

Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analysed, and explained where relevant.

Country	Timor Leste
Reporting period	January 2015 – June 2016
Fiscal period	January – December
If the country reporting period deviates from the fiscal period, please provide a short explanation	
Comprehensive Multi Year Plan (cMYP) duration	2015-2020
National Health Strategic Plan (NHSP) duration	2011-2030

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
NVS Penta in existing presentation	Extension	2017	90%	US\$	US\$ 30,000
NVS IPV in existing presentation	Renewal	2017	86%	US\$	US\$ 93,000

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year

*Not applicable for countries in final year of Gavi support

2. COUNTRY CONTEXT *(maximum 1 page)*



This section does not need to be completed for joint appraisal update in interim years

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

Leadership, governance and programme management.

The EPI programme is headed by the EPI manager who is part of the Department of Maternal and Child Health. During the reporting period the EPI department has been severely understaffed with essentially only one senior officer (the EPI manager) in the office. During the JA mission the Minister of Health at the Council of Directors meeting approved to expand the EPI team and recruit two additional staff (one to work on technical immunisation issues and another to focus more on cold chain and logistics management).

Nationally the health services are administered under 13 Municipality Health Service (MHS) offices. Under these municipalities there are 68 health centres, 227 health posts and more than 400 SISCa posts. Currently there is no immunisation focal point at the MHS offices. Recruitment of these officers have been approved by the Minister of Health

Coverage and equity and other system components

During the reporting period an EPI and VPD surveillance review was completed with a comprehensive set of associated recommendations focusing on increasing coverage, improving quality of the immunisation programme, improving monitoring and the use of data, reinforcing immunisation supply chain management, and reinforcing the VPD surveillance system, among others.

A DHS is currently ongoing. This is very timely as Timor will greatly benefit from a greater understanding of current coverage and equity in particular as well as broader systems performance.

During the reporting period 2015 EVM assessment and associated improvement plan was completed. During the JA mission the Minister of Health called for a council of Directors meeting to endorse the improvement plan, which has been pending for some time. This is a very welcome development as the improvement plan now has strong political backing.

At the same council of Directors meeting, the Minister of Health also approved to expand the national EPI team. Currently this is limited to just one EPI manager. The Minister approved an additional two support staff and EPI focal points at MHS offices.

Immunisation financing

Fiscal space for health continues to be tight in the coming years. Government allocation to health in nominal terms more than doubled between 2008 and 2015 but in 2016 saw a significant drop. Between 2016 and 2020 the government budget for health is forecasted to grow only moderately and for 2020 is expected to be still lower than the 2015 budget. Government expenditure for health as a share of general government expenditure has been decreasing but has stabilised in the recent years at about 2-3%, considered to be low compared to other LMICs. At the same time ODA to Timor Leste in general is falling, also affecting spending in the health sector¹.

Immunisation planning, budgeting, execution and reporting is fully integrated with other health programmes and therefore budget and expenditure tracking is complex. Procurement of vaccines is carried out by SAMES, a central procurement agency/store, who has a separate budget, which it directly submits to the MOF. There is concern over a decreasing trend in this budget in the recent years (in particular considering increasing expenses with higher co-financing obligations due to transition and possible planned new vaccine introductions). Public Financial Management challenges persist and are being given specific attention to improve the efficiency and effectiveness of spending in the health sector (and beyond). The main donors to immunisation are Gavi, WHO and UNICEF. No other donors support immunisation directly but some, such as DFAT and USAID support other initiatives within the maternal and child health area with beneficial impact on immunisation.

¹ Timor Leste Medium Term Expenditure Pressure, WB 2015

Other relevant events

A NITAG was established in late 2015. The NITAG consists of 11 members, of whom 6 are core members. Although the NITAG has only formally met twice since Q4 2015, they have established a workplan which is currently awaiting endorsement by the Minister of Health. Although requiring further development, this is a positive development (please refer to TA for further details).

Currently about 80% of households have access to electricity. The government's plan is to ensure 100% of households' access to electricity by 2020.

