

2018 Joint Appraisal Report

| | |
|---|---|
| Country | Haiti |
| Full JA or Updated JA | <input checked="" type="checkbox"/> Full JA <input type="checkbox"/> Updated JA |
| Date and location of Joint Appraisal meeting | 25-29 June 2018, Port-au-Prince, Haiti |
| Participants/affiliation | See Annex |
| Report frequency | Annual |
| Fiscal period ¹ | October 2016 - September 2017 |
| Comprehensive Multi Year Plan (cMYP) duration | cMYP 2016-2020 |
| Gavi transition/co-financing group | Initial self-financing |

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests have been submitted through the country portal

| | | | |
|--|---|-----------------------------|------------------------------|
| Vaccine renewal request (NVS) (due May 15) | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| HSS support renewal request | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| CCEOP renewal request | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |

Comments on vaccine request

| Population | | | | |
|---|---------------|-------------|----------|-----|
| Birth cohort | | | | |
| Vaccine | Pentavalent 3 | Rotavirus 2 | IPV | ... |
| Population in target age cohort | 341,640 | 341,640 | 341,640 | |
| Target population before being immunised (first dose) | 290,394 | 273,312 | 303,127 | |
| Target population before being immunised (last dose) | 273,312 | 239,148 | 273,312 | |
| Implicit coverage rates | 72% | 68% | 66% | |
| Last WUENIC coverage rate available 2016 | 58% | 48% | 45% | |
| Last admin coverage rate available (1st quarter 2018) | 67% | 66% | 64% | |
| Wastage rate | 5% | 5% | 5% | |
| Buffer stock | 3 months | 3 months | 3 months | |
| Reported stock | 258,433 | 119,091 | 70,430 | |

Indicative interest to introduce new vaccines or request HSS support from Gavi in the future²

| Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future | Schedule | Expected application year | Expected introduction year |
|--|-----------|---------------------------|----------------------------|
| | PCV - VIG | | 2018 |
| Health system strengthening (HSS) support | | 2018 | 2018 |

¹ If the country reporting period deviates from the fiscal period, please provide a short explanation.

² Providing this information does not constitute any obligation for either the country or Gavi, it is merely for informational purposes.

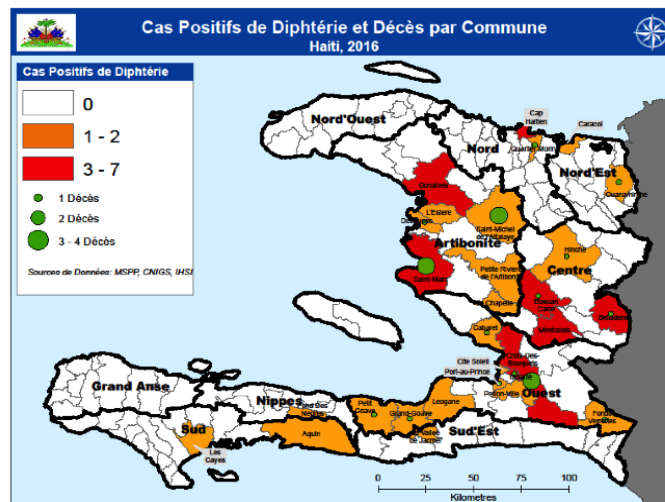
2. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR THE NEXT YEAR

Health background

• Diphtheria

Since 2014, the country has faced annual outbreaks of diphtheria, eliciting local and specific responses by both epidemiological surveillance teams and the EPI. The response to outbreaks that was put in place in 2015 has been modified multiple times and the immunisation component has not been implemented, due to a lack of resources. The situation became critical in 2017 with 186 probable cases, 74 confirmed cases and 3 deaths, for a fatality rate of 6.75%. In 2018, an estimated seven probable cases of diphtheria are reported and investigated each week, compared to an average of three cases per week in 2017. Furthermore, it should be noted that outbreaks have affected 9 out of 10 departments, and in 7 communes (Cap-Haitien, Cité Soleil, Croix-des-Bouquets, Mirebalais, L'Estère, Saint Marc and Gonaïves), there have been reported and confirmed cases of diphtheria since 2015.

This situation has caused the Ministry of Public Health and Population (MSPP) to organise supplementary immunisation activities via “mini-campaigns” in 37 high-risk communes within the 10 departments: those communes that reported at least one confirmed case of, or death from, diphtheria in 2016.



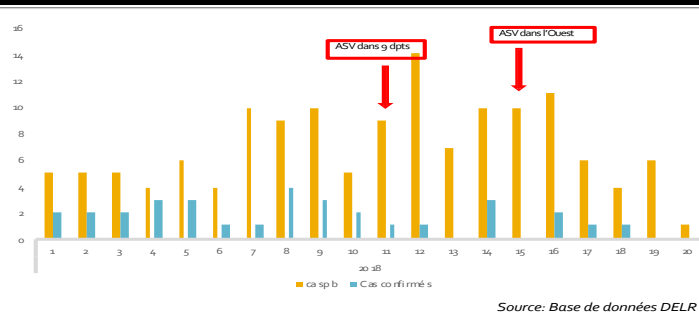
Positive Cases of Diphtheria and Deaths per Commune, Haiti, 2016

Legends: Positive cases of Diphtheria

- 1 Deaths
- 2 Deaths
- 3-4 Deaths

Data Source: MSPP, CNIGS, HIS

Distribution cas probables et confirmés de diphterie par semaine épidémiologique. 1ère-20ème SE 2018



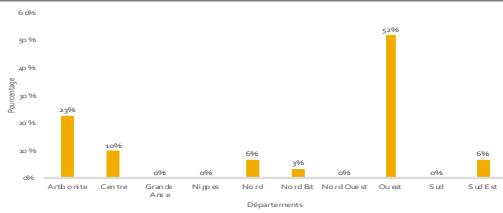
Distribution of probable and confirmed cases of diphtheria per epidemiological week 1st – 20th EW 2018

SIA in 9 departments

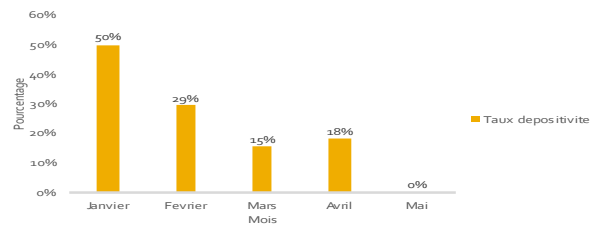
SIA in Ouest

Source: DELR database Confirmed cases

Proportion des cas positifs de diphtérie par département en Haïti, 1^{ère}-20^{ème} SE 2018



Taux de positivité des cas de diphtérie par mois. Janvier-Mai 2018



Distribution of probable and confirmed cases of epidemiologic diphtheria by department in Haiti, 1st to 20th EW 2018

Percentage
Departments

January-May 2018

Percentage
January February mMarch April May
Month
Positive test rate

Tableau 1- Caractéristiques socio démographiques des cas de diphtérie confirmés et des décès en Haïti, 1^{ère} -20^{ème} SE 2018

| | Cas n=31(%) | Décès n=3(%) |
|------------------------|-------------|--------------|
| Statut vaccinal | | |
| Vaccine | 11(35,5) | 2(66,7) |
| Non Vaccine | 7(22,6) | 0(0,0) |
| Inconnu | 12 (38,7) | 1 (33,3) |
| Pas d'information | 1 (3,2) | |
| Sexe | | |
| M | 16(51,6) | 1 (33,3) |
| F | 15(48,4) | 2(66,7) |
| Groupe d'âge | | |
| < 1 an | 0(0,0) | 0(0,0) |
| 1-4ans | 6(19,4) | 1(33,3) |
| 5 ans et plus (13) | 25(80,6) | 2(66,7) |

Cases n = 31 (%) Deaths n = 3

Socio-demographic characteristics for confirmed cases of diphtheria and deaths in Haiti, 1st – 20th EW 2018

Legends:

| | | |
|---------------------|--------|---------------------|
| Immunisation status | Gender | Age group |
| Immunised | M | < 1 year |
| Non-immunised | F | 1-4 years |
| Unknown | | 5 years and up (13) |
| No information | | |

• **Measles and Polio**

Because of the high numbers of people susceptible to measles, accumulated since 2012, a diphtheria immunisation campaign was planned and organised in 2016. For children aged 0 to 5 years, 1 dose of OPV was added to the measles/rubella (MR) dose administered to children aged 9 months to 5 years. In 2016, the oral trivalent polio vaccine (OPV3) was replaced by the bivalent (OPV2) vaccine. As part of this campaign, 80.6% of those under the age of 5 were immunised.

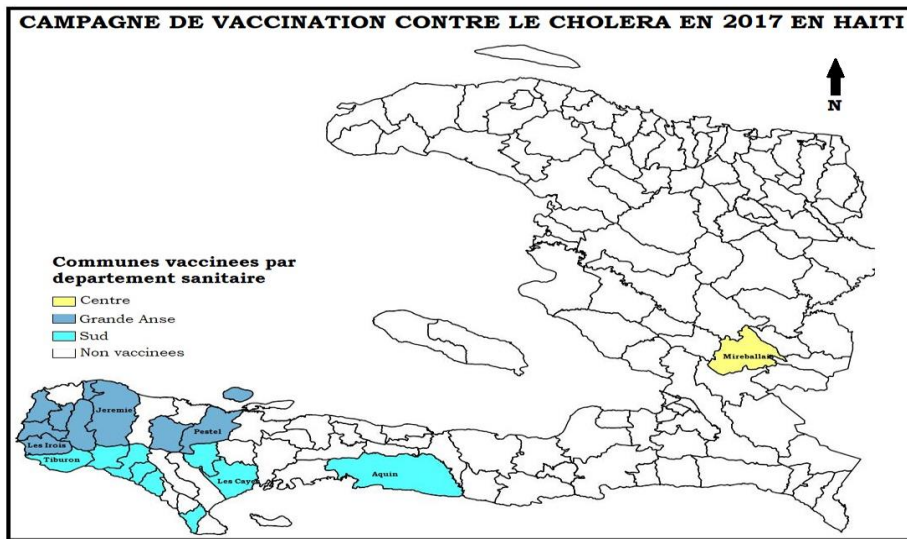
In 2017, the country began developing a polio outbreak prevention and response plan. This plan was revised in 2018. In parallel, environmental surveillance activities were launched two years ago and have not revealed evidence of a wild or vaccine-derived polio virus. However, weak epidemiological surveillance, low recorded immunisation coverage and the arrival of foreign nationals from countries where the wild polio virus is still present put Haiti's status as a country free from circulation of the polio virus at risk.

• **Cholera**

More than one year after Hurricane Matthew, health conditions in Haiti remain critical despite a trend towards fewer cholera outbreaks since 2010. The total number of presumed cases of cholera has decreased by 67% compared to 2016 (PRH, 2017, 2018), specifically due to cholera immunisation campaigns – in 18 communes in the Sud and Grande Anse departments and in the commune of Mirebalais in the Centre department – and activities such as household water chlorination and promotion of health.

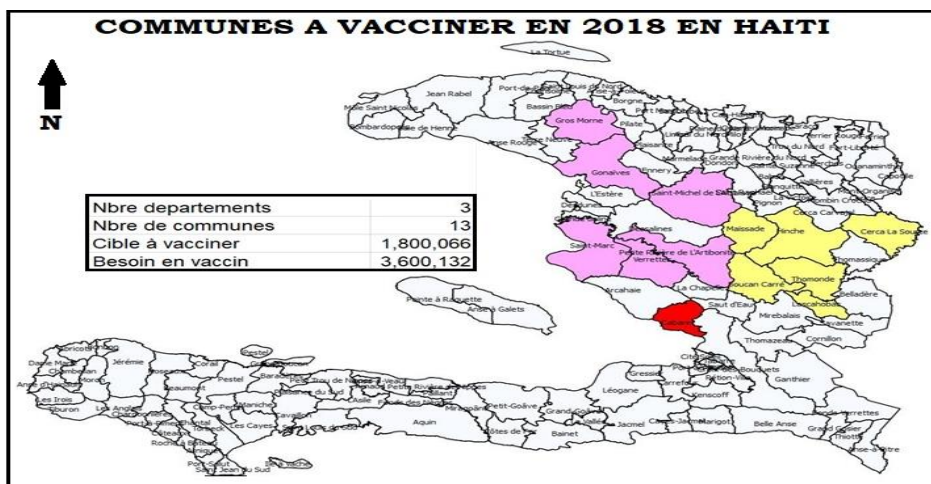
From November 2016 to January 2017, a first immunisation round was organised and resulted in 779,345 people being immunised (93% administrative immunisation coverage) in the 18 target communes. In May 2017, a second round of immunisation was organised in the same communes, where 654,143 people were

immunised, 555,315 of whom had then received two doses of cholera vaccine. In the commune of Mirebalais, of 98,563 target individuals, 88,377 (90%) were immunised from 16 to 21 November 2017 (1st round) and 85,112 (86%) from 10 to 16 December 2017 (2nd round), with 69,905 (71%) receiving the two doses.



