Joint Appraisal report update 2018

Country	Central African Republic (CAR)
Full JA or JA update	☑ full JA ☐ JA update
Date and location of Joint Appraisal meeting	22 to 23 August 2018
Participants / affiliation[1]	See Annex
Reporting period[2]	1 July 2017 to 30 June 2018
Fiscal period	1 July 2017 to 30 June 2018
Comprehensive Multi Year Plan (cMYP) duration	2018-2022
Gavi transition/co-financing group	Initial self-financing

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes ☒	No ☐	NA ☐
HSS renewal request	Yes ☐	No ☐	NA ☒
CCEOP renewal request	Yes ☒	No ☐	NA ☐

Observations on vaccine request

Population	**5,388,044**				
Birth cohort	**166 000**				
Vaccine	**DTP-HepB-Hib**	**YFV**	**MenA**	**IPV**	**PCV-13**
Population in the target age cohort	163,797	163,797	163,797	163,797	163,797
Target population to be vaccinated (first dose)	147,417	131,038	131,038	131,038	147,417
Target population to be vaccinated (last dose)	131,038	NA	NA	NA	131,038
Implied coverage rate	80%	80%	80%	80%	80%
Last available WUENIC coverage rate	47%	48%	NA	47%	47%
Last available admin coverage rate	54%	51%	40%	40%	51%
Wastage rate	15%	15%	15%	15%	5%
Buffer	98,600	28,600	28,400	25,600	76,300
Stock reported	174,500	2,400	39,540	28,250	112,830

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[3]

	Schedule	**Expected application year**	**Expected introduction year**
Indicative interest to introduce new vaccines or request HSS support from Gavi in the future	Rotavirus vaccine	2011	2019
	Measles-Rubella	2019	2020
	HPV	2020	2022

[1] If taking too much space, the list of participants may also be provided as an annex.

[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

[3] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes

	Hepatitis B	2021	2022

According to the 2018-2022 cMYP, the introduction of new vaccines conforms to the plan below:

- The introduction of the rotavirus vaccine has already been endorsed by the Inter-agency Coordinating Committee (ICC) and mutually agreed with Gavi. It has been rescheduled for 2019.
- Measles-Rubella (MR) will be introduced after a mass campaign in 2020 given the low immunisation coverage levels for MCV1 over the past three years (50% in 2015, 63% in 2016 and 52% in 2017).
- HPV and HepB at birth will both be introduced two years after the MR vaccine introduction, to allow for a post-introduction evaluation.

Prerequisites for these introductions concern a number of important elements, including:

- Strengthening human resources through recruitment of additional health workers and training them in the practice of immunisation on a day-to-day basis.
- Technical assistance will be implemented at the central level to accompany each new vaccine introduction, in addition to human resources at the peripheral level.
- Supply chain improvements and increased storage capacity at the regional, district and health facility level. This assumes that an adequate cold chain has been implemented in the districts and health facilities, with a permanent functional supply mechanism. CAR's successful application to the Gavi CCEOP should bring more improvements to its supply chain.
- Harnessing community involvement to obtain the support of beneficiaries. This is to be achieved through communication involving health care professionals, community leaders and other civil society stakeholders.

2. RECENT CHANGES IN COUNTRY CONTEXT, AND POTENTIAL RISKS FOR NEXT YEAR

Since the last Joint Appraisal, the following major changes have occurred in CAR's context:

- As per Decree 043/ MSP/DIRCAB/CMAJC of 18 October 2017 concerning the creation of health districts in the health regions, the number of health districts increased from 30 to 35. Some prefectures were divided into two or even three districts, specifically Health Regions Two and Three. Bangui's eight arrondissements were combined into three health districts. Bangui, the capital of CAR, has sufficient health staffing resources (both in terms of number and quality) to manage the districts and it also has partners.

This new system allows for:

i. Better identification of health areas

ii. Improved population counting to more correctly calculate the population denominator in each health area

iii. Better quality of data for the IDSR

The three factors listed above have helped to revitalise the National Health Information System (NHIS) and the IDSR.

To complete this revitalisation, CAR must:

a. appoint coordinators for the NHIS and IDSR at all levels;

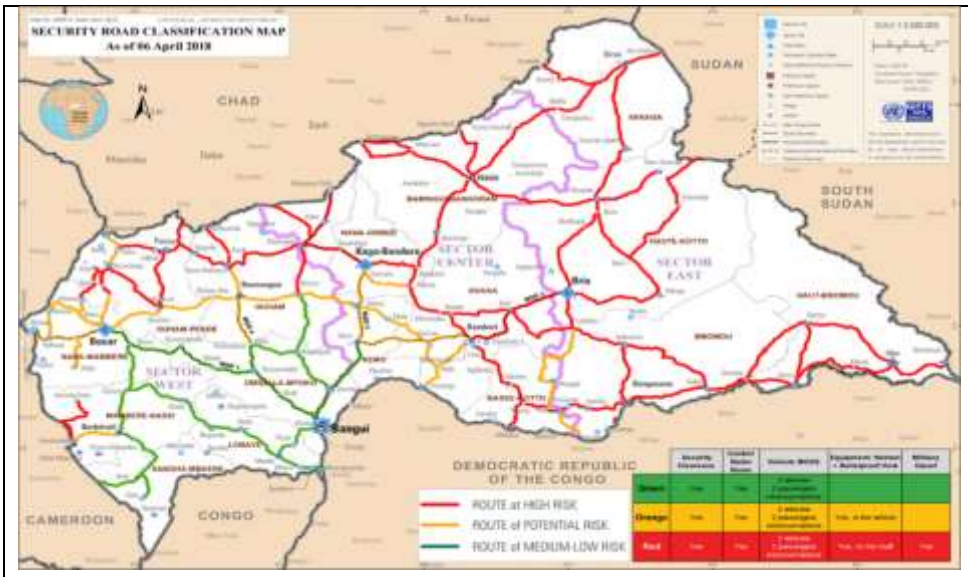
b. create a roadmap;

c. provide all levels with equipment to implement the DHIS2; and

d. organise coordinator training.

Since the fourth quarter of 2017, we have seen a resurgence of the crisis situation within CAR, specifically in Health Regions Three, Four, Five and Six and in Bangui city, associated with the effort to disarm militia groups in the KM5 district. Health facilities were pillaged and cold chain equipment was looted in Bangui 2, Paoua, Mobaye, etc. There were massive population displacements from unsafe areas towards relatively calmer ones, causing overpopulation situations in some cities such as Bangui, Bossangoa, Paoua Centre, Bangassou Centre and Bambari Centre.

Map of roads in CAR as of April 2018



This situation led to:

i. health centre workers and members of the District and Regional Management Teams leaving their positions;

ii. destabilisation and dysfunction of the NHIS/IDSR;

iii. the need to replace looted materials on an ongoing basis; and

iv. fluctuation in the coverage denominators for health interventions.

In early June 2018, the CCR (Central African Collective for Reconciliation) organised a roundtable meeting of stakeholders with the goal of signing a non-aggression pact. The real challenge is how to effectively apply this to definitively resolve the conflict, something that requires ongoing advocacy to identify humanitarian pathways and specific strategies in conflict zones and difficult-to-access areas (using a customised approach).

Measles epidemic flare-ups were documented in 2017 in CAR, resulting in the organisation of mini campaigns for measles immunisation during the year in the affected locations, specifically in the M'Baiki district in Health Region One in April and July and in the city of Bouaca in Ouham prefecture (Health Region Three) in April.

In light of the epidemiologic situation in the sub-region, the health monitoring system must be strengthened, with support from local partners.

The flexibility that CAR has received from Gavi, given the country's fragility, remains in effect. This has enabled the country to boost the level of technical assistance, continue funding new vaccines, mobilise additional resources to implement the urban immunisation strategy in Bangui city and submit a proposal to conduct a national measles immunisation campaign.

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

3.1. Coverage and equity of immunisation

CAR has undergone a decade of recurring conflicts with detrimental consequences for basic social infrastructure, in particular in the area of health and the delivery of preventive services such as immunisation. CAR thus has a large number of vulnerable children.

In this context of insecurity and the reconstruction of an already-fragile health system, routine EPI performance has remained poor, with no significant change over the past five years. The number of children missing Penta3 immunisation has remained relatively stable, with a slight downward trend in 2016.

However, it must be noted that the denominator both on a national and sub-national level remains difficult to pinpoint given that the last census was in 2003, and due to the effects of population movements. Consequently, any analysis of immunisation coverage from one district to another and from one year to another will contain ambiguities.

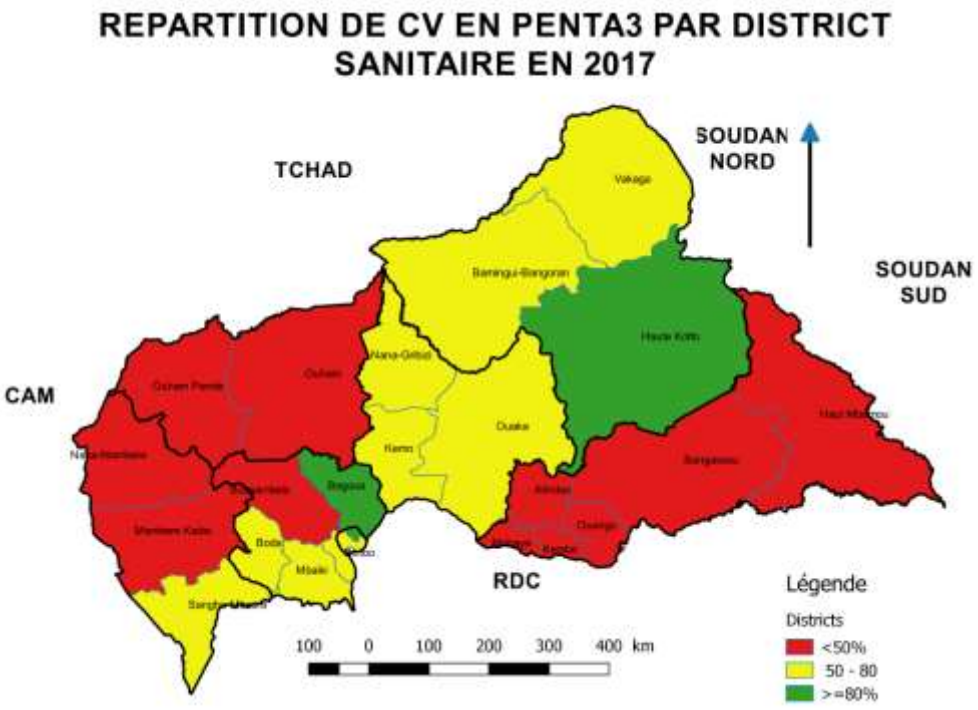
Table I: Change in main indicators for routine EPI from 2013 to 2017

Indicators	2013	2014	2015		2016	2017
	Admin	Admin	Admin	Survey	Admin	Admin
DTP-HepB-Hib1 coverage	44%	66%	69%	70%	79%	70%
DTP-HepB-Hib3 coverage	28%	41%	47%	53%	54%	54%
MCV coverage	29%	54%	50%	68%	65%	50%
% of districts with DTP-HepB-Hib3 ≥ 80%	4%	10%	7%	ND	17%	20%
Dropout rate for DTP-HepB-Hib1/ DTP-HepB-Hib3	36%	37%	28%	ND	31%	24%
BCG-MCV dropout rate	34%	3%	27	NA	18	26%
% districts with dropout rate >10%	100 %	97%	93%	ND	99%	83%

Nearly all of CAR's health districts are underperforming. Only six out of 30 districts (Bégoua, Haute Kotto, 1st Arrondissement, 2nd Arrondissement, 7th Arrondissement and 8th Arrondissement) achieved immunisation coverage of 80% for Penta3 in 2017. Use of immunisation services was poor in all health districts (dropout rates are higher than 10%).

The 2015 immunisation coverage survey showed better results than the administrative data, thus highlighting under-reporting at immunisation locations.

The even more significant difference for the measles antigen seems to be associated with a higher demand from beneficiaries for this specific vaccine and the fact that NGOs seem more likely to offer vaccines for diseases with high epidemic potential in locations for displaced persons.



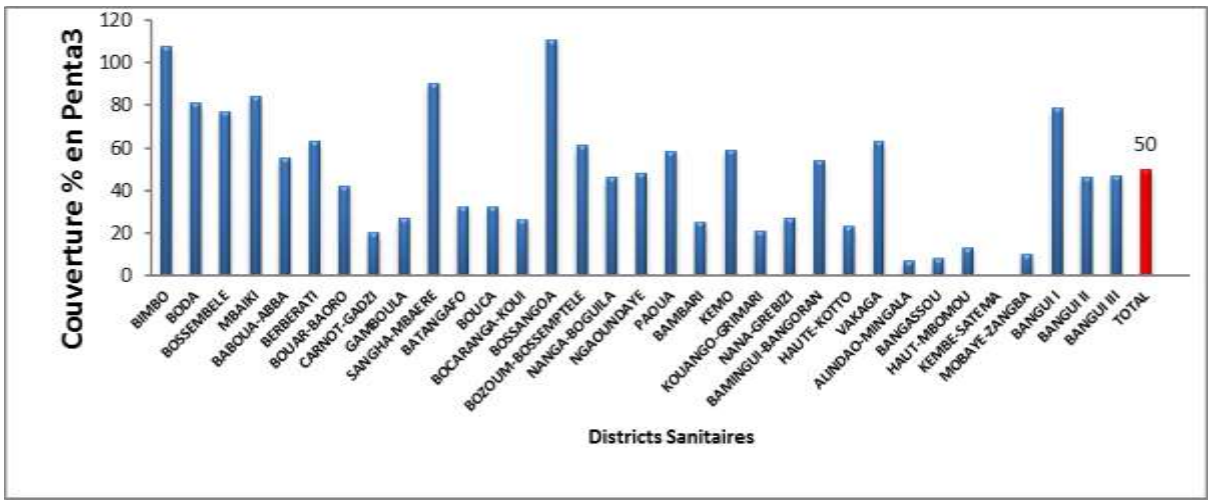


Figure 1: Penta3 immunisation coverage by health district, January-June 2018

Only six out of 30 districts achieved or exceeded immunisation coverage of 80%.