3. GRANT PERFORMANCE AND CHALLENGES (maximum 3-4 pages)



Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

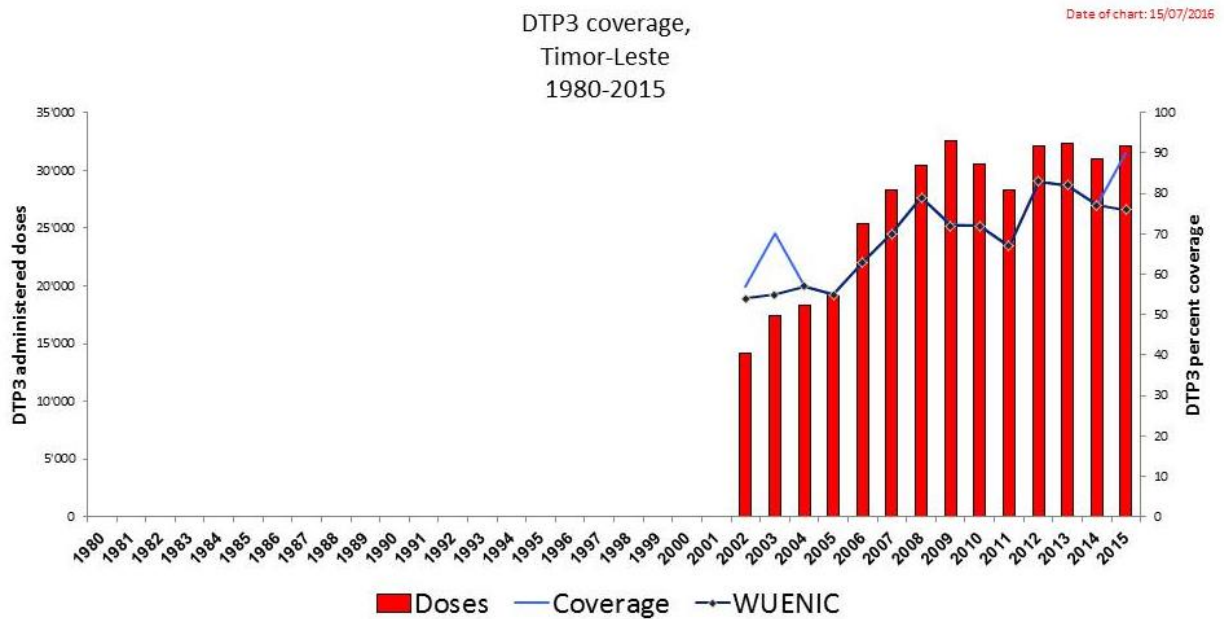
[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: programmatic performance of each vaccine programme against approved targets and planned activities, including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarity between all cash grants]

Coverage

Timor Leste recently completed its 2016-2020 cMYP. As part of this exercise, they have revisited their key immunisation-related targets. A summary of the most relevant targets (and current performance against these) is included below. During the JA, participants confirmed that these targets have all been approved by the Ministry.

Key metric	2015 actual (all admin)	2020 Target in the cMYP
Coverage: Penta3, MR1, FIC <1 year	76%; 70%; 63.6%	95%
Coverage: Rotavirus	N/A – plan to introduce 2018	80%
Coverage: MR2	Data not yet available (only switched from MSD to MR2 in Feb 2016)	80%
Drop-out: Penta1-3	5%	0%
Geographic equity: % of districts with ≥90% Penta3 coverage	38% ≥80%	92%
Vaccine wastage rate: MR	50% (in 2014)	25%

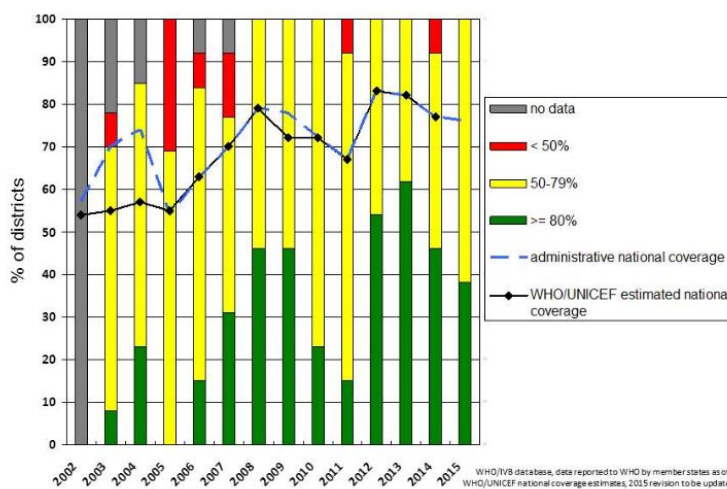
As per JRF, the coverage for routine vaccines paints a mixed picture. Administrative reported data suggests some declines (from 77% Penta3 coverage in 2014 to 76% Penta3 coverage in 2015 and 74% MCV1 coverage in 2014 to 70% in 2015). However, official estimates are $\geq 90\%$. These estimates are based on recent non-nationally representative surveys conducted. The reason for the differences in coverage rates is assumed to be a falling birthrate and the fact that the denominator has not been adjusted to reflect this change. A DHS is ongoing, it will provide additional (and independent) understanding of coverage and immunisation performance. There is also an EPI coverage survey planned in 2016 in Lautem district (following a recent survey in Dili district) using the revised WHO methodology. The EPI team has a strong desire to push ahead with this survey to compare results with those coming out of the DHS.



