Outputs Expected through GAVI-HSS: Indicator	Data Source	Baseline 2006	Source	Targets end-2010
1. DPT3 coverage (%)	SHHS	20%	MoH/EPI	45%
2. Counties achieving ≥80% DPT-3 coverage		Not available	MoH/EPI	20%
3. % children 6-59 months received vitamin-A supplementation within last 6 months	SHHS	40%	MoH/EPI	60%
4. % deliveries attended by skilled personnel	SHHS	10%	MoH/UNFPA	15%
5. Antenatal care by skilled personnel	SHHS	26%	MoH/UNFPA	33%
6. Under-5 Mortality Rate	SHHS	135/1000	MoH	130/1000

6.2: Output Indicators:

Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Date for Target
Improved health care delivery and access to vulnerable segments								
Number of hospitals/ PHC facilities functional	47 hosp 157 PHCCs 576 PHCUs	12 million	Inputs from DGs SMoH	70%	MoH	2008	90%	End-2010
Strengthening the workforce for health								
%age of middle cadre health care personnel trained on BPHS	All	12 million	MoH	0	MoH	2008	80%	End-2010
Percentage of trained community health workers performing outreach activities	All	12 million	MoH	20%	MoH	2008	80%	End-2010

6.3: Data collection, analysis and use:

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. % deliveries attended by skilled personnel	Community heath workers	State level	At all levels
2. Under five mortality rate (per 1000 LB)	County / payam health system	South Sudan level	Central level
3. National DTP3 coverage (%)	EPI	State/Central levels	All levels
4. Counties achieving ≥ 80% DTP3 coverage	EPI	State/Central levels	CMoH
5. Use of Oral Dehydration Therapy (ORT)	IMCI program	Central level	CMoH, SMoH
6. % children 6-59 months who received vitamin-A supplement within last 6 months	EPI	Central level	CMoH, SMoH
Output			
Institutional capacity, management and organization			
1. % SMOH with functioning organizational structure as per standards	DGs SMoH	CMoH	CMoH
2. % SMOH with functional planning directorates	DG Planning CMoH, DG SMoH	CMoH	CMoH
3. % States planning directorates using standard planning format	CMoH	CMoH	CMoH
4. % SMOH with functioning directorates of human resource	CMoH	CMoH	CMoH
Services delivery, access and utilization			
5. % health facilities (PHCCs/PHCUs) providing essential PHC package	SMoH, CMoH	CMoH	CMoH
6. % PHC workers who received integrated in-service training during last 1-year	CMoH	CMoH	CMoH
7. Health services utilization rate	CMoH/SMoH	CMoH	CMoH
8. % PHC facilities reported timely for health information	CMoH/SMoH	CMoH	CMoH

6.4: Strengthening M&E system

The HIS will be strengthened and special emphasis given to monitoring and supervision. An end-term evaluation will be carried out in the first quarter of 2011 of interventions carried out through the first two years of this program, and their impact on the overall health system enabling removal of the barriers to immunization, and other aspects of maternal and child health. The emerging reports will be compared with the baseline data and evaluated in the light of the targets and MDGs. All activities will be in line with Draft M&E Framework designed by MoH, GoSS. The M&E Unit shall function within the Directorate General of Health System Development, Research and planning in MoH. **Furthermore, during the project implementation, the TWG meetings will be held on a fortnightly basis, while the HSCC will meet at least once a month.**

6.5: Operational Research

A study has been proposed to determine the impact of community-based initiative on the success of programs and the health system as a whole. The study will be carried out in the second year of project life, will be designed in 2009 and carried on from 2009 till end-2010. Other studies will determine how to improve access to difficult areas, and developing better linkages of the existing system with the communities through outreach workers. Based on the results of the studies, new community-based initiatives may be designed to improve health outcomes adopting a holistic approach. Another study will look at logistic issues, with a view to improve their management and avoid wastage / stock-outs.