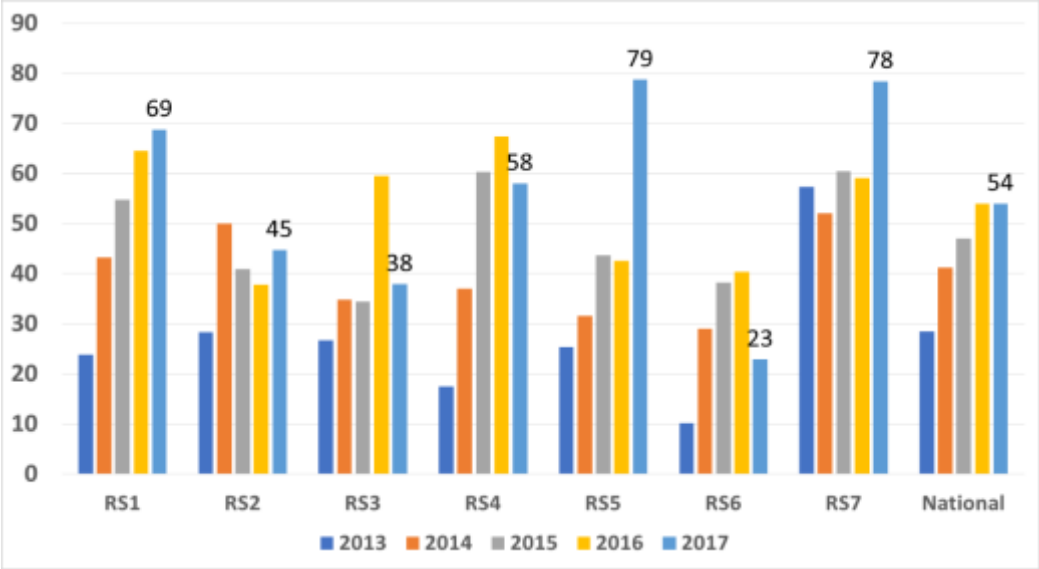


Figure 2: Trend in Penta3 immunisation coverage by region from 2013-2017

Excluding Health Districts Five and Seven, which achieved 75% immunisation coverage in 2017, all other health districts had low immunisation coverage during those five years (10-69%). The lowest coverage was recorded in 2013, in Health Region Six. Immunisation coverage nationwide, as in Health District One, has increased somewhat, although the assigned targets have not been reached.

This widespread underperformance is more prevalent in habitually unsafe areas. The causes are poor geographic coverage of immunisation locations for the EPI and a lack of qualified human resources.

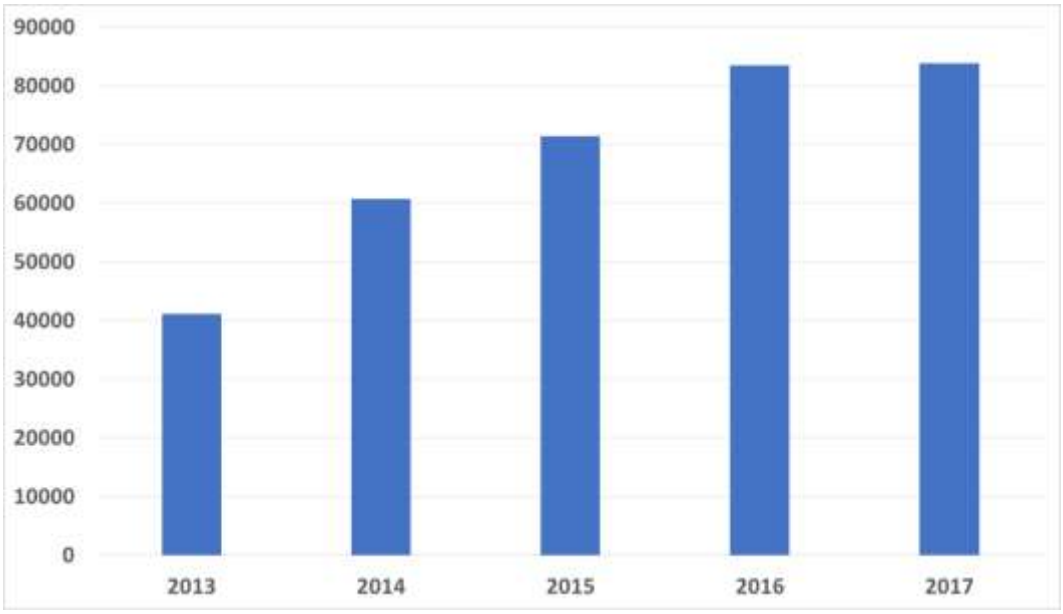


Figure 3: Number of children immunised with Penta3 from 2013-2017

The number of children immunised with Penta3 nationwide increased between 2013 and 2017, although the assigned targets were not met.

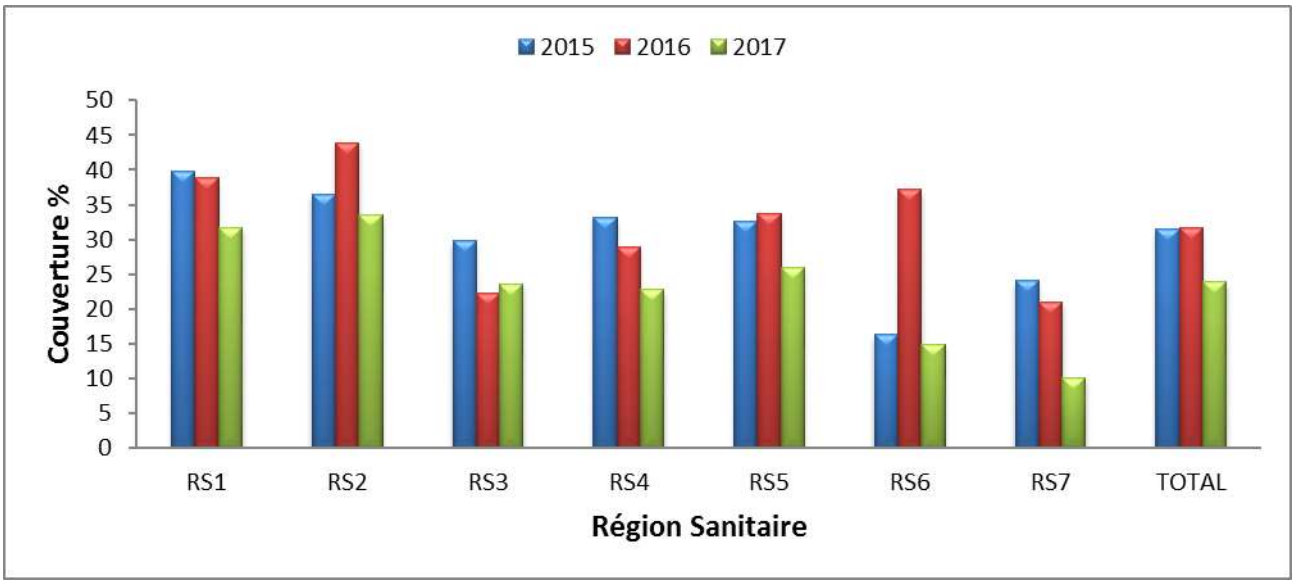


Figure 4: Trend of dropout rate from 2015-2017, by health region

The dropout rate remained significantly below the norm of 10% in all health regions during the three-year period. This is partially linked to poor availability of EPI services (geographic coverage, immunisation programme in health facilities), low demand from communities and lack of a system for catching dropouts in the target population.

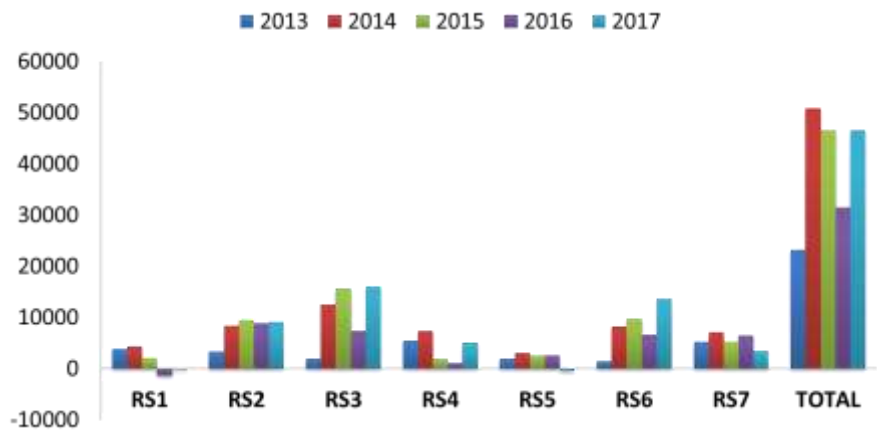


Figure 5: Number of unimmunised children by health region, 2013-2017

Figure 5 shows that the total number of susceptible targets during the five-year period remains very high (198,568). Health Regions Two and Three show the largest number of people likely to contract vaccine-preventable diseases due to their demographic characteristics and the effects of a series of security crises, including that in Health District Six.

With approval from the ICC, it would be beneficial to catch up children 12-23 months of age.

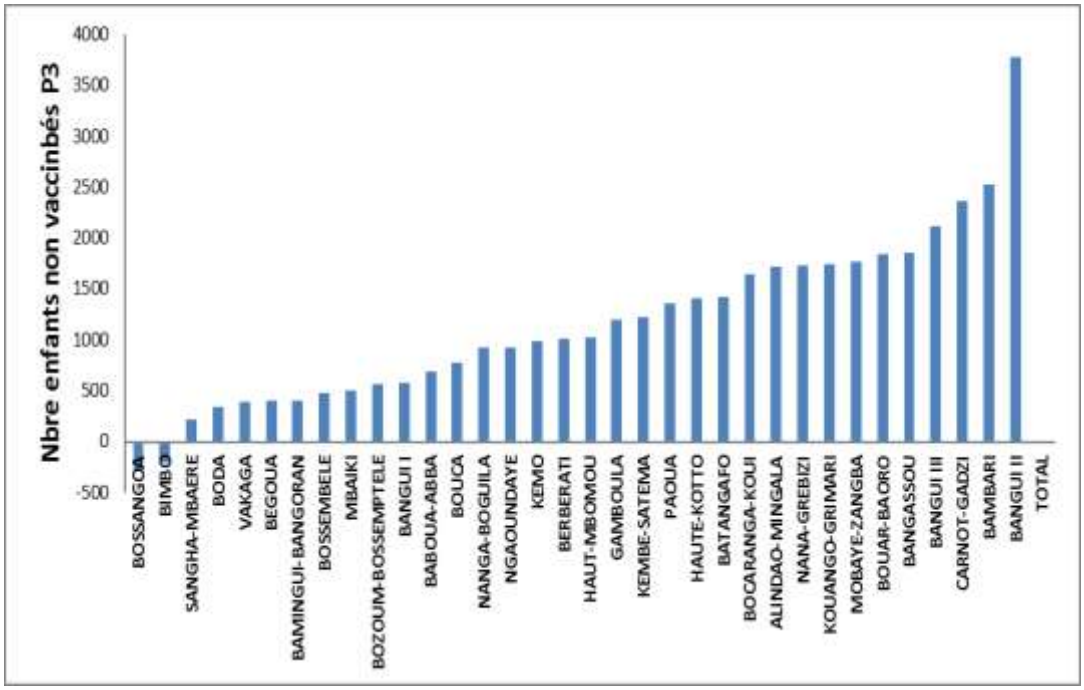


Figure 6: Number of children not immunised with Penta3 during the first half of 2018

Figure 6 shows that the number of children who were not immunised remains very high. Accelerating the implementation of the urban strategy in Bangui city, expanding it to other densely populated cities due to the security crisis and implementing methods to catch up with dropouts should change this.

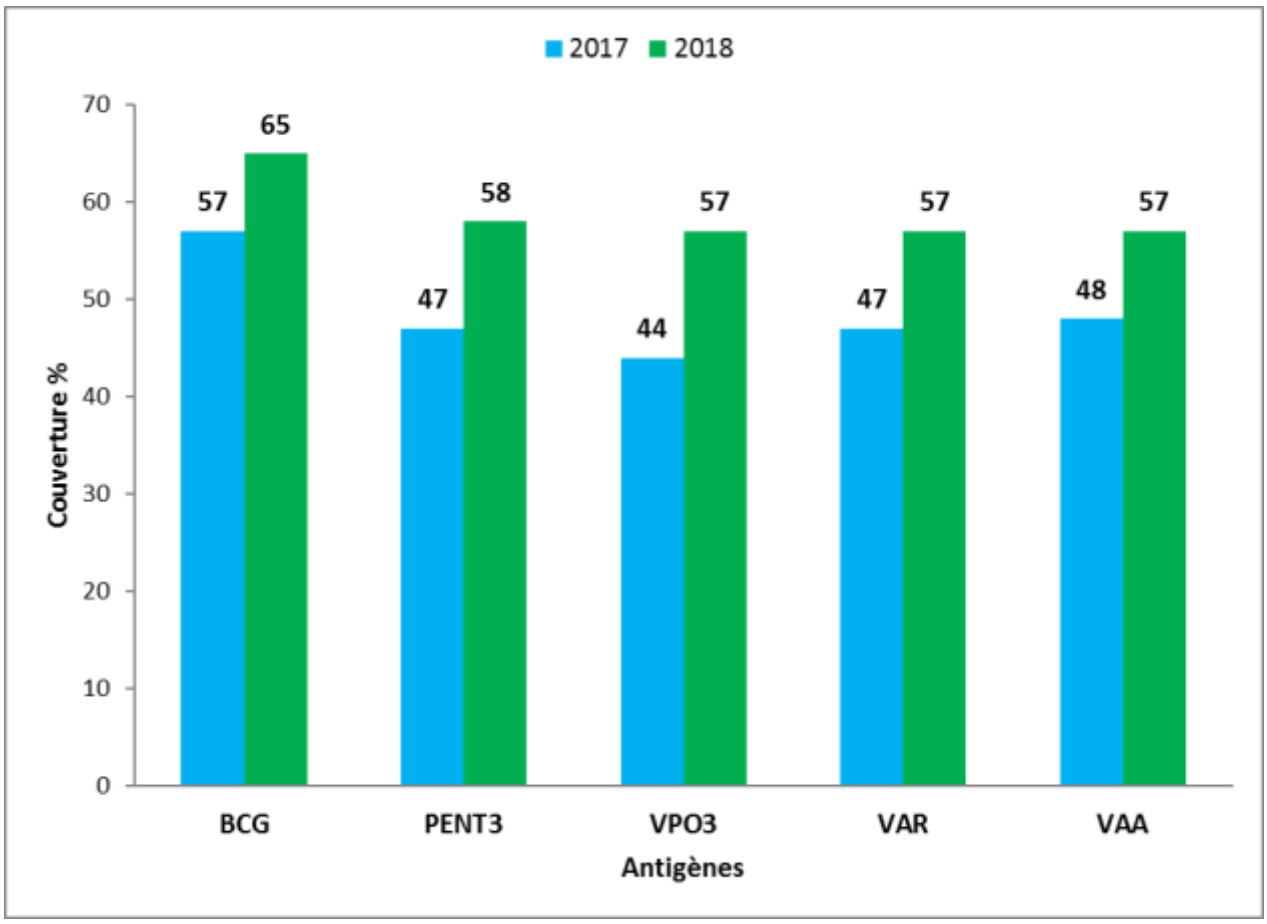


Figure 7: Comparison of immunisation coverage from first half of 2017 with first half of 2018

Despite all the negative factors, this figure shows that there has been significant improvement in the EPI's performance as compared to the same period in 2017. This progress is partially linked to improved reporting, which itself is the result of stronger leadership from the Minister of Public Health and Population.

