2018 Joint Appraisal Report

Country	Côte d'Ivoire
Full JA or Updated JA	☑ **Full JA** ☐ Updated JA
Date and location of Joint Appraisal meeting	10-14 September 2018, Abidjan
Participants/affiliation	See attached list of attendees
Frequency of outcome reports	2017
Fiscal period	1 January-31 December 2017
Comprehensive Multi Year Plan (cMYP) duration	2016-2020
Gavi transition/co-financing group	Preparatory transition

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests have been submitted on the country portal

NVS renewal requests (due by 15 May)	Yes x☐	No ☐	N/A ☐
Renewal request for HSS support	Yes x☐	No ☐	N/A ☐
Renewal request for CCEOP support	Yes ☐	No ☐	N/A x☐

Comments on vaccine requests

2019 Population	**26,914,245**				
Birth cohort (surviving)	**3.459%**				
Vaccine	Rotavirus vaccine	DTPHepB-Hib pentavalent vaccine	Pneumococcal vaccine (PCV-13)	Meningococcal A vaccine (MenA)	Combined Measles-Rubella vaccine (MR)
Population in the target age cohort	**931,055**	**931,055**	**931,055**	**931,055**	**931,055**
Target population before being vaccinated (first dose)	**931,055**	**931,055**	**931,055**	**931,055**	**931,055**
Target population before being vaccinated (last dose)	**931,055**	**931,055**	**931,055**	**N/A**	**N/A**
Implied immunisation coverage	**94%**	**94%**	**94%**	**94%**	**94%**
Latest WUENIC coverage rate available	**54%**	**84%**	**99%**	**N/A**	**78%**
Latest admin coverage rate available	**54%**	**98%**	**96%**	**N/A**	**91%**
Wastage rate	**5%**	**10%**	**5%**	**N/A**	**15%**

Buffer stock	593,800	998,608	981,638	N/A	N/A
Stock end Dec 2017	286,975	1,095,600	1,161,248	N/A	N/A

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[1]

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi	Programme	Expected application year	Expected introduction year
	HPV	2019	2019

2. RECENT CHANGES TO COUNTRY CONTEXT AND POTENTIAL RISKS FOR THE FOLLOWING YEAR

There are no notable changes in the general country context. The country has not been formally identified by Gavi as a fragile country.

- Security risk: preparations for the 2020 presidential elections will take place in 2019. Tensions risk being exacerbated during this period, negatively impacting health activities, both curative and preventive. If there are significant disturbances, immunisation services will continue to be provided by service providers through NGOs working in immunisation, as was the case during previous crises.
- Financial risk: If there is a national financial crisis, the country has funds available at the Copenhagen Supply Division to ensure vaccine and input procurement until the situation has returned to normal.
- Institutional risk: various governmental reorganisations are likely to lead to significant changes within the Ministry of Health as well as other technical ministries involved in managing the immunisation programme. All this can lead to delays in administrative procedures and a negative impact on programme management. A functioning ICC will minimise risk by ensuring continuity in implementing the immunisation programme.
- Social risk: The occurrence of ill-timed strikes within the health sector could negatively affect successful activity rollout. The NGO network can be used to ensure continuity of immunisation services

[1] Providing this information does not constitute any obligation for either the country or Gavi; it merely serves for informational purposes.

3. IMMUNISATION PROGRAMME PERFORMANCE

3.1. Immunisation coverage and equity

1. Immunisation coverage

There were positive changes in administrative immunisation coverage from 2016 to 2017, as confirmed by WHO/UNICEF estimates, as shown in Figures 1 and 2.

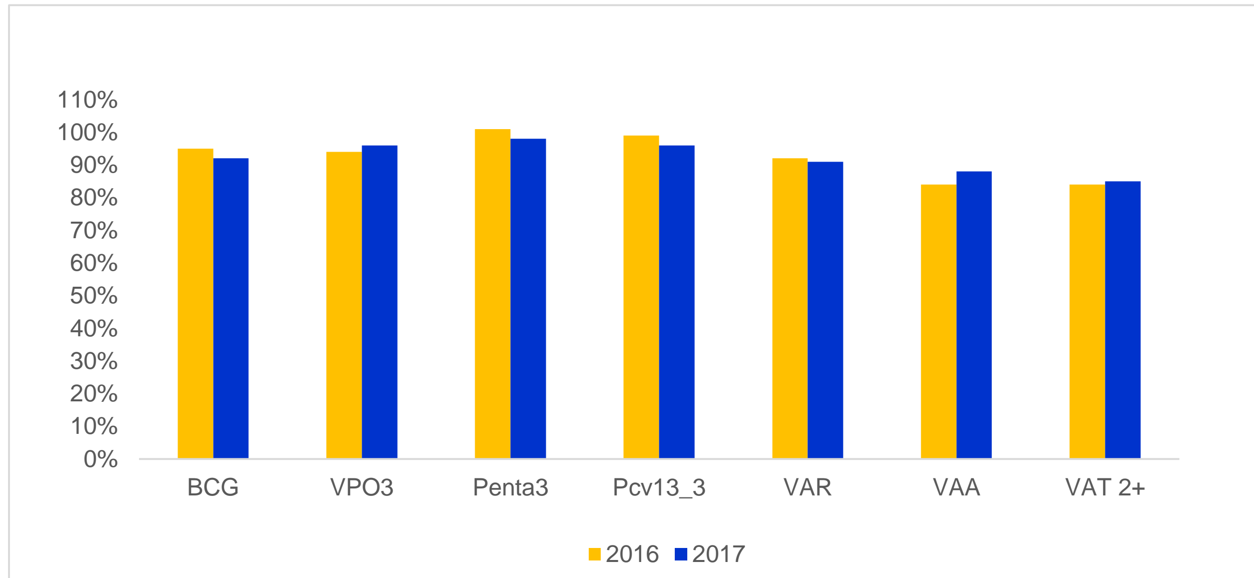


Figure 1: Changes in administrative coverage levels (Source EPI Coordination Office)

