Programme Support Rationale – 2016

This document is intended to accompany national health and immunisation plans, budgets, and other reporting (e.g. performance framework and operational workplan & budget) submitted to Gavi as part of routine monitoring.

Part A: Current Gavi support and lessons learned

1. Country information

Country name	**Guinea**
Years covered by National Health Plan:	2015 – 2024
Years covered by Health System Recovery and Resilience Plan	2015 – 2017
Years of the immunisation strategy (eg cMYP):	2016 – 2020
Start and end dates of national fiscal period	1 January to 31 December
Total annual immunisation budget (past yr):	*NA*
Start and end dates of annual operational work planning	June–November
Target date for finalisation of annual workplan	*31 December*
Target date for funds arriving in country	*January 2017*
Next portfolio review (year of immunisation strategy)	2020

2. Existing portfolio of Gavi support

Vaccines (routine, SIA)	**MenA campaign (2014), Penta, yellow fever and IPV**
Financial (HSS, Ops, VIG)	HSS1 (US$ 2,134,500; 2012–2016) Operational support for MenA (US$ 2,321,536; 2014–2015) EPI Recovery Plan (US$ 6,050,152; 2015) VIG ($356,500; 2015)

3. Status of country's performance against key immunisation indicators aligned to the Gavi Strategy (2016–2020), based on the country's updated performance framework

Measles-containing vaccine (first dose) coverage at national level (MCV1)	**62.8% (2016 Immunisation Coverage Survey)**
Reach of Routine Coverage: Penta3 coverage at national level (Penta3)	66 % (2016 Immunisation Coverage Survey)
Geographic equity of national immunisation coverage: percentage of districts or equivalent administrative area with Penta3 coverage greater than 80%	73% (2015 JRF)
Equity of immunisation coverage by wealth status: Percentage-point difference in Penta 3 coverage between poorest and wealthiest quintiles	*32.4 % for the poorest quintile and 62.2% for the wealthiest quintile, representing a difference of 29.8 percentage points (2012 DHS)*
Immunisation coverage by educational status of mother/caretaker: percentage point difference in Penta3 coverage among children whose mother/caretaker received no education vs. completed secondary education or higher	*43% for mothers who received primary education and 56% for secondary, representing a difference of 13 percentage points (2012 DHS)*
Data Quality: percentage point difference in Penta3 between national administrative coverage and survey point estimate	difference of 38 percentage points in 2015 (WHO/UNICEF 2015 estimate)
Country composite score on last Effective Vaccine Management (EVM) (year and aggregate score)	*37% (2016 EVM report)*
Drop-out rate between Penta1 and Penta3	difference of 9 percentage points (WHO/UNICEF 2015 estimate): DTP1=60 and DTP3=51

Investment in routine immunisation per child	*Prefilled by Secretariat*
Other relevant information…. (add as needed)	*Prefilled by Secretariat*

4. Past grant performance, implementation challenges and lessons (3-4 pages)

To complement the data as reported in the updated performance framework and financial reports, explain any issues such as the under achievement of targets, associated implementation challenges and key lessons from the past reporting period.

Briefly comment across vaccine (NVS) and health systems and immunisation strengthening support (HSS, Ops, VIG):

- **Actual vs. planned activities**
- **Significant over or under expenditures**
- **Participation of key stakeholders during the past year of implementation**
- **If relevant, the use of performance-based HSS payments**
- **Status / findings from data quality assessments or surveys completed since last reporting to Gavi**

In the course of the last five years, the Republic of Guinea benefited from a Gavi Health System Strengthening Grant (HSS 1) for the 2010-2016 period. This grant is jointly managed by the Ministry of Health and the WHO country office. It includes additional support for the post-Ebola recovery of the Expanded Programme on Immunisation – the EPI, (managed by UNICEF) – for 2015-2016.

1) Performance in the implementation of previous grants

1.1 HSS 1

The total Gavi grant to Guinea for "Health System Strengthening" (HSS1) amounted to US$ 2,134,200. The two main target objectives of this grant were poorly met. Immunisation coverage in 2015 was only 66% for Penta3 and 63.5% for MCV[1]. Furthermore, accessibility of essential care was low, with 8 out of 10 health facilities (81%) offering immunisation services. Only 7% were capable of offering the full service package (SARA, 2015). The main activities undertaken in the framework of HSS1 implementation included, among others: procurement in the cold chain, logistics, medicine and inputs in basic and comprehensive obstetric care (50 solar refrigerators, 50 motorbikes, 5 supervision vehicles, 2 ambulances, BEmOC and CEmOC kits, and the distribution of medicines and caesarian kits to health facilities); support for institutional strengthening, coordination at all levels (the organisation of regional and prefecture technical committees for health – RTCHs and PTCHs – and supervision visits from the central, intermediate and district levels).

The joint appraisal of the HSS1 performance framework carried out in 2015 underlined low levels of completion of planned activities (48%) and financial execution (38%). The reasons for this poor performance include, among others: (i) weak national leadership in grant management; (ii) lack of clear definition of roles and responsibilities in implementation and of the management stakeholders; (iii) repeated stockouts of vaccines and inputs; (iv) poor supply chain capacity; (v) insufficient administrative and financial management; and (vi) the situation linked to the Ebola Virus Disease (EVD), which had been rife in Guinea since the end of 2013. Following the joint appraisal, a request for extension and reprogramming of funds allocated to the HSS1 had been recommended.

1.2 EPI Recovery Plan (during and after the Ebola epidemic)

As part of EPI recovery in the Ebola context, Guinea benefited from an additional financial support of US$ 6,050,152 from Gavi for the short and medium term (18 months, from July 2015 to December 2016).

The performance of this plan has proven noteworthy, from the evaluation of its implementation: 69% of programme execution and 70% of financial execution as of 31 May 2016. Its main achievements concerned strengthening logistics and the cold chain (2 lorries, 100 motorbikes, 159 solar refrigerators); the recruitment of 100 health workers; the conduct of the measles monitoring campaign; immunisation coverage evaluation and effective vaccine management assessment. Still, the persistence of the Ebola epidemic (EVD) and the organisation of several series of polio immunisation campaigns have had an impact on routine immunisation per site. Despite the persistence of the last Ebola foci at the end of 2015 and the beginning of 2016, the country has made significant advances in simultaneous response to the polio epidemic that should be highlighted[2]. National immunisation campaigns in this difficult context have made access to unvaccinated children possible, above all at the level of certain areas poorly covered or still subject to the polio epidemic (Upper Guinea: Siguiri, Faranah district).

The activity areas with low HSS1/EPI Recovery Plan completion rates had to do with epidemiological surveillance, logistics chain management, strengthening of the management unit at the central EPI level, management of immunisation and surveillance data, capacity building for health personnel, supervision, and project monitoring/evaluation.

Activities whose costs were underestimated include the purchase of supply lorries (the amount provided for four

[1] Report on coverage survey among children aged 12 to 23 months, 2016.
[2] Report, 2nd independent evaluation of the cVDPV2 epidemic response in Guinea, Polio Global Initiative, 19 August 2016.

lorries covered only two) and communication for development and institutional support.

2) Evaluation of data quality management in immunisation

Stakeholders have perceived poor quality in the immunisation data sent in by the peripheral levels and the completeness of reporting. Data quality assessment conducted by the AMP in 2014 yielded the following observations:

- Completeness is generally good at all levels (HCs 100%, Districts 97% and Regions 90%).
- Promptness, on the other hand, is not always good (HCs 53%, Districts 48% and Regions 6-73%).
- Health centre reports to the districts were 70% exhaustive for the period assessed, district reports to the regional level rated 80%, and regional reports rated 25%.
- In 75% of HCs, there were no significant differences between reported and checked Penta3 data.
- Over-reporting was noted in 4 of the 20 centres visited (20%).
- Accuracy was good in 7 districts out of 10 (70%), with under-reporting in one district and over-reporting in another.

This poor performance could be linked not only to the weakness in leadership at the central level, but also to the insufficiency of proper work equipment and materials and low data processing, analysis and use capabilities at all levels.

3) Lessons learned

By way of lessons learned in HSS1 and Recovery Plan implementation, it is to be noted that:

a. In the implementation of the EPI recovery and HSS1 plans, several stakeholders (civil society organisations, technical and financial partners - UNICEF, WHO, AMP, USAID, UNPF, POSSAV - communities, NGOs, etc.) have helped carry out activities covered by the different grants, such as social mobilisation and the mobilisation of material, financial and human resources. This has made it possible to develop a solid and effective partnership between the different stakeholders.
b. The establishment of a multi-sector partnership (Ministry of Health/EPI – Unicef - POSSAV) in managing a project of multiple dimensions has turned out a model of success and good performance in terms of the EPI recovery plan (recruitment of foreign and national technical assistants, the use of accounting and financial tools and the proper supply mechanism, etc). This has redounded to the rapid procurement of inputs, logistics and the immunisation service offer to the population in the restrictive context of the Ebola crisis.
c. The conduct of the test on immunisation acceptability amongst the community and the applicability of the WHO guidelines in infection prevention (IP) have benefited population support and the implementation of activities in response to the measles epidemic in the districts of Gaoual and Koundara in the context of health crises (Ebola outbreaks) in 2014 and 2015.
d. Adequate guidance of health workers at the operational level has been hindered by poor capacity in several areas: (i) management (not enough personnel, profiles poorly adapted and qualified for the required tasks); (ii) coordination of the management teams of districts (no district was able to hold its four Prefectoral Technical Health Committee ordinary sessions in 2015) and of regions (no region held its two Regional Technical Health Committee ordinary sessions in 2014 and 2015); and in (iii) EPI coordination (not enough personnel assigned, organisational chart not suited to the work volume and poorly filled out to date). As a result, achievement of the expected performance level has remained unsatisfactory.
e. The lack of immunisation services integration into the private sector and in public hospitals limited access to and the use of the services during EPI recovery plan implementation.
f. The low level of technical skills and insufficiency of personnel monitoring in health service training did not facilitate satisfactory implementation of immunisation activities.
g. The absence of a national "Common Fund" for integrated assumption of the Minimum Package of Activities (MPA) affected the use of the funds available in the country to meet traditional vaccine purchase and co-financing obligations and the implementation of other operational activities for strengthening the health system, including immunisation.
h. The absence of harmonised procedures for administrative, accounting and financial management and of clear implementation guidelines for the National Health Development Plan (NHDP), the Health System Recovery and Resilience Plan (HSRRP), the operational action plans (AOPs) and the EPI Recovery Plan (EPIRP) has affected the effectiveness and efficiency of these plans at the national, regional and district levels.

5. Financial sustainability (and if relevant, transition planning)

For areas of Gavi's existing support that represent major investments in recurrent costs, briefly explain progress in planning/sustaining these financially once Gavi support ends.

If relevant, describe implementation progress of planned transition activities; and changes required to the

transition plan for coming years, including rationale and costing/proposed financing.

According to the Gavi classification, the Republic of Guinea belongs to the category of countries in the **"initial self-financing"** phase of the immunisation programme**.** These are countries whose Gross National Income (GNI) per capita is less than or equal to US$ 1,045[3]. To implement this, they contribute to co-financing in the sum of US$ 0.20 per dose.

To sustain Gavi grant achievements, the country will prepare a transition plan with the support of its partners. Implementation of this plan will require financing from the government, which takes account of a 2-percentage point annual increase for that part of the national development budget allocated to the health sector until it reaches 10% by 2019 and 15% in 2024. Likewise, the partial coverage of costs by service and delivery structure and the additional support brought in by technical and financial partners (UNICEF, WHO, World Bank, UNPF, EU, GIZ, USAID, the Global Fund, etc.) will also contribute to implementing the transition plan. The continuous improvement of health system governance will be a gage for the success of this transition. Currently, the country is in an initial and preparatory phase marked by consultations with the different stakeholders for this purpose.

