Joint appraisal report

Country	The Gambia
Reporting period	January – December 2014
cMYP period	2012-2016
Fiscal period	January to December
Graduation date	*N/A*

EXECUTIVE SUMMARY *(MAXIMUM* 2 *PAGES)*
Gavi grant portfolio overview

Immunization is one of the most cost-effective public health interventions that have helped to reduce childhood preventable diseases in The Gambia. There has been high immunization coverage over the years which are among the best in the sub-region. To sustain and consolidate these gains; The National Health Strategic Plan (NHSP) has outlined strategies to increase immunization coverage to at least 90% for all antigens at national and regional levels; and to ensure vaccine security for all vaccine preventable diseases NHSP, 2015-2020 Pg54) (cMYP, 2012-2016 p28).

Overall, the immunization coverage is stable with Penta 3 - 96%, OPV3 - 97%, HPV – 82%. There is a government budget line for the procurement of traditional vaccines and the co-financing of new and under-used vaccines. This has helped to facilitate the uninterrupted vaccine supply in the country.

The government of The Gambia is fully committed to the procurement of vaccines. This it does by paying for the procurement of all traditional vaccines and supplies (OPV, BCG, MCV1, TT, Yellow Fever and DPT) and co-financing for the procurement of new and under-used vaccines according to the co-financing policy. ICC plays an important role in advocating for the increase in budget funding for immunization services. In 2014, government disbursed 24 Million GMD, which is over 100% increment from the 2013 budget. The total expenditure for immunization in 2014 was US$ 4,515,679, out of which the government paid 19%.The rest was supported by partners (GAVI-62%, UNICEF-8%, WHO-11%)

The Gambia with support from Gavi has and continues to introduce new and under used vaccines in the routine immunization programme. The vaccines being co-financed presently include Pentavalent, PCV and Rota. Gavi exclusively pays for MCV2 and IPV. The Government of The Gambia pays for the procurement of all traditional vaccines, which includes BCG, OPV, DPT, TT, Yellow fever and MCV1.

Gambia has been receiving Gavi support since 2002. Gavi has provided US$ 22.5 million till date against a commitment of US$ 23.8 million. 89% of the support is for vaccines and 11% for non-vaccine support.

The country has received vaccine introduction grants $170,000 and $100,205 for HPV and IPV respectively in 2014. Partners including UNICEF, WHO and Rotary continue to support the programme in areas of cold chain supplies and equipment, technical support, supplementary immunization activities, implementation and improvement in routine immunization. These financial obligations for the immunization programme continue to increase annually. The ICC plays a critical role in the advocacy for continued funding for the immunization programme.

Summary of grant performance, challenges and key recommendations

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

Achievements:

The Gambia immunization programme over the years has introduced new and underused vaccines with support from Gavi and partners. In April 2015, IPV was successfully introduced into the routine programme in line with the Polio Endgame Strategy. This was preceded with the development of training materials and the review of data collection tools.

The country also implemented the HPV demo (launched in November 2014) in line with the global plan for cervical cancer morbidity and mortality reduction. The demo was successfully launched by Her Excellency, the First Lady and attended by Her Excellency the Vice-President, Ministers of Basic and Secondary Education, Health and Social Welfare, Energy, Youth and Sports. With support from WHO and UNICEF, the EPI training manual was reviewed and adopted to include all the immunization components and the eventual production and training of over 300 health workers country-wide on the manual.

The programme also conducted an EVMA (December 2014), which identified issues in vaccine management including cold chain in the routine programme. This was followed by the development of an Implementation Plan geared towards addressing the identified problems.

The conduct of joint bi-monthly meetings, supportive supervision, cold chain expansion and quarterly preventive maintenance, all help in monitoring programme progress and helps in the early identification of bottlenecks and remedial measures taken to avert them.

The development of a comprehensive EPI Communication Plan (2014 – 2020) geared towards demand creation uses different approaches and methodologies to ensure the last child is being reached. This is also reinforced with the quarterly ICC meetings to put the immunization agenda forward and advance advocacy for resource allocation in immunization services.