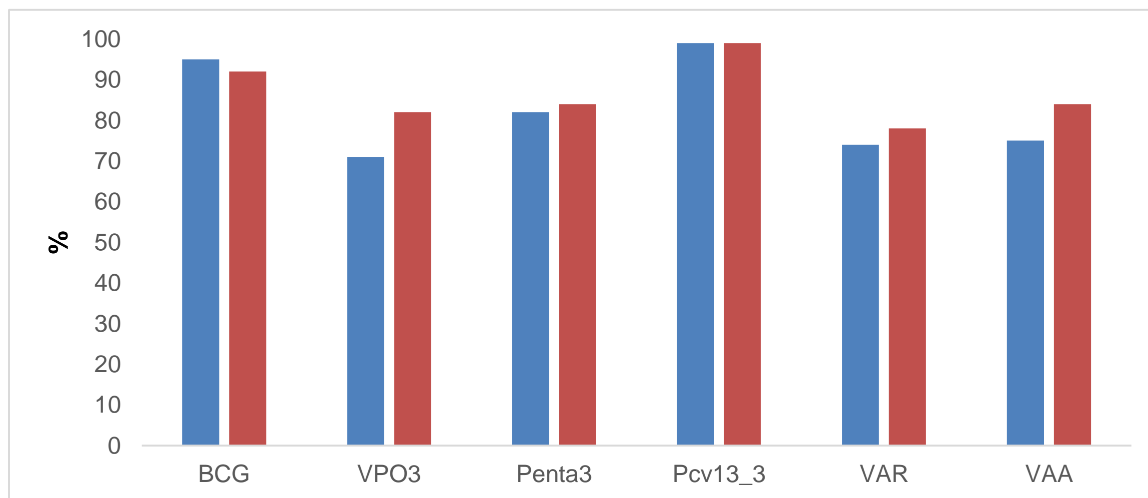
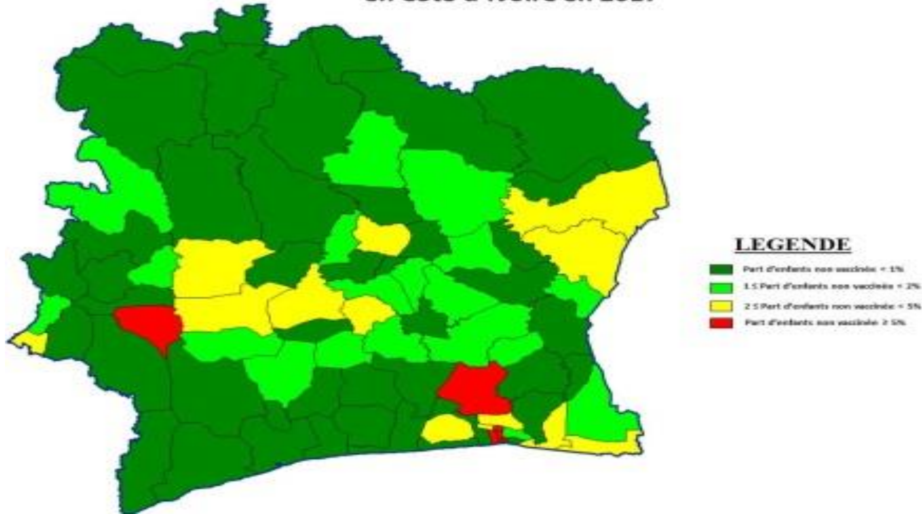


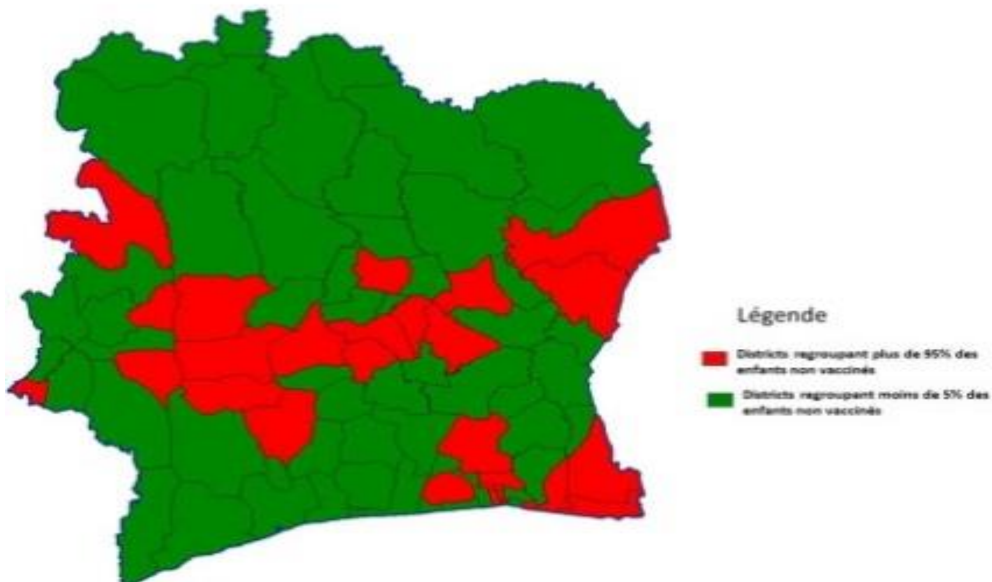
Figure 2: Changes in immunisation coverage levels per antigen (WHO/UNICEF estimates)

However, although this is an improvement seen at the national level, it hides disparities that exist at the district level. In 2017, the national objective set for all antigens was 92%. While this goal was reached by 70% of health districts for the 3rd dose of the pentavalent vaccine, 28% of health districts obtained immunisation coverage between 80 and 92%, and 2% had coverage below 80%. Refer to Figure 3 addressing district categorisation.