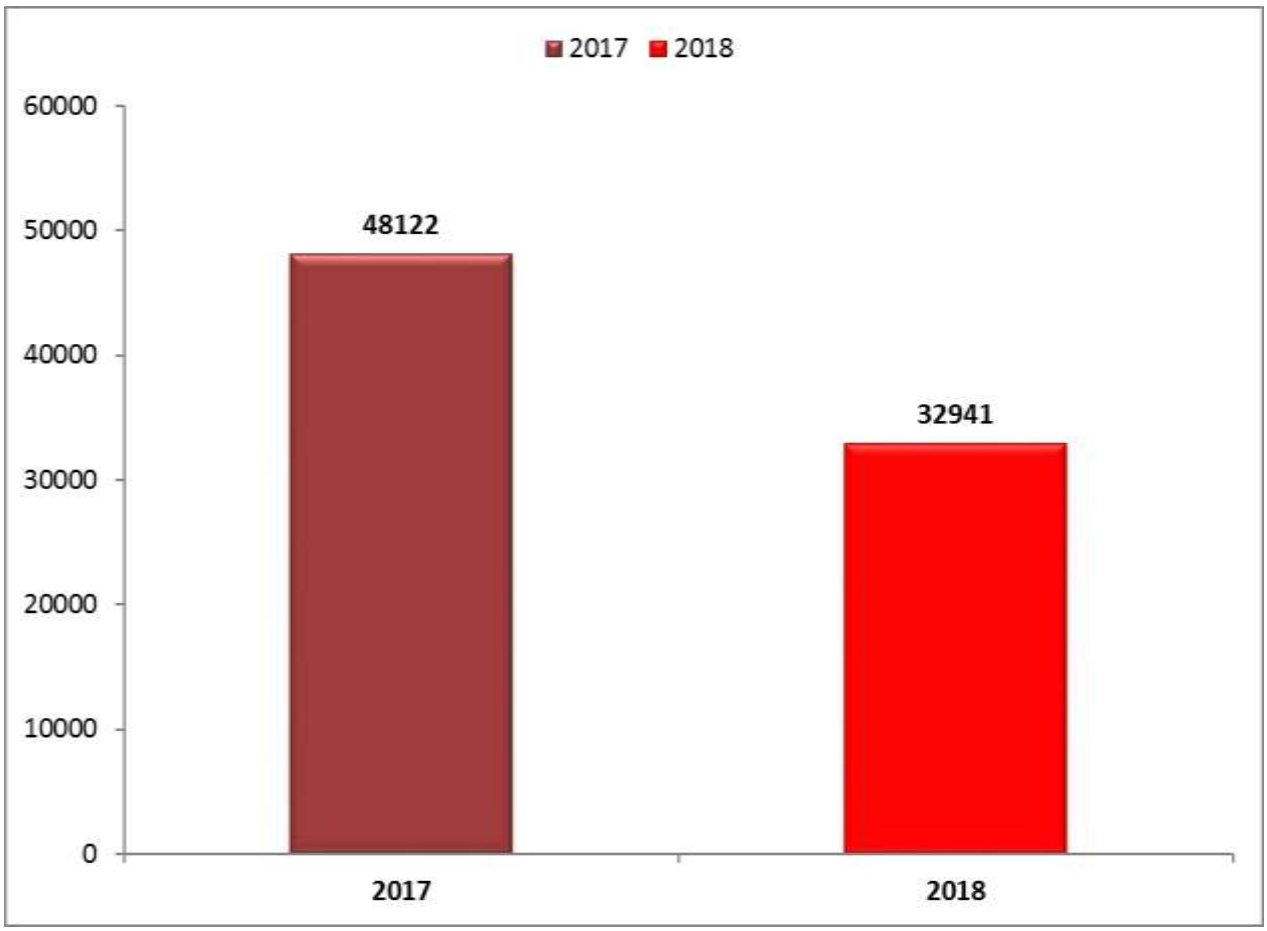


Figure 8: **Comparison of the number of unimmunised children in first half of 2017 and first half of 2018**

Figure 8 shows that the number of unimmunised children in the first half of 2018 (32,941) was significantly lower than in 2017 (48,122), a confirmation that the routine EPI's overall performance has improved.

- Strategies for improving the EPI's performance:

- Related to inadequate service provision:

- preparing and implementing microplans in the health districts and health facilities;
- implementing the urban immunisation strategy for Bangui city;
- organising outreach and mobile strategies and expanding the EPICs;
- strengthening the management capacity of the EPI management teams;
- providing tools for managing data, evaluating data quality and implementing the DQIP;
- organising mobile clinics and supplementary immunisation activities (SIAs), collaborating with armed groups and developing a national immunisation plan for special populations;
- signing contracts with private sector entities to support immunisation activities;
- signing contracts with partner NGOs and civil society, creating mobile clinics; and
- pooling funds by coordinating NGOs' work.

- Related to insufficient use of and demand for services:

- finalising the National Immunisation Policy document;
- finalising the communication plan, implementing the districts' public relations plans.
- organising efforts to locate dropouts, with community involvement; and
- strengthening the community approach (such as policy, leaders, liaisons).

3.2. Key drivers of sustainable coverage and equity

- **Staff**

The number of Ministry of Public Health and Population (MoPH) staff remains low. In addition, staff are unevenly distributed, with a higher concentration in the capital, Bangui. According to HeRAMS 2016, staff at the intermediate (regional) and operational (district and health facility) level were distributed as follows:

- At the regional level: 23 health staff lead activities
- At the district level: 82 health staff lead activities
- In health facilities there is:
  - One doctor per 24,769 inhabitants
  - One midwife per 18,509 inhabitants
  - One registered nurse per 20,457 inhabitants
  - One community health worker per 1,643 inhabitants

Community health workers represented approximately 51% of CAR's health facility staff in 2016. At the operational level, nearly all EPI services are provided by these poorly qualified workers; they also manage other health programmes, which impacts the quality of service delivery.

The MoPH has made substantial efforts to strengthen its health staff. In March 2017, the ministry hired 143 doctors, 5 pharmacists, 1 dental surgeon and 244 paramedics to meet pressing human resource needs. In June 2018, more than 250 other staff were recruited by the Government to work for the MoPH. This slightly improved service provision; however, the objective of achieving a ratio of 1 doctor per 10,000 inhabitants has not been reached.

- **Supply Chain**

The supply chain is organised according to the country's health pyramid, consisting of three levels: central, intermediate and operational (district and health facility). The central level has five cold rooms.

Only one intermediate level out of seven is operational. This is Health Region 7, located in Bangui city. This region is supplied from the national level, using the push system.

The MoPH's operational level includes 35 health districts, following Ruling No. 043 of 16 October 2017 that created health districts. Each district has at least one refrigerator for storing EPI vaccines. The district level is supplied directly from the national level except for the three health districts in Bangui city, which are supplied by Health Region Seven's warehouse. The health centre level includes 534 routine immunisation service locations that also organise SIAs. The EPI centres are supplied by the health districts.

The vaccine supply chain is characterised by difficulties in mobilising in-country resources for vaccine co-financing, a lack of adequate logistical resources for resupplying health districts, a lack of funding for creating management tools, and the absence of a standard operating procedure with an intervention plan in the event that equipment breaks down or if there is another emergency at the central level. However, preventive cold room maintenance is carried out at least twice a year by an international maintenance company thanks to the support of UNICEF.

There is a supply plan, but implementation suffers from a lack of funding. For some inaccessible regions such as Health Regions Five and Six, supplies are flown in by air to the districts' base with the support of partners. This method (air) relies on humanitarian flight schedules, which are frequently cancelled or delayed.

At the regional level: Of the country's seven health regions, only Health Region Seven has an intermediate storage facility but it does not have a supply of vehicles. Storage capacity for current antigen needs is

inadequate and this region stores some of its vaccines in the central warehouse; from there, they are distributed to the health districts.

In the health districts: The lack of standard operating procedures and a formal system for supplying the health centres, inadequate storage capacity, frequent stockouts of cold chain consumables such as fuel and fuses, looting of equipment due to safety issues, and fires caused by gas-powered refrigerators have a negative impact on the availability and operability of the cold chain and on effective vaccine management.

In the health facilities: the number of health facilities that need to offer immunisation services in order to meet the country's needs is unknown because there are no standards for this. The inventory showed that only 534 health facilities provide immunisation services, 391 of which have cold chain equipment and 143 no cold chain equipment. However, some vaccine stockouts have been noted at the immunisation units due to a lack of transportation (vehicles, motorbikes, bicycles).

The Effective Vaccine Management (EVM) assessment was conducted in June 2016 in a context of political/military conflict. The conflict caused the collapse of the health system, with the destruction/pillaging of health infrastructure and inputs, a near total shutdown in the delivery of healthcare services, including immunisation services, displacement of healthcare personnel and the loss of capacity to prepare for and respond to epidemics.

- ✓ Main lessons from the EVM report

The main lessons learned from the recent EVM assessment are as follows:

Central level:

Four out of nine criteria attained a score of ≥ 80%. These are the E3 criteria related to storage capacities, which had 84%, E5 (Maintenance) with 95%, E7 (Distribution) with 81% and E8 (Vaccine Management) with 86%. Scores for the other criteria ranged between 41% for E1 (Storage Temperature) and 78% for E9 (SIG, support functions). Three of the seven categories also had a satisfactory score. These were Buildings (87%), Capacity (87%) and Repairs/Maintenance (95%). Efforts must be made for improvements in the other categories, namely Management (66%), Training (72%) and Vehicles (58%).

Regional level:

With the exception of Health Region Seven, the other regions are not involved in the supply system for routine vaccines and for this reason do not have a vaccine storage facility. The national level supplies the districts of these regions directly, and the districts, in turn, supply health centres. The results obtained are thus relative only to the depot of Health Region Seven.

Thus, apart from criterion E8 on Vaccine Management, which obtained a score of 100%, the other criteria received scores ranging from 14% for E9 (SIGL, support functions) to 77% for E4 (Buildings, Equipment and Transport).

District level:

At the district level, criterion E8 (Vaccine Management) recorded a satisfactory score of 84%. The other applicable criteria at this level had a score ranging from 40% for E9 (SGL, support functions) to 72% for E4 (Buildings, Equipment and Vehicles.)

Health centre level:

Scores ranged between 25% for criterion E9 (SIGL, support functions) and 75% for E8 (Vaccine Management). As for the categories, scores ranged from 0% for Vehicles and 79% for Training.

- ✓ Implementing the EVM improvement plan

The EVM assessment led to the development of an improvement plan aimed at maintaining gains and providing corrective measures for weaknesses detected in order to make high-quality vaccines available at lower cost. The main activities completed were as follows:

Leadership

- Strengthening the EPI logistics committee through technical assistance (UNICEF/WHO)
- Training stock managers at the health district level on effective vaccine management
- Training depot managers in health logistics (LOGIVAC)
- Training 25 health workers on installing and maintaining solar refrigerators

Data management

- Revising and reproducing vaccine and supply management materials/tools
- Training/strengthening capacities of national level managers in using tools (SMT, inventory analysis, forecasting)
- Preparing supply forecasts

Equipping the supply chain

- Procuring continuous temperature loggers for the cold chain.
- Procuring 105 refrigerators that meet PQS standards and the new requirements for antigen protection

Continued improvement of the supply chain

- Developing a cold chain equipment maintenance plan
- Preventive maintenance contract for cold rooms
- Managing stocks
- Monitoring temperature records

Optimising the supply chain

- Enlisting the involvement of NGOs and United Nations agencies in supplying vaccines and consumables for districts and health facilities

➢ **Generating demand for immunisation**

An analysis of dropout rates (28% in 2014, 31% in 2016 and 24% in 2017) shows that there is a problem with the take-up of services and thus with generating demand for immunisation within communities. This is partially caused by a failure to implement the integrated communication plans that were prepared during the second half of 2018. A situational analysis conducted in March 2017 by the Department of Community Health (DCH) showed the following weaknesses:

- At the institutional level:
  - There is no focal point responsible for communication within the EPI, working with the DCH.
  - There are no national policy documents on immunisation.
  - There is no permanent community communication structure at the decentralised level.
- At the managerial level:
  - The integrated strategic communication plan for child development 2015-2018 has not been implemented.
  - There is a lack of human resources, in particular at the intermediate and operational level, with knowledge and skills in EPI communication.
  - There is no mechanism for monitoring and evaluation and documenting and sharing communication actions for immunisation.
- At the social and educational communication level:

- There is a continuing tendency to favour disseminating messages to the detriment of a C4D approach targeting communication for individuals and social change and community participation.

- Communication/mobilisation strategies are not customised for the routine EPI according to each context (equity, supply of services, geography, security, socio-cultural aspects, etc).

- There is insufficient advocacy directed at parliament and the Government regarding immunisation and the corresponding committed expenses.

- Opinion leaders, political leaders and community leaders are not sufficiently involved.

- Interpersonal communication at all levels (health workers, community liaisons, etc) is inadequate.

- There are insufficient strategies to support disadvantaged populations with regards to immunisation.

- Communities do not take sufficient ownership of immunisation because they are not made accountable (survey on inequity in immunisation).