Source:
WHO/IVB database, data reported to WHO by member states and
WHO-UNICEF estimates of immunization coverage (WUENIC) as of 15 July 2016



% of District reporting <50%, 50-79% and $\geq 80\%$ DTP3 coverage,
Timor-Leste
2000-2015



Source:
WHO/IVB database, data reported to WHO by member states as of 20 May 2016
WHO/UNICEF national coverage estimates, 2015 revision to be updated in July 2016

Timor Leste successfully completed the switch from tOPV to bOPV as planned. IPV was introduced in February 2016 along with the replacement of measles second dose by MR. Unfortunately Timor has been impacted by global IPV shortages and the visit to the central store confirmed 0 stock of IPV (and stock-outs starting to appear at sub-national level). There have also been stock-outs of BCG reported. Discussions during the mission also suggested there are more frequent stock-outs on smaller scales, but these are not necessarily captured in formal reporting. The challenge with poor vaccine stock management and reporting was highlighted and discussed in detail in the 2015 EVM assessment.

Data quality

Data quality and weak routine monitoring, data collection, reporting and management continue to hamper the immunisation programme in Timor. There has not been any recent data quality assessments conducted. It appears that quarterly reviews (being supported by Gavi HSS already) at municipality level are trying to institutionalise more routine data reporting practices and the analysis of this data to address performance issues and inform workplanning. However, these quarterly reviews are still not routinely conducted in all areas and the completeness and accuracy of data included in the reports submitted by CHCs and HPs are questionable. The EPI and VPD surveillance review provide substantially more details regarding data challenges. Capacity continues to prove a significant barrier, particularly to define an approach and strategy to improve both numerators and denominators.

Observations during the JA visit confirm the picture of poor quality in data collection (report forms outdated, mix of report forms), poor understanding among HWs on how to collect data (filling out the register and tally sheet), limited use of data to inform planning. On the other hand, in discussions with HWs it seems they know very well the number of children in their catchment area and are actively tracing defaulters and drop outs in the community.

Immunisation services

Currently services are provided through fixed posts and limited outreach. Due to poor access including lack of roads, poor roads, mountainous terrain flooding etc, as much as 20% of the population in hard to reach areas have no access to basic PHC services including immunisation. The government funded Family Health program (providing home visits to the population) is aiming to reach every family in a community to assess health status and also to collect data to establish a family registry.

Health workforce

Expansion of the health workforce with for example doctors trained abroad is partly addressing the problem of hard to reach areas, but there is also a problem of integration of newly trained doctors into the system. They need an introduction to the national system and more particularly introduction to IMCI to be able to provide services effectively.

3.1.2. NVS future plans and priorities

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any expected future applications (include in table 1 above), emerging new priorities for the national immunisation programme]

Despite ambitious targets set forth in the cMYP, geographic equity seems to be decreasing as % of districts with Penta3 coverage $\geq 95\%$ decreased from 15% to 8% and $\geq 80\%$ decreased from 46% to 38% between 2014 and 2015. Again, the 2016 DHS will prove crucial to understanding more concretely the current inequities in Timor and hopefully this data will inform required targeted interventions as needed.

The cMYP highlights future plans for NVS including MR and JE campaigns in 2017 and planned introduction of Rotavirus in 2018. These have been included in financial projections. Timor is completing a Rota burden study (which was part of the evidence put forward for consideration for future introduction).

There have also been some discussions regarding HPV and PCV in future years. HPV appears to have some political support. PCV has been discussed, but at present, there does not seem to be a big push towards introduction. During discussions, it was highlighted that if there were some catalytic funding offered to Timor (eg: donation / co-financing), they may be more likely to consider introduction. Without such catalytic funding, near-medium term, future introductions may be unlikely. The NITAG will consider available burden studies and evidence from neighboring countries for potential future vaccine introduction discussions.