Legends: Cholera Immunisation Campaign in 2017 in Haiti
 Communes immunised by health region
 Centre
 Grande Anse
 Sud
 Non-immunised

From 2017 to 2020, the country is targeting total, continual coverage for the communes in the departments of Centre and Artibonite, according to the epidemiological data. In 2018, an estimated 3.6 million vaccines are needed for the 12 communes in the departments of Centre and Artibonite along with other communes in other departments that may experience outbreaks. Despite the progress, cholera remains a serious threat and prevention and control efforts must be pursued in 2018. In 2017, the MSPP reported 13,681 suspected cases of cholera and 159 deaths. At least 45% of the population does not have access to an improved water source, 31% practice open defecation and 75% do not have access to a facility where they can wash their hands with soap (JMP WHO/UNICEF).



Legends: Communes to be immunised in 2018 in Haiti
 Number of departments
 Number of communes
 Target to immunise
 Vaccine need

▪ **Eliminating neonatal tetanus**

In 2017, following the survey to validate elimination of maternal and neonatal tetanus (MNT), Haiti was certified as a country that has eliminated MNT as a public health risk. This status is the culmination of major

efforts taken by the country which, from 2013 to 2015, led immunisation campaigns targeting women of child-bearing age in 65 communes classified as high risk. Actual immunisation coverage was higher than 80% in 67.8% of the target communes. However, to maintain its elimination status, Haiti must attain high coverage levels (=>80%) for tetanus and diphtheria in all communes and work to increase the number of safe deliveries.

▪ **PEF process**

From December 2016, the MSPP and its partners began Gavi's new country engagement framework (CEF) and this resulted in a HSS2-Gavi proposal of US\$ 8.7 million for five years (2018-2022), with US\$ 3.7 million of this budgeted for the first two years. Gavi's Independent Review Committee (IRC) recommended this proposal for endorsement after a field visit at the end of February 2018. Feedback was provided for the purpose of clarifying and specifying certain aspects, specifically supplementary MR immunisation activities planned for 2019, training activities, monitoring and supervision.

| Risk analysis | Description of risk | Probability level | Planned mitigation measures |
|--|---|-------------------|--|
| 1. Unforeseen circumstances that may affect plan execution | Natural catastrophes | High | Contingency plan to be developed |
| 2. Obstacles that may delay implementation or interrupt activity execution | Poor financial management | High | <ul style="list-style-type: none"> - Strengthen collaboration with administration and budget director, have follow-up meetings with department management, organise joint supervision missions with the Directorate of Administration and Budget (DAB) and financial partners - Develop framework for planning execution and budget monitoring with partners, DAB, and National Coordination Unit for the Immunisation Programme (UCNPV) |
| 3. Dependencies related to financial, human and material resources and third-party participants | <ul style="list-style-type: none"> - Strong programme dependence on external funding - Lack of law guaranteeing vaccine funding - Insufficient human resources Personnel rotation | High | <ul style="list-style-type: none"> - Develop proposal for immunisation law - Advocacy with the presidency, government and parliament to facilitate vote and adoption of the law - Produce an advocacy document about training and retaining personnel - Pursue nomination process for multiskilled community health workers (PCHWs) and other personnel at various levels within the system. |
| 4. Risk of stockouts | <ul style="list-style-type: none"> Co-financing delays - Inadequate system for managing inventory at the central, departmental and facility levels | High | <ul style="list-style-type: none"> - Provide regular monitoring of management and use of vaccines and vaccine inputs at various levels within the system - Assess management tools - Strengthen departmental capacity to use management tools |

| | | | |
|--------------------------------|--------------------------|-----|---|
| | | | <ul style="list-style-type: none"> - Strengthen collaboration with pharmacy management - Recruit a national senior consultant for the Cold Chain and Logistics Department |
| 5. Socio-political risk | Socio-political upheaval | Low | <ul style="list-style-type: none"> - Follow socio-political situation to be able to quickly implement contingency plan |

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

Immunisation coverage

Revised objectives and coverage

Comparing the immunisation coverage attained since the last joint appraisal in 2016 to those of 2017, we see a general downward trend (Table 1). Nevertheless, the JRF data show an improvement for some antigens when compared to 2016: BCG, Penta3, Rota. The other vaccines (specifically Penta, Polio3, MR and dT2+) have seen a significant drop. The dropout rate between Penta1 and Penta3 improved in comparison to 2016, decreasing from 9% to 6%.

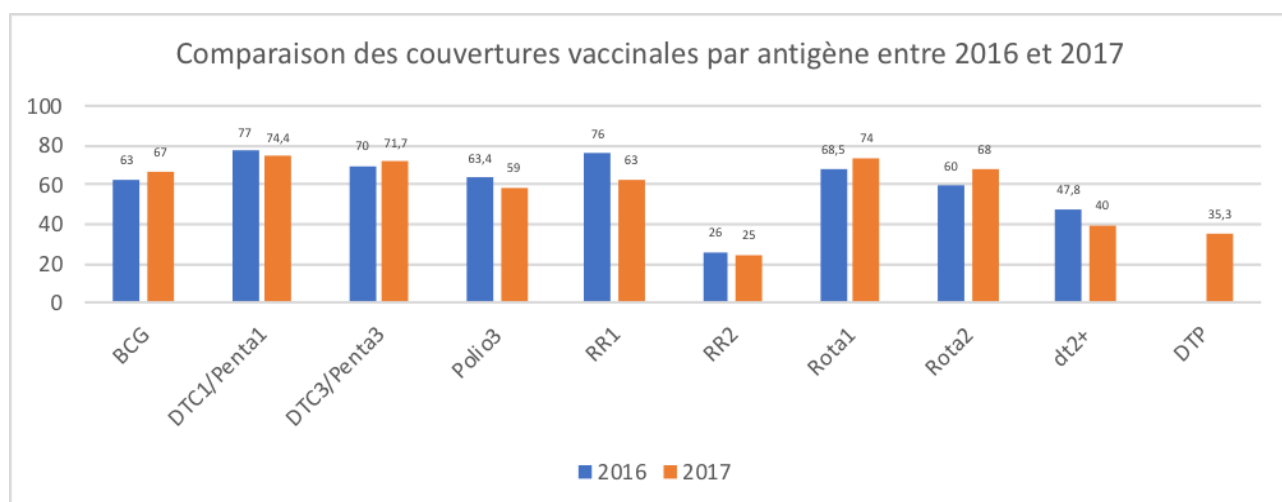


Table 1: Comparison of immunisation coverage by antigen from 2016 to 2017

| Immunisation coverage by antigen | | | | |
|----------------------------------|---------------------------|--------------------------|---------------------------|-----------------------|
| Antigen | Coverage achieved in 2016 | Revised targets for 2017 | Coverage achieved in 2017 | 2017 Gap (percentage) |
| BCG | 63% | 75% | 67% | 8 |
| Penta3 | 70% | 80% | 72% | 8 |
| OPV3 | 75% | 80% | 56% | 24 |
| MR1 | 76% | 80% | 63% | 17 |
| Rota2 | 60% | 70% | 68% | 2 |
| Td2+ | 48% | 75% | 40% | 35 |

Table 2: Immunisation coverage per antigen compared to objectives set in 2017 (JRF)

| Antigen | Year | | | | | | | | | | | | | |
|-------------|------|------|------|------|------|------|------|------|------|------|------|------|------|-------------------|
| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 ³ |
| BCG | 62 | 59 | 70 | 62 | 66 | 68 | 82 | 69 | 75 | 67 | 72 | 63 | 67 | 60 |
| DTP1/Penta1 | 57 | 90 | 77 | 77 | 73 | 98 | 92 | 99 | 90 | 71 | 79 | 77 | 78 | 73 |
| DTP3/Penta3 | 68 | 79 | 68 | 58 | 68 | 98 | 85 | 81 | 85 | 60 | 72 | 70 | 72 | 67 |
| Polio3 | 65 | 75 | 66 | 58 | 65 | 83 | 78 | 76 | 92 | 75 | 76 | 63.4 | 59 | 66 |
| IPV | | | | | | | | | | | | | 66 | 64 |
| MR1 | 59 | 66 | 54 | | 17 | 19 | 58 | 66 | 80 | 65 | 64 | 76 | 63 | 64 |
| MR2 | | | | | | | | | | | | 26 | 25 | 26 |
| Rota1 | | | | | | | | | | | | 68.5 | 74 | 71 |
| Rota2 | | | | | | | | | | 40 | 55 | 60 | 68 | 66 |
| Td2+ | | | | | | | | | | | | 47.8 | 40 | 34 |

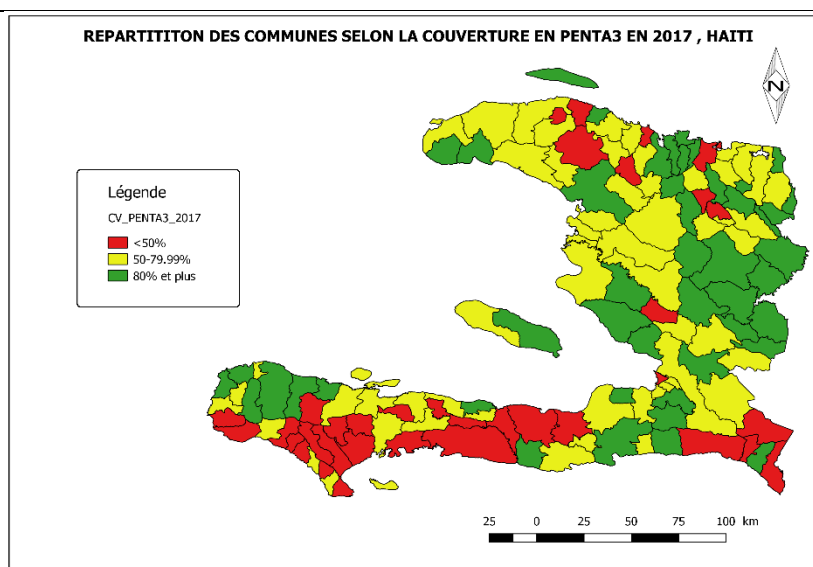
Table 3: JRF 2005-2018* data (1st quarter 2018 data)

Disparities remain between the various departments as well as between communes in the same department. Although the Penta3 immunisation coverage objective in the 2016 cMYP was set at 90% for the 140 communes, only 25% of them (35) reached that goal; 9% (12) reported coverage rates between 80 and 89%; 42% (59) have a rate between 50 and 79%; and 24% – the 34 remaining communes – still have a coverage rate below 50%. According to available data for the 2017 period, we note that in the communes of Aire Métropolitaine, Artibonite, and those in West and South, there is a high concentration of unimmunised children.

| Department | BCG | Penta1 | Penta3 | IPV | Polio3 | Rota1 | Rota2 | MR1 | MR2 | Td2+ |
|--------------|--------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Aire M | 57.4% | 71.14% | 70.53% | 66.59% | 59.38% | 66.05% | 61.05% | 65.20% | 26.47% | 45.24% |
| Artibonite | 77.3% | 81.87% | 72.69% | 72.74% | 64.40% | 80.36% | 74.89% | 68.20% | 25.61% | 48.26% |
| Central | 97.3% | 110.19% | 93.90% | 89.67% | 80.58% | 96.96% | 82.90% | 74.32% | 34.14% | 62.37% |
| Grande Anse | 86.2% | 92.23% | 81.07% | 73.22% | 70.92% | 93.56% | 91.15% | 80.31% | 17.36% | 20.37% |
| Nippes | 51.2% | 55.94% | 53.52% | 52.08% | 47.81% | 54.86% | 54.57% | 50.17% | 22.71% | 20.73% |
| Nord | 70.1% | 77.58% | 73.65% | 62.14% | 54.84% | 72.23% | 64.79% | 61.90% | 19.52% | 33.76% |
| Nord-Est | 81.2% | 85.39% | 88.77% | 77.67% | 62.22% | 86.80% | 86.03% | 79.20% | 22.55% | 60.49% |
| Nord-Ouest | 56.8% | 73.04% | 67.12% | 55.33% | 54.07% | 70.47% | 62.16% | 54.88% | 24.31% | 32.93% |
| Ouest | 63.1% | 79.35% | 66.79% | 59.16% | 59.33% | 76.00% | 64.57% | 58.84% | 17.14% | 34.03% |
| Sud | 43.1% | 45.44% | 40.18% | 38.26% | 32.25% | 44.54% | 40.42% | 31.49% | 20.70% | 18.12% |
| Sud-Est | 70.8% | 90.62% | 91.08% | 80.46% | 56.78% | 88.67% | 85.15% | 70.59% | 49.99% | 43.30% |
| Haiti | 66.9% | 77.52% | 71.76% | 66.12% | 58.98% | 73.92% | 67.57% | 63.17% | 25.21% | 40.34% |