Overall, the immunization coverage is stable with Penta 3 - 96%, OPV3 - 97%, HPV – 82%. There is a government budget line for the procurement of traditional vaccines and the co-financing of new and under-used vaccines. This has help to facilitate the un-interruption of vaccine supplies in the country. In 2014, government allocated 23 million GMD, an increment of over 100% from the previous year.

Challenges:

With the success gains in immunization, the programme still faces challenges which would affect progress. The EVMA revealed that there is an inadequate cold chain storage capacity at national level, which affects vaccine shipment plans. There is also a lack of cold chain storage facility in two of the health regions and inadequate dry store for supplies at regional levels. These are critical in maintaining immunization coverage. The developed EVMA implementation plan is geared towards addressing the vaccine management and cold chain gaps. These are factored in the GAVI HSS (June 2015), UNICEF Work Plan and WHO Biennium.

The inability to conduct an out of school census to validate the target for the out of school girls during the HPV demo makes validating the census data a challenge. From the lessons learnt from the first year evaluations, the programme plans to conduct an out of school census before the commencement of the second year of the demo project.

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

1. Cold chain maintenance and expansion. This is factored in the Gavi HSS proposal
2. Training of health workers giving immunization services on EPI activities
3. Expansion and rehabilitation of outreach services
4. Implementation of the EPI communication plan
5. Provision of data collection tools for immunization services

Requests to Gavi's High Level Review Panel

Grant Renewals
New and underused vaccine support The programme requests extensions for these vaccines, which will be included in the next cMYP 2017 – 2020. The development of the cMYP will also be aligned to the country National Health Strategic Plan 2014 – 2020. • Renewal of Measles second dose (10 dose vial). • Extension of PCV13 (single dose vial 2017 and 4 – dose vials onwards). • Extension of DTP-HepB-Hib (10 dose vial). • Renewal of Rota Virus Vaccine (1 dose vial). Switch to Rotarix from 2016 • Renewal of IPV (10 dose vial). Health systems strengthening support The country has never implemented the HSS grant

Brief description of joint appraisal process

The process of the Joint Appraisal development started with discussions at the Inter-Agency Coordinating Committee (ICC) for the Expanded Programme on Immunization (EPI). The EPI programme convened meetings inviting partners like WHO and UNICEF, the senior management team of the MOH as well the representatives of the ICC. In this initial meeting, the EPI manager took the team through the joint appraisal planning guidance and the joint appraisal reporting guidance whilst the whole team reviewed the joint appraisal template. The development process was spearheaded by a team including the Expanded Programme on Immunization (EPI), Directorates of Human Resource for Health and Planning & Information (DPI) of the Ministry of Health and Social Welfare, UNICEF, WHO, CSOs. The team then had a series of meetings to discuss key issues relevant to the report.

The draft report was shared with Gavi and regional offices of WHO and Unicef. The comments received were included in the report to finalize the report.

The report was endorsed by ICC and submitted to Gavi.

COUNTRY CONTEXT

1. **Leadership, governance and programme management:** The Immunization programme is fully managed by staff under the Expanded Programme on Immunization with direct supervision from the Director of Health Services and the Permanent Secretary. The programme manager heads the day-to-day running and implementation, with support from the technical staff. The ICC plays an important role in relation to policy direction and advocacy for immunization services. These are being discussed during the quarterly ICC meetings, which are chaired by the Honourable Minister of Health and Social Welfare. In 2014, the ICC met four times and issues discussed included HSS activities, vaccine financing, immunization advocacy, NVS introduction and Polio Eradication (End Game Strategic Plan).