There are no immediate concerns for financially sustaining Pentavalent and IPV programmes in Timor. There are some programmatic areas of weakness that are relevant to all vaccines (immunisation data and monitoring systems, coverage and equity challenges, training and capacity of vaccinators etc).

The HSS grant is being used to address several of these and discussions during the JA explored quite in depth whether some reallocation of HSS funds could be considered to further strengthen efforts.

More specifically:

Routine immunization

- The target is to increase immunization coverage up to 95% or higher to reach VPD control/elimination targets. The strategy includes repositioning SISCa; by increasing mobile clinics/outreaches; by systematizing a strategy for defaulter tracking with clear guidelines and budget allocation
- Ensure the quality of the immunization programme; by documenting and scaling-up existing standards and best practices within health system and health practitioners; by ensuring regular supportive supervision at all levels and quarterly review in municipality
- Improve programme monitoring and use of data; by obtaining reliable population data and EPI targets, through family health registration; by analysing regularly immunization coverage data to identify low performing areas; by updating recording and reporting tools to include new vaccines
- Reinforce immunization supply chain management; by expanding cold chain to cover all health posts as appropriate; by accelerating implementation of Effective Vaccine Management implementation plan; by establishing a cold chain maintenance system at all levels
- Guarantee the success of new vaccine introduction; by ensuring good preparations for the MR and IPV introduction; by considering replacing the M9 dose with MR dose immediately after completion of the MR campaign and for MR dose at 18 months; by carrying out a school vaccination readiness assessment for the Td booster dose introduction at 6 years
- Enhance health promotion and community mobilization; by developing a communication strategy for routine immunization within the framework of the PHC programme; by increasing Church, school and local Government involvement in health promotion activities at all levels

Vaccine preventable diseases surveillance

- Reinforce the VPD surveillance system and ensure it fully functions; by designating a focal surveillance person at each health facility; by designating the national hospital and the 5 referral hospitals as sentinel surveillance sites establishing surveillance team; by training all health staff on VPD surveillance especially newly recruited medical doctors; by ensuring that surveillance guidelines, recording and reporting forms are available at all health facilities
- Build laboratory capacity at regional hospitals and CHCs for sample collection, storage and transportation
- Quarterly review and evaluate the VPD surveillance performances at municipality level using WHO standard surveillance indicators

Diseases elimination and control

- Ensure Timor-Lesté remains polio-free; by achieving and sustaining universally high population immunity through high routine coverage and periodic targeted SIAs; by achieving and sustain high quality AFP surveillance including laboratory testing; by updating wild poliovirus and cVDPV preparedness plan; by activating the NCCPE.
- Prepare Timor-Lesté for the polio “endgame”; by introducing IPV supplemental dose before end 2015; by documenting the last wild poliovirus type 2 in Timor-Lesté for the Global Certification Commission; by complying with laboratory containment requirements; by planning the shift from t-OPV to b-OPV in 2016

- Ensure the highest quality of MR campaign; by seeking the highest political commitment; by establishing a coordination mechanism and operational working groups; by ensuring good micro-planning at all levels; by seeking immediately social mobilization support of Church, Ministry of Education, Ministry of State Administration, and local Authorities; by considering phased implementation of campaign activities
- Further increase and sustain high TT protection; by reducing missed opportunities for mother and child vaccination; by improving documentation of doses provided and investigating protection; by considering vaccinating women of child bearing age in remote areas during routine immunization sessions; by developing a strategy to reach high coverage with new DT booster; by considering introducing TT (or Td) through school based immunization
- Enhance MNT surveillance; by conducting annual review of MNT related data; by encouraging maternal and neonatal death registration and audits; by encouraging community based Surveillance.
- Promote health facility/assisted/clean delivery; by exploring means to address access issues (free transport, incentives, communication tools); by improving community awareness on safe and clean delivery and clean cord care

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunisation, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]

The strategic focus of the HSS grant is well in line with the identified needs to improve coverage in equity. The main part of the budget is allocated to support training, micro planning, supportive supervision, and outreach activities at district and CHC levels. Observations during the JA mission confirm that these activities are an integrated part of the routine work at the district and CHC levels. Another important activity is MLM training which aims at improving management capacity at district level. The HSS grant also supports expansion of cold chain and transportation including provision of motor-bikes at CHC level for vaccine supply, outreach, and supportive supervision.