Situation des districts par rapport au nombre d'enfants non vaccinés en dtc3 en Côte d'Ivoire en 2017



Districts regroupant plus de 95% des enfants non vaccinés au dtc3 en Côte d'Ivoire en 2017



CV DTC3 en Côte d'Ivoire en 2017

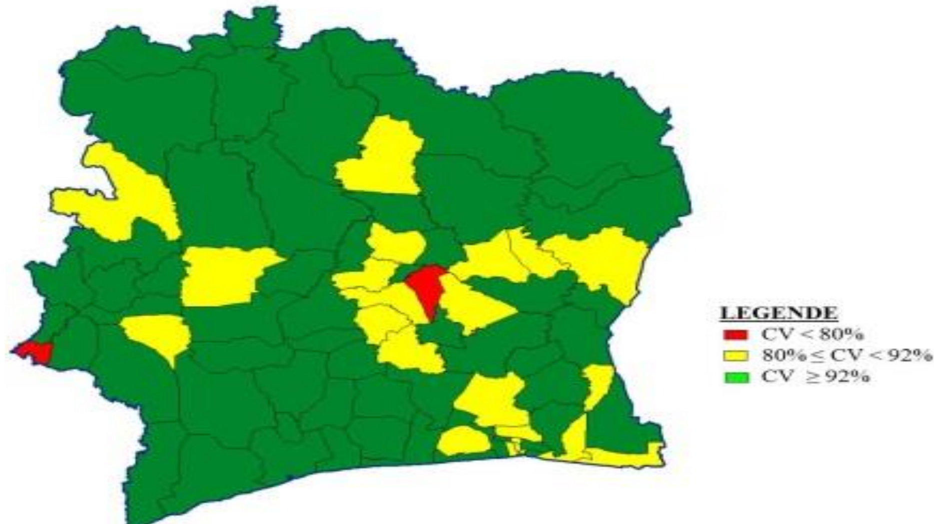


Figure 3: Categorisation of districts by DTP3 performance

As for measles vaccine coverage among health districts, 47% reached coverage of 92%, 36% reached between 80% and 92%, and 17% had coverage below 80%.

In addition, the 2015 external EPI review showed that targets who live in urban areas had higher full immunisation coverage levels than targets who live in rural areas (52% as opposed to 39%).

The 2016 Multiple Indicators Cluster Survey (MICS) also revealed significant disparities, specifically between children in the poorest households and those in the wealthiest. Although the percentage of children who are fully immunised was 28.6% for children in the poorest households, it was 57.3% for children in the wealthiest.

These examples clearly show that children elude immunisation and that it is important to seek out the causes to improve not only immunisation coverage but also to establish equity.

It should be noted that, according to the 2015 external EPI review, there was no significant difference in immunisation coverage between boys and girls.

3.2. Main factors of coverage and sustainable equity

- ***Health workforce***

The availability indicators for human resources for the 2017 national plan are as follows: 1 doctor per 7,390 residents, 1 nurse per 2,335 residents, and 1 midwife per 1,333 women of childbearing age (AHSR 2017).

Even if these national data meet international recommendations, pronounced gaps persist, particularly in terms of the doctor/population ratio between health regions, evidenced by 1 doctor per 20,000 residents in Cavally Guemon.

These gaps also exist within health regions. In the Abidjan region, for example, there are gaps among different health districts. Although the Yopougon-Est district has 1 doctor per 22,818 residents, 1 nurse per 8,376 residents and 1 midwife per 3,220 women of childbearing age, the Cocody Bingerville health district has 1 doctor per 3,042 residents, 1 nurse per 2,226 residents and 1 midwife per 778 women of childbearing age (AHSR 2017).

The management of Human Resources for Health (HRH) faces challenges linked to:

- *inequal distribution of HRH resources due to the lack of an HRH information management system and lack of a work load evaluation in health facilities, with a deficit in planning HR resources at the decentralised level;*
- *insufficient specialised HRH resources, due to the lack of a continuing training plan for health workers and the civil service's lack of recognition for medical and paramedical specialities along with weak recruiting of specialised personnel;*
- *loyalty among HRH resources, highlighted on the one hand by lack of motivation among personnel in general and specifically among those in remote areas difficult to access, and on the other by lack of regulations covering personnel mobility and the lack of a career profile;*
- *lack of production of high-quality HRH resources along with weak investment in training, and the difficulties of implementing reforms to the educational system (LMD)*
- *no grasp of private-sector HRH resources, due to absence of mapping and lack of an observatory and an HRH resource policy development document.*

Since 2017, the country has adopted a strategic plan for community health that addresses the status of community health workers (CHW) and an incentive system that includes financial incentives.

- ***Supply Chain***

The last EVM conducted in Côte d'Ivoire dates from 2015. Only two out of nine indicators received an average score higher than the norm of 80%. These are Criteria E3 Storage and transport capacity (83%) and E8 Vaccine management (84%). The lowest average score was related to Criterion E7 Vaccine distribution (45%).

Implementation of the improvement plan following the EVM led to the following outcomes:

- E1 Vaccine arrival procedures: Implementation of a fast track for releasing funds for the government to pay for vaccines and supplies. A contract including penalty clauses was established with the freight forwarder.
- E2 Temperature monitoring:
  - ✓ Procurement of 2,200 30-day continuous temperature recorders (Logtag) at all levels and 110 temperature data readers/recorders.
  - ✓ Implementation of temperature mapping for cold rooms at national level.
- E3 Storage and transport capacity:
  - ✓ Procurement and putting into service 10 positive cold rooms with gross capacities of 40 m3 each, as well as a mixed cold room with a capacity of 25 /15 m3.
  - ✓ Procurement and putting into service a 500 KVA generator.
- E4 Buildings, equipment and transport: equipment for 10 National Institute of Public Hygiene regional warehouses in the form of a computer kit (computer, printer); 4 regional warehouses under construction; funding for districts to purchase 23 motorbikes.
- E5 Maintenance: contracts for maintenance at the national and peripheral levels established, along with implementation of a system to monitor initiatives.
- E6 Stock management: installation of an application that enables data to be gathered on vaccine and supply stocks.
- E7 Distribution:
  - ✓ Procurement of 4 refrigerated vehicles and 4 utility vehicles for supplies.
  - ✓ Distribution plan developed and implemented with available financial resources.
- E8 Vaccine Management: display of VVM guidelines, the open vial policy and shake test in EPI rooms; training of workers in immunology.
- E9, MIS and supportive functions:
  - ✓ The following three software packages are used for the logistics information system:
    eDVDMT for immunisation data, monitoring and input management;
    SMT for vaccine inventory management;
    SIG Inventaire for cold chain and ground transportation management.
  - ✓ Standard Operating Procedures (SOP) developed.

In 2019, Côte d'Ivoire plans to conduct an internal EVM, and this self-assessment will identify weaknesses and urgent actions to be implemented.

