

Joint Appraisal (JA) report 2018

Country	Republic of Guinea
Full JA or JA update	<input checked="" type="checkbox"/> Full JA <input type="checkbox"/> JA update
Date and location of Joint Appraisal meeting	17-21 September 2018 in Conakry, GUINEA
Participants/affiliation¹	MoH, Gavi, WHO, UNICEF, Dalberg, ICC, BMGF
Reporting period	Annual
Fiscal period²	1 January 2017 to 31 December 2017
Comprehensive Multi Year Plan (cMYP) duration	2016-2020
Gavi transition / co-financing group	initial self-financing

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes X	No <input type="checkbox"/>	N/A <input type="checkbox"/>
HSS renewal request	Yes X	No <input type="checkbox"/>	N/A <input type="checkbox"/>
CCEOP renewal request	Yes X	No <input type="checkbox"/>	N/A <input type="checkbox"/>

Observations on vaccine request

Population	11,412,641 (projected population based on the 2014 INS GPHC)			
Birth Cohort	456,506			
Vaccine	DTP-HepB-Hib	Yellow fever	IPV	
Population in the target age cohort	410,855	410,855	410,855	
Target population to be vaccinated (first dose)	390,312	328,684	287,599	
Target population to be vaccinated (last dose)	312,250	328,684	287,599	
Implied coverage rate	70	64	70	
Last available WUENIC coverage rate	45	43	45	
Last available admin coverage rate	90	90	90	
Wastage rate	10	20	10	
Buffer	292,400	103,300	103,300	
Stock reported	1,045,000	548,200	340,290	

¹ If taking too much space, the list of participants may also be provided as an annex.

² If the country reporting period deviates from the fiscal period, please provide a short explanation.

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future³

	Programme	Expected application year	Expected introduction year
Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future	PCV-13	2019	2020
	Rotavirus	2019	2020
	MR	2020	2021
	MenAfriVac	2019	2020
	Td	Not applicable	Introduced in 2017
	HPV	2020	2021
	Ebola*		
	MCV2	2018	2019
	Hepatitis B birth dose	2020	2021

**(waiting for the Ebola vaccine to be made available)*

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

a) Changes since the last appraisal

Guinea did not experience any natural disasters, political instability or displaced populations in 2017 that might have affected programme performance. Other relevant information include the existence of hard-to-access health zones/areas; a significant increase in the share of the government budget allocated to health (from 3.76% in 2015 to 8.2% in 2017); and a low rate of fund disbursement. In 2017, the country reported measles outbreaks in 28 of the 38 health districts and responded with a mass immunisation campaign that was conducted in several phases, beginning in Nzérékoré (March 2017), followed by Conakry (7-17 April 2017) and ending in 22 other health districts (26 April to 2 May 2017). With regard to polio eradication, the OBRA 3 assessment in January 2017 showed that Guinea is no longer in outbreak status. It is, however, classified as a vulnerable country, which is why four immunisation campaigns were organized in 2017 (three national immunisation days and one local immunisation day). Partners (including WHO, UNICEF and CDC) are currently involved in transferring skills in the areas of disease surveillance, service delivery, data management, logistics and communication.

In terms of governance, the process to restructure the Inter-Agency Coordinating Committee (ICC) has begun and is continuing thanks to support from Gavi through Dalberg, which has assisted with revising and validating ICC documents. The first National Forum on Immunisation was organized in October 2017 with support from technical and financial partners (TFPs). The primary goal of that forum was to review the progress made in all areas of the Expanded Programme on Immunisation (EPI), analyse weaknesses and refine strategies and interventions in order to address persistent bottlenecks and operationalise the Addis Ababa Declaration by heads of state to support immunisation.

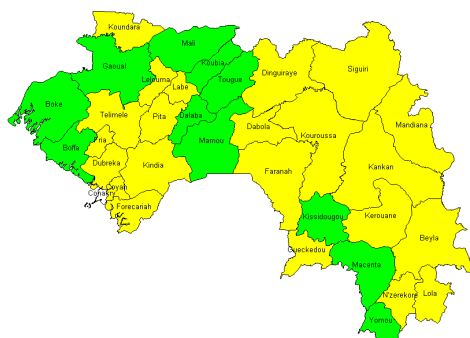
The audit of Gavi-funded programmes was also prepared and conducted in 2017 using the services of a national accounting firm (Gesny Africa), which assisted the EPI in establishing the necessary audit conditions.

b) Country category

Guinea falls in the category of countries in initial self-financing.

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

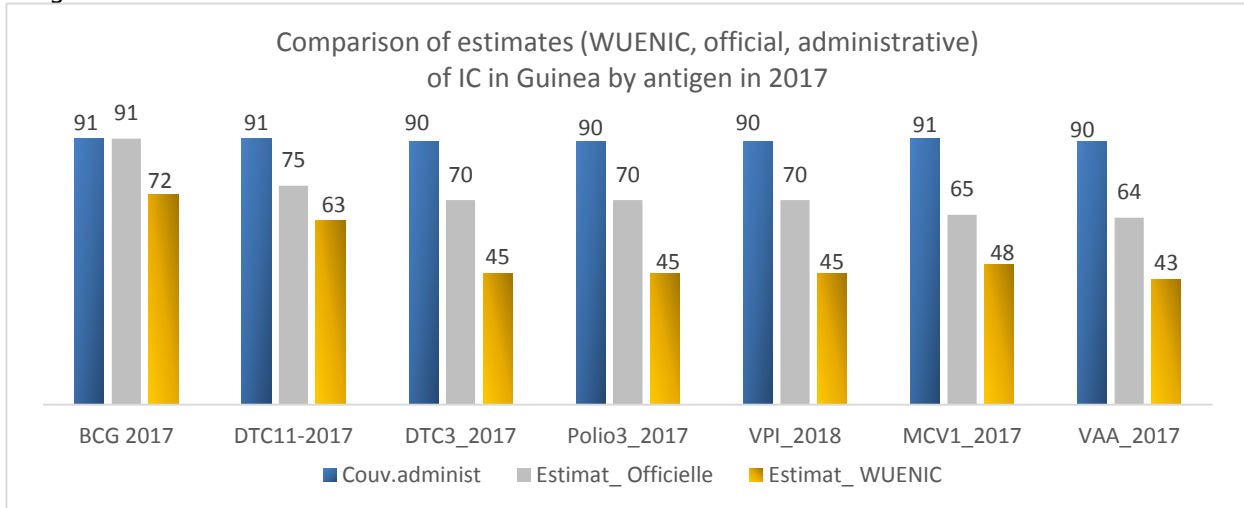
RISK ANALYSIS		
Risk areas	Risks	Mitigation measures
I. Change in the immunisation programme	Low coverage that interferes with the introduction of new vaccines	Increase immunisation coverage (IC), incorporating routine immunisation in health posts/private facilities and strengthening community health
II. Barriers to achieving goals	Hesitation by the population since the Ebola epidemic	Involve communities more in microplanning the REC approach and implementing immunisation activities Anticipate when to implement non-routine activities (such as campaigns, outreach strategies). Advocate to political leaders (in both the governing and opposition movements) to suspend (or declare a truce on) political demonstrations when major public health interventions are being conducted. Such a truce was obtained between political actors in February 2016 during the measles immunisation campaign.
	Socio-political problems during pre-election periods	
III. Dependence (on financial, human, and material resources)	Poor disbursement of the government's share	Advocacy from the health commission in the National Assembly to disburse the government's share
	Increased service costs with the increased price of fuel	Make immunisation a priority and increase its budget Update budgets for inflation
	Insufficient personnel (in terms of quality and quantity)	Recruit new staff members and train them on immunisation practices
	Some outdated health facilities and equipment	Build and/or renovate infrastructure and equipment
IV. Previous problems	Outbreaks (Ebola, polio, measles)	Strengthen surveillance and response



3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

3.1. Coverage and equity of immunisation

Despite ongoing progress in restarting routine EPI, WHO and UNICEF estimates indicate that coverage rates remained stagnant from 2015 to 2017. The figure below illustrates the situation using IC estimates by antigen in 2017.



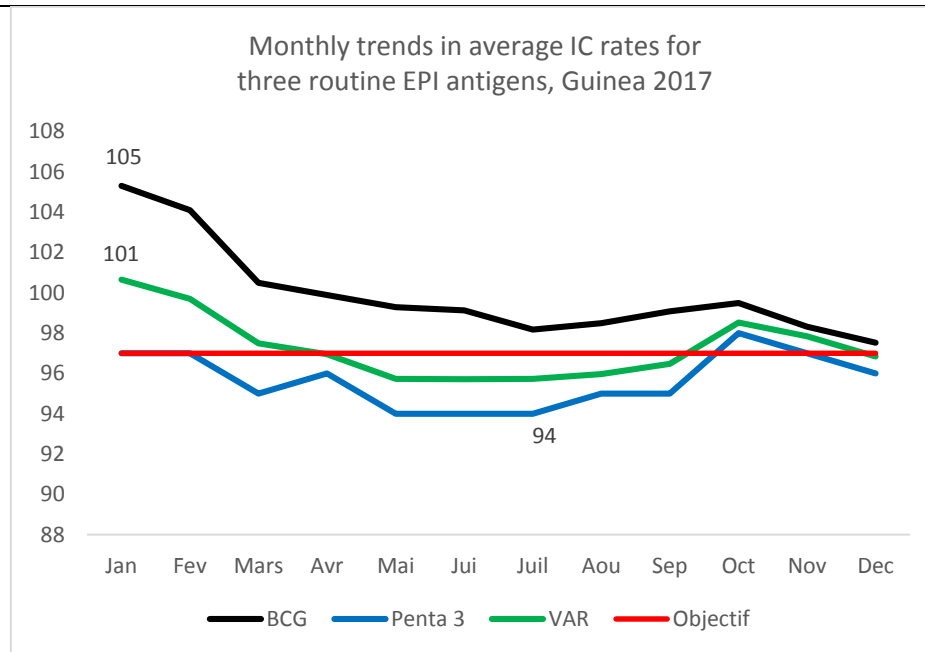
Blue: Administrative coverage; grey: Official estimates; orange: WUENIC estimates

At the national level, there are notable variations between administrative and WUENIC coverage rates for all antigens generally, with significant discrepancies for Penta3/OPV3 (90% vs 45%) and MCV1 (91% vs 48%). In 2017, differences between vaccines that are administered at the same time were also observed, from 1% for YFV and MCV1. This may be due to poor geographic health coverage or gaps in implementation of the Reach Every Child (REC) approach, including supportive supervision and monitoring for action. In fact, vaccines are administered at fixed sites in only 413 public health centres out of the 1,468 health centres and posts in the country.

Health facilities in the private non-profit sector are often not suitable, and are poorly equipped to offer immunisation services. In this context, routine immunisation activities have been incorporated into some private facilities, including in the Ratoma commune. About 40% of the target population lives outside a 5 km radius from fixed immunisation points (preventive services), including 22% who live further than 15 km away. One third of health posts are located more than 50 km from a health centre, often with a population over 7,000 (especially in the mining districts of Kouroussa, Sigui, Mandiana, Dinguiraye and Kérouané). Because of this, the new HSS2 grant includes strengthening fixed strategy immunisation services in all 1,468 public, private, and religious health facilities.

Source: Guinea Analysis, 2017 JRF (administrative data)

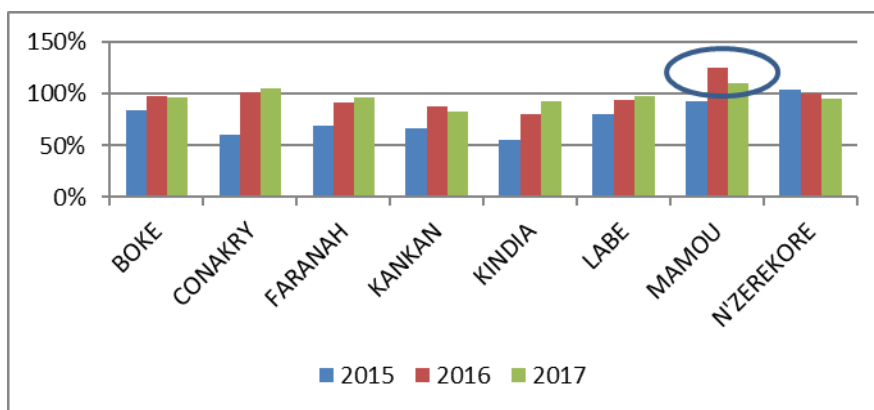
- Coverage by other antigens (routine immunisation or campaigns)



Black: BCG, blue: Penta3; green: Measles; red: Objective

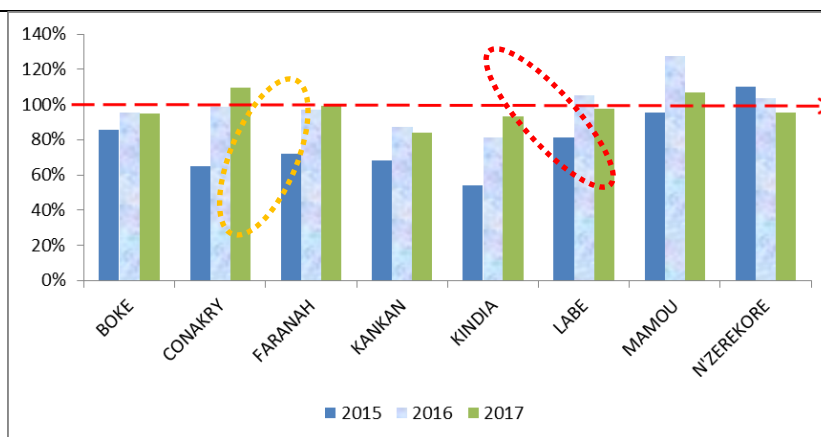
In 2017, administrative data showed an overall downward trend in immunisation coverage, yet BCG coverage has remained above the national target. The analysis showed an increase in IC in October 2017, primarily due to the effect of intensified vaccination activities during mother-child week. In January 2017, IC was over 100% for BCG and MCV. Such over-reporting of immunisation data is due to underestimating the target population. Note that Penta3 coverage is below the 95% target. Activities to support routine immunisation were insufficient in 2017 because of a lack of funding. It was a transition year, between the end of funding for the post-Ebola relaunch plan and the delayed start of HSS2 grant activities. Activities funded as part of the HSS and immunisation programme began late due to several factors, including the non-completion of some suspension conditions in the requirements for grant management. However, some direct payments and financial commitments to acquire materials have been possible since April 2017 because of additional measures taken by UNICEF to manage fiduciary risks.