The new HSS 2 grant and immunisation support for the 2017-2021 period will make it possible to maintain the achievements of previous grants and will target 21 priority health districts performing poorly, distributed over 8 regions. The criteria used to select these 21 districts are:

- IC Penta 3/MCV <80 %
- % of children aged 12-23 months who have not received any routine dose;
- Absence of TFPs in the districts.

For the purposes of Gavi support for this application, these 21 districts have been subdivided into two categories based on the complementary nature of the interventions to implement:

a) Category 1 (12 Health Districts): Implementation of the comprehensive package (EVM plan, capacity building for staff, coordination mechanism, monitoring, etc.). These are: Kankan, Mandiana, Kouroussa, Kerouane, Siguiri, Forecariah, Dubreca, Telimele, Gaoual, Matoto, Ratoma and Pita.

b) Category 2 (8 HDs): districts where the complementary package (vaccines/logistics) will be provided for the interventions proposed by the TFPs present in these districts. Technical and financial partners are, among others, the World Bank (project to improve primary healthcare services), the GF (support for health system strengthening for AIDS, malaria and tuberculosis), German Cooperation (projects to improve mother and child health coverage in vulnerable areas), French Cooperation (capacity building for biomedical diagnosis in health facilities), and USAID (project for surveillance and international safety in health). These districts are: Labe, Dabola, Dinguiraye, Faranah, Kissidougou, Gueckedou, Macenta, Lola and Yomou.

Regarding sustainability, this proposal purports to continue and extend preceding interventions. Current government initiatives (the gradual recruitment of 2,000 health workers a year, implementation of the national compact, increasing subsidies to the benefit of health facilities, the commitment to progressively raise that part of the budget allocated to the health sector from 4% in 2016 to 10% by 2020, the consequent provision for the budget line and the effective disbursement of funds for immunisation). The government likewise intends to strengthen the consultative framework and the consultations with technical and financial partners. Likewise, progressive appropriation of domestic financial resources for health by the government (mobilisation of financial resources from the mining sector, taxes on mobile telephony, tobacco, petroleum products, etc.). All these collaboration initiatives address the continuity of investments and will contribute to meeting needs in medicines and routine vaccines, the supply of caesarian kits, and the maintenance and operation of the cold chain, vehicles and motorbikes for health staff use.

Part B: Overview of the action plan for the duration of the national immunisation strategy

6. Planned vaccine introductions for the duration of the national immunisation strategy

This section should include any future vaccines currently under consideration (including recurrent campaigns) by the country. This document is indicative of countries plans and does not represent a commitment by the country to introduce the vaccines listed below.

6.1. Vaccines planned for use in the immunisation programme, including in recurrent campaigns

Vaccine		**Month / year of introduction or SIA**	**Comments**, including preferred presentation	**Routine or campaign**
1	Vaccine against pneumococcal infections (PCV-13)	March 2018	4 doses per vial	routine
2	Vaccine against diarrhoeal rotavirus (rota)	October 2018	1 dose per vial	routine

[3] General Guidelines for Application in 2016, Gavi.

	infections			
3	Conjugated vaccine against meningococcal meningitis A (Men A)	March 2019	10 doses per vial	routine
4	Vaccine against human papillomavirus (HPV)	June 2019	1 dose per vial	routine
5	Type 2 polio vaccine (type 2 mOPV)	December 2016	20 doses per vial	SIA
6	Tetanus-Diphtheria vaccine (Td)	January 2017	10 doses per vial	routine
7	Measles-rubella vaccine (MR)	June 2020	10 doses per vial	routine

6.2 Request for Vaccine Presentation Switches		
Vaccine	**Month / year of switch**	**Comments**, including preferred presentation
Not applicable (NA)		

6.3 New Vaccine Introductions and recurrent campaigns

If the proposed introductions and campaigns are not included in national strategies, further information may be required by Gavi.

- For introductions and SIA planned in the next two years: indicate the additional annual co-financing requirement and briefly summarise major programmatic challenges to be addressed prior to introduction for each vaccine or SIA (ie cold chain expansion). Activities preparing for vaccine introduction should be reflected in the country's annual work plan.
- For introductions and SIA planned in the next 3-5 years: indicate the vaccine and estimated year of introduction, the rationale for inclusion, a description of internal consultation (NITAG, ICC, MoH) and decision making process including timing for decision, programmatic and financial sustainability considerations and identification of Technical Assistance needs in the coming years.

Vaccine 1	Estimated year of introduction	Estimated annual co-financing
Vaccine against pneumococcal infections (PCV-13)	2018	US$ 209,939 (2018)

Major programmatic challenges to be addressed prior to introduction of each vaccine or SIA and associated steps/timing to prepare for introduction:	For PCV 13 introduction, following programmatic challenges are to be noted: - **Poor storage capacity at the intermediate and local levels** Positive storage capacity at the central level is sufficient for the introduction of this vaccine in 2018. However, this remains insufficient at the intermediate and local levels. To meet demand, Guinea projects to remodel its supply system by the end of 2016 by conducting a study/evaluation on its cold chain. The results of this evaluation and the acceptance of the application to the cold chain equipment platform will make it possible to deal with the challenges related to insufficiencies in storage capacity and supply at the intermediary and peripheral levels. While waiting for the results of this study, conversion of the three cold rooms available in Kankan, Labe and Nzerekore to solar power and their use as sub-national storage facilities could enable improvement of the distribution system. At the district and health centre levels, storage capacities must be strengthened starting in 2017, account taken of future introductions (PCV-13, rota, MenA, HPV). During the recovery plan implementation, 175 SDD solar refrigerators were installed. In the context of the new Gavi application, this process will be pursued starting in 2017. - **Poor country capacity to sustainably ensure both purchase of traditional vaccines, with co-financing remaining a great challenge** (see Chapter 5, financial sustainability). - **Shortcomings in biomedical waste management.** In the context of biomedical waste management, the country has 25 incinerators installed and 26 not installed. The big challenge is to install all these incinerators and make them operational. Account taken of biomedical waste (BMW) hazards, the national strategy for biomedical waste management (BMWM) plans to equip each health centre with a solar incinerator. Apart from Redline incinerators, the others are practically

	unsuitable for our conditions (high fuel consumption, complicated maintenance, not environment-friendly, with electrical demands that are hard to meet). The incinerators provided by China during the epidemic did not respond to expectations and are not always used. The incinerators are basically located in the hospitals, while immunisation occurs in the communities; i.e., at health centre level. Prior to introduction of the PCV 13, the following steps are needed: - **Coordinating Committees**: the set-up of functional coordinating committees at all the levels of the health system at least 6 months before start-up is indispensable to the conduct of any campaign or new vaccine introduction. - **Planning, in particular Micro-planning**: the involvement of the different agents and partners in all the steps of introduction planning is fundamental; the preparation of micro-plans for the districts (HPs, HCs and DHTs) with the involvement of CHWs who have in-depth knowledge of their areas and the members of the COSAH will enable better resource distribution and prevent stockouts. - **Supervision**: the quality of local supervision has an impact on immunisation team performance and coordination. This quality depends on the quality of the supervisors hired, their training, but above all their regular monitoring and evaluation. - **Waste management**: a waste management plan with input, among others, from hospitals as to the destruction of waste from immunisation activities, reinforces safe waste management. The monitoring and evaluation for the implementation of this plan is critical. - **Monitoring**: the systematic organisation of monitoring before (preparations), during (rapid convenience survey) and after (coverage monitoring) the activity, including immunisation coverage surveys, is indispensable to track and correct shortcomings in the course of implementation. - **Resources**: the timely deployment of sufficient resources allows for the proper execution of activities; hence, the need to accelerate guidelines and procedures for the release and use of resources. - **Communication**: the involvement of government, political, traditional, religious and other authorities, above all at the community level, who are skilled in communication, helps improve community support for immunisation activities. - **Consolidating** and disseminating good practices that have emerged from past campaigns. - **Training**: this should be conducted over time with adapted tools by trainors who have themselves been previously trained.
For long-term plans, rationale for inclusion, description of decision-making process, lessons learned from past introductions, and TA needs	1) **Rationale**: on the epidemiological level, the main causes of morbidity and mortality are related to communicable diseases, including potentially epidemic diseases and vaccine-preventable diseases. Among the other communicable diseases, 6%[4] of children less than five years old present symptoms of acute respiratory infection. These pathologies are the second greatest cause of mortality among children **under 5.** Neonatal infections are also significant causes of mortality in this age segment. Introduction of PCV-13 will enable effective reduction of pneumococcal-related risks of mortality. 2) **Decision-making Process**: in accordance with strategic international and regional orientations, and account taken of national priorities in the light of the disease burden and the advantages linked to the introduction of the vaccine concerned, the EPI Coordination will prepare and submit a conceptual note to the ICC and/or the NITAG for opinion and approval by the Cabinet. A communiqué will be sent to the Council of Ministers to provide information. 3) **Lessons learned** from previous introductions (DTP-HepB-Hib and IPV) are

[4] Source: PNDS (NHDP)

	as follows: – Good preparation at least 6 months before IPV and pentavalent introduction into the routine EPI coupled with TFP support have been shown to guarantee the success of that event at all levels. – Organising a post-introduction evaluation made it possible to draw important lessons and correct shortcomings for future introductions. – The use of 10-dose vials as against mono-dose vials facilitated pentavalent vaccine management at the level of immunisation sites. In this context, the country will be needing technical support, particularly in the areas of micro-planning and the preparation/revision of tools.

Vaccine 2	**Estimated year of introduction**	**Estimated annual co-financing**
Vaccine against rotavirus (rota) infections	2018	NA
Major programmatic challenges to be addressed prior to introduction of each vaccine or SIA and associated steps/timing to prepare for introduction:	The programmatic challenges before the introduction of the rotavirus vaccine and the associated steps/timing for preparing the introduction are identical to those of PCV 13. Those steps previously mentioned in PCV13 introduction are identical for rotavirus vaccine introduction.	
For long-term plans, rationale for inclusion, description of decision-making process, lessons learned from past introductions, and TA needs	1) **Rationale**: viral diarrhoea remains one of the main causes of child morbidity and mortality in Guinea. They represent 16% of the transmissible diseases[5] among children under five and are the third greatest cause of child mortality. Introduction of the rotavirus vaccine will make it possible to reduce child mortality caused by viral diarrhoea. 2) **Decision-making process**: in accordance with strategic international and regional orientations, and account taken of national priorities in the light of the disease burden and the advantages linked to the introduction of the vaccine concerned, the EPI Coordination will prepare and submit a conceptual note to the ICC and/or the NITAG for opinion and approval by the Cabinet. A communiqué will be sent to the Council of Ministers to provide information. 3) **Lessons learned**: The lessons learned from the introduction of PCV 13 will make it possible to improve rotavirus vaccine introduction. In this context, the country will be needing technical support, particularly in the areas of micro-planning and the preparation/revision of tools.	

Vaccine 3	**Estimated year of introduction**	**Estimated annual co-financing**
Vaccine against meningococcal meningitis A (MenA) infections	2019	US$ 60,559.
Major programmatic challenges to be addressed prior to introduction of each vaccine or SIA and associated steps/timing to prepare for introduction:	For MenA introduction, the programmatic challenges are: ▪ The existence of a gap de 7,934 litres for Men A introduction, which will require: (i) the installation of an additional cold room of 40 m3 at the central level, (ii) the adaptation of 3 sub-national storage facilities to solar energy, and (iii) the strengthening of storage capacities at the district level and at health centres; ▪ An accumulation of susceptible subjects (children aged 1 to 5 years) between the preventive campaign organised in August 2015 and the projected date for MenA introduction, for whom a campaign is organised in the 17 health districts of the meningitis belt.	