Section 7: Implementation arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	Director General, Research, Planning and Health System Development, under the overall guidance and supervision of the Under Secretary, Central Ministry of Health, Government of Southern Sudan Juba
Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	1. Ensures that GAVI/HSS support in addition to ongoing GAVI support and coordination of inter-sectoral donor activities for HSS, is managed according to the best practices for the management of global health partnerships at the country level; 2. Reviews/authenticates annual budget and other details on the financial implications of the proposal; 3. Monitors and guides on implementing the variety of GAVI/HSS activities; 4. Reviews the progress and teases out/ addresses any hurdles in implementation on a monthly basis; 5. Reviews and approves the progress reports for submission to the GAVI secretariat; and 6. Coordinates with allied programs and activities in health sector, ensuring best practices for managing global health partnership at country level.
Mechanism for coordinating GAVI HSS with other system activities and programs	HSCC for GAVI/HSS since brings together members from ICC, Steering Committee for MDTF/ DHSD project, private sector and civil society, this forum will bridge different programs and major activities undergoing in the health sector. In addition, the Directorate General of International Health, GONU that is on HSCC will ensure dialogue and coordination between different actors in health sector with competing interests.

7.2: Roles and responsibilities of key partners (HSS members and others)

Title / Post	Organisation	HSCC member	Roles and responsibilities of key partners in the GAVI HSS application implementation
Undersecretary	MOH- GoSS	Yes	In addition to being the Chair of HSCC and thereby responsible for providing leadership to the carrying out of all functions of HSCC (see 7.1) and monitor and review progress, he being head of public sector health system has management responsibility for the efficient use of GAVI/HSS support.
Head of Office	WHO Southern Sudan	Yes	1. Ensures mainly technical support and the coordination role with allied programs and activities in the health sector; 2. Assures coordination of the best practices for managing the global health partnership are adhered to in implementing the GAVI/ HSS support; and 3. Facilitates the provision of TA required for the implementation of GAVI/ HSS support.
Head of Office	UNICEF, Southern Sudan	Yes	Facilitates the provision of technical support and material inputs for the EPI program.
Head of Office	UNFPA Southern Sudan	Yes	Facilitates the provision of technical and logistic support and material inputs for MCH/EPI program.
Director	USAID Southern Sudan	Yes	Facilitates the provision of technical support and material inputs for the overall health service strengthening
Director General, External Assistance	MOH-GoSS	Yes	Being in the knowledge of MoH's own budget and external assistance, he is best suited to ensure the dialogue and active coordination between different actors in the health sector with competing interests for avoiding any overlap.

Director General, Research, Planning and Health System Development	MOH-GoSS	Yes	In addition to discharging the responsibilities as Focal Point and secretary of HSCC , the DG provides stewardship of the technical working group and coordinates: 1. A detailed plan of action for different components of GAVI/HSS proposal; 2. Implementation of GAVI/HSS support activities at the national and state level; 3. The design and implementation of a system to monitor the implementation of GAVI/HSS support; and 4. Presents periodic/annual progress reports for review by NHSCC and sharing with the partners;
Director General, Primary Health Care	MoH-GoSS	Yes	In addition to discharging the responsibilities as a member of HSCC he: 1. Coordinates for the efficient use of input at the national, state and locality level aimed at improving access to primary health care; 2. Ensures the Director PHC work with Director Health Planning in states for the effective implementation of the planned activities; and 3. Identify activities which can improve child and maternal survival and work with DG, R,P&HSD for their inclusion in the plan.
Directors General State Ministries of Health	SMoHs	Yes	Coordinate implementation of all health activities under the overall policy guidance of MoH-GoSS
National Program Officer, EPI	MOH-GoSS	Yes	He coordinates and monitors GAVI/ISS and GAVI/HSS support under the guidance of the Focal Person. He also assists in monitoring the outcome and impact indicators for GAVI/HSS support

