Joint Appraisal report (JA) 2018

Country	Mauritania
Full JA or JA update	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	23 to 27 July 2018 in Nouakchott
Participants/affiliation	Ministry of Health, WHO, Unicef ; GAVI, for list of those present see appendix
Reporting period	2017 – 2018
Fiscal period	2017 – 2018
Comprehensive Multi Year Plan (cMYP) duration	2016 – 2020
Gavi transition / co-financing group	Co-financing

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes ☐X	No ☐	N/A ☐
HSS renewal request	Yes ☐	No ☐X	N/A ☐
CCEOP renewal request	Yes ☐	No ☐	N/A ☐X

Observations on vaccine request

Request for renewal of support for new vaccines:

Population 2019	4 077 347				
Birth cohort	151 532				
Vaccine	**Penta**	**PCV13**	**Rota**	**IPV**	**MR**
Population in the target age cohort	145 458	145 458	145 458	145 458	145 458
Target population to be vaccinated (first dose)	139 294	139 294	139 294	139 294	139 294
Target population to be vaccinated (last dose))	132 367	132 367	132 367	132 367	132 367
Implied coverage rate (in 2019)	91%	91%	91%	91%	91%
Last available WUENIC coverage rate	81%	77%	76%	68%	78%
Last available admin coverage rate (end 2017)	90%	90%	90%	90%	90%
Wastage rate	8%	8%	8%	8%	8%
Buffer	110500	104700	69900	37000	44400
Stock reported (as of 31 December 2017)	520 350	124 350	53700	22600	1 907 900

Mauritania has already submitted a request for renewal of support for new vaccines for 2019.

The MR stock available at the end of 2017 concerns the SIAs organised in February 2018. The vaccine was introduced into routine vaccination just at the end of these SIAs.

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

Indicative interest to introduce new vaccines or request HSS support from Gavi	**Programme**	**Expected application year**	**Expected introduction year**
	HPV	2018	2019
	2nd dose of MR	2019	2020

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

The rainfall deficit during 2017 definitely had an impact on lifestyles and the state of health of rural communities in particular. Population movement was inevitable in search of pasture, access to water points or alternative work.

Furthermore, cases of haemorrhagic fevers and dengue fever were also recorded, particularly in Nouakchott. At times this led to large influxes of people at healthcare facilities and overstretched staff workloads, which may have disrupted immunisation services. Another consequence of the situation was that some households gave up on preventive care.

The impact of these events on vaccination remains a hypothesis that has not been verified with factual data.

Since the last joint assessment, the country has not been identified by GAVI as being vulnerable, although the repercussions of the socio-political context have meant that Malian refugees (around 56,000) have remained in their accommodation in Bassiknou. However, some partners (MSF) are starting to withdraw.

Mauritania has been certified polio-free since 2007 and has seen a reappearance of new cases of Wild Polio Virus (WVP) imported between October 2008 and April 2010. Thanks to the combined efforts of all actors, transmission was able to be stopped in April 2010. The last case dates back to 29 April 2010 in the Moughataa of Amourj (Wilaya of Hodh Echargui) on the border with Mali and was confirmed on 02/05/2010. Since then, no cases have been recorded in the country. However, surveillance has been poor, as the country has not yet reached the non-polio AFP rate required under certification criteria, which is 1.9/100,000 children under the age of 15. Some regions have been silent for more than two years. Polio committees are experiencing dysfunction problems, with the result that only 8 of the 19 reported AFP cases in July 2018 were classified. The country faces the risk of losing its polio-free status if urgent measures, including the recommendations of the May 2018 surveillance review, are not implemented.

On the institutional front, a series of municipal, parliamentary and regional elections are scheduled for September 2018. Of particular note is the election of regional councils - a body recently created with a view to regionalizing the management of development programmes. A reform of public finances has also been launched to introduce programme budgets.

Following the approval of the national strategy for accelerated growth and shared prosperity (SCAPP 2016-2030) and the introduction of mechanisms for implementing and monitoring it, a Sectoral Coordination Committee for its health component was set up and made operational.

The National Health Policy to 2030 (PNS) and the National Programme for Health Development (PNDS) for the period 2017-2020 were developed with a medium-term expenditure framework (MTEF) and a monitoring--assessment plan. A compact was signed by the Government and the main donors and defined, inter alia, the establishment of a common fund as one of the procedures for the management of external financing.

Structuring projects are underway in the health sector. These include performance-based financing with the support of the World Bank, the Universal Health Coverage project with the support of Belgian Technical Cooperation (BTC), DHIS2 being piloted with technical support from WHO with a view to its widespread use supported by a number of partners, and operationalisation of the community approach initiated by a joint project (Global Fund, GAVI, UNICEF) to deploy 500 CHW (Community Health Workers) in locations not covered by health structures. Lastly, a new social registry project has been launched by the Tadamoun Agency to identify, on a national scale, the 150,000 poorest households.

On the administrative front, two new Moughataa have been created: Ghabou in Guidimagha - located

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

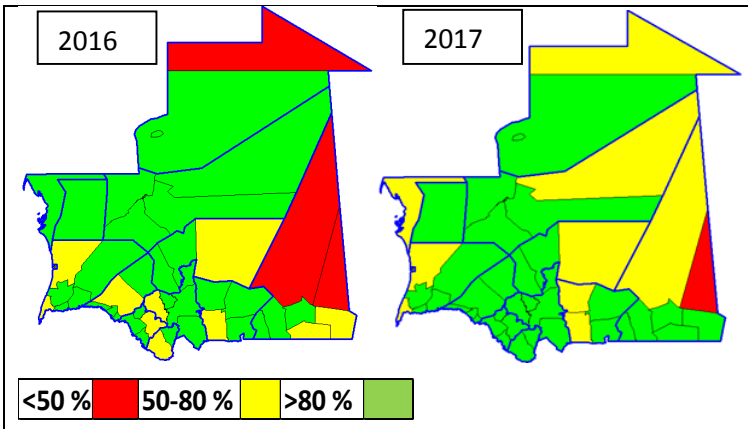
Administrative immunisation coverage has gradually increased from 86% of Penta 3 in 2016 to 89% in 2017 (see Annex 1, Table II). With regard to WHO-UNICEF estimates, coverage increased from 73% in 2016 to 81% in 2017.

This coverage rate includes Malian refugees in the Bassiknou district in the east of the country.

In 2017, of the 55 districts in the country, 41 or 75% had a penta3 vaccine coverage (VC) greater than or equal to 80% compared to 36 or 65% in 2016.

The improvement in vaccine coverage in the target intervention area was relatively good in 2017; the Moughataa of Oualata and Tichit with coverage at <50% in 2016 improved in 2017.

We note that 29 out of 55 in 2017 achieved the national target of 89% compared to 30 in 2016 with a target of 87%. Only the Moughataa of Dhar still had less than 50% coverage in 2017.



Drop-out rate in 2017 :

The national average drop-out rate in 2017 was 11%. It had decreased by 3 points compared to 2016. Out of the 55 Moughataa, 25 had a drop-out rate of less than 10%, 8 of them with a negative drop-out rate.

Infants under-vaccinated with Penta 3 (DTP3)

Available administrative data make it possible to geographically locate under-vaccinated children per Moughataa but not to determine their profile. (See table in annex) The vast majority of under-vaccinated children are in urban areas.

Three of the Nouakchott Moughataas (Riyadh, Arafatt and ElMina) together account for 6845 under-vaccinated children, i.e. 45% of all the 15435 under-vaccinated children.