➢ **Obstacles related to gender inequality**

According to the survey on inequity in immunisation carried out in 2015, immunisation coverage by sex and by antigen does not show significant differences between boys and girls.

➢ **Leadership, management and coordination**

The EPI ICC held two extraordinary meetings between August 2017 and July 2018. Ordinary sessions have been delayed or held irregularly, which hinders an in-depth analysis of the underlying factors related to the routine EPI's poor performance.

The EPI Technical Advisory Committee (TAC-EPI) meets monthly and as needed to discuss aspects of programming and monitoring. It plays an important role in the technical analysis of documents to be submitted to the ICC for endorsement. In total, six meetings were held between August 2017 and July 2018.

In addition to the ICC and the TAC-EPI (which work to coordinate the EPI), there are two other coordination entities: the new Health Sector Coordinating Committee (HSCC) and the single Steering Committee that handles all of the MoPH's projects and programmes. These two entities have just been created and are still being brought up to speed.

At the regional and district level, quarterly coordination meetings are held regularly in the districts and regions where the area offices of UNICEF and WHO are located. Sessions are irregular in the other districts and regions because of a lack of support.

Several NGOs are continuing to play a vital role in implementing health activities, in particular for immunisation and health system strengthening, especially in remote and insecure areas. The EPI's long-term goal is to formalise this NGO support through an accountability framework for the interventions of all partners. Currently, cooperation and coordination frameworks are weak, thus preventing optimisation of these NGOs' efforts.

➢ **Public financial management**

The fragility of government institutions and chronic political instability has increased financial risks in CAR. This is exacerbated by the lack of a banking system within the country. Because of this unique situation, HSS funds are managed by UNICEF during an initial 18-month transition period. An evaluation of the MoPH's financial management capacities – which should put an end to this transitional period if the results are satisfactory – has not yet been done. It seems that there have been no significant changes to the MoPH's management capacities.

Grant funds will be administered in accordance with financial regulations and financial management rules and any other applicable UNICEF regulations, procedures and practices. UNICEF is obligated to keep accurate accounts describing the use and disbursement of grant funds. At present, UNICEF remains solely

responsible for disbursing grant funds for activities listed in the budget. UNICEF is responsible for taking all necessary measures to ensure that all grant funds are used with the sole objective of carrying out planned activities. Any significant change in the scope or schedule of activities will be reviewed beforehand by the Government and UNICEF, who will then be responsible for obtaining confirmation from Gavi.

After UNICEF receives the funds, they are disbursed when the MoPH submits requests that comply with the action plan for that time period.

Following creation of technical documents for implementation prepared by the ministry's technical directorates, funds are transferred from UNICEF's account to the bank account of the executing partner. Two signatures are needed for disbursement and for implementation of activities in the field.

Once the resources have been made available to the MoPH, UNICEF's quality assurance process (HACT) is applied. This includes:

- Programming visits to verify effective implementation of activities in accordance with the established plan.
- Spot checks intended to assess the quality and validity of the accounting information and documents – carried out alongside capacity building for implementation partners.
- An audit is triggered when a report of poor management and financial misappropriation is issued.

➢ **Other critical aspects influencing immunisation performance**

1. Accessibility problems
   - Geographical accessibility related to poor implementation of the reach every district (RED) approach
   - Insecurity and armed conflicts
2. Insufficient supervision at all levels
3. Insufficient or complete lack of data analysis at all levels for corrective actions.

3.3. Data

Data quality remains a concern in CAR.

NHIS is partially compliant with Gavi's four requirements on data quality.

Survey (min 1/5 yrs)	In-depth review of data quality (min 1/5 yrs)	Desk review (every year)	Improvement Plan Data Quality
ICS carried out in 2016	The 2012 review factored this in. However, several DQS were also carried out in 2017 and 2018	No	Prepared but not yet implemented.

For the NHIS in general, the following actions were carried out:

- NHIS evaluation (data quality analysis on NHIS norms and standards: basic data, collection materials and data tools, the monitoring and evaluation system, data analysis and management competencies, harmonising databases, etc)
- Review of indicators
- Creation of data collection tools and procedural manuals
- Creation and validation of the 2018 operational plan to strengthen the NHIS.

The next steps are to prepare and implement a roadmap that should lead to the implementation of the DHIS2.

Specifically for the EPI, an immunisation coverage survey carried out in 2016 showed that immunisation coverage data are higher than administrative data and data from WHO/UNICEF estimates.

In general, data completeness has improved since the last Joint Appraisal, with internal completeness (data sent from health facilities to the districts) now 75% and external completeness (data sent from the districts to the central level) 85%. This improvement is partially related to the strengthening of the MoPH's leadership, particularly at the central level.

The main weaknesses/challenges related to data quality are:

- EPI managers are insufficiently trained at all levels of the pyramid.
- There is a lack of data management materials.
- There is a lack of supervision at all levels.
- Data at the health region and district levels are not computerised.
- There is a lack of data harmonisation in the health districts and health regions that are not supported by Gavi HSS, before the data are sent to the central level (Department of Integrated Epidemiologic Surveillance and Immunisation: DSEIV).
- There is no data quality self-assessment due to a lack of capacity on the part of the health district and health region framework teams.
- There is a failure to capitalise on the immunisation data from certain NGOs in routine data.
- There is an absence of coordination with the MoPH's results-based funding (RBF) unit to capitalise on all of the benefits of this strategy.
- The denominator is incorrect due to ongoing security-related population displacements and the failure to update census data (from 2003).

Main efforts/innovations/best practices:

- Pilot experience of the electronic data management system (ODK and MAGPI).
- Meetings to harmonise and monitor data.

Outlook:

- Implement the data quality improvement plan.
- Strengthen capacities of the different stakeholders in EPI management, including data management.
- Strengthen regular supervision of data management-related activities at all levels.
- Use computerised data tools at all levels (DVD-MT).
- Scale up the electronic data management system (ODK and MAGPI).
- Hold data harmonisation meetings at the operational and intermediate levels.
- Prepare a roadmap to implement the DHIS2.
- Organise a consultation workshop with the MoPH, partners and funding providers on NHIS and the possibilities for funding.

3.4. Immunisation financing

The public health services environment has completely changed in CAR with the military-political turmoil. Funding for health services is highly dependent on external aid.

Health funding comes from strategic sectoral planning (PIS 2018-2019; cMPY 2018-2022, AWP, etc) and multi-sectoral planning (National Plan for Creating and Solidifying Peace: PCPCA 2017-2021).

The Interim Plan for the Health Sector (PIS) has a total budget of 105,944,450,087 CFA francs, of which 21% is allocated to maternal and child health, which includes immunisation. The PIS is in effect until the NHDP III is prepared.

The cMYP and its associated operational plan were prepared based on microplanning for the previous year (2017).

Internally, funding sources are primarily the Central Government, households, communities, territorial groups and the private and religious sectors.

Externally, funding sources come from grants and loans via:

- Multilateral aid: UN agencies, the World Bank, the Global Fund, the European Union, BADEA, BAD, etc
- Bilateral aid: France, Germany (KfW, WWF), Japan, China, Egypt, Morocco, the United States (CDC Atlanta), etc
- International and humanitarian NGOs
- Other sources: Gavi, the Bill & Melinda Gates Foundation, Rotary International, etc

Table 2: Central government budget allocations for 2017 (in CFA francs)

Expenses	Allocations	Commitments
Operating expenses	25,562,696,000	5,268,471,470
- Personnel (wages)	5,025,972,000	952,070,179
- Other (interventions)		
Total Government Budget		

Source: Ministry of Health/Finance, 31 October 2017

This table shows that the budget allocation for health is 167,643,365,000 CFA francs. Overall, the Government only covers the payment of wages for personnel and operating expenses for administrative structures.

We note that this allocation represents an average of 10.67% of the Central Government's overall budget, thus remaining below the Abuja target of 15%.

According to the 2018 law on finances, a total of 449,000,950 CFA francs was allocated to the immunisation programme, divided as follows: Capital investment (33%), co-financing for vaccines (48%), immunisation campaigns (0.6%), operations (4%), and equipment repair and maintenance (13%).

However, the MoPH has encountered many difficulties in mobilising in-country resources.

EPI funding depends on external resources because of the following reasons:

- poor advocacy for the mobilisation of additional resources for the EPI;
- lack of understanding and control of budget execution procedures and public contracting procedures by managers and loan administrators;
- delays in developing recruitment programmes and forecasting plans for awarding contracts;
- lack of consistency between the amounts projected in the cMYP and the amounts contained in the central government budget;
- lack of clarity in execution of resources allocated to the EPI;
- the gap between the EPI's planned activities and the disbursement of allocated funds due to the country's financial problems;
- delay in the disbursement of funds allocated to the EPI; and

- absence of an internal strategy for mobilisation of additional resources for immunisation.

As part of the vaccine co-financing policy, the country has been making efforts to honour its commitments to Gavi. An amount of 107,000,000 CFA francs has been disbursed by CAR to absorb its portion of the 2017 payment and advance the first tranche for 2018. Furthermore, in the context of CCEOP, a budget line item was created in the 2018 finance law to support cold chain equipment maintenance.

The fragility of government institutions and political instability has increased financial risks in CAR, exacerbated by the lack of banking structures. Because of this unique situation, HSS resources are being managed by UNICEF for a transitional period of 18 months, after which the MoPH will assume management. A management unit will be set up within the ministry, with the transfer to occur after evaluations of financial management capacities. To reduce delays in transferring funds, the plan is to transfer funds to the regions and districts using innovative methods (such as Orange Money, religious systems).

Grant funds will be administered in accordance with financial regulations and financial management rules and any other applicable UNICEF regulations, procedures and practices. UNICEF is obligated to keep accurate accounts describing the use and disbursement of grant funds and remains solely responsible for disbursing grant funds for activities listed in the budget. UNICEF is responsible for taking all necessary measures to ensure that all grant funds are used with the sole objective of carrying out planned activities. Any significant change in the scope or schedule of activities will be reviewed beforehand by the Government and UNICEF, who will then be responsible for obtaining confirmation from Gavi.

After UNICEF receives the funds, they are disbursed when the MoPH submits requests that comply with the action plan for that time period. Following creation of technical documents for implementation prepared by the ministry's technical directorates, funds are transferred from UNICEF's account to the bank account of the executing partner. Two signatures are needed for disbursement and implementation of activities in the field.

Based on a breakdown of funding by health regions and health districts, the central level disburses funds to health regions and health districts through the delivery of cash transported by road or by air. This is very risky for those transporting the money over land. The recent availability of electronic funds transfers offers a new option to explore.

In the context of managing the HSS project, a technical committee was created to monitor implementation of the project (Service Memo No. 105/MSP/DIRCAB/DGPGEH/DEP of 16 March 2018) while awaiting availability of the Steering Committee for sectoral programmes (the only steering committee for health projects: Gavi HSS2, PASS project, Bekou Fund, EU-WHO project).

4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

Table 3: Performance achieved in 2017 and the first quarter of 2018

Immunisation coverage by vaccine & other indicators	Immunisation coverage objectives (%)	Outcomes achieved in 2017			Outcomes achieved in the first half of 2018 (Jan to June)
		Official data (%)	Administrative data (%)	2017 WHO/ UNICEF estimate (%)	Administrative data (%)
BCG	70	59	59	74	57
OPV3	60	51	51	47	49
DTP-HepB-Hib1	70	70	70	69	66
DTP-HepB-Hib3	60	54	54	47	50
Third dose PCV-13	60	51	51	47	34
IPV	60	40	40	47	44

MCV	60	50	50	49	49
YFV	60	51	51	48	48
TT2+	60	62	62	NA	64
MenA	60	40	40	NA	38
Specific dropout DTP-HepB-Hib1-DTP-HepB-Hib3	< 10	24	24	NA	24

This table shows that the annual immunisation coverage objectives were not reached in 2017, with the exception of Penta1.

WHO-UNICEF estimate data more or less align with the JRF data, with the exception of BCG, for which WUENIC immunisation coverage is higher than the administrative data.

The results are due to implementation of the following strategies and activities:

- Programme governance and accountability at all levels was strengthened.
- As part of the vaccine co-financing policy, efforts have been made by the Government over three years to honour its commitments to Gavi. Thus, the country was able to liquidate its portion of the co-financing for 2017 and pay the first tranche of co-financing for 2018.
- Meetings of the technical and steering committee to coordinate HSS2 implementation monitoring have been held.
- An advocacy meeting with mayors/neighbourhood leaders/group leaders in Bangui was held to advocate for immunisation, chaired by the Minister of Public Health and Population.
- Coordination and planning meetings were held at the central, regional and district levels.
- Six vehicles were purchased at the central and district level to strengthen supervision and supervision missions by the central, regional and district levels were carried out. In total, 20 supervision sessions were organised by the District Management Teams in health facilities. Ten supervision sessions by the Regional Management Teams were organised in the health districts, and 10 supervision sessions were conducted by the central level.
- An awareness-raising meeting was held at the national level for public health entities, chaired by the Prime Minister and various other ministers.
- Training for public health management committees was conducted at all levels.
- Strategic and technical meetings (ICC and EPI-TAC, task force) were held regularly to better coordinate the EPI's activities.
- There were improvements to service quality.
- Implementation of RED strategies occurred in 19 high-priority health districts: 204 health facilities were supported in implementing immunisation activities. Immunisation teams completed a total of 2,970 missions to cover all outreach locations in villages that are more than 5 km from a health facility.
- Supervision by the central level focused on Health Regions One, Two and Three and the 10 health districts, with districts supervised jointly with the regional level. The regional level completed a supervision mission to the health districts to monitor implementation of activities and to strengthen the capacities of district management teams.
- Concerning implementation of immunisation strategies for special populations: In the context of the polio eradication initiative, it was recommended that special populations be immunised with OPV and the other antigens, with an expansion of the age range up to 10 years old. Thus, WHO and UNICEF funding for these activities was implemented in the five high-priority health districts that were targeted (Ouham, Ouham-Pende, Sangha Mbaere, Nana Mambere and Mambere Kadéi).
- For outreach strategies, 100 motorcycles and 100 bicycles were purchased and distributed.

