Joint Appraisal Update report 2018

The italic text in this document serves as guidance, it can be deleted when preparing the Joint Appraisal (JA) Update report.

Gavi's support to a country's immunisation programme(s) is subject to an annual performance assessment. The Joint Appraisal (JA) is a key element of this performance review. It is an annual, country-led, multi-stakeholder review by the senior leadership of the MoH and its partners of the implementation progress and performance of Gavi's support to the country, and its contribution to improved immunisation outcomes.

Joint Appraisals require careful preparation. This includes:

- ***By 15 May: Submission of the vaccine renewal request*** *on the country portal (including provision of end of year stock reporting, targets, wastage rates, etc.)*
- ***4 weeks before the Joint Appraisal:***
  - ***Submission of required reporting documentation*** *on the country portal;*
  - ***Submission of HSS and CCEOP renewal request*** *(if new tranche needed), on the country portal including HSS budget for requested tranche;*
  - ***Gavi partners (WHO, UNICEF and others)*** *to report progress against their milestones and PEF functions on the partner portal.*

Reporting requirements

The following reporting is required for renewal purposes *and must be posted on the country portal 4 weeks before the JA:*

- ***Update of the grant performance framework (GPF)***
- ***Financial reports, annual financial statements and audit reports*** *(for all types of direct financial support received)*
- ***Reporting on any campaigns/SIA conducted*** *(if applicable)*
- *End of year stock reporting (which is to be submitted by 15 May together with the vaccine renewal request)*

Other required reporting information *to be posted on the country portal 4 weeks before the Joint Appraisal includes:*

- *Immunisation financing and expenditure information*
- *Data and survey requirements*
- *Annual progress update on the Effective Vaccine Management (EVM) improvement plan*
- *Updated CCE inventory (if receiving CCEOP support)*
- *HPV specific reporting (only if applicable)*
- *HSS end of grant evaluation (only if applicable)*
- *Post Introduction Evaluation (PIE) reports (only if applicable)*
- *Gavi transition and/or polio transition plans or asset mapping information (if applicable)*
- *Expanded Programme on Immunization (EPI) review / plan of action implementation report (if available)*

Note: Failure to submit the renewal requests as well as required reporting on the country portal four weeks ahead of the Joint Appraisal meeting (except for the vaccine renewal request, which is to be submitted by 15 May) may impact the decision by Gavi to renew its support, including a possible postponement, and/or decision not to renew or disburse support.

Country	The Gambia
Full JA or JA update	☐ full JA ☑ **JA update**
Date and location of Joint Appraisal meeting	
Participants / affiliation[1]	Attached as Annex
Reporting period	January to December 2017
Fiscal period[2]	January to December
Comprehensive Multi Year Plan (cMYP) duration	2017 – 2021
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 ☐	N/A ☐
HSS renewal request	Yes ☑	No ☐	N/A ☐
CCEOP renewal request	Yes ☐	No ☐	N/A ☑

Observations on vaccine request for 2019

*Briefly comment on **assumptions and observations concerning the vaccine renewal/extension request and vaccine allocation**, such as quantification data triangulations conducted, target coverage used as basis for requested doses; available stock, stock-outs, variations/trends in the stock held & consumption; significant changes (+/-5%) in number of doses required, etc.*

Population	**2327600**				
Birth cohort	**93,014**				
Vaccine	**PCV Vaccine**	**Penta Vaccine**	**Rota Vaccine**	**IPV**	**HPV**
Population in the target age cohort	**85,948**	**85,948**	**85,948**	**85,948**	**31,142**
Target population to be vaccinated (first dose)	**82,510**	**82,510**	**82,510**	**82,510**	**26,471**
Target population to be vaccinated (last dose)	**81,651**	**81,651**	**81,651**	**81,651**	**23,979**
Implied coverage rate	**95%**	**95%**	**95%**	**95%**	**73%**
Last available WUENIC coverage rate* 2016	**95%**	**95%**	**95%**	**95%**	
Last available admin coverage rate* 2017	**91%**	**92%**	**93%**	**20%**	

[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.

Wastage rate	**10%**	**10%**	**5%**	**10%**	**5%**
Buffer	**3 Months**	**3 Months**	**3 Months**	**3 Months**	**3 Months**
Stock reported					

Discussion on above data points. Is NVS request in line with actual needs?

The NVS request is based on the intended coverage to be achieved as a percentage of the surviving infants (SI) in 2019. The SI are derived from the 2013 census projections conducted by the Gambia Bureau of Statistics (GBoS). Annual projections are based on the growth rate as stipulated in the GBoS census Report 2013.

The wastage rate per antigen is also factored in order to derive the actual number of doses as requested in the NVS request.

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

Indicative interest to introduce new vaccines or request HSS support from Gav	**Programme**	**Expected application year**	**Expected introduction year**

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

N/A

The JA update does not include this section.

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

N/A

The JA update does not include this section.

3.4. Immunisation financing

Please provide a brief overview of the main issues affecting the planning, budgeting, allocation, disbursement and execution of funds for immunisation. Please take the following aspects into account:

- ***Availability of national health financing framework*** *and* ***medium-term*** *and* ***annual immunisation operational plans and budgets****, whether they are integrated into the wider*

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

national health plan/budget, and their relationship and consistency with microplanning processes.

- ***Allocation of sufficient resources in national health budgets for the immunisation programme/services****, including for Gavi and non-Gavi vaccines, (integrated) operational and service delivery costs. Discuss the extent to which the national health strategy incorporates these costs and any steps being taken to increase domestic resources for immunisation. If any co-financing defaults occurred in the last three years, describe any mitigation measures that have been implemented to avoid future defaults.*
- ***Timely disbursement and execution of resources:*** *the extent to which funds for immunisation-related activities (including vaccines and non-vaccine costs) are made available and executed in a timely fashion at all levels (e.g., national, province, district).*
- ***Adequate reporting*** *on immunisation financing and timely availability of reliable financing information to improve decision making.*

Immunisation Financing

The Immunisation programme is well captured in the National Health Strategic Plan as a pivotal component to achieving the mission statement and Goal of the Ministry of Health and Social Welfare. This is fully costed as per local available resources and from partner contribution.

The Government is fully committed to financing of immunisation services, as there is high political commitment, which is also reinforced by partner support. There is a dedicated budget line in the recurrent budget for the procurement and co-financing of vaccines. The Budget line pays for the procurement of all the traditional vaccines (BCG, bOPV, HepB, DPT, TT, MR and Yellow Fever). At present, the vaccines co-financed includes PCV, Penta, and Rota, which is also paid from the dedicated vaccine budget line of the recurrent budget as well. Gavi is solely responsible for the procurement of IPV. Furthermore, salaries for immunization service providers are paid directly by the central government through the basic salaries budget line.

In addition, the Government of the Gambia is currently implementing Programme Based Budgeting (PBB) which is anchored on Medium Term Expenditure Framework (MTEF). This is a three year financing strategy program for government which the National Health Sector Strategic Plan (NHSP 2014-2020) as well as the ministry's PBB structure are aligned and integrated.

On the reporting of immunization financing and the availability of information for improved decision making, the Ministry of Finance and Economic Affaires has set up an M&E unit under the Directorate of Budget to monitor and report national budget execution. A reporting template is shared with all Ministries, Departments, and Agencies (MDAs) including Ministry of Health and Social Welfare for completion and this is used as a source of information for immunization financing. Timely disbursement and execution of resources still serves as a major challenge as delays in fund disbursement from the MoH&SW in 2017 fiscal year led to blockage of the UNICEF system. This has led to very low implementation of EPI activities and fund utilization. In a bid to address this, the MoH&SW had strengthened the Project Coordinating Unit (PCU) to enhance efficient financial management.