With 836 under-vaccinated children, Malian refugees account for 5% of this number of under-vaccinated children; they represent 79% of under-vaccinated children in the Moughataa of Bassiknou where the Mberre camp is located, and 42% of all refugee children. The Moughataa of Sélibaby (with support from Gavi and Unicef) saw an improvement in its Penta 3 vaccination coverage in 2017 (83%) compared to 2016 (64%). However, the number of under-vaccinated children is still high (1470, i.e. 10% of children under-vaccinated at national level), although the number is lower than in 2016 (3039, i.e. 20%).

The remaining 40% of under-vaccinated children were spread over 36 other Moughataas, as shown in the table below, which also shows that 13 Moughataas vaccinated 3018 children over and above their target, among these: 46% in Ksar and Teyarett in the Wilayas of West and North Nouakchott respectively.

Moughataas with under-vaccinated children	Number of children	%	Number of Moughataas
> 1000	9 367	61%	6
500 à 1000	3 367	22%	4
100 à 499	5 285	34%	21
< 100	434	3%	11
Surplus of vaccinated children	-3 018	-20%	13
Totals	**15 435**	**100%**	**55**

In terms of equity, the available data on vaccine coverage do not allow for an easy analysis that would help to identify communities with poor coverage in an accurate way. In addition, most of these statistics are relatively old.

As shown in the Vaccine Coverage and Equity Analysis Tables (Appendix 1), some parameters relevant to equity analysis such as gender, housing environment, mother tongue, and levels of welfare and education were only collected by the Vaccine Coverage Survey in 2014 and the MICS Survey in 2015 and these parameters were only collected at national level.

The 2015 MICS shows a slightly higher coverage rate for boys (64%) than for girls (61%), but the opposite is true in the Vaccine Coverage Survey (VCS) (92% for girls and 91% for boys). However, these differences, which vary between 1 and 3 points, do not seem significant. The difference between the vaccination of urban and rural children was not assessed by the VCS whereas the PENTA3 coverage was 16 points higher for urban children according to the MICS (71% to 55%).

Although vaccination is officially free of charge, the largest disparities are observed between the richest and the poorest quintiles (37 points difference in the MICS and 12 points in the VCS), the richest quintile being far better vaccinated.

Regarding other social characteristics, Wolof children are more likely to be vaccinated, but lower vaccine coverage rates are recorded among Arabs according to MICS and among Fulani people according to the VCS. Children of mothers with higher education are more likely to be vaccinated than those of mothers with lower levels of education.

Geographically, the 2015 MICS identified the wilayas of Hodh Echargui and Guidimakha as having the lowest coverage with more than half of the children not vaccinated. In 6 other wilayas more than one child in 4 is not vaccinated (Assaba, Tagant, Gorgol, Hodh Elgharbi, Adrar and Brakna). However, the 2014 VCS found that all wilayas had coverage above 80% and that only the Gorgol, Guidimakha, Trarza, Hodh Elgharbi and Hodh Echargui regions did not reach 90%.

The explanation for such disparities undoubtedly lies in the availability, accessibility, acceptability and uptake of immunisation services.

In this respect, it is important to note that vaccination is widely accepted and requested by most populations and refusals have only been reported in rare cases during campaigns. Furthermore, vaccination is officially free of charge and there should be no financial barrier to accessing it. An analysis of the availability of the vaccination service (see table in the appendix) shows that the Moughataas with the lowest coverage rates and the highest numbers of unvaccinated children are urban centres such as the Nouakchott Moughataas and the Bassiknou Moughataa, where the M'berré refugee camp is located. These Moughataas have the highest population ratios per vaccination unit (from 22,000 to 40,000 inhabitants per fixed vaccination post), which indicates a real problem in terms of the capacity of the service to meet the demand. The Moughataaa of Sélibaby is one such area, although it is not such a large urban centre. However, it has a shortfall of 13 vaccination posts in comparison with the number of localities with more than 1000 inhabitants where health structures have been installed as a matter of priority. The fact that Moughataas that have exceeded their vaccination targets often have more fixed vaccination posts than localities with more than 1000 inhabitants makes this analysis more plausible, although it is certainly not the only explanation for vaccination underperformance and inequalities.

Surveillance of diseases that are avoidable through vaccination

As for the surveillance of EPI target diseases, the epidemiological situation is not known with certainty, due to the fact that the surveillance system is inefficient. For example, the two performance indicators for measles surveillance have not been achieved for the last three years (2015, 2016, 2017).

Active surveillance of congenital rubella syndrome is not in place and sentinel surveillance of diarrhoea caused by rota virus is also not operational.

3.1. Coverage and equity of immunisation

No characteristics of vaccinated or unvaccinated children are available in current administrative data. Therefore, the impact of each of the parameters below remains considerable until there is proof to the contrary.

- **Health personnel**:

  The healthcare workforce is insufficient, poorly allocated; it is mobile and scattered across a vast network of 463 delivery structures where the health worker is often the only person at the centre. Work comes to a halt when this officer is on leave or on an assignment. Management of this workforce is more administrative than performance-based. Basic training does not cover the essential components of the programme and in-service training is rare due to lack of funding. Supervision is rare at regional and central level due to lack of adequate funding. In addition, the content and methodology of training courses are not appropriate for transferring know-how rather than knowledge. An increase in the number of healthcare schools, enhancement of the capacities of the Faculty of Medicine, and the implementation of structuring projects such as performance-based financing and Universal Health Coverage are major opportunities to improve workforce management, to increase staff performance and to meet some of their expectations.

- **Supply chain management:**

  An EVM evaluation was conducted in 2010, 2014 and 2017. The results showed a gradual improvement in indicators at different levels of the supply chain (51% in 2010, 66% in 2014 and 72% in 2017). However, adequate performance has not yet been achieved, especially at the operational level. Irregularity in the rate of vaccine supply due to a lack of wheeled transport logistics and low use of vaccine management tools at the operational level. Inadequacies in vaccine management, including failure to control vaccine wastage rates, are due in part to a lack of appropriate operator training and regular supervision.

  With regard to improving the supply chain, the country, in collaboration with its partners, plans to implement the EVM recommendations (see EVM Improvement Report) through, amongst other things, the implementation of the CCEOP.

- **Generating demand**:

  The last data collected on demand for vaccination date back to the 2014 programme review. Like all survey data, they present aggregated national-level data that are not very useful in promoting demand, particularly in the communities where coverage is lowest. In 2017, emphasis was placed on building vaccination providers' interpersonal communication skills, which led to a reduction in drop-out rates in UNICEF-supported RED districts. Other activities were also organized: the head of the EPI communication unit was given training in demand generation; 15 journalists were taught about vaccination; African Vaccination Week was celebrated; a study known as TIP (Tailoring Immunization Program) in Nouakchott is now being carried out with the aim of understanding the social barriers to vaccination and improving demand for it.

  In addition to that, social mobilisation campaigns have been conducted in conjunction with supplementary vaccination activities and independent monitoring has, on this occasion, identified a few cases of rejection that remain to be explored.

  A communication plan supported by UNICEF has been available since 2015. The priorities of the programme to increase demand are to update and finance the communication plan; to generalise the process of training/supervision/coaching in Interpersonal Communication and to carry out a Knowledge, Attitude, Practices (KAP) survey.

- **Barriers related to gender inequality**:

  In Mauritania, the available quantitative and qualitative data do not raise any particular problems of this kind in terms of vaccination. Data collection tools have been updated to highlight gender information.

- **Leadership, management and coordination:**

  Despite the lack of qualified human resources, in 2017 the national programme demonstrated its leadership in the key aspects of the EPI and ensured a minimum of political dialogue on vaccination. It drew closer to the other departments and services, in particular, the DPCIS (*Direction de la Planification, de la coopération et de l'information Sanitaire* / Planning, Cooperation and Health Information Directorate) as part of the GAVI HSS review process.