[5] Source: NPHD 2015-2024

	Introduction will observe the steps previously described (see PCV13 and rotavirus).
For long-term plans, rationale for inclusion, description of decision-making process, lessons learned from past introductions, and TA needs	1) **Rationale**: Guinea is located in the meningitis belt, with 17 of its 38 districts at risk. For this reason, it is faced with meningococcal meningitis epidemics. In the past three years, the country recorded 85 cases of meningitis, with a fatality rate of 15.29% in 2013; 582 cases and 96 deaths in 2014, the epidemic threshold having been crossed in two health districts (Mandiana and Siguiri); and 131 cases with 23 deaths in 2015[6]. In the face of this situation, a response for both districts was organised in June 2014. For the other 15, a preventive meningococcal menigitis immunisation campaign was conducted in August 2015. The epidemiological situation from week 1 to week 37 of 2016 involved 109 cases of meningitis, with 62 deaths[7]. Given this context, introduction of the MenA vaccine into routine EPI in Guinea is manifestly vital. WHO guidelines recommend the introduction of MenA into routine EPI three to five years after the last mass campaign. 2) **Decision-making process**: in accordance with strategic international and regional orientations, and account taken of national priorities in the light of the disease burden and the advantages linked to the introduction of the vaccine concerned, the EPI Coordination will prepare and submit a conceptual note to the ICC and/or the NITAG for opinion and approval by the Cabinet. A communiqué will be sent to the Council of Ministers to provide information. 3) **Lessons learned**: The experience acquired during the support for the introduction of PCV-13 and the other previously mentioned antigens will be useful for that of the MenA vaccine.

Vaccine 4	**Estimated year of introduction**	**Estimated annual co-financing**
Vaccine against the human papillomavirus	2019	NA
Major programmatic challenges to be addressed prior to introduction of each vaccine or SIA and associated steps/timing to prepare for introduction:	The adaptation of 3 sub-national storage facilities to solar energy and the strengthening of storage capacities at the district level and in health centres for PCV 13 introduction will make it possible to avail of sufficient storage capacities for HPV at the intermediate and peripheral levels. The remaining challenge lies in the implementation of a transitory introduction phase at the level of two health districts (demonstration), one in the Conarky region (Kaloum) and the other in the Mamou region (Pita) before moving up to scale. This phase is intended to test and control the strategies and costs of introducing this vaccine, the target of which is not the usual EPI target, affecting other sectors not sufficiently involved in the implementation of routine immunisation activities up to now. The steps previously mentioned in PCV13, Rotavirus and MenA introduction are identical for HPV vaccine introduction.	

[6] Source: Meningitis Campaign Implementation Plan
7 Source: Weekly DPLM report for week 37, 2016.

For long-term plans, rationale for inclusion, description of decision-making process, lessons learned from past introductions, and TA needs	1) **Rationale**: The Human Papillomavirus (HPV) is transmitted mainly by sexual contact and this occurs at the very beginning of adolescent sexual activity. Two types of HPV (16 and 18) cause 70% of cervical cancers and precancerous lesions. According to available data, cervical cancer in Africa occurs in women of low socio-economic status between age 30 and 49. In 2012, some 270,000 women died from cervical cancer. Over 85% of these deaths took place in low- or intermediate-income countries. In Guinea, at the oncology centre of the Donka National Hospital, it represents 50% of all cancers, posing a real public health problem. In 2014 and 2015, 177 and 186 cases were diagnosed respectively. The upsurge of genital infections leading to cases of cervical cancer in women and the poor level of pre-cancerous lesion screening, the prospects for the treatment of this disease at a very advanced stage being rather mediocre and the existence of two vaccines that can provide protection against HPV 16 and 18 justify the introduction of this vaccine among girls aged 9 to 13 in Guinea before their first sexual relations**.** The introduction of the HPV vaccine will consist of a demonstration phase (2019-2021) at the level of two districts and a phase of moving up to scale. The pilot phase will concern 10% of the population of girls in two health districts. The lessons learned from this demonstration will be applied to full-scale operation. 2) **Decision-making process**: in accordance with strategic international and regional orientations, and account taken of national priorities in the light of the disease burden and the advantages linked to the introduction of the vaccine concerned, the EPI Coordination will prepare and submit a conceptual note to the ICC and/or the NITAG for opinion and approval by the Cabinet. A communiqué will be sent to the Council of Ministers to provide information. 3) **Lessons learned**: The experience acquired during the support for the introduction of PCV-13 and the other previously mentioned antigens will be useful for HPV vaccine introduction.

Vaccine 5	**Estimated year of introduction**	**Estimated annual co-financing**
Type 2 polio vaccine (type 2 mOPV)	2016	
Major programmatic challenges to be addressed prior to introduction of each vaccine or SIA and associated steps/timing to prepare for introduction:	This is not a new introduction; rather, the use of this vaccine type purports to contribute to stopping the circulation of vaccine-derived poliovirus (cVDPV type 2). This will only involve two health districts (Kankan and Siguiri). The main programmatic challenges are: ▪ Obtaining authorisation by the Director General of the WHO for the release of mOPV type 2. ▪ Vaccine management during and after the organisation of SIAs (separate use during SIAs and withdrawal after SIAs). The steps of use will be those usually followed for the organisation of SIAs in the country.	
For long-term plans, rationale for inclusion, description of decision-making process, lessons learned from past introductions, and TA needs	1) **Rationale**: Since September 2015, the country has been facing an epidemic due to the type 2 vaccine-derived poliovirus. In response to this epidemic, seven (7) national and local immunisation days were organised, as well as two independent evaluations. In the absence of conclusive proof that the poliovirus has stopped circulating, the evaluation mission (OBRA 2) has recommended the use of the type 2 monovalent polio vaccine on a reduced scale in two health districts for future SIAs by the end of 2016. 2) **Decision-making Process**: in accordance with strategic international and regional orientations, and account taken of national priorities in the light of the disease burden and the advantages linked to the introduction of the vaccine concerned, the Ministry of Health will prepare and submit a request to the WHO for the authorisation and use of mOPV during SIAs.	

	3) **The lessons learned** (Labelling, targeted communication, procurement, stock management, etc.) from the introduction of bivalent OPV (bOPV) will orient the process of using mOPV in the course of SIAs. The on-site availability of technical assistance (WHO/Unicef consultants) will support the implementation of this intervention.

Vaccine 6	**Estimated year of introduction**	**Estimated annual co-financing**
Tetanus-Diphtheria vaccine (Td)	2017	
Major programmatic challenges to be addressed prior to introduction of each vaccine or SIA and associated steps/timing to prepare for introduction:	This involves the replacement of TT by Td in routine EPI and SIAs. Routine EPI targets pregnant women, while SIAs target women of childbearing age. The main programmatic challenge is the registration of this vaccine at the level of the national directorate of pharmacies and laboratories. The steps for introduction will be those usually followed for the other vaccines previously mentioned.	
For long-term plans, rationale for inclusion, description of decision-making process, lessons learned from past introductions, and TA needs	1) **Rationale**: Guinea is among the countries that have still not eliminated maternal and neonatal tetanus. According to the report of the National Security Agency of the Republic of Guinea, 61 suspect cases of maternal and neonatal tetanus were recorded between the first and the 37th week of 2016, with 20 cases of death[8]. The country has always used monovalent TT to prevent this disease. But following the recommendations of recent studies (WHO), the country proposes to use the bivalent tetanus-diphtheria vaccine (Td) from now onward. This latter has an added value in the immunisation of the population, to the extent that it consists of two antigens, the diphtheria fraction of which provides broad immunity. When the recommended number of Td doses is administered, it gives protection for practically 100% of tetanus cases and 95% of diphtheria cases. Moreover, the vaccine reduces the virulence of these diseases among those affected. One other advantage of this vaccine (Td) is that it can be used in mass campaigns. **2) Decision-making process**: the decision will be made through dissemination of a ministerial decision authorising the use of Td to replace TT with no immunisation programme modification. 3) **The lessons learned** from preceding replacements and introductions will be applied for the success of this replacement. The on-site availability of technical assistance (WHO/Unicef consultants) will support the implementation of this intervention.	

Vaccine 7	**Estimated year of introduction**	**Estimated annual co-financing**
Measles-rubella vaccine (MR)	2020	
Major programmatic challenges to be addressed prior to introduction of each vaccine or SIA and associated steps/timing to prepare for introduction:	This entails the replacement of MCV by MR (Measles-Rubella) and the introduction of a second dose in routine EPI at the age of 15 months. The programmatic challenges of this introduction will benefit from the achievements of preceding introductions or replacements, in particular, for PCV13. The following steps are required prior to MR introduction: - **Coordinating Committees**: the set-up of functional coordinating	

[8] Weekly report of the ANSS, Guinea, S37, 2016.

	committees at all the levels of the health system at least 6 months before start-up is indispensable to the conduct of any campaign or new vaccine introduction. - **Planning, in particular Micro-planning**: the involvement of the different agents and partners in all the steps of introduction planning is fundamental; the preparation of micro-plans for the districts (HPs, HCs and DHTs) with the involvement of CHWs who have in-depth knowledge of their areas and the members of the COSAH will enable better resource distribution and prevent stockouts. - **Supervision**: the quality of local supervision has an impact on immunisation team performance and coordination. This quality depends on the quality of the supervisors hired, their training, but above all their regular monitoring and evaluation. - **Waste management**: a waste management plan with input, among others, from hospitals as to the destruction of waste from immunisation activities, reinforces safe waste management. The monitoring and evaluation for the implementation of this plan is critical. - **Monitoring**: the systematic organisation of monitoring before (preparations), during (rapid convenience survey) and after (coverage monitoring) the activity, including immunisation coverage surveys, is indispensable to track and correct shortcomings in the course of implementation. - **Resources**: the timely deployment of sufficient resources allows for the proper execution of activities; hence, the need to accelerate guidelines and procedures for the release and use of resources. - **Communication**: the involvement of government, political, traditional, religious and other authorities, above all at the community level, who are skilled in communication, helps improve community support for immunisation activities. - **Consolidating** and disseminating good practices that have emerged from past campaigns. - **Training**: this should be conducted over time with adapted tools by trainors who have themselves been previously trained.
For long-term plans, rationale for inclusion, description of decision-making process, lessons learned from past introductions, and TA needs	1) **Rationale**: Measles is a highly contagious, serious disease caused by a virus. It continues to be one of the most significant causes of death in children under five. A very effective, safe vaccine that protects children against measles for less than one dollar has existed for more than forty years. Measles-related mortality has considerably decreased, but efforts to fight measles and rubella have also faced challenges. While the routine measles first dose (MCV1) coverage has increased globally from 73% in 2000 to 83% in 2009, this coverage has stalled and remained at 78% since 2010 in the 73 countries receiving Gavi support. Other challenges include financial and programmatic sustainability for countries, determination of the target age group and ensuring the high quality of campaigns. 2) **Decision-making Process**: in accordance with strategic international and regional orientations, and account taken of national priorities in the light of the disease burden and the advantages linked to the introduction of the vaccine concerned, the Ministry of Health will prepare and submit a request to the WHO for the purchase of MR and the authorisation of its introduction. Beforehand, an MR monitoring campaign targeting children aged 9 to 59 months will be conducted throughout the territory in 2019, three years after that of 2016. Introduction into the routine EPI will be done in 2020. 3) **The lessons learned** from preceding replacements and introductions will be applied for the success of this replacement. The on-site availability of technical assistance (WHO/Unicef consultants) will support the implementation of this intervention.