DTP3 coverage from 2015-2017, health regions



Overall, the regions of Conakry, Faranah, Labé and Kindia continually improved DTP3 coverage from 2015 to 2017. Immunisation coverage in all regions was close to 100% in 2017 apart from in Kankan, due to the instability of the population in mining areas. Coverage rates in Mamou exceed 100%, peaking in 2016 as a result of an underestimation of the region's population. From 2015 to 2017, the two regions whose IC rates increased the most were Conakry and Kindia, especially between 2015 and 2016 due to campaigns to raise awareness about immunisation services in the post-Ebola period.

Trend in coverage for MCV1 by region, 2015-2017



Guidelines state that the target for eliminating measles is 95%. In 2017, seven of the eight regions met or exceeded that target for MCV1 coverage. Between 2015 and 2017, Conakry and Kindia significantly increased their coverage rates; however, the opposite was true for Nzérékoré, where IC fell.

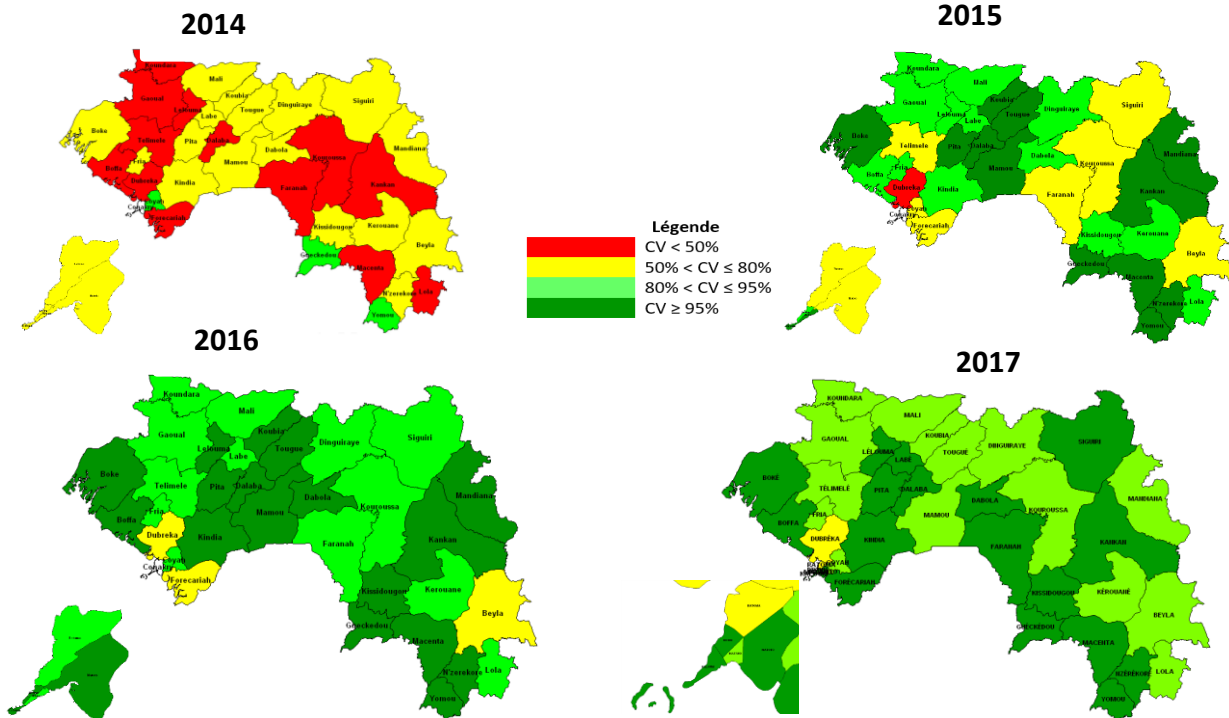
Ranking of regions by newborns under-immunised or unimmunised with DTP1 and DTP3

Régions san	Cible	Non vaccinés DTC1	Non vaccinés DTC3
BOKE	41,802	240	1,576
CONAKRY	64,470	-6512	3,743
FARANAH	36,441	-1941	1,192
KANKAN	76,780	6277	12,910
KINDIA	60,269	-748	4,367
LABE	38,489	-1702	1,082
MAMOU	28,299	-4848	3,044
N'ZEREKORE	64,305	-316	3,322

Horizontal: Health regions; Target; Unimmunised DTP1; Unimmunised DTP3

In 2017, all regions had DTP1 immunisation rates above the target with the exception of Kankan and Boké. The negative numbers in the table mean that the number of children immunised was greater than the target number. This indicates target numbers are underestimated in the regions of Conakry, Faranah, Kindia, Labé, Mamou and Nzérékoré. On the other hand, the target number of children immunised with DTP3 was only achieved in Conakry and Mamou. The regions of Kankan, Kindia and Nzérékoré show high numbers of children who are not immunised with DTP3.

Trends in Penta3 administrative coverage by district in Guinea from 2014 to 2017



Administrative data show that between 2014 and 2017, fewer districts were underperforming from one year to the next. Performance remained low between 2014 and 2016, then gradually improved between 2016 and 2017. However, given the significant differences between administrative data and survey data, this performance should be studied in greater depth, particularly with regard to data analysis and management.

Additional analyses: Equity in immunisation

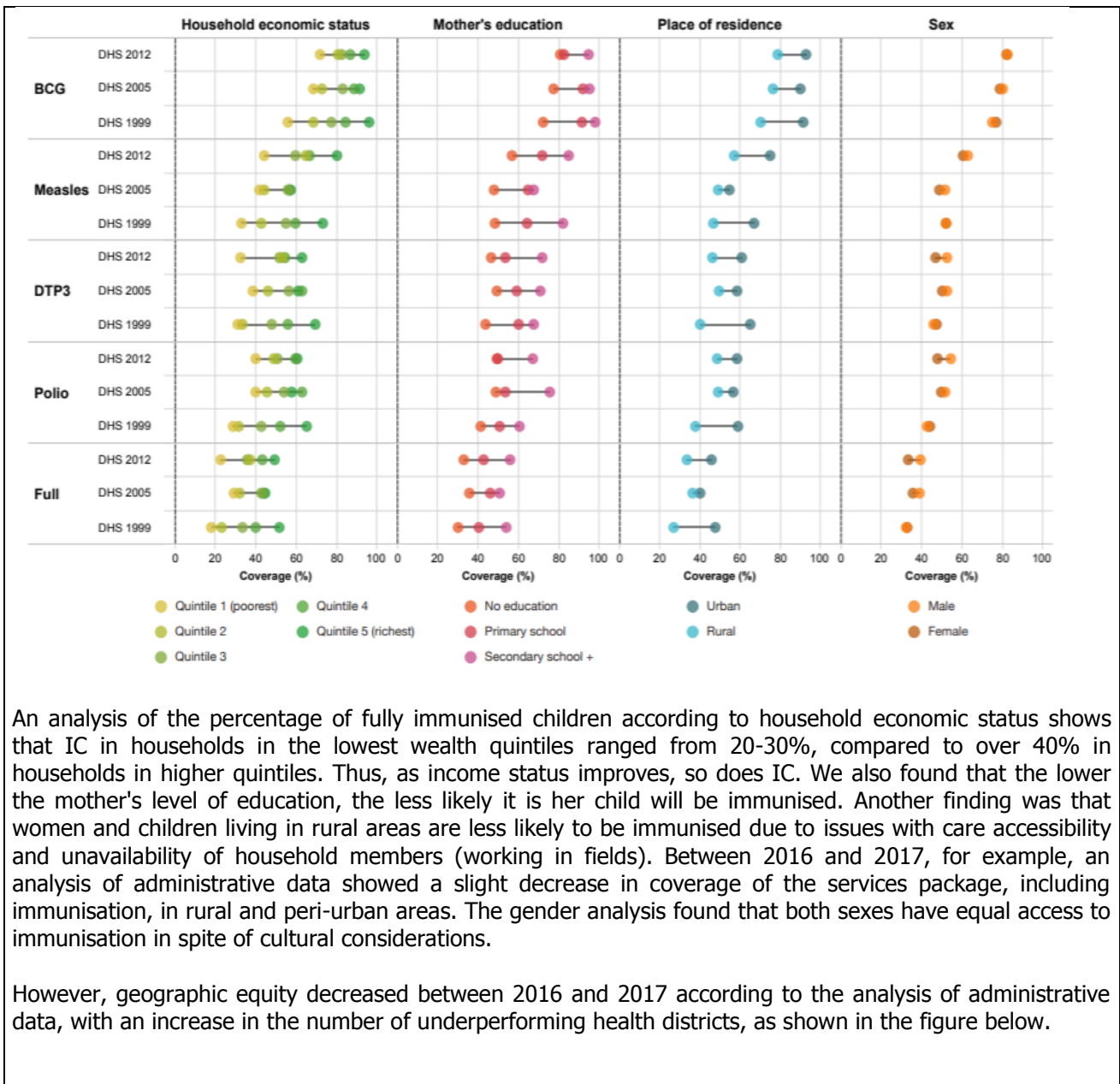
Difference and/or inequality ratio:

Disaggregated by household economic status (quintile 5-quintile 1), mother's education (secondary or higher-no education), place of residence (urban-rural), sex (male-female).

Additional analyses:

Coverage trends within groups identified or suspected as vulnerable (ethnic groups, religious groups, people living in slums, refugees, internally displaced persons, etc). Other available analyses were taken from the recent equity analyses.

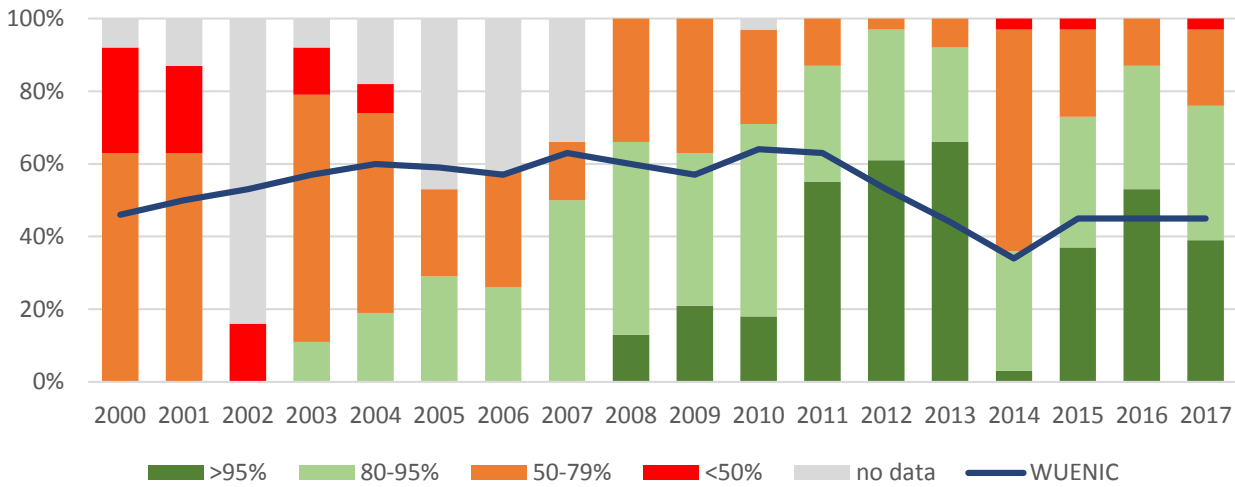
Analysis of immunisation coverage by equity in Guinea (www.who.healthequityanalysis)



An analysis of the percentage of fully immunised children according to household economic status shows that IC in households in the lowest wealth quintiles ranged from 20-30%, compared to over 40% in households in higher quintiles. Thus, as income status improves, so does IC. We also found that the lower the mother's level of education, the less likely it is her child will be immunised. Another finding was that women and children living in rural areas are less likely to be immunised due to issues with care accessibility and unavailability of household members (working in fields). Between 2016 and 2017, for example, an analysis of administrative data showed a slight decrease in coverage of the services package, including immunisation, in rural and peri-urban areas. The gender analysis found that both sexes have equal access to immunisation in spite of cultural considerations.

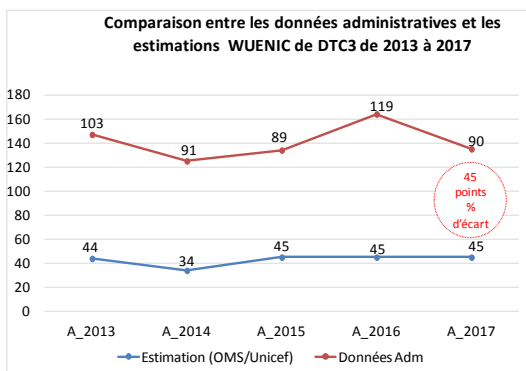
However, geographic equity decreased between 2016 and 2017 according to the analysis of administrative data, with an increase in the number of underperforming health districts, as shown in the figure below.