2. **Costing and financing:** The government of The Gambia is fully committed to the procurement of vaccines. This it does by paying for the procurement of all traditional vaccines and supplies (OPV, BCG, MCV1, TT, Yellow Fever and DPT) and co-financing for the procurement of new and under-used vaccines according to the co-financing policy. ICC plays an important role in advocating for the increase in budget funding for immunization services. In 2014, government disbursed 24 Million GMD,

which is over 100% increment from the 2013 budget. The total expenditure for immunization in 2014 was US$ 4,515,679, out of which the government paid 19%.The rest was supported by partners (GAVI-62%, UNICEF-8%, WHO-11%)

3. **Cold chain and logistics:** The procurement of vaccines and logistics is done using the UNICEF procurement mechanism. This ensures potent and viable vaccines meeting WHO requirements are delivered in country. The same applies for the procurement of cold chain equipment that are being used at different levels of the health system. The EVMA (Dec 2014) revealed that there is an inadequate cold chain storage capacity at national level, which affects vaccine shipment plans. There is also a lack of cold chain storage facility in two of the health regions and inadequate dry store for supplies at regional levels. These are critical in maintaining immunization coverage. The developed EVMA implementation plan is geared towards addressing the vaccine management and cold chain gaps. The absence of a computerized stock management control system at the national vaccine store, the lack of accountability for diluents and injection material were observed at all levels. There was no cold chain inventory and standard operating procedures for vaccine management. These are factored in the GAVI HSS (June 2015), UNICEF Work Plan and WHO Biennium.

4. **Human Resource:** The staffs delivering the immunization services are all paid by the government as established positions. This includes staff from central level coordinating the programme, regional level health management team coordinating immunization programmes in regional levels and health facility staff at service delivery level. Incentive is key in maintaining and retaining staff at all levels for effective service delivery. At health facility level, designated staff are responsible of immunization activities; at regional level the Regional Immunization Officer together with the Principal Public Health Officer under the direct supervision of the Regional Health Director supervise and manages immunization services; at central level, the national EPI supervises and manage all immunization programmes. Health workforce distribution is uneven across the different levels of care in the country. Over 75% of all skilled staff is located within the existing seven hospitals in the country at the detriment of 45 major and minor health centers. Staff from the latter facilities is involved in the 257 outreach services sites. The lack of an institutionalized continuous training programme and performance appraisal system within the health system hinders a systematic staff development. Staff motivation and retention is a major challenge in the country; high staff turnover affects the continuity and quality if service delivery.

5. **Disease Surveillance**: The Gambia maintains a surveillance system for all vaccine preventable diseases. This is reported to WHO on a weekly basis using case based forms. The country is also maintaining a Rota impact surveillance to determine the effectiveness of rotavirus in reducing morbidity and mortality due to rotavirus.

6. **Service Delivery:** Access and utilization of EPI services in the country is high, with both BCG and Penta 3 coverage at 96% (WUENIC 2014). However, fully immunized under one year, which is an indicator of quality of immunisation services is relatively low (76%) nationally with significant rural and urban variations; ranging from 67% in the rural area to 84% in the urban area. (DHS 2013, pg 12).

Immunization services in the Gambia are delivered as part of an integrated RCH services and significant issues and challenges do exist. These include:

- Overcrowded clinic sessions: The low density of service delivery points particularly in urban areas contributes to overcrowded clinic sessions affecting both facility based and outreached clinics. In addition many clinics do not have adequate infrastructure,

furniture and equipment for orderly management of the mothers and care-givers including sick children. Consequently, there are long queues, long waiting hours and unconducive working environment with the clinic.

- The frequency of outreach services to population is very low in some areas.
- Irregular and appropriate training for skills development: For the past two years, newly qualified nurses and public health officers have not received routine periodic in-service training. In addition, there is no systematic in-service training programme. Health workers at both regional and health facility levels were found to lack adequate skills to use vaccine and logistics forecast tools resulting in frequent stock-outs or overstocking. **(Regional Monitoring Reports 2014).**
- There are 257 RCH outreach sites country wide. Of this number, only 37(14.4%) outreach clinics are located in the urban areas. All these urban outreach clinics are found in the two mainly urban and most densely populated regions(WHRI and WHRII-60% of total pop).Based on outreach inventory, none of the outreach sites is fully functional in terms of furniture and equipment. There is a major imbalance on the distribution of RCH outreach sites between urban (14.4%) and rural (85.6%). This is a likely explanation for the coverage disparity observed.
- The capacity for management of service delivery including the immunization programme is generally low. The National Health Strategic Plan stipulates the institutionalization of supportive supervision to improve service delivery, but implementation is yet to be initiated. Presently standard programme management tools such as monitoring and supportive check list and standard operational procedures, guidelines and other tools are not being used (EVMA 2014, Gambia IMNCI Health Facility Survey Report 2014).