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country	A separate bank account of the Central Ministry of Health will be used for receiving funds from GAVI to avoid any mix-up. This account will be operated by the Under-Secretary, DG Planning any other authorized officers in their absence. The expenditure will be incurred according to government procedures and all transactions will be used to fund activities planned for the GAVI/HSS support. The Ministry of Finance will assist MoH by training certain staff in financial procedures. **Every effort will be made to ensure that program implementation gets underway by January 2009 so that the progress can be evaluated in December 2010 at the end of the program life.**
Mechanism for channelling GAVI HSS funds from central level to the periphery	Funds from GAVI/HSS support will be provided to states for local payment through government account operated by the Director General Health in the States Ministries of Health
Mechanism (and responsibility) for budget use and approval	The mechanism will be strictly in accordance will the rules of government of Southern Sudan governing external assistance. The disbursement of funds will be made by the authorized officers to eligible recipients towards approved activities for GAVI-HSS support. Regular financial reports will be prepared by the GAVI-HSS Focal Point for presenting to the HSCC.
Mechanism for disbursement of GAVI HSS funds	Disbursement from the amount received through GAVI/HSS support will be made against the planned activities approved by the HSCC.
Auditing procedures	The GAVI-HSS Focal Point will arrange and facilitate annual audit of accounts provided for GAVI/HSS support, and the audited financial reports will be submitted to the GAVI Secretariat on a yearly basis throughout the project life.

7.4: Procurement mechanisms

The procurement mechanisms of the Government of Southern Sudan will be practiced in a highly transparent manner. However, along with mechanisms for transparency and accountability a measure of flexibility will be thrown in to allow for some decentralization so that there is no undue hindrance in the utilization of funds. Meanwhile, the World Bank is assisting the Ministry of Finance in streamlining and reforming the procurement procedures. Reliance will also be placed on UNICEF for procurement of most items in view of their comparative advantage.

7.5: Reporting arrangements

The reporting will emerge from the state level and be consolidated at the Central level by the Focal Person. At the State level the Director General shall be responsible for monitoring and reporting all the activities.

7.6: Technical assistance requirements

Major Activities	Year 1 (2009)				Year 2 (2010)				Anticipated Duration	Anticipated source
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
									Preferably national or if not available then international Technical Assistance mainly through WHO support in view of its comparative advantage	
Objective 2: Strengthening of the fragmented health workforce for ensuring better health outcomes										
Activity 2.1: TA for carrying out Training Needs Assessment of all health care professional and health care providers	**X**								**3 months**	
Activity 2.10: TA for Health Management Information System Data compilation, analysis and use for decision making in States	**X**								**3 months**	
Activity 2.12: TA for sustainability of private sector health facilities and establishment of additional public sector facilities at carefully selected sites					**X**				**3 months**	
Objective 3: To ensure better governance, policies and mechanisms for Health Financing at Central and State levels										
Activity 3.1: TA for drawing up an inventory of Health Financing in South Sudan					**X**				**3 months**	
Activity 3.3: TA for regulation and standard setting of public and private health care providers					**X**				**3 months**	
Activity 3.5: Long term TA for all aspects of Health System Strengthening including policy support			**X**	**X**	**X**	**X**	**X**	**X**	**18 months**	

Section 8: Costs and funding for GAVI HSS

8.1: Cost of implementing GAVI HSS activities (worksheet showing micro-costing annexed)

Area for support	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	TOTAL COSTS
	2008	**2009**	**2010**	
Activity costs				
Activity 1.1		60,000	120,000	180,000
Activity 1.2		200,000	240,000	440,000
Activity 1.3		400,000	400,000	800,000
Activity 1.4		500,000	500,000	1,000,000
Activity 1.5		60,000	120,000	180,000
Activity 1.6		0	50,000	50,000
Activity 1.7		25,000	50,000	75,000
Activity 1.8		100,000	0	100,000
Activity 1.9		28,000	52,000	80,000
Total		**1,373,000**	**1,532,000**	**2,905,000**
Activity 2.1		45,000	0	45,000
Activity 2.2		63,000	54,000	117,000
Activity 2.3		72,000	100,000	172,000
Activity 2.4		20,000	0	20,000
Activity 2.5		158,000	0	158,000
Activity 2.6		0	113,000	113,000
Activity 2.7		15,000	103,000	118,000
Activity 2.8		89,000	0	89,000
Activity 2.9		82,000	0	82,000
Activity 2.10		45,000	0	45,000
Activity 2.11		0	12,000	12,000
Activity 2.12		0	45,000	45,000
Total		**589,000**	**427,000**	**1,016,000**
Activity 3.1		0	45,000	45,000
Activity 3.2		100,000	0	100,000
Activity 3.3		0	45,000	45,000
Activity 3.4		200,000	0	200,000
Activity 3.5		75,000	241,000	316,000
Activity 3.6		72,000	144,000	216,000
Activity 3.7		44,000	0	44,000
Activity 3.8		119,000	197,000	316,000
Activity 3.9		56,000	76,000	132,000
Total		**666,000**	**748,000**	**1,414,000**
Grand Total		**2,628,000**	**2,707,000**	**5,335,000**