The Ministry of Health and Social Welfare (MoH&SW) has been implementing Programme Based Budgeting (PBB) since the format was roll out to the sector in 2014 financial year. Immunization Services is one of the sub budget programs under Family Health which receives

allocation from the health budget. The analysis in table1 below shows that allocation to Immunization Services over the past four years has seen some modest improvement; however, the share of immunization budget as a percentage of total health budget over the last four budget cycles fluctuates downwards.

Table 1: Trends of Government Health Expenditure on Immunization Services

FY	Approved Health Budget	Approved Immunization Budget	% of Health Budget
2014	615,391,000.00	22,000,000.00	3.57
2015	684,769,000.00	24,225,000.00	3.54
2016	764,796,000.00	24,050,000.00	3.14
2017	794,867,000.00	24,072,000.00	3.03
2018	790,029,063.00	27,350,000.00	3.46

The Government Local Fund (GLF) administered by the Ministry of Finance and Economic Affairs, allocates annual budgets for immunisation. This is usually requested by the Ministry of Health & Social Welfare bi-annually and paid through UNICEF to ensure payment of vaccines. The procurement process is all handled by UNICEF Supply Division in consultation with UNICEF country office.

4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

*Provide a succinct analysis of the performance of Gavi vaccine grants, focusing on **recently (i.e. in the last two years) introduced vaccines,** or planned to be introduced vaccines, and **campaigns**, supplementary immunisation activities (SIAs), demonstration programmes, MACs etc., as well as switches in vaccine presentations. This section should capture the following:*

- ***Achievements against agreed targets**, as specified in the grant performance framework (GPF), and other grant-related activity plans. If applicable, reasons why targets as specified in the GPF have not been achieved, identifying areas of underperformance, bottlenecks and risks.*
- ***Overall implementation progress** of Gavi vaccine support.*
- ***Campaigns:** Provide information on the periodicity of campaigns and key results of the post-campaign survey, including the coverage achieved. If achieved coverage was low, provide reasons. How was the operational cost support spent? Explain how the campaign contributed to strengthening routine immunisation e.g. by identifying zero-dose children and lessons learned.*

- *Update of the **situation analysis for measles and rubella** (using the latest immunisation coverage and surveillance data for measles, rubella and congenital rubella syndrome from national and sub-national levels[4]) and update of the country's **measles and rubella 5 year plan** (e.g. future dates of MR intro, MCV2 intro, follow-up campaigns, etc.).*
- ***Describe key actions related to Gavi vaccine support in the coming year** (e.g. decision-making on vaccine introduction, future application, planning and implementation of introduction/ campaigns) **and associated needs for technical assistance[5].***

Achievements against agreed targets

The Gavi HSS objectives are aligned to the overall National Health Strategic Plan objectives of reducing morbidity and mortality in the country. These objectives align adequately with the systemic bottlenecks to achieving and sustaining high immunization coverage.

Due to delay in the start of the HSS (started July 2017) several HSS activities had been delayed such as DQA, construction of outreach posts etc. Therefore, the performance indicators are currently being revised to meet country targets. A joint consultative meeting is being organized to finalize the indicators and align them with the current HSS grant implementation timeline.

Table 2: showing indicators, targets and coverage

	***Indicators for Joint Appraisal, 2017**				
Indicators	**Target 2017 (%)**	**2014 coverage (%)**	**2015 Coverage (%)**	**2016 Coverage (%)**	**2017 Coverage (%)**
Penta 3 coverage	**98**	96	97	95	92
PCV 3 coverage	**98**	96	97	95	91
MCV1 coverage	**95**	96	97	97	90
Rota Vaccine (2) coverage	**98**	92	97	95	93
Drop-out rate Penta1 and Penta 3	**2**	2	2	4	1
Drop-out rate PCV1 and PCV 3	**2**	2	2	4	1
Drop-out rate MCV1 and MCV2	**10**	24	21	19	23
Drop-out rate RV1 and RV last dose	**2**	4	1	4	1

[4] Please refer to the JA analysis guidance document for additional information on the expected analyses for measles and rubella.

[5] Note: When specifying Technical Assistance (TA) 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 in the JA. TA needs should however describe - to the extend 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 reference guide.

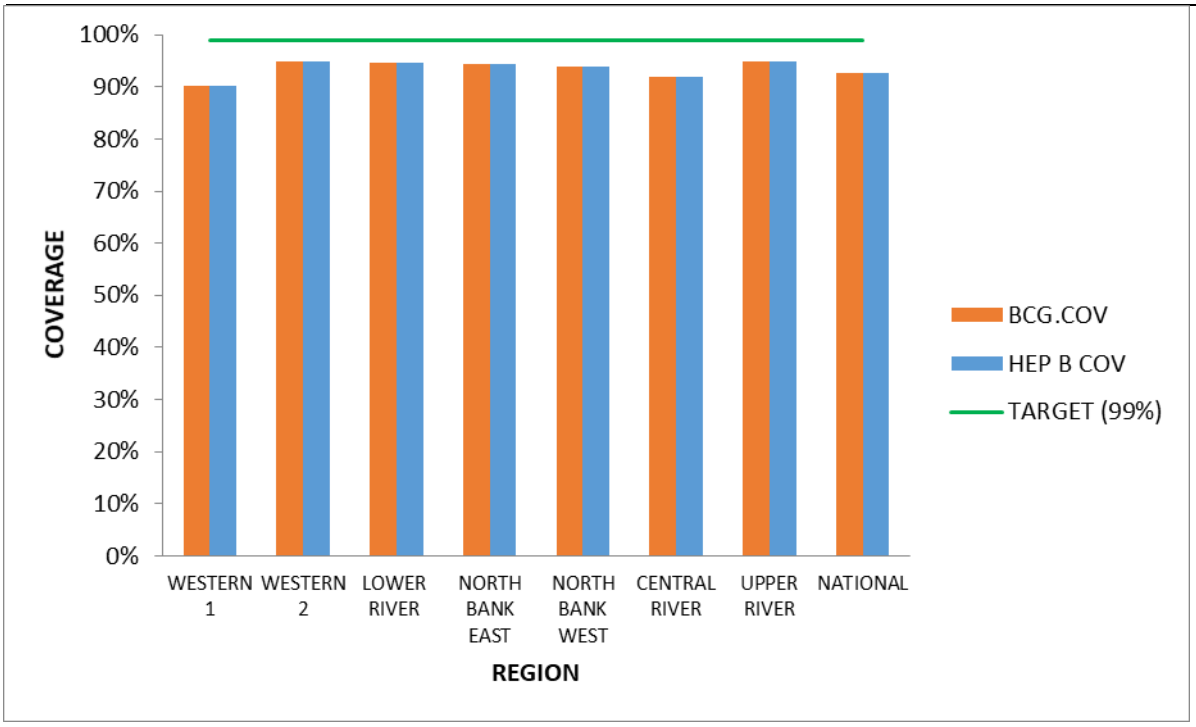

Figure 1: ***Routine Immunization Coverage for Live Birth Doses, Gambia 2017***

Coverage for BCG and Hep B vaccines (Live Birth doses) has been relatively good with all the seven regions reaching at least ninety percent (90%) of their target. However, none of the regions have achieved the 99% national target.