7. **The Health Management Information System:** The system is under the management of the Directorate of Planning and Information, Ministry of Health and Social Welfare (MoH&SW) where health data is sent for collation, analysis and dissemination. This unit has staff complement of eleven. Within the HMIS unit, there is an ICT section with 6 staff, with only 3 having had specialized training. Currently the ICT unit is poorly resourced with only 5 computers at their disposal (HRMIS Database). The high attrition rate of ICT personnel makes it even more challenging (National Health Policy 2012-2020). The HMIS and ICT unit do not have sufficient technical capacity to fully support the programmes and to include new data set and more generally to maintain the DHIS2. So far only 2 staff have had training on DHIS2. More staff will need to be trained to ensure sustainability in the event of staff attrition. (Rapid Assessment and Proposal for Strengthening HIS in The Gambia 2013).

The following challenges also affect the management of health information system in terms of data collection, collation, analysis and timely reporting.

- Inadequate infrastructure and ICT equipment (data storage, security, etc) at central and regional levels
- Inadequate data management skills at central, regional and facility levels
- Inadequate skills in data analysis and utilization at central, regional and facility levels
- The value of health information systems is not well appreciated

8. **Communication and demand generation:** The development of an EPI Communication Plan 2014 is geared towards demand creation for immunization services. Funding for the implementation is factored in the GAVI HSS proposal. At national level, the EPI communication Officer is responsible of coordinating all communication activities in conjunction with the Directorate of Health Promotion and Education of the Ministry of Health and Social Welfare; at regional level, the Regional Immunization Officer in conjunction with the Regional Health Promotion Officer are responsible for health communication activities; at health facility level, the Public Health Officer together with the Community Health Nurse are responsible for immunization

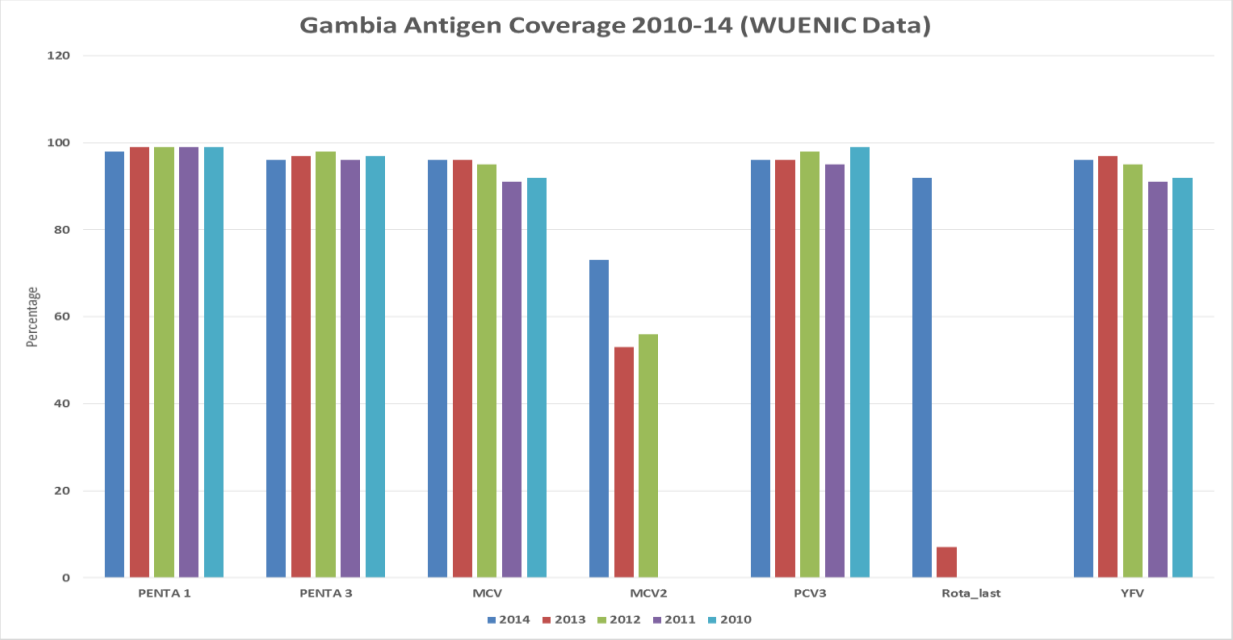
communication activities. Low community sensitization on the value of immunization services is contributing to low coverages observed in the country particularly in urban populations. Strategies for social mobilization have so far been limited to activities related to new vaccine introduction and NIDs. The previous EPI communication plan 2007 – 2012 was not well implemented due to low availability of funds (cMYP 2012 – 2016). Also, implementation of the current plan 2014 – 2019 is yet to be started. Therefore, there is no well-organized system for mass community mobilization and sensitization activities by the EPI programme. The presence of mass communication media in the urban area is not well utilized for immunisation services.

GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS
(MAXIMUM 3-5 PAGES)

New and underused vaccine support
Grant performance and challenges

In implementing GIVS, The Gambia continues to introduce new and under-used lifesaving vaccines. The Gambia introduced the PCV-7valent vaccine in August 2009 and switched to a 13 valent, Measles Second Dose in 2012, Rota in 2013 and IPV in April 2015. In line with GAVI co-financing principles, the country will continue to fulfill its commitment in this regard.

The implementation of the activities mentioned below led to the smooth introduction of these vaccines:
Programmatic Performance and Challenges: There was no new vaccine introduced into the routine immunization programme in 2014. The immunization coverage over the last five year has been consistently high as seen from the graph below.



The country started a HPV demo in 2014, targeting girls 9 – 13 years in Brikama Local

Government Area. Coverage for the first dose was 82% and the second dose, 69%. There was a school census conduced to validate the target population. The initial target was 6097 but the school census showed that the target was 9432. The formation of a technical working group to lead the HPV made coordination easier. The involvement of the Ministry of Basic and Secondary Education in the whole process proved to be very effective in the delivery of the programme. The shift from three to two doses upon SAGE recommendations has reduced the risk of stock outs and operational costs for implementation. The high level of acceptance from the community was a great strength for the programme, which could be attributed to the political involvement of the office of the First Lady. The inability to conduct an out of school census was a challenge in determining the out of school target. Other challenges included the closure of some schools before the stipulated national school calendar. Although these schools were reached later on, this had affected the scheduled date for the second dose consequently affecting the second dose coverage.

All the vaccine shipments were received in 2014 as scheduled except Rota, due to inadequate storage capacity at central level.

Progress in the implementation of new introductions/campaigns: Advocacy and communication play a key role in the overall immunization service delivery and these have been fully utilized to sensitize decision/policy makers and religious leaders. Social mobilization activities included the sensitization of Regional and District authorities as well as TAC members, who in turn sensitized their respective communities. The country conducted two rounds of polio campaigns achieving a coverage of 99.5% and 102% in the first and second rounds respectively. This is done in line with PEI end game strategies and was used to strengthen surveillance activities at community level.

Data management: The review and finalization of data collection tools to capture new vaccines introduced in consultation with stakeholders at regional and health facility levels proved to be very crucial. Facilities submit the program data on a monthly basis in the DHMIS and data management for all programs in the MOH is done through the DHMIS. However, because EPI reports to the WHO monthly, it receives reports from the regions on a monthly basis and the data is entered in the DVD MT at national level. The reports are used for the monitoring and review of programmes. The quality of data in general appears to be good, although there are some minor concerns regarding target populations and denominators. The coverage's of the recent EPI Cluster Survey, MICS, and EPI administrative data are all in the mid-to-high 90s and consistent with each other. Data quality verification activities at central, regional, and health facility levels have been conducted to resolve data challenges, including questions about denominators, and training and retraining on effective and timely data management is planned.