7. Indicative financial support in US$ (HSS, operational campaign support, VIG): *Health Systems Strengthening and immunisation support may be adjusted from year to year*

HSS OBJECTIVES	ALLOCATION PER YEAR (US$)					TOTAL PER OBJECTIVE
	2017	2018	2019	2020	2021	
To increase the functionality of health districts from 52% in 2015 to 80% in 2021, particularly for the 21 target districts	0.5	0.7	0.5	0.5	0.4	2.6
To increase the coverage of completely immunised children in the 21 target districts from 53% in 2015 to at least 80% in 2021	1.8	3.9	1.9	1.7	1.5	10.8
To raise the average EVM score from 37% in 2016 to at least 80% by 2019, and to maintain it up to 2021.	1.5	1.5	0.5	0.5	0.5	4.5
From 2017 to 2021, to provide 20% of the funds for the purchase of cold chain equipment within the framework of the CCEOP.	2.2	0.8	0.1	0	0	3.1
To reduce the proportion of children not vaccinated due to parents' or guardians' lack of information from 55.9% in 2015 to at most 10% in 2021, thanks to proper use of the immunisation services	0.7	0.7	0.5	0.5	0.6	3
To reduce the gap between Penta3 administrative data and the immunisation coverage survey data from the 30 points in 2015 to 5 points in 2021	0.6	0.7	0.4	0.4	0.4	2.5
SUBTOTAL 1	**5**	**7**	**5.5**	**5**	**4**	**26.5**
Lump sum new vaccine introduction	0.5	1	1	0.5	0.5	3.5
SIA	0.5	0.5	0.5	0.5	0.5	2.5
80% from Gavi for CCEOP						12.4
SUBTOTAL 2						**18.4**
APPLICATION TOTAL						**44.9**

Programmatic investments

8. Description of priority interventions for the duration of the national immunisation strategy, specific to Gavi's investments

8.1. Briefly summarise how Gavi's support fits within the overall context of national health strategy, priority setting and immunisation plan and is complementary to funding from both domestic (government) and external sources (other donors).

Since 2014, Guinea has had a National Health Development Plan (2015–2024 NHDP) that includes the three strategic orientations (SO) below.

SO1: To reduce the disease and mortality linked to communicable and non-communicable diseases as well as to emergency situations.

SO2: To improve health at all stages of life.

SO3: To improve the performance of the national healthcare system.

The first three years of this plan are devoted to the recovery and resilience of the health system following the Ebola epidemic. The three priority results of the health system recovery and resilience plan (HSRRP 2015-2017) are the following: **(i)** Elimination of Ebola and other diseases of epidemic potential (measles, meningitis, yellow fever, polio, rubella) through infection prevention and control, integrated disease surveillance and response, and the application of international health regulations; **(ii)** District health system strengthening (improvement of service delivery: MPA, CPA, high-impact mother and child interventions); **(iii)** Management and governance system strengthening.

With regards to immunisation, the objective of the comprehensive Multi-Year Plan (2016–2020 cMYP) is to reach, by the end of 2020, immunisation coverage for all antigens of at least 90% at the national level and at least 80% in all the 38 health districts over the period. Specifically, it will be necessary to:

- increase immunisation coverage and reduce dropout rate;
- support the introduction of new vaccines[9];
- conduct Supplementary Immunisation Activities (SIAs);
- improve the quality of immunisation data;
- ensure the availability of vaccines, injection material and cold chain equipment;
- provide surveillance of vaccine-preventable diseases;
- strengthen communication and social mobilisation in the field of immunisation;
- improve EPI programme management.

The support requested from Gavi falls within the framework of Strategic Objectives 1, 2 and 3 of the NHDP, priority outcomes 1, 2 and 3 of the HSRRP, and the strengthening of all the EPI fields included in the cMYP objectives. The recovery of the routine EPI is also the foremost priority in the roadmap of the Ministry of Health for 2016.

The government has also undertaken to progressively increase its share of the budget allocated to the health sector, from 4% in 2016 to 10% by 2020. Furthermore, the partners have undertaken to support the Guinean government in meeting the EPI objectives via the implementation of the NHDP and the cMYP.

In an effort to ensure complementarity with HSRRP funding, a workshop was held on 7 June 2016 to work on harmonising partner and government financing. This workshop made it possible to identify the financial commitments of the Guinean government and the technical and financial partners (TFPs) in the country as concerns strengthening its post-Ebola health system. This workshop was followed by the Country Dialogue workshop, held on 8–10 June 2016, with the participation of all the sectoral partners, the private sector, civil society, the National Assembly and the TFPs. This made it possible to work out the consolidated draft proposal for health system strengthening support and immunisation services support to submit to Gavi. The signing of the national compact is also a guarantee of partner and government commitment in co-financing for health in general and immunisation in particular.

The government and its partners (USAID, UNICEF, EU, GIZ, WHO, CDC, Global Fund, UNPF and the World Bank) are helping to strengthen the national health information system (NHIS), leadership and governance.

For the availability of vaccines (traditional and co-financed), injection material and management tools, the government of Guinea, under the vaccine independence initiative (strengthening of immunisation capacity) is contributing in the amount of US$ 1.6 million in 2016, US$ 313,500 for co-financing and US$ 118,000 USD to purchase the traditional EPI vaccines for the first half of 2016. This process of government commitment to strengthening immunisation capacity (contained in MTEF 2017-2019) will be pursued and increased during proposal implementation, for a projected US$ 2.6 million in 2017, 3.7 million in 2018 and 4.9 million in 2019. In addition to the Gavi grant, the World Bank project to improve primary health services (PASSP) will devote some of its funds to the purchase of essential vaccines and medicines.

For logistics and the cold chain, in addition to the equipment and vehicles acquired with Gavi funds, it should be noted that some partners such as the CDC (48 refrigerators) have announced that they will contribute. The gap to be met consists of the purchase of 966 refrigerators, 2 cold rooms (one 40m3 and one 60m3), the construction of a new building to house the EPI office and the construction of regional and prefecture storage facilities. Gavi will provide part of the funding for these. The government undertakes to increase the number of healthcare facilities, and partners such as the European Union (the PASA project in the forest region), KFW (starting in 2017) and others (AfDB, Saudi Fund, etc.) are involved in the construction/rehabilitation of health centres, regional hospitals and district hospitals. The maintenance of infrastructures, cold chain equipment and vehicles is currently ensured by Gavi, GF, GIZ, USAID, the EU and the government under heading 3 (Goods and Services) of the national development budget for health (BND). The BND will progressively assume this maintenance before proposal implementation ends. It undertakes to recruit personnel specialised in maintenance among the new civil servants assigned to health each year (50 from among 3,000 new hires were recruited in 2016).

The government undertakes to recruit 2,000 health workers over a three-year period, to be composed of different

[9] Td, PCV 13, MR, Rotavirus, Men A, HPV, Ebola, mOPV Type 2

health professionals. Furthermore, the WB is helping to fund the recruitment of 50 technical health workers for each of the 9 health districts of the Faranah and Labe regions, as well as 530 community workers. The UNPF has helped to fund the recruitment of 100 midwives, and Gavi has contributed to the recruitment of 100 health workers for immunisation support. The additional needs will be submitted to Gavi and other TFPs. The Guinean government will progressively incorporate the workers recruited via partner funding into the civil service. The results-based financing (RBF) approach is currently being implemented in Guinea with the support of the WB (9 districts, including Faranah 4 and Labe 5), GIZ (8 districts, including Mamou 3 and Kindia 5) and Netherlands Cooperation via the NGO KIT (pilot phase in Mamou that started in July 2016).

The expected support from Gavi will be used to partially fill the funding gap in health system strengthening and support for immunisation, with the aim of boosting equitable immunisation coverage.

8.2. Objectives and priority interventions for Gavi financial support for HSIS, as per national health strategy and immunisation plan

For each objective provided in the performance framework:

- **Provide an indicative budget amount (total amount required for 3–5 years for each objective).**
- **Indicate how the objective shall eliminate health system bottlenecks so as to substantially increase immunisation coverage and equity and to achieve the expected immunisation outcomes. Provide a summary of the issue to be addressed *(e.g., EVM score is less 80% due to distribution and cold chain volume).***
- **Indicate the key activities (top 2-3 priority interventions per objective) which will lead to achievement of the objective.**
- **Provide a short rationale explaining why these activities have been prioritised as such, to achieve improved outcomes, including the rationale for targeting certain geographic zones or populations. Also include complementary and key activities or financial support from other sources that are contributing to reaching the objective.**

Objective 1:	To increase the functionality of health districts from 52% in 2015[10] to 80% in 2021,[11] [12] particularly[13] the 21 target districts
Indicative budget:	US $2.6 million

Health system bottleneck(s) to be targeted:	**Activities**
▪ Poor coordination of the interventions by different players in the field. ▪ Weaknesses in planning, M&E for health interventions. ▪ Weak mobilisation of local financial resources for immunisation and for the operational costs of the health districts and health facilities. ▪ Poor management of the financial resources made available by the TFPs. ▪ Insufficient quality and number of health staff, managers and support workers.	1. Support the operation of coordinating authorities at all levels (HSCC, CRCSS, CPCSS, TCC, RTCH, PTCH/TCCH, CTSPS and the health sector joint annual reviews). 2. Support the implementation of health system accountability frameworks at central and decentralised levels. 3. Support the implementation of a local resource mobilisation framework with a view to creating a common fund for HSS and immunisation. 4. Support recruitment and capacity building by setting up an attractive incentive and loyalty-building system for health personnel.

Rationale:	Numerous coordinating authorities have been set up at different levels (central: HSCC,

[10] NHDP pp 49,63
[11] HSRRP pp 38,42
[12] cMYP p 61
[13] The evaluation of district functionality will deal with the following elements: leadership/coordination, planning, resource management and M&E.

	ICC, ICN, GTS, TCC, CNC and the Monitoring Committee for the recovery plan; regional: CRCSS and RTCH; prefecture: CPCSS and PTCH; sub-prefecture or community: CSPCSS/CCCSS) to support and better coordinate recovery and resilience for the health system of Guinea. The functional capacity of these authorities remains insufficient due to weak technical capability, the absence of an accountability framework and poor financial support. According to the NHDP for 2015-2024, the process of preparing Annual Work Plans is essentially based on available and targeted resources (from partners), not on a system-based vision of problems specific to the district. Analysis such as is conducted (i) does not enable the identification of shortcomings with regard to equity and demographic and geographic disparities; (ii) does not systematically examine the bottlenecks and barriers concerning environment, supply, demand and the quality of services and interventions (iii) does not allow for realistic targets and objectives that take account of real programme performance and real implementation capacities, and (iv) leads to a budget that is not based on realistic targets and objectives, capacities of absorption and physical space. The aforementioned finding would be explained by an insufficiency of technical competence on the part of human resources in health as regards planning and M&E for interventions. As regards health sector financing, the country is strongly dependent on foreign funding due to the poor level of financing from the national budget, the weak exploitation of the financial potential of the private sector and other innovative financing sources such as taxes on plane tickets, alcohol, tobacco and mobile telephony. This is why households pay the heaviest part of the burden, financing around 62.20% of health expenses in 2010. On the level of human resources, the analytical report on the situation in human resources for health for 2012 shows, among other findings, that these are badly distributed and underperforming. Health structures in the rural areas and in poor prefectures are particularly affected by a widespread dearth of qualified health professionals. The same report underscores low human health resource productivity, dubious service quality, user and manager dissatisfaction and low motivation on the part of health workers at all health system levels, particularly in underserved areas. This would all relate to the poor use of the human resources produced by training institutions and the absence of a mechanism for motivating and building loyalty among them. In response to the situations described above, it would be vital to support the operation of health system coordinating authorities at all levels by organising periodic encounters and reviews. These activities will make it possible to evaluate the integration and complementary character of the interventions by different players. This will also be an occasion to define and monitor accountability frameworks, conduct advocacy with a view to the mobilisation of additional resources and evaluate the effectiveness and pertinence of health interventions. The training of different agents in operational planning and district management will make it possible to improve the quality of AWPs. Contracts with national and international training institutions would in any case be recommendable. Post-training monitoring and/or coaching would prove a significant advantage in sustaining the gains from such training. Advocacy with the private sector and the National Assembly will make it possible to mobilise funds in support of the health sector, on the one hand, and apply innovative resource mobilisation strategies on the other. The implementation of these different approaches will benefit from the preparation of a resource mobilisation plan. Over time, the objective aimed at is the creation of a common fund for financing health, including immunisation. To illustrate this procedure, Guinea has just signed the national compact, which binds government partners to: respect and support leadership development and national priorities, accept the coordination and management procedures necessary, and deploy resources in accordance with the principles of the new governance in health. Annual audits will be conducted for improved financial resource management and periodic financial reports will be prepared to strengthen accountability obligations[14]. The development of an effective human health resource management mechanism, decentralisation of HHR management, HHR redeployment and recruitment, the development of partnerships for HHR availability, training supervision at all levels, the set-up of an HHR performance management system and the implementation of a system for motivating HHR and winning their loyalty in rural and remote areas represent, among

[14] Common fund implementation process

	others, activities that will enable improvement in quality HHR availability and their equitable distribution[15]. This request will place particular emphasis on the performance of the 21 target health districts for all the above-mentioned corrective activities. It will supplement the funding from the WB, WHO, Unicef, GIZ, KFW, UE, AFD, USAID and GF in the other districts.