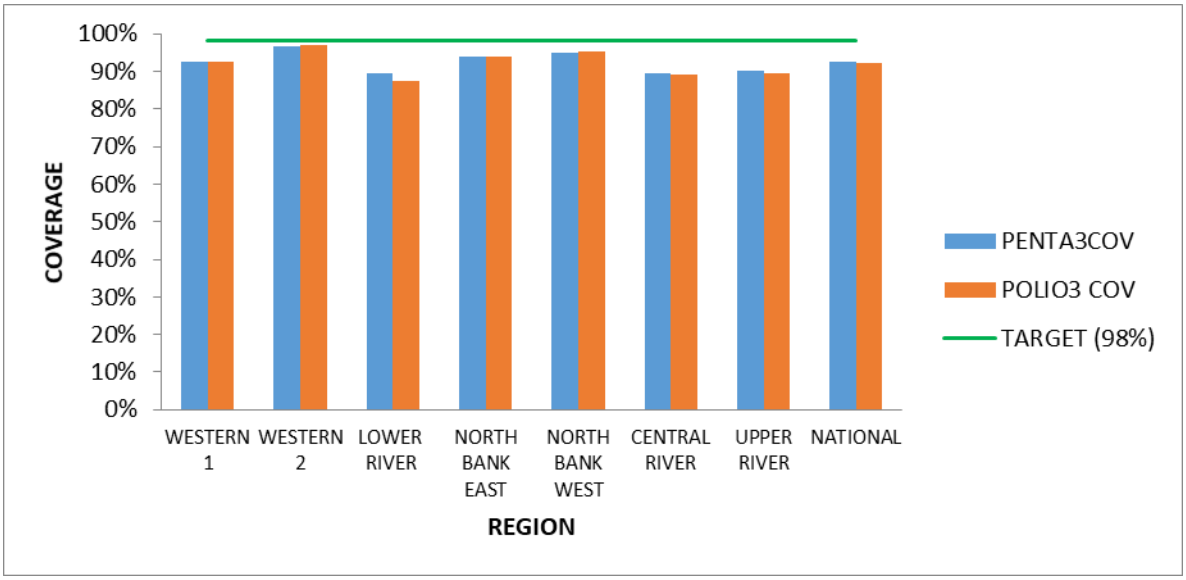

Figure 2: ***Routine Immunization Coverage for Surviving Infant Doses, Gambia 2017***

Similarly, coverage for Penta3 and OPV3 (Surviving Infant Doses) are below the national target in all the regions, consequently resulting in a lower national coverage. There are regional variations in coverage, with the Lower River, Central River, and Upper River Regions recording the lowest coverage.

The ambitious targets/denominators as recently been argued by the regions of being high, could be a major attributing factor to the low coverage shown by the administrative reports. Equally, there have been a lot of family planning interventions in the regions especially those implementing the Maternal and Child Nutrition and Health Results Project (MCNHRP).

Although there is no research done to support this argument, there is a general believe that these interventions are reducing birth rates, thereby affecting the target projections for immunization. The country has currently requested for a TA support from WHO to guide the development of a Data Quality Improvement Plan (DQIP).

Nationally, 90% of infants target in 2017 were fully immunized (received all the vaccines scheduled from birth to nine months). However, similar to other doses, regional variations were evedent in these doses with three regions – Lower River, Central River, and Upper River Regions way below the national target.

Dropout rate have been relatively low for DPT1 and DPT3 with the national target at 1%. However, this has been very high above the national target of 10% for Measles-Rubella1 and Mrasles-Rubella2 doses. Significant dropout differences between regions were recorded, and the national rate remains high at 23% for Measles –Rubella 1 and Measles –Rubella 2. This could be largely attributed to mother's not coming for immunization services after their children attain their first birth day.

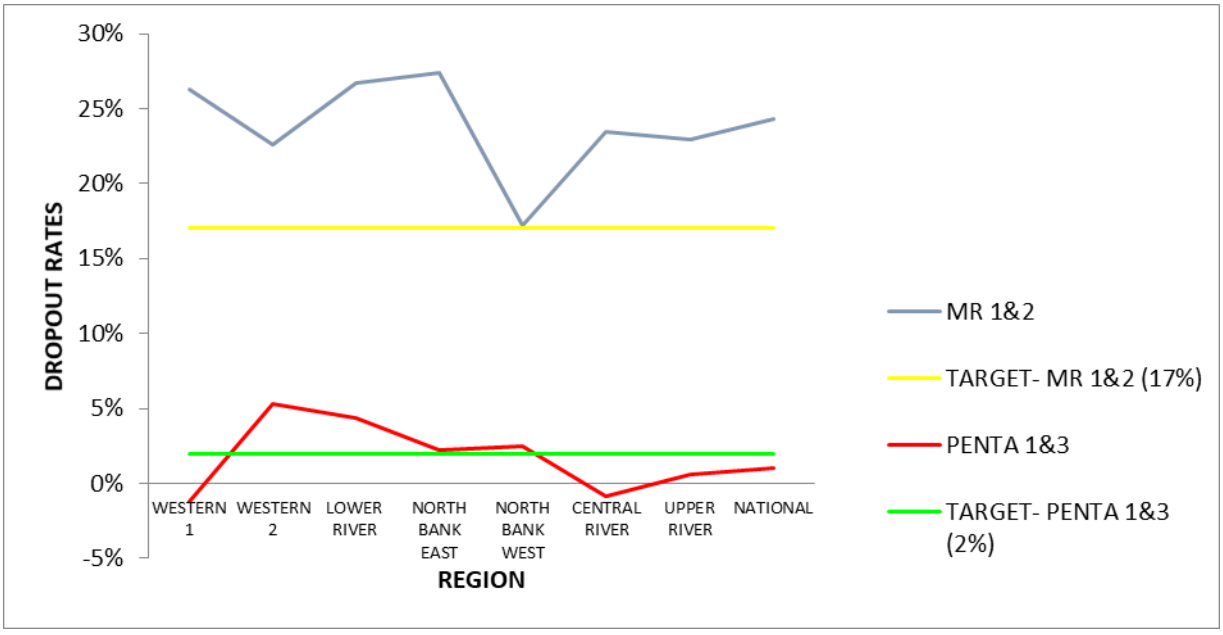

Figure 4: ***Routine Immunization Dropout rates for Key Indicators, Gambia 2017***

Dropout rate have been relatively low for Penta 1&3 in most of the health regions. There have been regional differences with Western 2 and Lower Region Regions recording more than the national target. However, the national dropout or remains within the set target which suggests that the regional differences was due to interregional movement.

Conversely, the dropout rate for Measles 1&32 was high in all the regions with only one region

(North Bank West) meeting the national target, hence the national dropout remains high at 24%. This could be largely attributed to mother's not coming for immunization services after their children attain their first birth day. To address the dropout issues, the country have planned community sensitization and engagement activities aimed at increasing awareness to enhance uptake all vaccines in the routine immunization program.

Since immunization coverage has a correlation with vaccine supply adequacy, the new vaccine request, if approved will enhance improvement or at least, maintenance of the performance registered in 2017. The use of the SMT and the implementation of the VVS are measures used to improve stock management

Possible factors for the low immunisation coverage

There has been significant drop in coverage in 2017 compared to the previous years. This could be attributed to several factors as discussed below.