Additionally, as per the recommendations from the previous Joint Appraisal, specific strategies were implemented for Bangui city. A specific urban immunisation strategy was developed for Bangui city that includes two phases: a short-term strategy covering the period from September to December 2017, which consisted of implementing intensified immunisation activities to boost immunisation coverage in 2017 (results are listed in Table 4); and a medium and long-term strategy running from January 2018 to December 2019, with implementation imminent.

Table 4: Increase in immunisation coverage from SIAs in November and December 2017 in Health Region Seven.

Antigens	Targets to be immunised in	Total doses administered in	% IC	Total immunised in 2017 during	Routine CA IC AD in %	Total immunised during 2 SIAs	SIA IC AD in %

	2017	2017		routine (w/o SIA)			
Antigènes	**Cibles à vacciner pour 2017**	**Total doses administrées en 2017**	**CV en %**	**Total vacciné en 2017 pendant la routine (sans AVI)**	**CV DA routine en %**	**Total vacciné pendant les 2 AVI**	**CV DA AVI en %**
BCG	30854	25677	83	24000	78	1677	5
Penta 1	26799	23379	87	19922	74	3457	13
Penta 3	26799	21022	78	15208	57	5814	22
VAR	26799	17142	64	10991	41	6151	23
Men A	26799	10552	39	4513	17	6039	23
Td 2+	30854	19905	65	12658	41	7247	23

Source: DSEIV Report IIA 2017

For the antigens shown in this table, we can see an increase in coverage of between 5% (BCG) and 23% (MCV, MenA and TD2+). Penta3 immunisation coverage increased by 22%, with 631 more children immunised (5,814) than the target for the two SIA rounds (5,183 children).

Equipment maintenance

Maintenance of equipment remains inadequate in CAR. At the central level, in the context of the cooperation agreement between UNICEF and CAR, a preventive maintenance contract was signed with a sub-regional company to maintain the cold rooms and the generator at the central warehouse. This company periodically (every six months) performs preventive maintenance on the equipment.

In the health regions (Health Region Seven) and health districts, the EPI coordinators (one per district) have been trained and provided with installation and maintenance kits for the solar cold chain equipment. However, these employees are often unable to deal with outages that require a more qualified and better-equipped technician. There is an acute need for qualified maintenance staff for the health sector throughout the country. While CAR has an EPI cold chain equipment maintenance plan, implementation frequently suffers from a shortage of funds. A disbursement of 40,000,000 CFA francs is included in the central government budget for this purpose (see attached maintenance plan). While waiting for effective implementation of this maintenance plan, HSS2 financial resources are required for urgent activities such as training, kits and corrective maintenance from the central level.

Optimising cold chain equipment

The cold chain equipment optimisation request submitted to the platform is still being reviewed. It includes two phases.

- The first phase (2019) applies to 19 districts in Health Regions One, Two, Three and Seven, which are deemed accessible from a security standpoint. For these regions, the evaluation of the sites that began in Bangui city suffers from a lack of funding needed for finalisation.
- The second phase (2020) includes districts in Health Regions Four, Five and Six, where security issues are still a concern.

The country wishes to draw from that budget line item to purchase cold chain equipment in HSS2 to fund the subsequent site evaluations. The equipment (solar panels and refrigerators) will be equipped with anti-theft mechanisms due to the security context in CAR. The cost of this remains to be calculated, and funding needs to be secured. Additionally, aside from physical security for equipment, the deployment plan will include community involvement to ensure security of the facilities. The project management committee will take the necessary provisions to ensure this.

Supply chain

The supply chain is organised according to the country's health pyramid. After the vaccines are received, the supply chain includes the central, regional, district and health facility levels. The first three are levels at which vaccines and supplies are stored and distributed to the programme. The health facility level is an operational level that administers antigens to the target population. In practice, the regional level remains a goal, as health districts are supplied directly by the central level. To remedy this deficiency and as part of HSS2, plans call for two regional warehouses in Health Regions Two and Three to bring vaccines closer to the operational level and to reduce the risks of antigen stockouts. A technical assistant must be recruited to strengthen the supply system, including creating two regional warehouses. The cold chain equipment gap at

each level, aside from CCEOP support, will be re-evaluated in light of the new districts, the possibility of expanding the EPI's targets, and the introduction of new vaccines with a review of the packaging of certain vaccines such as PCV-13.

At the central level two trucks are expected in the third quarter of 2018, to be used to resupply vaccines and inputs. Renovations to the dry storage area at the central level are ongoing.

Vaccine management in 2017 and the first half of 2018

Table 5: Vaccine procurement from the central warehouse in 2017

Antigens	Number of deliveries	Number of doses
bOPV	2	450,000
DTP-HepB-Hib	3	497,500
PCV-13	2	214,500
IPV	5	130,200
YFV	2	111,200
MCV	2	207,000
MenA	1	68,000
BCG	2	240,000
TD	2	382,200
bOPV Campaign	5	3,808,000

Aside from the bOPV deliveries for the local vaccination days in 2017, the central warehouse complied with the average of two deliveries per year. The IPV delivery (5) did not meet the order because of a worldwide shortage of this antigen.

Central warehouse stockout in 2017

CAR experienced stockouts of BCG (19 days) and IPV (23 days) in 2017. The IPV stockout is related to worldwide production shortages of this antigen.

Table 6: Health district vaccine procurement situation in 2017

List of secondary warehouses (that receive vaccines)	Total population	Number of vaccine deliveries per month in 2017												
		Jan	Feb	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
23	**5 154 080**	**16**	**8**	**57**	**24**	**42**	**37**	**8**	**10**	**5**	**41**	**17**	**11**	**276**
Mbaïki	208,405	1	1	2	2	2	2	1			2	1		**14**
Boda	113,926		1	1		2	2				3	1		**10**
Bégoua	161,812	1		2	1	4	2		1		2			**13**
Bimbo	167,058	1		2	2	1	2		1		1	1		**11**
Bossembélé	136,887	1		2	1		2			1	1	1		**9**
Mambéré-Kadéi	476,293	1		6		2	1	1		1	4		1	**17**
Nana-Mambéré	305,085			4	1	2	2		1		3			**13**
Sangha-Mbaéré	131,967		1	3		3	1		1		3			**12**
Ouham	482 071	2		4		4	1	1	2		3	2		**19**
Ouham-Pendé	562,089		1	6		2	1			1	3	1	1	**16**
Kémo	154,615			5		2	3		1	1	4			**16**
Nana-Gribizi	153,826	1		3	1	3	1		1		1		1	**12**
Ouaka	361,285	1		1	2	-	3			1	2	1		**11**
Bamingui-Bangoran	56,442	1	1	2		2	2				2		1	**11**
Haute-Kotto	117,921		1	1		1	1	2			1	1		**8**
Vakaga	68,227		1	2		4		2			3			**12**
Mobaye-Zangba	126,419	1		1	3									**5**

Alindao-Mingala	120,004	1	-	2	2			1					1	**7**
Kémbé-Satéma	78,879	1		1	1	1								**4**
Bangassou	130,982	1		1	1	1	2							**6**
Ouango-Gambo	83,156	1		1	1		2							**5**
Haut-Mbomou	75,208			1	3		1		1		1			**7**
Région Sanitaire N°7	881,523	1	1	4	3	6	6		1		2	8	6	**38**

Vaccine procurement for the health districts experienced some problems related to the failure to comply with the set schedule for that level, caused primarily by the following: numerous SIAs, insufficient storage capacity in certain health districts, insufficient cold chain operations and inadequately skilled vaccine management staff. Moreover, due to security concerns, health districts in Health Region Six did not receive sufficient supplies this year (See attached: SMT 2017).

Table 7: Vaccine procurement from the central warehouse in 2018

Antigens	Number of deliveries	Number of doses
bOPV	1	260,000
DTP-HepB-Hib	1	90,500
PCV-13	2	171,700
IPV	2	56,605
YFV	1	31,800
MCV	1	65,000
MenA	1	45,000
BCG	1	140,000
TD	1	100,000
bOPV Campaign	1	1 233 000

Table 8: Health District vaccine procurement situation in 2018

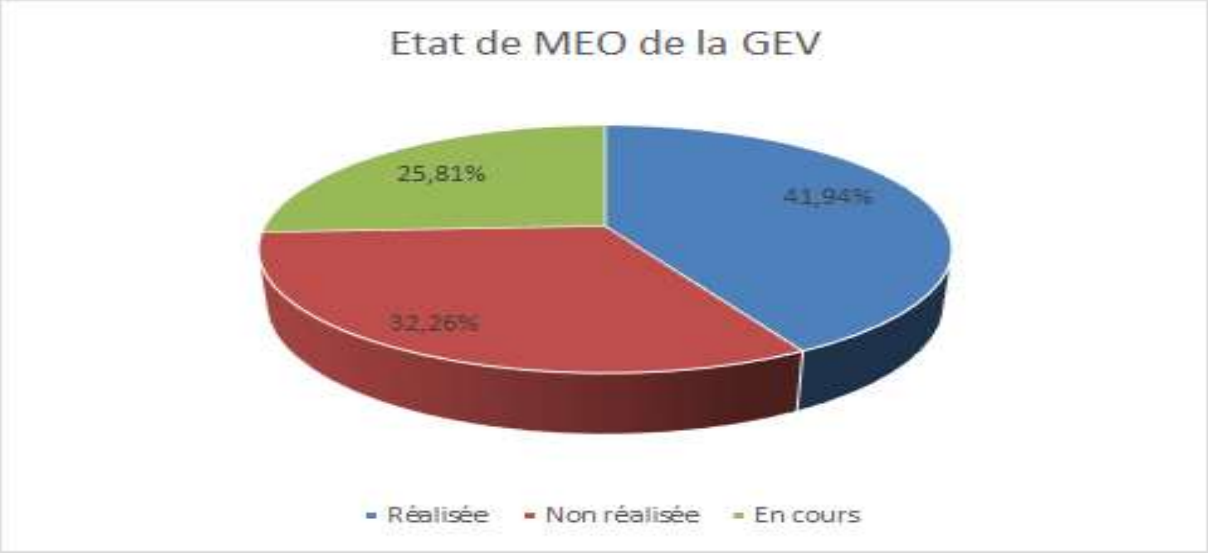
List of secondary warehouses (that receive vaccines)	Total population	Number of vaccine deliveries per month in 2018							
		January	February	March	April	May	June	July	Total
35	**3 657 572**	**9**	**27**	**11**	**20**	**12**	**11**	**17**	**103**
Mbaïki	212,347		1		1		1	1	**4**
Bégoua	116,081	1	1	1		1		1	**5**
Bimbo	164,872		1		1	1			**3**
Boda	170,217		1	1	1		1	1	**5**
Bossembélé	139,476		1	1	-	1		1	**4**
Sangha-Mbaéré	181,868	1	1	1	1		1	1	**6**
Berberati	195,345		1		1	1		1	**4**
Carnot Gadzi	108,088		1		1	1	1	1	**5**
Gamboula	100,765		1		1		1	1	**4**
Bouar Baoro	210,090	1	1	1	1	1		1	**6**
Baboua abba	134,463		1		1			1	**3**
Bozoum Bossemptele	137,169	1	1		1	1		1	**5**
Paoua	74,458	1	1		1	1			**4**
Bocaranga Koui	166,825		1		1		1	1	**4**
Ngaoundaye	112,736		1		1			1	**3**
Bossangoa	95,939	1	1	1	1		1	1	**6**
Nana Boguila	146,252		1	1	1		1		**4**
Batangafo	212,134		1	1	1			1	**4**
Bouca	118,395		1	1	1			1	**4**

Bambari	157,539		1	1	1			1	**4**
Kouango Grimari	222,110				1	-	1		**2**
Kemo	146,008	1	1	1		1	1		**5**
Nana Gribizi	156,735	1	1		1	1	1		**5**
Haute Kotto	57,509	1				1			**2**
Vakaga	120,151		1			1			**2**
Bamingui Bangoran	69,517					1			**1**
Mobaye Zangba	128,810		1			1			**2**
Alindao-Mingala	122,273		1						**1**
Kembe Satema	80,371								**-**
Bangassou	133,459		1			1			**2**
Ouango Gambo	84,728								**-**
Haut Mbomou	76,630	1						1	**2**
Bangui I	177,363	1				1	1	1	**4**
Bangui II	461,159	1		1	1	1	1	1	**6**
Bangui III	264,746	1	1		1	1	1	1	**6**

The health districts in Health Regions Five and Six are still difficult to supply, for security reasons.

- To improve vaccine management and logistics, seven logistics officers were recruited, trained and deployed: two at the central level, one at the regional level and four at the operational level. In addition, vaccine management and equipment maintenance SOPs were created.
- The tOPV mop-up campaign plan was prepared and submitted so that resources can be released.

Figure 9: Implementation of EVM recommendations



Legend: Green: complete; Red: not done; Blue: in progress

The figure above shows the implementation status for the EVM recommendations (see details; attached).

- Improvement in the quality of the NHIS
- Purchase of computer equipment for NHIS management units at the central and district level
- Preparation and validation of the NHIS operational plan
- NHIS tools are currently being reviewed and harmonised
- Revised EPI management tools are being photocopied
- Development of a data quality improvement plan (waiting for validation)
- Cascade training for introducing the DVD-MT (central level and Health Regions One, Two, Three and Seven).

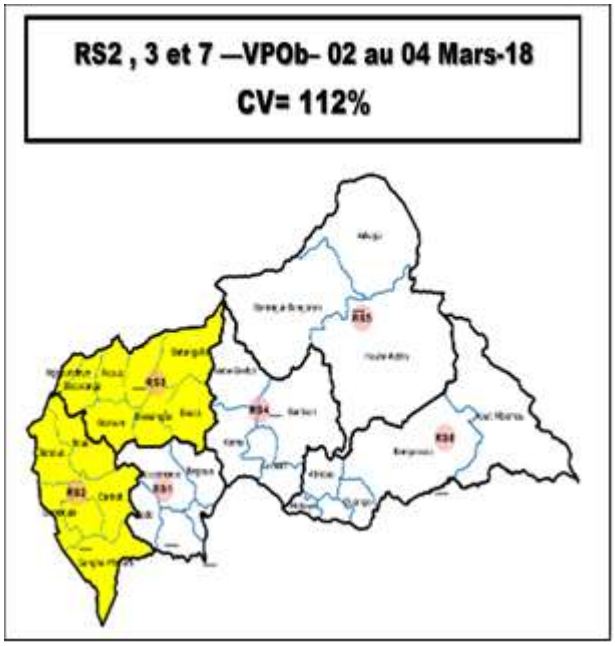
- Use of the MAGPI tool (FICR-UNICEF) to improve the promptness and completeness of reports and computerised data management.
- Use of the ODK tool to manage surveillance data
- Strengthening of the community health component in the context of the overall policy of primary healthcare/demand generation/immunisation demand.
- Search for dropouts has now been included in the job description for community liaisons and CSOs, as per the national strategy for integrating community action. This consisted of implementing customised tools and strategies for searching for dropouts and providing training for the liaisons: 134 community liaisons were trained in Health Region 1. Calendars and monitoring sheets to help search for dropouts are being created.
- A communications plan for the routine EPI was prepared and validated. Integrated communications plans for the districts in Health Region Seven were developed with support from UNICEF.
- Strengthening of technical assistance:

In addition to existing technical assistance from WHO, UNICEF and AEDES, the Department of Research and Planning (DRP), DCH and DSEIV received additional assistance from Gavi to build capacity in terms of both quality and quantity.