8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	TOTAL FUNDS
	2008	2009	2010	
Birth cohort	510,319	525,628	541,397	
Allocation per newborn		US$ 5	US$ 5	
Annual allocation	**---**	**2.628**	**2.707**	**5.335**

Source and date of GNI and birth cohort information:
GNI: New Sudan Centre for Statistics and Evaluation in association with UNICEF. Towards a Baseline: Best Estimates of Social Indicators for Southern Sudan. June 2004. p. 68
Birth cohort: cMYP, EPI Program and SHHS, 2006

8.3: Sources of funding for GAVI HSS Activities[2]

Funding Sources	Allocation per year (Million US$)						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3	Year 4	Year 5	TOTAL FUNDS (for 5 years)
	2008	2009	2010	2011	2012	2013	
GAVI HSS	----	2.628	2.707	2.788	2.872	2.958	13.953
Government	10.000	13.000	16.000	20.000	25.000	30.000	114.000
MDTF	5.000	6.500	8.000	10.000	12.500	15.000	57.000
TOTAL FUNDING	15.000	22.128	26.707	31.788	40.372	47.958	184.953
Total unfunded	**40.000**	**50.000**	**60.000**	**70.000**	**90.000**	**110.000**	**420.000**

Source of information on funding sources:

Government: MoH, GoSS based on 2008 projections.....
.....

MDTF-N: MoH, GoSS based on 2008 projections.....
.....

[2] Including Government, GAVI and four main named contributors

8.4: Sources of all expected health sector spending

Funding Sources	Cost per year (Million US$)						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3	Year 4	Year 5	**TOTAL FUNDS**
	2008	2009	2010	2011	2012	2013	
GAVI/ ISS, NVS, INS	1.010	1.200	1.200	1.300	1.300	0	**6.010**
Government (CMOH budget)	70.000	75.000	80.000	85.000	90.000	95.000	**495.000**
Government (states and district budgets)	15.000	16.000	17.000	18.000	19.000	20.000	**105.000**
WHO	5.800	7.000	7.500	8.000	8.500	9.000	**45.800**
UNICEF	14.000	15.000	16.000	17.000	18.000	18.000	**98.000**
UNFPA	5.000	5.500	6.000	6.500	7.000	7.500	**37.500**
GFATM (incl. TB, HIV, Malaria, TB-HIV)	23.803	22.604	25.846	30.027	31.651	0	**133.931**
GFATM R-8 HSS (applied for)		2.722	5.623	4.454	2.274	2.299	**17.373**
MTDF-N	20.000	22.000	24.000	26.000	28.000	30.000	**150.000**
TOTAL FUNDING	**154.613**	**167.026**	**183.169**	**196.284**	**205.725**	**181.799**	**1088.614**

* Subject to performance

Source of information on funding sources:

GAVI-ISS based on first year's releases. The rest is subject to performance .....

Government: MoH, GoSS .....

WHO: WHO Office Southern Sudan .....

UNICEF: UNICEF Southern Sudan, Head of Health Section .....

UNFPA: .....

Global Fund: UNDP Southern Sudan / GFATM contracts .....

Total: summed up all financial inputs .....

Section 9: Endorsement of the Application

9.1: Government endorsement (see attachments)

The Government of Southern Sudan commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests the GAVI Alliance to contribute financial assistance in order to support the strengthening of health systems as outlined in this application.

Ministry of Health:	***Ministry of Finance:***
Name:	Name:
Title / Post: Central Minister for Health, Government of Southern Sudan, Juba	Title / Post: Central Minister for Finance, Government of Southern Sudan, Juba
Signature:	Signature:
Date:	Date:

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting held on . The signed minutes are attached as Annex C.