  With regard to coordination, the four statutory meetings of the Inter-Agency Coordination Committee (ICC) were held in a timely manner and provided an opportunity to review important aspects of the programme. The Technical Advisory Group on Vaccination has just been set up. Meanwhile, there has been an improvement in management through the development of an annual EPI plan fixing the priorities of the central EPI.

  At the national level, the programme must work to improve the quality of monitoring by the ICC by arguing for the contextualisation and adoption of its terms of reference while at the same time providing effective coordination between all stakeholders at a technical level. It will work towards empowering the Wilayas and Moughataas to implement HSS2 activities (forthcoming) and will follow all pilot schemes more closely with a view to drawing lessons from them for submission to the ICC.

The programme needs to focus more on strengthening the skills of the regions, so that they are able to exercise their full leadership and coordination role at a devolved level. To do this, the EPI will need to build on ongoing projects and initiatives such as HSS2, the RED approach, health mapping, the MasterCard project, DHIS2 and others.

3.2. Data

Vaccination and health system

In 2017, all the monthly reports from the Moughataa were received and processed centrally. However, a punctuality review revealed that these reports were not always made available on time (43%). In fact, it was observed that delivery of some reports usually takes longer. The table in the appendix – *Table VII* – indicates the level of punctuality of reports forwarded to the central level for the year 2017. This situation of poor punctuality is not confined to 2017. A look back over the last 3 years reveals that punctuality declined steadily over the months between 2013 and 2016.

Data are collected from vaccination delivery structures by staff who are generally overworked, poorly trained and, in most cases, lacking motivation.

These data have to be forwarded to Moughataa level where they are compiled and collated for dispatch to regional level and then to national level.

The lack of training, supervision, monitoring and adequate means of transport all affect the completeness, the accuracy and the timeliness of the data at the base level where they are collected, recorded and reported. This basic stage influences the rest of the process at the higher levels of the system.

The tool currently used nationally is DVD_MT from Moughataa level upwards.

With regard to DHIS2, the WHO-backed programme has set up a pilot area in the three Nouakchott Wilayas and a Moughataa in the Wilaya of Trarza. Health workers have been trained in the use of the tool.

Denominators

The quality of administrative data raises the issue of control of denominators in a context where the civil registry is still relatively unreliable and the size of population groups is calculated on the basis of predictions. In the last MICS survey conducted by the National Statistical Office (ONS) the tools used were not those used by the national programme, which furthermore had no involvement in validating the questionnaires or training the interviewers. However, it is unclear whether the impact of this weakness on the quality of the survey results was assessed. In addition, the vaccination coverage surveys were not subjected to critical analysis with regard to the quality of the data. Nevertheless, they were jointly piloted by the EPI and the technical partners (WHO, UNICEF, CDC) and the data were collected by heath workers. An exercise of this kind may have involved biases that are not easy to ascertain.

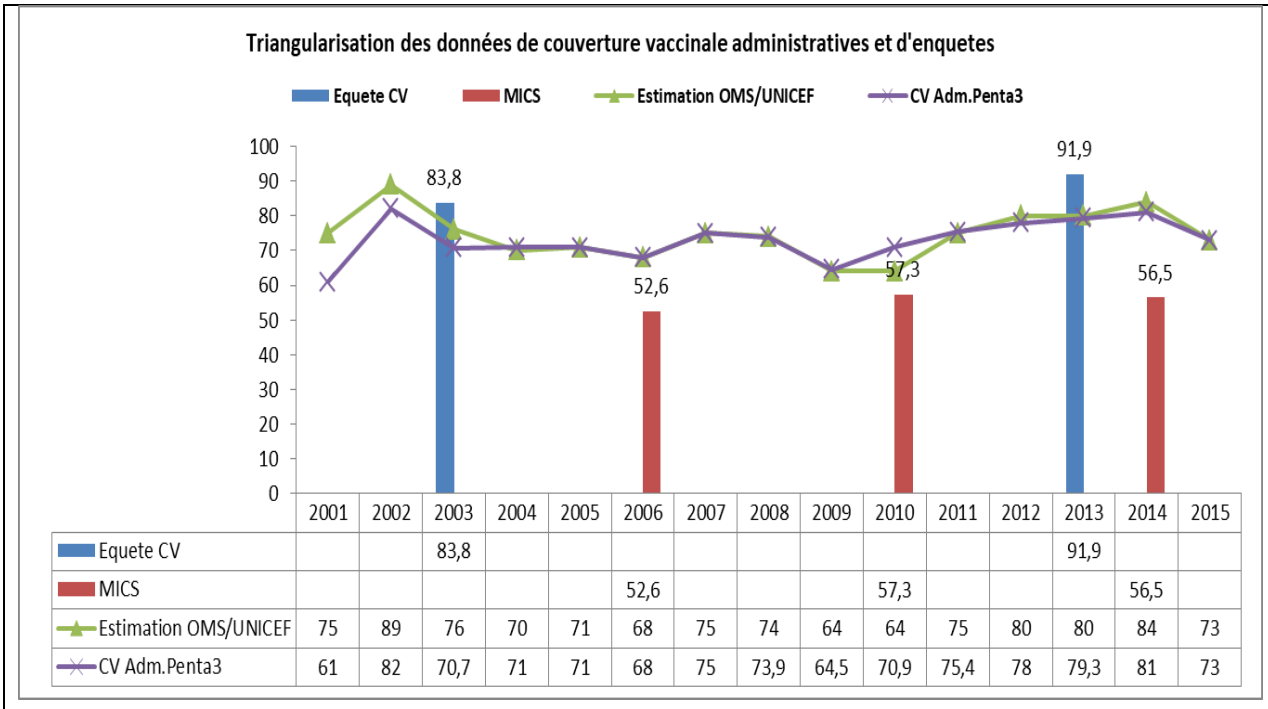
The issue of data quality thus remains a major challenge for the programme, which can only be addressed by an independent survey. In this context, hopes are pinned on a possible DHS survey requested by the Ministry of Health and its partners, for which efforts to mobilize resources have already been launched.

Vaccine coverage rates of >100% can be explained, among other things, by the movement of populations from the interior of the country and from the outlying areas to the economic hubs. This situation affects the denominators and is partly explained by inadequate records of the origin of vaccinated persons in the registry.

Efforts are now being made to improve the reliability of population data through digitisation of civil records and innovative projects such as MasterCard. A general population census was undertaken in 2013 and predictions have been made for each of the country's 15 Wilayas. Additional monitoring and mapping strategies need to be introduced.

Data availability, quality and use*,*

Data from the vaccine coverage surveys (2004 and 2014) show high vaccine coverage (>80%) for all antigens. Moreover, the values found are higher than those in the administrative data. On the other hand, for the 2015 MICS survey, vaccine coverage is lower than that in the administrative figures. Experience in other countries has shown that survey results are often lower than administrative values, whereas the opposite is true in Mauritania.