Distribution of districts per Penta3 coverage category

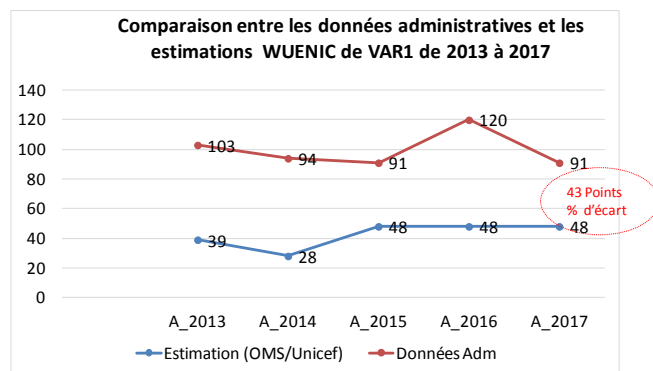


This situation is likely related to the fact that about 40% of the target population lives beyond a 5 km radius from fixed immunisation points (preventive services), including 22% who live further than 15 km away. One third of health posts are located more than 50 km from a health centre, often with a population of over 7,000 (especially in the mining districts of Kouroussa, Siguiri, Mandiana, Dinguiraye and Kérouané). An additional factor is that in some places, primarily urban areas, payment for immunisation is demanded illegally, which limits access to immunisation services for the poorest populations.

The Government and alliance partners are involved in efforts to improve immunisation equity in a variety of areas so that operational strategies can be incorporated to reach hard-to-access populations, such as those living on islands, the hillsides and valleys of Fouta, religious groups and nomadic groups. These efforts included a continuation in 2018 of the immunisation equity analysis started by UNICEF in June 2017, following the sub-regional workshop in Dakar on capacity building in countries using the immunisation equity analysis. Actions have also included: conducting decentralised, periodic monitoring in the last quarter of 2017 and 2018 to analyse the bottlenecks that prevent increasing the percentage of fully immunised children; providing 818 motorcycles for health facilities; relaunching outreach strategies for immunisation; and training immunisation workers in CAD in the second half of 2018. The provision of facilities (health centres and posts in the private non-profit medical sector) and the improvement in cold chain coverage to optimise the supply platform will undoubtedly bring immunisation services closer to populations and households that are far from immunisation facilities.



Comparison between administrative data and WUENIC estimates for DTP3 between 2013 and 2017
Blue: Estimates (WHO/UNICEF); red: Administrative data



Comparison between administrative data and WUENIC estimates for MCV1 between 2013 and 2017

We note a significant difference between administrative data and WHO/UNICEF estimates, as shown in the figures above. The difference is 45 points for DTP3 and 43 points for MCV1. Efforts are under way to reduce this difference to five points, as recommended in the cMYP. Such discrepancies indicate poor data quality at

all levels, which may be due to a lack of or insufficient verification of data before they are sent to the next level, or to inadequate analyses and validation of the data received.

3.2. Key drivers of sustainable coverage and equity

Health work force: availability and distribution of health workers

Immunisation activities are performed by a combination of (a) permanent, full-time government workers, and (b) contract workers, primarily technical health workers and health aides. Very few doctors offer immunisation services, being more involved in managing and supporting health districts, regions and the central level. The analysis of health workers revealed inadequacies in terms of both quality and quantity, as well as inappropriate distribution of existing staff. A significant percentage are concentrated in large cities and around Conakry, serving fewer than 30% of beneficiaries. To address this issue, in 2017 the Civil Service Ministry made around 4,460 health workers in all categories available to the Ministry of Health.

National coordination of the EPI suffers from a lack of personnel, as noted in the organisational and institutional analysis performed by Deloitte in 2016. Some of their conclusions concerned the assignment of additional workers for coordination. While awaiting this decision, the EPI is receiving support from interns and assistants. To ensure the quality of service delivery, the health workers recruited received training or continuing education in primary healthcare. Supportive supervision was also organised by the central level and management teams from regions and districts to strengthen their field skills. In addition, Gavi support made possible initiatives that deployed 100 health providers of immunisation to hard-to-reach areas, with training in immunisation practices and effective vaccine management (EVM). This initiative increased IC in these areas and should be continued with support from the HSS2 grant. The plans for the HSS2 grant in 2018 include assigning staff members to make up the deficit of workers at the central EPI and in regional and prefecture health departments. This primarily concerns 21 focal points, who will be assigned to the 21 underperforming districts, and eight NOB staff members, three of whom are in place in all eight regions, to help providers analyse the bottlenecks to immunisation services and come up with appropriate solutions. The central EPI will also receive staff to support its activities.

The table below summarises the main factors that may affect immunisation services in the areas of equity and coverage, demand generation and coordination at the various levels.

Summary of the performance analysis of equity and demand generation		
Areas	Priority problems	Possible solutions
Coverage and equity	<ul style="list-style-type: none"> No mapping of the expected target for immunisation or catch-up by locale (neighbourhood/sector/village/district) Poor integration of immunisation activities in private facilities 	<ul style="list-style-type: none"> Population count that incorporates mapping of each level of the health system and uses specific strategies to reach hard-to-access populations Set up a framework for collaboration with private facilities
Demand generation	<ul style="list-style-type: none"> Low community involvement in planning, implementing, and monitoring immunisation activities 	<ul style="list-style-type: none"> Re-energise the COSAH Set up community health workers/liaisons Set up a community platform that includes groups, CSOs, religious groups, the media, and traditional healers
Coordination	<ul style="list-style-type: none"> Lack of a platform to coordinate actors involved in implementing immunisation activities at the operational level 	<ul style="list-style-type: none"> Set up platforms to coordinate actors involved in implementing immunisation activities at all levels

Logistics and supply chain

The EVM assessment conducted in 2016 gave an overall score of 37%. Significant supply chain bottlenecks interfere with the achievement of programme objectives. The barriers include: (a) insufficient storage capacity at all levels (central, regional, district and some health centres); (b) outdated cold chain equipment and recurring outages; (c) lack of EPI focal points in health regions and districts; (d) insufficient training and supervision of staff, even as new technology is being introduced for vaccine and cold chain management; (e) insufficient means of transport at the central level to distribute vaccines; (f) inadequate resources to operate outdated equipment; (g) lack of qualified maintenance workers, especially in health districts and regions; (h) vaccine stockouts in health districts and centres; and (i) weaknesses in the system for managing stock and creating the report. Furthermore, the regional level is not involved in the supply chain. The main challenges for the programme are supplying quality vaccines to beneficiaries and strengthening the cold chain. The 2016 inventory revealed a number of inadequacies in the operation and quality of cold chain equipment.

An improvement plan was developed following the EVM assessment. The table below shows the progress made in implementing activities.

Progress in planned EVM activities by key area

Area	Activities planned	Activities completed	Completion rate	Activities in progress	% of activities in progress	Activities not completed	%
System remodelling/ optimisation	11	3	27%	6	55%	2	18%
Logistics system manager	7	0	0%	5	71%	2	29%
Data for logistics system management	7	2	29%	2	29%	3	43%
Cold chain equipment	21	5	24%	8	38%	8	38%
Continuous system improvement	1	0	0%	1	100%	0	0%
Total	47	10	21%	22	47%	15	32%

The following activities were conducted in these key areas:

(i) System design: The managerial and management skills of two central-level workers and eight regional-level workers were strengthened. Health regions are in the process of becoming more involved in the supply chain and the process for optimising and modelling the vaccine supply chain is also under way. Following an initial workshop in 2017, a second workshop was scheduled for November 2018. One of the buildings that houses some central cold rooms was brought up to standard with renovation of the vaccine loading and unloading area.

(ii) Cold chain equipment and maintenance: At the Central level, storage capacity was increased with the installation of a 40 m³ refrigeration cold room. At the health district level, 38 solar, battery-free (SDD) refrigerators were installed in 38 districts. At the health centre/post level, 197 refrigerators were installed and at the regional level, solar cold rooms are being installed. Every health district received five 20-litre coolers and every health centre at least seven vaccine carriers. Maintenance kits and personal protection items are available and being distributed. A maintenance technician will be recruited in 2018 to support the central level and eight others will be available in the eight regions.

(iii) Temperature monitoring: Three of the seven central cold rooms have been mapped. Continuous temperature loggers (Multilog2) were purchased in 2017 and will be installed in November 2018. Refrigerators in health districts and centres/posts will be fitted with Fridge Tag2. Freeze indicators are available to monitor vaccine temperature during transport.

(iv) Distribution: The vehicle fleet at the central level has been strengthened since 2017 with the purchase of two supply trucks and eight supervision vehicles. An additional six trucks will be ordered in 2018 (two for the central level and four for regions) and 818 motorcycles will be deployed at the operational level: 408 motorcycles have already been received and the other 410 are expected for strengthening outreach and surveillance activities. The current input distribution circuit does not incorporate the regional level; instead, the central level directly supplies health districts. The modelling process that is under way will help redefine an appropriate circuit.

The table below summarises the main factors that affect the relationship between CCEOP and logistics management tools, the supply chain and planning of EPI logistics activities.

Identification and summary of logistics and vaccine activities

Areas	Priority problems	Possible solutions
<p>CCEOP and logistics management</p>	<ul style="list-style-type: none"> No logistics committee established Change in the local Haier Retard representative for SMT analysis and transmission Insufficient cross-analysis between DVD-MT and SMT Low availability of management tools 	<ul style="list-style-type: none"> Name assignments to the CCEOP monitoring committee and make it operational Evaluate the management skills of the local Haier representative Send the SMT and analysis report on time and perform a quarterly cross-analysis of DVD-MT and SMT
<p>Supply chain design</p>	<ul style="list-style-type: none"> Delayed implementation of the supply chain modelling process Delayed Ministry of Health decision on integrating/combining the EPI storage facility with the PCG 	<ul style="list-style-type: none"> Speed up the modelling implementation plan Follow up with the decision on integrating/combining the storage facility
<p>Activity planning</p>	<ul style="list-style-type: none"> Low completion rate of activities scheduled in the improvement plan (10/47 activities completed in 2018, or 21%) Financial difficulties implementing the maintenance plan 	<ul style="list-style-type: none"> Continue to resolve Gavi's suspension conditions to release HSS2 funds in order to facilitate implementation of the improvement and maintenance plans

(v) Human resources: In 2017, the Ministry of Health assigned 4,460 civil servants to health facilities. As part of HSS2 implementation, nine data managers (one at the central level and one in each health district) were recruited and deployed in the field. In addition, 105 immunisation workers were hired locally in under-performing districts with Gavi funding support. These workers also received training in immunisation practices, including EVM. The programme will be further strengthened in 2018 through the recruitment of 21 EPI focal points for the 21 priority districts, one maintenance technician for the central level and eight doctors responsible for immunisation in each health region. Health personnel in the Kankan region also received training in EVM.

(vi) Logistics management information system: Most of the insufficiencies found in the 2016 inventory were corrected with the placement of high-performing solar refrigerators. Stock management tools were revised and are available in health facilities. In 2017, the programme received computer equipment for the central, regional and health district levels. Reports and data quality have improved, both in timeliness and completeness, since a data manager was recruited in March 2018. Updated, validated management tools have also been put in place.

Despite this progress, however, it should be noted that financial difficulties have hindered implementation of the improvement plan. The evaluation of plan implementation in July 2018 showed that only 10 of the 47 activities planned for 2018 across the basic supply chain areas have been conducted, for a completion rate of 21%. Another 22 activities (47%) are currently in progress. However, 15 activities (32%) could not be completed. Furthermore, the biomedical waste management system remains inadequate due to a lack of operating incinerators in districts and a weak mechanism for collecting, transporting and disposing of such waste.

Obstacles related to gender inequality and other issues

Factors that may hinder immunisation equity include religion, culture, prejudices and mores that discriminate against females. Although no significant difference was found in the MICS and DHS surveys of immunisation coverage between boys and girls, the analysis of refusals revealed beliefs that vaccines might later cause

sterility in girls. Previous studies (the 2005-2012 DHS) also showed the effect of maternal illiteracy on a child's immunisation status, and that fewer girls than boys were fully immunised, at 36% and 39%, respectively. Other factors that hinder equity include the lack of an in-depth analysis of the dimensions of immunisation equity and the incorporation of strategies to reach hard-to-access populations. These populations include those living on islands; poor populations in urban areas and remote rural areas; inhabitants of the hillsides, valleys and remote regions of Fouta; and migrants, religious groups and nomadic and mining populations. Elements that would help to considerably reduce the number of unimmunised or under-immunised children and pregnant women include providing health centres with motorcycles for outreach activities; integrating immunisation into the satellite health posts of community health centres; adjusting the schedules of immunisation services and encouraging/motivating immunisation teams to visit and immunise hard-to reach populations; and having vaccine defenders inform and educate communities. All of these operational approaches should be supported through quality supervision and supplies of vaccines and vaccine inputs.

Generating demand for immunisation

According to the 2016 immunisation coverage survey associated with the MCV post-campaign assessment, 47% of children aged 12-23 months are not fully immunised. The primary reasons for non-immunisation of these children are a lack of information (55.9%) and a lack of motivation (26.9%). The 2018 survey of factors related to the persistence of measles in the country stressed that **64% of health centres** do not have communication or management tools for communication activities; 10% of the authorities are not involved in routine immunisation; and approximately 30% of parents do not realise that immunisation is a means of preventing measles. The main reasons for the lack of information were "mother not informed" (40.7%) and ignorance of the need for immunisation (19.4%). The main drivers behind the lack of motivation to immunise children were a lack of confidence in immunisation (8.8%) and rumours (7.8%). Other equally important factors that are responsible include suboptimal provision of immunisation and a low commitment level in communities. This situation can be explained by:

- low involvement of parliamentarians, locally elected officials and administrative authorities at all levels, religious leaders, the private sector (mining companies, mobile telephone operators, banks, insurance companies), public and private media, civil society organisations (CSOs) and community actors and female leaders to mobilise populations in favour of immunisation;
- insufficient communication materials and high-visibility materials (banners, flyers, aprons, vests, posters, megaphones, image boxes);
- a distrust in the population of outsiders and strangers in the area;
- insufficient coordination, planning, implementation and monitoring of communication and social mobilisation activities around the three immunisation strategies (fixed, outreach and mobile) at the community level for routine immunisation and supplementary immunisation activities;
- insufficient information for the population about the dates and times immunisation teams will be present;
- not following the schedule for outreach strategies in the target location, insufficient interpersonal communication during immunisation sessions at health centres; and
- inadequate documentation and transmission of data on communication and social mobilisation.