Objective 2:	To increase the coverage[16] of completely immunised children[17] in the 21 target districts from 53% in 2015 to at least 80% in 2021[18]
Indicative budget:	US$ 16.8 million

Health system bottleneck(s) to be targeted:	**Activities**
▪ Poor health and geographic coverage in immunisation services, especially in rural areas. ▪ Insufficient implementation of immunisation activities (Routine and SIAs). ▪ Poor performance of vaccine-preventable disease and AEFI surveillance system.	1. Sustain the introduction of fixed, accessible and quality immunisation services at 300 new immunisation sites (health posts, private association and confessional facilities, garrisons) and support the activities of advanced and mobile strategies. 2. Ensure the effective implementation of the Reach Every District/Community/Child approach in the 21 target health districts. 3. Support the introduction of new vaccines into the routine EPI and strengthen surveillance of AEFI and vaccine-preventable diseases.

Rationale:	Immunisation coverage remains low in Guinea due to poor health and geographic coverage and insufficient implementation of effective immunisation interventions (routine activities and SIAs). In effect, immunisation at fixed sites takes place only at the level of the 410 public health centres the country avails of. In contrast, the healthcare facilities of the private and not-for-profit sector are often not appropriate and poorly prepared to offer immunisation services. It should be noted that around 40% of the target population lives beyond a 5-km radius from fixed immunisation sites (preventive healthcare units), 22% of them further than 15 km[19]. Likewise, one-third (1/3) of health posts are over 50 Km away from a health centre with a population often greater than 7,000 inhabitants (above all in the mining districts of Kouroussa, Siguiri, Mandiana, Dinguiraye, Kerouane, etc). The vulnerable populations from urban/peripheral urban zones (Matoto, Ratoma, Siguiri, Kankan, Nzerekore), inter-urban zones (the Conakry triangle, Dubreka, Coyah), the shadow zones (the Benty islets, Malanta and Diatifere plateaux), the mining zones of the health districts of Siguiri, Kouroussa, Kerouane, Mandiana, Forecariah, etc, the Conakry jetties, Dubreka, Forecariah and the poorer populations living in the poverty areas (Dinguiraye, Kerouane, Kouroussa, Forecariah, Telimele, Mandiana, etc. are badly covered due to poor accounting for the equity aspect in the course of immunisation activity planning and implementation monitoring. Another, not less important problem of immunisation in Guinea is the poor quality of SIAs linked to shortcomings in planning, implementation and monitoring. Despite the existence of lethal children's diseases– pneumonia and diarrhoea respectively represent the 2nd and 3rd cause of death for children under five after malaria[20] – the country has not managed to introduce new vaccines against them since 2011 due to its poor routine EPI performance. To this is added the poor performance of vaccine-preventable disease and AEFI surveillance due to insufficient qualified human resources, the poor coordination of interventions and the under-equipped facilities charged with surveillance at all the levels. Increased immunisation coverage with emphasis on equity, allowing not only to improve the population's immunisation status but also to introduce new vaccines with a view to reducing the disease and mortality rate of children and mothers. This will be made possible by strengthening the existing immunisation strategies (fixed and advanced strategies in the health centres and mobile strategies conducted from the main district sites) and

[15] Strategic HHR Development Plan p 20
[16] Report on coverage survey among children aged 12 to 23 months, 2016.
[17] Completely immunised child = a child that has received BCG, 3 doses of polio, 3 doses of Pentavalent, MCA and YF. This indicator will be measured by means of immunisation coverage survey.
[18] CMYP p 62, NHDP 2015-2014 p 51, HSRRP p 41, cMYP p 62
[19] RPGH 2014
[20] Statistical Yearbook, 2012

	implementing innovative approaches. Innovative approaches will deal with the integration of fixed immunisation in 300 new sites (health posts, private association and confessional facilities, garrisons) and the creation of 1500 advanced immunisation strategy points around these new sites, supported by 600 community health workers who will be trained to immunise in large remote villages and satellites to the new sites. Villages located further than 15 km will be covered at least once every quarter by the district mobile team using the 4x4 vehicles purchased in the context of the response to Ebola. The organisation of intensified immunisation activities (SIAs), the mother-child health week, the convergence and integration approach (Child-Friendly Community), immunisation solidarity between health areas, the implementation of new management tools, particularly immunisation records at immunisation sites and records of listed targets at the community level, will also contribute to the gradual increase of health coverage. All these strategies will be sustained by the strengthening of health district management though the effective implementation of the Reach Every District/Community/Child approach. The operational planning of this approach should take account of related specific features: i) gender, ii) geographic and remote areas, iii) demography, iv) socio-cultural aspects (religious sects, reluctant communities, etc). The relaunching of training supervision based on problem resolution plans (PRPs), capacity-building in effective vaccine management (EVM, MLM, etc) among 2,000 health workers/community health representatives manning the posts, the regular holding of monthly meetings, improvement of data management quality, the holding of Prefecture Technical Committees in Health (PTCH) and sub-prefecture monitoring syntheses will have a significant added value in raising immunisation coverage levels. During implementation of the different interventions at the points of service delivery, emphasis will be placed on respect for standards (reception, ethics, injection safety, the free nature of immunisation, etc) to guarantee quality and increase the use of immunisation services. Implementation of all these strategies evoked to benefit the offer and strengthen district governance and leadership will contribute to gradually raising immunisation coverage (Penta3) by 5 percentage points per year in keeping with cMYP projections[21]. Thus, reaching an immunisation coverage higher than 70% will facilitate the introduction of new vaccines into routine EPI. The introduction of the rotavirus, pneumococcal, meningococcal A vaccines and the 2nd dose of measles will contribute to lowering the infant mortality linked to vaccine-preventable diseases. On this particular, each introduction will be subject to an operational plan that will take account of the guidelines previously developed for the purpose. Each new vaccine will be registered with the national regulatory authority (NRA). The experience acquired in the course of previous vaccine introductions (yellow fever, pentavalent, Hep B, IPV) and the replacement (bivalent VPO instead of the trivalent) will be used to benefit new introductions. The data and documentation on the new vaccines that the country avails of, the best practices and the lessons from other countries that have introduced these new vaccines, among other sources, are the elements that will orient the process of introducing the new vaccines into routine EPI in Guinea. These introduction processes will likewise be supported by strengthening the surveillance of the diseases targeted by the EPI, AFP cases and Adverse Effects Following Immunisation (AEFIs), as well as laboratory capacity for confirmation. Systematic mapping at the level of each Health Centre, the local recruitment of different players (vaccinators, mobilisers and local supervisors, etc.), independent supervision, the monitoring of the effective deployment of the players and the use of the independent monitoring results/LQAS to correct shortcomings will make it possible to conduct quality SIAs with a view to increasing disease immunity. The progressive implementation of "Results-Based Financing" (RBF) in the 21 target health districts and the granting of bonuses to health workers in remote areas will contribute to motivating personnel and winning their loyalty with a view to quality immunisation services. In the other 17 health districts, the country will see to it that the same activity package is implemented with the support of other TFPs (WHO, WB, Unicef, GIZ, EU, etc) to complement the support contributed by Gavi.

[21] cMYP 2016-2020 p 59

Objective 3:	To raise the average EVM score from 37% in 2016 to at least 80% by 2019, and to maintain it up to 2021.
Indicative budget:	US$ 20 million
Health system bottleneck(s) to be targeted:	**Activities**
▪ Inadequacy in cold chain and distribution in terms of quality and quantity ▪ Inadequacy in effective vaccine management ▪ Inadequacy in waste management ▪ Inadequacy in appropriate infrastructures for the EPI programme	1. Implement the improvement plan for effective vaccine management (EVM) prepared in 2016. 2. Strengthen the supply chain quantity-wise and quality-wise (cold chain and logistics) and support it through a robust logistics information system and a functional and decentralised maintenance system; 3. Build a central storage facility and a new headquarters for the EPI coordination office. 4. Equip the health centres of the target area with small-capacity solar incinerators.

Rationale:

The recent EVM assessment conducted between December 2015 and January 2016 has shown a score very much lower than the 80% recommended by the WHO[22], due to insufficient cold chain storage volume and a weak supply chain.

The results of the inventory conducted in 2016 show that only 65% of the 619 equipment items were working well, as against 21% out of order and 14% in need of repair. Likewise, only 47% of the equipment respond to PQS[23] standards (performance quality and safety).

In addition, for several years, the expanded programme on immunisation has been confronted with difficulties essentially linked to the lack of electric power, the lack of staff in terms of numbers and quality, the inappropriate state of the national coordinating office premises, the non-operativity of regional storage facilities, and the weakness of the maintenance system at all levels. The health posts and healthcare facilities of the private sector and the third sector targeted for the implementation of the fixed immunisation strategy are generally not well-adapted for effective vaccine management and the conduct of immunisation activities[24].

Lastly, it must be underscored that the biomedical waste management system is weak due to the insufficient number of functional incinerators at the district level and the shortcomings of the waste collection, routing and elimination mechanism.

With a view to remedying this poor performance and faced with the prospect of new vaccine introductions over the next 5 years (PCV 13, Rotavirus, MenA, MR and HPV), the solutions below have been proposed:

- construction/rehabilitation of health centres and posts;
- training of health workers in effective vaccine management;
- strengthening vaccine storage capacity at all levels;
- strengthening the supply chain for vaccines and other inputs;
- regular equipment maintenance for the cold chain and other equipment items at all levels;
- construction of a new office for national EPI coordination,
- implementation of the different plans prepared;
- preparation of a waste management plan in the health districts, which will facilitate the proper disposal of waste posing infection risks.

In other words, the request to Gavi includes government purchase of cold chain equipment amounting to US$ 3.1 million, or 20% of the total cost of equipment submitted to the CCEOP. Part of the HSS funds will make it possible to procure 2 cold rooms (measuring 40 m3 and 60 m3) to strengthen storage capacities at the central level, in view of the introduction of new vaccines and the procurement of material for transport, such as iceboxes, vaccine flasks and freeze indicators, as well as the implementation of EVM, rehabilitation and maintenance improvement plans.