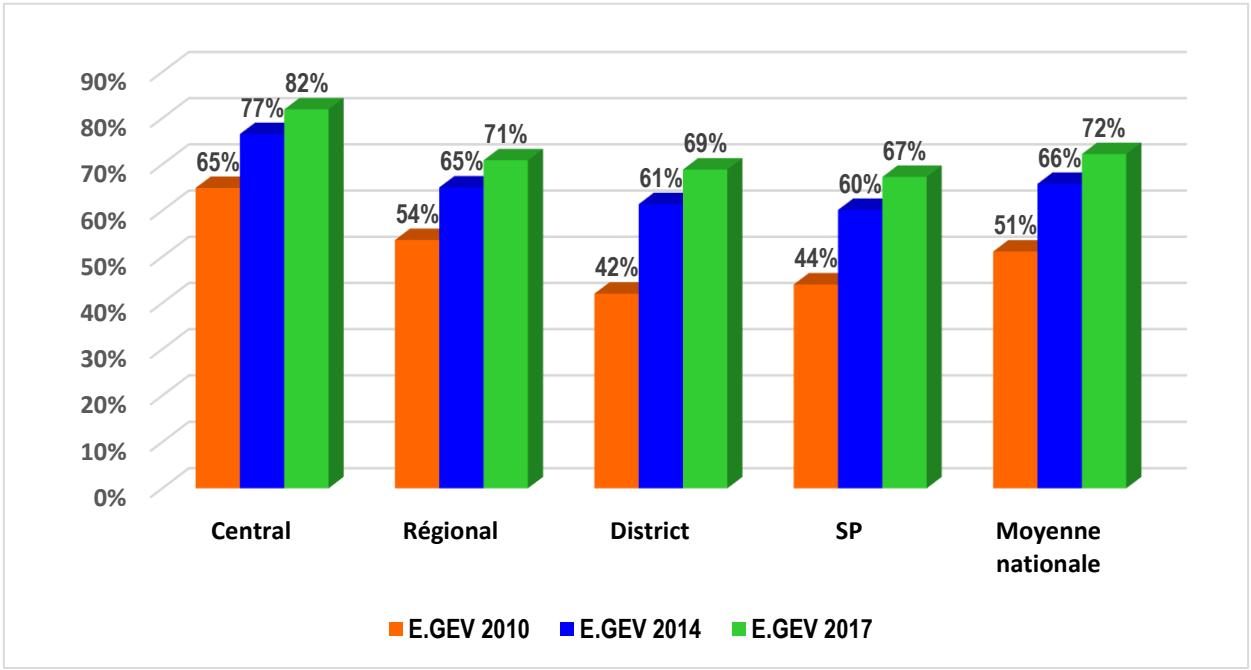
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Equete CV			83,8										91,9		
MICS						52,6				57,3				56,5	
Estimation OMS/UNICEF	75	89	76	70	71	68	75	74	64	64	75	80	80	84	73
CV Adm.Penta3	61	82	70,7	71	71	68	75	73,9	64,5	70,9	75,4	78	79,3	81	73

The issue of data quality remains a major challenge for the programme. A data quality improvement plan is to be introduced in collaboration with partners.

Efficient vaccine management:

Since 2010, Mauritania has adopted regular organisation of the Effective Vaccine Management (EVM) assessment under WHO supervision. In this context, the EVM assessment was carried out in Nov. 2010, March/April 2014 and June 2017.

The results of the EVM assessment showed a gradual improvement in indicators at the various levels of the supply chain. However, performance has not yet reached the target level. The graph below shows the national average for criteria at the various levels per evaluation year.



3.3. Immunisation financing

Management of public finances :

Mauritania has subscribed to the Vaccine Independence Initiative since 1996. A permanent budget line out of the national budget has been created for the purchase of vaccines and consumables.

In partnership with GAVI, Mauritania co-finances under-used and new vaccines as well as consumables.

Vaccines and consumables are supplied through UNICEF on the basis of a partnership agreement between the Ministry of Health, the Ministry of Economy and Finilance on the one hand and UNICEF on the other. Funds for the purchase of vaccines are transferred annually to UNICEF.

The following table shows the volume and sources of funding for the programme for the year 2017

Expenditure categories		State B. (MRO)	WHO (MRO)	UNICEF (MRO)	GAVI (MRO)	Total in MRO	Total in $ USD	Rate
Improving staff skills	Training		16 449 360			16 449 360	46 998	0,55%
	Supervision		1 278 000		12 883 850	14 161 850	40 462	0,48%
Strengthening the capacities of the programme	Safety & Vigilance (SAV)		3 150 000			3 150 000	9 000	0,11%
	RED			44 135 083		44 135 083	126 100	1,48%
	Purchase & maintenance of CCE	89 450 000				89 450 000	255 571	3,01%
	Programme operation	16 074 000				16 074 000	45 926	0,54%
	AVS (Polio et RR)		124 333 345		314 737 295	439 070 640	1 254 488	14,76%
Purchase of vaccines	Routine	386 269 706			1 499 575 000	**1 885 844 706**	5 388 128	63,40%
	SIA (Polio & MR)			38 662 225	427 700 000	466 362 225	1 332 464	15,68%
Total in MRO		**491 793 706**	**145 210 705**	**82 797 308**	**2 254 896 145**	**2 974 697 864**	**8 499 137**	**100,00%**
Total in USD		**1 405 125**	**414 888**	**236 564**	**6 442 560**	**8 499 137**		
Rate		**17%**	**5%**	**3%**	**76%**	**100%**		

Since 2017, the Ministry of Health has placed an order out of the State budget for 38 solar refrigerators and 2 cold boxes, which are expected to be delivered in 2018.

It should be noted that the Ministry of Health has been investing in procurement of pre-qualified CCE items from state funds since 2014. During the period 2015 to 2017, the Ministry distributed: 275 CCE items, including 165 solar direct drive and 110 electric ILRs.

Other specific funding is provided for vaccination. For example, funds made available by partners in response to the food crisis or the refugee crisis, particularly when these are used for integrated mobile activities, staff training and supervision, or for monitoring indicators.

In prospect, the Global Fund's results-based financing project (RBF), the European Union's budget support, and institutional support from AFD (French Development Agency) and the multi-sponsor DHIS2 project will all contribute to vaccine funding.

For these reasons, coordination of these funding resources and monitoring their implementation must be a priority for the future in order for them to be taken into account in subsequent reviews.

The EPI has adopted a transition strategy from absorption CCE to modern solar direct drive compression refrigerators (SDD) and ice line refrigerators (ILR) that are pre-qualified by WHO (registered with the PQS).

4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

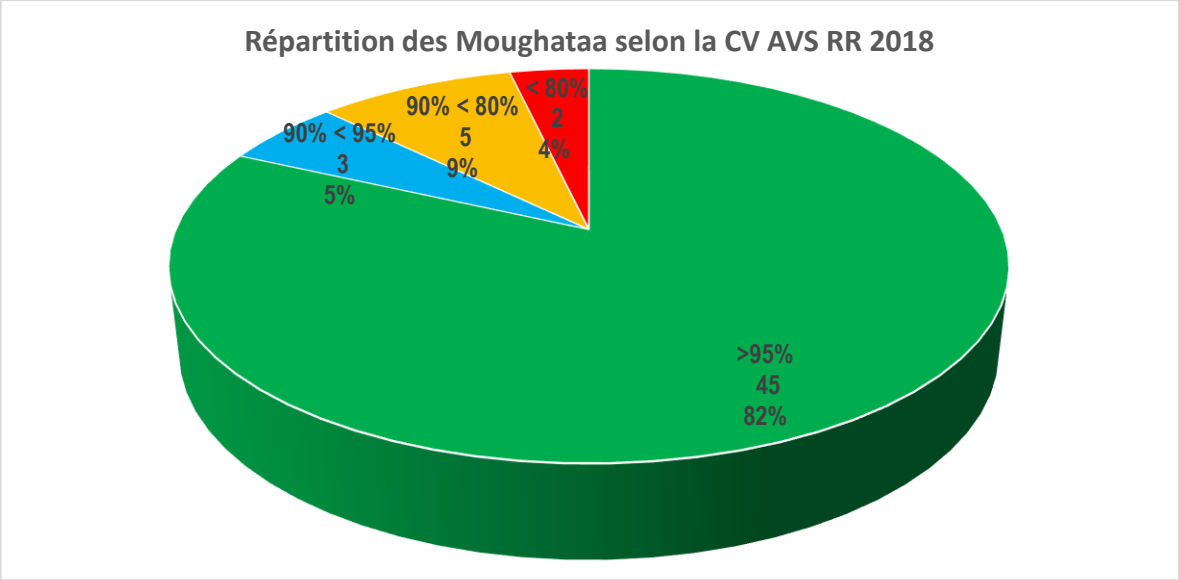
GAVI support made it possible to introduce the combined rubella and measles (MR) vaccine and to organise SIAs against these two diseases at the beginning of 2018.