Providing services and generating demand:

In 2017, all immunisation facilities implemented fixed, outreach and mobile immunisation strategies. The government built 136 new immunisation facilities to improve geographic accessibility. In big cities specifically, district teams were provided with logistical support for immunisation at outreach posts. Support mostly consisted of providing tarpaulins, chairs and tables. Health districts and the national level organised supportive supervisions, and this led to deficiencies being corrected to ensure better immunisation services (adapting immunisation programmes to community activity programmes, receiving individuals properly in immunisation facilities, and interpersonal communication.)
However, several targets did not complete their immunisation series: for this period, it can be noted that 53% of health districts had a global drop-out rate greater than 10%, and 8% of districts had a specific drop-out rate greater than 10%. These data show that there is a problem with the continuity of immunisation services in certain districts.

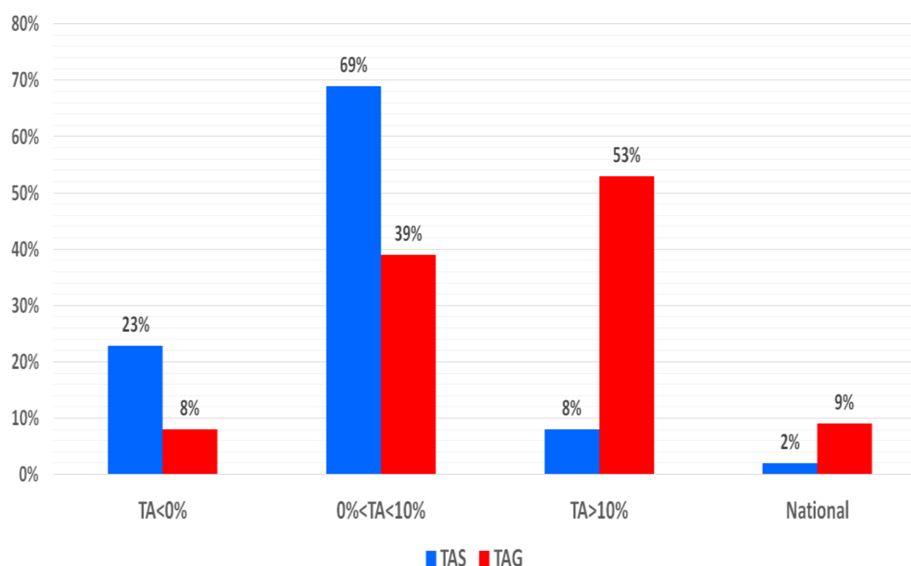


Figure 4: *Specific and global drop-out rates from January to December 2017*

To improve the continuity of immunisation services, activities are conducted within the framework of community engagement. These are regular coordination meetings organised at the operational level. These meetings have made health activities possible in general and immunisation activities in particular. These meetings have seen participation and involvement by administrative and community authorities in monitoring immunisation activities.
In addition, CHWs, NGOs and CSOs have contributed to seeking out drop-outs in health areas through home visits and group discussions.

- ***Barriers related to gender inequality encountered by care givers***

  In Côte d'Ivoire, there are no gender-related barriers: immunisation facilities are for both men and women. Immunisation sessions are organised by adapting them to mothers' activities programme (market days, returning from agricultural work). Isolated cases where children's fathers are reticent exist but are generally managed with the support of community leaders.

- ***Leadership, management and coordination***

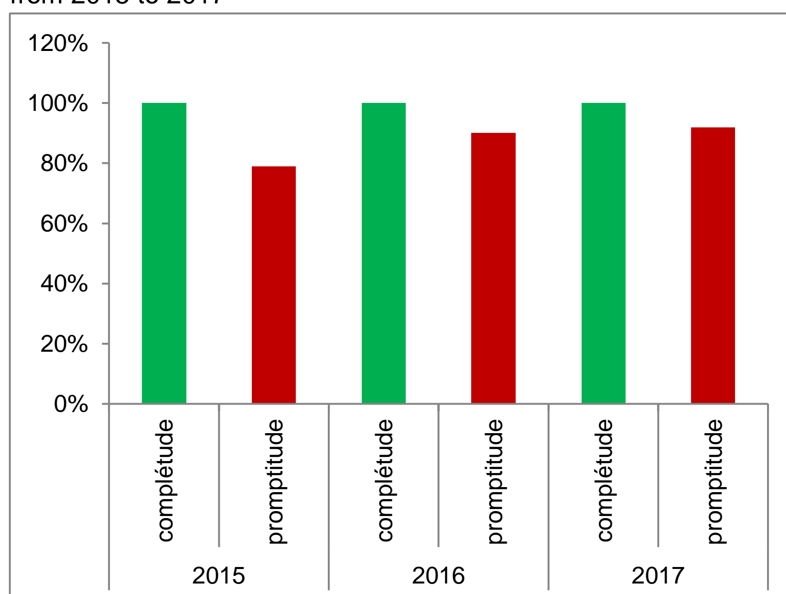
At the national level, changes in specialised personnel that occured in 2017 reduced the programme's capacity in strategic document development and in activity monitoring. In addition, a lack of qualified personnel to support the various EPI services should be noted.
With regard to the supply chain, the EPI Coordination Office did not achieve EPI vaccine optimisation; vaccines continue to be stored and managed by regional National Institute of Public Hygiene facilities. Due to this, the EPI Coordination Office is not able to efficiently monitor regional stock management.
Immunisation activities were not sufficiently coordinated at the regional level due to the lack of a regional EPIC. In addition, district management teams and regional health teams were not sufficiently trained in EPI management, analysis or the use of data for decision-making.