The immunisation schedule is not known by most of the population and is not widely broadcast. The socio-anthropological study conducted by the University of Sonfonia in the Ratoma, Matoto and Siguiri health districts highlights the following reasons for non-immunisation of mothers and children:

- the vaccine makes girls sterile and prevents reproduction
- the vaccine makes children rebel against parental authority
- the vaccine lowers life expectancy
- the vaccine is a poison
- political reasons
- religious reasons
- cultural causes
- lack of parental information
- the vaccine is dangerous
- the vaccine makes children sick
- parents who are illiterate or uneducated often believe rumours
- non-involvement of community political leaders in immunisation campaigns
- not incorporating some lists of young immunisation workers provided by neighbourhood heads, especially in the Matoto commune during immunisation campaigns

There is also a lack of community commitment to primary healthcare for the following reasons:

- Communities do not take ownership of health issues, per the Guinean local community code and the Bamako Initiative.
- Community budgets do not allocate 15% to the health system as recommended by the 2008 Ouagadougou conference of health ministers.

However, despite these issues, communities are gradually becoming more trusting of the health sector.

Recall that this situation was aggravated by the outbreak of the Ebola virus, which significantly strained community trust of health workers and negatively affected the use of health services, including immunisation services.

Leadership, management and coordination

Coordination entities exist at the various levels: (a) central level: Health Sector Coordinating Committee (HSCC), ICC, ICN, GTS, Central Technical Committee (CTC), National Certification Committee (NCC) and Monitoring Committee for the Relaunch plan; (b) regional level: CRCSS and Regional Health Technical Committee (CTRS); (c) prefecture level: CPCSS and Prefecture Health Technical Committee (CTPS/CTCS); (d) sub-prefecture or community level: CSPCSS/CCCSS. These entities have continued to support and coordinate EPI interventions. However they are not sufficiently operational due to their low technical skills, an insufficient accountability framework and lack of financial support.

An HSS2 monitoring committee was established and holds weekly meetings to monitor and evaluate HSS2 implementation. The HSS2 grant, while intended for improving immunisation coverage and equity in the lowest-performing health districts, also helps strengthen the pillars of the health system (such as human resources, the health information system and the supply chain) that are not solely managed and monitored by the EPI.

Other support entities have been set up, such as the NITAG and the AEFI committee and decrees naming their members are now available. The AEFI committee is operational and held its first meeting on 5 September 2018 to enhance AEFI surveillance.

In 2017, an evaluation was conducted of the programmatic and organisational quality of the response to the measles outbreak that occurred from February to June 2017. Several recommendations resulted from that evaluation: (i) take the integrated microplans from health centres and prefecture and regional health departments into account; (ii) prioritise communication channels using health workers, private radio stations, public criers and social mobilisers; (iii) improve community engagement; and (iv) increase the number of immunisation teams in rural areas to reduce the distances between immunisation services and the receiving populations.

Some of these recommendations are currently being implemented. Much thought has been given to how to formally integrate the private sector into immunisation activities in Conakry to make it independent in terms of equipment.

Furthermore, an external EPI review is planned as part of the HSS2, scheduled to begin in July 2018.

Periodic meetings and reviews should be organised to support the operations of these health system coordinating entities at all levels to help ensure that interventions by the various actors are integrated and complementary. Other actions will include defining and monitoring accountability frameworks, advocating to mobilise additional resources and assessing the effectiveness and relevance of health interventions.

Governance, management and coordination, funding, and HSS2 next steps		
Area	Priority problems	Possible solutions
EPI governance and human resources	<ul style="list-style-type: none"> Organisational framework needs to be revitalised at the regional level (using the central level model). Low visibility of human resources in terms of skills, activities, and responsibilities at the central and peripheral levels. 	<ul style="list-style-type: none"> Transfer skills to the regional level by setting up a “peer mentoring” system between the central and regional levels Develop a chart of skills, training, and contractor and intern hiring to cover needs
Accountability	<ul style="list-style-type: none"> The performance framework and operational performance indicators are being developed High proportion of human resources with intern or volunteer status limits their motivation 	<ul style="list-style-type: none"> Define the accountability framework and a performance framework involving decentralised levels Offer financial incentives to workers at the decentralised level, including interns
Programming, planning, and coordination	<ul style="list-style-type: none"> A plethora of coordination entities whose actions and decisions are not very visible The process of preparing the operational action plan (OAP) needs to be reviewed There should be more discussions between the central and peripheral levels about the OAP 	<ul style="list-style-type: none"> Organise a workshop to prepare the OAP with regional health departments, health districts, etc. Ensure projects by governance and coordination entities in the health sector are complementary and justified
<p>Public financial management</p> <p>Public financial management suffers from the lack of a manual for administrative financial, and accounting procedures that are agreed on and incorporate all branches of management. This weakness was also noted during Gavi's audit of its 2015-2017 funding, which further highlighted the lack of tools to manage EPI property, regulatory mechanisms applicable to EPI procurement, and the crucial lack of a formal procedure for limited EPI consultations. To rectify these gaps, in 2018 the joint Ministry of Health-UNICEF team worked with Gavi support to assume responsibility for critically reviewing and updating the manual, including additional measures agreed on for the HSS2 grant framework; these include tools related to (i) budget validation and monitoring; (ii) expenditure commitments; (iii) accounting records of expenditures; and (iv) methods for justifying expenditures (list of supporting documentation, deadline for returning documentation, checks to implement and formalise at each level of the health pyramid, etc). The relevant accounting management tools were established in Guinea in 2017 by UNICEF, and additional measures for programme monitoring and spot checks are in place for the regional and prefecture health departments to ensure they are using these tools on a regular basis and according to standards. Drafting of the procedures manual began in 2017 and was in the final stages as of September 2018. Once completed, users will be trained in its use.</p>		

3.3. Data

Data for the immunisation and health system are collected in the field using the following key tools: immunisation registers, stock management records (vaccines and immunisation supplies), tracking sheets, child health cards, maternal health cards, and the immunisation activities monthly report template. Data from most health centres and districts are then transcribed into DHIS2 (the main data management tool

at the Ministry of Health). Note that at this time, DHIS2 does not incorporate all of the indicators in DVD-MT and SMT, so these systems are still being used in parallel. AEFIs are reported through DVD-MT. However, integrated disease surveillance and response (IDSR) for diseases with epidemic potential and other adverse events (maternal and child deaths) are managed in SAP. Surveillance data are harmonised and analysed by various actors (ANSS, EPI, WHO, CDC) on a weekly basis under the aegis of the National Agency for Health Safety (ANSS) and published in Guinea's Weekly Epidemiological Record.

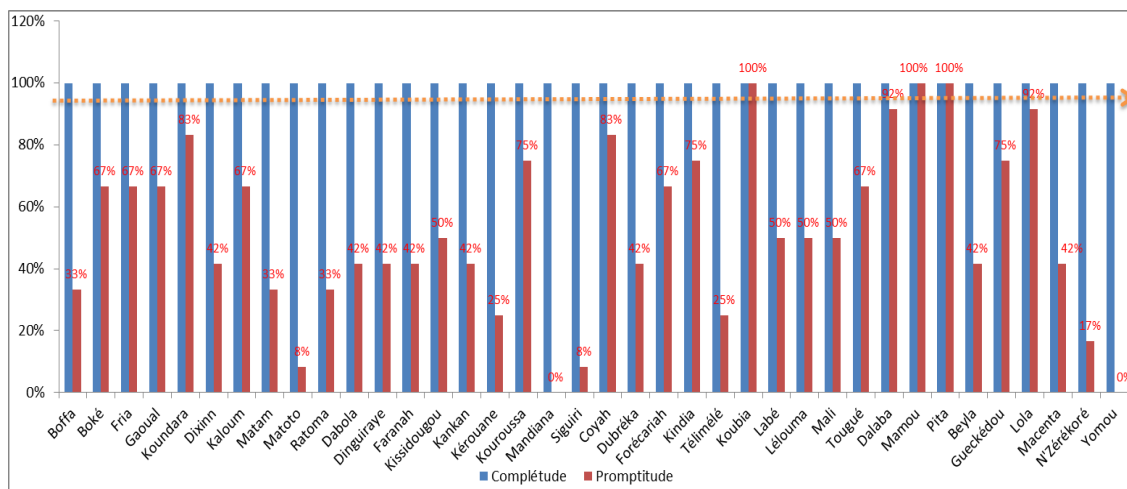
Data are transmitted monthly, using the following schedule:

- the 5th of each month: from health centres to districts
- the 10th of each month: from health districts to regions
- the 15th of each month: from regions to the central level

This data reporting system operates at all levels but issues with both data quality and report completeness and timeliness have been observed. DHIS2 has been implemented in all health districts and regions and is in the process of being implemented in health centres. However, there has been a lack, or at times a complete stockout, of key tools (such as RUMER, tracking sheets, input registers, immunisation registers, child sheets and health cards) for collecting immunisation data at immunisation sites. This situation has been further aggravated by poor archiving of immunisation documents.

The level of report completeness in DVD-MT was satisfactory (100%) in 2017 but the on-time levels were only 52% nationally on 31 December.

Summary table of EPI report completeness and timeliness by health district; source: DVD-MT 2017

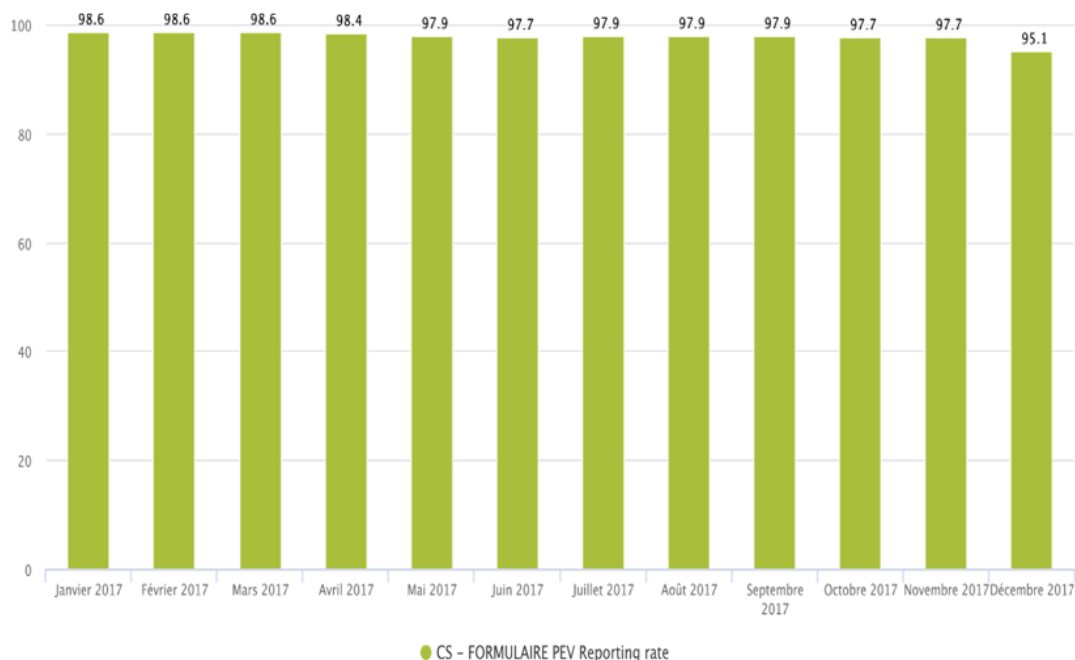


Blue: Completeness; purple: Timeliness

Population data are taken from the 2014 census, with a projection by the National Institute of Statistics. This projection has led to incorrect coverage rates (over 100%) in some places, yet the denominator for national and local polio immunisation days uses the number of children aged 0-59 months who were immunised in the previous round. A new approach will be gradually introduced at the various levels with the support and involvement of MATD: triangulating immunisation data with population counts taken during national immunisation days, or counts from community liaisons, with UN estimates. The programme therefore is planning to count population numbers by health area to come up with a denominator that is close to the true number, as part of the framework for an integrated approach to community health in HSS2.

The figure below shows that in 2017, report completeness per DHIS2 was below 100% for the period.

Completeness of immunisation reports in 2017; source: DHIS2



The independent assessment of EPI data quality conducted in 2014 by the Agency for Preventive Medicine revealed a discrepancy in immunisation data between tools at the different levels, with 75% precision at the health centre level and 70% at the health district level. The salient results from the report of the independent assessment of immunisation data quality conducted in 2017 highlight several factors that were involved in the decision to engage in an ongoing data quality improvement process.

At the community level:

- inconsistencies between the data in the immunisation registers and information about 10 children that was checked in the community; lack of awareness in households about the importance of saving the health card or immunisation card; and
- low incentives, leading to limited commitment by those responsible for managing immunisation data to improve data quality.

Health facility level:

- Poor understanding of the procedures and materials used for entering data;
- Poor records in immunisation management tools, which limit the possibility of having validated data in the community or health district;
- Inadequate archiving system;
- Irregular integrated supportive supervision;
- DQS results show that 18 of the country's health districts have a high number of children (out of those surveyed) who are not immunised with Penta3 and MCV. Note that nearly all health districts show IC greater than or equal to 80% for all monitored antigens. These IC rates are brought into question by the results of the SARA survey, which showed that only one of every four children in Guinea is fully immunised. The DQS will be integrated and led by data managers in health districts so that continual attention can be given to improving the practices of monitoring and managing immunisation activities;
- Observations in the field, an analysis of administrative data on routine immunisation in health districts, estimates of IC by partners (WHO/UNICEF) and various other surveys conducted in the country all indicate that immunisation data are poor at all levels. For example, administrative IC is over 100% in nearly all health districts. The discrepancy between administrative IC and WUENIC estimates in 2017 is 45 percentage points for DTP3 and 43 percentage points for MCV; 42 measles outbreaks in 2017 contradict the administrative IC of 91% for MCV1; and so on. The Ministry of Health is aware of this and through the EPI and with partner support has decided to develop a plan to improve immunisation data quality. The general goal of this plan is to have at

least 95% of health districts send quality immunisation data to the EPI in real time by the end of 2020. Particular attention will be paid to the verification factor by antigen (ratio between information validated in the field and information reported through the DQS) and the QDR will periodically conduct an in-depth review of the data management system at the various levels.