The SIAs against measles and rubella were scheduled for implementation in December 2017 but due to cumbersome procedures and compliance with the requirements of the management process, they were postponed to February 2018.

Implementation and introduction of the SIAs went very smoothly.

The results of that campaign show good vaccine coverage in the majority of Moughataas. However, some were unable to achieve the 95% target (detailed results in appendix 3).

A total of 45 of the 55 Moughataas in the country recorded vaccine coverage of 95% or more. Among the 10 Moughataas that failed to achieve that target, 3 recorded coverage of >90%, 4 between 80% and 90% and 3 recorded <80% as shown in the graph below:



During the measles and rubella vaccination campaign, 33 cases of minor AEFIs (Adverse Events Following Immunisation) were reported from the entire national territory. No serious cases were reported.

Post-campaign assessment has been entrusted to WHO and has not yet been completed.

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

The implementation of HSS1 (2012-2017) encountered delays that led to a reprogramming of resources with the involvement of some partners to accelerate the implementation of activities. The necessary measures resulted in decisions to strengthen the Financial Affairs Directorate (DAF) and the Directorate of Planning and International Communication (DPCIS), and to use WHO and UNICEF for the execution of procurement. Activities related to priority strategies (free care, delegation of tasks, use of retired nurses, in addition to supporting district activities, such as supervision and advanced activities) were carried out using funds available in the DAF account, and reprogrammed funds were transferred to the EPI account. Implementation of the reprogrammed activities took place during the period from October 2016 to 30 December 2017.

These measures were intended to stimulate discussion about this approach at national level.

- The free health care strategy is a package made available to health facilities for the care of children under 5 years of age and pregnant women registered by the local authorities as destitute. Although data did not reach central level, this strategy is likely to have increased uptake of services by these targeted categories. As regards the provision of care for pregnant women in the Moughataas where the obstetrical package is in operation, the contribution of destitute women (5500 MRO) is deducted from the free package. Some Head Physicians believe that free care would be more effective than the delegation of tasks strategy. Further analysis on the impact of this strategy and its possible interactions with other initiatives to remove financial barriers is needed.
- The delegation of tasks strategy consists in the payment of bonuses to certain health personnel (115 health workers) who perform additional higher-level tasks in the 9 Moughataas of the GAVI/HSS1 ZCI. However, the allocation criteria and implementation procedures vary according to the district medical officers responsible for implementing this strategy. There have been improvements in performance in terms of coverage for key interventions however, it is necessary to review the strategy based on lessons learned in order to adapt it to needs in the field, before it can be implemented at national level. Also, tools need to be developed and Head Physicians trained in the use and follow-up of the strategy.

- Use of contractual agreements with retired nurses: This strategy involved 4 Moughataas, with one health worker per Moughataa out of the 9. The areas that benefit are those that are totally devoid of staff (isolation, difficult living conditions). This approach will not be repeated in HSS2.
- The other support activities (advanced strategy, mobile phones, supervision) have had a clear impact on vaccination levels and on the use of preventive services in general (see section: EPI data).

The HSS1 grant is part of a global framework involving other partners (Global Fund, World Bank, etc.) for health systems strengthening, in particular community activities and vehicle procurement for the remaining Moughataas not covered by GAVI, strengthening the national health information system through technical assistance and procurement of IT equipment for the target Moughataas. The contribution of these partners is in the process of being finalised.

The main bottlenecks encountered during the execution of HSS1 are:

- Insufficient capacity of the implementation and monitoring structures (DAF, DPCIS)
- Delay in the submission of supporting documents (quality of documents, low training levels and lack of supervision)
- Insufficient supervision activities from central to regional and local level
- Limited involvement of the DRAS (Directors of health actions at regional levels)
- Mobility of healthcare workers and low level of training

The majority of these problems were solved by providing technical assistants and deploying additional staff at DAF and DPCIS levels.

The implementation of the project was coordinated by a Monitoring Committee chaired by the Secretary General and composed of the DPCIS, DSBN (EPI), DAF and WHO. This Committee meets regularly each month. It has recently been extended to UNICEF and other beneficiaries (DRAS, DHP, DLM). The terms of reference of this Committee will be reviewed to adapt to the requirements of the new HSS2 grant and to ensure the link with other sectoral monitoring and coordination frameworks (CONAP, ICC, etc.).

The table below lists achievements related to the initial objectives of HSS1:

Objective 1	
Objective of the HSS grant (as per the HSS proposals or PSR)	O1. By September 2017, increase coverage of basic health services, including immunisation, in the ZCI
Priority geographies / population groups or constraints to C&E addressed by the objective	23 Moughataas Selected on the basis of the following criteria: - Low level of vaccine coverage - Isolation - Poverty level
% activities conducted / budget utilisation	All reprogrammed activities were 100% completed
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Activities undertaken: 23 4X4 vehicles for mobile activities in the 23 districts in the ZCI 23 kits of mobile activity materials (Folding equipment: screen, table, chairs, bed,...) for the 23 Moughataa Health Districts (CSM) in the ZCI. 14 incinerators adapted for 14 health facilities in the ZCI 33 solar energy units for lighting 33 Health Stations in the ZCI 33 Health stations in the Basic Care Equipment ZCI 23 ZCI CSMs equipped with adequate cold chains (VLS 400A refrigerators and freezers) 23 ZCI CSMs provided with equipment to ensure good storage conditions (metal cabinets, chairs, desks, etc.). Activities not implemented: All activities were carried out, UNICEF covered the costs of removal, transit and transport of equipment other than incinerators. The costs of transporting the incinerators and preparatory work for their installation on site were not foreseen, which has delayed completion of this project.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated needs for technical assistance)	See HSS2

Objective 2 :	
Objective of the HSS grant (as per the HSS proposals or PSR)	O2. By September 2017, strengthen the resources of the 9 CSMs in the initial ZCI by pursuing 2 innovative strategies for strengthening human resources for health: delegation of tasks and bringing in retired health workers on a contractual basis.
Priority geographies / population groups or constraints to C&E addressed by the objective	ZCI
% activities conducted / budget utilisation	Ditto
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	2.1 Continue payment of bonuses for tasks delegated to healthcare workers in the 9 CSMs of the GAVI/HSS1 ZCI (Bonus for delegated tasks: 115 healthcare workers / Quarter / 69,000 UM) 2.2 Continue payment of salaries for additional staff recruited from among retired healthcare workers in the CSMs of the GAVI/HSS1 ZCI (4 workers / Month / 123,000 UM)
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**)	Technical assistance See table showing TA and input from other partners
Objective 3 :	
Objective of the HSS grant (as per the HSS proposals or PSR)	O3. By September 2017, strengthen capacity for monitoring/ assessment and health data management in the ZCI and handle the administration and evaluation of the grant
Priority geographies / population groups or constraints to C&E addressed by the objective	Ditto
% activities conducted / budget utilisation	
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	3.1 Assist personnel involved in data management by providing IT tools (Procurement of 23 IT units) 3.2 Organise 2 training sessions on data collection and processing for the focal points of the CSMs in the ZCI (1 session: 3 days / 2 trainers / 12 participants)
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **needs for technical assistance**)	

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

The CCEOP project submitted in 2017 was approved by GAVI and the mission preparation process was launched with a first mission in April 2018 by a regional consultant from UNICEF. A roadmap was adopted for the purpose. It includes, among other things, setting up a national Project coordination committee, carrying out a georeferenced inventory of cold chain equipment (CCE) and developing a roll-out plan for new CCE. The collection and disposal of decommissioned cold chain equipment, in addition to its maintenance, constitutes a major challenge in terms of environmental protection for the CCEOP Project. The Project requires the manufacturer/supplier to provide training in the use and maintenance of the equipment for the benefit of personnel in the recipient structures. However, training alone will not be enough. A mentoring and monitoring system for the operation of these items of equipment by the Public Hygiene Directorate (DHP) and the EPI is essential for at least the first two years following installation of the equipment. This is to ensure a genuine transfer of skills in preventive maintenance and in the recording of maintenance operations on the cold chain equipment.