[22] EVM Report 2016
[23] Inventory Report 2016
[24] NPHD 2015-2024

Objective 4:	By 2021, at least 95% of the target population in the 21 selected health districts will be demanding immunisation services as a right[25].
Indicative budget:	US$ 3 million

Health system bottleneck(s) to be targeted:	**Activities**
▪ Poor involvement by the authorities, the CHWs and the community stakeholders in communication activities for immunisation. ▪ Insufficient communication and social mobilisation to promote immunisation activities. ▪ Communication activities for immunisation do not sufficiently take specific, marginal, remote and faith groups into account.	1. Organise advocacy sessions targeting authorities, members of parliament, community and religious leaders, civil society and economic operators to obtain their involvement and support for immunisation activities. 2. Support the intensification activities to inform with the mass media and to raise community base awareness in order to increase levels of knowledge and support for immunisation. 3. Organise a socio-anthropological survey to identify the bottlenecks linked to immunisation.

Rationale:

The percentage of children completely vaccinated[26] before 12 months of age is the specific indicator for the performance of an expanded programme on immunisation. According to the immunisation coverage survey of 2016, 47% of children aged 12-23 months (more than 140,000 children) are not completely vaccinated. The reasons for non-immunisation for these children are principally the lack of information (55.9%) and the lack of motivation (26.9%). For lack of information, the "uninformed mother" (40.7%) and ignorance of the need for immunisation (19.4%) are the leading causes. Regarding lack of motivation, the lack of confidence in immunisation (8.8%) and rumours (7.8%) are the main motives for not immunising children.

The situation described above would be accounted for by:

- low involvement by members of parliament, local elected officials and administrative authorities at all levels, as well as the private sector, civil society organisations and community stakeholders in mobilising populations for immunisation.
- insufficiency in the coordination of communication activities at community level for routine immunisation and SIAs.
- the high proportion of women with no levels of education (67%) and their low exposure to the media (25%) during information campaigns.
- the high proportion of refusals during SIAs (19%).

It should also be recalled that this situation was aggravated by the persistence of the Ebola epidemic, which strongly undermined community faith in health workers, negatively affecting consultations with the health services, including immunisation services.

With regard to the problems created, the following activities are contemplated:

- advocacy among the individuals who have the capacity to strengthen the knowledge, skills and practices of communities regarding the need to have their children immunised is a key step to relaunching EPI activities.
- organisation of advocacy meetings at several levels of the administrative and political pyramid, as well as at local community level, to achieve influential focus on immunisation.
- intensifying informative activities and raising awareness among grassroots communities to increase levels of knowledge and support for immunisation.

The strategic approaches for implementation are:

- the use of sponsors who have contributed to the response against Ebola (ministers, governors, prefects, sub-prefects, mayors, parliament representatives) for community awareness-raising to promote the immunisation of children.
- revitalisation of regional and prefecture social mobilisation committees who are assigned specific missions and allocated resources in the framework of the communication programme implementation.
- integration of the interventions of all the stakeholders in the promotion of immunisation and those of other essential family practices around the central theme of disease

[25] A KAP survey is planned for the end of 2016 to determine baseline value, to be followed by one survey each year to measure progress towards achievement of the objective.
[26] Completely immunised child = a child that has received BCG, 3 doses of polio (OPV3), 3 doses of Pentavalent (penta3), MCA and YF.

prevention in the form of grassroots communication campaigns and activities.

- revitalisation of the community platforms left over from the response to Ebola (village watch committees, surveillance committees in the Ebola belt), social groups and community health workers will make it possible to strengthen communication to promote immunisation and restore public confidence in the health system.
- adapted use of the mass media with partnership agreements in immunisation promotion programmes, including a media and monitoring plan. This should operate through negotiation with the owners of the press and the training of journalists.
- innovations in structured communication to reach the youth. Adolescents will be initiated through the development of alliances with telephone operators to facilitate text message dispatches to parents regarding immunisation.
- the set-up of coordinating structures that will ensure supervision for communication activities at all levels.
- the establishment of a partnership with a Guinean advertising agency, the social networks and every other communication channel to reinforce the visibility of the programme and the partners involved.
- the creation of alliances with community representatives through operational plans that specify what is expected of them and how to go about initiatives targeting social change through community dialogue.
- the creation of an effective partnership with civil society representatives versed in endogenous dynamics, with planning, financing, implementation, and the monitoring and evaluation of communication in support of immunisation.
- the involvement of youth in the promotion of immunisation at the school level (adopting students) and the association movement in the form of a memorandum of understanding with the technical units concerned, under the supervision of school authorities, for initiation and reinforcement.
- **Implementation of the mechanism for motivation and capacity-building among the different players in favour of a change in behaviour**:
    - *the primary targets (mothers, fathers and guardians of children) considered as key players will benefit as such from the entire interpersonal and media communication package justifying the immunisation of children.*
    - *parents in their role as educational peers will be considered "champions" or "sponsors" of immunisation in religious communities and will play a role of leadership in promoting immunisation among their peers.*
    - *signs of acknowledgement in the form of congratulations and gifts (caps, T-shirt, cloth and other materials) will be given to mothers who have finished the immunisation series before the first year is over as "promoters" and "positive models".*
    - *grandmothers and mothers-in-law have a great advisory role to play through their influence and power over men and young mothers in promoting immunisation and EFPs. Community health workers should collaborate with them, equipping them to raise awareness effectively among their sons, daughters or in-laws.*
    - *to improve the effectiveness of player interventions, training in interpersonal communication will be conducted for all participants in communication interventions, including EPI workers.*
    - *for improved communication activity planning and success in implementation and monitoring, the strengthening of Interpersonal Communication and media skills for all agents is indispensable.*
- **Definition of a framework for monitoring and evaluation**:
    - *development of mechanisms for community monitoring to make it possible to evaluate results, address constraints and identify opportunities for performance improvement.*
    - *measurement of knowledge, attitude and practice indicators through reviews, KAP surveys and management data (NHIS).*
    - *integration of pertinent immunisation questions at the DHS level to better appreciate the indicators of communication on the EPI.*
    - *use of the most representative indicators to reprogram communication activities in support of the EPI to better change behaviour to the benefit of immunisation.*

The support requested from Gavi will allow for the implementation of all the activities described above.

Objective 5:	To reduce the gap between Penta3 administrative data [27] and the immunisation coverage survey data[28] from the 30 points in 2015 to 5 points in 2021
Indicative budget:	US$ 2.5 million

Health system bottleneck(s) to be targeted:	**Activities**
• *Poor data quality* • *Low availability of quality tools for the collection and analysis of immunisation data at the peripheral and intermediate levels.* • *Low level of promptness and completeness in data.*	1. Support for the activities of collecting, analysing, transmitting, disseminating, archiving and conducting self-evaluation on data quality (DQS) and data quality control in health (DQA) at all the levels of the health pyramid online with Dhis2 and DVD-MT. 2. Support for the conduct of training, integrated supervision, decentralised monitoring and review activities. 3. The conduct of studies and surveys to evaluate the effects of health interventions and to understand the causes of certain bottlenecks (KAP survey, Coverage Evaluation Survey and Socio-Anthropological Studies).

Rationale:

Quality data in real time are indispensable for programme decision-making and planning. But for the moment, the data quality provided by the peripheral level does not respond properly to this requirement.

The DVD-MT indicates that the promptness of report transmission on routine EPI to the national coordination level was 33% in 2015. The independent evaluation on EPI data quality conducted in 2014 by the French Preventive Medicine Agency (AMP) has demonstrated the disparity in immunisation data between tools at different levels (accuracy: 75% for health centres, 70% for health districts). The survey conducted in 2016 has shown overestimation in administrative immunisation coverages (ICs) in 28 health districts over 38 during the measles campaign. The same survey reveals a deviation of 30 points between routine administrative data and the data from the survey focusing on Penta3 in 2015.

The human resources charged with data management are insufficient in number and poorly qualified at all levels. At the health district level, data management is under a single person (data manager). At the health centre level (HC), the data are managed by the head of the centre. Unfortunately, these staff members do not have the technical skills required in data processing, and the tools and equipment placed at their disposal do not always allow them to perform quality work.

A scarce conduct of studies and surveys on immunisation and health system strengthening is to be observed. In any event, even if studies and surveys are conducted, implementation of their recommendations remains poor.

With a view to improving data management at all levels, the following are necessary:

- to equip facilities with data management tools to harmonise data processing.
- to train staff in the use of data gathering and analysis tools and software made available for health centres through WHO financing.
- to install and monitor the use of integrated data management software (Dhis2, DVD-MT, etc.) to facilitate data gathering, analysis, interpretation, quality control and dissemination in accordance with national guidelines.
- to ensure integrated training supervision taking account of immunisation to strengthen the skills of the staff in charge of data management. This supervision is ensured by the managers at all the levels according to the calendar defined in the national guidelines (once a month for health district levels, once every quarter for regional levels and once every six months for the central level).
- to conduct regular self-evaluations regarding data quality (DQS) and audit missions to control data quality (DQA) wherever necessary.
- support for the conduct of decentralised six-monthly monitoring will make it possible to verify the availability and quality of the data produced. This platform is a venue for encounter and dialogue among the different players (communities, health workers, elected local officers, partners, political and administrative authorities, etc.). It also permits data sharing and assessment of the level of achievement for objectives. Gavi financial support for the implementation of this intervention will supplement financing from other partners taking place in the field (USAID, EU, GIZ, Unicef, WHO, WB, GF, etc.).

[27] Mechanism for data collection, analysis, transmission and feedback
[28] Mechanism for quality control/verification

	▪ periodical reviews of data analysis and interpretation will also make it possible to delve deeper into quality control, specifically for surveillance data and routine EPI. Review is conducted every three months and assembles managers from the health regions and districts supported by the central level and the partners. These are basically financed by the WHO. These reviews should lead to the preparation of a data quality improvement plan that must be monitored on a regular basis. ▪ The conduct of surveys/studies will allow for better understanding of the causes for the bottlenecks hampering use of the health services, including immunisation, by its beneficiaries; it will also make it possible to better define strategic high-impact interventions contributing to the reduction of disease and mortality among children and mothers. The pace for the conduct of the different surveys projected is defined in the performance framework attached. A monitoring framework has been developed to orient the implementation of interventions, monitor demand and evaluate the performance and effect of the programme. It will essentially entail regular monitoring of activity implementation, the conduct of periodic reviews, the production of progress reports, the conduct of interim and final evaluations and the conduct of studies and surveys. The monitoring framework attached gives more details on this point and includes a narrative and a performance framework. Support for the effective implementation of the activities mentioned above will contribute without a doubt to the objective set due to their technical feasibility and the financial support brought in by several partners.

9. Financial management:

Describe, for example: cash utilisation performance and financial capacity constraints; modifications from previous financial management arrangements; major issues arising from Programme Capacity Assessment, cash programme audits or monitoring review; degree of compliance with Financial Management Requirements
The 2009 Gavi/HSS grant made it possible to acquire goods and services in the health system strengthening field. More specifically, it facilitated the purchase of 2 ambulances, 50 motorcycles, 50 solar refrigerators, 5 supervision vehicles, equipment for Comprehensive Emergency Obstetric Care (CEmOC), Basic Emergency Obstetric Care (BEmOC), medicines, and consumables for 5 health districts. However, the rates of completion of planned activities (48%) and of financial execution (38%) remained below expectations (2015 Joint mission report). The audit of cash-support programmes showed that the conditions for financial management were not respected. Significant weaknesses were identified in the following fields: – planning, budgeting and coordination/supervision; – budget execution; – procurement; – accounting and financial reporting; – internal control and external auditing[29]. Support for the programme would help significantly to improve these weaknesses. Technical assistance over several months could be useful to set up appropriate financial management tools and to proceed in training financial managers. Some major bottlenecks were eliminated by the strengthening of the system for co-management of Gavi accounts between the MoH and WHO, involvement by UNICEF (via the recruitment of national and international technical assistants to manage leftover HSS1 funds from 2015), the committee to monitor the EPI/HSS Recovery Plan as well as the definition of roles and tasks of the management team, the designation of a project coordinator (Bureau of Strategy and Development) and two dedicated accountants from the MoH. They also improved the transparency of financial management and the performance of the HSS grant as of 31 May 2016 (70%). The results of the programme evaluation will enable us to better define all the management mechanisms to set up.