This plan was developed in accordance with the guidelines of the Global Vaccine Action Plan, the goals of the regional strategic plan for immunisation and the 2017-2021 cMYP. The situation was analysed in terms of the strengths, weaknesses, opportunities and threats of data quality components, which identified vulnerabilities. Seven intervention areas were identified to address this challenge and a budgeted action plan for 2019-2020 was developed accordingly. To effectively implement the activities in this plan, resources in addition to the national development budget will be mobilised with the support of TFPs. Implementation of these interventions will improve data quality at all levels, especially in health districts.

Measures have been defined, with technical assistance from WHO, to continue to develop and integrate EPI data into DHIS2; strengthen supportive supervision and quality control; and build the skills of workers involved in national EPI coordination in data management. Eight data managers have been recruited at the regional level to provide technical assistance to regional managers. Through the Bureau of Statistics and Development (BSD) and with WHO support, the Ministry of Health is in the process of setting up an operational committee for data quality improvement.

3.4. Immunisation financing

The budget of the Ministry of Health represented 5.6% of the national development budget in 2017. The health budget decreased in 2012 (1.98%), 2013 (1.75%) and 2014 (2.16), then rose in 2015 (3.22%), 2016 (4.9%) and 2017 (5.6%).

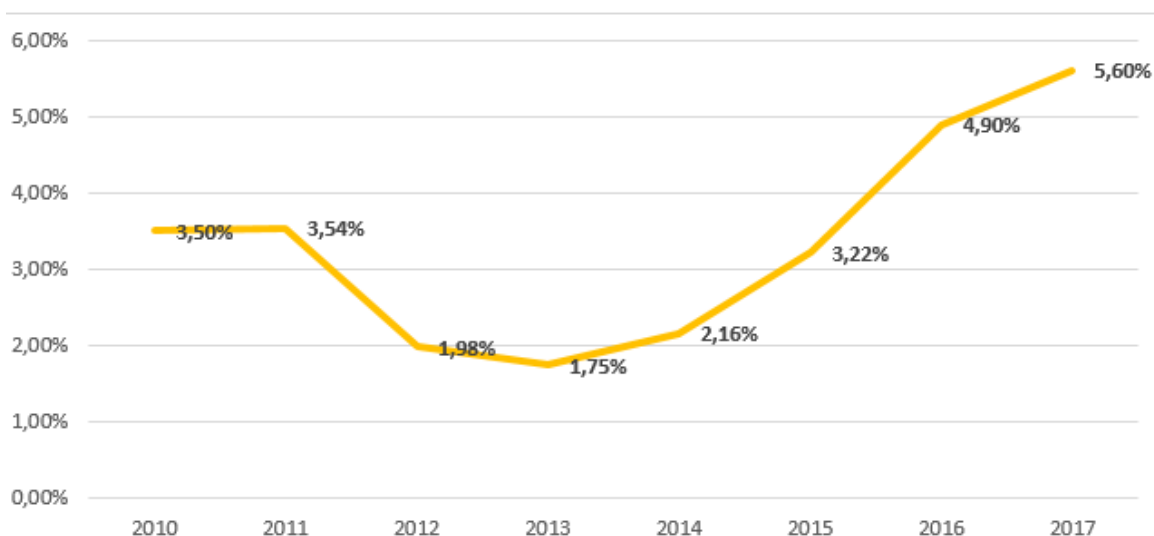


Figure 4: Evolution de la part du budget de la santé dans le BND entre 2010 et 2017, Guinée

Figure 4 : Trend of the health budget in the National Development Budget between 2010 and 2017, Guinea

Allocations to the Ministry of Health budget have increased since 2013, with the Government funding vaccine procurement and Gavi co-financing. However, the EPI in Guinea is highly reliant on outside funding for its operations and activity implementation. The EPI's estimated funding needs in 2017 were US\$ 22.6 million, US\$ 21.6 million of which were covered. The Government's share of these needs was 16%, including co-financing. The co-financing amount for traditional vaccine procurement (yellow fever and DTP) was US\$ 232,500 in 2017 (source: UNICEF). Grants from partners cover 84% of EPI funding, primarily from Gavi (33%), WHO (24%) and UNICEF (23%), according to the revised cMYP.

In the medium term, EPI funding needs in the cMYP have gradually shown a decline in secured funding

from various contributors, even as needs increase. The funding gap is expected to increase from US\$ 942,187 in 2017 to US\$ 5.1 million in 2020, an increase of 82% in the requirement for secured funding. However, cMYP estimates show an increase in the government co-financing budget for vaccine procurement, from 2% in 2017 to 5% in 2020, although government contributions to other costs (such as operations, human resources and equipment) will go down.

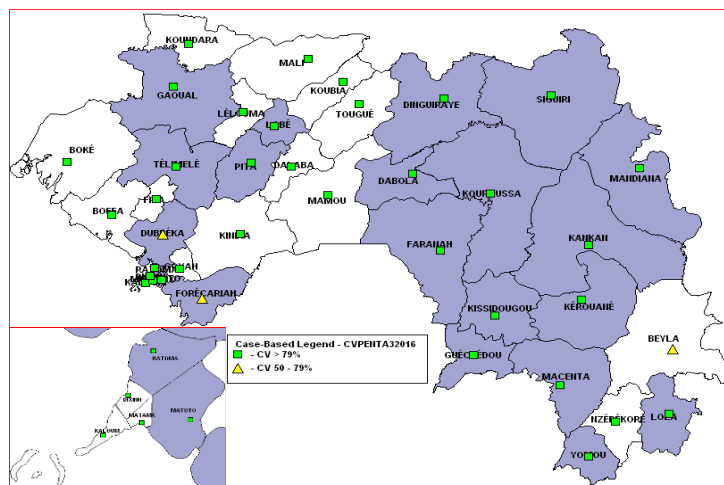
Financial difficulties hindered implementation of the EPI's operational plan overall in 2017. The plan implementation evaluation in July 2018 showed that only 9 of the 126 activities planned between June 2017 and July 2018 across all of the basic EPI areas were carried out, for a completion rate of 7%; and only 11 are well under way (9%). A total of 27 activities (21%) are currently in progress. However, 74 (59%) could not be conducted. A remaining challenge is how to pool financial resources at the EPI coordination body, the entity in charge of coordination, leadership and technical support, for regional and district health departments to improve the quality of immunisation services. Such pooling should constitute the framework for all funding support payments allocated by the health sector TFPs to support implementation of the operational workplan and national coordination of the EPI as the operational leadership entity.

4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

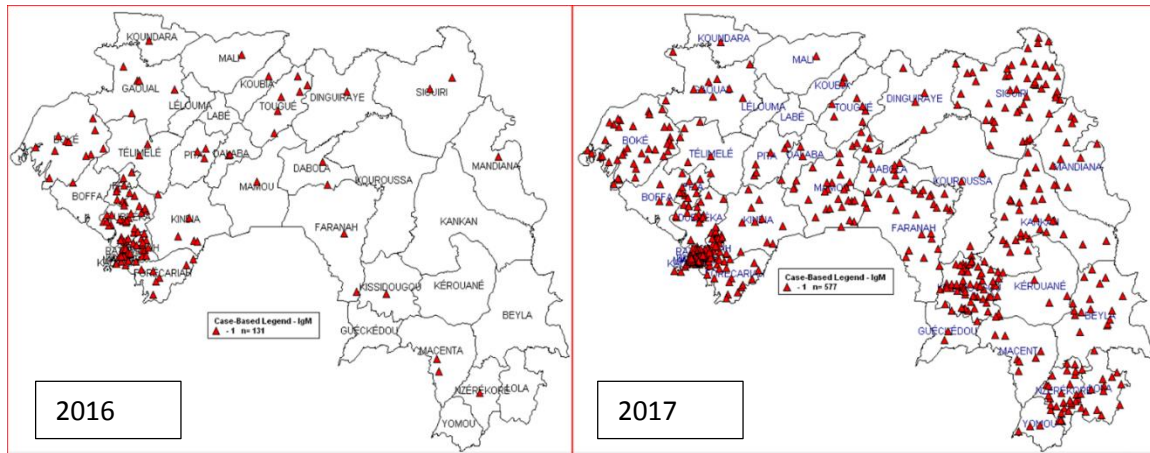
Guinea has not introduced any new vaccines in the past two years. However, Gavi support for 21 health districts boosted efforts by the Ministry of Health and other partners to improve immunisation coverage in all health districts.

Map: 21 health districts targeted for Gavi support



Guinea has experienced recurring outbreaks of measles since 2016, with the surveillance system reporting 7,545 suspected cases in 2017, 316 of which were IgM positive. All health districts have reported suspected cases of measles, predominantly in areas with high population densities (Conakry, Guéckédo, Mamou, Kankan and Siguiri).

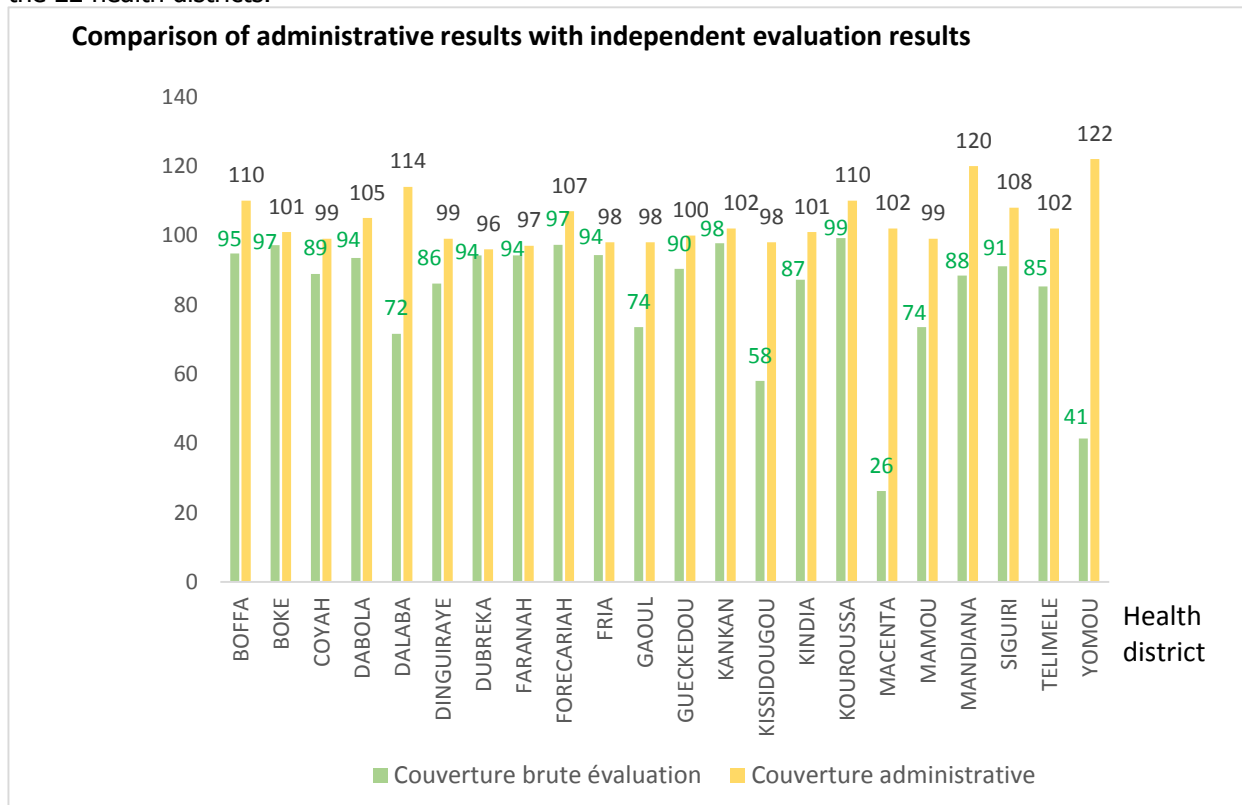
Distribution of confirmed suspected cases by health district in Guinea, 2016 and 2017



Analysis showed that 71% of confirmed cases are in the under-five age range, followed by the 15 and older age range (13%) and the 10-14 age range (11%). The specific incidence of confirmed measles cases varies from 55.8 (<5 years) to 10 (5-9 years) and 3.4 (10-14 years).

During the 2017 measles outbreak, the Measles and Rubella Initiative provided financial support for outbreak preparation and response in 22 health districts. According to administrative results, coverage was 104%, with all health districts achieving at least 96% IC.

The figure below compares administrative results with those found during an independent evaluation of the 22 health districts.



Green: Crude evaluation coverage; yellow: Administrative coverage

The post-response campaign independent evaluation showed crude IC (card and history) of only 83.6%, below the 95% target. Only four of the 22 districts (Boké, Forécariah, Kankan and Kouroussa) had IC above 95%.