Hence the need for technical assistance to provide coaching in maintenance and in the elimination of biomedical waste.

4.4. Financial management performance

Absorption :

Implementing body	Planned amounts (USD)	Amounts used (USD)	Residual balance returned to GAVI (USD)	Absorption
State	371,43	348,00		93,69%
WHO	627,56	627,56		100,00%
UNICEF	874,012	838,617.61		95,95%
Residual balance returned to GAVI by the State			23,43	
Residual balance returned to GAVI by UNICEF			35 394,69	
TOTAL	**1 873,00**	**1 847,45**	**35 418,12**	**98,64%**

NB: *82 million MRO must be added to the initial reprogramming of the HSS1 (i.e. 234,286 USD, which was in the DAF account and not taken into account in the reprogrammed amount)*

Conformity: GAVI grants were subject to an external audit commissioned by the Ministry of Health covering the 2014, 2015 and 2016 fiscal years of HSS1 funds administered by the DAF. Similarly, the GAVI Audit Department carried out a scoping mission in Mauritania from 16 to 20 April 2018. This mission was organised as a prelude to the audit of GAVI funds scheduled for September 2018.

Observations of the GAVI pre-audit mission and the capacity assessment mission for HSS2:

No major anomalies were found in the financial statements. Nevertheless, it should be noted that some of the evidence for the use of locally available funds has not yet been reported to central level.

The GAVI capacity assessment team found a number of weaknesses which were appropriately tackled by the technical assistants (strengthening of the DAF, Tompro management software, procedure manual, etc.).

Financial management system: TOMPRO accounting software has been introduced in the DAF and the EPI. It is a financial management tool with a dual function: to facilitate the implementation of a reliable information system and to produce timely financial reports. DAF and EPI staff have been trained in the use of this software.

It is planned to introduce this software into Mauritania's fifteen (15) regional health directorates (DRAS) to make it more generally available for the effective management of grants.

Other partners of the Ministry of Health view the introduction of this tool and the strengthening of DAF capacity as major investments that facilitate progress towards the development of a common fund in line with the national health compact. This will also require the development of a common management framework for this tool, including agreement on procedures at all levels.

During the joint appraisal, an independent mission to monitor the impact of the strengthening of the DAF was undertaken.

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

N/A

4.6. Technical Assistance (TA)

With GAVI support, UNICEF provided technical assistance of two types: (i) UNICEF staff, including an international P3 professional who was a specialist in maternal and infant health until 30 August 2017, a national vaccination specialist on a temporary post until 30 August 2018 and a national specialist in communication for 3 months; (ii) a consultant for strengthening the interpersonal communication skills of vaccination providers.

In addition to this support, two other staff (one international P4 and one National Officer category C [NOC]) hired with UNICEF's own funds also contributed in providing assistance to the EPI.

All this technical input helped to support the EPI in the implementation of its work plan, including vaccination campaigns and their communication component, and also made it possible to deliver 3 out of 5 TCA milestones; those for the RED experiment and for the strengthening of the CIP were extended as they required considerably more time and resources. UNICEF assistance also made it possible to support the Ministry of Health's central level in sectoral coordination and the development of policies and strategies.

With regard to UNICEF, the year 2017 saw the development of a new 2018-2021 cooperation programme which maintains vaccination as a priority and guarantees continuity of the projects launched in this area in agreement with the Ministry and GAVI, i.e. working alongside the central EPI and local health teams to develop an operational model for the implementation of the RED strategy to boost vaccination performance and equity. The new UNICEF programme structure includes some minor changes that require GAVI support to adapt UNICEF technical assistance to the challenges and ambitions of the health sector. This has been done by setting up a unit comprising two national officers (an NOC paid from existing UNICEF funds and an NOB funded by GAVI, for whom recruitment has been set in train) to assist the districts and the regions in planning and implementing equity-aware work plans. An international P4 post is being created to oversee sectoral reforms already under way or in the process of being launched and to ensure that lessons learned from the implementation of programmes at operational level are capitalised on. This important position can only be filled by someone with a minimum of 2 years' salaried service.

Depending on the availability of resources, UNICEF may, in addition, be able to send national and international consultants to support the introduction of HPV, the CCEOP project, the development of community-based monitoring approaches to the immunisation status of children in real time and in other relevant areas in consultation with the EPI and local health system managers.

For the year 2017-2018, technical assistance (WHO) covered the following areas:

1. Support for the training of EPI staff: (a) Training of the 32 health workers responsible for the EPI in 3 regions of the northern axis (Inchiri, Adrar and Tiris Zemmour). The training took place in 2 pools (20 agents in Atar for the Wilayas of Adrar and Inchiri and 12 agents in Zouerat for the Tiris Zemmour region), (b) Training of the 24 health agents responsible for the EPI in 1 region of the southern axis (the Guidimagha region). Preparations for the training of EPI staff in the Trarza region are in hand
2. Support for improving data quality: (a) Training of focal points, and Head Physicians of the 9 districts (Moughataas) on DHIS2 in the 10 pilot sites, (b) paying for the EPI data manager for participation in the JRF workshop, (c) (f) paying for, and organising a national workshop to review the EPI data, and to update the data quality improvement plan, (g) financial support, and technical assistance for the organisation of an in-depth review of the quality of EPI data (ongoing), (h) Technical assistance, and financial support for a training of trainers workshop on DHIS2 for the DHIS/ EPI technical group
3. Support for the implementation of the post-introduction assessment of the IPV, and the SWITCH: this activity has been implemented, and the report has been completed and shared with the partners
4. Implementation of the Tailoring Immunization Programme (TIP) in two districts (or regions?) of Nouakchott South and North: Technical support, and financial support for a workshop on the EPI, during which: (a) an overview of the vaccination programme, (b) an introduction to concepts related to vaccination behaviour and an overview of the TIP approach, (c) stakeholder engagement in the TIP process and initial contributions on obstacles and catalysts that affect vaccination in three areas: 1) factors related to health services and to the system; 2) social, cultural and community factors; and, 3) individual factors. Recruitment of a consultant to do the situational analysis, and the results of this analysis were presented at a workshop that was organized with the EPI. The report of this analysis is currently being finalised.
5. Technical and financial support for the training of 15 journalists in Nouadhibou on vaccination topics, and the treatment of public health emergencies
6. Support for the reprogramming of HSS1; this has made it possible to acquire 23 vehicles (purchased through WHO), which will be available to the 23 priority districts of the EPI
7. Technical and financial support for the introduction of the MR vaccine, and the launch of the national MR vaccination campaign. The post-campaign review is in preparation.
8. Technical and financial support for the organisation of the Polio campaign, independent monitoring, and the reports has been finalised and shared with partners
9. Technical and financial support for the preparation of the Wellness Pass/MasterCard project, through the organisation of a brainstorming workshop, and analysis of the EPI situation (drop-out rate, denominator/target population), and finalisation of the concept note with the budget.