1. **Service Delivery**: Immunisation Service Delivery points has been inadequate in urban areas as majority of urban health facilities do not conduct or have limited outreach services. This results in low access to immunisation services. Mothers/caregivers usually stay longer at the clinics to receive services and thus discouraged them from returning for subsequent visits.

   Inadequate service delivery points leads to congestion or overcrowding. This unfavourable environment may result in overloading health workers consequently leading to missed opportunities**.** Additionally in 2017, a drop out study conducted in a health facility in LRR by university students revealed that poor screening of Infant Welfare Cards (IWCs) contributes to missed opportunities. Although this was a small scale study, however result may be similar in the other health facilities due to similarities in settings.
   The vehicles provided for outreach services are inappropriate as they cannot carry the whole outreach team thus creating inconvenience to the staff, resulting in some service providers not attending the RMNCAH clinic. This can compromise quality of services rendered.
   In a bid to address some of these gaps, there is a need for:
   - Expansion/extension of more outreach sites especially in the urban areas.
   - Procurement of appropriate outreach trekking vehicles and motor bikes.
   - Conduct large scale operational research.

2. **Data quality**: Inadequate data verification and supervision at all levels has been a contributing factor to the low immunisation coverage. Data generated at primary level is not adequately verified by facility staff and their supervisors and this may compromise data quality. Absence of functional data quality teams has been much blamed as well. This results in inadequate data analysis and use and health facilities will blindly deliver services without measuring their performances.

   The presence of data quality teams would have paved the way for the development of data improvement plans at all levels and would have helped to solve some of the data

quality challenges. This would have provided concrete evidences and explanations to the observed inconsistencies in the generated and reported data.

Limited ICT equipment at service delivery points has contributed to data quality issues. Health workers manually collate data on monthly basis and in so doing may likely miscalculate the data thereby compromising the quality of the reported data.
Fragmented reporting of data at regional and national levels has also contributed to the low quality of data. The same data reported by health facilities are not the same in both the DHIS2 and the EPI database.
The denominator issue continue to be blamed for the low coverage. Many of the health facilities and regions have been raising concerns on the accuracy of their target populations. Increase in uptake of family planning services could be a contributing factor affecting the denominator, however, further research need to be conducted to determine the facts.
In order to improve the quality of immunization data, there is need to:

- Conduct data management trainings for regional and health facility service providers to build their capacity on data management, which will further enhance immunisation data quality.
- Procure and distribute computers with accessories to regions and health facilities to improve data collection, collation and reporting.
- Conduct in-service meetings (monthly and quarterly) to create an interface between service providers and their supervisors
- Establish/strengthen functional data quality teams at all levels
- Use new innovations such as the E-Tracker in the DHIS2, MyChild solution and VVS.
- Strengthen integrated supportive supervision at all level
- Harmonize data reporting into the DHIS2 platform.
- Service of a TA to assist in addressing denominator issue

3. **Human resource**: Inadequate number and capacity of staff to provide child health services has been a key factor contributing to the low immunization coverage. Uncoordinated transfers of health workers and attrition are also impacting negatively on immunization coverage.

   In a bid to address the human resources issues, the following have been identified:
   - Implementation of the finalised incentive scheme to attract/motivate staff and retain them in the health work force.
   - Trainings of staff on immunization service delivery.

4. Community empowerment and CSO engagement

   The 2015 Knowledge Attitude Behavior and Practice (KABP) study on the uptake of immunization revealed knowledge gap on importance of immunization among caregivers. Many community members do not know the immunisation schedule and results in them defaulting to bring their children for immunisation. Furthermore, inadequate communication support materials on immunisation have equally contributed to limited

knowledge on the importance of immunization which can lead to low service uptake.

Men are the key decision makers in many families and as such, their support for immunisation services will play a crucial role in coverage. However male involvement in immunisation services is limited. Similarly, there is limited utilization of existing community structures (VHW, CBCs, and VSGs) to promote uptake of immunisation services.

Recently, an EPI communication strategy has been developed and validated, aimed at engaging and empowering individuals, families and communities. Equally, an IPC training manual was developed to enhance the IPC skills of health service providers on communication.

Engagement of civil society organisations has been very limited in the routine immunisation programme. However, Health Promotion and Development Organization (HePDO), a local CSO has been engaged to support the implementation of the communication component of the Gavi HSS Grant.
The following has been identified to enhance community empowerment and CSO involvement;

- Support the implementation of the EPI communication strategy
- Conduct IPC training for immunisation service providers

INNOVATIVE SOLUTIONS BEING PILOTED

Currently, three innovative solutions are being piloted in The Gambia; two of them by the EPI (the Vaccine Visibility System and the E-tracker) while the other by SHIFO (My Child Solution) through Action Aid the Gambia. These are all geared towards improving immunization data quality, management, and storage. Depending on the efficiency and effectiveness of the innovative solution as may be revealed by their respective planned evaluations, the country will adopt and rollout nationwide.

1. **Vaccine Visibility System (VVS):**

The Vaccine Visibility System (VVS) is a web based vaccine logistics management tool that utilizes 3D barcodes to improve the stock management of vaccines. The system tracks all routine EPI vaccines from central level through regional stores to health facilities, thereby improving data visibility and enabling better stock management via shipment tracking, expiry notifications, etc. The VVS is an online database currently on pilot phase and deployed at the EPI central store, North Bank West Regional Store and Brikama District Hospital store. The data below is generated from VVS report module on EPI Central Store as of 25th October, 2017.
VVS issues

Challenges

- Limited capacity of store manager and EPI staff on VVS
- Lack of barcodes on all vaccine and the secondary packaging
- Unreliable internet connection
- Sustainability assessment not yet done

2. E-Tracker

With support from the BID Learning Network (BLN) under PATH's Better Immunization Data (BID) Initiative, the country is piloting the E-Tracker of DHIS2 in 2 health facilities. This system is used to register children electronically as they receive their vaccinations and track their immunization records over the period. The health facilities are using both the E-Tracker and paper systems and are provided with a laptops and data cards.

Challenges

- The system is dependent on internet connectivity, which is poor in most regions of the country.
- Improper handling of devices
- Frequent staff turnover and high training needs
- Irregular supportive supervision

3. THE MYCHILD SOLUTION – THE GAMBIA

The system registers every child with a Unique ID as they received their vaccination series which is registered on a "smart paper". These smart papers are scanned at regional level to aggregate the data into a national PDF report. It provides SMS reminders to parents/guardians to ensure follow-up of children who missed their vaccination visit.

Key Challenges

- Availability of affordable printing of the MyChild forms conform to the requirements and standards for the Smart Paper Technology Engine.
- Internet connectivity at the Regional Office is not adequate enough to support synchronization via the scanners.
- Power supply at the Regional Office is potentially a hindrance as there is no backup power source for when electricity goes off.
- Concerns about the data verification process and required human resources to rectify data
- Costing of printing of smart papers proves more expensive than current paper system
- MyChild is not yet aligned with DHIS2 creating parallel systems
- Lack of visibility of data at health facility level

The VVS is currently being expanded to 23 other sites as it has helped in reducing stock outs and also alerts on expiry status. The E Tracker is being evaluated and the programme awaits for the findings of the evaluation for decision making. MyChild has been evaluated and will be further expanded to 12 facilities in WR1 and 7 in WR2. MyChild is plan to be harmonized into to DHIS2.