[29] Republic of Guinea, *Report on the audit of support programmes in cash (APS) 2009-2014, January 2015*

10. Financial sustainability and transition:

10. 1. Please describe how the government is going to ensure the sustainability of the results and investments (human resources, equipment maintenance, etc.) of the programme obtained thanks to Gavi support.
The government intends to emphasise the implementation of better founded strategies on appropriate investments, improved financial resource management and the continuous and periodic assessment of the programmes to ensure the sustainability of the results and investments (human resources, equipment maintenance, etc.) of the programme obtained thanks to Gavi support. It should be noted that, in the framework of NHDP 2015-2024 implementation, the government committed itself to the post-Ebola health system recovery plan 2015-2017 and the development of universal health coverage (UHC). The government has also committed itself to free healthcare for pregnant women and intends to increase the health budget by 2 percentage points a year starting in 2015 in order to progressively reach 10% of the national budget by 2019 (MTEF-Health, 2016) and 15% by 2024. This government budget effort will make it possible to strengthen the availability of essential drugs for the care of children and women of childbearing age to better finance, among others, hospital equipment and cold chain maintenance, personnel supervision, motivation and loyalty through the improvement of salaries and working conditions, career plan monitoring, performance-based financing (PBF) and the organisation of central, regional and prefecture coordinating authorities (HSCC, Technical Coordination Committee, Regional and Prefecture Technical Committees). Moreover, the government has likewise undertaken to recruit, train and transfer 2,000 health workers every year (majority of which will be assigned to health facilities in the interior) until it has met the needs of the public health system. This exercise will make it possible to resolve the current shortcomings in human resources (HHR) and consequently ensure effective vaccine management, preventive and corrective maintenance for buildings and equipment, and optimal implementation of immunisation activities, in particular effective local strategies to reach individuals and groups in underserved or badly-covered areas. Over the medium and long term, the Ministry has envisioned the development of strategies aiming at strengthening the financing system for health, to wit: (1) promote the sharing of disease risks in the framework of a national policy for social protection in partnership with the Ministry charged with Social Action; (2) set up a "Purchase Fund" revolving around health facilities to test and develop the procurement system, assuring health establishments access to resources against quality service that is accessible to different target clients under negotiated conditions, and (3) set up a distribution system for the resources mobilised for the sector in order to guarantee the pertinence and equity of expenses. Decentralisation aimed at the assumption of responsibilities for the management of basic social services by communities will contribute to a better management of health posts and centres. All these measures will contribute towards setting up sustainable financing to support the supply and demand for immunisation services.

10. 2. How has a government-led process ensured transparency and coherence regarding co-financing, partner and other donor support?
The involvement of the sectoral partners, the TFPs and civil society in developing and submitting the grant request to Gavi has helped to ensure transparency and coherence in co-financing and in support from other partners and donors, and clarified the responsibilities of each stakeholder in the funding.

11. Prioritised country needs

Summarise the highest priority country needs and strategic actions for the coming 1-2 years that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable.

TECHNICAL ASSISTANCE

Programmatic area	Activity	Output	GRADE	Source of the need
Leadership, management and coordination	1. Strategic planning Accountability 2. EPI/HSS Intersectorality 3. Integrated supervision	1. National and sub-national HSS and EPI plans prepared and implemented 2. Framework of accountability defined and monitored at all levels 3. Governance and coordination mechanisms operative at all levels (GTS, CTRS, CTPS, etc.) 4. Integrated supervision revitalised and operative	**NOC**	**UNICEF**
	1. Advocacy/Lobbying/Local resource mobilisation 2. HR management and loyalty building (focus on remote areas) 3. Integration, intersectorality & HSS 4. Universal Health Coverage (Common Fund) 5. Coordination of the management of financing dossiers for the EPI signed by the Ministry of Health with the TFPs, and between the Ministry of Finance and/or the Budget Directorate and the Ministry of Health.	1. Government contributions to vaccine purchases have increased 2. The funds allocated to the EPI by TFPs in the framework of financing agreements and projects are disbursed on time. 3. Reports on the use of the funds received from different TFPs are prepared and dispatched on time. 4. Coordination mechanisms for the immunisation system are operative. 5. Additional resources are mobilised. 6. Legislation in favour of immunisation is adopted. 7. The text on the creation of the ICC is revised and adopted.	**P4 (Support to the BSD/Dir EPI)**	**UNICEF**
Coverage & Equity	1. NITAG set up (preparation new vaccine introductions) 2. Support for AEFI Plan implementation	1. The NITAG is operative. 2. New vaccine introduction plans for 2018 are prepared. 3. The existing AEFI Plan is adapted and implemented as necessary	**Consultants (3 international and 3 national) for 2 months**	**WHO**
	1. Support for the implementation of the "Reach Every Child" (REC) approach 2. Support for the preparation and implementation of plans integrating specific innovative strategies to reduce inequities 3. Activation of community system platforms	1. The Reach Every Child (REC) approach is implemented in all the health districts 2. Deviations related to inequities are reduced 3. Community system platforms are operative	**1P3 and 4 NOB immunisation (1P3 at central level and 2 NOB at BZO, 1 NOB at BZE and 1 NOB at BZS)**	**UNICEF**

Programmatic area	Activity	Output	GRADE	Source of the need
Supply chain	Support for the implementation of national strategy on biomedical waste management	An operational plan for biomedical waste management (by levels) is prepared	**1 P3 and 1 NOB at central level**	**WHO**
	1. Support for the supply system (vaccine management, logistics & CC) 2. Support for maintenance (decentralised)	1. Support for the supply system (vaccine management, logistics & CC) 2. Support for maintenance (decentralised)	**1 P3 (CCL) at central level and NOB at central level & 3 G6 (Maintenance) at regional level (1 Maintenance staff for 2 Regions)**	**UNICEF**
Demand promotion	1. Support for the commitment of platforms, community alliances and CSOs 2. Support for the preparation of specific strategies for marginalised targets (mining areas, agglomerations, cross-border areas, shadow areas, etc) 3. Support for the production and dissemination of material adapted to specific populations	1. Platforms, community alliances and CSOs are operative 2. Specific strategies for marginalised targets (mining areas, agglomerations, cross-border areas, shadow areas, etc) are developed and implemented 3. Adapted materials are produced and disseminated for specific populations at all levels	**1 P3 1 NOC (central level) and 8 NOA (1 per region)**	**UNICEF**
Monitoring and Evaluation	1. Decentralised monitoring 2. Data quality/Quality assurance	1. The performances of immunisation services are analysed and a plan for bottleneck resolution is implemented 2. The deviation between administrative data and data from immunisation coverage surveys is reduced	**1 P3 1 NOB (central level) 1 NOA per region (N=8)**	**WHO**
	EPI review	EPI performances are evaluated	**4 Consultants (2 International and 2 National)**	**WHO**

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

Part C: National documentation

The following documents are typically shared with Gavi as part of routine monitoring of Gavi support, and no need to resubmit. However, these should be referred to alongside this Programme Support Rationale to help inform discussions and decisions on future Gavi support.

Retrospective documents	Forward-looking documents
Insights into Gavi's grant support and implementation • Joint appraisal from previous year • Performance Framework • Operational workplan & budget • Financial reports **Data on programme status, challenges** • EPI review • Assessments related to coverage & equity of immunisation • EVM Assessments and progress on improvements • Surveys on coverage data and/or quality (coverage surveys, DHS or MIC survey) • An explanation of specific geographic areas and populations (hard-to-reach, marginalised populations, or low coverage areas) that will be targeted through the Gavi HSS support **Data on programme functioning** • Programme and financial audits • Programme Capacity Assessment	National strategies, plans, and budgets for health and immunisation (e.g. cMYP), including the transition plan when relevant

ANNEXES

ANNEX 1: Gavi-Guinea HSS2 Request Monitoring and Evaluation Framework

1.1. Monitoring & Evaluation Mechanism

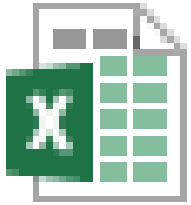
The Ministry of Health, through the Bureau of Strategy and Development (BSD), is the main body in charge of monitoring the implementation of the activities described in the present support request sent to Gavi for the 2017–2021 period. It receives technical support from the national coordinating office of the Expanded Programme on Immunisation (EPI).

A National Plan for EPI Monitoring and Evaluation will be drawn up in order to guide the implementation of M&E activities. This plan will include, among other points: (i) the description of the roles and responsibilities of the different stakeholders involved in M&E; (ii) the data collection, analysis and transmission mechanism; (iii) the reporting timeline; (iv) the evaluation plan; (v) the matrix of indicators; (vi) the feedback mechanism; (vii) the evaluation plan; (viii) the research agenda; and (ix) the action plan for the M&E plan.

A performance framework and an operational workplan will facilitate the implementation of the interventions included in the request. The performance framework includes the indicators and their definition, the values and years of reference for the indicators, the frequency of reporting and the targets to reach (cf. performance framework attached). As for the operational plan, it shall include the objectives to be met, the schedule of activities, the activity cost and the body responsible for implementing it.

Quarterly, six-monthly and annual reviews will be conducted by the BSD, the EPI and the partners. These will be used as well to evaluate progress towards achievement of the results anticipated and to identify the main problems in implementing the activities included in the request. This will enable performance evaluation as well as the readjustment of operational action plans. A quarterly progress report will be sent (via the portal on electronic file) to the Gavi Secretariat. It will mainly consist of the description of implementation level for the activities and the achievement of the performance framework indicators, as well as the use of the financial resources allocated.

On the institutional plane, the EPI Inter-agency Coordinating Committee (ICC) will play the part of supervisor in grant implementation. It must also ensure that the allocated funds are transparently managed. The annual increase in EPI immunisation coverage, the update of mortality and morbidity data on vaccine-preventable diseases, the reductions in vaccine wastage rates and dropout rates between Penta1 and Penta3, and the reduction of the gap between administrative coverage data and evaluation survey data are all local indicators that the ICC will be able to use to regularly monitor EPI performance and decision-making. The progress report will be sent regularly to the ICC members.