Accordingly, 13 experts (financial management, logistics, EPI, primary healthcare, community liaisons and monitoring-evaluation) were recruited under the supervision of the MoPH's Department of Resources to improve technical capacity and coordination capacity in three departments.

Outside of the EPI's routine activities, SIAs were conducted, specifically:

- Four polio SIA rounds between August 2017 and June 2018



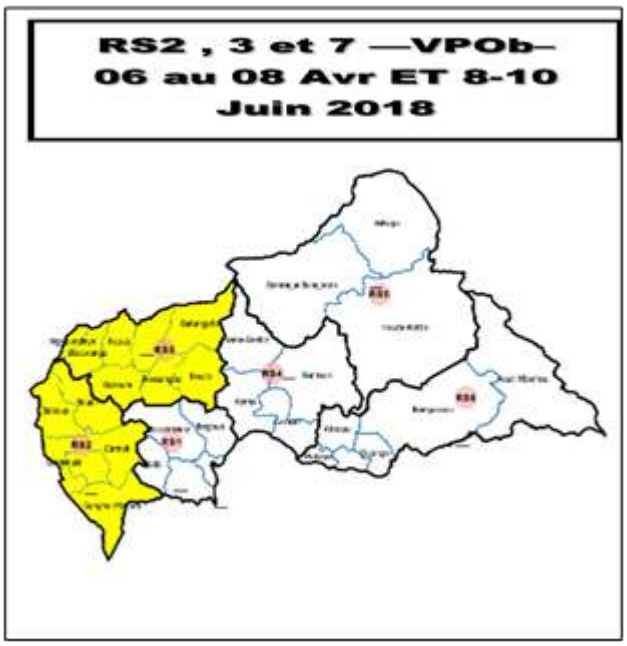


Figure 10: Legend : HS2, 3, and 7- bOPV 2-4 March 2018 IC=112% **HS2, 3, and 7-bOPV 6-8 April and 8-10 June 2018**

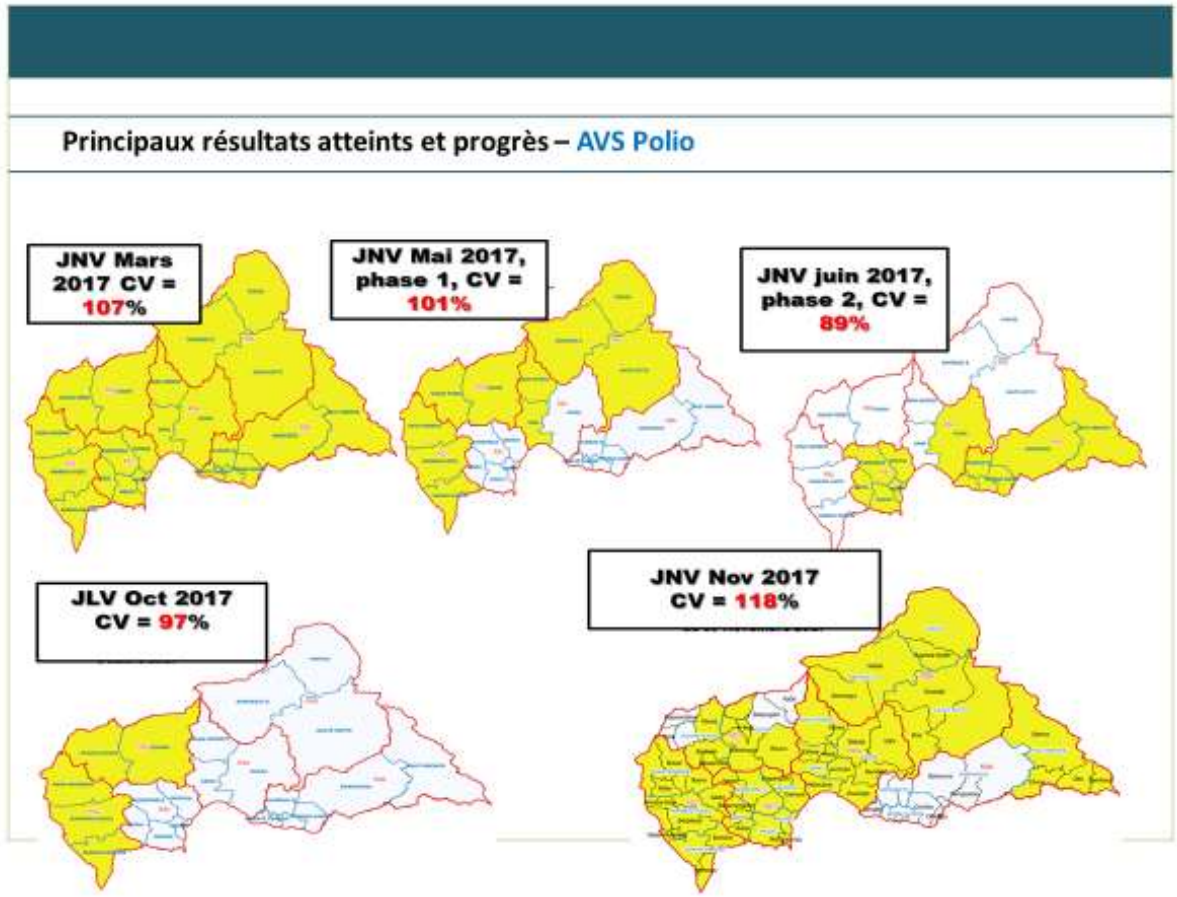


Figure 11: Primary results achieved and progress – Polio SIA

Legend: JNV = national immunisation day; CV=IC

Table 8: Performance of measles surveillance indicators by health region in the first 26 weeks of 2018

Column headings: A: Health region; B: Total population; C: District no.; D: District that investigated; D: SMIR; E: Case/case; F: % measles IgM + (≤10%); G: % Rubella IgM + (≤10%); H: Annualised investigation rate ≤ 2.0/100,000; I: Rate of non-measles febrile eruptions; J: % of Districts sampling ≥ 1 case (≤80%).

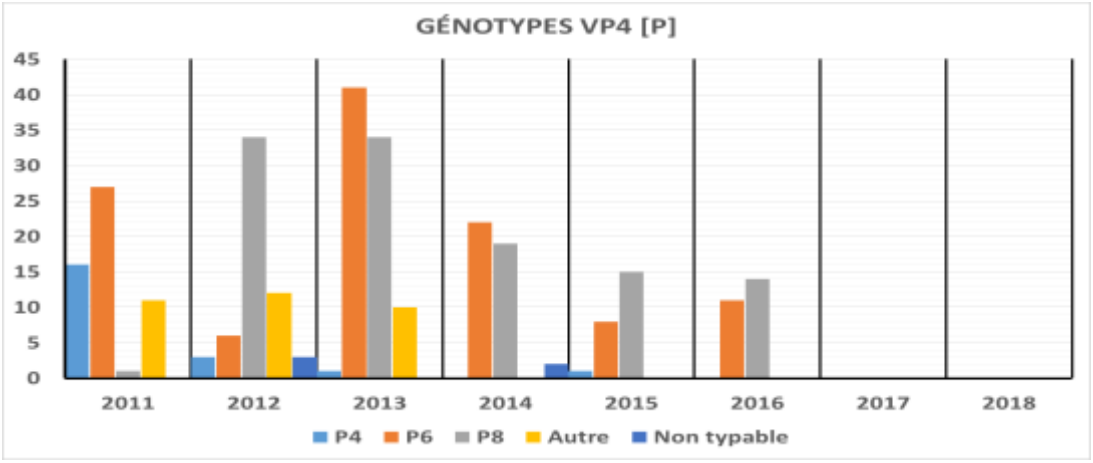
Région sanitaire	Population totale	Nbe district	district ayant investigué	SMIR	CAS/ CAS	% Rougeole IgM + (≤10%)		% Rubéole IgM + (≤10%)		Taux d'investigation annualisé ≥ 2,0/100 000	Taux d'éruptions fébriles non rougeoleuses	% Districts ayants prélevés ≥1 cas (≥ 80%)
						Nbre	%	Nbre	%			
RS1	802993	5	4	46	36	0	0%	0	0%	8.97	8.97	80
RS2	930619	6	3	10	5	1	20%	1	25%	1.07	0.86	50
RS3	1063908	8	5	12	11	1	9%	0	0%	2.07	1.88	62.5
RS4	682392	4	2	47	12	0	0%	0	0%	3.52	3.52	50
RS5	247177	3	2	1	3	0	0%	0	0%	2.43	2.43	67
RS6	626271	6	1	15	1	0	0%	0	0%	0.32	0.32	17
RS7	903268	3	3	65	46	1	2%	1	2%	10.19	9.96	100
RCA	5256628	35	20	196	114	3	3%	2	2%	4.34	4.22	57

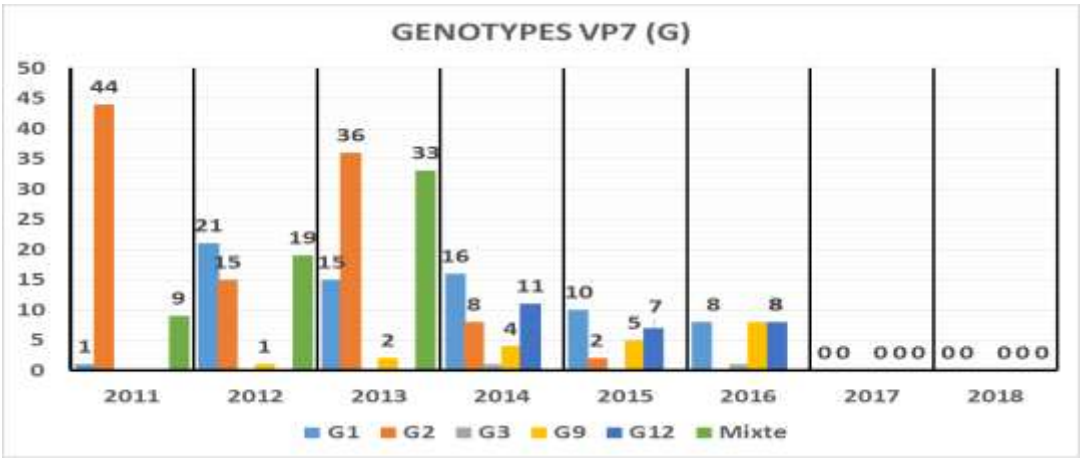
Table 9: Yearly indicators for performance of rotavirus surveillance by the sentinel site, 2011-2018

Column headings: A: Performance indicators; B: # annual reports; C: # Cases reported; D: # Samples collected; E: % Samples collected; F: # Samples tested; G: EIA positive; H: # EIA positive with related genotype; I: % EIA positive with related genotype; J: # Diarrhoea; K: # Chronic diarrhoea; L: # Bloody diarrhoea

INDICATEURS DE PERFORMANCE	# Rapports annuels	# Cas rapportés	# Echantillon Collectés	% Echantillon Collecté	# Echantillons Testés	% Echantillons Testés	# EIA Positif	# EIA Positif avec genotype lié	% EIA Positif avec Genotype lié	# Diarrhée	# Diarrhée Chronique	# Diarrhée Sanglante
2011	4	54	54	100	54	100	28	28	100	54	0	0
2012	11	149	149	100	149	100	56	55	98	149	0	0
2013	10	268	268	100	268	100	148	86	58	267	0	0
2014	10	115	115	100	115	100	43	42	98	114	0	0
2015	9	62	62	100	62	100	22	21	95	60	0	0
2016	8	86	86	100	86	100	60	27	45	86	0	0
2017	12	301	301	100	300	100	150	0	0	301	3	1
2018	5	168	168	100	167	99	60	0	0	168	6	1

Figure 12: Yearly genotyping results, 2011-2018





A measles monitoring campaign is being prepared, to be implemented in the first quarter of 2019. MR introduction is planned for 2020. The rotavirus introduction was initially planned for the third quarter of 2018, however, because of numerous challenges, the introduction was delayed until the first quarter of 2019.

4.2. Performance of Gavi HSS support (if country is receiving HSS support)

In December 2016, CAR submitted a new HSS2 proposal with WHO and UNICEF support to ensure continuity of Gavi support. This resulted in a new three-year grant for US$ 7.56 million. In July 2017, US$ 6,040,817.00 was received in the UNICEF account for 2018-2019. The HSS2 project covers Health Regions One, Two and Three as well as Bangui city, and includes the urban immunisation strategy. This project focuses on the following objectives:

- Strengthening governance and coordination of immunisation activities at the central, regional and peripheral levels;
- Ensuring the conditions and quality of curative and preventive care and health promotion services in compliance with the minimum and additional packages of activities, including immunisation in Health Regions One, Two and Three.
- Strengthening the quality and use of health information for epidemiologic surveillance and for the EPI.

With support from some technical and financial partners (TFPs), the MoPH prepared and validated the PIS for 2018-2019.

In 2018, the WHO supported updates to the Health Map.

Performance-based funding (PBF) has been implemented in Health Regions Two, Three, Four, Five and Six, with EPI indicators paid for with support from some international NGOs.

In the context of complementarity between the interventions, the PBF programme supports some EPI indicators through implementation of the minimum package of activities; specifically:

- Number of children 0-11 months who received the third dose of pentavalent during that month
- Number of children 0-11 months who received a dose of measles vaccine during that month
- Number of pregnant women who received TT2+ or higher during that month

Likewise, we note that implementation of community PBF through support for the "searching for dropouts" indicator, including searching for children who missed their appointment (community liaisons do this), significantly lowered the dropout rates in the districts in question.