Table 4: Coverage by antigen and by department

³ 1st quarter 2018



Graph 1: Distribution of communes according to Penta3 coverage in 2017, Haiti

Legends

Coverage PENTA3 2017

<50%

50-79%

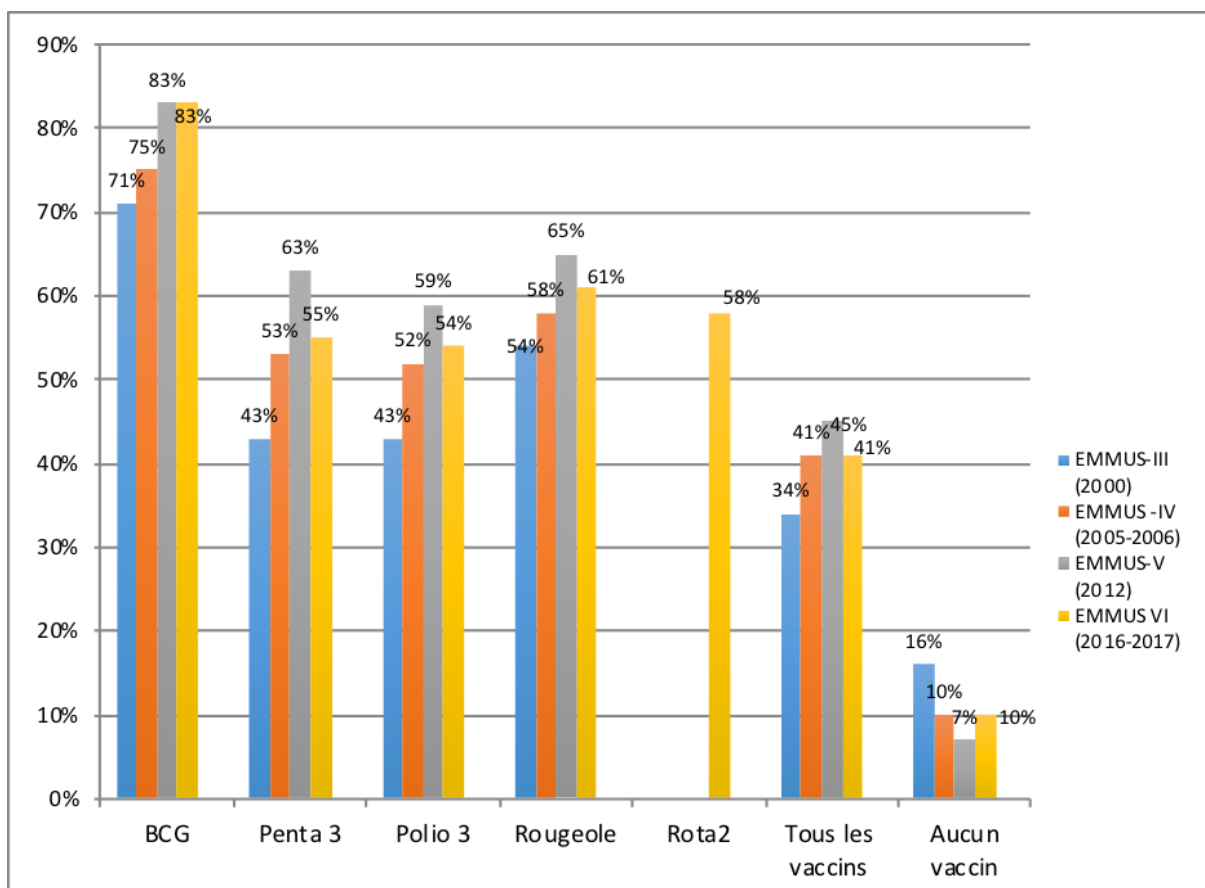
80% and higher

Review of the **Mortality, Morbidity and Use of Services Survey (EMMUS)** shows clear improvement in immunisation coverage in Haiti between 2000 (EMMUS III) and 2012 (EMMUS V), but a significant decline in coverage in 2017 (EMMUS-VI). Whatever the trend, coverage remains short of the objectives set by the country. Among immunised children aged 12-23 months, the proportion of children receiving all EPI immunisations dropped from 45% in 2012 to 41% in 2017– a 4-point drop (Graph 2).

Similarly, the proportion of children who have never been immunised increased from 7% in 2016 to 10% in 2017. More specifically:

- 83% of children aged 12 to 23 months have received the BCG vaccine
- 55% Penta3
- 38% the polio 0 vaccine dose (at birth)
- 54% OPV3
- 61% MR
- 58% Rota2

We also note the dropout between the first and third doses of the pentavalent vaccine (84% vs 55%) and the polio vaccine (84% vs 54%), and between the first and second dose of the rotavirus vaccine (73% vs 58%).



Graph 2: Evolution of immunisation coverage in children aged 12 to 23 months per the EMMUS survey from 2005 to 2017

Legends : BCG; Penta 3; Polio 3; Measles; Rota2; All vaccines; No vaccine

▪ **EQUITY IN IMMUNISATION**

Geographic disparities

- *Rural/urban*

While 50% of children living in urban areas receive all vaccines, only 37% in rural areas do. Moreover, in rural areas, 12% of children have received no vaccines, compared to 6% in urban areas who have received none (EMMUS VI, 2016-17). However, there is a difference here in absolute terms that does not reflect the more profound disparities when one looks at the high number of children who have not been immunised.

In addition to the significant differences between urban and rural immunisation coverage, Aire Métropolitaine remains an area where there is a high concentration of unimmunised children and where more than half (52%) of Haiti’s population lives. This creates and encourages an environment that favours the emergence of vaccine-preventable diseases (VPDs), especially in shanty towns. Many factors contribute to this situation: the population’s mobility, the lack of basic infrastructure in certain areas, vaccine stockouts, poor experiences had by mothers during previous immunisation sessions, and, primarily, insecurity.

| Immunisation coverage by antigen in urban and rural areas | | | | | | |
|---|-----|--------|--------|--------|----|-------|
| | BCG | Penta3 | Polio0 | Polio3 | MR | Rota2 |
| Urban | 88 | 65 | 51 | 79 | 68 | 65 |
| Rural | 81 | 50 | 31 | 66 | 58 | 54 |

Table 5: Immunisation coverage by antigen in urban and rural areas 2016-2017

- *Interdepartmental disparities*

In 2017, according to the available administrative data for Penta1 immunisation coverage, Sud (45%), Nippes (56%) and Aire Métropolitaine (71%) were the lowest performing departments. With regards to use and performance of services, Penta3 coverage rates in 2017 were lower than 80% in all departments except Centre (94%), Nord-Est (89%) and Sud-Est (91%).

When we analyse data relative to the number of children who have not been immunised with Penta3 and MR1, we note that those numbers are quite significant in **Aire Métropolitaine, Artibonite, Ouest and Sud**.

| Department | Target | 2017 | | | | | | | | |
|--------------|---------------|-----------------------|---------------|---------------|---------------|---------------|---------------|---------------|--------------|---------------|
| | | Immunisation coverage | | | Immunised | | | Not immunised | | |
| | | Penta1 | Penta3 | MR1 | Penta1 | Penta3 | MR1 | Penta1 | Penta3 | MR1 |
| Aire M | 75107 | 71.14% | 70.53% | 65.20% | 53430 | 52972 | 48971 | 21677 | 22135 | 26136 |
| Artibonite | 47640 | 81.87% | 72.69% | 68.20% | 39003 | 34629 | 32491 | 8637 | 13011 | 15149 |
| Central | 20579 | 110.19% | 93.90% | 74.32% | 22675 | 19323 | 15295 | -2096 | 1256 | 5284 |
| Grande Anse | 12914 | 92.23% | 81.07% | 80.31% | 11911 | 10470 | 10371 | 1003 | 2444 | 2543 |
| Nippes | 9446 | 55.94% | 53.52% | 50.17% | 5284 | 5055 | 4739 | 4162 | 4391 | 4707 |
| Nord | 29430 | 77.58% | 73.65% | 61.90% | 22831 | 21675 | 18216 | 6599 | 7755 | 11214 |
| Nord-Est | 11712 | 85.39% | 88.77% | 79.20% | 10001 | 10397 | 9276 | 1711 | 1315 | 2436 |
| Nord-Ouest | 20098 | 73.04% | 67.12% | 54.88% | 14679 | 13490 | 11029 | 5419 | 6608 | 9069 |
| Ouest | 36020 | 79.35% | 66.79% | 58.84% | 28583 | 24058 | 21195 | 7437 | 11962 | 14825 |
| Sud | 21372 | 45.44% | 40.18% | 31.49% | 9711 | 8588 | 6730 | 11661 | 12784 | 14642 |
| Sud-Est | 17445 | 90.62% | 91.08% | 70.59% | 15809 | 15889 | 12314 | 1636 | 1556 | 5131 |
| Haiti | 301763 | 77.52% | 71.76% | 63.17% | 233917 | 216546 | 190627 | 67846 | 85217 | 111136 |

Table 6: Immunisation coverage and number of unimmunised children per department in 2017 (DHIS2, 2017)

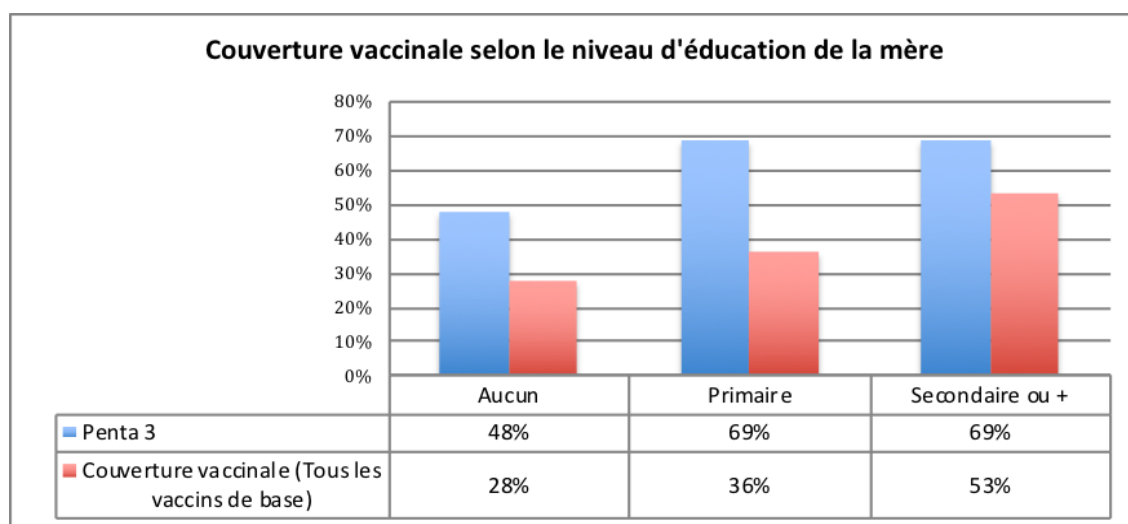
- Gender and birth order

According to survey data (EMMUS 2016-2017), 44% of girls and 38% of boys have received all basic vaccines. For Penta3, for example, 59% of girls have been immunised as have 52% of boys.

Birth order seems to influence parental decisions on immunising their children, with immunisation coverage falling from 48% for the first born to 29% for the sixth or last born – for all vaccines.

- Mother's education level

The profile of children who have not been immunised seems to be influenced by the mother's education level. The proportion of children who have been fully immunised rises with the mother's education level, increasing from 28% for those whose mothers have no education, to 36% for those whose mothers have a primary education, and 53% for those whose mothers have the equivalent of a secondary education or higher (EMMUS VI).

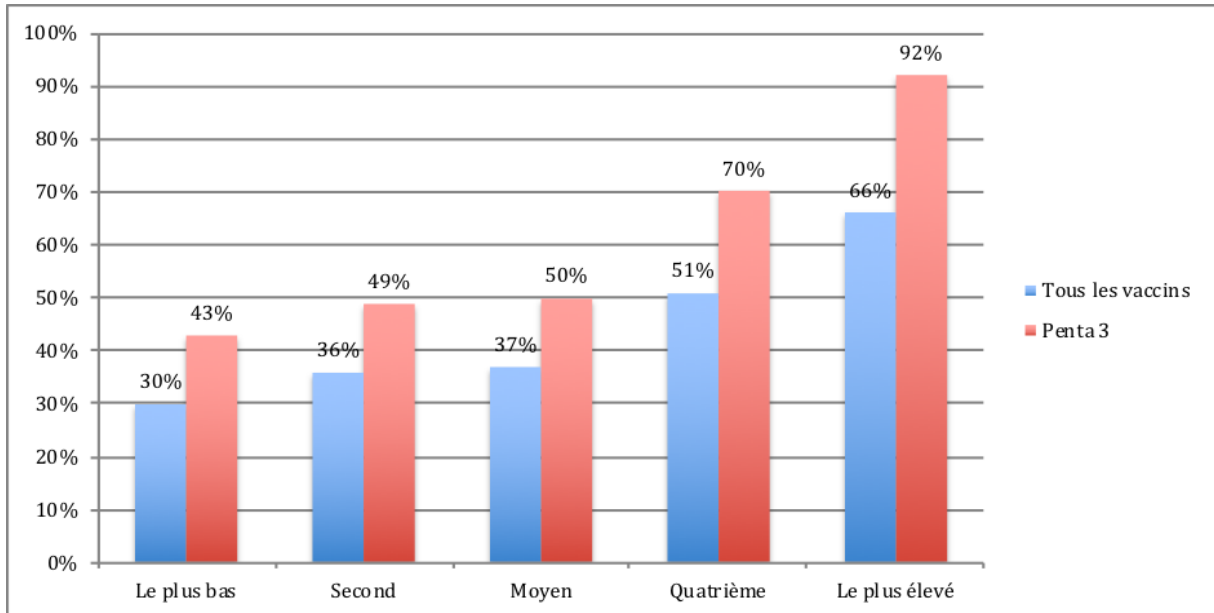


Graph 3: Immunisation coverage according to mother's level of education (EMMUS VI-2016-2017)

Legends: Penta 3 None Primary Secondary or higher
 Immunisation coverage (all basic vaccines)

▪ *Economic status*

Survey data show that a child is more likely to be immunised if their family falls into a high wealth quintile. The higher the wealth quintile, the higher the immunisation coverage (EMMUS 2016-2017).