At DPCIS level (Planning, Cooperation and Health Information Directorate), a consultant to oversee the implementation of the HSS and two others to strengthen the NHIS in the DHIS2
At EPI level, technical assistance is needed in the following areas:
- Support for the work of the ICC
- DHIS2 monitoring,
- Introduction of the HPV vaccine,
- RED

Summary table of technical assistance needs 2018 / 2019

Priority needs and strategic measures	*Timetable for implementation of the proposed measures*	*Is technical assistance necessary? *(yes/no) If yes, indicate the type of assistance required*
Implementation of the RED appproach	*2018-2019*	*Yes, national consultants (2) One year UNICEF technical support*
Implementation of the routine EPI Communication Plan	*2018-2019*	*Yes, National consultants (2) three months UNICEF technical support*
Introduction of the anti HPV vaccine	*2018-2019*	*Yes, national consultant (1) /one year*
Implementation of the MR campaign	*2018*	*Yes, national consultants (2) one month*
Introduction of DHIS2	*2018-2019*	*Yes national consultants (2) one year*
Extension of cartography	*2018-2019*	*Yes national consultant one year*
Implementation of HSS2	*2018 - 2019*	*One national consultant (1 year) UNICEF technical support*
Development and configuration of the DHIS2 IT platform	*2018-2019*	*Yes IT consultant / 6 months*
Support for the DPCIS by a public health expert	*2018-2019*	*Yes, one national consultant /1 year UNICEF technical support*
Preparation for the implementation of HSS2	*2018-2019*	*Yes national consultant / 1 year*
Support for the DCD by an expert in surveillance of AFP, meaasles and other disease under surveillance /new vaccines	*2018-2019*	*Yes, national consultants (2) one year*
Support for the DCD : Ongoing assessment of surveillance activities	*2018-2019*	*Yes national consultant one year*
Support for the DPCIS for the transition from MAURI6 to DHIS2/ IT component	*2018-2019*	*YES, national consultant one year*
Support for the DPCIS for the development of an institutional/legal framework for health data	*2018-2019*	*YES, national consultant 6 months*
Support for the DPCIS/Training/leadership and management	*2018-2019*	*Yes, 1 person*
Support for the DPCIS/Training/Health economics	*2018-2019*	*Yes, 1 person*
Support for the DPCIS/Training/DHIS2	*2018-2019*	*Yes, 2 people*
Support for the DPCIS//HRD/EPI/ Human resources development plan	*2018-2019*	*Yes, 1 national consultant for 6 months*
Support for the EPI/ Development of a national waste management plan	*2018-2019*	*Yes, 1 national consultant for one year UNICEF technical support*
Support for the EPI/Technical assistance for the ICC	*2018-2019*	*Yes, 1 national consultant for one year UNICEF technical support*
Support for the EPI/ Elaboration of a national plan for cold chain maintenance	*2018-2019*	*Yes, 1 national consultant for one year*
Support for the EPI/Training/leadership and management	*2018-2019*	*Yes, 1 person*
Support for the EPI/Training/ health logistics	*2018-2019*	*Yes, 1 person*
Support for the EPI/Training/ Data management	*2018-2019*	*Yes, 2 people*
Support for the EPI/Training/MLM	*2018-2019*	*Yes, 3 people*
Support for the EPI/ for implementation of the CCEOP	*2019-2020*	*Yes, 1 person*
Support for the EPI/ Creation of NITAG	*2018-2019*	*Yes, a consultancy*
Support for the DAF/ Situational analysis of the DAF (Financial Affairs Directorate)	*2018-2019*	*Yes, a consultancy / 3 months*

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Introduction of the HPV vaccine 2. The RED approach 3. DHIS2/data 4. Cartography 5. Operational research 6. Assistance for the communication component 7. Support for monitoring the implementation of HSS 8. Support for DPCIS by a public health expert 9. Development and configuration of the DHIS2 IT platform 10. Preparation for the implementation of HSS2 11. Support to the DCD by an expert in the surveillance of AFP, for measles and other diseases under surveillance/new vaccines 12. Support for the DPCIS for the transition from MAURI6 to DHIS2/ IT component 13. Support for the DPCIS for the development of an institutional/legal framework for health data 14. Support for the DPCIS/Training/leadership and management 15. Support for DPCIS/Training/Health Economics 16. Support for the DPCIS/Training/DHIS2 17. Support for the DPCIS//HRD/EPI/ Human resources development plan 18. Support for the EPI/ Development of a national waste management plan 19. Support for the EPI/Elaboration of a national plan for cold chain maintenance 20. Support for the EPI / Training / Leadership and Management 21. Support for the EPI/Training/Health Logistics 22. Support for the EPI/Training/Data Management 23. Support for the EPI/Training/MLM 24. Support for the EPI/Training/Communication 25. Support for the EPI/ Creation of NITAG 26. Support for the DAF/ Situational analysis of the DAF (Financial Affairs Directorate)	1. Planned for 2019 2. Achieved in 5 Moughataas 3. Achieved in 14 Moughataas 4. Not achieved 5. Not achieved 6. Partially carried out by UNICEF 7. Achieved 8. Not achieved 9. Not achieved 10. Achieved 11. Not achieved 12. Partially achieved (requires more effective coordination with the Global Fund) 13. Not achieved 14. Not achieved 15. Not achieved 16. Achieved 17. Not achieved 18. Not achieved 19. Achieved 20. Not achieved 21. Not achieved 22. In progress 23. Not achieved 24. Not achieved 25. In progress 26. Achieved
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**

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

The Financial Mechanism was not appropriate for some activities such as mapping, action research etc.
These activities will be repeated in HSS2 to inform thinking on coverage and equity in urban areas as a complement to TIP activity and RED implementation.

Key finding / Action 1	**Upscaling to DHIS2**
Current response	Normative framework developed: revision of data collection tools, consensus on the battery (162 indicators) agreed with all priority programmes of the Ministry of Health in order to avoid parallel systems.
Agreed country actions	These tools will be tested in the Brakna region (funded by the EU AI-PASS project)

Expected outputs / results	Training for 15 Regional Health Action Directorates (DRAS), 57 Head Physicians, 15 Regional Focal Points and on the normative framework of 57 Moughataa Focal Points and 733 Head of Mission nurses (ICP) Training on the basis of data from 15 DRAS, 57 Head Physicians, 15 Regional Focal Points. Computer equipment for the 10 pilot Moughataas with WHO support.
Associated timeline	18 months from August 2018
Required resources / support	Finance for the training of providers (head physicians, focal points, etc.) for upscaling Two national consultants (Statistician and IT specialist) for 18 months Computer equipment for the 10 pilot Moughataas with WHO funding
Key finding / Action 2	**Introduction of new vaccines (HPV)**
Current response	Request has been accepted; the shipment of vaccines has been scheduled for early 2019 and preparations are underway
Agreed country actions	Communication campaign with prior identification of key messages on the basis of factual data
Expected outputs / results	Vaccine introduced into the country's immunisation calendar with coverage targets achieved for both school-going and out-of-school girls
Associated timeline	October 2019
Required resources / support	Technical assistance to support the introduction of HPV including data collection, development and implementation of a communication plan Technical support from UNICEF
Key finding / Action 3	**Maintenance of cold chain equipment, waste disposal and further preparation of the CCEOP project including the collection and destruction of old equipment used in the system.**
Current response	Maintenance of equipment is not currently carried out and the waste collection and disposal system is inadequate. Implementation of the CCEOP project has begun and will continue in 2019 with the collection and possible disposal of old refrigerators
Agreed country actions	Development of an Implementation Plan for the National Biomedical Waste Management Strategy that the government has funded. Development of a national strategy and plan for the maintenance of biomedical equipment, including the cold chain. Support for the operation of incineration units acquired for biomedical waste; staff training; transport and installation of equipment. Support for the implementation of the CCEOP Project including the identification, collection and disposal of old equipment
Expected outputs / results	The strategy developed; functional and suitable incinerators; the CCEOP implementation plan developed and monitoring in place, with old equipment collected and a solution found for disposal of it
Associated timeline	2018-2019
Required resources / support	1 long-term technical assistance for maintenance and 1 technical assistance in the form of a consultancy for the development of the action plan resulting from the strategy; training workshops for widespread training in the national strategy for the management of biomedical waste; monitoring and support activities. Equipment for collection, storage and transport of waste on the model already applied by the World Bank through the Inaya project. Finance for transport of incinerators and the completion of pre-installation work. Support over 6 months for the pilot operation of incinerators in order to plan for budgeting from State resources. Technical support from UNICEF
Key finding / Action 4	**Improving coverage and equity in urban and rural areas**
Current response	Identification of needs, TIP strategy, implementation of equity-based planning and programming in 10 districts including 2 in Nouakchott, Action Research and Mapping project are available