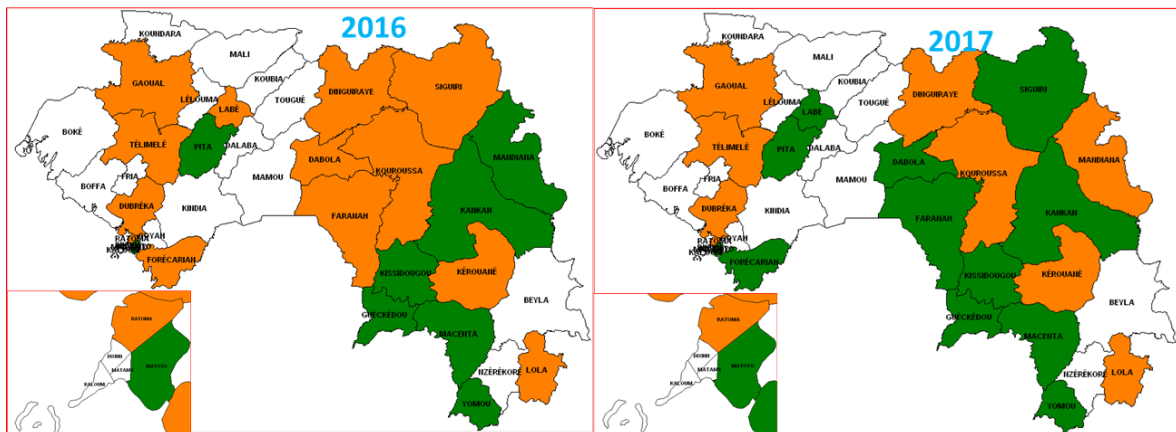
Disparities were found between administrative IC and the independent evaluation IC in some health districts: Yomou (122% vs 41%), Macenta (102% vs 26%, and Kissidougou (98% vs 58%). This evaluation also found significant differences between health districts: Macenta (26%), Yomou (41%), Kissidougou (58%), Dalaba (72%), Gaoual/Mamou (74%) and Kouroussa (99%). The poor performance

in most of the health districts that participated in the measles response is due to insufficient immunisation of the target population during the response campaign, which has resulted in recurring measles outbreaks in the country. The discrepancy between administrative and independent evaluation coverage rates may be due to the quality of the campaign rather than an incorrect denominator.

This situation shows that routine immunisation, supplementary immunisation activities and previous response campaigns have not increased herd immunity sustainably enough to prevent circulation of the virus and occurs in the context of a health system weakened by the recent Ebola outbreak. Thus the risk of measles transmission has increased, with numerous risk factors persisting in most of the country's health districts, namely: (i) high population density in urban areas, especially in Conakry (1,775,130), Siguiri (896,663), Boké (501,504), Kindia (475,694) and Dinguiraye (219,880); (ii) the persistence of cases of refusal/hesitancy in some localities; (iii) poor accessibility and use of health services, which result in low IC for target children; (iv) the poor performance of the measles surveillance system, with an overall reporting rate of less than 1 case/100,000 inhabitants/year; and (v) the lack of an immunisation platform in the second year of life and of a second dose of measles in routine immunisation. In addition to the risk factors listed above, low motivation and a shortage of qualified health workers further limit the provision of immunisation services.

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

Comparison of performance in the 21 health districts between 2016 and 2017 using three indicators: DTP3 IC > 80%, MCV1 IC > 80% and percentage of children not immunised with DTP3 < 5%



<i>Critères de performance dans 21 Districts sanitaires</i>	
	<i>District ayant atteint 3 indicateurs</i>
	<i>District n'ayant atteint 3 indicateurs</i>
	<i>Districts non RSS2</i>

Performance criteria in 21 health districts
 Green: District achieved the 3 indicators
 Orange: District did not achieve the 3 indicators
 White: Non-HSS2 districts

Based on the goal of increasing health district functionality from 52% in 2015 to 80% in 2021, especially in certain target districts, and looking at the three indicators (DTP3 IC > 80%, MCV1 IC > 80% and percentage of children not immunised with DTP3 < 5%), overall EPI performance improved between 2016 and 2017, with 43% of these health districts (9 of 21) showing appreciable performance in these indicators in 2016 compared to 51.1% in 2017 (12 of 21). The improvement is due to better availability of inputs (vaccines, management tools, cold chain) and human resources (more people involved in immunisation, capacity building). However, indicators did not improve in nine health districts (Dubreka, Dinguiraye, Gaoual, Kérouané, Kouroussa, Mandiana, Telimélé, Ratoma and Lola) due to several factors, including: problems accessing populations and pendulum migration in mining areas; immunisation services not fully incorporating populations in contiguous health areas; an insufficient number of quality supervision training visits; insufficient funding for district microplans; and weak application of the

accountability framework.

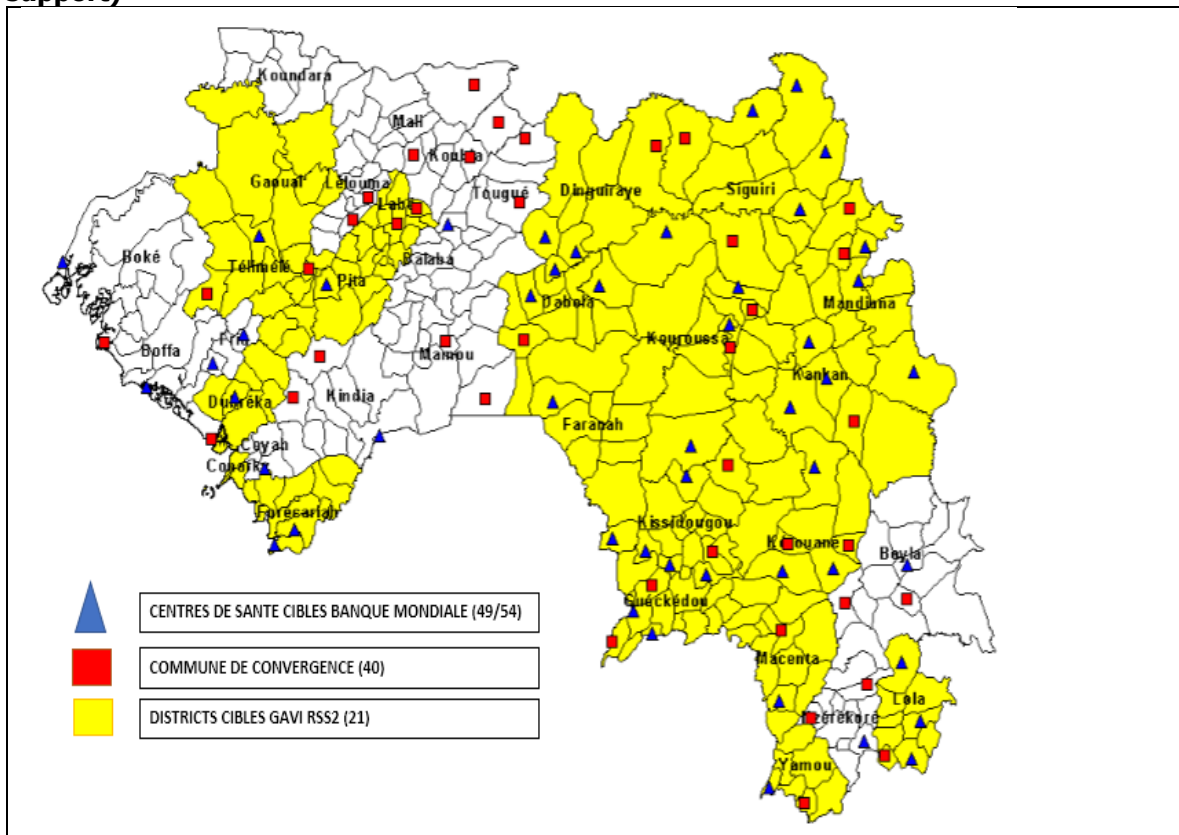
Achievements against agreed targets:

To mitigate the main risk factors responsible for low immunisation rates, Gavi support should focus on the following as priorities: (i) funding health district microplans, with an emphasis on monitoring (fully immunised child, real-time monitoring); (ii) district operationality (setting up the accountability framework, which also includes coordination with the central EPI); (iii) community engagement; and (iv) sustained advocacy to the Government to increase the EPI's share of the budget in government financing. To improve overall immunisation programme performance, services should support immunisation strategies in the public and private sectors.

The activities implemented in the 2017 operational action plan were relevant but focused on cold chain logistics and vaccine supply. However, the delayed availability of HSS2 financial resources partially impacted immunisation services in hard-to-access areas.

To resolve the implementation bottlenecks identified in 2017, the team will update the budget reallocation plan in Annex B before the end of 2018. Moreover, the Ministry of Health has included results-based funding (RBF) as a strategy (2015-2024 NHDP) to improve health system performance as it moves towards universal healthcare. The ministry's pilot project started in the Mamou district in 2016 and results show an encouraging comparative advantage, which has motivated the ministry and its partners to include RBF in some projects, such as HSS2. Training sessions are planned for DMTs and HCCs on the RBF approach in the 21 districts targeted by HSS2 during the fourth quarter of 2018, to begin in 2019. The RBF tools will be reviewed and validated for application in the health sector (procedures manual, indicators, costing). Note that several Ministry of Health managers were trained in Cotonou on RBF implementation.

Map of partner interventions (HSS2, World Bank, 40 convergence communes with UNICEF support)



Blue triangle: Health centre targets, World Bank (49/54)

Red box: Convergence communes (40)

Yellow box: Target districts Gavi HSS2 (21)

In 2017, funding support from Gavi HSS2 was focused on 21 so-called underperforming health districts (DTP3 and MCV1 IC < 80%, the percentage of children not immunised with DTP3 > 5% and no technical or financial partners). Initiatives to boost the synergy and complementarity of actions have been in place

since the second half of 2017, but these need to be consolidated to address the needs in the field. In 2018, the Government collaborated with UNICEF to establish a convergence programme whose primary objectives are to improve the availability of vaccines for effective coverage; to complement the support from other financial partners and the responsibilities of local officials, champions of immunisation, and community and religious leaders; and to organise community dialogue sessions to promote immunisation. Similarly, the World Bank is assisting the Government in setting up the pilot RBF project in the health system to boost the accountability of immunisation actors. The World Bank also provided a significant amount of equipment for primary healthcare to support health services in 54 of the country's sub-prefectures and improve healthcare provision. These efforts should be fully deployed as part of making resources mutually available in order to improve immunisation service delivery overall, as an essential component of the health system.

One of the objectives of Gavi's HSS2 is to increase the coverage of fully immunised children in the 21 target districts from 53% in 2015 to at least 80% in 2021. A review of these initial priority health districts is planned for the first half of 2018. This, together with the anticipated results from the DHS-5, the external EPI review, the JRF data analysis and the equity analysis, means that districts requiring equity in immunisation, particularly in urban areas, will be better targeted.

Objective 1	
Objective of the HSS grant (as per the HSS proposals or PSR)	Increase the functionality of health districts, especially the 21 target districts, from 52% in 2015 to 80% in 2021
Priority geographies/population groups or constraints to C&E addressed by the objective	21 underperforming health districts
% of activities conducted/budget utilisation	10 of 40 activities conducted. Despite low HSS2 budget commitments in the first half of 2018, some activities were conducted with support from another programme.
Major activities implemented & review of implementation progress including key successes & outcomes/activities not implemented or delayed/financial absorption	<ul style="list-style-type: none"> • Analysis of the EPI organisation and human resources, in progress; • External EPI review funded in the HSS2 and accounts by other WHO and UNICEF resources • ICC meetings • Institutional support for CTRS in health regions funded in the HSS2 in late August 2018 • Revision of the Ministry of Health manual for financial management procedures and training of actors • Institutional support for the EPI • Participation in the National Health Assembly through the health commission in EPI activities and mobilisation of government resources for EPI using funding from regular UNICEF resources
Major activities planned for the upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance)	<ul style="list-style-type: none"> • Support for developing annual operational action plans integrated in the 21 health districts and eight health regions • Conduct a study of COSAH cost recovery and functionality • Organise four quarterly meetings per year of the NITAG, with technical assistance from IST and WAHO • Organise meetings to advocate for the mobilisation of resources at the national, regional and prefecture levels • Conduct supportive supervision in regions, districts and health areas.
Objective 2:	
Objective of the HSS grant (as per the HSS proposals or PSR)	Increase the coverage of fully immunised children in the 21 target districts from 53% in 2015 to at least 80% in 2021
Priority geographies/population groups or constraints to C&E addressed by the objective	21 so-called underperforming health districts
% of activities conducted/budget utilisation	<ul style="list-style-type: none"> • 6 of 15 activities conducted. These activities received funding for 20% of their expenditures for January-September 2018 from HSS2.

<p>Major activities implemented & Review of implementation progress</p> <p>including key successes & outcomes/activities not implemented or delayed/financial absorption</p>	<ul style="list-style-type: none"> • Training of certain providers on immunisation practices • Supervision visits in some districts • Provide 818 immunisation sites, including those that are hard to reach, with 125cc all-terrain motorcycles for outreach strategies • Finalise the recruitment process for 21 EPI focal points in Gavi-supported districts. The hiring process did not incur any costs • Train health agents on EPI management in health centres • Organise outreach immunisation sessions • Support the system for recording births and reporting disease surveillance data (copy tools).
<p>Major activities planned for the upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance)</p>	<ul style="list-style-type: none"> • Organise and implement REC microplans in the 21 health districts • Train health workers in how to implement the REC approach in the 21 Gavi-targeted districts • Organise outreach strategy immunisation sessions in the 861 immunisation sites • Train DMTs and HCCs in RBF in the 21 HSS2 target districts • Expand the RBF approach in eight target districts as part of improving EPI indicators • Organise training in mid-level EPI management (MLM course) at the regional level • Deploy 21 EPI focal points to districts.
<p>Objective 3:</p>	
<p>Objective of the HSS grant (as per the HSS proposals or PSR)</p>	<p>Raise the average EVM score from 37% in 2016 to at least 80% by 2019, and maintain it until 2021.</p>
<p>Priority geographies/population groups or constraints to C&E addressed by the objective</p>	<ul style="list-style-type: none"> • Pendulum migration population in the 18 health districts with mining areas • Populations living in peri-urban/urban agglomerations, islands and hard-to-access areas
<p>% of activities conducted/budget utilisation</p>	<ul style="list-style-type: none"> • 11 of 35 activities conducted. This achievement level was obtained with expenditures incurred from January-September 2018 (25%), specifically concerning the direct procurement of materials and equipment
<p>Key activities implemented and review of current implementation status</p> <p>including key successes & outcomes/activities not implemented or delayed/financial absorption</p>	<ul style="list-style-type: none"> • Train an EPI manager on the solar cold chain, organised by the Logivac centre • Hold quarterly meetings of the National Logistics Technical Committee • Train managers at health centres/posts in EVM • Provide the central level with two 40 m³ cold rooms • Perform curative and preventive maintenance on some solar refrigerators • Provide prefecture and regional health departments with curative maintenance kits for the cold chain • Provide the Ministry of Health with five 4x4 vehicles for supervision (four for EPI coordination and one for the BSD) • Acquire CCEOP equipment (246 solar refrigerators with 20% co-financing and 846 solar refrigerators purchased with CCEOP funding) • Acquire 1,200 freeze indicators for vaccine transport • Supply fuel to the central EPI to run cold room • Install the data logger • Recruit and deploy one P3 logistics specialist
<p>Primary activities planned for the upcoming period (mention significant changes/budget reallocations and</p>	<ul style="list-style-type: none"> • Conduct a cold chain modelling study • Train 100 district and regional managers, including the national pool of trainers, in EVM • Provide regions and districts with sufficient coolers to handle