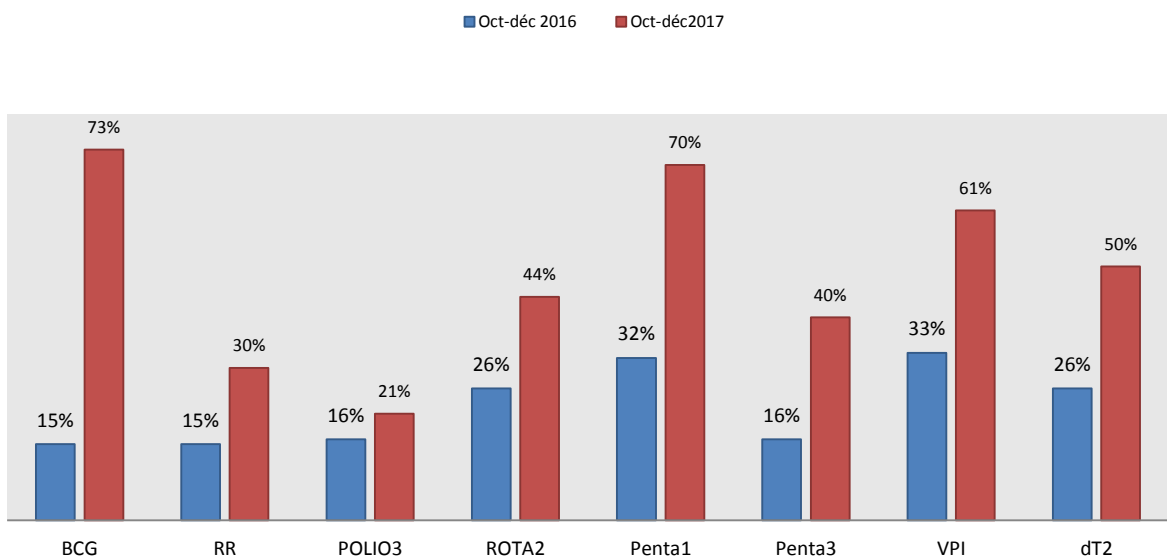


Graph 4: Immunisation coverage according to wealth quintile (EMMUS VI-2016-2017)

Lowest quintile Second quintile Middle quintile Fourth quintile Highest quintile All vaccines Penta3

Situation specific to Cité Soleil

Following the identification of low immunisation coverage in the commune of Cité Soleil, UCNPV requested and obtained Gavi assistance to study the situation and propose a service model. A five-phase model was proposed, a three-month action plan was developed and the communal health committee was reactivated.



Graph 5: Comparison of Cité Soleil immunisation coverage from 2016 to 2017

Oct – Dec 2016 Oct – Dec 2017

| FACILITES | TARGET | BCG | IPV | Penta1 | Penta3 | Rota1 | Rota2 | Polio2 | MR |
|---------------|--------|------|------|--------|--------|-------|-------|--------|-----|
| Lumière | 368 | 64% | 50% | 73% | 74% | 86% | 91% | 70% | 66% |
| Fontaine | 2257 | 24% | 18% | 23% | 23% | 22% | 22% | 17% | 18% |
| MISSEC | 812 | 3% | 0% | 4% | 6% | 4% | 4% | 4% | 9% |
| St-François | 280 | 49% | 0% | 108% | 72% | 119% | 80% | 67% | 60% |
| Rosalie Rendu | 1590 | 151% | 137% | 162% | 90% | 136% | 90% | 130% | 82% |
| MIJ | 283 | 331% | 93% | 87% | 58% | 89% | 59% | 33% | 14% |
| Pèlerin | 280 | 73% | 85% | 123% | 109% | 110% | 94% | 83% | 46% |
| CHOSCAL | 2936 | 16% | 6% | 8% | 7% | 7% | 7% | 5% | 4% |
| CHAPI | 1468 | 27% | 27% | 21% | 34% | 20% | 22% | 24% | 29% |

Table 7: Performance of nine facilities from January to December 2017

▪ **Surveillance of MR, congenital rubella syndrome, neonatal tetanus and acute flaccid paralysis**

A significant increase of VPD cases was observed in 2013, the year the project task force for strengthening epidemiological surveillance of VPDs began. This project ended in 2015 but VPD surveillance continues in all of the country’s health regions. Even though objectives for the expected suspected cases of MR, congenital rubella syndrome (CRS) and acute flaccid paralysis (AFP) were not usually reached, it should be noted that there was an improved notification rate for MR in 2018. Most importantly, up to the present, no cases of MR or CRS have been confirmed.

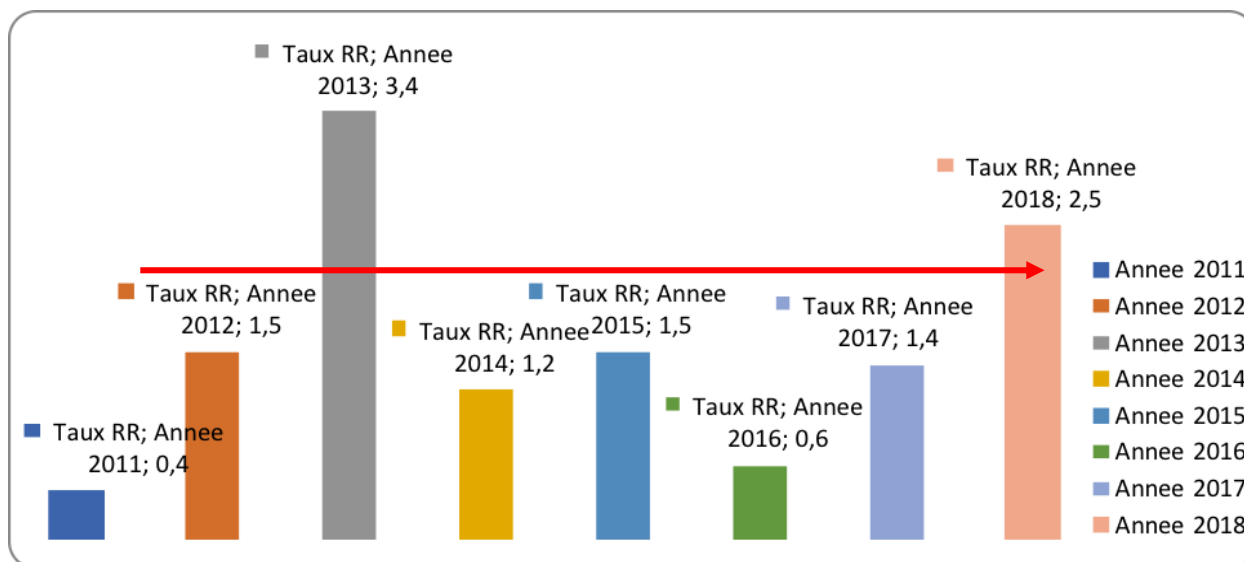


Table 8: Incidence of suspected cases of MR per 100,000 residents, Haiti 2011-2018* (>2/100 000 residents)

*Through the 23rd epidemiological week

Blue: MR Rate; 2011; 0.4
 Red: MR Rate, 2012; 1.5
 Grey: MR Rate; 2013; 3.4
 Yellow: MR Rate; 2014; 1.2
 Blue: MR Rate; 2015; 1.5
 Green: MR Rate; 2016; 0.6
 Light blue: MR Rate; 2017; 1.4
 Pink: MR Rate; 2018; 2.5

Annee = Year

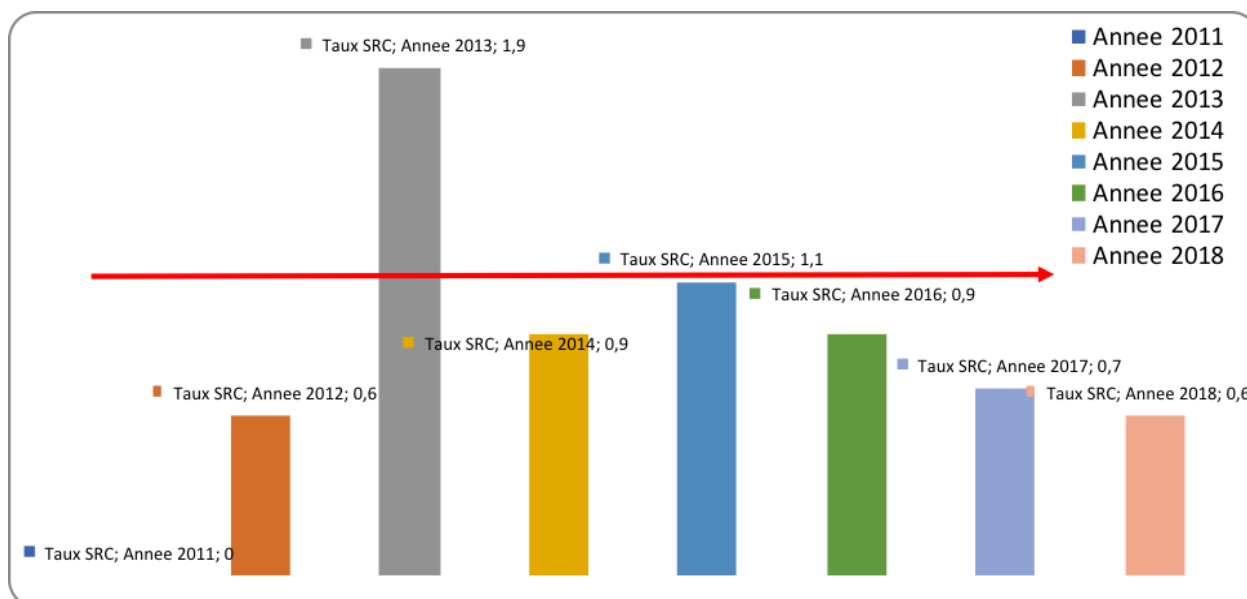


Table 9: Incidence of suspected cases of CRS per 10,000 residents, Haiti 2011-2018* (>1/100 000 live births)

*Through the 23rd epidemiological week

Blue: CRS Rate; 2011; 0
 Red: CRS Rate; 2012; 0.6
 Grey: CRS Rate; 2013; 1.9
 Yellow: CRS Rate; 2014; 0.9
 Blue: CRS Rate; 2015; 1.1
 Green: CRS Rate; 2016; 0.9
 Light blue: CRS Rate; 2017; 0.7
 Pink: CRS Rate; 2018; 0.6

Annee = Year

| Year | Suspected cases of MR* | Population | National Notification Rate |
|--------|------------------------|------------|----------------------------|
| 2012 | 129 | 10,644,927 | 1.2 |
| 2013 | 383 | 10,937,675 | 3.5 |
| 2014 | 127 | 11,094,444 | 1.1 |
| 2015 | 170 | 11,550,387 | 1.5 |
| 2016 | 62 | 11,870,966 | 0.5 |
| 2017 | 171 | 12,201,338 | 1.4 |
| 2018** | 138 | 12,542,135 | 2.5 |

Table 10: Suspected cases of measles and rubella reported per year and 2012-2018 reporting rate

*MR: Measles/Rubella; ** through the 23rd epidemiologic week

| Departments | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018* |
|-------------|------|------|------|------|------|------|-------|
| Artibonite | 1.1 | 1.8 | 0.6 | 0.4 | 0.3 | 0.4 | 4.0 |
| Central | 1.0 | 10.2 | 1.5 | 3.2 | 1.0 | 1.4 | 0.5 |
| Grande Anse | 1.6 | 3.6 | 1.0 | 2.0 | 1.5 | 0 | 0.0 |
| Nippes | 0.0 | 5.5 | 1.1 | 3.3 | 2.3 | 4.7 | 6.0 |
| Nord | 3.5 | 3.8 | 1.3 | 2.3 | 1.2 | 4.5 | 4.1 |
| Nord-Est | 1.8 | 13.1 | 2.3 | 1.8 | 0.0 | 1.3 | 1.0 |
| Nord Ouest | 0.0 | 2.5 | 1.8 | 1.8 | 0.4 | 0 | 0.5 |
| Ouest | 0.7 | 1.6 | 0.4 | 1.1 | 0.3 | 1.6 | 2.9 |
| Sud | 0.0 | 6.0 | 3.7 | 1.3 | 0.0 | 0.3 | 1.1 |

| | | | | | | | |
|---------|-----|-----|-----|-----|-----|-----|-----|
| Sud Est | 4.1 | 3.3 | 2.1 | 2.1 | 0.4 | 1.0 | 0.3 |
|---------|-----|-----|-----|-----|-----|-----|-----|

Table 11: Notification rate for suspected cases of MR, per department
*Through the 23rd epidemiologic week

- **Insufficient human resources in terms of quantity and quality**

A shortage of qualified personnel at all levels is a significant impediment to a good performance of the immunisation system. At the central level, there are an estimated 30 employees and one quarter of these do not meet minimum requirements, which harms programme management and execution. At the departmental level, the human resources problem remains significant but it is less critical than at the local level. In 4 out of 10 departments, the majority of EPI services are coordinated by an experienced nurse who is supported by two assistants. At the local level, and specifically in facilities, there is not sufficient personnel to provide high-quality services. In general, we note a work overload for the nursing assistant who is responsible for all components of the Basic Package of Services. In addition, there is a significant need for PCHWs who serve as intermediaries between the population and healthcare facilities. When possible, these workers will be integrated into the Family Health Teams (ESFs) to provide basic care, including immunisation, and to do so in compliance with the model of organising integrated and comprehensive healthcare services for Haitian families. Out of the 5,400 PCHWs required to reach the quota of 1 PCHW per 2,000 residents, only an estimated 3,960 have been trained by the EPI.