Key Lessons Learnt:

- Community sensitization provided adequate public awareness and acceptance in the introduction of new vaccines and NIDs.
- Supportive monitoring and supervision ensured quality data and improved coverage in immunization service delivery.
- Strong surveillance system with the lab component strengthened AEFI surveillance to detect and investigate cases
- The use of standardized data collection tools helped to generate and harmonize data at all levels
- Adequate cold chain capacity helped to prevent vaccine shortages
- Strong political support ensured regular supplies of vaccines

NVS renewal request / Future plans and priorities

New and underused vaccine support

- Renewal of Measles second dose (10 dose vial).
- Extension of PCV13 (single dose vial 2017 and 4 – dose vials onwards).
- Extension of DTP-HepB-Hib (10 dose vial).
- Renewal of Rota Virus Vaccine (1 dose vial). Switch to Rotarix from 2016
- Renewal of IPV (10 dose vial).

The targets for all vaccines are appropriate.

The country has already been approved for the MR campaign in November 2015 and this will be introduced into the routine immunization services in April 2016. The country plans to apply for the introduction of the MenAfric in 2016 and into the routine immunization in 2017. Due to vaccine storage issues, the country plans to switch to Rotarix in 2016.

Health systems strengthening support

The country has never implemented a HSS grant but got approved recently for a HSS grant (2016 – 2020).

Health systems strengthening (HSS) support

N/A

Strategic focus of HSS grant

N/A

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

N/A

Graduation plan implementation *(if relevant)*

N/A

Financial management of all cash grants

The Gambia received VIGs in 2014 for the HPV demo and IPV introduction. Usage for the IPV VIG funds started in 2015 and was in line with the budget. The usage of the HPV demo funds started in 2014 with the national launching and administration of the first dosage, communication and social mobilisation activities. These funds were managed by UNICEF country office and disbursement was as per the budgeted activities.

The Gavi ISS funds were managed by the accountant at the national drug revolving fund of the MOH&SW. The accounts were audited yearly by the National Audit Office and this included the 2014 year under review. The project did not have a separate bank account instead funds disbursed to the programme are credited to the Treasury Main Account (basket account) maintained at the Central Bank under the control of the Director of Treasury.

The Gavi ISS funds started operating under the Integrated Financial Management Information System (IFMIS) system of the Government of The Gambia in 2011.

The EPI is staffed with key positions geared towards providing effective and efficient service delivery. With the approval of the GAVI HSS, the programme will include in the staff complement, an accounts clerk and senior accountant directly under the EPI unit to be supervised by the Principal Accountant in Ministry of Health and Social Welfare. This will help in giving the programme a strong footing in programme implementation and management of resources for maximum impact. This is an opportunity for the programme to have all the complement staff needed to effectively run a viable immunisation programme.

Recommended actions

Actions	Responsibility (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
Update EPI Policy to include all new vaccines	MoH&SW, WHO,	Oct – Dec 2015	$10,000.00
Establish an AEFI surveillance system	MoH&SW, WHO	Oct – Dec 2015	$5,000.00
Build regional stores for dry materials	Gavi, MoH&SW,	Jan – Dec 2016	$45,000.00
Strengthen supportive supervision at Central and regional level	Gavi, MoH&SW, WHO, UNICEF	Quarterly	$25,000.00
Expand Cold Chain system at all levels to accommodate Rota Teq supplies	Gavi, UNICEF	Jan – Dec 2016	$32,000.00
Institutionalize defaulter tracing systems at facility level	MoH&SW, WHO, UNICEF	Jan – Dec 2016	$10,000.00
Train staff on vaccine wastage, coverage and drop-out rates not being calculated at health facility level	Gavi, WHO, UNICEF	Jan – Dec 2016	$20,000.00
Construction and refurbishment of outreach services	Gavi	Jan – Dec 2016	$197,100.00

TECHNICAL ASSISTANCE

(MAXIMUM 1 PAGE)

4.1 Current areas of activities and agency responsibilities

Technical and financial support for communicationduring the past NIDs was provided by WHO and UNICEF. There was an international consultant to lead the development of the EPI Comprehensive Communication Plan with the objective to raise awareness among the population through the provision of relevant health information that would promote, protect and improve health outcomes. The communication plan provides a detailed strategic framework for communication in support of routine immunization.