associated needs for technical assistance) ⁴	<p>maximum supplies</p> <ul style="list-style-type: none"> • Provide 1,361 sites with solar refrigerators • Provide supportive supervision • Continue training in EVM • Build a storage facility and administrative services facility for national EPI coordination
Objective 4:	
Objective of the HSS grant (as per the HSS proposals or PSR)	By 2021, at least 95% of parents of the target population in the 21 selected health districts accept and demand immunisation services
Priority geographies/population groups or constraints to C&E addressed by the objective	<ul style="list-style-type: none"> • Pendulum migration population in the 18 health districts with mining areas • Populations living in peri-urban/urban agglomerations, islands and hard-to-access areas
% of activities conducted / budget utilisation	<ul style="list-style-type: none"> • 2 of 17 activities conducted. These account for the expenditures incurred (10%) since the beginning of January, with the recruitment and deployment of C4D consultants
<p>Major activities implemented & Review of implementation progress</p> <p>including key successes & outcomes/activities not implemented or delayed/financial absorption</p>	<ul style="list-style-type: none"> • Support for IEC meetings on each point of the outreach strategy to better incorporate immunisation questions in the information package provided to women of child-bearing age • CSO contracting process (38 districts have a CSO network); process begun without any costs • Since the start of January 2018, 9 C4D consultants recruited and deployed including 1 at the level [sic]
<p>Major activities planned for the upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance)⁵</p>	<ul style="list-style-type: none"> • Organise a national workshop on the development of a multimedia plan and revise immunisation communication modules • Develop specific messages for the introduction of new vaccines (French and five national languages) • Organise sessions twice a year to raise awareness (in 38 districts and eight regions) with religious groups and traditional healers so they comply with immunisation • Advocate to deputies (health commission) for their engagement with immunisation activities in their districts • Organise annual advocacy meetings (by level) with paediatrician associations, media, mobile telephone companies and the private sector to involve them in immunisation • Train members of women's groups on awareness raising and mobilisation for immunisation • Periodically share information on immunisation with mayors of urban communes and sub-prefects to increase their ownership and obtain their support for routine immunisation • Conduct high-level advocacy meetings with religious leaders in Conakry • Train 91 journalists and facilitators (2 x 33 health districts and 5 x 5 communes in Conakry) and radio station directors • Produce radio commercials in French and five national languages (Soussou, Malenke, Poular, Kpele, and Kissi) • Produce TV commercials in French and five national languages (Soussou, Malenke, Poular, Kpele and Kissi)

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

⁵ Ibid.

	<ul style="list-style-type: none"> Establish a contract with seven television channels to disseminate messages promoting routine immunisation Train eight managers in the EPI and Ministry of Health communication unit in strategic communication Train one communication focal point in each of the 8 regions, 38 health districts and 412 health centres.
Objective 5:	
Objective of the HSS grant (as per the HSS proposals or PSR)	Reduce the gap between the Penta3 administrative data and data from the Penta3 immunisation coverage survey from 30 points in 2015 to 5 points in 2021
Priority geographies/population groups or constraints to C&E addressed by the objective	<ul style="list-style-type: none"> 21 priority districts
% of activities conducted/ budget utilisation	<ul style="list-style-type: none"> 6 of 15 activities conducted
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	<ul style="list-style-type: none"> Revise/adapt data management tools to integrate them with DHIS2 Copy the revised data management tools from the child survival and development programme Produce and distribute national and quarterly newsletters on child survival Joint appraisal Take on a NOB data manager technical assistant for the central level Take on nine NOA assistants recruited for data management Counter-monitoring of activities in the 21 priority districts
Major activities planned for the upcoming period (mention significant changes/budget reallocations and associated needs for technical assistance) ⁶	<ul style="list-style-type: none"> Recruit one IP data manager to integrate EPI indicators into the DHIS2, support the data manager network in regional health departments and set up/facilitate the CAQD (data quality improvement committee). Organise immunisation and surveillance data quality audit missions by the central level to districts and regions Support the financial balance sheets of health centres (once per year for the first two years and then once every two years) Train management teams from the central, regional and prefecture level on the use of data management and evaluation tools

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

Guinea receives CCEOP support with the implementation process being established. The following are expected shortly: 848 refrigerators, 5 Arkteks and 2,000 continuous temperature loggers.

The table below summarises the key information concerning the amount requested for the next year

Total amount of CCEOP grant	US\$ 15,390,320
Duration of CCEOP grant (from... to ...)	March 2017-December 2019
Year/period for which CCEOP renewal (next tranche) is requested	2019
Amount of CCEOP renewal request	No CCEOP renewal request is planned. However, by the end of March 2019 Guinea is planning to submit a request for an additional US\$ 5,060,022 of funding for its HSS to purchase the equipment included in the CCEOP for 2019 and 2020 that was not purchased with the initial CCEOP grant.

⁶ Ibid.

Country joint investment	Country resources	
	Partner resources (World Bank)	US\$ 126,240 Purchasing cold chain equipment
	Gavi HSS resources	Co-investment 2018: US\$ 187,269 2019: US\$ 769,181

4.4. Financial management performance

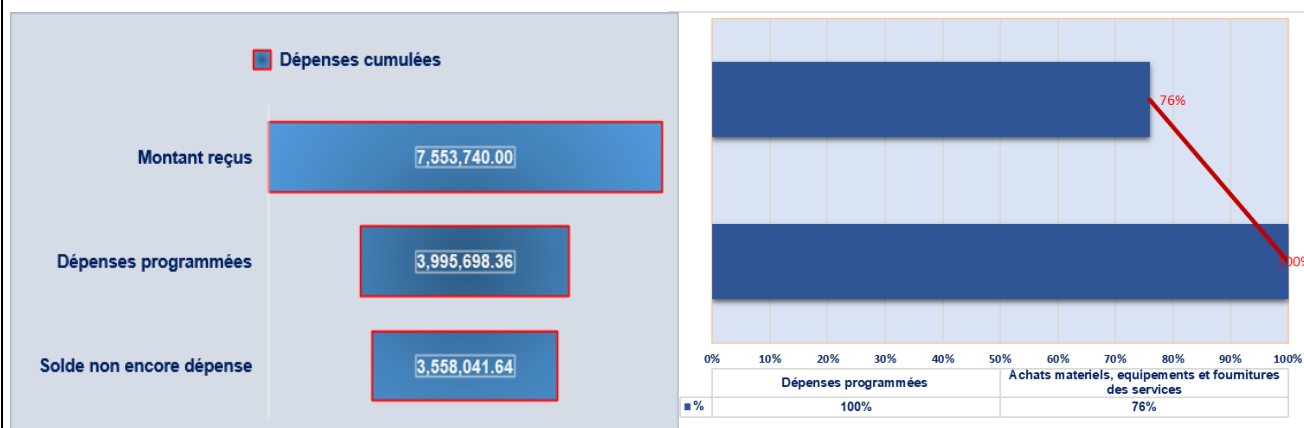
The EPI's operational activities in 2017 were funded by TFPs in the amounts of **58,138,513,978 Guinean francs (GNF)** in 2016 as compared to **38,223,882,451 GNF in 2017**. The increase in total EPI grants is due to the nine campaigns conducted in 2016, versus four in 2017.

Grants for the operational costs of the four 2017 campaigns are estimated to be **28,712,724,200 GNF**. The EPI received a total of 33,223,583,640 GNF for the four measles response campaigns: 28,712,724,200 GNF for operational costs and 4,510,859,440 GNF for social mobilisation activities (*source: EPI 2017 annual report*). There were no grants for the introduction of new vaccines in 2017.

Overall summary on the use of Gavi HSS2 funds from 21 September 2017 to 31 July 2018

Of the total amount, **US\$ 15,107,479**, that was agreed on in the tripartite agreement, 50% (US\$ 7,553,740) was transferred to UNICEF and received on 21 September 2017 (grant activation date in the UNICEF system).

Overall summary of the use of Gavi HSS2 funds from 21 September 2017 to 31 July 2018



Above figure:

- Cumulative expenditures
- Amount received
- Programmed expenditures
- Balance not yet spent

- Programmed expenditures
- Purchase of materials, equipment and service delivery

Programmed expenditures (effective and commitments) account for approximately US\$ 3,005,698.36 (55%), with US\$ 3,558,041.64 (47%) remaining. The purchase of materials and equipment and service delivery represents 76% of all programmed expenditures (details in Annex 1).

There was **compliance** with financial reporting and audit requirements (listing the compliance with each cash support grant separately, as above).

Financial management systems: While waiting for the suspension measure to be established, the tripartite agreement is being managed by UNICEF in accordance with the modalities defined in that agreement.

Funds	Agreements	Reporting	Disbursement process	Stakeholders	Procurement

HSS2	Grant agreements	UNICEF procedures	<ul style="list-style-type: none"> • Direct procurement through the procurement centre or approved suppliers • Direct payment of activities upon official request by the Ministry of Health as per the tripartite agreement • Funds made available quarterly 	MPH (BSD, EPI, RHD)	<ul style="list-style-type: none"> • UNICEF procedures for UNICEF purchases because the EPI does not yet have a procedures manual
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4.5. Transition planning (if applicable, eg country is in accelerated transition phase)

According to Gavi's classification, the Republic of Guinea falls in the category of countries in "initial self-financing" of the immunisation programme, with a per capita gross national income less than or equal to US\$ 1,045. The Government's share of vaccine co-financing is therefore US\$ 0.20 per dose.

The country has not yet reached the stage of transition planning. However, advocacy activities are under way to vote on a law to promote immunisation and increase the EPI health budget accordingly.

A tripartite agreement was signed between the Government, Gavi and UNICEF as part of HSS2 grant management and support for immunisation from 2017 to 2021. This grant will help retain previous gains and targets 21 underperforming priority health districts selected on the basis of clearly defined criteria, across the eight regions.

As a reminder, the criteria used to categorise health districts as underperforming were:

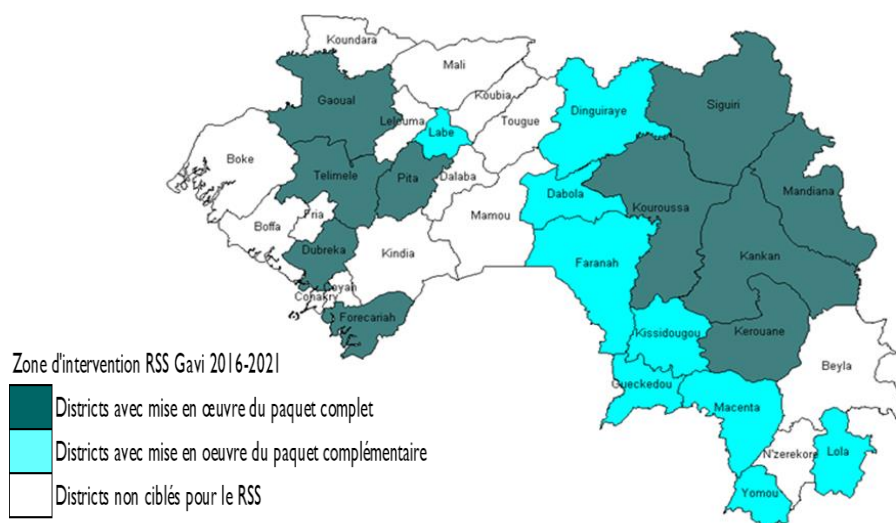
1. Penta3/MCV IC < 80%
2. Percentage of children aged 12-23 months who have not received any routine vaccine doses
3. No TFPs in the districts

For Gavi support, these 21 health districts have been subdivided into two categories, depending on the complementarity with interventions:

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

(b) Category 2 (9 districts): Districts where the complementary package (vaccines/logistics) will be provided for the interventions proposed by the TFPs present in those districts. The organisations include the World Bank (project to improve primary health care), GF (support for health system strengthening for AIDS, malaria and tuberculosis), German Cooperation (projects to improve mother and child health coverage in vulnerable zones), French Cooperation (capacity building for biomedical diagnoses at health facilities) and USAID (project for surveillance and international safety in health). The districts are: Labé, Dabola, Dinguiraye, Faranah, Kissidougou, Gueckedou, Macenta, Lola and Yomou.

Gavi-HSS2 intervention areas



Gavi HSS intervention areas 2016-2021

Green: Districts with implementation of comprehensive package
 Blue: Districts with implementation of complementary package
 White: Districts not targeted for HSS

Note that district classifications are currently being reassessed to determine which districts will receive the HSS2 grant.

The grant helps with the continuity and extension of previous Gavi interventions, with the Government recruiting and deploying 4,460 health workers in all positions in 2017. Current government initiatives include: gradual recruitment of 2,000 health workers per year; implementing the national compact; increasing the grant to benefit health facilities; committing to gradually raising the budget share allocated to the health sector from 4% in 2016 to 10% by 2020; and, as a result, supplying the budget line item and effective disbursement of funds for immunisation. Other plans include strengthening the consultation framework with TFPs and the gradual appropriation of domestic funding sources for the health sector. All of these collaborative initiatives work towards sustaining investments.