3.3. Data

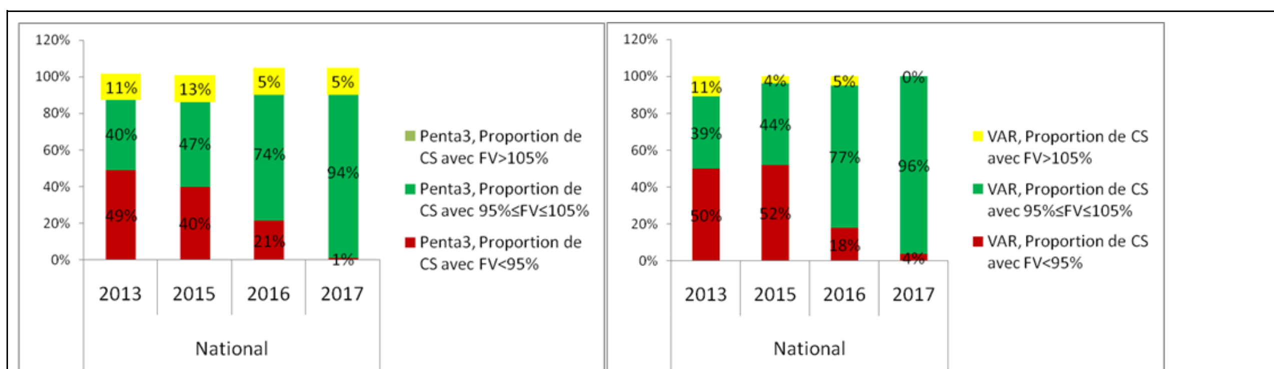
Immunisation data collection begins in immunisation facilities and is accomplished through the registration of immunisation procedures using various paper materials including a tracking sheet, immunisation cards and immunisation registries. These data are manually compiled and transmitted to the health district. In the majority of cases, these facilities are managed by government-certified nurses and midwives, but it should be noted that immunisation documentation – the creation of monthly reports – is the nurse's responsibility.
At the district level, data management is computerised and monthly reports from the health facilities are compiled using DVD-MT, which provides a general monthly performance analysis to be used for decision-making.
At the regional level, monthly district reports are compiled electronically to produce regional reports. The analysis made at this level is shared with the districts at regional coordination meetings.
At the national level, the monthly report is produced using compiled regional reports. This report is then transmitted to the Ministry of Health and its immunisation partners. At quarterly monitoring meetings, performance analysis feedback reports are provided to district and regional-level chief physicians.
The personnel responsible for managing immunisation data are also involved in the Health Management Information System. This health information is entered at the health district level in a computer application called "DHIS2".

In 2017, the denominators used were adjusted using general population census data from 2014 and health district performance related to routine immunisation, supplementary immunisation activities and immunisation doses used.

Regarding data availability, a change in the level of national data completeness and timeliness can be noted from 2015 to 2017



In compliance with Gavi guidelines related to data quality requirements, the programme has regularly conducted data quality self-assessments since 2013 and most recently in 2017.
The analysis compared the change in verification factors from 2013 to 2017, showing an increase in the proportion of health facilities with satisfactory verification factors for DTP-HepB-Hib-3 and MCV. It then increased from 40% to 94% for DTP-HepB-Hib 3 and from 39% to 96% for MCV.



Within the framework of improving data quality, a peer data quality self-assessment combined with the LQAS survey was organised in a total of 83 districts.

The outcomes of this self-assessment led to improvements in targeting initiatives at the health district level for improved programme performance and data quality. These initiatives are:

- organising catch-up immunisation for children who had dropped out, for outreach and mobile strategies;
- updating microplanning for immunisation activities in large cities;
- reorganising the data quality improvement plan;
- regional level conducting supervisory missions of the health districts;
- organising monitoring meetings with the health districts;
- organising monthly data validation meetings at health areas before the data are sent to the regional and national levels;
- DMT coaching FCHF service providers on how to fill in data collection tools;
- creating outreach immunisation posts in city neighbourhoods and regularly organising immunisation sessions in these neighbourhoods;
- increasing active searching for children who have not been immunised or who have dropped out.

3.4. Immunisation funding

EPI annual action plans are drawn from the cMYP and prepared by the EPI Coordination Office in collaboration with the other technical departments of the ministry in charge of health and development partners. These various documents are endorsed by the ICC.

At the regional and district level, action plans incorporating immunisation have been developed according to national focus areas. The budgeting process occurs in year n-1 at the conclusion of the budgetary conferences, and the budget is implemented during the first quarter of the budget year. However, at the regional and district levels the adopted budget is an integrated budget that takes into account the EPI package of activities.

The EPI budget was CFA Franc 6.5 billion in 2016 and 6.4 billion in 2017. This budget enabled both purchase of traditional vaccines and Gavi co-financing. In addition, for the first time in 10 years, the country did not experience a vaccine stock-out. However, certain budget line items remain under-funded, particularly preventive and curative maintenance of cold chain equipment and transport and vaccine transit costs.

During 2017, funding for immunisation strategies was inconsistent. With the beginning of HSS2 implementation, since June 2018, all districts receive support from the national level to implement outreach and mobile strategies and to fund outreach posts.

The Gavi funds that back up the government's budget are executed, according to the tripartite agreement signed between the government, UNICEF and Gavi, for an initial transitional period of 18 months while waiting for the DGH management capacities to be strengthened for improved management of these funds. The national level makes funds available via mobile money to the peripheral level for up to the last beneficiary. As for the government budget, it is executed through the traditional path of public expenditures. As of today, the regional health directorates and health districts do not have their own bank accounts that would allow for funds to be transferred from the national level to the districts and then from the district level to the health facilities.

4. GAVI SUPPORT PERFORMANCE

4.1. Performance of vaccine support

In the last two years, the EPI introduced the injectable polio vaccine in 2016 and the rotavirus vaccine in March 2017. However, the IPV experienced an international stock-out several months after it was introduced. Immunisation coverage for the rotavirus vaccine was 54% in 2017.
The measles and rubella immunisation campaign was the only campaign that was planned but not conducted during the year. In addition, introduction of the MR vaccine was scheduled for 2018. The country has not yet decided whether the second dose of this vaccine will be introduced.
From administrative coverages, it can be noted that objectives were reached for routine immunisations for the first and third dose of the pentavalent vaccine at the national level and that all districts obtained at least 80% coverage for Penta3.

With regard to sentinel site monitoring, the proportion of stool samples testing positive for rotavirus decreased from 23% before introduction to 16% after introduction. For Haemophilus influenzae meningitis, out of all patients who received a lumbar puncture, only 1.24% had purulent CSF with bacterial growth, and there were zero confirmed cases of Hib meningitis.

Introduction of the meningitis A vaccine into routine immunisation and organisation of the catch-up meningitis A campaign were planned in 2018. In addition, the country plans to introduce the HPV vaccine into routine immunisation in 2019.

4.2. Performance of Gavi HSS support (for applicable countries)

Funds required to implement HSS2 had to be available in March 2017 to comply with the timeline in the proposal submitted to Gavi on 6 September 2016. But these funds were not received as of September 2017. Considering that the funds had to be included in the government's budget and that there were only three months left in 2017, 2017 activities were reprogrammed for 2018. Therefore, 2018 will be the first year that HSS2 is actually implemented.