NVS future plans

The programme has planned to conduct a MenA catch up campaign in quarter 4 of 2018 and will subsequently introduce the vaccine into the routine immunisation in the first quarter of 2019. This

catch up campaign was planned for Quarter 3 of 2017 but was delayed due to challenges in fund liquidation within the Ministry of Health and Social Welfare. The campaign microplanning has started in August 2018.

The programme submitted a HPV proposal which was approved by Gavi for national rollout. The national roll-out was planned for quarter 4 of 2018, but this is not possible due to the shortage of the HPV vaccine in the world market. As a result, the national roll-out is now planned for Q4 of 2019 and the programme has completed and updated the plan of action for HPV introduction.

Measles Rubella Burden

Measles is still a major public health threat and can occasionally cause epidemics. In the Gambia, from 2006 to 2009, there was no confirmed case of measles. However, the measles case-based surveillance data showed two (2) confirmed measles cases in 2010 suggesting the possible accumulation of susceptible cases overtime. There has been a decline in confirmed measles from 2010 to 2014. Due to the delay in implementing the planned MR campaign in 2015, the country experienced an outbreak in late 2015 to early 2016 with 71 and 58 confirmed cases respectively. The index case was detected in the Sabi border of Upper River Region (URR) and travelled to the West Coast Region and caused a protracted localized outbreak in Brikama and part of Kombo north District. Based on the evidence from the national data, the frequently affected regions in the country are URR and Western Region 1 and 2.

The Gambia has been implementing measles reduction strategies which include strengthening routine immunization, catch-up and follow up SIAs and effective surveillance since the late 2000s.However, with the implementation of surveillance for Measles and Rubella, a total of 114 suspected measles cases of which 37% were IgM positive for rubella and none for measles in 2011. The trend continued to increase in 2012 and 2013 with 42% and 49% respectively of all suspected measles cases were IgM positive for rubella. A study conducted in The Gambia by Medical Research Council (MRC) describe around a 10% Sero-prevalence of Rubella-Specific antibodies in 9 and 10 months old infants; thus, providing evidence of ongoing rubella transmission within The Gambian population. This necessitated the switch from measles vaccine to measles-rubella vaccine in 2017.

Table 3 showing Lab Confirmed Measles cases in the Gambia 2012-2017

	2012	2013	2014	2015	2016	2017
WR1	0	0	0	26	45	1
WR2	0	0	0	37	4	0
LRR	0	0	0	0	0	0
NBW	0	0	0	0	0	0
NBE	0	0	0	4	1	0
CRR	0	0	0	2	0	0
URR	0	0	0	2	8	0
NATIONAL	**0**	**0**	**0**	**71**	**58**	1

Table 4: showing Lab Confirmed Rubella cases in the Gambia 2012-2017

	2012	2013	2014	2015	2016	2017
WR1	34	55	20	2	3	0

WR2	0	5	10	1	1	0
LRR	2	1	0	0	0	0
NBW	3	2	1	0	0	0
NBE	0	1	0	1	0	0
CRR	1	2	0	0	0	0
URR	0	0	4	0	0	0
Rubella	**40**	**66**	**35**	**4**	**4**	0

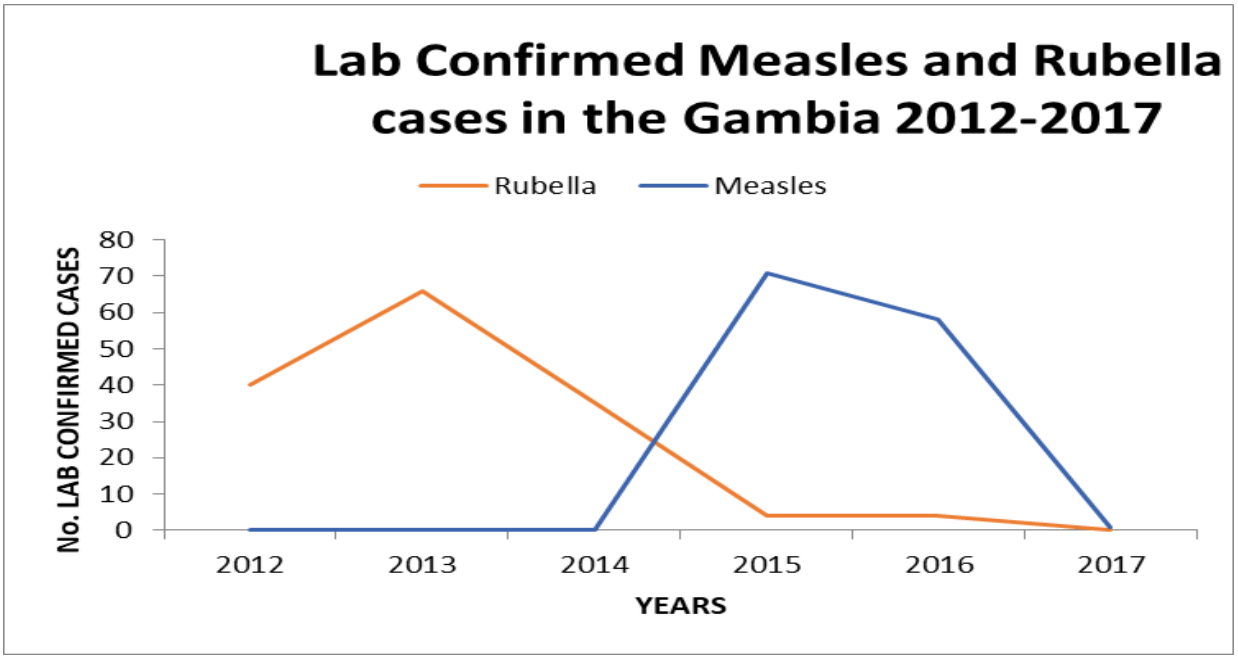

Figure 5: Lab confirmed measles and rubella cases from 2012 to 2017

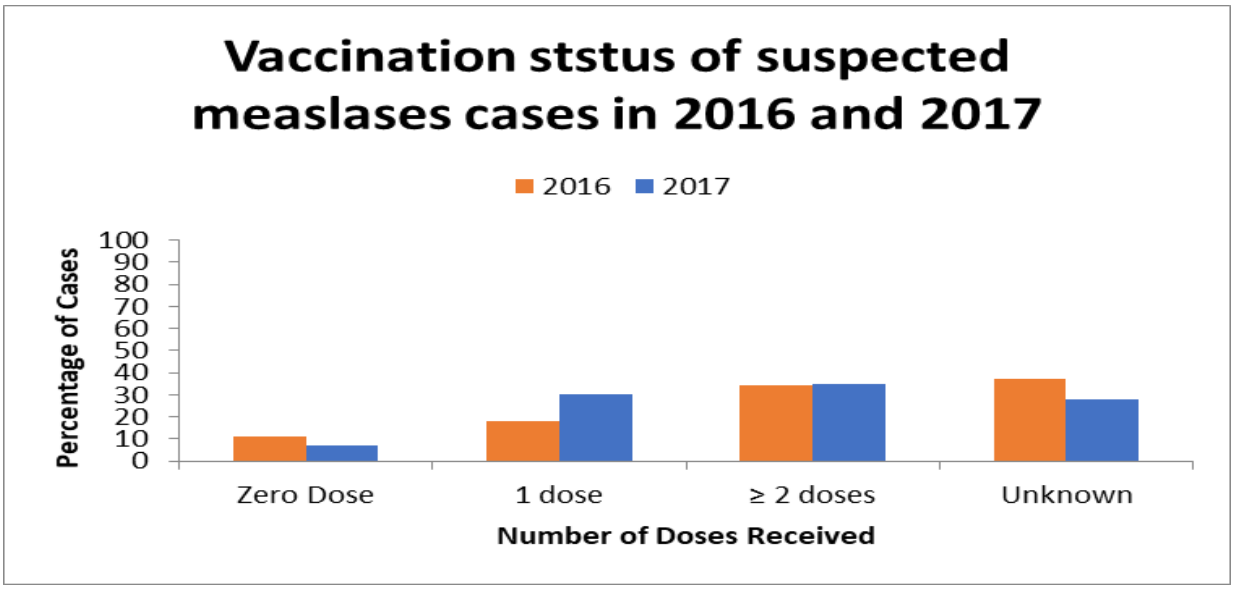

FIGURE 6: vaccination status of measles cases in 2016 and 2017.