CSOs involvement like the GRCS and HePDO also helped in creating demand for immunization especially during mass vaccination campaigns. The existence of an Association of Health Journalists presents itself as an opportunity to EPI.

Conduct of the four HPV demo mandatory evaluations was spearheaded by consultants. The Post introduction evaluation (WHO), coverage survey (PATH), Adolescent health intervention (UNICEF) and Costing analysis (WHO).

4.2 Future needs

The EPI needs support from partners to conduct the following key activities geared towards improving programme performance and robustness.

TA Need	Justification / Actions	Intended outcome	Modalities	Possible provider	Included in cMYP / HSS
KAP on immunization services	Inadequate base line information	To determine knowledge, attitude and practice of caregivers on immunization	Survey	Gavi	HSS
Temperature mapping study	To determine the different temp ranges in the cold room	To help in maintaining the potency of vaccines for quality EPI services	Mapping	UNICEF	EVM
Comprehensive immunization programme and surveillance reviews	To identify strengths and weaknesses of the EPI	To develop a 5 year operational plan for the EPI	Desk review	WHO, Gavi	HSS
SARA	To assess and monitor service availability and readiness of the health sector	To develop strategies against areas identified	Survey	Gavi	HSS
Mid and End Evaluations on Gavi HSS	To identify strengths weaknesses and possible solutionsof the HSS grant implementation	To determine the level of achieving the progress of the set objectives	Desk review	Gavi	HSS
CRS surveillance	To introduce CRS surveillance in the country	To determine the prevalence of CRS in the country	Sentinel surveillance	Gavi/WHO	HSS

ENDORSEMENT BY ICC, HSCC OR EQUIVALENT& ADDITIONAL COMMENTS
(MAX. 1 PAGE)

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism: The ICC met on Thursday 10th September 2015 to review the Joint Appraisal. The meeting was chaired by the Honourable Minister of Health and Social Welfare and in attendance included civil society organizations, WHO, UNICEF and other Ministry of Health and Social Welfare colleagues. There was a general presentation of the document looking at the different headings. These were reviewed and adopted to truly reflect what the issues are at the moment. The TA need were as well discussed as key strengths geared towards improving the immunization programme. The chairman approved the document for onward submission to Gavi.
Issues raised during debrief of joint appraisal findings to national coordination mechanism: The major issues raised were the issue of TA needs. It was advised that a schedule be done on the TA need to avoid overlap of activities.
Any additional comments from Ministry of Health: Partners: Gavi Senior Country Manager:

ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]
Annex A. Key data (this will be provided by the Gavi Secretariat)

Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Program: Urgent need to focus on quality of service delivery, HR retention, capacity building and institutionalization of a supportive supervision and review process. Specific plans to address immunization coverage in urban areas.	Increasing motivation of health staff by providing incentives to them is factored in the HSS grant. Also, the EPI unit is strengthened with additional staff at central and regional level. The construction of more outreach sites in urban areas is also factored in the HSS grant to bridge the coverage gaps
Governance: Strengthen ICC and use it to review and guide EPI. Update EVM Improvement Implementation status report	ICC expanded in 2014 and quarterly meetings were held EVM improvement plan is being updated quarterly as per the status of implementation

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

Annex D. HSS grant overview

General information on the HSS grant							
HSS grant approval date							
Date of reprogramming approved by IRC, if any							
Total grant amount (US$)							
Grant duration							
Implementation year			month/year – month/year				
(US$ in million)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Grant approved as per Decision Letter							
Disbursement of tranches							
Annual expenditure							
Delays in implementation (yes/no), with reasons							
Previous HSS grants (duration and amount approved)							
List HSS grant objectives							
Amount and scope of reprogramming (if relevant)							

Annex E. Best practices (OPTIONAL)