- **Supply chain and cold chain difficulties**

The central level is responsible for delivering vaccine and supplies to the departments on a quarterly basis and departments supply facilities monthly, with exceptions. However, we note that quarterly supply does not always occur in Artibonite, Ouest and Aire Métropolitaine, specifically because of their low storage capacity. In certain cases, the lack of vaccine availability due to stockouts (in the case of the oral bivalent polio vaccine) prevents a uniform quantity of vaccines from being distributed or deadlines from being met.

The challenges related to distribution from the departmental level to facilities are linked, among other factors, to a lack of appropriate transport and to the low levels of funding assigned to the distribution budget. Funding is not sufficient to meet the needs expressed by the departments. In addition, not every department has a distribution plan and this leads to stockouts or overstock in certain facilities. Cold chain discontinuity recurs at the facility level. Even though we estimate that around 89% of healthcare facilities have sufficient capacity to store routine vaccines, the vast majority of them have refrigerators that operate using propane gas and are hard to supply (lack of available propane gas and transport). Despite training provided to cold chain technicians, other constraints related to cold chain equipment repair and maintenance remain (for example, difficulties in using logistical management tools and the availability of spare parts).

- **Bottlenecks linked to service provision**

The shortage of qualified human resources impedes the provision of daily routine immunisation services. In most health facilities, immunisation services are offered one time per week, and in some others, one time per month. At the community level, only 7 out of 10 facilities (71%) offer immunisation services and approximately 6 out of 10 facilities (58%) offer all basic childhood vaccines (DTP/pentavalent, polio, measles, BCG). In terms of immunisation service frequency, approximately 6 out of 10 facilities (58–61%) provide the polio, pentavalent and DTP vaccines at least five days per week, and 22% only one or two days per week. Finally, only 50% of private facilities offer immunisation services according to the results of the Assessment of Healthcare Service Offerings (EPSSS, 2013).

Geographic accessibility is another major constraint to immunisation services. The mountainous terrain in the rural regions of Haiti hampers families from going to healthcare facilities. The EPSSS notes that more than half of the population lives at least 5 km from a healthcare facility and several isolated communities are inaccessible by car or motorbike and have no service providers. In the disadvantaged urban areas that are, a priori, physically accessible such as Cité Soleil, there is a “social distance” between the service providers and parents who are often busy with their daily work during hours when immunisation is offered.

- **Creating demand/community mobilisation**

The Knowledge-Attitude-Practices (KAP) survey conducted in 2012 (MSPP, UNICEF and GENESIS-GSIS, 2013) and the analysis of barriers to high, sustainable and equitable immunisation coverage in Haiti (MSPP, 2013) identified various challenges to creating demand for immunisation that could be resolved by implementing efficient communication strategies. Despite the drafting of a communication plan in 2014,

implementation and monitoring of activities has not been carried out in a systematic way due to the lack of available funding for this type of activity.

Factors contributing to increased dropout rates include: the lack of local communication strategies to educate the population about the benefits of full immunisation and following the immunisation calendar; the absence of, or inadequate interpersonal communication activities between the service provider and parents; the negative experience certain parents have had in terms of the technical and impersonal quality of services (services not being available the day of the visit, long wait times, a poor welcome); the failure to disseminate messages encouraging routine immunisation in the communes; and the lack of information on the importance of vaccines, complete doses and vaccine side effects. While it is acknowledged that campaigns can be activities above and beyond the routine programme and as such, engender an additional workload or cause certain programme activities to be displaced, communications produced during campaigns contribute to the EPI's strengthening. Communication mobilises the community around immunisation in general, strengthening the training of service providers and contributing to an improved supply chain.

▪ **Risks related to management and coordination**

In Haiti, there is no law on immunisation nor any formal national policy defining a vision, funding strategies or EPI governance. There are no regulations providing sanctions for not having children fully immunised before they start primary school (cMYP, 2016-2020). As for funding, the most significant national contribution is the MSPP's shouldering the cost of salaries of personnel at public facilities and service providers at the level of mixed healthcare facilities.

The EPID is the MSPP entity responsible for managing the EPI and its leadership is crucial to coordinating entities like the ICC and the TC-EPI. In addition, the EPID's efficiency in managing and coordinating activities in the departments, communes and health facilities depends on effective endorsement by other levels of the healthcare system and improvements in immunisation coverage. However, many factors such as a lack of technical personnel and the dependence on external funds contribute to weakening the EPID leadership and its endorsement of the programme (cMYP, 2016-2020).

Moreover, there are no formalised partnerships between the EPI and organisations in civil society such as the Haitian Society of Pediatrics, the Haitian Red Cross and the Haitian Platform for Civil Society Organisations to Strengthen Immunisation. However, in addition to being members of the ICC, these organisations contribute to carrying out supplementary immunisation activities, and sometimes to their funding.

In accordance with the cMYP 2011-2015, every year, the EPID develops annual operational plans and facility microplanning at the department level, jointly with programme partners, healthcare facilities and representatives from the local communities. However, between 2011 and 2017, plan development was not completed within the deadline. When implementation finally occurred, immunisation activity monitoring was very difficult to carry out as planned.

At the national level, twice-yearly monitoring meetings for the annual operational plans have been held (one per year on average) but the time spent on these activities hampers the conduct of a proper analysis of the EPI situation and taking the corrective measures required for efficient programme management at the operational level.

At the departmental level, organising quarterly monitoring meetings with the participation of managers from all service facilities remains a challenge. This is due mainly to a lack of technical support at the central level, weak rates of prompt statistical reporting as well as the overlap of activities between the central and departmental levels. This affects the calendars and the timely implementation of monitoring activities.

The EPI uses administrative immunisation coverage data and has regularly conducted demographic surveys, such as the EMMUS. The preliminary report of the last EMMUS VI (2016-2017) was made available at the beginning of 2018. Significant challenges remain in terms of data collection, how information is shared up the chain from facilities to departments and then onto the central level, as well as data validation. The lack of available quality data constrains planning and efficient decision-making, thereby not encouraging the emergence of strategies to improve immunisation coverage and equity in Haiti.

3.1. Data

The programme experienced major changes from 2016 to 2017. The MSPP decided to use a single database to manage health-related information, DHIS2. Information related to immunisation activities is collected using various available tools and support at all levels of the system. The data gathered during immunisation sessions at facilities or in communities (meeting places) are then transmitted to the health department (sometimes by way of the commune) by facility managers. Through 2016, this information was

entered at the departmental level into an EPI database (SISPEV), then transmitted to the EPID for analysis at the national level. Since the start of 2017, the EPI data management system has been officially integrated into the SISNU (DHIS2). This is a national database that takes all national health programmes into account. However, for various reasons (compatibility problems between the existing EPI collection tools and SISNU database, lack of available personnel and manager training, problems connecting to the internet), this transition has not yet been completed for the EPI. For example, January 2017 EPI data were not integrated into the DHIS2 because, contrary to the new database's requirements, they were not disaggregated by gender. Therefore, some data from departments in Grande Anse, Sud and Nippes were not available in the DHIS2 platform. In addition, report completion (76% in 2017 against 82% in 2016) was estimated on the basis of 765 [facilities] that provide immunisation services. Beginning in September 2017, some actions have been taken to ensure consistency between SISPEV and SISNU. A training workshop addressing quality immunisation monitoring was conducted for EPID, DELR and UEP managers with regional level technical support from OPS and the WHO in Geneva.

3.2. Immunisation funding

- A situational review undertaken by EPID shows that vaccine funding and supply are very dependent on external aid. Furthermore, the lack of legislation on immunisation does not encourage access to additional funding.
- However, it should be noted that the 2017-2018 immunisation budget for vaccines sent out in 2018 was endorsed by the parliament in October 2017. Yet, 2019 doses are not yet guaranteed because they will be evaluated during the next budgetary exercise planned for June 2018 (for the 2018-2019 fiscal year). The co-financing of new vaccines, including PCV-13, has also been approved in the 2018 budget.
- In addition, there are often unexplained funding problems within MSPP's financial management procedures, a situation that leads to recurring problems with disbursements. A commitment by all partners, the Directorate of Administration and Budget, other concerned directorates and all other entities within the MSPP, is required if financial management of the EPI is to be improved.

PERFORMANCE OF GAVI SUPPORT

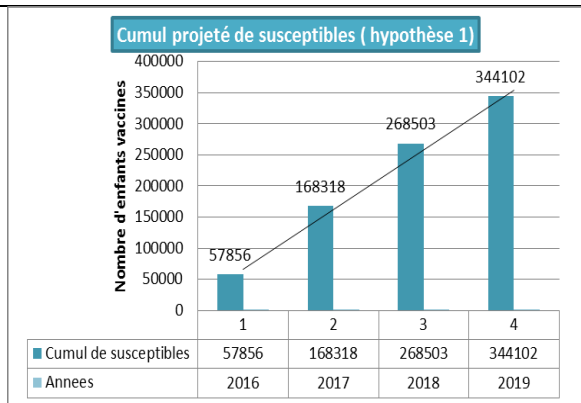
3.3. Performance of vaccine support

- **Global implementation progress of Gavi support for vaccines**

The goal of Gavi support for immunisation programmes in Haiti provided through HSS funds is to contribute to and maintain immunisation coverage throughout the country and reduce child morbidity and mortality due to VPDs. The Gavi grant has allowed new vaccines to be introduced into Haiti's immunisation calendar, including vaccines against meningitis, pneumonia and other infections related to *Haemophilus Influenzae* type b, hepatitis B (pentavalent vaccine introduced in 2012), against diarrhoea caused by the rotavirus (introduced in 2014), and the injectable polio virus (2015). The introduction of PCV-13 is planned for the last quarter of 2018.

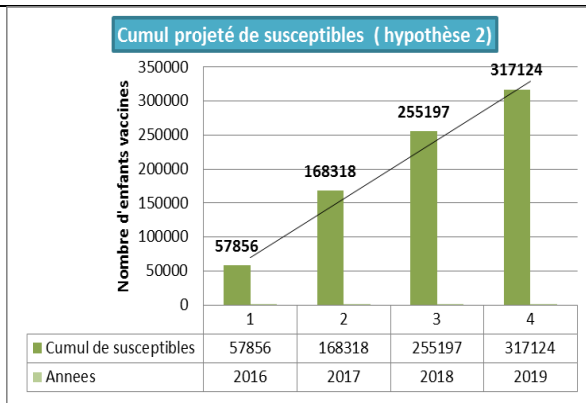
- **Measles/rubella analysis**

Haiti has been certified as a country free of endemic transmission of the MR virus. No imported cases of measles or rubella have been reported since certification. However, like other countries in the Americas, Haiti is constantly at risk of importing and reintroducing the virus and this could undo the progress made in recent years. Therefore, conducting high-quality follow-up campaigns for MR is a basic strategy for attaining equitable levels of immunity within the population. As reported in Haiti, MR coverage has not reached 95% (coverage: 64–80% per administrative data) for the past five years for the first dose of MR. Furthermore, in 2016, the country introduced the second dose of MR and coverage was 26%. Thus, Haiti has periodically conducted follow-up campaigns aiming to reduce the number of people susceptible to MR and prevent transmission to adolescents and young adults who have not been immunised. Even though the 2016 follow-up campaign contributed to a significant reduction in the number of those susceptible, cumulative since 2012, projections calculated using coverage rates recorded by the routine programme in 2016 and from January to October 2017 show that by 2019, even with optimistic assumptions (see graphs below), the number of those who are susceptible will be equal or close to a cohort of new-borns.



Graph 1: Susceptible individuals - Assumption #1: coverage rates projected for children aged 1 year and younger for MR: 2017, 2018, 2019 respectively: 75%; 80%; 90%

Cumulative projected susceptible individuals (assumption 1)
 Number of immunised children
 Cumulative susceptible individuals
 Years



Graph 2: Susceptible individuals - Assumption # 2: coverage rates projected for children aged less than one year for MR: 2017, 2018, 2019 respectively: 75%; 85 %; 95%

Cumulative projected susceptible individuals (assumption 2)
 Number of immunised children
 Cumulative susceptible individuals
 Years

- **Primary actions for Gavi vaccine support for the coming year**
 - Introduction of PCV-13 vaccine:
 - Begin planning for MR campaign scheduled for 2019
 - Implement annual Gavi-HSS2 action plan (see annex)

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

- **Progress on implementation of HSS grant against objectives and budget**

For 2017, the HSS grant retained the three strategic axes used in the initial proposal. At the request of the MSPP, some activities were redirected or reformulated according to the context and the routine EPI situation. This rearranging of activities primarily concerned improving programming capacity and monitoring, and immunisation services at the three levels of the health system. It was also geared to strengthening access to, and organising, immunisation services. This reorientation contributed to removing barriers associated with weak supervision and expanding service offerings, including outreach immunisation to reach the target population that does not spontaneously use services offered by health facilities.