This support, through payment for these health indicators that the health facilities receive in the areas covered by PBF, allows them to further develop strategies to cover targets in their areas, improve the work environment, and motivate their staff to produce better results. A method for motivating the staff who work in high-risk/difficult areas must be prepared and validated. However, PBF did not result in improvements to the EPI's data, and in some cases led to the falsification of immunisation data. The number of targets immunised with Penta3 is sometimes two to three times the number of children immunised with Penta1 in some health facilities. In addition, good collaboration between the EPI and the PBF programme is necessary in order to reach this strategy's full potential. Strengthening and revitalising the entities that coordinate the work of TFPs (BM/Gavi/NGOs) is a must, with the goal of making this work more effective.

In the context of the Global Financing Facility, a roadmap has been implemented in order to prepare a capital spending budget based on an analysis of health performance equity. This method provides an appropriate framework for mobilising resources, and its goal is to harmonise interventions and improve human capital for maternal and child health.

The status of HSS implementation is shown in the following table:

Objective 1	
Objective of the HSS grant (as per the HSS proposals or PSR)	Strengthening governance and coordination of immunisation activities at the central, regional and peripheral levels
Priority geographies / population groups or constraints to C&E addressed by the objective	Health Regions One, Two and Three Some difficulties: ➢ Armed groups are present in some districts, such as Paoua, Bocaranga, Nanga boguila, Ngaoundaye, Batangafo, Baboua- Abba, Gamboula, Carnot Gadzi, Bangui 2. ➢ With the new category system (Ruling 043/MSP/DIRCAB/CMAJC of 18 October 2017, creating health districts in the health regions), there are now 19 districts instead of 10, in addition to the 3 districts in Bangui, for a total of 22 target districts. ➢ The 22 districts cover a total population of 3,500,699 people. This results in a target of 122,524 children.
% activities conducted/budget utilisation	**24 of 31 activities completed, or 77% completion.**

	54% of the provisional budget for objective 1 was absorbed; infrastructure renovations are a major part of the unused budget.
Major activities implemented & Review of implementation progress including key successes & outcomes/activities not implemented or delayed/financial absorption	➢ Recruiting specialised contractors to strengthen technical capacities and coordination at the Department of Integrated Epidemiologic Surveillance and Immunisation (DSEIV), the Department of Research and Planning (DRP) and the Department of Community Health (DCH). ➢ Implementing a project financial management system. This is ongoing, through recruitment of a consultant to prepare a manual that details all aspects of administrative, financial and accounting management related to the Gavi-HSS project. ➢ Revitalising the cooperation entities for primary healthcare at the national, intermediate and peripheral levels, and reactivating the Management and Primary Health Care Committees at the national level through: ➢ organising an education and advocacy meeting at the national level, which resulted in high-level political commitment to health interventions; ➢ ongoing CONGES and COGES training (217 members already trained). ➢ Organising meetings of the technical group (UNICEF, WHO and EPI), the EPI-TAC and the Gavi HSS2 steering committee, in the context of a series of three meetings for the HSS2 project monitoring committee. ➢ Obtaining six Land Cruisers and 100 motorcycles required for training and supervision activities at the central, regional and district levels. This includes a year of insurance, quarterly fuel supplies and maintenance costs. ➢ Activating a management unit at the central level through provision of computer equipment intended for the three departments at the central level; payment of costs and communications expenses for nine months. ➢ Support for management teams in Nana Mambere, Sangha Mbaere and ECR2, with the aim of building capacities at the decentralised level through purchasing computer supplies, office supplies, fuel and vehicle maintenance. ➢ Organising monitoring missions in the project's 10 districts in order to ensure monitoring of how funds are being managed at the decentralised level and implementing planned activities. **Support for microplanning activities in the health districts** ➢ Specific support for coordination of EPI activities at the district level. Coordination meetings at the regional level were organised, as was a national coordination meeting. This resulted in immunisation-related commitments from the district management teams; the Minister of Public Health and Population was present. ➢ Renovations and new equipment for administrative offices of the EPI, the DSEIV and the DCH as well as for three of the project's target health regions in the districts of Bouar, Bozoum, and Bimbo. The sites were evaluated but for security reasons this was limited to Regions One and Two during the first year. Contract awards are in process.
Major activities planned for upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance	The following activities could not be implemented and will be rescheduled for the subsequent year of the project: • Strengthening staff capacities through a full-time 13-month technical assistance contractor in the EPI, DSEIV/DSC. • Ensuring that the management unit accountant is paid for full-time work. • Providing specific support for coordination of EPI activities at the regional level. • Revitalising stakeholder cooperation entities (primary healthcare entities) at the intermediate level (2) and at the peripheral level (10). • Revitalising the Management Committees (COGES) and Management Councils (CONGES) in the 10 target districts.

	• Organising integrated supervision for the health regions/districts/health facilities in target zones. • Organising monitoring missions in the districts receiving support (team of three inspectors), including performing supervision for the health regions and health districts. • Ensuring that fuel is provided for the vehicles purchased in the context of the project (central level). • Ensuring maintenance for the vehicles purchased in the context of the project. • Purchasing insurance for the vehicles purchased in the context of the project. • Strengthening the capacities of the newly created districts. • Preparing an immunisation procedures manual and writing and validating it. • Renovating and purchasing equipment for the administrative entities in the three target health districts and three departments at the central level. • Implementing tools to ensure communication, documentation, and visibility of the activities supported.
Objective 2:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**Ensuring the conditions and quality of curative and preventive care and health promotion services, in compliance with the minimum package of activity.**
Priority geographies/population groups or constraints to C&E addressed by the objective	**Health Districts in Regions One, Two and Three**
% of activities conducted/ budget utilisation	**17 activities out of 29 completed, or 58% completion, with 44% of the budget allocated to Objective 2 used**
Major activities implemented & Review of implementation progress including key successes & outcomes/activities not implemented or delayed/financial absorption	Implementation of the RED approach to improve immunisation coverage. Activities related to immunisation outreach strategies, including community mobilisation, supportive supervision and data monitoring with the Data Quality Survey methodology (DQS). **Strengthening the supply chain and maintaining the cold chain at the central and operational level and in the three target regions.** In total, 45,886 litres of fuel were purchased and made available to the health facilities and the districts between October and December 2017. A total of 32,160 litres were delivered during the first quarter of 2018 and 37,920 litres during the second quarter. Strengthening human resources at the operational level by recruiting 50 health workers for this level. Strengthening the community health component to improve the EPI's performance by searching for immunisation dropouts. Community liaisons and CSOs are responsible for this. A total of 134 community liaisons are being trained; schedules and monitoring sheets for dropouts have also been created. **Renovating and purchasing equipment for health facilities.** Given the security situation in Health Region Three, the work during 2018 focused on six health facilities in Regions One and Two. An evaluation of the sites showed that three health facilities need total renovation and the three others need partial renovation (see attached: list of health facilities selected). **Developing the urban immunisation strategy for Bangui city**. This strategy included two phases: a short-term strategy covering the period from September to December 2017, which consisted of implementing intensified immunisation activities to boost immunisation coverage in 2017, and another medium and long-term strategy covering the period from January 2018 to December 2019.
Major activities planned for upcoming period	The following activities are planned for year two of the project: • Renovating the EPI's dry storage area at the central level.

(mention significant changes/budget reallocations and associated needs for technical assistance	• Building/renovating the two intermediate warehouses in Regions Two and Three. • Purchasing two trucks to transport vaccines and medications. • Ensuring cold chain maintenance at the operational level. • Ensuring fuel supplies for medication transport trucks. • Ensuring maintenance for medication transport trucks. • Purchasing insurance for medication transport trucks. • Ensuring coordination with other stakeholders and defining roles and responsibilities in the 22 districts. • Preparing the outreach mission strategy, in cooperation with the other stakeholders. • Mobilising the communities in question. • Developing appropriate tools and strategies to strengthen research. • Identifying incentives according to the criteria set forth. • Evaluating the scope and necessity of searches for dropouts in order to target activities and motivate the liaisons. • Renovating 10 high-priority health facilities targeted by the programme (purchasing equipment for health facilities and installing or improving water sources in health facilities). • Purchasing 308 solar refrigerators planned as part of CCEOP. • Recruiting a technical assistant to improve the vaccine and medication procurement system. • Providing training in corrective and preventive maintenance of equipment. • Providing the Department of Pharmacy, Laboratories and Traditional Medicine with two 4x4 vehicles and other financial resources to supervise the procurement system. • Providing the health districts with maintenance kits. • Funding corrective maintenance missions in the health districts. • Recruiting a technical assistant to support the introduction of the rotavirus vaccine. • Implementing measures to motivate and retain workers responsible for immunisation and district management teams not covered by other partners. • Providing salaries for the 50 qualified health workers recruitd for health facilities in targeted health districts. • Compensating community liaisons who search for EPI dropouts. • Training health district staff in catching up targets between 12-23 months of age who are not fully immunised. • Catching up targets 12-23 months of age who are not fully immunised under the routine EPI. • Preparing and implementing a plan to strengthen health districts.
Objective 3:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**Strengthening the quality and use of health information for epidemiologic surveillance and for the EPI**
Priority geographies/population groups or constraints to C&E addressed by the objective	**Health Districts in Regions One, Two and Three**
% of activities conducted/budget utilisation	**7 activities out of 9; 77% completion with 67% absorption of the budget allocated to Objective 3**
Major activities implemented & Review of implementation progress including key successes & outcomes/activities not implemented or delayed/financial absorption	**Revision of the NHIS tools** A meeting to revise the EPI's management tools was organised by the MoPH and the revised tools were validated by the EPI-TAC. The revised tools are being photocopied. **Monthly meetings to monitor immunisation data and the NHIS at the district level** **Strengthening and maintaining computer equipment in districts not supported by other partners**

	Strengthening the cold chain: this is ongoing. The transfer of funds to purchase 100 refrigerators (20% of the contribution for the country's portion) is on hold, pending the CCEOP decision letter.
Major activities planned for upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance)[4]	The primary activities planned for the second year of the project are: • Creating quarterly and annual bulletins for the NHIS. • Purchasing computer setups (computer, printer, power source, etc) for the NHIS, to complement EU/WHO, Bekou and PASS interventions. • Providing district-level facilities with computer protection and maintenance software. • Supporting implementation of the NHIS operational plan to improve data quality, including the introduction of the DHIS2. • Creating and distributing tools for collecting and processing NHIS data. • Paying costs for an international expert mission to re-launch annual preparation of the statistics yearbook in 2019. • Ensuring half-yearly monitoring for health facilities and health districts. • Supporting district management teams in monitoring immunisation data (DQS) in health facilities and districts/prefectures. • Supporting health districts in organising monthly immunisation data monitoring meetings. • Organising monthly NHIS data validation meetings by the district management teams with all health facilities in the districts in Health Regions One, Two and Three that are not covered by other partners (Nama Mambere and Sangha Mbaere). • Supporting community monitoring. • Supporting validation and implementation of the data quality improvement plan. • Supporting surveillance of invasive bacterial diseases and diarrheal enteropathogens: Sentinel site and laboratories. • Supporting surveillance of vaccine-preventable diseases. • Preparing a roadmap to implement the DHIS2. • Revising the EPI's tools to account for catching up targets 12-23 months who are not fully immunised under the routine EPI.

4.3. Performance of Gavi HSS support (if country is receiving HSS support)

CAR successfully submitted a CCEOP application in September 2017.

After the budget is revised, the CCEOP will fund the purchase and installation of 325 pieces of solar-powered cold chain equipment as well as seven passive devices over the long term, throughout CAR. These purchases will help to modernise equipment.

Given the situation in CAR, implementing this project requires rigorous organisation. In addition, CAR implemented a CCEOP management team called the Programme Management Team, one of whose roles is to ensure appropriate installation of equipment via an operational deployment team.

In the context of its security situation, CAR applied for and received a revision of the deployment plan over two years (2019 and 2020) from Gavi, according to the programme's needs. This operational deployment

[4] Note: When specifying Technical Assistance needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated here. TA needs should, however, describe – to the extent known to date – the type of TA required (staff, consultants, training, etc), the provider of TA (core/expanded partner), the quantity/duration required, modality (embedded, sub-national, coaching, etc), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc) when specifying TA priorities for the coming year. The TA menu of support is available as a reference guide.

plan must include all the characteristics of each site where cold chain equipment is installed. While waiting for the decision letter and with support from WHO and UNICEF partners, the country began an evaluation survey of EPI centres to facilitate the installation of equipment.

With technical assistance, the EPI was able to implement site evaluation strategies. To date, 236 health centres in 16 districts deemed accessible due to security improvements have been evaluated. These 16 districts will benefit from the first deployment plan.

The project team must finalise the first deployment plan before the end of October 2018

4.4. Financial management performance

Cash support from Gavi that is currently being executed in CAR involves HSS funds, with management assigned to UNICEF. Since the August 2017 Joint Appraisal, the MoPH has implemented a procedure for monitoring funding of activities submitted to UNICEF. This procedure involves establishing sessions of the HSS technical monitoring group that are held monthly under the leadership of the Minister's cabinet. This session allows for review of funding progress and eligibility of expenses during the month, the status of field activities, possible adjustments, roadblocks and proposed solutions.

Additionally, there is almost no banking system in CAR, which causes delays in transferring funds to the peripheral level. Transferring funds in cash from the central level to the districts is risky: the cash could be lost and there are issues with traceability.

Furthermore, in the context of transferring financial management from UNICEF to the MoPH, the plan is that at the end of the first 18 months, UNICEF will create a procedure that includes strengthening human resources in the departments involved and developing financial management tools and procedures.

Related to this objective, the MoPH has an employee recruited by the DRP (six months ago) who works with the various departments involved, and with UNICEF, to collect financial information related to the HSS project and report on this.

Overall, US$ 3,906,644 has been allocated for year one, which runs from July 2017 to June 2018. As of 30 June 2018, the overall execution rate was 49%.