The main concern is related to the slow implementation of the grant (13% up until June 2016). The slow implementation will require a reprogramming/budget reallocation for activities to be implemented by end of 2018. The fact that the country is also transitioning out of Gavi support reinforces the need to adjust the HSS support to ensure activities contributes to sustainability in the EPI programme.

3.2.2. Grant performance and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: achievements of targets and intermediate results; actual versus planned activity implementation and financial expenditure; use of PBF reward and budgets/plans; degree of participation of key stakeholders in implementation of HSS proposal; implementation bottlenecks and key challenges regarding financial management of HSS grant; compliance with data quality and survey requirements]

HSS support to Timor Leste is well into its third year of implementation. Although first year of implementation (2014) was essentially according to plan, implementation to date is very slow. At the end of the current reporting period only 13% of the total budget of US\$ 2.9 million has been spend.

Activities which were planned but have been delayed include:

- MLM training: only 3 out of 8 planned batches have been trained;
- Roll out of micro planning at CDC level: out of total 13 micro planning has so far been introduced in 3 districts, 2 more are planned for 2016;

- Health needs assessment and baseline M&E in all districts is pending implementation;
- Central level supportive supervision is pending implementation;
- Development of financial management guidelines and costing tools (under MoH Finance Team) is pending implementation.

The JA also found that very few activities are approved for implementation in 2016 (total budget approximately US\$ 40,000).

The main reasons for slow implementation and low absorptive capacity are the same as identified in previous joint appraisal including. These include unclear procedures for how Gavi funded activities should be accounted for and handled within the government planning and budgeting system and limited staff capacity in MoH to prepare and push proposals through the system for approval and release of funds. The JA team had in-depth discussions with both technical staff and the director of financing within MoH to try to understand the reasons for slow approvals. The JA team also pointed out that there is a risk that Timor will lose funds which are not spent within the agreed timeframe (end of 2018). A new procedure will be introduced where Gavi HSS activities are included in the annual workplan of the MoH and will be acknowledged as MoH activities. The secretariat will follow up on the new procedure during the Transition Plan mission in September. The JA also found that some activities were over-budgeted and a reallocation of funds would be needed.

The problem of preparing proposals for approval will however remain, the MoH is still heavily dependent on technical support from the partners (WHO and UNICEF) to provide support in this area.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]

As mentioned above the JA found that the challenges of slow implementation of HSS activities need to be addressed urgently. Several things were proposed to speed up implementation:

- First of all the MoH will put in place new procedures for including HSS activities in their annual workplan and ensure that these activities are acknowledged as MoH activities with funding from Gavi. This will make it easier for administrative staff to identify proposed activities and make references to the Annual Workplan.
- Secondly the JA proposed urgent reprogramming, partly to expand already planned activities such as training, partly to add new activities addressing needs identified during the JA and Transition Assessment. These activities include activities such as:
 - Support towards implementation of EVM improvement plan; in the context of transition planning activities where it would make sense to use HSS funds would have to be identified, and activities where other partners/government could provide funding would have to be agreed.
 - Capacity building of the National Training Institute (INS) such as training of trainers. The INS plays a critical role in the sector providing in-service training packages to health workers. The JA found that INS can significantly scale up their training but in doing so would benefit from capacity building activities including training of trainers, short term technical support of external experts, and other similar activities.
 - Further investment in data quality (perhaps linked to DHIS2 pilot evaluation) was also identified as an area of great importance. The EPI team agreed that it is very timely to conduct an in-depth data quality assessment and review of existing immunisation data

systems and practices. This assessment could then lead to the development of a data quality improvement plan.

- Reallocation of HSS funds to help implement the EVM improvement plan and particularly to procure additional ILRs for CHCs is proposed.

A short proposal for these activities with an associated budget should be developed and submitted to the Secretariat for consideration and reallocation of HSS funds.

During the JA, it was also recognised that the metrics submitted with the original HSS application to be monitored are not very feasible and not aligned with current data collection and monitoring. It was agreed that the Timor team will re-work the HSS performance framework metrics to make these more realistic and feasible and submit these to Gavi for review.

3.3. Transition planning (if relevant)

[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]

Transition assessment mission took place in June 2016. Transition plan to be developed for implementation in 2017.

The JA was a joint mission with the transition assessment. As such, there was ample opportunity to discuss main challenges and their root causes related to sustainability challenges. Discussions on new activities to be considered for the HSS grant (due to slow implementation and original over-budgeting leading to very low cash utilization) emphasised the need for expanded or new activities to contribute to sustainability post-Gavi. The JA team also clarified that recurrent costs would not be considered under the current HSS support. The transition plan will be developed during the next mission 17-21 October 2016 and will use this JA report as a key document.