Objective 1	
HSS grant objective (in compliance with HSS proposals or the PSR)	**By 2021, strengthen the immunisation services offered for outreach and mobile strategies including outreach posts in 29 targeted health districts**
Geographic/priority population groups or coverage constraints and equity addressed by the objective	29 targeted health districts
% of activities launched/ use of budget	0%
Primary activities implemented and review of implementation status specifically primary successes and outcomes/activities that were not implemented or were delayed/financial absorption	No activity conducted in 2017

Primary activities planned for coming period (indicate significant changes/budget reallocations and **needs related to technical assistance)**	- Train 1858 health workers (2 per health area), in the 20 health districts targeted for immunisation. - Implement outreach and mobile strategies, including outreach posts in targeted health districts. - Conduct regional supervision in the 29 targeted health districts. - The 29 targeted health districts conduct bi-monthly supervisions of their respective health areas. - Organise development action plan workshops in the 29 targeted health districts. - Ensure transport from EPIC to monitor immunisation activities at immunisation facilities. - Adapt and reproduce training modules for district management teams to optimise health district management.
Objective 2:	
HSS grant objective (in compliance with HSS proposals or the PSR)	**By the end of 2021, strengthen the demand for immunisation services in the 29 targeted health districts.**
Geographic/priority population groups or coverage constraints and equity addressed by the objective	29 targeted health districts
% of activities launched/ use of budget	0%
Primary activities implemented and review of implementation status specifically primary successes and outcomes/activities that were not implemented or were delayed/financial absorption	No activity conducted in 2017
Primary activities planned for coming period (indicate significant changes/budget reallocations and **needs related to technical assistance)**[11]	- Train 29 local CSOs in the 29 targeted health districts on basic health concepts, communication techniques and social mobilisation. - Every four months, organise local awareness-raising campaigns on health by local CSOs in the 29 targeted health districts. - Every six months, hold an activity monitoring meeting about programme activities at the district level, expanded to administrative authorities, local authorities and communities, in the 29 targeted health districts. - M-Vaccine implemented
Objective 3:	
HSS grant objective (in compliance with HSS proposals or the PSR)	**By the end of 2021, improve quality and utilisation of immunisation data at all levels of the health pyramid.**
Geographic/priority population groups or coverage constraints and equity addressed by the objective	86 health districts
% of activities launched/ use of budget	0%

Primary activities implemented and review of implementation status specifically primary successes and outcomes/activities that were not implemented or were delayed/financial absorption	No activity conducted in 2017
Primary activities planned for coming period (indicate significant changes/budget reallocations and **needs related to technical assistance**	- Organise a health data quality survey (DQS) annually, combined with LQAS by peers. - Organise a consensus workshop on integrating immunisation data into DHIS2. - Train 125 national, regional and district level stakeholders on DHIS2 and immunisation data analysis. - Organise two national immunisation coverage surveys. - Test electronic stylus in two health regions.
Objective 4:	
HSS grant objective (in compliance with HSS proposals or the PSR)	**By the end of 2021, strengthen vaccine storage capacity in the 82 health districts.**
Geographic/priority population groups or coverage constraints and equity addressed by the objective	86 health districts
% of activities launched/ use of budget	0%
Primary activities implemented and review of implementation status specifically primary successes and outcomes/activities that were not implemented or were delayed/financial absorption	No activity conducted in 2017
Primary activities planned for coming period (indicate significant changes/budget reallocations and **needs related to technical assistance**	- Procure 340 solar refrigerators (TCW 40SDD), 296 electric refrigerators (TCW 2000), 50 electric refrigerators (TCW 3000), 468 stabilisers, and 1,638 30-day continuous temperature readers. - Build facilities to install new cold rooms in Daloa and Divo. - Train 12 logistics experts in the logistics of immunisation in Ouidah (Benin). - Install and equip cold rooms in Daloa and Divo.

Objective 5:	
HSS grant objective (in compliance with HSS proposals or the PSR)	**By the end of 2021, coordination and HSS programme management**
Geographic/priority population groups or coverage constraints and equity addressed by the objective	86 health districts
% of activities launched/ use of budget	0%
Primary activities implemented and review of implementation status specifically primary successes and outcomes/activities that were not implemented or were delayed/financial absorption	No activity conducted in 2017
Primary activities planned for coming period (indicate significant changes/budget reallocations and **needs related to technical assistance**	- Support DGH in periodically organising integrated supervision missions, logistical monitoring (cold chain, infrastructure and ground transportation) and monitoring of HSS programme implementation. - Train 1 person from DGH per year in quality and health-system organisation/ - Provide DGH with computer and office equipment. - Ensure funds for fuel and communications for programme management. - Organise HSS assessment. - Conduct an external audit on Gavi funds management. - Conduct an internal audit on Gavi funds management. - Organise two monitoring meetings per year with the RHDs and DHDs in the target districts.

4.3. Performance of Gavi CCEOP support (for applicable countries)

Not applicable: the country is in the process of requesting its first CCEOP equipment.

4.4. Financial management performance

Currently, five grants are being used. These include the HSS1 grant, which was extended through 31 December 2018 under special circumstances, so that companies contracted to build regional cold rooms could be paid. The use rate for each grant is shown in the table below.

The global grant absorption rate is 73% (Source: UNICEF).

Grant	Amount (USD)	Funds Validity	Expenditures/ Réquisition (USD)	Balance as at 10/09/2018 (USD)	Utilisation
Autonomisation du PEV (RSS1)	2,450,462	16 June 2016 to 31 December 2018	2,397,890.33	52,571.68	98%
MR Campaign	8,701,500	08 September 2017 to 31 December 2018	8,065,185.06	636,314.94	93%
RSS2	2,927,658	30 August 2017 au 29 August 2019	454,382.54	2,473,275.46	16%
MR Routine	683,500	09 October 2017 to 31 December 2018	208,434.13	475,065.87	30%
Men A SIA	465,417	09 May 2018 to 08 May 2019	579.60	464,837.40	0%
TOTAL	**15,228,537**		**11,126,471.65**	**4,102,065.35**	**73%**

A programme capacity assessment was conducted in 2017 and led to formulating requirements to satisfy the Ministry of Health regarding improved grant management. While waiting for these requirements to be met, funds are temporarily being managed by UNICEF. This transitional period is to be used to strengthen the Ministry of Health's capacity so it can take over. To this end, Dalberg has been recruited by Gavi to support the actions taken by UNICEF toward this goal.