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

Provide a succinct analysis of the performance of Gavi's HSS support for the reporting period.

- ***Progress of the HSS grant implementation*** *against objectives and budget, and significant deviations from plans (e.g. implementation delays, low expenditure rates, etc.),* ***using the below table****.*
- ***Achievements against agreed targets*** *as specified in the grant performance framework (GPF), and key outcomes. E.g. how does the number of additional children vaccinated and under-immunised children in districts supported by the HSS grant compare to other non-supported districts. Which indicators in the GPF were impacted by the activities conducted?*
- *How is Gavi support* ***contributing to address the key drivers of low immunisation*** *outcomes:*
  - *contributing to advancing the overall performance of the immunisation programme/service delivery structure supporting immunisation and health sector strategies;*
  - *targeting districts and/or population groups with lower coverage (including in urban slums, remote rural settings and conflict settings);*
  - *addressing key barriers to coverage & equity identified in section 3 above.*
- *Comment whether the* ***selection of activities is still relevant****, realistic and well prioritised in light of the situation analysis conducted, as well as financial absorption and implementation rates.*
- *Provide information on* ***plans to address implementation bottlenecks****, including planned budget reallocations (please attach the revised budget).*
- *If applicable, briefly describe the usage and results achieved with the* ***performance based funding*** *(PBF) the country received. What grant performance framework (GPF) metrics will be used to track progress?*
- *Briefly describe how Gavi HSS support is aligned, coordinated and* ***contributing to the country's health sector strategies*** *and plans. Mention synergies with other development partners' support.*
- *(If pertinent, mention other relevant initiatives not supported by Gavi that address the key drivers of low coverage and equity.)*

To note, following the 2018 JA meeting, the country and Gavi have updated the GPF to align with the delayed start of the HSS grant and strengthen the country tailored indicators.

Objective 1	
Objective of the HSS grant (as per the HSS proposals or PSR)	To maintain the high immunization coverage (≥ 95%) and improve the quality and equitable access to RCH service delivery
Priority geographies / population groups or constraints to C&E addressed by the objective	Country-wide
% activities conducted / budget utilisation	**Total Budget: 724,017.46** **Expenditure: 591,697.00** **% Utilisation: 81.72**

Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Four (4) RCH Vehicles and eleven (11) Motor-Cycles were procured and distributed. The vehicles were given to NBE, CRR, WR1 and WR2, and the motor cycles to all the 7 health regions. The use of this appropriate outreach trekking vehicles enhance the movement of all the RCH trekking team thereby impacting on the team's ability to provide the required quality services in a timely manner. The remaining fleet of vehicles are expected to be procured in the next procurement phase. The country procured a 40m3 cold room and 20 sets of TCW 2000 SDD for cold chain expansion at national and Lowest distribution points respectively for effective vaccine storage. There are plans to construct a structure to house the cold room for installation. An assessment was conducted to map out ideal sites for construction of outreach sites. It was realized that the budget allocated was found to be lower than needed, this will be factored during the reallocation of the HSS budget. The construction and refurbishment of RCH outreach sites will address the issues of equity in the urban areas so as to reduce travel distance, waiting time and improve working environment.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	• *Training and retraining of health staff in EPI/RCH/IMNCI/Disease Surveillance, AEFI surveillance/ Data Management* • Construction of regional stores pending the supply chain assessment results • Procure vehicles and motor cycles • Continuation of construction and refurbishment of outreach sites
Objective 2:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**To strengthen the generation and timely use of quality data and information for decision making in RCH services**
Priority geographies / population groups or constraints to C&E addressed by the objective	**County - wide**
% activities conducted / budget utilisation	**Total Budget: 164,795.00** **Expenditure: 33,040.00** **% Utilisation: 20.05**

Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	A total of 20 computers with accessories were procured with the aim of improving data accuracy and efficiency. This will ease the process of data collection and improve quality of data reporting including immunization Data management training was conducted for 50 participants. Participants include health workers from major health facilities, Regional Data Managers, EPI Regional Operation Officers, Directorate of Planning and Information and other units of the Ministry of Health. The aim was to build capacities of health workers, data managers and stakeholders to enhance quality immunization data generation and management that would be responsive to the needs of the MoHSW and partners. In-service meetings were conducted at regional and central level. The regions converged at central level to discuss on performance monitoring (coverage, dropout, and surveillance), best practices, main challenges and recommendations.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[11]	Develop, implement and monitor the data quality improvement plan Hire the service of a TA to support in addressing denominator issue and DQIP Expand VVS to 23 new sites in the country
Objective 3:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**To enhance the capacities and work environment of health workers for improved RCH services**
Priority geographies / population groups or constraints to C&E addressed by the objective	Country wide
% activities conducted / budget utilisation	**Total Budget: 92,640.00** **Expenditure: 36,387.00** **% Utilisation: 39.28**
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	An incentive scheme is being finalised to guide the identification of staff who will benefit. The Incentive Scheme will help to attract/motivate staff and retain them in the health work force. The implementation of the incentive scheme is expected to start in the first quarter of 2019**.**

Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[6]	• Immunisation service review meetings at all levels • Support a comprehensive incentive package for RCH service providers. • strengthening the Human Resources Information System
Objective 4:	
Objective of the HSS grant (as per the HSS proposals or PSR)	**To empower communities, CSOs and other local actors to improve the utilization of RCH services including immunization services by 2019**
Priority geographies / population groups or constraints to C&E addressed by the objective	Country wide
% activities conducted / budget utilisation	**Total Budget: 189,266.00** **Expenditure: 107.449..00** **% Utilisation: 56.77**
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	EPI Communication strategy have been developed and validated by stakeholders. The overall goal of the Strategy is to engage and empower individuals, families and communities, through strategic behavior change communication, to make their children available for immunization and related family health services in accordance with the national schedule. An IPC training manual was developed to enhance the IPC skills of health service providers on communication in RCH including immunization. HePDO as the local CSO has conducted assessment on communities' knowledge, attitude and practice on RCH including immunization (Interviews with communities, FGD and PRA)
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**[7]	• *Train health workers and Multidisciplinary Facilitation Teams (MDFTs) on inter-personal communication (IPC) skills* • *Build the capacity of CSOs and organized community groups on RCH services* • *Promote EPI and RCH Service through communication support*

[6] Note: When specifying Technical Assistance (TA) 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 in the JA. TA needs should however describe - to the extend 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 reference guide.