3.4. Financial management of all cash grants (e.g. HSS, VIG, campaign operational cost grant, transition grant)

[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]

The below table illustrates the cash support to TL and the utilization to date. There has been no adequate financial reporting received to date to understand the progress, utilization and expenditure to date of Gavi grants. The only formation received has been from the 2014 APR and subsequent bank statements.

Further no audit reports have been noted for the HSS grant.

Grant	Start Year	End Year	Approved Grant	Disbursed	Expenditure	Balance
HSS	2013	2018	3,071,667	868,513	405,896	462,617
VIG - IPV	2015	2015	100,000	100,000	40,000 ²	60,000
VIG - Penta	2012	2012	100,000	100,000		100,000

Financial and audit reports must be provided before future funding tranches are released to the country.

² Informal reporting

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritised strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Prioritised strategic actions from previous joint appraisal / HLRP process	Current status
1. Implementation of planned Gavi HSS activities in 2016 including carry over activities of 2014 and 2015	Not achieved, only a few activities are planned for implementation in 2016 (budget of approximately US\$ 40,000)
2. Full implementation of recommendations of joint national and international EPI and VPD Review 2015	Not achieved, however, during the JA mission the MoH endorsed the report and is committed to implement the recommendations.
3. Strengthen human resource capacity at the national EPI programme management by recruiting minimum of two new professional staff	Not achieved, however during the JA mission the MoH approved the recruitment of two new staff in line with the recommendations.

5. PRIORITISED COUNTRY NEEDS³

[Summarise the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]

Prioritised needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance?* (yes/no) If yes, indicate type of assistance needed
Urgently reprogramme HSS support in line with recommendations in the report	September 2016	TA support from WHO and UNICEF
Full implementation of recommendations of EPI and VDP review	Implementation to start in 2016	Government with support from WHO and UNICEF
Strengthen HR capacity in the EPI team and appoint immunisation focal points at the MHS offices	Starting 2016	Government with support from WHO and UNICEF

**Technical assistance not applicable for countries in final year of Gavi support*

³ Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS



This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

<p>Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism</p>	<p>The JA was a joint mission with the transition assessment. Information was collected by the JA Team during the mission to inform both the JA and the Transition Planning. Initial draft was prepared by the Gavi Secretariat with input from WHO and UNICEF and the EPI programme manager. Further improved draft was shared with the Head, MCH, MoH and National Director, Public Health. MOH. Following obtaining their comments, final draft was approved by the EPI Working Group prior to the submission for GAVI secretariat.</p>
<p>Issues raised during debrief of joint appraisal findings to national coordination mechanism</p>	<p>The meeting was raising the concern that procurement of vaccines through UNICEF SD might be in danger due to a 10% limit (of the total budget of SAMES) to single sourcing is allowed. The Minister of Health will bring this issue to the attention of the Prime Minister.</p> <p>The meeting was very concerned about the slow implementation of HSS activities. The Minister of Health proposed a monthly follow up of implementation and urged all relevant teams to eliminate unnecessary delays in the approval process. The new process proposed by the Director of Finance was also discussed.</p> <p>The meeting also raised the issue of advocate for more funds from Ministry of Finance and the need for evidence on progress in the health sector (return on investment for vaccines for example). WHO, UNICEF and Gavi will support in this respect.</p> <p>PBF was discussed and the Meeting agreed that a plan for how to use the PBF funds should be presented in September.</p>
<p>Any additional comments from:</p> <ul style="list-style-type: none"> • Ministry of Health • Gavi Alliance partners • Gavi Senior Country Manager 	<p>The MoH reiterated the importance of technical support from WHGO and UNICF.</p> <p>The MoH raised the issue of need to recruit more staff to the health sector and that difficulties in recruiting staff is impacting on service delivery.</p>

7. ANNEXES



This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

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

The initial draft was prepared by the WHO and UNICEF immunisation NPOs with the advice from the national EPI programme manager. The draft was further developed by EPI, WHO and UNICEF Cos, and commented on by Gavi Secretariat. The final draft was shared with the head MCH and National Director public Health within the MoH in Timor Leste before being submitted to the Gavi Secretariat.

Annex B: Changes to transition plan *(if relevant)*

Changes proposed	Rationale for changes	Related cost (US\$)	Source of funding for amended activities	Implementation agency	Expected result