4.5. Transition planning (as applicable, for example, if the country experiences an accelerated transitional phase)

Côte d'Ivoire is in the preparatory transitional phase. At this stage, the country has not yet developed its transition plan. But the actions below have been taken to ensure availability of vaccines, injection supplies and operational costs for programme implementation. This involves:

- joining the immunisation independence initiative in December 2016 by signing a memorandum with UNICEF, giving access to supply facilities and covering up to USD$ 2.5 million, payable in 60 days;
- joint communication by the Ministries of Health, Budget and Economy to the Council of Ministers on 14 September 2016, with the following results:
  - payment expected from the beginning of the year for vaccines and supplies by funds transfer up to the value of the credits provided by the UNICEF Supply Division in Copenhagen;
  - removal of budget regulations for credits allocated for the supply of vaccines and supplies;
  - obtaining an annual customs duty exemption for vaccines and supplies.

This process has enabled the following:

- budget made available in 2017 (FCFA 4.2 billion) and 2018 (FCFA 10.1 billion) according to the government's statement, to which is attached the estimated budget, signed by the Ministers of the Budget and Economy and Finance;
- 2017: transfer of annual provision of 4.2 billion to UNICEF, during the first half of the year;
- 2018: commitment of 2.7 billion for co-funding, while awaiting transfer;
- creation of an escrow account by the Ministry of the Economy and Finance, in 2017.

To be carried out to ensure financial viability for the future:

- Determine methods with which to supply the escrow account.
- Reconfirm commitment to government's budget plan after 2020.
- Draft and implement a domestic resource mobilisation plan (Government, Private Sector (agricultural, industrial, local development initiatives, etc., and associations).
- Continue advocacy for:
  - a budget provision that covers the amount that has been subtracted from Gavi's contribution;
  - a significant provision for operational costs, maintenance, cold chain updates and transit fees;
  - maintaining Gavi vaccine costs for the country graduating from Gavi funding, through UNICEF or central purchasing.

In addition, the World Bank recently completed an analysis of the evaluation of the system for funding health and the transitional process for immunisation programmes. The results of this evaluation will be taken into consideration during the "transition assessment" that will take place in 2019.

4.6. Technical assistance

Within the partnership framework, WHO, UNICEF and the World Bank were able to provide technical assistance to the country through the EPI. This assistance focused on:

- Developing proposal documents for the Men A campaign and the introduction of Men A into the routine EPI, preparatory documents for the measles and rubella campaign and proposal documents for scaling up HPV, including support for evaluating the cost of the HPV demonstration phase.
- Support for implementing the measles and rubella vaccine campaign.
- Improving data quality through monthly data analysis and feedback to stakeholders at the national and operational levels.
- Organising quarterly meetings to standardise data, involving all parties who participate in immunisation and monitoring.
- Developing user guides for vaccine management tools and for personnel training at the national level;
- identifying priority districts (13 districts) that will allow assistance to be provided to the supervision missions through the Stop Team's activities. Also, support in organising a twice-yearly monitoring meeting with regional and district stakeholders made it possible to share programme performance and to jointly identify priority actions that contribute to improved immunisation coverage.
- Revitalising the National Logistics Committee (Technical Immunisation Committee).
- Training Ministry of Health personnel in the use of new technologies for monitoring temperature and vaccine quality.
- Conducting an analysis of the evaluation of the system for funding health. This evaluation led to the creation of a summary of the questions related to financial and institutional mechanisms within the health system, to clarify political discussions about resource mobilisation, the transition of donor support, as well as related health insurance reforms, strategic procurement and governance. The evaluation focuses on understanding economic growth, the macro-budget context, the management of public finances, health policy, demographics and population health outcomes, efficient and equitable health care coverage, equitable financial protection, efficiency, health system organisation, funding care, resource mobilisation, purchasing, material resources, human resources and medications. The analysis also includes an immunisation analysis the results of which have been discussed in the above section on transition.

The primary difficulty highlighted in relation to partner commitment is the delayed availability of TCA funds, which often limits implementation of activities planned for the beginning of the year.

The country has also received additional technical assistance from the AMP and VillageReach.
This assistance respectively focused on improving coverage and equity in 10 health districts and implementing the M-Vaccine project, the purpose of which is to improve demand generation by sending SMS reminders for immunisation appointments.
Successes: measures and educational materials to strengthen applied immunology capacity were developed and made available to the EPI Coordination Office and 84 immunisation stakeholders at the national, intermediary and operational levels (regional CSASs, new RDHs, district CSASs, EPI Coordination Office) [who were] trained in this field; the EPI data standardisation process was relaunched at the national and district levels.
Use of data management and analysis has been strengthened; strategies for improving immunisation demand and EPI performance in urban areas and revitalisation of the RED approach were defined following studies conducted on these topics.
The M-Vaccine project was officially launched, and its active SMS reminders phase is planned for 2019.
The primary difficulty encountered for this additional technical assistance is the delay in signing contracts with both AMP and VillageReach, and a delay in funds being made available.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Strengthen participating stakeholder capacity in CCE maintenance at all levels of the system - TA/PEF/Private sector partnership needs.	Completed
2. Strengthen the monitoring system to improve detection for EPI target diseases being monitored (polio, measles, NNT, yellow fever, meningitis, AEFI) - Need for TA/PEF.	Partially completed, the MR and Men A components remain
3. Support implementation of community communication plan to generate demand – Need for TA/PEF.	Partially completed, still awaiting finalisation and signing of contracts with NGOs
4. Strengthen DGH technical programming management and financial capacities for improved coordination and synergy with partners who contribute to strengthening health system initiatives for all partners within the National Health Development Plan framework.	Ongoing
5. Update and implement data quality improvement plan (2018-2020)/integrate immunisation indicators into DHIS2 - TA/PEF need.	Ongoing
Additional significant IRC/HLRP recommendations (if applicable)	**Current status**
Conduct advocacy to increase budget allocated to CCE maintenance at all levels.	Completed
Procure and install a large-capacity incinerator in Bouaké to treat biomedical waste including immunisation waste.	Not completed because a large-capacity incinerator was built at Abobo for the Ministry of Health
Mobilise financial resources to build facilities to house cold rooms in Korhogo, Daloa and Divo.	Completed
Conduct a study on the cost and impact of immunisation on the population and the national economy.	Not completed but a similar study was conducted by the World Bank
Organise tripartite meetings between departmental directors in the Ministries of Health, Economy and Budget to remove bottlenecks that impede implementation of annual tax exemption decrees for vaccines/supplies and expected payment for vaccines.	Completed
Draft the text of laws related to national immunisation policy.	Ongoing
Explore opportunities for funding/supply for immunisation escrow account.	Ongoing
Organise evaluations for new vaccine introductions and perform mid-term review of EPI strategic plan.	Not completed, but moved to 2019