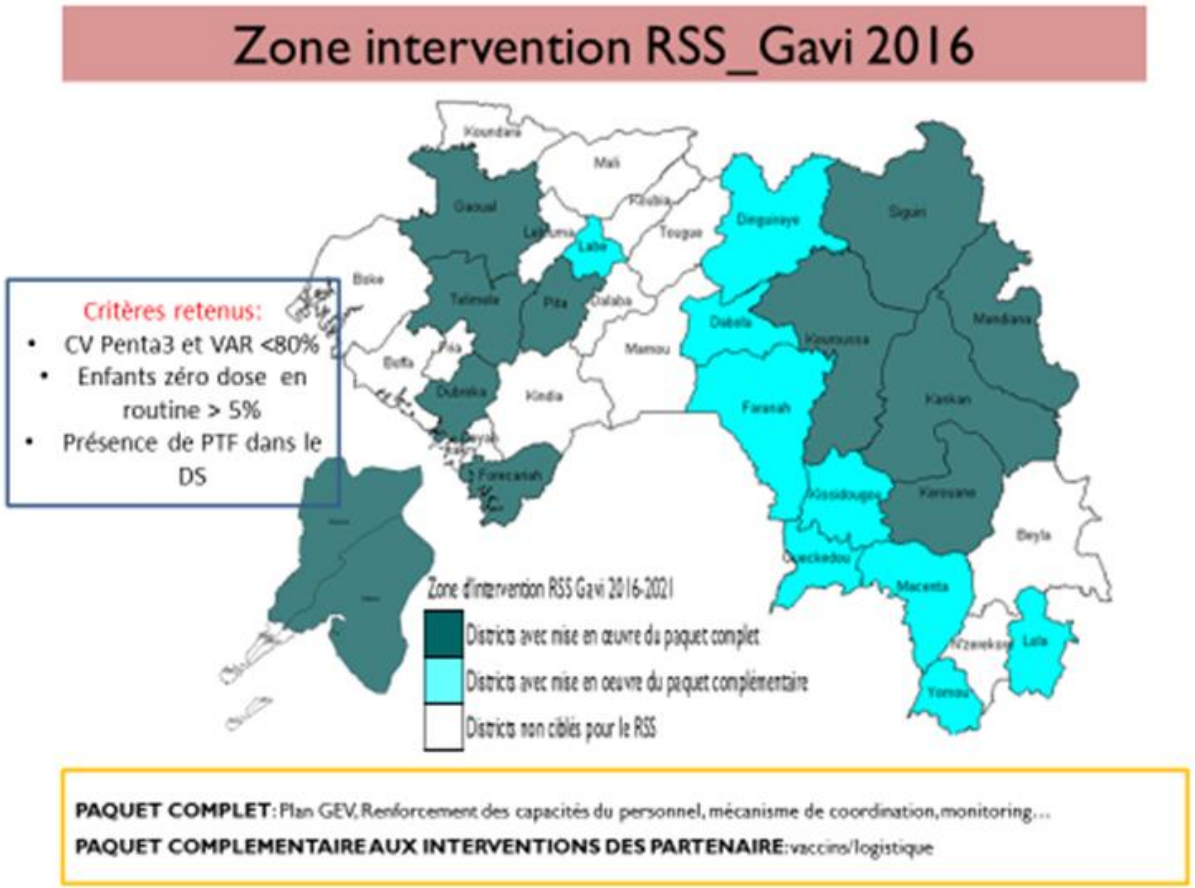


Microsoft Excel
97-2003 Worksheet

ANNEX 2: Criteria for the selection of the 21 health districts in the HSS2 GAVI-Guinea request

Annexes 3 : Couvertures vaccinales selon l'enquête de couverture vaccinale 2016

REGION	PREFECTURE	COUVERTURE VACCINALE			% ENFANTS ZERO DOSE > 5%			DISTRICTS SELECTIONNES
		PENTA 3	VAR	VAA	REGION	PREFECTURE	% enfants n'ayant reçu aucune dose de vaccin en routine	
Boké	BOFFA	93,5	92,4	90,0	Boké	BOFFA	1,9	
	BOKE	81,4	78,6	41,0		BOKE	1,4	
	FRIA	88,6	87,1	85,4		FRIA	1,4	
	GAOUAL	61,3	58,6	47,2		GAOUAL	9,4	1
	KOUNDARA	92,9	88,6	86,4		KOUNDARA	0,5	
Total Boké		***82,8***	***81,0***	***61,7***	***Total boké***		***3,0***	
Conakry	DIXINN	62,5	58,1	75,0	Conakry	DIXINN	4,3	
	KALOUM	75,8	72,5	79,1		KALOUM	3,8	
	MATAM	78,7	75,2	78,7		MATAM	2,9	
	MATOTO	60,9	58,6	60,0		MATOTO	7,1	2
	RATOMA	62,9	57,6	63,8		RATOMA	6,2	3
Total conakry		***64,8***	***64,4***	***66,4***	***Total conakry***		***4,9***	
Faranah	DABOLA	68,4	65,9	86,1	Faranah	DABOLA	5,9	4
	DINGUIRAYE	80,0	78,3	72,0		DINGUIRAYE	9,4	5
	FARANAH	63,1	62,4	56,1		FARANAH	10,0	6
	KISSIDOUGOU	53,3	47,1	54,1		KISSIDOUGOU	14,8	7
Total faranah		***64,6***	***63,4***	***64,4***	***Total faranah***		***10,0***	
Kankan	KANKAN	73,5	73,5	69,3	Kankan	KANKAN	10,4	8
	KEROUANE	45,8	42,4	49,7		KEROUANE	15,7	9
	KOUROUSSA	39,8	35,7	40,8		KOUROUSSA	20,0	10
	MANDIANA	50,6	48,8	72,9		MANDIANA	7,6	11
	SIGUIRI	48,1	44,3	43,8		SIGUIRI	10,5	12
Total kankan		***52,5***	***48,9***	***54,2***	***Total kankan***		***12,8***	
Kindia	COYAH	78,3	78,1	57,2	Kindia	COYAH	1,0	
	DUBREKA	61,8	57,6	49,1		DUBREKA	15,6	13
	FORECARIAH	6,9	8,1	19,9		FORECARIAH	41,9	14
	KINDIA	70,6	70,6	70,2		KINDIA	0,5	
	TELIMELE	62,3	60,7	59,1		TELIMELE	7,3	15
Total kindia		***56,4***	***55,0***	***52,6***	***Total kindia***		***13,2***	
Labé	KOUBIA	86,2	85,9	78,8	Lab_	KOUBIA	7,6	
	LABE	56,6	55,2	31,8		LABE	17,6	16
	LELOUMA	88,6	87,1	87,7		LELOUMA	4,3	
	MALI	78,5	76,8	73,1		MALI	3,3	
	TOUGUE	78,8	74,5	88,9		TOUGUE	2,8	
Total labé		***73,5***	***75,9***	***64,2***	***Total lab_***		***7,1***	
Mamou	DALABA	89,7	89,1	91,0	Mamou	DALABA	1,9	
	MAMOU	92,2	90,0	86,1		MAMOU	0,0	
	PITA	71,0	67,4	67,5		PITA	8,4	17
Total mamou		***84,1***	***82,1***	***80,4***	*Total mamou*		*3,4*	
Nzérékoré	BEYLA	51,9	49,1	58,1	Nzérékoré	BEYLA	3,8	
	GUECKEDOU	67,6	64,8	75,7		GUECKEDOU	7,6	18
	LOLA	59,8	56,1	53,6		LOLA	16,0	19
	MACENTA	58,9	53,7	45,8		MACENTA	6,4	20
	NZEREKOR	85,1	84,8	87,8		NZEREKOR	6,7	
	YOMOU	79,6	78,4	83,2		YOMOU	6,6	21
Total Nzérékoré		***67,6***	***64,5***	***68,2***	***Total Nzérékoré***		***7,9***	
TOTAL		**66,0**	**63,5**	**62,8**	**Guinée**		**8,1**	



Annex 3: Map of the agencies intervening in financing the Guinea health system for the 2017-2019 period

DONOR	TOTAL BY DONOR (in thousands of US$)	Geographic Zone
1- Government (National Development Bank - BND)	**598.937**	**Entire country**
Steering and support of the health system	3.133	
Strengthening of prevention and taking care of diseases and emergency situations	203.824	
Promoting mother, child, adolescent and senior-citizen health	89.788	
Improving physical access to facilities, equipment and other good-quality health technologies	112.588	
Developing of human resources	189.479	
Developing the health information and research system	125	
2- UNICEF (regular resources and other resources that do not come from PASA, GF, Gavi, WB, IDB)	**15.800**	**Entire country**
Technical and administrative assistance		
Capacity building	**1.500**	
Health products and equipment	**6.000**	
Infrastructures and other equipment	**6.000**	
Communication tool	**600**	
Monitoring and Evaluation	**1.700**	
Planning and administration	**-**	
3- UNPF	**-**	**Entire country**
4- WHO	**-**	**Entire country**
5- EU	**64.550**	
PASA (co-financing 10th EDF and AFD) investments (construction/rehabilitation/equipment: RHD, PHD, Hospitals, PCG warehouse), purchase of medicines, institutional support	**18.950**	**Nzerekore**
PASA 2 (funding for 11th EDF; priorities and activities to be determined in 2017)	**45.600**	**Nzerekore + other regions TBD**
6- USAID Surveillance and international health security, mother and child health, strengthening and modernisation of the NHIS and of governance	**103.319**	
7- Global Fund HSS	**28.375**	**Entire country**
HIV	22.282	
Malaria	6.093	
Tuberculosis	-	

DONOR	TOTAL BY DONOR (in thousands of US$)	Geographic Zone
NHIS strengthening and modernisation	2.000	
8- Guinea Plan	**-**	
9- KFW	**17,000**	
Construction of health centres and rehabilitation of hospitals, medicines	17,000	Faranah, Labe, Boke Regions
10- IDB	**29.714**	
Donka and district hospital construction and equipment	29.714	
11- Saudi Fund	**19.067**	
17- GIZ	**15,000**	
Reproductive and family health	15,000	Labe, Mamou, Faranah, Kindia
19- World Bank (PASSP)		**Labe + Faranah + Mamou**
Improvement of primary healthcare access	19.500	Labe + Faranah + Mamou
Support for human and animal health surveillance	30,000	Entire country
20- AFD		
Laboratories project	**10.481**	

ACRONYMS

VIG:	Vaccine Introduction Grant
RED/REC:	Reach Every District/Community/Child
SIA:	Supplementary Immunisation Activities
BSD:	Bureau of Strategies and Development
ICC:	Inter-agency Coordinating Committee
HSCC:	Health System Coordinating Committee
CDC:	Centers for Disease Control and Prevention
CC:	Cold chain
MTEF:	Medium-Term Expenditure Framework
HC:	Health Centre
UHC:	Universal Health Coverage
TCC:	Technical Coordinating Committee
PTCC:	Prefecture Technical Coordinating Committee
RTCC:	Regional Technical Coordinating Committee
DHIS2:	District Health Information Software
DVD-MT:	District Vaccination Data Management Tool
DQS:	**D**ata Quality Self-assessment
DHS:	Demographic Health Survey
GF:	Global Fund
PBF:	Performance-Based Financing
Gavi:	Global Alliance for Vaccines and Immunisation
EVM:	Effective Vaccine Management
GIZ:	German cooperation
GNF:	Guinean Francs
NITAG:	National Immunisation Technical Advisory Group
HPV:	Human Papillomavirus
NCA:	National Coordinating Authority
iHRiS:	Integrated Human Resource Information System
LQAS:	Lot Quality Assurance Sampling
MenA:	Meningococcal A Conjugate
mOPV:	Monovalent Oral Polio Vaccine
EVD:	Ebola Virus Disease
WHO:	World Health Organization
NGO:	Non-government Organisation
SO:	Strategic objective
OAP:	Operational Action Plan
CPA:	Complementary Package of Activities
VVM:	Vaccine Vial Monitor
EPI:	Expanded Programme on Immunisation
MPA:	Minimum Package of Activities
NHDP:	National Health Development Plan
POSSAV:	*Plateforme des Organisations de la Société Civile pour le Soutien à la Santé et à la Vaccination* (CSO Platform Supporting Health and Immunisation)
cMYP:	Comprehensive Multi-Year Plan
HSRP:	Health System Recovery Plan
EPIRP:	Expanded Programme on Immunisation Recovery Plan
TFP:	Technical and Financial Partner
HSS:	Health System Strengthening
HHR	Health Human Resources
Rota:	Rotavirus vaccine
SARA:	Service Availability and Readiness Assessment
LMIS:	Logistics Management Information Systems
CEmOC:	Comprehensive Emergency Obstetric Care
BEmOC:	Basic Emergency Obstetric Care
NHIS:	National Health Information System
NVS:	New Vaccines Support
Td:	Tetanus-diphtheria toxoide
EU:	European Union
UNPF:	United Nations Population Fund
UNICEF:	United Nations Children's Educational Fund
USAID:	US Agency for International Development
YF:	Yellow Fever vaccine
IPV:	Inactivated poliovirus vaccine

bOPV: Bivalent Oral Polio Vaccine