The MSPP places a particular emphasis on expanding the community health service model, using ESFs to carry out community-based immunisation activities.

The table below illustrates the distribution of the 2017 budget as defined during the TC-EPI meeting that took place at the beginning of 2017.

| Objectives | Budget 3 rd tranche 2017 | Total 3 rd tranche |
|--|-------------------------------------|-------------------------------|
| Improve capacity of planning and monitoring of immunisation programme and services at the three levels of the system | 312,109 | 28 |
| Strengthen the EPI information system | 120,424 | 11 |
| Strengthen access to and organisation of immunisation services | 693,673 | 62 |
| Total 3rd tranche | 1,126,206 | 100 |

Table 12: Distribution of 2017 budget according to the three strategic objectives

The funds for the third tranche allocated for conducting the activities noted in the action plan were transferred using letters of agreement (13) signed by DHDs and MSPP. To date, seven letters of agreement have been completed (finalised from an administrative and accounting perspective). The others are in the final report stage. It should be noted that some activities, such as coordination meetings, central level missions to the departments, supply missions and the purchase of supplies, have been paid for by OPS using Gavi funds.

The Sud department was not able to benefit from Gavi support in 2017 due to administrative difficulties encountered when submitting previous reports.

• **Achievements vis-à-vis agreed targets:**

Principal Results

- First quarter 2018:
 - ✓ The 2018 EPI central level operational plan was developed
 - ✓ All 10 departments have submitted their annual operational plans to UCNPV
 - ✓ 8 out of 10 departments updated their facility microplans (updated targets) and held monitoring sessions and planned supervisions
- Of the 140 communes receiving grant funds:
 - ✓ 87% (122) benefited from Gavi funds according to the final 2017 UCNPV report
 - ✓ 24% (34) had Penta3 coverage above 95%, 14% (20) had coverage higher than 80% and the remaining 33% (46) had coverage between 50% and 79%.
- Of the 301,360 children aged under 1 year in the target population:
 - ✓ 28% (85,069) did not receive Penta3
 - ✓ 22% (67,712) did not receive Penta1
 - ✓ 72% (110,949) did not receive MR1
- For supplementary immunisation activities, three rounds took place in 27 prioritised communes in 8 departments benefiting 101 facilities and a target population of 30,473 infants aged under 1 year.
- Between 2017 and the 1st quarter of 2018, results related to improving access and organising immunisation services were as follows:
 - ✓ In 2017, the operational costs of 400 PCHWs and 26 AIPs (Ennery, Croix des Bouquets, Cité Soleil and Carrefour) were covered. The 400 PCWHs and 26s AIPs benefited from training on EPI standards and procedures.
 - ✓ In 2018, operational costs, supervision and training of 689 ESF members in eight communes in Ouest (Croix des Bouquets, Carrefour, Cité Soleil, Port au Prince, Pétiion Ville, Delmas, La Gonâve and Kenscoff) and 25 in Artibonite (Ennery, Raboteau, and Gonaïves) are being covered.
- Other activities related to expanding the model, such as community meetings, strengthening health committees and creating a network for facilities, activities planned for the ESFs in the Aquin commune, have not yet been carried out due to DHD administrative difficulties.

Disbursement status

- ✓ In February 2017, the third and last Gavi HSS grant tranche was disbursed in the amount of US\$ 1,126,206.
- ✓ Delays in submitting reports and justifications for funds transferred to beneficiaries in 2016 led to delays in processing letter of agreement signatures with DHD and MSPP for 2017. This situation had an impact on carrying out activities that had been planned and that were finally started in June.
- ✓ In May 2018, the execution of funds corresponded to 57.4% of the amount of the third tranche (US\$ 1,126,206 disbursed in 2017) and to 86% of the total amount of the total Gavi HSS1 grant, which is US\$ 3,299,875.00.

Considering the fund expiration date of June 2018, the MSPP, in agreement with its partners, decided it was wise to proceed with a request for an extension without fees, through December 2018.

Objective 1

| | |
|--|--|
| HSS grant objective (in compliance with HSS or PSR proposals) | To improve programme planning and monitoring capacity and immunisation services at the three levels of the system |
|--|--|

| | |
|---|--|
| <p>Geographic groups/priority population or constraints on coverage or equity addressed by the objective</p> | <p>Beneficiaries:</p> <ul style="list-style-type: none"> ▪ Administrative entities: UCNPV, DELR, 10 DHDs ▪ Geographic entities: 10 departments, 140 communes, 765 health facilities that provide immunisation ▪ Priority population: 301,763 surviving children and 360,314 pregnant women for 2017 |
| <p>% of activities conducted/budget utilisation</p> | <ul style="list-style-type: none"> ▪ Available budget: US\$ 312,108.00 (28% of the total budget for the third tranche 1, US\$ 126,306.00) ▪ Activities launched: <ul style="list-style-type: none"> - Around 80% of supervision activities were led at the departmental level - 90% of operational plans at the departmental level were developed - 76% of facilities updated the microplans |
| <p>Major activities implemented and review of implementation progress, including key successes and outcomes/activities not implemented or delayed/financial absorption</p> | <p>Microplanning: Holding of an integrated microplan update workshop in every department with the manager of each facility and a community representative</p> <p>In 2017, funds were made available to DHDs to create facility microplans with the following objectives: Update population data Define strategies and activities to be carried out Make the adjustments necessary per each facility's service limits</p> <p>Supportive supervision for EPI personnel from the central level to the departments and from the departments to the health facilities:</p> <p>From the central level to the department: at the end of 2017, 100% of DHDs had received at least two supportive supervision visits. Nevertheless, feedback and follow-up on recommendations did not take place.</p> <p>From the department to the health facilities: nine integrated missions of five days each were planned and funds were allocated to pay for team per diems. All departments except for the HDD carried out these missions using the allocated funds, most as part of a departmental supervision plan.</p> <p>To guarantee the means of transport to conduct missions, funds were transferred for maintenance, fuel and repair of vehicles, five of which belong to the UCEPI. However, due to transport shortages, vehicles were rented to support implementation of this activity.</p> <p>To strengthen human resource capacity for supervision, funds were made available to recruit six EPI technical assistants and three cold chain technicians as well as consultants assigned as follows: Assistants: EPID (1) DSO (2), DSA (1), DSSE (1), DSNO (1) Cold chain assistants for EPID (1), DSA (1) and DSNE (1) A national EPI consultant was recruited to support UCNPV management An international consultant was recruited to develop a new proposal for the Gavi HSS2 grant</p> |
| <p>Major activities planned for upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance)</p> | <p>Continue supervision missions from the central level to the departments (two missions are planned to take place by December 2018). Continue supervision missions from department level to the health facilities (at least one supervision visit).</p> <p>A funds expansion request is in process to ensure activity continuity</p> |
| <p>Objective 2:</p> | |
| <p>HSS grant objective (in compliance with HSS or PSR proposals)</p> | <p>To strengthen the EPI information system</p> |
| <p>Geographic groups/priority population or</p> | <p>Beneficiaries:</p> <ul style="list-style-type: none"> ▪ Administrative entities: UCNPV, DELR, 10 DHDs |

| | |
|--|---|
| constraints on coverage or equity addressed by the objective | <ul style="list-style-type: none"> ▪ Geographic entities: 10 departments, 140 communes, 765 health facilities that provide immunisation ▪ Priority population: 301,763 surviving children and 360,314 pregnant women for 2017 |
| % of activities conducted/budget utilisation | <ul style="list-style-type: none"> ▪ Available budget: US\$ 120,424.00 (11% of total budget for the third tranche 1, US\$ 126,306.00) ▪ Activities launched: <ul style="list-style-type: none"> - Around 76% of monitoring activities are launched at the departmental level |
| Major activities implemented and review of implementation progress, including key successes and outcomes/activities not implemented or delayed/financial absorption | <p>Monitoring quarterly EPI indicators</p> <ul style="list-style-type: none"> - 9 out of 10 departments have conducted at least one of the two sessions that were planned for quarterly EPI monitoring at the health facility level (immunisation and epidemiological surveillance), except for Sud which has not yet received the funds. - Two monitoring meetings were conducted in June 2017 and the beginning of 2018. - In 2017 and the first quarter of 2018, a dependable internet connection was installed at UCNPV to facilitate the circulation of information. In addition, computer equipment and other equipment was made available to the programme - Update tool training activities in nine DHDs. |
| Major activities planned for upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance) | <ul style="list-style-type: none"> - Continue monitoring activities (at least one monitoring session in each department with all IS) - Renew EPID's internet connection - Organise two review meetings at the national level - Complete training on updated data collection tools <p>A funds expansion request is in process to ensure activity continuity</p> |
| Objective 3: | |
| HSS grant objective (in compliance with HSS or PSR proposals) | To strengthen access to and organisation of immunisation services |
| Geographic groups/priority population or constraints on coverage or equity addressed by the objective | <p>Beneficiaries:</p> <p>Administrative entities: UCNPV, DELR, 10 DSDs</p> <p>Geographic entities: 10 departments, 140 communes, 765 health facilities that provide immunisation</p> <p>Priority population: 301,763 surviving children and 360,314 pregnant women for 2017</p> |
| % of activities conducted/budget utilisation | <p>Available budget: US\$ 673,693.00 (62% of total budget for the third tranche 1, US\$ 126,306.00)</p> <p>Activities launched:</p> <p>80% of communes (24 out of the 34 targeted) have conducted SAVs</p> <p>150% of supply missions from the central level to the departments (six out of the four that were planned)</p> <p>99% of activities outlined in the strengthening plan for Cité Soleil were carried out</p> |
| Major activities implemented and review of implementation progress, including key successes and outcomes/activities not implemented or delayed/financial absorption | <p>Contribute to operational costs for community expansion of the services provided by PCHWs</p> <p>The operational costs for 400 PCHWs and 26 AIPs (Ennery, Croix des Bouquets, Cité Soleil and Carrefour) were covered as were those of immunisers and social mobilisation workers. This was part of the implementation of accelerated activities for immunisation as well as other activities related to expanding the service model for organising health services such as community meetings, strengthening health committees and the implementation of a facility network.</p> <p>After the MSPP took charge of 1,114 PCHWs, the HSS-Gavi grant continued to reinforce expansion of the community health model, strengthening ESFs in the communes of Croix des Bouquets, Carrefour, Cité Soleil, Port au Prince, Pétiou</p> |

Ville, Delmas, La Gonâve and Kenskof in Ouest; and Ennery, Raboteau and Gonaïves in l'Artibonite.

The DHDs in Sud were not able to carry out any activity due to problems justifying use of funds.

Training of family health teams in the EPI

During 2017, a total of 477 PCHWs and 33 target assistant nurses were trained in EPI standards and procedures to improve service offerings at the community level and make the Basic Package of Services effective in the communities of Ennery (Artibonite), Aquin (Sud), Croix des Bouquets, Cité Soleil and Carrefour (Ouest).

Within the same framework, training is currently in progress for 652 PCHWs, 21 AIPs and 17 ICs in the Ouest department; and 14 PCHWs, 9 AIPs and 2 ICs in Artibonite. Training for 33 PCHWs, 2 AIPs and 2 ICs has also been scheduled in Nippes.

A manual on EPI standards and procedures was developed and distributed during the training

Equipment was made available to the ESFs and funds for strengthening information management and activity supervision conducted by the ESFs were allocated

Funds were transferred to the departments to implement acceleration activities in 27 communes: Artibonite (6), Ouest (4), Grand d'Anse (1), Nippes (4), Nord (4), Nord' Est (3), Nord' Ouest (2), and Sud 'Est (3); 7 communes initially slated in the Sud department were not able to carry out activities due to problems justifying use of funds.

Vaccine and input supply

Six supply missions against four initially planned were carried out in the nine CDAs, BCSs, UAS, UCS and DSO facilities. Three supply missions from the central level to the CDAs must be conducted between July and December 2018. To ensure supply from the departmental level to the health facilities, funds must be allocated to the departments and there must be support for making vehicles from UNICEF available.

In terms of supply from the departmental level to the facilities, as well as support in the form of vehicles provided by UNICEF, financial support was provided to supply health facilities.

In addition to Gavi-HSS funding, the CCEOP project contributed to cold chain strengthening.

Develop innovative strategies in urban areas (high concentration of the population)

A plan to strengthen immunisation operations was carried out in the last quarter of 2017 in the commune of Cité Soleil. This activity was implemented by the DSO, commune leaders and nine health facilities that offer immunisation services: with a significant improvement in coverage for all antigens; active community participation and a community health committee; the strengthening of nine facilities; monitoring and supervision of the DSO and BCS; and systematic supply.

The table below shows the comparative coverage results for the October-December 2016 and 2017 periods. Immunisation coverage experienced overall improvement.

| | BCG | Penta1 | Penta3 | OPV3 | IPV | Rota1 | Rota2 | Td2 |
|-------------|-----|--------|--------|------|-----|-------|-------|-----|
| 2016 | 15 | 32 | 16 | 16 | 33 | 32 | 26 | 26 |
| 2017 | 73 | 70 | 70 | 21 | 61 | 70 | 44 | 50 |

During this initiative, a coverage survey was conducted by DSO and DELR; these results are not yet available.