Prepare a plan to anticipate the start of the accelerated transition phase.	Ongoing
Refine study on equity in immunisation.	Ongoing

See table above.

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

The table below provides an overview of all primary activities scheduled for the following year.

Key finding/action 1	**The country is prepared for transition**
Current response	Lack of transition plan, lack of transition assessment
Agreed country actions	Prepare the country for 2021-2025 accelerated transition
Deliverable products/results	Transition evaluation report is available to develop a transition plan
Associated timeline	2019-2020
Required resources/support	Need for TA/PEF
Key finding/action 2	**Study on equity in immunisation has been completed**
Current response	Lack of an equity study
Agreed country actions	Conduct equity study
Deliverable products/results	Study report on equity is available with recommendations
Associated timeline	2018 -2019
Required resources/support	Need for TA/PEF
Key finding/action 3	**2018-2020 data quality improvement plan is available**
Current response	There is no data quality improvement plan.
Agreed country actions	Draft and implement the data quality improvement plan (2018-2020)/integrate immunisation indicators into DHIS2
Deliverable products/results	Implementation report for data quality improvement plan is available
Associated timeline	2018 to 2020

Required resources/support	Need for TA/PEF
Key finding/action 4	**Introduction of new vaccines**
Current response	The HPV vaccine has not yet been introduced into routine EPI
Agreed country actions	Introduce HPV vaccine into routine EPI nationally
Deliverable products/results	Implementation report for HPV quality improvement plan is available
Associated timeline	2019
Required resources/support	Need for TA/PEF
Key finding/action 5	**Monitoring of vaccine-preventable diseases and AEFIs for routine EPI are strengthened**
Current response	Insufficient implementation of monitoring supervision activities
Agreed country actions	Intensify monitoring of vaccine-preventable diseases and AEFIs for routine EPI in areas with poor performance
Deliverable products/results	Extend environmental monitoring to other regions Strengthen AEFI monitoring in the routine
Associated timeline	2018 and 2019.
Required resources/support	Need for TA/PEF

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

The 2018 joint appraisal took place from 11-23 September, in two phases.

- 1st stage: **Workshop from 11 to 13/09/2018**

The methodology used for the joint appraisal was based on the following points:

- ➢ introductory visits to the Ministry of Health and to alliance partners;
- ➢ 3-day workshop (from 11 to 13/09/2018);
- ➢ presentations and discussions in the plenary session;
- ➢ work groups and debriefing in the plenary session;
- ➢ specific sessions;
- ➢ use of additional HSS funds;
- ➢ M-Vaccine project;
- ➢ HPV introduction in 2019;
- ➢ Rotateq supply problems;
- ➢ summary of conclusions.

Several parties participated in this workshop, including:

- stakeholders from the Ministry of Health and Public Hygiene;
- stakeholders from the Ministry of Economy and Finance and Budget;
- scientific groups: NCPE;
- **Gavi partners:** Gavi secretariat, WHO, UNICEF, World Bank;
- **NGOs and Civil Society:** AMP, FENOS-CI, VillageReach, Jhpiego;
- **Private partnerships:** Orange Côte d'Ivoire, Dalberg.

- 2nd phase: **ICC debrief**

The debriefing occurred on 14/09/2018 and was chaired by the Minister of Health and Public Hygiene. **Twenty** of the **28** statutory members from various ministries and technical and financial partners participated.

8. ANNEXES

Annex 1: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF)* reporting against all due indicators			
Financial Reports*			
Periodic financial reports			
Annual financial statement			
Annual financial audit report			
End of year stock level report (which is normally provided by 15 May as part of the vaccine renewal request) *			
Campaign reports *			
Supplementary Immunisation Activity technical report	x		
Campaign coverage survey report	x		
Immunisation financing and expenditure information			
Data quality and survey reporting			
Annual data quality desk review			
Data improvement plan (DIP)			
Progress report on data improvement plan implementation			
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)			
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
(CCEOP): updated CCE inventory			
Post-Introduction Evaluation (PIE)			
Measles & rubella situation analysis and 5 year plan			
Operational plan for the immunisation programme	x		
HSS end of grant evaluation report			
HPV specific reports			
Reporting by partners on TCA and PEF functions			

No audits were conducted on GAVI funds in 2017.

Annex 2: Additional recommendations and priority actions

I. Recommendations
The recommendations below were formulated at the end of the joint appraisal.

1. Maintain the technical assistance provided to the decentralised level to improve equity.
2. Identify a mechanism for funding the operational costs of the M-Vaccine project.
3. Create a committee to monitor implementation of the tripartite agreement (Ministry of Health, Gavi, UNICEF) regarding use of funds.
4. Within UNICEF, appoint an individual who will be responsible for processing payments directly to stakeholders.
5. Support the process of using a digital stylus to improve data quality.

II. Priority actions

The various discussions among the different national and international partners gave rise, at the end of the joint appraisal, to the following priority actions needing technical assistance:

1. Accelerate the transfer of the management of Gavi funding by UNICEF to the Ministry of Health.

2. Implement the partner agreement with civil society organisations.

3. Conduct advocacy targeting the Ministry of Budget for an increase in the budgetary allocation for operational costs at the district level.

4. Support DIEM in implementing guidelines for CCE maintenance.

5. Support implementation of the multi-year SMT.

6. Conduct an internal EVM.

7. Finalise the study on the immunisation policy document.

8. Draft and adopt the law on immunisation.

9. Support CCEOP implementation.