[7] Note: When specifying Technical Assistance (TA) 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 in the JA. TA needs should however describe - to the extend 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 reference guide.

	materials (print and electronic) • *Conduct national immunization consultative forum with stakeholders*

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

If your country is receiving CCEOP support from Gavi, provide a brief update on the following:

- ***Performance** of CCEOP indicators – achievement against agreed targets as specific in the grant performance framework (GPF);*
- ***Implementation status** (number of equipment installed / waiting installation, user feedback on preventive maintenance training, refrigerator performance, etc.), including any challenges / lessons learned;*
- ***Contribution** of CCEOP to immunisation performance;*
- ***Future needs for technical assistance** in implementing CCEOP support.*[11]

Note: an updated CCE inventory must be submitted together with the CCEOP renewal request.

CCEOP

The country applied for the CCEOP with a budget of US $893,337.00 for the initial support phase only. Twenty percent of total (US $178,667.00) will be the country's joint investment to the Gavi CCEOP and US $15,187.00 for procurement fees will be financed using the ongoing Gavi HSS grant. The country will procure 114 units of CCEs for the 3 years duration which will be deployed to the 7 LDs and 74 SPs during the initial phase of the project. The approved CCEOP proposal would strengthen the cold chain system to provide potent and uninterrupted vaccine supplies to realize optimal immunization coverages.

Table 6: shows the number of equipment to be procured over the CCEOP period.

EQUIPMENT	2018	2019	2020	TOTAL
TCW 15 SDD	41	0	0	41
TCW40 SDD	21	1	0	22
TCW2043	7	0	0	7
TFW40	10	2	0	12
TCW3043	7	21	2	30
VLS 064 RF AC	2	0	0	2
	88	24	2	114

After the successful approval of the CCEOP, another mandatory document that was needed before procurement begins is the Operational Deployment Plan (ODP). UNICEF provided a

consultant to this effect from the 5th to the 9th of February, 2018. Among the key areas discussed and developed included:

- Approach to the implementation of the ODP
- Role of local service providers in the ODP installation and training
- Risk mapping for the ODP
- Custom clearance during for CCEOP equipment
- The formation of the project management team (PMT) for the ODP
- Deviation and deviation protocols during the ODP
- Assessment for data collection on the ODP tool

The data collection of the health facilities for the ODP was conducted by the EPI Regional Operation Officers and validated by UNICEF and EPI to ensure deviations are minimized. The ODP was finalised and submitted to Supply Division in May 2018. The procurement process is currently underway. The tenders are currently being evaluated, with cost estimates and transfers expected in October 2018 and order placements in November 2018. Equipment are expected in country and to be installed in 2019.

It was recommended by the IRC during the CCEOP review that the country needs to conduct an assessment on the cost-benefits of constructing and equipping a cold store in WR1 and WR2 who gets there supplies directly from the national depot. UNICEF have been supporting this assessment through the TCA 2018 with a preliminary stakeholder workshop conducted in August 2018.

The goal of the assessment was to:

- To inform decision on the procurement of CCEOP equipment in WR1 and WR2
- To provide evidence on which storing and distribution iSC system is suitable at the primary store to the LDs (WR1 7 WR2) and the SPs under them
- To compare existing networks with other options for recommendations.

Findings of the assessment are expected in November 2018 and will inform the second year of the CCEOP procurement. The assessment is ongoing and the country awaits for the findings from the assessment in order to make an informed decision.

4.4. Financial management performance

Provide a succinct review of the performance in terms of financial management of Gavi's cash grants (for all cash grants, such as HSS, PBF funding, vaccine introduction grants, campaign operational cost grants, switch grants, transition grants, etc.). This should take the following aspects into account:

- *Financial **absorption** and utilisation rates on all Gavi cash support listed separately[8];*
- ***Compliance** with financial reporting and audit requirements noting each grant (listing the compliance with each cash support grant separately, as above);*
- *Issues arising from review engagements (e.g. Gavi cash programme audits, or Gavi programme capacity assessments, annual external audits, internal audits, etc.) and the implementation status of any recommendations;*
- *Financial management **systems**[9].*

Grant	Amount Disbursed	Amount Utilized	Current Balance	% Utilized
MR VIG	$99,998.98	$87,110.98	$12,888.00	87%
HSS	$1,574,306.00	$798,719.97	$775,586.03	51%
Men A	$298,424.38	$17,471.38	$280,953.00	6%

Utilisation of Gavi grants as of 31st October 2018 and includes funds commitments made

Financial Management. Funds from Gavi for activity implementation are disbursed through UNICEF, who manages the in country funds. This arises from the tripartite agreement between UNICEF, Gavi and Government. The EPI programme then requests the funds from UNICEF through the PS using a standard Itemise Cost Estimate (ICE) and FACE forms. These are then reviewed and funds transferred to the Ministry of Health through the PCU. The Cheques are then paid in the name of the programme staff identified by the Programme Manager who would be responsible for the conduct of the activity and liquidating of the funds. The conducted activity is then retired using a standard form, highlighting the expenditure and variance if any.

There is currently a comprehensive review of the Ministry's Project Coordinating Unit (PCU) underway supported by Gavi to address the system bottlenecks that have resulted in the delays in implementation and to strengthen the overall financial management system. There are plans to develop SOPs and guidelines and provide training for key staff to ensure effective management of funds for the smooth implementation and delivery of programmes and the overall strengthening of the health care delivery system.

Fund disbursement and receipt: The PCU is now responsible for the financial management of these funds once disbursed by UNICEF. This they also do with the support of the programmes and the PS, as the lead. Programmes are informed accordingly when activity funds are received and time lime given as to when implementation is expected and retirement due.

PCU structure: The PCU is now staffed with a Programme Manager, Financial Controller, and Senior Accountant. Following the recruitment of a HSS Accountant at the EPI, this accountant is

[8] If in your country Gavi funds are managed by partners (i.e. UNICEF and WHO), fund utilisation by these agencies should also be reviewed.
[9] In case any modifications have been made or are planned to the financial management arrangements please indicate them in this section.

also now housed at the PCU to help support in the financial management.

4.5. Transition planning (if applicable, e.g. country is in accelerated transition phase)

If your country is transitioning out of Gavi support, specify whether the country has a transition plan in place. If no transition plan exists, please describe plans to develop one and other actions to prepare for transition.

- *If a transition plan is in place, please provide a brief overview on the following:*
  - *Implementation progress of planned activities;*
  - *Implementation bottlenecks and corrective actions;*
  - *Adherence to deadlines: are activities on time or delayed and, if delayed, the revised expected timeline for completion;*
  - *Transition grant: specify and explain any significant changes proposed to activities funded by Gavi through the transition grant (e.g., dropping an activity, adding a new activity or changing the content/budget of an activity);*
  - *If any changes are requested, please submit a consolidated revised version of the transition plan.*

N/A

4.6. Technical Assistance (TA)

- *Describe the strategic approach to Technical Assistance (TA) delivery to improving coverage and equity in reaching the under-immunised and unimmunised children. (i.e. embedded support, subnational support, support from expanded partners etc.)*
- *On the basis of the reporting against PEF functions and milestones, summarise the progress of partners in delivering technical assistance.*
- *Highlight progress and challenges in implementing the TA plan.*
- *Specify any amendments/ changes to the TA currently planned for the remaining of the year.*

Technical Assistance provided by partners aligned in the One TA plan following the JA in 2017 and priority activities identified.