Major activities planned for upcoming period
(mention significant changes/budget reallocations and associated needs for technical assistance)⁴

- Continue to cover operational ESF costs in the communes of Ennery (Artibonite), Aquin (Sud), Croix des Bouquets, Cité Soleil and Carrefour (Ouest).
- Conduct three supply missions by December 2018.
- Support the departments as they supply inputs and vaccines to facilities.

A funds expansion request is in process to ensure the continuity of activity.

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

• **Activity implementation progress**

- Develop equipment deployment plan by department
- Transmit list of refrigerator deployment to Copenhagen
- Contingency plan
- Hold cold chain committee meetings
- Install 191 solar refrigerators
- Validate work installations for each MSPP team
- Develop a collection and monitoring database and temperature reading and alarm reading databases
- Train 20 cold chain technicians

As part of the CCEOP project, 191 refrigerators were installed in various departments between October 2017 and February 2018, which enabled partial resolution of the recurring problems linked to vaccine availability, frequent propane gas stockouts, dependability and accessibility. In this context, priority was given to the following facilities:

- 35 SDD solar refrigerators in operational EPI facilities not in possession of a cold chain unit
- 63 SDD solar refrigerators were installed in facilities using household refrigerators – refrigerators that were not prequalified by OPS-UNICEF
- 93 SDD solar refrigerators were installed in facilities where refrigerators were not working and could no longer be repaired (most of these operated using propane gas).

In addition, 191 CCEOP refrigerators, 37 refrigerators donated by the CDC and 17 refrigerators were installed using support from the World Bank via UNICEF.

Table of activities carried out in 2017 in the framework of CCEOP

| Department | # Arkteks installed | # of TCW40SDD refrigerators installed | # of refrigerators validated by the EPID | # of facilities evaluated for 2018 |
|-------------|---------------------|---------------------------------------|--|------------------------------------|
| Artibonite | | 36 | 22 | 37 |
| Central | | 11 | 7 | 16 |
| Grande Anse | | 30 | 18 | 6 |

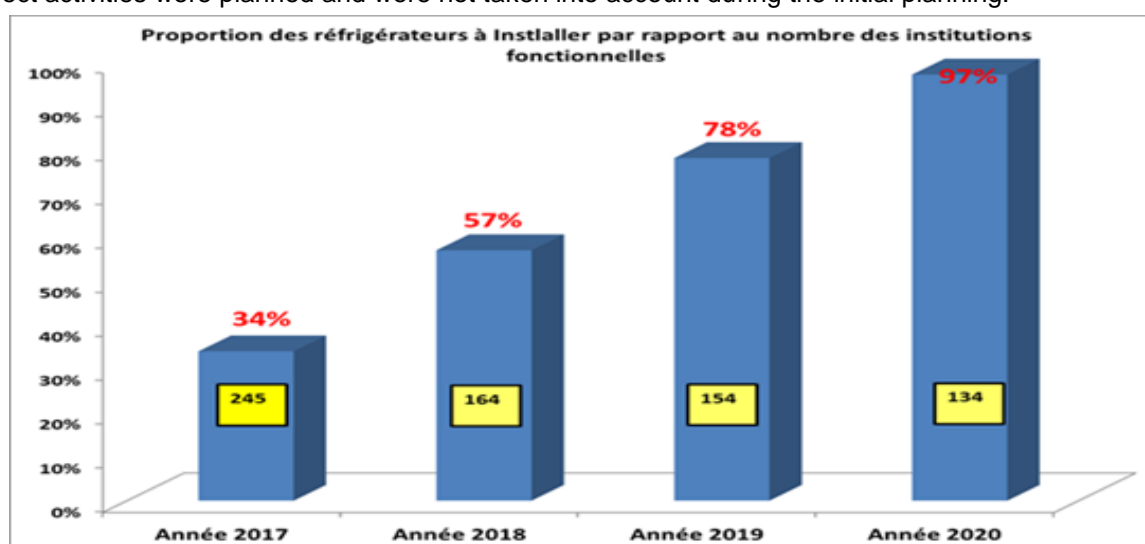
⁴ Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should, however, describe – to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

| | | | | |
|--|-----------|------------|------------|------------|
| <i>Nippes</i> | | 22 | 12 | 6 |
| <i>Nord</i> | | 16 | 9 | 24 |
| <i>Nord-Est</i> | | 10 | 6 | 8 |
| <i>Nord-Ouest</i> | | 9 | 5 | 14 |
| <i>Ouest / Aire Métropolitaine</i> | 4 | 10 | 4 | 62 |
| <i>Ouest</i> | 6 | 15 | 9 | 42 |
| <i>Sud</i> | | 20 | 12 | 14 |
| <i>Sud-Est</i> | | 12 | 8 | 16 |
| Total | 10 | 191 | 114 | 245 |

The graph below shows the number of solar refrigerators to be installed per year as well as the coverage of solar refrigerators to be installed relative to the number of operational EPI facilities.

It should be noted that the number of solar refrigerators in this graph do not include the large-capacity solar refrigerators scheduled to be installed to strengthen departments and communes within the context of introducing new vaccines (20 refrigerators planned in 2018, 23 in 2019 and 25 in 2020).

Considering solely the CCEOP project, at the end of 2020, 97% of facilities will be equipped and 3% of facilities will not be solar-powered for the reason that newly operational EPI facilities were created after project activities were planned and were not taken into account during the initial planning.



Percentage of refrigerators to be installed in relation to the number of functional facilities

Année = Year

| | 2017 | 2018 | 2019 | 2020 |
|--|------|------|------|------|
| Number of refrigerators to be installed | 191 | 184 | 177 | 169 |
| Long-term storage coolers | 10 | - | - | - |
| Remote temperature recorders | 13 | 14 | - | - |
| Continuous temperature recorders | 600 | 600 | - | - |
| Spare parts for old solar refrigerators purchased between 2013 and 2016 | 30 | 30 | 18 | 23 |

Table of solar refrigerators installed per year

• Difficulties encountered

Since site assessments for refrigerator installation did not take place in the first year, we were required to prioritise the facilities with concrete roofs due to the time required to order equipment.

To resolve the problem of no assessments, a contingency plan was developed and several pre-visit missions were conducted at various sites before the team of technicians arrived in the field for installations.

- Some facilities initially slated to remain open in the initial plan were closed
- There was a lack of security (lack of an enclosed area, for example) for materials
- Late responses to central level requests by the departments

• **CCEOP contribution to immunisation system performance**

Recurring problems linked to vaccine availability, frequent propane gas stockouts, dependability and accessibility have been partially resolved in cases where refrigerators have been installed.

• **Further country needs related to technical assistance for CCEOP implementation**

To implement CCEOP, three positions currently funded (one P3, one NOC and one NOB) are sufficient to cover CCEOP activities. Recruiting a specific person for CCEOP does not appear to be necessary.

3.6. Financial management performance

Financial management of Gavi funds is done directly via existing funding mechanisms within OPS/WHO and UNICEF, who define procedures that the various Health Directorates must take into consideration for the use and justification of amounts disbursed. The new administrative provision put in place by the Ministry of Finance added to the delay in justifications for funds received, in turn delaying activity implementation. However, efforts are in progress to monitor the budget execution by entities that implement operational activities, with the involvement of the DAB at the MSPP.

▪ **Financial absorption and utilisation rate**

Implementation of the Gavi/HSS grant began with the first tranche in the amount of US\$ 1,137,842 in February 2014 but activities were delayed until the end of that year. Activities were accelerated at the start of January 2015 and this resulted in good levels of activity completion.

The second grant tranche in the amount of US\$ 1,035,827 was made available in October 2015 in complement to the 2014 yearly balance, which was US\$ 988,935.45. Therefore, a total of US\$ 2, 024,762 was mobilised to implement the 2015 activities with a balance of US\$ 848,394.35 as of December 2015.

In 2016, the existing balance from 2015 enabled activities to be carried out with a 78% execution rate and a balance of US\$ 203,044.59. A third and last tranche of this grant was transferred in February 2017 in the amount of US\$ 1,126,206. At the end of December 2017, cumulative execution was 73% for the third disbursement with a balance of US\$ 914,462.82 executed or committed for execution for activities in progress.

In May 2018, total cumulative execution for the grant was 86% with a balance of US\$ 434,499.37.

Considering that the date scheduled for the end of the grant is June 2018, the MSPP will ask the Gavi Secretariat for an extension without fees through December 2018. This situation reveals the difficulties related to absorption capacity and execution of funds within deadlines.

| Gavi HSS1 grant execution 2014-2018 (May) | | | | | | | | | | |
|---|---------------|---------------------------------------|----------------|--|------------|--|---------------|--|-------------------|---------------------------|
| Total amount approved | 2014 | | 2015 | | 2016 | | 2017 | | 2018* in progress | |
| US\$3,299,875.00 | First tranche | % of 1 st tranche executed | Second tranche | % of 1 st and 2 nd tranches executed | | % of 1 st and 2 nd tranches executed | Third tranche | % of 1-2 and 3 rd tranches executed | | % of total grant executed |
| Date | | Dec-14 | | Dec-15 | | Dec-16 | | Dec-17 | | May 2018 |
| OPS funds disbursement | 1,137,842.00 | | 1,035,827.00 | | | | 1,126,206.00 | | | |
| Execution of funds | 148,907.00 | 13% | 1,176,368.00 | 61% | 645,349.76 | 91% | 430,089.00 | 73% | 434,499.37 | 86% |
| Balance | 988,935.00 | | 848,394.35 | | 203,044.59 | | 914,462.82 | | | |

| Overview | |
|-----------------------------|-------------------|
| Total grant | 3,299,875.00 |
| Total executed (April 2018) | 2,835,213.13 |
| Balance | 464,661.87 |

3.7. Transition planning (if applicable, eg country is in accelerated transition phase)

| |
|----|
| NA |
|----|

3.8. Technical Assistance

During this period, OPS provided technical assistance in line with the objectives identified in the Gavi-HSS1 proposal and per the needs established during the joint appraisals. Technical assistance for 2017-2018 was deployed according to six components and is described below:

| Approach | Resource | Summary of progress achieved |
|---|---|--|
| HEALTH SYSTEM STRENGTHENING | | |
| Technical support for project implementation and coordination of the grant as well as other synergistic activities | An international consultant was recruited for grant coordination and management | <ul style="list-style-type: none"> - Transfers to and technical and financial monitoring of the MSPP and the 10 DSDs for implementation, improvements to the immunisation programme through 9 of 10 letters of agreement - Direct support of central level activities to encourage expansion of the community health model - Three letters of agreement were signed with DSDs to carry out the activities validated by DPSPE - Technical and logistical input into the preparation process for the HSS2 proposal |
| Technical input into the preparation process for the HSS2 proposal | An international consultant was recruited to develop the final proposal | <ul style="list-style-type: none"> - Coordination of the new participative PEF process - Proposal created and accepted - Responses to CE comments submitted - Consolidation of joint appraisal document |
| Support for assessment of new healthcare model | | <ul style="list-style-type: none"> - Four supervision missions from the model were carried out with the DPSPE focal point in the communes involved |
| Support an efficient supportive supervision at the central, departmental and facility levels | | <ul style="list-style-type: none"> - Accompaniment on 80% of the joint supervision missions by UCNPV team - Logistics support for mission execution - Several missions were delayed due to overlapping agendas - The feedback process to DHDs and monitoring of improvement plans has not yet begun |
| Support community health worker training on EPI standards and procedures | | <ul style="list-style-type: none"> - Transfers to and technical and financial monitoring of the MSPP and two DHDs for implementation of ESF training activities through letters of agreement with DSO and DSA out of the five planned for (DSNi, HDD and MSPP). - Support to training activities and provision of training materials and work supplies as well as translation of the EPI guides into Creole for the PCHWs. |
| COUNTRY PLANNING, MANAGEMENT AND MONITORING | | |
| Conduct efficient supportive supervision at the central, departmental and facility levels | | <ul style="list-style-type: none"> - OPS managers participated in the joint supervision missions: ✓ 1st half of 2017: three departments participated in three missions with the central level ✓ 2nd half of 2017: integrated supervision of 10 departments from July to November 2017 ✓ 1st half of 2018: participation in five DHD missions; supervision mission, regular programme monitoring, diphtheria campaign in the DHDs and prioritised communes |
| Development of operational EPI plan | | <ul style="list-style-type: none"> - A national workshop was conducted to develop the departmental AOP-EPI |