Chair of HSCC (or equivalent):

Name: Dr Monywiir Arop Kuol	Post / Organisation: Under Secretary Central Ministry of Health
Signature:	Date:

Person to contact in case of enquiries:

Name: Dr Olivia Lomoro	Title: Director General, Research, Planning and Health System Development, Ministry of Health Government of Southern Sudan, Juba
Tel No: Mobile: Fax No:	
Email: achaber@yahoo.co.uk	

ANNEX 1: DOCUMENTS SUBMITTED IN SUPPORT OF APPLICATION (Annex-B)

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
South Sudan National Health Policy 2006-2011, Ministry of Health, Government of South Sudan	Yes	2006-2011	
Building an equitable health system for Southern Sudan: Options for GAVI Health Systems strengthening funding, USAID	Yes	Current	
Comprehensive Multi-Year National Immunization Plan 2007-2011, Ministry of Health, Government of South Sudan in collaboration with WHO and UNICEF	Yes	2007-2011	
Sudan Household Health Survey, 2006 prepared by Central Bureau of Statistics, GOSS, in collaboration with UNICEF, PAPFAM), WFP, UNFPA, WHO, USAID and League of Arab States.	Yes	2006	
The Basic Package of Health Services in Southern Sudan, Ministry of Health, Government of South Sudan in collaboration with WHO	Yes	Current	
South Sudan Interim Health Strategy 2006-2008, Ministry of Health, Government of Southern Sudan	Yes	2006-2008	
Towards a baseline: Best estimates of social indicators for Southern Sudan: New Sudan centre for statistics and evaluation in association with UNICEF May 2004 see p.68	Yes	2004	
The report of the First Government of Southern Sudan Health Assembly (GOSSHA) held in Juba from 18 - 21 June, 2007	Yes	Current	
Southern Sudan draft policy for Human Resources for Health 2007-2017, Ministry of Health, Government of South Sudan in collaboration with WHO	Yes	2007-2017	
Southern Sudan Policy for Human Resource for Health	Yes	2006 - 2011	

In addition, the following documents are being submitted with the application:

1. Government decree for the constitution of NHSCC dated 14 August 2007 (Annex A)
2. Emails indicating the communication with partners in developing the application (see Annex-C)
3. Minutes of meetings of NHSCC/TWG since July 2007 along with signed attendance sheets and photographs (Annex-D)
4. Endorsement of H.E. the Minister for Health (Annex-E)
5. Endorsement of Under Secretaries of Health and Finance (Annex-F)
6. Worksheet showing micro-costing of various activities (Annex-G)

ANNEX 2 BANKING FORM (separate bank account being opened, to be submitted later)

GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATION	**Banking Form**

SECTION 1 ***(To be completed by payee)***

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunization dated . . . . . , the Government of . . . . . .

hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: ***(Account Holder)***		
Address:		
City – Country:		
Telephone No.:	**Fax No.:**	
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**
For credit to: ***Bank account's title***		
Bank account No.:		
At: ***Bank's name***		

Is the bank account exclusively to be used by this programme? **YES ( ) NO ( )**

By whom is the account audited? .....

Signature of Government's authorizing official:

Name:	.....	**Seal:**
Title:	.....	
Signature:	.....	
Date:	.....	

SECTION 2 ***(To be completed by the Bank)***

FINANCIAL INSTITUTION	**CORRESPONDENT BANK (*In the United States)***
Bank Name:	
Branch Name:	
Address:	
City – Country:	
Swift code:	
Sort code:	
ABA No.:	
Telephone No.:	
Fax No.:	

I certify that the account No. . . . . is held by *(Institution name)* . . . . . .at this banking institution.

The account is to be signed jointly by at least …… *(number of signatories)* of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name:	**Signature :**
Title:	**Date:**
2 Name:	**Seal:**
Title:	
3 Name:	
Title:	
4 Name:	
Title:	

COVERING LETTER

(To be completed by UNICEF representative on letter-headed paper)

TO: GAVI – Secretariat
Att. Dr Julian Lob-Levyt
Executive Secretary
C/o UNICEF
Palais de Nations
CH 1211 Geneva 10
Switzerland

On the …… I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	Title
Government's authorizing official		
	.....	.....
Bank's authorizing official		
	.....	.....

Signature of UNICEF and WHO Representatives / Heads of Offices in Southern Sudan:

Name .....

Signature .....

Date .....