Agreed country actions	TIP strategy; implementation of equity-based planning and programming in 10 districts including 2 in Nouakchott; Support for planning and coordination in Assaba with a view to developing a regional health system model; Action Research and mapping projects are available. Mobile vaccination strategies; free health care strategy.
Expected outputs / results	The TIP strategy and counting of targets will be tested in 2 regions of Nouakchott; equity-based microplanning in 10 districts, including 2 in Nouakchott and 5 in Assaba with a regional approach; mapping to locate children and for assessing new infrastructure needs for the health areas in the Nouakchott Moughataas; introduction of a system to monitor the availability of immunisation services in real-time
Associated timeline	TIP and counting of targets March 2019-March 2020 in Nouakchott Equity-based micro-planning September 2018 - February 2019 Mapping and health areas March 2019-March 2020 A system to monitor the availability of services in real time to be introduced - December 2018 - July 2019
Required resources / support	1 technical assistance for mapping and planning the health areas Resources required to install the necessary infrastructure in the identified health areas Support for community-based organisations to count and monitor targets in 10 Moughataas Support for the implementation of equity-based microplans in 6 Moughataas that do not benefit from HSS2, Technical support from UNICEF
Key finding / Action 5	**Projet MasterCard**
Current response	Partnership with MasterCard, WHO, GiftedMom and the Government of Mauritania
Agreed country actions	Pilot scheme in the Nouakchott wilayas and Ouad Naga district
Expected outputs / results	Unique identification of each child through a "unique identify" card; registration and follow-up of the vaccination using a MasterCard card with read-out on tablets; SMS reminder system; opening of the child's first bank account
Associated timeline	2019
Required resources / support	Purchase of equipment (reading terminals/tablets, vaccination card), Analysis of the necessary technologies, 1 technical assistance for training in the use and maintenance of the equipment (technical support)
Key finding / Action 6	**Improving institutional coordination in the implementation of HSS2**
Current response	The compact has been signed, and structuring projects supported by other partners (WB, EU, GF) are in hand. Further coordination efforts are needed to ensure better integration and complementarity with HSS2 The national institutional framework for decentralisation now includes the creation of regional councils whose functioning will have a direct impact on the health system at regional and district level
Agreed country actions	Need for support for institutional coordination of the various sectoral reforms and initiatives and funding to strengthen the health system
Expected outputs / results	Integration of HSS2 into the national mechanism for financing and coordinating the health system Complementarity of the various interventions by the health system Better positioning of Regional Health Action Directorates (DRAS) in the programmes and in the development of experiments in the field in order to inform policy dialogue on reforms
Associated timeline	2019 a 2020
Required resources / support	Technical assistance for the Planning, Cooperation and Health Information Directorate (DPCIS) for scheduling, coordination of partners Financial support for the DPCIS Technical assistance from UNICEF

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

The GAVI programme coordination mechanism is managed by
- the national steering committee for the sector (CONAP)
- the Inter-Agency Coordination Committee (ICC) of the EPI
- the GAVI Programme Technical Monitoring Committee (CTS)
- subcommittees are set up whenever necessary to look into specific or occasional issues.

The committees are established according to their level of deliberation, implementation and coordination with other partners. These bodies have the advantage of often being formed from the same internal and external organisations. The Secretariat of CONAP and CTS is provided by the DPCIS and that of the ICC by the EPI

These bodies are created by memoranda issued by the Ministry of Health. Their terms of reference would benefit from further development and simplification to better clarify roles and responsibilities and determine their modus operandi.

The 2018 comprehensive joint assessment process began as soon as it was announced. Thus a select committee was appointed to prepare the review at the meeting of the Programme Monitoring Committee on 18 June 2018 (Minutes attached).

The committee was constituted as follows:
- a representative from the DPCIS (Planning, Cooperation and Health Information Directorate)
- a representative from the DSBN (Basic Healthcare and Nutrition Directorate)
- a representative from the EPI
- a representative from WHO
- a representative from UNICEF
- the consultant, in charge of monitoring HSS/GAVI

This committee held several meetings during which it:
- completed the Grant performance framework for the programme and posted it on the GAVI portal
- assembled all the required documents, namely:
    - the 2017 joint appraisal
    - the preliminary report of the 2018 joint appraisal
    - Comprehensive Multi-Year Plan (cMYP)
    - Recent information from the WHO/UNICEF Joint Reporting Form on Vaccine-Preventable Diseases (JRF 2017)
    - HSS budgets and financial reports,
    - terms of reference and minutes of the CONAP/ICC/CCSS meetings from the previous period
    - vaccine introduction plans, annual work plan
    - national health development plan
    - Recent report on the activities of the Expanded Programme on Immunization (EPI),
- held a conference call to determine how the review would be conducted, including the methodology to be followed and the field visit
- informed all stakeholders and sent terms of reference and invitations to participants
- prepared the workshop agenda and logistics
- prepared and shared a first draft of the joint appraisal report.

The review took place from 23 to 27 July 2018 for 5 days in accordance with the following timetable:
- the first day was devoted to contacts with partners, the Ministry of Health and the actors involved in implementation, and preparation of the field visit
- the second day was devoted to field visits
- the third and fourth days were dedicated to the review's workshop
- the fifth day was devoted to presenting the results of the review to the ICC.

The complete annual joint review concluded with a meeting of the ICC on Friday 27 July 2018 at 09:00 a.m. in which the report was approved after having been reviewed in its entirety by a small group of members of the ICC (Minutes of the ICC meeting held on 27 July 2018, attached with a list of those present).

The review was well attended by several teams:
- the Ministry of Health team including representatives from the regional and operational level
- the GAVI Country Team
- the GAVI Administration team
- the UNICEF regional team
- the WHO regional team
- the UNICEF Field Office team
- the WHO Field Office team
- A representative of SENLS, the principal beneficiary
- the PwC Audit Office team

The discussions took place in an atmosphere of equanimity and open-mindedness (see attendance list).

8. APPENDIX: 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	Non	Not applicable
Grant Performance Framework (GPF) * reporting against all due indicators	x		
Financial Reports *			
Periodic financial reports	x		
Annual financial statement			
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	x		
Data quality and survey reporting			
Annual data quality desk review			
Data improvement plan (DIP)			
Progress report on data improvement plan implementation			
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)			
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
CCEOP: updated CCE inventory			
Post Introduction Evaluation (PIE)			
Measles & rubella situation analysis and 5 year plan			
Operational plan for the immunisation programme			
HSS end of grant evaluation report			
HPV specific reports			
Reporting by partners on TCA and PEF functions			

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.

Annexes :

Appendix 1 : Coverage analysis report

Appendix 2 : VC and Equity Analysis (xlsx)

Appendix 3 : Results of the SIAs against measles and rubella carried out in February 2018.

Appendix 4 : Minutes of the ICC meeting of 27 July 2018