| | | |
|---|---|--|
| | | <ul style="list-style-type: none"> - Participation and logistical support provided for the meetings for the UCNPV to develop the EPI AOPs. |
| Meeting for national EPI results | | <ul style="list-style-type: none"> - Participation and logistical support for 2 national results meetings (June 2017 and February 2018) |
| | | <ul style="list-style-type: none"> - A first EPI training for PCHWs and AIPs by EPID, DSO, DSA, HDD with OPS/WHO support took place in March 2017. A second training is currently in progress |
| INFORMATION SYSTEM SUPPORT | | |
| Support data collection, analysis and feedback | | <ul style="list-style-type: none"> - A support mission for entering data into the SISNU was conducted in the departments with the most reliable rates of data completion (Sud, Nippes and Grande Anse). - In six departments, data validation sessions took place with managers from certain facilities in the framework of monitoring missions |
| Support for regular quarterly EPI performance meetings at the national and departmental levels | | <ul style="list-style-type: none"> - two results meetings at the national level took place |
| Support implementation of a data quality audit (DQA) and development/implementation of a plan to strengthen data management | <p>Recruitment of a data management consultant to provide EPI information system support.</p> <p>A PAHO WDC mission provided support to the central level to prepare the DQS and execute the DQS programming report for end 2018 or beginning 2019.</p> | <ul style="list-style-type: none"> - A monitoring workshop was conducted with support from the main office, support for updated tools training for providers in 9 of the 10 departments - Coordination meeting for the conduct of DQS delayed to end 2018 or beginning 2019 - Training on quality immunisation data was conducted for certain EPID managers and on the malaria project - Due to DQS reprogramming, a portion of the funds was used to strengthen the information system - Support for computer equipment and supplies for UCNPV and DSO to facilitate data communication and management, and monitoring of community health and immunisation activities |
| Surveillance of vaccine-preventable diseases | | <ul style="list-style-type: none"> - Support for investigative activities in the field, active research, supervision and operation of sentinel surveillance centres for new vaccines (rota, penta, pneumo). |
| MANAGEMENT AND MONITORING OF NATIONAL PLAN | | |
| Support operation of EPI governance entities: ICC, TC-EPI and NITAG | <p>Recruitment of a senior national professional to provide technical support for programme management and planning</p> <p>Recruitment of and cost coverage for five months of a national EPI consultant to support EPID strengthening</p> | <ul style="list-style-type: none"> - Support creation and operation of a national ESAVI committee - Technical support for NITAG and ICC TDR development was endorsed but has not yet been applied - Technical and logistical support and participation in extraordinary ICC meetings within the context of validation, submission and PSR review - Due to non-execution of all funds for NITAG and ICC meetings - Support was provided for task force meetings - Coordination meetings and technical and logistical support for immunisation task force meetings |
| SUPPLY CHAIN AND WASTAGE MANAGEMENT | | |
| Improve vaccine and supply management at the central departmental level (use of VSSM) | | <ul style="list-style-type: none"> - A round of supervision was conducted by EPID cold chain team in eight departments (except DSA and NO) - The VSSM is only operational in the Centre department, this activity did not take place |

| | | |
|--|--|--|
| | | - A reformulation for the beginning of team training is scheduled for the departmental level |
| ASSISTANCE FOR PREPARING THE PROCESS (CEF) 2017 | | |
| | | - Technical and logistical support for the CEF process/MSPP/Gavi - Technical and logistical support for Gavi high-level mission |

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

| Prioritised actions from previous Joint Appraisal | Current status |
|--|---|
| 1. Sign the ToRs for the ICC and the TC/EPI and improve their operations | Partially completed |
| 2. Improve the coordination of interventions in the EPI framework (reorganisation, strengthening the EPID) | Initiated (organisational diagnostic) |
| 3. Develop the 2016-2020 Comprehensive Multi-Year Plan | Partially completed |
| 4. Implement components from the RED strategy in all communities (outreach and mobile strategies, communication/social mobilisation for routine EPI) | Partially completed (with Japanese funds) |
| 5. Continue improving cold chain management at the facility level | Ongoing |
| 6. Conduct a financial viability study of the EPI | Incomplete |
| 7. Continue implementing EVM | In process |
| Additional significant IRC/HLRP recommendations (if applicable) | Current status |
| | |
| | |

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

| |
|--|
| <ol style="list-style-type: none"> The ICC TC/EPI and Terms of Reference CT/EPI were signed but how these function has not improved In 2017, an organisational diagnostic of the EPID was conducted along with an assessment of the programme's capacity. At the start of 2017, within the framework of the LMC funds, the company, Dalberg, also conducted an assessment of the programme and proposed a reorganisation that is still under discussion. The 2016-2020 cMYP was developed in 2017 but the costing component in this plan is still being finalised. The RED strategy components were implemented in 73 communes – 28% were in 1 month, 4% (2 months), 14% (3 months), 15% (4 months), 7% (5 months), and 17% (6 months). The study on the EPI's financial viability was not conducted. |
|--|

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

Overview of key activities planned for the next year:
See table below:

| | |
|-----------------------------|---|
| Key finding/action 1 | Encourage equitable access to immunisation services and increase immunisation coverage to at least 80% in the 38 communes that have a high number of unimmunised children in Ouest and Sud |
| Current response | |
| Agreed country actions | 1.1 Implementation of strategies key to immunisation service offerings |

| | |
|-----------------------------|---|
| | <ul style="list-style-type: none"> - 1.1.1 Continue implementation of activities in the urban immunisation model in Cité Soleil commune (Aire Métropolitaine) <p>1.2. Strengthen routine immunisation</p> <ul style="list-style-type: none"> - 1.2.1 Conduct microplanning in the country's 10 departments (767 facilities) - 1.2.2 Conduct planning and management of resources for the 38 target communes (RED) - 1.2.3 Implement outreach strategies (target Ouest 19 communes - Sud 19 communes) (RED) - 1.2.4 Conduct supervision of local management of RED approach for 292 facilities in 38 communes (RED) - 1.2.5 Strengthen ties with the community (RED) - 1.2.6 Conduct monitoring of routine performance indicators in the country's 10 departments (767 facilities) - 1.2.7 Provide retraining for service providers on EPI standards and procedures document - 1.2.8 Conduct integrated supervision by the central level of the departments - 1.2.9 Departments conduct integrated supervision (including UAS/UCS/BCS) of facilities - 1.2.10. Finance ESF operational costs (116 PCWHs, 29 AIPs, 16 nurses) in 7 communes (Ouest, AM, Sud, Artibonite) - 1.2.11. Organise monthly monitoring meetings for community activities led by ESFs <p>1.3. Strengthen communication activities and generate demand</p> <ul style="list-style-type: none"> - 1.3.1 Train service providers in interpersonal communication - 1.3.2 Conduct KAP survey - 1.3.3 Review communication strategy - 1.3.4 Develop and implement communication plans at all levels |
| Expected output/results | See work plan |
| Associated timeline | See work plan |
| Required resources/support | <ul style="list-style-type: none"> ▪ OPS/WHO (PEF TCA) - Support preparatory activities funded by the PCV-13 introduction grant - Support implementation of MR follow-up campaign and SSRC at the national, departmental, commune and local UAS levels - Support ESF training (PCHWs and AIPs) ▪ UNICEF TA (PEF TCA) - Monitor implementation of social mobilisation and communications plan - Generate demand for immunisation ▪ ADDITIONAL TA (expanded partners)(funded by Gavi) - Support for EPID in replicating key immunisation model components for urban areas - Evaluate efficiency of outreach strategies to increase immunisation coverage and reduce the number of children who have not been immunised |
| Key finding/action 2 | Improve the supply chain and cold chain at the national level through effective vaccine management |
| Current response | |
| Agreed country actions | <ul style="list-style-type: none"> - 2.1.1 Carry out work to renovate the space before hosing the cold room in Sud - 2.1.2 Install a solar cold room in Sud - 2.1.3 Purchase five vehicles (three in 2018 and two in 2019) to supply facilities with vaccines - 2.1.4 Perform maintenance and repairs on new vehicles - 2.1.5 Perform maintenance and repairs on existing vehicles - 2.1.6 Train providers (pharmacists, storekeepers, assistants, managers) on EPI logistics tools (VSSM) - 2.1.7 Supervise users of logistics tools - 2.1.8 Supply facilities with vaccines and consumables |
| Expected outputs/results | See work plan |

| | |
|-------------------------------|--|
| Associated timeline | See work plan |
| Required resources/support | <ul style="list-style-type: none"> ▪ OPS/WHO TA (PEF TCA) <ul style="list-style-type: none"> - Conduct supervision of VSSM in all departments ▪ UNICEF TA (PEF TCA) <ul style="list-style-type: none"> - Develop EVM assessment - Strengthen supply chain and implement initiatives from the EVM improvement plan |
| Key finding/action 3 | Strengthen national immunisation programme management and coordination to make it more efficient to better serve the target population and improve immunisation coverage and equity |
| Current response | |
| Agreed country actions | <p>3.1 Strengthen organisation of UCNPV managerial capacity, NIP coordination of departmental directorates, BCSs</p> <ul style="list-style-type: none"> - 3.1.1 Evaluate training needs - 3.1.2 Develop training plan - 3.1.3 Organise training workshops <p>3.2 Improve coordination between partners</p> <ul style="list-style-type: none"> - 3.2.1 Develop AOP in 2019 and annual NIP results meetings - 3.2.2 Conduct monitoring meetings with partners: 1 twice-yearly ICC meeting, 12 CT-NIP meetings, 2 NITAG meetings <p>3.3 Improve financial management at UCNPV and DHD levels</p> <ul style="list-style-type: none"> - 3.3.1 Organise training workshops to strengthen the role and functioning of public accountants, administrators and department directors <p>3.4 Strengthen local level management (UAS/UCS)</p> <ul style="list-style-type: none"> - 3.4.1 Organise training workshops on management for the communes - 3.4.2 Acquisition and donation of equipment - 3.4.3 Organise community meetings in communes to approve Community Health component by administrative unit while ensuring community participation and recognition of BCS/UAS as an extension of MSPP central services <p>3.5. Improve data availability</p> <ul style="list-style-type: none"> - 3.5.1 Train providers (assistants, nurses, workers, etc) on SYSPEV - 3.5.2 Organise supervision workshops in DHDs and facilities - 3.5.6 Copy and distribute data collection tools <p>3.6. Improve data quality</p> <ul style="list-style-type: none"> - 3.6.1 Conduct DQS in 2018 - 3.6.2 Develop and implement an improvement plan for managing data from DQS results and recommendations - 3.6.3 Implement the improvement plan. <p>3.7. Improve epidemiological surveillance</p> <ul style="list-style-type: none"> - 3.7.1 Strengthen active research, adequate investigation and monitoring of VPDs - 3.7.2 Purchase sampling kits and laboratory reagents, and means of transport for confirmation |
| Expected outputs/results | See work plan |
| Associated timeline | See work plan |
| Required resources/support | <ul style="list-style-type: none"> ▪ OPS/WHO TA <ul style="list-style-type: none"> - Support activities related to strengthening managerial and technical capacities at all levels (LMC) - Support development of 2018 and 2019 operational plans - Support coordination activities between partners (LMC) - Technical support for project implementation and coordination of the grant (PEF TCA) - Technical support for implementing HSS2 (PEF TCA) - Strengthening expansion of new healthcare model as linked to EPI objectives (PEF TCA) ▪ WORLD BANK TA |

| | |
|--|---|
| | <ul style="list-style-type: none"> - Technical assistance will be provided to the Government to ensure planning, regulations, procurement procedures and appropriate payment for enabling the Government to purchase vaccines from its own 2018-2019 national budget using OPS revolving funds. - Support Options Note for a more efficient community worker model to be produced this year (2017-2018), as well as results-based funding (RBF) in progress for the Bank and a key partner in Haiti. A specific analysis and recommendations on options for a greater focus on immunisation within the RBF framework (including higher rates for current immunisation indicator and new immunisation indicators) and estimates for various scenarios will be produced. ▪ CDC TA <ul style="list-style-type: none"> - Participation in planning the first MR campaign to guarantee high-quality preparation, implementation and follow-up for the measles campaign. - Continue to strengthen and expand meningitis surveillance - Conduct surveillance of trends of diarrhoea from all causes and from hospitalisations from diarrhoea due to rotavirus in children under the age of five, before and after the vaccine is introduced. |
|--|---|

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

7. ANNEX: Compliance with Gavi reporting requirements

| | Yes | No | Not applicable |
|--|-----|----|----------------|
| Grant Performance Framework (GPF) * Reporting on all required indicators | x | | |
| Financial Reports * | x | | |
| Periodic financial reports | | | x |
| Annual financial statement | x | | |
| Annual financial audit report | | | x |
| Report on end-of-year stock levels (which must be provided on May 15 in the framework of the vaccine renewal request) * | x | | |
| Campaign reports | | | x |
| Technical supplementary immunisation activity report | | | x |
| Report on surveys on campaign coverage | | | x |
| Information on funding and expenditures related to immunisation | | | x |
| Data quality and survey reporting | | x | |
| Annual data quality document review | | x | |
| Data improvement plan (DQIP) | | x | |
| Progress report on implementation of data improvement plan | | x | |
| In-depth data assessment (conducted in the last five years) | | x | |
| Nationally representative coverage survey (conducted in the last five years) | | x | |
| Annual progress update on the Effective Vaccine Management (EVM) improvement plan | x | | |
| (CCEOP): ECF inventory updated | x | | |
| Post-Introduction Evaluation (PIE) | | | x |
| Situation analysis and five-year measles/rubella plan | x | | x |
| Operational plan for immunisation programme | x | | |
| HSS end-of-grant evaluation report | | x | |
| HPV-specific reports | | | |
| Partner reports on PEF TCA functions | | | |

Should one of the reports requested not be available at the time of the joint appraisal, please indicate when the missing document/information will be available.

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|--|