The following has been supported by UNICEF:

1. The CCEOP ODP has been completed and submitted to UNICEF Regional Office and Supply Division in June 2018. Process for procurement ongoing.
2. The scope of the independent evaluation was widened and used as an opportunity to conduct a broader assessment of vaccine storage, distribution and network design between primary store and service delivery points. Stakeholder consultative workshops completed and draft report available. A roadmap for implementation of the recommendations to be developed and incorporated with EVM Improvement Plan
3. The temperature monitoring study has not yet been conducted due to competing priorities but is scheduled in Q1 2019, before the EVMA.
4. A construction engineer is on board to support construction and refurbishment of outreach

sites for increased access to immunization services. There have been delays in the process of finalizing the design and costs which is being done in consultation with the MoHSW.

5. The Equity Assessment was delayed to await the findings of the MICS. It is planned in 2019.
6. GIS analysis for visual mapping of immunization service delivery points is currently ongoing. This will be integrated into DHIS2 and staff trained on its use.
7. The training of staff on logistics and vaccine supply chain management is delayed. Staff have been identified for a training course in April 2019.

The following has been supported by WHO:

1. There has been a delay in implementing the TCA activities, however, a request has been sent to AFRO to support the data related activities.
2. A TOR has been developed for the recruitment of the local consultant to support the programme.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Provide the status of the prioritised strategic actions identified in the previous Joint Appraisal[10] and any additional significant Independent Review Committee (IRC) or High Level Review Panel (HLRP) recommendations (if applicable).

Prioritised actions from previous Joint Appraisal	Current status
1. **Provide additional support for the construction of RCH outreach sites**	Construction Engineer has been hired. Cost-estimates, design and tender documents have been prepared and tendering for construction is underway
2. **Strengthen data quality**	A Health Information System Technical Working Group (HISTWG) has been formed at central level to look at monitoring and evaluation issues within the Ministry. A sub group of Data Quality Team was composed from the HISTWG to specifically look into the data quality issues in all program units. The team comprises of EPI, EDC, HMIS, M&E and ICT.
3. **Continuous strengthening of coverage and**	IPV reintroduced in May 2018 but Men A

[10] Refer to the section "Prioritised Country Needs" in last year's Joint Appraisal report

equity	pending due to delay in conducting the catch-up campaign. Equity assessment still not yet conducted.
4. **Strengthen immunization supply chain**	CCEOP ODP completed and submitted. PMT of the CCEOP ODP formed and trained. EVMA postponed to 2019. Quarterly preventative maintenance ongoing
5. **Strengthen surveillance activities**	Surveillance review conducted and the findings are being implemented. Surveillance guidelines and protocols developed (AFP, CRS, Measles)
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**
N/A	

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 6 below).

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

*Briefly summarise the **key activities to be implemented next year** with Gavi grant support, including if relevant any introductions for vaccine applications already approved; preparation of new applications, preparation of investment cases for additional vaccines, and/ or plans related to HSS / CCEOP grants.*

*In the context of these planned activities and based on the analyses provided in the above sections, describe the five **highest priority findings and actions to be undertaken to enhance the impact of Gavi support or to mitigate potential future risks to programme and grant performance**.*

Please indicate if any modifications to Gavi support are being requested, such as:

- *Changes to country targets as established earlier, either from the agreed Grant Performance Framework (GPF) or as part of the NVS renewal request submitted by 15 May;*
- *Plans to change any vaccine presentation or type;*
- *Plans to use available flexibilities to reallocate budgeted funds to focus on identified priority areas.*

Overview of key activities planned for the next year: To note, country agreed to incorporate the JA action points into its annual planning document and quarterly EPI review process to assess progress

Key finding / Action 1	**Service delivery and new vaccines/coverage and equity**
Current response	
Agreed country actions	- Preparations for HPV introduction: o implementation of HPV introduction plan o Coverage survey - HPV o Mapping of out of school girls Operational Research on MOV and dropout rates Institutionalize defaulter tracing mechanism Construction of new outreach sites
Expected outputs / results	o Reduction in missed opportunities and dropout rates o HPV successfully introduced in to the routine o Construction of outreach sites for increased access
Associated timeline	January to December , 2019
Required resources / support	o TA for the operational research o TA for MOV assessment o Support for TA construction engineer
Key finding / Action 2	**Strengthen Surveillance activities**
Current response	
Agreed country actions	o Training of expert committee on AEFI o Develop guidelines and protocols (AEFI) o Orientation of community structures on surveillance o Development communication materials on VPD surveillance o Institute MenA case base surveillance o Institutionalize CRS sentinel surveillance
Expected outputs / results	o A robust VPD surveillance system established o Guidelines and protocols developed
Associated timeline	January – December, 2019
Required resources / support	o TA for institutionalisation of national AEFI system o TA to institutionalize MenA case base, and CRS sentinel surveillance
Key finding / Action 3	**Immunization Data Quality and Data Systems**
Current response	
Agreed country actions	1. Continued integration of immunization data into DHIS2 Developing EPI dashboard

	2 Implement DQIP with regional and facility level. 3. Deployment and training on the EPI data quality module in DHIS2 4. Conduct quarterly data audit
Expected outputs / results	Improved immunization data reporting and quality
Associated timeline	January to December, 2019
Required resources / support	TA for data management Funds for the implementation of the DQIP
Key finding / Action 4	**Logistics and Supply chain management**
Current response	
Agreed country actions	- Conduct EVM assessment in 2019 - Deployment of year 1 CCEOP - Conduct quarterly preventive maintenance -
Expected outputs / results	EVMA successfully conducted
Associated timeline	January to December 2019
Required resources / support	TA to support EVMA and improvement plan
Key finding / Action 5	**Leadership, Management and coordination**
Current response	
Agreed country actions	- Quarterly review meetings to monitor the progress of EPI annual work plan including the JA action plans - Engage dialogue with MOH on HR training plan to sustain capacity investments - Implementation of incentive scheme Establishing the NITAG
Expected outputs / results	EPI work plan developed and monitored periodically HR training plan developed and incentive scheme developed
Associated timeline	January to December 2019
Required resources / support	TA to train NITAG

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

COMMENTS

- *Does the national Coordination Forum (ICC, HSCC or equivalent) meet the Gavi requirements (please refer to http://www.gavi.org/support/coordination/ for the requirements)?*
- *Briefly describe how the Joint Appraisal was reviewed, discussed and endorsed by the relevant national Coordination Forum (ICC, HSCC or equivalent), including key discussion points, attendees, key recommendations and decisions, and whether the quorum was met. Alternatively, share the meeting minutes outlining these points.*
- *If applicable, provide any additional comments from the Ministry of Health, Gavi Alliance partners, or other stakeholders.*

The JA was presented to the ICC on the 14th November, 2018 and was unanimously endorsed by the members.

8. ANNEX: Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal. ***It is important to note that in the case that key reporting requirements (marked with *) are not complied with, Gavi support will not be reviewed for renewal.***

	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 report (which is normally provided by 15 May as part of the vaccine renewal request) ****	**x**		
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		**x**	
Data improvement plan (DIP)		**X** (under development)	
Progress report on data improvement plan implementation		**x**	
In-depth data assessment (conducted in the last five years)		**X** (MICS due in Nov)	
Nationally representative coverage survey (conducted in the last five years)		**x**	
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
CCEOP: updated CCE inventory			x
Post Introduction Evaluation (PIE)	**x**		
Measles & rubella situation analysis and 5 year plan			x

Operational plan for the immunisation programme	x		
HSS end of grant evaluation report			x
HPV specific reports	**x**		
Reporting by partners on TCA and PEF functions	x		

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.