4.6. Technical assistance

UNICEF PEF 2017 technical assistance

- One NOC technical assistant (specialist in HSS) recruited in 2017, who supports strategic planning and accountability, EPI inter-sectorality and EPI/HSS coordination body operations (inter-sectorality): (i) 100% of CTRS meetings held in the eight regions and 38 districts; (ii) accountability frameworks established in 13 communes with low IC in the Kankan and Faranah regions; (iii) support for national and decentralised planning using harmonised planning tools; (iv) support for developing eight regional integrated OAPs and a joint health sector OAP.
- One P3 technical assistant responsible for the cold chain and logistics supported organisation of the vaccine and inputs distribution chain, strengthened the temperature control and surveillance system, helped implement the EVM improvement plan and supported capacity building in logistics management: (i) 178 health workers and providers were trained in EVM, 7,240 immunisation workers were trained in immunisation practices including EVM; (ii) SMT is available and has been shared. However, there have been delays in updates and sharing with partners. An analysis was performed and shared.
- UNICEF also received five NOB technical assistants (one based in Conakry and four in area offices) who supported implementation of the REC approach, taking specific groups and hard-to-reach populations into account. They also helped to implement innovative strategies to reduce inequities. Technical and financial support was provided for conducting supportive supervision in the convergence communes, including hard-to-reach communes in the Labé, Kankan and Faranah

regions (16 health centres), with significant advocacy with administrative and local officials to promote immunisation, catching up hardship sheets, mapping hard-to-reach areas and updating outreach strategies. Support was given for developing microplans and implementing outreach strategies in convergence communes.

WHO PEF 2017 technical assistance

- NITAG was established in anticipation of new vaccine introduction: two technical assistants (one P3 and one NOB) were recruited to develop terms of reference and have them validated by group members. The decree creating the NITAG was drafted and signed.
- One technical assistant was recruited to monitor the drafting and signing of the decree creating the National AEFI Experts Committee and the validation of the AEFI surveillance guide. The technical documents validated by the ICC, along with the ministerial decrees concerning the committee and the group, allow members to hold technical meetings as part of governance of the immunisation system.
- For logistics, two experts (one national and two international) were recruited by WHO and an operational plan for biomedical waste management was developed; this plan is available but not validated.
- The process of recruiting nine data managers to strengthen immunisation data quality began in 2017 and was completed in February 2018. These data managers are currently working to improve data quality (such as completeness/timeliness, internal consistency, developing and implementing microplans to improve immunisation data quality in health districts).

JSI 2017 assistance

Additional technical assistance was provided to the EPI in 2017 by JSI through one technical advisor and one EPI logistics technician based at the EPI's coordination office. Four interventions areas were targeted and planned activities have been conducted. These areas are:

- supporting implementation of the Reach Every District/Reach Every Community approaches in three regions;
- building the skills of staff members, including those recently recruited in the Conakry region, for appropriate management of routine immunisation;
- improving the system for monitoring immunisation and the use of quality data to make decisions; and
- implementing the improvement plan for vaccines and the logistics system.

JSI also supported the central level in planning and implementing other activities at the EPI's request (such as supplementary immunisation activities, surveillance, MNT risk assessment and DQS).

HSS2/TCA technical assistance

The process of recruiting technical assistants began in 2017 and continued into 2018 (some are still ongoing), including:

UNICEF

During 2018, UNICEF's technical assistance focused on transferring skills at the national, regional and district levels. Coordination bodies at the national level were actively involved in monitoring the implementation of grant management requirements that came out of the programme capacity assessment. Two accountants were assigned to the central EPI team (beginning in September 2018); regional accountants were evaluated through a capacity building plan; a financial management manual for Ministry of Health funds was developed with the IGF and the ministry's Accounting and Finance Division; and 21 focal points were chosen and recruited. A G6 accountant for HSS2 was recruited by UNICEF and deployed to the EPI to strengthen its accounting unit. High-level advocacy led to CCEOP appropriation and commitment by the Ministry of Health to cover the costs of customs clearance and renovation of the sites scheduled to receive the cold chain equipment. The process to facilitate the HSS1 grant audit was conducted in 2018; accounting management tools have been available since 2017 in the regional and prefecture health departments, which are monitored through occasional checks and scheduled visits. Technical and financial assistance was provided to draft strategic documents, ie, the measles elimination plan, the 2019 measles campaign plan, the plan to introduce MCV2 into the EPI, the external EPI review, and the joint appraisal. Communication assistance included setting up the contracting process with CSOs

and national and local radio and television stations, and support with establishing a mechanism for coordinating and monitoring health promotion communication, all providing an opportunity to revitalise community participation structures.

These results were obtained with support from the human resources provided as part of the 2018 technical assistance, including two P3 (one immunisation specialist and one cold chain/logistics specialist), seven NOB (five immunisation, one maintenance technician and one C4D), eight NOA C4D and one G6 accountant.

WHO

- One P3 (external EPI review)
- One NOC (external EPI review)
- One NOB data manager
- Eight NOA data managers

However, despite progress (strategic EPI documents drafted, technical groups established, REC approach implemented, hard-to-reach populations taken into consideration, EVM improvement plan), the regular course of the technical assistance plan was complicated by implementation problems. These included:

- problems mobilising technical assistants internationally;
- short consultation timeframes for international stakeholders;
- under-estimating costs;
- delays in releasing Gavi-TCA funds;
- interference in operational activities (such as mass campaigns); and
- slow appropriation of fund management requirements.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Put immunisation independence in effect (vaccine/input/management tool procurement by the government + co-financing)	Ongoing
2. Implement the ICP (integrated communication plan)	
3. Involve civil society in communication, advocacy and social mobilisation in support of the EPI by setting up a coordination framework	Ongoing
4. Improve governance, leadership and management of immunisation services at all levels	Ongoing
5. Distribute human resources equitably across the entire country	Completed: Nearly 4,460 newly recruited workers have been assigned to regions and health districts
6. Include vaccinology in the training curricula for health workers	Ongoing, with WHO support
7. Strengthen logistics: cold chain, transportation (trucks, 4x4 vehicles, motorcycles), monitoring cold chain T°	Ongoing
8. Revise, standardise and disseminate EPI management tools at all levels	Completed
9. Strengthen SNIGS including immunisation data management/quality	Ongoing
10. Conduct regular supervision missions to better monitor and manage health workers	Completed
11. Improve health coverage, including extending immunisation services by including the private sector, religious facilities, military health services, health posts	Ongoing
Additional significant IRC/HLRP recommendations (if applicable)	Current status

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

Overview of key activities planned for the next year:

Objective 1: Increase the functionality of health districts, especially the 21 target districts, from 52% in 2015 to 80% in 2021

1. Support the operations of coordination entities at all levels (CCSS, CRCSS, CPCSS, CTC, CTRS, CTPS/CTCS, CTSPS and annual joint appraisals of the health sector).
2. Support setting up health system accountability frameworks at the central and decentralised levels.
3. Support setting up a framework for mobilising domestic resources to create a common fund for HSS and immunisation that considers the issue of equity.
4. Support recruiting workers and building skills by establishing an incentive system that attracts and retains health workers.
5. Operationalise the NITAG and AEFI committee.

Objective 2: Increase the coverage of fully immunised children in the 21 target districts from 53% in 2015 to at least 80% in 2021

1. Support the introduction of fixed location immunisation services in 300 new immunisation sites (health posts, not-for-profit private and denominational facilities, garrisons) as well as the outreach and mobile strategies.
2. Effectively implement and supervise the RED/REC approach in the 21 target health districts, taking immunisation equity into consideration.
3. Support the introduction of new vaccines into the routine EPI while strengthening surveillance of AEFIs and vaccine-preventable diseases.

Objective 3: Raise the average EVM score from 37% in 2016 to at least 80% by 2019, and maintain it until 2021

1. Implement the EVM improvement plan developed in 2016.
2. Strengthen the supply chain in terms of both quantity and quality (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. Provide health centres in the target area with small-capacity solar incinerators.

Objective 4: By 2021, at least 95% of parents of the target population in the 21 selected health districts request immunisation services as a right

1. Organise advocacy sessions targeting authorities, members of parliament, community and religious leaders and economic operators to obtain their involvement in and support for immunisation activities.
2. Support intensified information activities through mass media and awareness raising at the community level to increase understanding of and compliance with immunisation.
3. In addition to the immunisation equity analysis that UNICEF will conduct, a socio-anthropological survey will be organised to identify immunisation bottlenecks in order to transform paradigms and negative perceptions in society into positive views of immunisation.

Objective 5: Reduce the gap between the Penta3 administrative data and data from the Penta3 immunisation coverage survey from 30 points in 2015 to 5 points in 2021

1. Support activities involving the collection, analysis, transmission, dissemination, archiving and self-evaluation of data quality (DQS) and quality control (DQA) of health data at all levels of the healthcare pyramid related to the DHIS2 and the DVD-MT.
2. Support activities in training, integrated supervision, decentralised monitoring and reviews.
3. Conduct the studies and surveys needed to evaluate the effects of health interventions and to understand the causes of bottlenecks (KAP survey, coverage evaluation survey, socio-anthropological studies).
4. Establish and operationalise the data quality improvement committee.

5. Incorporate EPI data in the DHIS2 and make sure that the system is interoperable with the DVD-MT.

Key finding/action 1	Establish an accountability framework that integrates the region/prefecture health department performance mechanism with redefined roles for technical assistance as part of HSS2 at the intermediate level
Current response	RBF pilot funded by the World Bank
Agreed country actions	Revision of the institutional framework for regional and prefecture health departments based on their coordination missions
Expected outputs/results	- Tools to evaluate district operations are in place - Accountability framework that integrates the region/prefecture performance mechanism is in place
Associated timeline	By the end of 2019
Required resources/support	Support from technical and financial partners
Key finding/action 2	Organise follow-up campaign against measles in November 2019
Current response	Waiting for approval and funding from Gavi
Agreed country actions	Document validated by the ICC and submitted to the Gavi portal
Expected outputs/results	The immunity of at least 95% of target children to measles is strengthened
Associated timeline	Schedule developed and available
Required resources/support	US\$ 3,774,119
Key finding/action 3	Introduce MCV2 into routine immunisation in December 2019
Current response	Guinea's application for technical and financial support was submitted to the Gavi portal
Agreed country actions	Document validated by the ICC and submitted to Gavi, incorporating Gavi's observations on Guinea's support request
Expected outputs/results	The second dose of the measles vaccine is introduced into routine immunisation
Associated timeline	Schedule developed and available
Required resources/support	US\$ 422,841
Key finding/action 4	CCEOP
Current response	CCEOP implementation (848 refrigerators and 5 Arkteks expected shortly)
Agreed country actions	Customs clearance, transit costs paid, technical monitoring committee established, doors widened
Expected outputs/results	Refrigerators installed, operational and followed up with preventive maintenance
Associated timeline	Next steps implemented
Required resources/support	US\$ 15,390,320
Key finding/action 5	Improve the quality of EPI data
Current response	Continue setting up the DHIS2, incorporating key EPI indicators
Agreed country actions	Recruit one IP data manager to transition to the DHIS2 as part of WHO/TCA
Expected outputs/results	<ul style="list-style-type: none"> • Key EPI indicators are incorporated into the DHIS2 • CAQD is operational • Regional health department data managers know how to use the DHIS2 • Quality improvement plans are developed and implemented in health districts • Discrepancies between self-reported IC and verified/audited IC decrease by at least 50 percentage points
Associated timeline	May 2019 - April 2020
Required resources/support	TCA funds/2019

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

The ICC for the EPI in Guinea was created by a ministerial decree dated 19 January 2001. In 2017, the ICC responded on the basis of its terms of reference to Gavi requirements regarding its composition, mandate and governance.

Out of a concern for performance and to include feedback from similar countries, Gavi asked for this committee to be restructured. Consultations therefore started in 2017 among the various members (EPI, institutions, ICC, etc) that led to a new decree being written and endorsed in 2018; this decree is now in the process of signature.

8. ANNEX: Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF)* reporting against all due indicators			
Financial Reports*			
Periodic financial reports			
Annual financial statement			
Annual financial audit report			
End-of-year stock level report (to be provided by 15 May for vaccine renewal requests)			
Campaign reports*			
Supplementary Immunisation Activity technical report			
Campaign coverage survey report			
Immunisation financing and expenditure information			
Data quality and survey reporting			
Annual data quality desk review			
Data improvement plan (DIP)			
Progress report on data improvement plan implementation			
In-depth data assessment (conducted in the last five years)			
Nationally representative coverage survey (conducted in the last five years)			
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
(CCEOP): updated CCE inventory			
Post-Introduction Evaluation (PIE)			
Measles & rubella situation analysis and 5-year			
Operational plan for the immunisation programme			
HSS end-of-grant evaluation report			
HPV-specific reports			

Reporting by partners on TCA and PEF functions			
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In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.

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9. ANNEX: Summary of recommendations from the joint appraisal

No.	Recommendation	Responsible party	Deadline	Support partners
1	Develop the annual operations plan for the 2019 EPI with a detailed budget	National EPI coordination	Before end of November 2018	Alliance partners
2	Develop budgeted microplans in the 13 districts with the highest number of unimmunised children (include targeted urban strategies)	National coordination of the EPI, regional and prefecture health departments	Before end of Q1 2018	Alliance partners
3	Begin the process of developing an additional proposal with HSS2 platform funds			Alliance partners
4	Finalise the process for verifying accountant skills in regional health departments and report to the secretariat on whether any recruitment will be needed	Secretary General of Health	By end September 2018	Alliance partners
5	Finalise the external EPI review and share the report with partners and the consultant who helped prepare the EPI's 2019 action plan	National EPI coordination	By end October 2018	Alliance partners
6	Inform the Gavi secretariat of the decision regarding the construction of a storage facility and EPI offices	National EPI coordination	Before end of November 2018	
7	Finalise and operationalise the supply chain model with revised vaccine distribution diagrams	National EPI coordination	Before end of November 2018	
	Finalise and operationalise the supply chain model with revised vaccine distribution diagrams			