This amount was allocated in compliance with the clauses in the tri-partite agreement between the MoPH, UNICEF and Gavi, as follows:

- After the ICC validates the action plan and the HSS programme budget, the resources were provided to UNICEF by Gavi.
- Financial management works according to UNICEF's internal procedures as it is in charge of the funds.
- Requests are drawn up by technical directorates to fund activities and sent to UNICEF.
- After analysis of the request and a favourable opinion from UNICEF that takes its procedures into account, the latter proceeds with payment for the request.
- After implementation, the directorate or partner responsible for the activity sends the technical and financial reports to UNICEF for clearance. UNICEF will apply its quality assurance procedures to ensure that the financial and programme activities are carried out effectively. These quality assurance factors centre on:

    1. Programmatic visits conducted jointly by UNICEF programme managers and the implementation partner during implementation to ensure the quality and effectiveness of interventions. Since the project began, three programme visits have been conducted within the departments responsible for implementing the projects, with reports to support them.
    2. Spot checks conducted by UNICEF's quality assurance team to evaluate the quality and validity of financial and accounting documents related to the intervention. A spot check was conducted, and two others are planned, specifically within the EPI and the DCH.
    3. Audits (in case of irregularities) are not routine; they are triggered when irregularities are noted during spot checks.

    In February 2018, an internal audit of UNICEF was conducted. The programme audited was UNICEF's EPI. UNICEF's use of HSS funds was one of the points addressed by the auditors sent by UNICEF's head office. The final report is expected before the end of the year.

At this point, there is no information about the Gavi HSS project's use of resources that would be cause for an audit.

Summary of financial budget execution, year one HSS2					
Objective number	Objective name	Year 1 projection	Year 1 execution	Year 1 remainder	Usage rate
Objective 1	Strengthening governance and coordination of immunisation activities at the central, regional and peripheral levels.	1,096,943	592,927	504,016	54%
Objective 2	Ensuring the conditions and quality of curative and preventive care and health promotion services, in compliance with the minimum package of activities in Health Regions One, Two and Three.	2,496,609	1,097,977	1,398,632	44%
Objective 3	Strengthening the quality and use of health information for epidemiologic surveillance and for the EPI.	270,041,74	179,894,07	90,147,67	67%
Objective 4	Provide programme management	43,051	31,108	11,943	72%
Overall Total		3,906,644	1,901,906	2,004,738	49%

Although some objectives reached a resource usage rate of more than 50%, the overall use of funds remains at 49%. There are many reasons for this, including:

- Delays in recruiting additional staff at the central level; salaries began to be paid only in the first quarter of year 1.
- Failure to recruit additional staff in health centres (50 contract employees) whose salaries are paid from the funds remaining for year 1 (approximately US$ 127,000).
- Savings on bulk purchases of motorcycles, vehicles and computer equipment through UNICEF. Through bulk purchasing and pooling offshore procurement sources, a significant amount (nearly US$ 100,000) has been saved on purchases of vehicles and computer equipment.
- The budget for renovating administrative offices and health facilities. The first disbursement was used to assess the current status of health facilities and public buildings that need renovations. The renovation budget (US$ 274,000) has not yet been activated, and this has an impact on the overall usage rate.
- The CCEOP funds (US$ 782,000). The CCEOP application has been submitted and approved by Gavi. The country is waiting for the decision letter, which will allow funds to be transferred to UNICEF's Supply Division to purchase and procure cold chain equipment.
- Delays in identifying a method to motivate staff, which has caused a significant amount of money (US$ 56,000) to be held back and not disbursed. Currently, there are many motivation methods being used in CAR through various partners. Under the leadership of the Director General for Population and Specific Endemic Disease Prevention, efforts are being made to identify a uniform way of motivating health staff. International technical assistance is urgently needed to help with this.

A problem-solving plan needs to be developed to identify and analyse roadblocks in order to remedy the delay and improve the usage rate for available resources.

4.5. Transition planning (if applicable, eg C ountry is in accelerated transition phase)

NA

4.6. Technical assistance

The country has received significant technical assistance in various forms:

a. Remote technical assistance provided by regional offices and the head offices of various partners (UNICEF, WHO, Gavi, AEDES, etc).
   - Such assistance was provided through field missions by experts from these organisations, focusing on specific topics such as: the process for the EPI external review, the development of the 2018-2022 cMPY, the introduction of new vaccines, implementation of the meningitis campaign, the Lake Chad polio response, the development of the CCEOP plan, the development of the measles campaign and the Joint Appraisal process.
   - This also involved teleconferences, specifically monthly teleconferences for monitoring EPI performance for high-priority countries. WCARO, AFRI/IST and the Gavi Secretariat actively participated in this.

b. On-site technical assistance
   - The EPI-TAC platform: This platform enabled the development and implementation of a human resources strengthening plan through support partners (WHO, UNICEF and AEDES). Through this platform, UNICEF was able to receive support for six positions (6-12 months), three for WHO (for 12 months) and two for AEDES (12 months). This technical assistance is provided on a contractual basis with beneficiary organisations and measured against specific and measurable results (twice per year) related to the following programming areas: Cold chain, management and introduction of new vaccines, coverage and equity, data quality, strengthening the health system, surveillance of EPI diseases, measles campaign and the urban immunisation strategy.
   - Through HSS, the three departments affected by the implementation of project activities (DRP, EPI and DCH) were able to recruit 13 additional experts to strengthen their human resources in a sustainable manner.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
Include the CCEOP application in the 2018-2022 cMYP.	cMYP prepared and validated by the ICC, including the CCEOP application.
Accelerate the launch of HSS2 high-priority activities (recruiting, purchasing).	Four-wheeled vehicles, motorcycles and computer equipment purchased and made available to the various entities; staff recruited and contracts signed with the MoPH.
Include Health Region Seven in HSS2 by developing an urban strategy.	Urban strategy prepared and approved by the ICC; approval letter from Gavi received; implementation plan being prepared in the health districts.
Finalise the HSS2 performance framework.	First draft sent to Gavi; waiting for feedback from Gavi to finalise the performance framework.
Restart coordination with TFPs and NGOs	Organise two forum meetings with TFPs and NGOs in 2018 to validate the new collaboration framework (HSCC); currently awaiting signature.
Prepare a national health development plan to replace the HSTP.	Prepare, validate and distribute the Health Sector Interim Plan (HSTP) 2018-2019 and have technical departments prepare operational implementation plans.
Plan to submit an application for the measles monitoring campaign.	Successful application for the measles monitoring campaign; budget being reviewed to close the gap.

Prepare a data quality improvement plan and strengthen the NHIS.	Plan prepared and being validated. The health map, to be used when implementing the DHIS2, has been prepared. The DVD-MT has been implemented at the central level, in the health districts in Health Region Seven, and is ongoing in Health Regions One, Two and Three. The DQR is being distributed. Implementation of the DHIS2 as the primary data management platform at the district level is being studied.
Accelerating the process of creating health districts in CAR.	Creating Regional Management Teams and District Management Teams, appointing various management teams with the process of empowering management team members ongoing.
Additional significant IRC/HLRP recommendations (if applicable)	**Current status**
Greater advocacy for more regular payments for vaccine co-financing from the central government budget.	Increase the budget for co-financing in the central government budget. First disbursement of 107,500,000 CFA francs has already occurred and the process for the final disbursement of 2018 (92,500,000 CFA francs) by the treasury department is ongoing.
Produce a manual of procedures for project fund management and provide training in the use of the manual	Process of preparing the manual with the UNICEF consultant and writing the first draft is in progress.
Have UNICEF create a skills transfer plan for financial management	In the context of skills transfer, the various programme managers have been trained in funds management procedures using the UNICEF model (HACT), including preparing requests, receiving and documenting the use of funds and financial reporting.

Activity in progress but not yet completed

6. ACTION PLANS: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Key finding/Action 1	Strengthen the NHIS by introducing DHIS2 at the district level and implementing the data quality improvement plan (DQIP) at all levels.
Current response	Given the multitude of data collection platforms, the MoPH has opted for harmonisation by progressively migrating toward DHIS2. Also, given the lack of data quality evidence, the MoPH is leaning toward implementing PAQD, with DVD-MT being implemented at the district level with regular DQRs and DQSs.
Agreed country actions	• Availability of international technical assistance to analyse the situation and prepare a roadmap to introduce the tool and support implementation of the DQIP. • Availability of international technical assistance to monitor data quality. • Availability of in-country and international technical assistance for the NHIS/DHIS2.
Expected outputs/results	- A roadmap is developed following an in-depth situational analysis - Data collection tools are reviewed and photocopied - Staff's ability to use the tool and the approach improves
Associated timeline	- September 2018-September 2019
Required resources/support	- Availability of international technical assistance to monitor data quality. - One in-country and international technical consultant on NHIS/DHIS2 for 12 months - Computer equipment (computers, equipment, internet kits)
Key finding/Action 2	Implement the MNT elimination plan

Current response	The country is committed to eliminating MNT as per the plan prepared at the global level. The country has a draft elimination plan that is ready for validation
Agreed country actions	Availability of international technical assistance to support implementation of the plan
Expected outputs/results	- TD immunisation coverage ≥ 80% - Three mass campaign rounds - Monitoring, with <1 case per 1,000 live births
Associated timeline	- September 2018-September 2019
Required resources/support	- Consultants (one in-country and one international) for 12 months - Financial resources - Vaccines and injection materials
Key finding/Action 3	Implement the urban strategy in Bangui
Current response	- Draft of Bangui urban strategy prepared
Agreed country actions	- Implement the urban strategy
Expected outputs/results	- Strengthen the routine EPI
Associated timeline	August 2018-September 2019
Required resources/support	Two technical assistance consultants Financial resources
Key finding/Action 4	Capacity building MLM for District and Regional Management Teams and EPI daily practices for the workers who immunise in health facilities
Current response	- Identifying new districts - Appointing new District and Regional Management Teams - The majority of EPI health workers are community health workers with no training
Agreed country actions	- Train the Regional and District Supervisory Teams in EPI management (MLM and EVM courses) - Train health workers in practical immunisation, including effective vaccine management
Expected outputs/results	- Improved capacity of Regional and District Management Teams and health workers
Associated timeline	September 2018-September 2019
Required resources/support	- WHO and UNICEF staff and one WHO and one UNICEF consultant for three months - Financial resources
Key finding/Action 5	Implementation of the CCEOP
Current response	CCEOP approval by Gavi Evaluation of facility sites is ongoing
Agreed country actions	- Finalise evaluation of sites - Installation of equipment
Expected outputs/results	- CCEOP project implemented
Associated timeline	August 2018-September 2019
Required resources/support	International TA. Financial resources
Key finding/Action 6	Introduction of new rota vaccine and strengthening of surveillance for vaccine-preventable diseases
Current response	- Introduction plan available - Sentinel surveillance of rotavirus diarrhoea in paediatric treatment and in national reference laboratories has improved - Surveillance of vaccine-preventable diseases
Agreed country actions	- Update rotavirus vaccine introduction plan - Introduce rotavirus vaccine - Strengthen rotavirus surveillance

Expected outputs/results	- Effective introduction of rotavirus vaccine into the routine EPI - Vaccine preventable disease surveillance data are available and of high quality
Associated timeline	September 2018-September 2019
Required resources/support	- Two international technical consultants (one for laboratories) - One in-country technical consultant - Financial resources - Material resources
Key finding/Action 7	Catching up targets 12-23 months of age who are not fully immunised under the routine EPI
Current response	- MoPH authorities have agreed - Gavi agreed to fund the additional vaccines with no co-financing from the Government - NGOs are available to assist the MoPH with this in unsafe areas
Agreed country actions	- Review and photocopy management tools - Train stakeholders in health districts
Expected outputs/results	- The number of individuals susceptible to vaccine preventable diseases in health districts is decreased
Associated timeline	- January-December 2019
Required resources/support	- Financial resources - Material resources
Key finding/Action 8	- Develop and implement a district health system strengthening plan
Current response	- The country has officially adopted a district health system with the ruling no043/ MSP/DIRCAB/CMAJC. - District management teams have been appointed by rulings no 021/MSP/DIR.CAB/DR/SGRHF.018. - District health management training modules exist
Agreed country actions	- Update training modules - Train district management team members in managing health districts - Create health development plans and operational action plans for the health districts - Strengthen sectoral and inter-sectoral coordination in the health districts
Expected outputs/results	- The health districts are managing their own activities and their performance has improved
Associated timeline	- January-December 2019
Required resources/support	- International TA - Financial resources - Material resources

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

The 2018 Joint Appraisal process began on 6 July 2018 with a meeting organised by the Department of Hospital Planning and Management to target the main stakeholders involved (EPI, DRP and DCH) and to discuss the work methods as per Service Memo N°706/MSHPP/DIRCAB/DGPGEH/DEP signed on 15 June 2017 by the MoPH's Cabinet Director, creating a small committee to prepare the work for the Joint Appraisal.

Subsequently, the committee successfully:

- held a meeting to share the form to be completed by the coordinators;
- had the HSS and EPI sub-groups do preliminary work to fill out the form;
- shared appraisal components;
- sent letters of information to the Government
- briefed the MoPH on the terms of reference; and
- held a technical meeting with the three directorates involved

The Joint Appraisal report review work by the committee was done during a two-day workshop with the participation of national experts from ministerial departments (Health, Finance, FACSS), civil society and NGOs. A mission of external evaluators also participated in the workshop, consisting of experts from WHO and UNICEF from IST, AFRO, regional and headquarter offices.

Four working groups were created to examine the different parts of the report. The working group reports were presented and endorsed in plenary.

The different amendments were compiled by the editing team and will be submitted for ICC approval before being officially sent to Gavi's IRC.

8. ANNEX Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF)* Reporting against all due indicators	x		
Financial Reports			
Periodic financial reports	x		
Annual financial statement	x		
Annual financial audit report			x
End-of year stock level (must be provided on May 15 in the context of requesting vaccine renewal)*	x		
Campaign reports*			
Technical activity report on supplementary immunisation activities	x		
Report on surveys concerning campaign coverage	x		
Immunisation financing and expenditure information	x		
Data quality and survey reporting			
Annual document review of data quality		x	
Data improvement plan (DIP)		x	
Progress report on implementation of DQA improvement plan	x		
In-depth data assessment (conducted in the last five years)		x	
Nationally representative coverage survey (conducted in the last five years)	x		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
CCEOP: Updated cold chain inventory	x		
Post-Introduction Evaluation (PIE)		x	
Situation analysis and five-year measles-rubella plan	x		
Operational plan for the immunisation programme	x		
HSS end-of-grant evaluation report	x		
HPV-specific reports			x
Partner reports on the role of the TAC and the EPF	x		